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Key Considerations For Collaborative School-Based Mental Health Services: Partnering Community Psychology Principles With Systems Of Care Methodology To Address Issues Of Stigma

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Key Considerations For Collaborative School-Based Mental Health Services:

Partnering Community Psychology Principles With Systems Of Care

Methodology To Address Issues Of Stigma

A Dissertation

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Antioch University Seattle
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By

Brittany L. Foxley

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KEY CONSIDERATIONS FOR COLLABORATIVE SCHOOL-BASED MENTAL HEALTH

SERVICES: PARTNERING COMMUNITY PSYCHOLOGY PRINCIPLES WITH SYSTEMS OF

CARE METHODOLOGY TO ADDRESS ISSUES OF STIGMA

This dissertation, by Brittany Foxley, has
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DOCTOR OF PSYCHOLOGY

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ABSTRACT

KEY CONSIDERATIONS FOR COLLABORATIVE SCHOOL-BASED MENTAL HEALTH SERVICES: PARTNERING COMMUNITY PSYCHOLOGY PRINCIPLES WITH SYSTEMS OF CARE METHODOLOGY TO ADDRESS ISSUES OF STIGMA

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Mental health issues among school-aged children are a growing concern and subject of intervention and prevention studies nationwide. While several implementation and service delivery models exist for school-based mental health services (SBMHS) they are often localized, population or program specific, and do not adequately address the issues related to stigma. Building on Cook and Kilmer's 2012 article integrating community psychology principles and systems of care values, a review of the literature is conducted to identify issues and barriers from stigma in current school-based and mental health service delivery. Key guidelines and specific considerations are presented to address identified limitations and augment the current implementation models for collaborative SBMHS through the practical application of community psychology principles. The creation and function of a coalition in the spirit of collaboration uniquely provided by partnering systems of care & community psychology principles is a central component. While the main focus and application of these objectives is at the micro and exosystem levels for change, the local community and school, school district and state, they can also be integrated at the macrosystem level for initiatives, legislation, and policy changes. This dissertation is available in open access at AURA, http://aura.antioch.edu/ and Ohio Link ETD Center, https://etd.ohiolink.edu/etd

Keywords: School-based mental health, stigma, community psychology, systems of care, school-based mental health implementation model, school-based mental health services, children's mental health, bioecological model

Dedication

This dissertation is dedicated to everyone who has been affected by issues of stigma regarding mental health.

Acknowledgments

First and foremost, I want to express my gratitude to all the children, families, and professionals I have had the honor to work with, learn from, be challenged by, celebrate, and support through the years past and in those to come. I dedicate this work to you. I want to acknowledge my editor and dissertation committee for their support and mentorship throughout this ever-evolving project and my epic writing blocks. Lastly, I want to acknowledge my dear friends and the many various individuals who encouraged and helped me in a myriad of ways during this process. I could not have done this without you.

Personal Rationale

After completing a year and a half of clinical training at an elementary school serving children of homeless families and the subsequent failure of my first dissertation project, my collaborative spirit diminished. During my last six months at the school, along with three other doctoral psychology students, we conducted a pilot study that used a mixed qualitative and quantitative survey to obtain caregiver, staff, and faculty's views and experiences of mental health services within the school. No caregiver surveys were returned. We speculated that the surveys may not have been returned in part due to delays resulting in their distribution during the last two weeks of the school year. Additionally, when we reviewed and discussed the findings with the school, questions arose regarding caregiver possible concerns about stigma when questioned about mental health services and history even though the surveys were anonymous and protocols for protecting anonymity were maintained.

From the pilot study, and through my clinical work at the school, I established relationships with stakeholders for a full program evaluation of their SBMHS as my dissertation project. The proposed study passed the institutional review board when changes in structure, status, and administration at the elementary school rendered the project unfeasible. I felt defeated, limited by a changing system shrouded in politics, and struggled with how to salvage what I could from the work I had done thus far. Yet even more indelibly impactful, I saw the needs of the children remained, even intensified while the school-based mental health and other supports splintered or ceased, creating another enactment of traumatic experience, which so many of the students had already experienced in their young lives. The community felt the shockwaves of the sudden changes compounded with the structural changes they knew were coming in terms of the transition to charter school status.

The resulting fractures that were at first minor on the surface, now ran deep. Later, just a few days before the next school year was to begin, the board president announced that only kindergarten, first, and second grades would be taught. The school closed its doors to the enrolled third through fifth graders.

As the school radically reorganized, I struggled with an inner conflict of working clinically to the best of my ability within broken systems and felt overwhelmed with a desire to effect positive change at a time of diminished resources. Furthermore, I felt stifled by pressures in the field for quantifiable research and scientism that did not reflect the qualitative, contextualized, and multidimensional aspects of collaborative SBMHS. I was eager, but I knew I had to learn more about myself, and the field. I strove to understand what happened and to ground myself in the collaborative spirit of the work again.

Through my coursework with Dr. Philip Cushman and discussions with fellow students, I came to better understand the conflict I was experiencing through the lens and language of hermeneutic philosophy and the postmodern critical writers of a movement called the sociocultural turn (Cushman, 2012; Kirschner & Martin, 2010; Stern, 2013). While Western psychology has made great strides and benefitted many people, these writers pointed out there is a tendency to promote theories, treatments, and frameworks that present a person as self-governing, self-contained, ahistorical, and whose behaviors are to be understood and treated with empirical research and evidence-based modalities. This has unwittingly resulted in a narrower, flattened perspective that has shifted away from the sociocultural, historical, and moral dimensions of human existence toward more prominent individualistic and scientific modalities in theory and practice (Cushman, 1995, 2012). Richardson, Fowers, and Guignon (1999) aptly

reflected the issue at hand in their statement, "Few psychologists critically evaluate the metaphysical and moral underpinnings of their methods or theories" (p. 173).

Grounded in the works of Heidegger and his pupil Gadamer, ontological hermeneutics focuses on understanding the shared meaning making that brings the world to light from particular cultural perspectives (Cushman, 1995; Fleming, Gaidys, & Robb, 2003; Gadamer, 2004; Stern 2013). In hermeneutics people are understood as linguistically shaped, culturally embedded interpreters of experience and self. When people come together to form a community, they develop social practices and begin doing things a certain way as they establish and work toward common goals (Gadamer, 2004; Taylor, 2002). These goals become valued as something worthwhile, with language that implies a certain way of seeing things, interpreting the world or situation as a communal way of life is created based on this shared meaning (Gadamer, 2004; Stern, 2013). Over time, the origin and reasons for these goals and values evolve and are sometimes obscured. Hermeneutics provides a powerful way to examine the implicit assumptions, meanings, and values from ideologies that govern social practices when applied to clinical psychology.

By engaging in a hermeneutic reflection, I began to recognize I was not alone as I came to understand some of the reasons for the difficulty I was having and inner conflict I was feeling stemming from my own cultural and historical context and experiences. Clinically, I wanted to understand the way families viewed and experienced mental health services. It was becoming clearer to me that barriers related to stigma were present and not being addressed, even within a wraparound setting. I recognized I needed to also understand more deeply my own beliefs about what is and should be for these cannot simply be bracketed off but indeed inform and influence how I interact and practice. It felt especially important to be clear about what it meant for me to

practice as part of a system and avoid contributing to stigma and barriers, and reduce the likelihood that I would be perceived as an "expert" that is distant, above, or superior. Rather, I sought to become an effective, compassionate, reflective, and responsible person in my work, and with each person and system encountered.

A dialogue about issues related to stigma in children's mental health specifically seemed to be missing at the family, school, organizational and community system levels. It is the ontological hermeneutic cycle that fosters deeper questioning and surfaces biases as the nature of our experiences and sense of reality are examined. With this curiosity and the hermeneutic lens, I could explore ways to have ongoing dialogue that might begin to address the stigma and barriers when collaborating to provide SBMHS. This requires holding space for myself and each child, parent, and professional I work with in their social, political, historical, and cultural context, while also questioning the language we use, its context, and implications.

While I recognized a hermeneutic study of stigma in children's mental health was warranted, it was not feasible for me to undertake it at that time, when a program evaluation had been the original study. I decided to use my hermeneutic grounding to create a discourse using the current language in community psychology and systems of care through a bioecological framework to understand the issues of stigma in children's mental health. While continuing in my clinical and coursework, I returned to the research articles I had reviewed in my community psychology course with Dr. John Moritsugu and a project for which I focused on the intersectionality of SBMHS and community psychology. I reread the 2012 article by Cook & Kilmer titled, "Systems of Care: New Partnerships for Community Psychology" and eventually, returned to Wolff's chapter on "Engaging Spirituality as Your Compass for Social Change" (2010, p. 197). Through these readings, my professional work,

personal experiences, and research, I began to increase my questioning about barriers and wonder about the impact of stigma. I became particularly interested in how the role of stigma impacts families and children, especially in low socio-economic populations such as the ones I had worked with at the school. I began to see a way forward, how to use my experiences and learning, passion and spirit, and a hermeneutic-informed lens to contribute to and facilitate a discourse to aid in addressing the limitations in current SBMHS programs and implementation models pertaining to issues of stigma.

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Introduction

Children's mental health is an essential part of a child's overall health. Mental health for

children means reaching developmental, psychological, and emotional milestones, learning

social skills, and coping with stress and challenges (American Psychological Association [APA],

2004; Centers for Disease Control and Prevention [CDC], 2013). Childhood mental health

disorders or conditions are generally defined as significant differences in the way children

behave, learn, or express their emotions that cause distress and problems self-regulating, relating

to others, getting through the day, and succeeding in school (APA, 2004; CDC, 2013). Examples

of mental health problems may include self-harming, anxiety, depression, attention-

deficit/hyperactivity disorder, learning disorders, cognitive and developmental disabilities, as

well as social, emotional, mood, and behavioral disorders (CDC, 2013; Merikangas et al., 2010).

Given that half of all lifelong mental illnesses begin by age 14, and an estimated 79% of children

and adolescents are not receiving any mental health care, profound and longstanding impacts

result for the individual and society (CDC, 2013; Kataoka, Zhang, & Wells, 2002; Kessler et al.,

2005).

In 2013, the CDC estimated that in a given year up to one in five children aged three to

seventeen experience a significant mental health problem. During childhood and adolescence,

the brain undergoes significant developmental changes, establishing neural pathways and

behavior patterns that will last into adulthood (National Research Council and Institute of

Medicine, 2009). Adolescence, in particular, is a critical period for mental, social, and emotional

wellbeing and development. Because their brains are still developing, adolescents are more receptive to the positive influences of appropriate interventions, social and emotional learning, and behavioral modeling (Cicchetti & Cohen, 2006). In 2007, the annual cost of these mental health concerns was an estimated $247 billion to families, individuals, and society (National Research Council and Institutes of Medicine, 2009). Given the significant personal, community, and system-level impact of mental health concerns among children, addressing means of treatment is a necessary area of focus both clinically and empirically.

The majority of mental health services for children are usually delivered as: (1) socio-economically based, through Medicaid state and federal programs; (2) community based, meaning that services are provided in community clinics or in the private practice sector; or (3) school-based, meaning that services are provided within the school or school district. Treatment for mental health conditions in children are most often comprised of individual/one-on-one therapy and/or group therapy/activities. While there is increasing concern for the mental health of school-aged children among families, individuals, professionals, and law makers, children and adolescents in schools experiencing mental health problems often remain unidentified and many do not receive services (APA, 2004; Ballard, Saunders, & Klimes-Dougan, 2014; National Association of School Psychologists [NASP], 2016). Students may not receive mental health services for a variety of reasons including, though not limited to; barriers from stigma, bias, cultural differences, lack of access due to transportation, lack of funding, lack of available professionals, and inconsistent services (Ballard et al., 2014; CDC, 2013; NASP, 2016; Ofonedu, Belcher, Budhathoki, & Gross, 2016). These barriers are particularly concerning, given that numerous studies show that early intervention and preventative treatment can have significant positive impacts, especially for more severe mental health conditions (Sanchez et al., 2018).

Stigma in mental health is generally conceptualized as the labeling, stereotyping, discrimination, separation, status loss, and power imbalance that can be experienced, perceived, and internalized (Corrigan & O'Shaughnessy, 2007; Phelan & Link, 2011). The present study aims to critically evaluate the extant literature relative to stigma as a barrier to the accessibility and feasibility of SBMHS for children.

Since the turn of the 20th century, educational school boards have noted the value of providing mental health services in schools, recognizing that mental health issues can negatively impact learning due to decreased motivation, reduced ability to focus, inability to self-regulate mood and emotion, and difficulty employing social skills. Nationally, school-based wraparound service models (i.e., set of services and supports that are individualized for children and their families to facilitate positive outcomes), which include mental health services have been on the rise (NASP, 2016; Office of the Superintendent of Public Instruction [OSPI], 2008). In 1992, federal agencies were prompted to action by a growing family movement to recognize the fragmentation and duplication of services, and the lack of coordination among agencies and funding streams. They further recognized reduced efficacy and even potential harm for children and families (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). In response, programs were created with the intent to integrate service delivery systems across mental health, education, child welfare, and juvenile justice for children and youth, from birth to age 21, diagnosed with a serious mental health condition with emotional disturbance. One of the largest ongoing programs is the Comprehensive Community Mental Health Services for Children and Their Families Program, created in 1992 under SAMHSA in the U.S. Department of Health and Human Services (2015). This program is now called The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances and is also known

as the Children's Mental Health Initiative (CMHI), authorized by public law 102-321 in 2013. While federal and state governments, schools, and agencies are making efforts to address the increasing rate of children's mental health needs, a 2013 study of eleven states found the availability of mental health services still lacking. Children of low socio-economic status were chronically underserved (Behrens, Lear, & Price, 2013). This study is consistent with the reports cited above. While the prevalence of children's mental health conditions continued to rise, services were not reaching those in greatest need: in residential institutions, foster care, juvenile justice and welfare systems, high poverty, minority children, and children within immigrant communities (Levine, 2015).

More recently, numerous SBMHS programs have been developed and researched, such as Social and Emotional Learning (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011) Cognitive Behavioral Intervention for Trauma in Schools, and Positive Behavioral Interventions and Supports (U.S. Office of Special Education Programs, 2017). These programs have been implemented using various models and frameworks (i.e., Interactive Systems Framework, Systems of Care [SOC], Multi-Tiered System of Supports, and Response to Intervention; Allen, Chinsky, Larcen, Lochman, & Selinger, 2017; U.S. Office of Special Education Programs, 2017). However, SBMHS programs and implementation frameworks that enhance service delivery by addressing barriers, particularly those related to stigma, are still lacking (Kaushik, Kostaki, & Kyriakopolous, 2016). Hinshaw (2005) predicted greater access, utilization, and positive outcomes for children with mental health concerns when the barriers from stigma are more thoroughly addressed and considered in SBMHS.

This critical review of the existing literature on children's mental health services focuses on the issues related to stigma. More specifically, this dissertation critically evaluates limitations of extant SBMHS. This is done with the aim of proposing key considerations and reasons for implementing a successful model of collaborative SBMHS that accounts for previously unaddressed barriers from stigma. Ultimately, this dissertation is undertaken with the goal of providing direction for addressing issues of stigma related to the accessibility, efficacy, quality, barriers, and overall success of SBMHS serving children and adolescents.

Problem Statement

There is growing emphasis on providing mental health services in schools due to the increasingly recognized impacts of mental health issues on learning, academic achievements, and behavior (CDC, 2013; NASP, 2016). The increased availability of evidence-based prevention and intervention programs along with growing national emphasis on students' mental health has contributed to a shift in research focus from efficacy to implementation and dissemination (Domitrovich, Gest, Jones, Gill, & DeRousie, 2010). However, the growing body of research in the development and employment of evidence-based implementation models often leaves out or gives minimal mention to addressing issues of stigma in seeking and accessing mental health treatment and services.

While stigma is a broadly recognized issue and potential barrier, there is a paucity of research on stigma as it pertains to child and adolescent development, mental health, and treatment. Contributing to the problem, the fields of community and school psychology have historically provided children's mental health services in parallel rather than in tandem, often with overlapping application and duplication of resources. This problem stands to be examined

through a lens that acknowledges and builds on the similarities of how children's mental health services are viewed and provided in a contextualized way.

Statement of Purpose

This project reviews the relevant literature on stigma and children's mental health, drawing connections between current and historical aspects of mental health services for children to understand how the issues of stigma are embedded at each level of interaction and intervention. Using a bioecological lens, a review of predominant school and community based mental health service models and frameworks is presented. This is followed by a proposal to partner community psychology principles with system of care methodologies to provide an opportunity to understand and address stigma-related issues of sustainability, efficacy, and barriers to mental health service access. Accordingly, the current project provides key considerations for the development and implementation of SBMHS with informed and contextualized considerations to address issues of stigma. The considerations presented aim to augment existing SBMHS programs and models to facilitate productive discourse and change that directly addresses stigma from the micro level of a child's community and schools, to the macro level through engagement with research, state and social policy makers.

Claimed Premises

While community based mental health services are important and impactful, this project assumes that the collaboration of communities and schools, professionals, agencies, universities, and policy makers, provides the best opportunity for a student mental health needs to be met. The key considerations are created and posited with the intent that they are relevant and applicable regardless of the program, implementation model, and diverse community composition including culture, race, ethnicity, spiritual beliefs, socio-economic status, and

diverse backgrounds. The issues related to stigma should not be special considerations, afterthoughts, or cursory mentions in the growing body of research and model development; rather, they should be at the forefront of development and promotion of models for SBMHS. Without this shift, well-intended individuals and groups risk unwittingly enacting bias, contributing to oppression and stigmatization, and creating additional barriers that inhibit the success of their models and programs.

Structural Framework: Bronfenbrenner's Bioecological Model

As children and adolescents are at the center of this project, Bronfenbrenner's bioecological model of a child's development is employed as the grounding framework for this investigation (2004). This model provides a visual illustration for the contextualized understanding of a child's development in the various systems and levels of interaction as issues of stigma are examined. According to Bronfenbrenner, the microsystem includes the child, and the structures and relationships with whom the child has direct contact, such as parents and caregivers. The interdependent and bi-directional connections between the structures of the child's microsystem are called the mesosystem (i.e., the parent's interactions with teachers). The exosystem contains the larger systems, social settings, and relationships that impact a child more indirectly through the microsystem, such as the school system, mass media, and extended family members. The larger macrosystem level comprises the attitudes, ideologies, customs, laws, and values of the culture and has a cascading influence throughout the interaction of all other layers. The chronosystem encompasses the dimension of temporal factors as it influences a child's development. This interaction level can be internal (i.e., the physiological changes that occur as a child ages) or external (i.e., the timing of a parent's death or another traumatic event). Bronfenbrenner's bioecological model has been expanded and redesigned herein to include

specific influencing factors such as personal technology, social media, and mental health care as illustrated in the figure and defined in Figure 1 and Table 1.
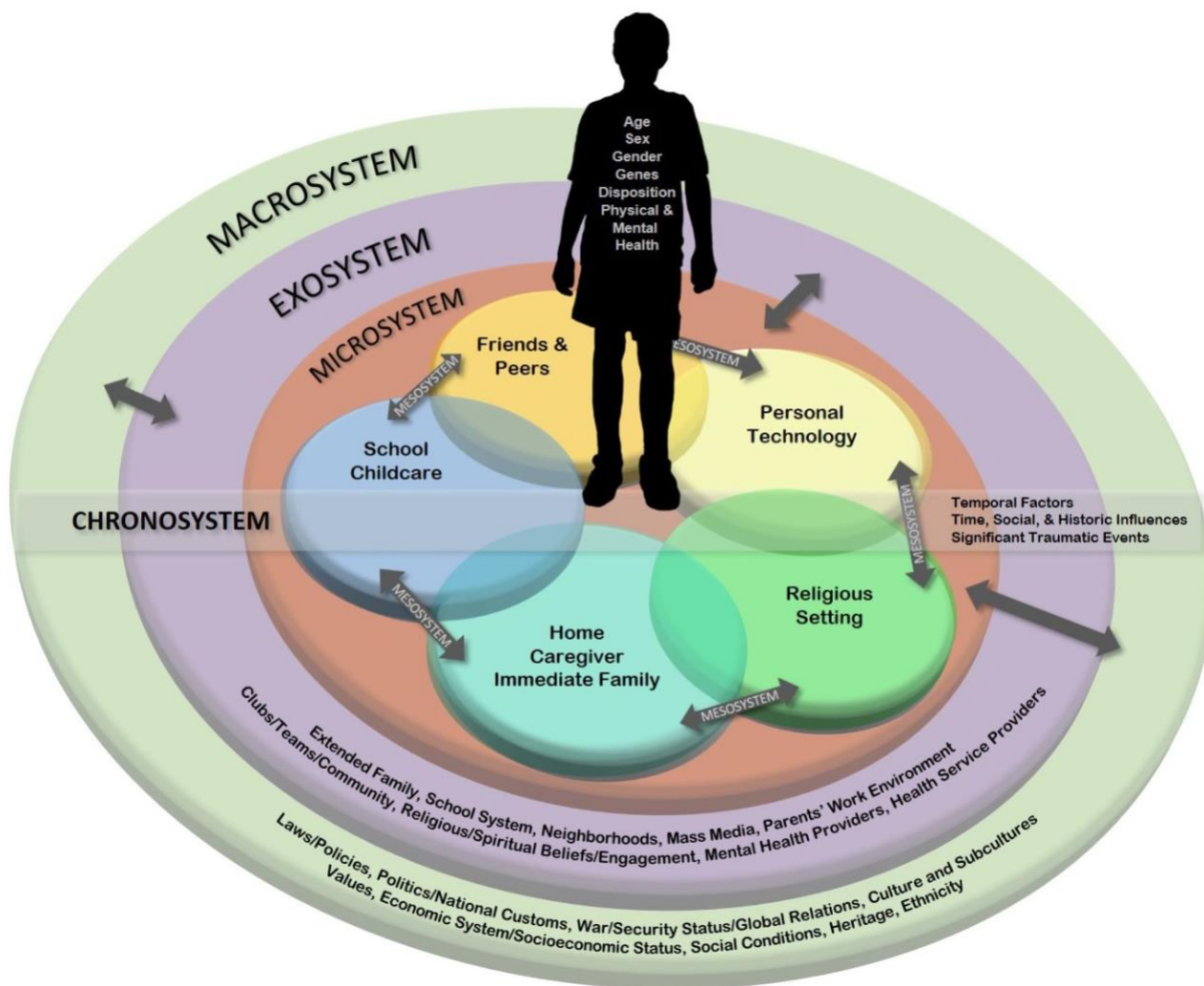

Figure 1. Adapted From Velez-Agosto, Soto-Crespo, Vizcarrondo-Oppenheimer, Vega-Molina, & Garcia Coll (2017).

Table 1

Adapted Descriptions of Bronfenbrenner's Bioecological Systems With Expanded Examples of Factors/Shaping Influences (2004)

System	Description	Factors/Shaping Influences
Microsystem The Individual is at the center	Aspects of the child and direct connections an individual makes within their immediate environment. The people, groups, and settings that a child interacts with on a regular basis.	Age Sex Gender Genetic/biologic composition Disposition Physical health Mental health
		Parents/caregivers School/daycare setting Siblings Friends/peers Home Environment Coaches/teachers Personal technology/media Religious setting
Mesosystem	Connections and relationships between systems and microsystems	(i.e., parent's interactions with teachers)
Exosystem	Larger systems and social settings that influence a child more indirectly through their microsystem	Extended family School system Neighborhoods Mass media Social media Parents' work environment Religious/spiritual beliefs/engagement Clubs/teams/community Mental health providers Health service providers Social services
Macrosystem	Attitudes, ideology, power, and relationships of cultures, states, and nations.	Laws/policies Politics/national customs War/security status/global relations Culture and subcultures Values Economic system/socioeconomic status Social conditions Heritage Ethnicity
Chronosystem	Any environmental event that happens during the course of an individual's life.	Temporal factors Social & historic influences Significant/cumulative traumatic events Developmental disruptions

Literature Review

Historical and Current Perspectives on Children's Mental Health

The labeling of emotional and behavioral concerns as mental health problems was not a construct that existed until the early 20th century (Cichetti & Cohen, 2006). Prior to the 1850s, and before the field of children's mental health began to emerge, manifestations of mental illness were conceptualized as moral deficiencies in the individual; and for children, also within their parents who must lack in parenting skills (Paternite, 2005; Taylor, Weist, & DeLoach, 2012). The notion of children's mental health policy could not exist until more recently due to children across all socioeconomic levels being seen as property parents could deal with as they pleased. This idea only began to shift in the mid-19th century when children were removed from immigrant families deemed too poor or unstable to care for them (Levine, 2015). At that time, the removal of these children was not as a matter of social policy or welfare any more than that of cattle; both were considered private property and thus remained outside of the public purview (DeMause, 2006).

The shift from viewing children as property is greatly complex, non-linear, and in many ways, still unresolved. Less than a century ago, children were expected to labor slavishly for the gain of those to whom they belonged. However, beginning with the post-industrial society's middle class, the purpose of childhood shifted to become the dominant social construct it is today. Childhood became viewed as an important time when children were prepared for the rigors of adulthood. The primary task of children, as it is considered currently, is that of healthy growth and development (Elkind, 1993; Levine, 2015). These types of dominant cultural shifts often precede changes in social policy and programming. For example, it was not until the child

was viewed as worthy of human rights and deserving protection that child labor laws were proposed for and enacted (DeMause, 2006).

Stemming from children's status as property whereby children were expected to behave accordingly, problems that evidenced as variant behaviors were not viewed in medical or psychological terms, rather as an issue of morality in the child and family (Cicchetti & Cohen, 2006). Values that were prevalent in the middle class began to influence the treatment of mental health issues. Those in higher socioeconomic classes could afford to give their children the time and freedom to play, explore, and follow their own interests (Devore & Schlesinger, 1991).

The first community-based "child guidance" clinics opened in 1922, commissioned for the prevention of juvenile delinquency. Some clinics had direct ties to juvenile courts, some were connected to schools, and others were oriented toward social reform and quality of life improvement for the impoverished population of children and adolescents primarily being served (Levine, 2015). However, the treatment populations of these child guidance clinics rapidly evolved to serve middle to upper class children and adolescents whose mothers who could participate in the "talking" therapies popularized in the burgeoning mental health field by Freud's increasing popular influence. By 1933, the focus of child guidance clinics had almost entirely shifted from social workers treating delinquency to providing clinic-based individual therapy for anxious Caucasian children of self-referred middle- and upper-class mothers (Levine, 2015). This early shift in focus foreshadowed the gap that continues today between services provided to children of different socioeconomic statuses.

Naturally, as the conception of children's mental health has expanded and shifted through time, the ways in which mental health issues are addressed have changed as well. The field of psychiatry, along with the parents who refused to accept the stigmatizing status quo of blame,

contributed to the shift toward questioning and beginning to understand mental illness in children as having biological etiology. The treatment of mental illness in children is now understood as needing intervention across the bioecological systems (i.e., biological factors, environmental factors, etc.; Bronfenbrenner, 2004) regardless of the cause of the problem (Stroul & Friedman, 2011). Child and adolescent mental health conditions can now be seen in much the same way that we view similar psychopathology in adults; psychological symptoms and experiences that impair or disrupt functioning in life domains (Cicchetti & Cohen, 2006).

Despite the progress in understanding the influencing factors of children's development and mental health, there has remained a bifurcation of mental health service provision between the middle- and upper-class families who can afford private treatment, and those of lower socioeconomic status who must rely on school-based and subsidized social services for treatment. Furthermore, minority children, and especially African American males, are often overdisciplined in what has been called the "school-to-prison pipeline," leading to disproportionate numbers of children funneled out of public schools and into juvenile justice systems (Schiff, 2013). Over 70% of children and adolescents caught in this pipeline have undiagnosed and untreated learning disabilities or other mental health issues and histories of poverty, trauma, abuse, or neglect (Schiff, 2013; Shufelt & Cocozza, 2006). As part of the exosystem, juvenile justice and child welfare systems are crucial components in providing safe and rehabilitative environments for children dealing with mental health issues. Although addressing mental health issues has been recognized as a crucial service for increasing children's rehabilitative success in these systems, reports consistently reflect the disparity between the population's needs and the available resources.

Systems of Care

Systems of care were first developed in the 1980s out of the federal push for integrated models of mental health service delivery specifically for underserved children and adolescents. Systems of care are currently defined as a coordinated network of community-based services and supports to meet the challenges of children and adolescents and their families (SAMHSA, 2015). Systems of care aim to provide collaborative, comprehensive, child and family-centered, culturally-relevant community-based mental health services (Stroul & Friedman, 2011). Stroul and Friedman, who have been involved in SOC development and research since the 1980s, released an updated report of SOC implementation in 2011. This most recent report found that after six months in services 28.4% of the over twelve thousand children and youth served nationwide in SOC showed a significant reduction in overall mental health symptomology. This number rose to 33.2% at twelve months and to 40.1% by eighteen months. Within this improvement, case management is one of the strongest components of system of care. Case managers link families with services, ensure good communication among providers, and help families identify resources.

In efforts to sustain SOC programs the 173 grant communities, comprised of both public and private organizations, were encouraged to expand the funding initially granted in 2008–2010 by developing ways to match federal grant dollars that slowly decline over the five-year funding period (Stroul & Friedman, 2011). Many of the grant communities, which included 21 federally recognized tribal communities, were able to sustain their programs by combining or blending funding from the mental health, juvenile justice, and child welfare systems to provide needed services. This type of coordination uses resources more effectively and increases the ability of service providers to coordinate care for children and youth who need services from multiple

systems of care. Of note, issues of stigma are only mentioned as needing attention and are not a key component in SOC service delivery.

Despite these efforts, current research shows that students receiving mental health treatment in community-based settings have more inconsistent participation than those served within the school setting (Merikangas et al., 2010; Weist, Ambrose, & Lewis, 2006). This may in part be due to SBMHS being perceived as more accessible by families (Green et al., 2013; Sanchez et al., 2018). An estimated 47% of students who sought mental health treatment did so from teachers, school psychologists, or school counselors (Green et al., 2013; SAMHSA, 2015). When mental health services are provided in the school setting, students have access to vital services without affecting caregivers' schedules, as well as reduced risk of interference from other mitigating circumstances, such as financial limitations (Ballard et al., 2014). Furthermore, the need for SBMHS was prescribed by the 2004 American Academy of Pediatrics Committee on School-Based Mental Health and the President's New Freedom Commission on Mental Health published in 2003. This national and state focus on mental health called for educators and mental health providers to collaborate to creatively solve the problems in providing SBMHS by partnering with community agencies, universities, and other professionals. To date, the SOC approach and proposed expansion strategies by Stroul and Friedman (2011) do not explicitly include increased collaboration with schools.

School-Based Mental Health

Nearly half, and by some estimates more, of school-age children first sought help for mental health issues from school staff (Green et al., 2013). Furthermore, few public schools have a mental health counselor on site and systemic school-based methods implemented for

providing mental health service interventions and prevention programs. Given the problems and disparities of community-based children's mental health treatment, and the widely recognized impact on a student's learning and education, teachers and school staff have found themselves on the frontlines of addressing and identifying affected children. In the programs for treating and preventing children's mental health issues that have been developed, they are often implemented by highly trained staff and outside providers rather than embedded school professionals under natural school conditions (Owens et al., 2013; Sanchez et al., 2018). Many such programs and their related research studies report efficacy and support for ongoing SBMHS. However, the aspects necessary for continued services that require attention to generalizability, feasibility, and sustainability (Sanchez et al., 2018), and issues of barriers such as stigma are notably lacking. More recently, SBMHS have been recognized as helpful in reducing the enduring disparities regarding access to children's mental health that have persisted in community-based services as they are perceived as less stigmatizing (Alegría, Green, McLaughlin, & Loder, 2015; Atkins, Cappella, Shernoff, Mehta, & Gustafson, 2017; Farmer, Burns, Phillips, Angold, & Costello, 2003).

With the federal mandate of "free and appropriate public education" (now known as the Individuals with Disabilities Education Act [IDEA]), children with serious emotional or behavioral conditions are entitled to assessment, therapeutic services, behavior management, and special classes or schooling in the least restrictive environment possible. If the necessary mental health services are not available, schools are required to use their own funds to send these students to specialized private residential or day schools. However, parents, caregivers, and advocates report that children are not receiving the necessary and appropriate mental services from the school systems (National Council on Disability, 2017).

Currently, mental health services are required to be provided for children and adolescents identified as having a disability under IDEA in a school setting. There remains a population of children and adolescents whose problems will not qualify them for these federally mandated services. The issue of access, level of involvement for parents and professionals, and which services are covered has led to extensive state and federal litigation (e.g., Board of Education v. Rowley, 1982; T.R. et al. v. Lashway and Teeter, 2009) with varied outcomes and more broad improvements despite extensive efforts being made.

Previous studies on SBMHS have provided support for prioritizing the integration of mental health services into schools. In a rigorous meta-analysis published this year, the authors studied the empirical literature on the effectiveness of controlled SBMHS and programs for elementary school age children delivered exclusively by school personnel, not by those directly involved in the research (Sanchez et al., 2018). The researchers sought to identify the conditions under which the 43 programs reviewed yielded differential results. Overall, mental health services delivered by school personnel demonstrated a small to medium effect in decreasing student's mental health problems. Primary findings identified the largest effects resulted from targeted interventions which aim to address specific mental health concerns (i.e., externalizing problems such as aggression, and social emotional dysregulation). Strong effects were also found when services were integrated into student's academic instruction; targeting externalizing problems, those incorporating contingency management, and when implemented multiple times per week, sometimes daily.

Contingency management refers to behavioral therapy based on behavior analysis principles in which children are reinforced or rewarded for positive behaviors and change. This type of behavioral therapy demonstrated the most effective outcomes, rising above the others

assessed such as psychoeducation, emotion regulation, and problem-solving. Furthermore, when mental health services were integrated into the *normal* academic curriculum program effectiveness significantly improved. The varying grade levels and distribution of participants from lower socioeconomic status, race, and ethnicity did not influence the effectiveness of SBMHS. While universal prevention strategies showed relatively weaker effects when compared with more targeted services, consistent with other qualitative reviews and meta-analyses, the authors note the importance of small effects, as they can still have large impacts for children particularly in reaching a broader population of children (Sanchez et al., 2018). This presents a compelling argument for the further development and implementation of universal prevention programs as they may reduce stigma by including all children rather than singling out individual students.

Stigma, Mental Health, and Children

While stigma is an emerging area of literature, research, and discussion, more focus on stigma is needed to understand and address the issue more directly and effectively across systems. Historically, symptoms of mental illness have carried a legacy of stigmatization and blame. Given the dearth of research on the topic, the role of stigma in children's mental health is not well-conceptualized (Kaushik et al., 2016; Mukolo, Heflinger, & Wallston, 2010). Research and understanding about stigma and the related barriers have lagged behind that of mental health and illness. The emerging body of literature and research is largely focused on stigmatization in adults with mental conditions rather than on children and adolescents. Similarly, the research and development of SBMHS implementation models has lagged in their inclusion of recognizing and addressing issues of stigma.

Stigma is a significant barrier to any type of mental health service access and utilization, particularly for low socioeconomic status, racial, and ethnic minority children (Mukolo et al., 2010; Oetzel et al., 2006; Thompson, Noel, & Campbell 2004; Young & Rabiner, 2015). Too frequently, mental health treatment separates mental illness from the contexts in which it emerges and is defined. Social and cultural factors are often seen as secondary or may not even be taken into account, especially when mental health services are encountered in clinics and treatment only includes the individual. This is also because many psychological, behavioral, and cognitive treatment approaches focus solely on the individual self (Kirschner & Martin, 2010). Although there is progress in our scientific knowledge regarding the causal factors of mental conditions and for the development of evidence based treatments, the perception of mental illness continues to be engulfed in stigma. For approximately 17 million children and families in the United States alone, mental health issues create suffering and impairment that is compounded by factors of stigma surrounding mental illness (CDC, 2013; Hinshaw, 2005; World Health Organization [WHO], 2013).

Stigma and Types of Stigma

Stigma is the degrading and debasing attitude of persons, organizations, and society that discredit a person or group because of a seen or unseen attribute that damages the bearer's reputation and degrades them to a socially rejected and devalued status (Goffman, 1963; Mukolo et al., 2010). Illness, socioeconomic status, physical deformity, skin color, ethnicity, and religious affiliation are among the many variables where stigmatizations exist. Stigma is a primary contributor to the shame and silence associated with mental illness (Hinshaw, 2005). Stigma consists of stereotyping, prejudice, and discrimination (Corrigan, 2005; Fiske, Gilbert, & Lindzey, 2010). Stereotyping is the cognitive process in which someone categorizes and views members of a group with oversimplified and

often negative traits or attributes. Stereotypes are embedded in society and media, fostering individuals to make quick impressions even if they do not necessarily believe in them (Crocker, Major, & Steele, 1998). Prejudice is the endorsement of a stereotype; emotionally laden with negative pre-judgements and reactions which inevitably leads to discrimination, behavior, and actions that are avoidant and create social distance, historically limiting the rights and power of castigated groups and people. Stigma consciousness is the extent to which a person is aware of public stigma (Thornicroft, Rose, Kassam, & Sartorius, 2007). One of the resulting coping behaviors of an affected person is internalized stigma. This perceived and internalized stigma is equally destructive whether or not actual discrimination occurs (Hinshaw, 2005).

Negative consequences of stigma. Stigma erodes a person's dignity, marginalizes affected individuals, violates basic human rights, markedly diminishes the chances of the stigmatized person of achieving their full potential, and creates barriers for accessing help and recovery in turn seriously hampering the pursuit of happiness and contentment. When stigma is associated with a mental health condition it can prevent individuals from seeking evaluation and treatment, disclosing their symptoms or diagnoses to the people most likely to provide support, and inhibit their ability to follow treatment guidelines. While society has elevated the status of those who seek and receive treatment for physical and medical conditions (i.e., cancer survivors as heroes), those who live with mental illness are often subjected to stigmatization from many sources. Stigmatization can take the form of implicit assumptions. For example, the mental illness is a result of a character defect or personal failure, and for children, assigning blame to their families and caregivers (Hinshaw, 2005; Kaushik et al., 2016).

Measuring stigma. Given the prevalence of children's mental health issues, it is surprising that measurement of stigma in children's mental health has received little attention.

Manifestations of stigma can be a barrier for peer acceptance. Peer acceptance is not only important in maintaining good mental health for children and adolescents, it also helps to facilitate recovery when issues arise (Meadows, Brown, & Elder, 2006; Warren, Jackson, & Sifers, 2009). Accordingly, understanding the mechanisms and manifestations of stigma in children is required to develop effective anti-stigma strategies. Most studies adapt adult questionnaires without presenting evidence on their appropriateness or psychometric properties. In the last few years, two stigma measurement tools have been developed for use with children and adolescents. McKeague, Hennessy, O'Driscoll, and Heary (2015) in Ireland, created the Peer Mental Health Stigmatization Scale used with 562 children and adolescents aged nine to sixteen years. Initial findings indicated the children and adolescents distinguish between societal stigma (what others think) and personal stigma (what they think). Empirical research on children's social cognition identified that personal stereotypes and societal stereotypes typically develop by nine or ten years of age (Augoustinos & Rosewarne, 2001). The researchers suggest that the Peer Mental Health Stigmatization Scale can be readily adapted to focus on stigma associated with specific mental health disorders. In 2017, a collaboration between one psychiatry department in the United States and six in the United Kingdom resulted in the development of the Paediatric Self-Stigmatization Scale (PaedS) and parent completed subscale (PedsQL) to investigate the self-stigma of children and adolescents eight to twelve years of age with mental health problems who access treatment (Kaushik et al., 2017).

Specific types of stigma. Stigma operates across all ecological levels and systems – within individuals, families, schools, communities, media, and social policies, compounding the suffering of children and families dealing with mental illness. While stigma, broadly, is a significant barrier to accessing mental health services, it is necessary to examine the specific

types and impacts of stigma as it pertains to the population of interest: children and adolescents. Specifically, this review examines types of stigma through the framework of the aforementioned Bronfenbrenner bioecological theory and the components of his process–person–context–time model (2004). This is done by examining first the impact of stigma within an individual child, and second their various associated systems (i.e., mesosystem, exosystem, and macrosystem) which begin with family, and extend to broad social policy that affects mental health service availability.

Children. Little is known about the developmental factors related to children's perceptions of mental illness, yet even young children are known to hold persistently negative views regarding the labels and behaviors perceived to signify mental illness (Hinshaw, 2005; Rose, Thornicroft, Pinfold, & Kassam, 2007). Stigmatizing views in children and adolescents are believed to emerge from a combination of parental/caregiver views and media or societal representation (Gale, 2007). According to Hinshaw (2005), "Stigmatization of child/adolescent conditions is related to the low status of children throughout history as well as the continuing devaluation of mental disorders" (p. 714).

When discussing issues of stigma in children, it is also important to acknowledge self-stigma. Self-stigma is the internalization of stigmatizing experiences that occur outside the self (Corrigan & Watson, 2002). When children and adolescents self-stigmatize, they are more likely to display behaviors associated with negative stereotypes of mental illness such as violent behavior or withdrawal, with resulting effects of lowered self-esteem, avoidance of treatment, and the perpetuation of their vulnerability and poor outcomes (Corrigan & Watson, 2002).

Children with mental health issues are believed to be more stigmatized (i.e., they receive stigma based on perception from others) and stigmatizing (i.e., they hold stigmatizing

perceptions toward others) than their adult counterparts. Thus, they are less likely to access services due to concerns about receiving a stigmatizing label, reduced peer acceptance, and lowered self-esteem (Phares, 2003). Many children with more severe mental health and learning disorders or those who do not receive treatment, who also lack adequate support and sufficient protective factors, are at greater risk for suicide, dropping out of school, and subsequently poor economic outcomes. Thirty-seven percent of students with a mental health condition age fourteen to eighteen drop out of school; the highest dropout rate of any disability group. In adolescents who have been identified as having severe emotional disturbances, 61% drop out of school and only 32% graduate from high school (Merikangas et al., 2010). When students drop out of school they face difficulties getting and maintaining jobs and thus have lower levels of employment or hold multiple jobs, earning less income than other students with disabilities (National Council on Disability, 2017). However, the sequelae for children with mental health issues who have dropped out of school extend beyond employment; within three years an estimated 70% will have been arrested, and children who end up incarcerated are less likely to receive mental health services, and more likely to abuse drugs with increased rates of recidivism (Schiff, 2013).

Given the prevalence of mental health issues among children and adolescents in minority groups, it is necessary to acknowledge the unique, compounding impact of stigma. The challenges faced by immigrant and refugee families include oppression, poverty, displacement, and educational disadvantages which perpetuate their vulnerability and chances of criminal involvement, prostitution, substance use, child abandonment, and various forms of abuse. Those who are affected by these factors, especially the children and adolescents, have perhaps the greatest unmet need for mental health services and likely experience the most stigmatization.

Minority children, especially Native American, Latino/Latina, and African American children with mental health conditions are overrepresented in juvenile justice and child welfare systems (de Voursney & Huang, 2016). An estimated range of 50 to 75% of children and adolescents placed in foster care, and 60 to 75% of those in the juvenile justice system have a diagnosed mental health condition (de Voursney & Huang, 2016). In addition to experiencing stigma, children and adolescents with mental health concerns are sometimes also more at risk for enacting stigma upon others (Hinshaw, 2005; Kaushik et al., 2016). This is a cycle that gets perpetuated and further compounds the development and impact of stigma.

Little information is available about gender differences in children's experiences and enactment of stigma. Literature on mental health stigmatization among adults found that males were themselves more stigmatized, and were more stigmatizing toward others than females, positing that this may be due to the stereotype that males should be self-sufficient at managing any mental health difficulties contributing to the reduced likelihood for male children to seek help (Andersson et al., 2010; Burke, Kerr, & McKeon, 2008; Chandra & Minkowitz, 2006; Kaushik et al., 2016). Kaushik et al. (2016) also found that stigmatizing beliefs generally increased as children moved into adolescence. When measured, self-stigmatizing attitudes in children were found to be lower than in adults with mental health conditions at a rate of 25% (Moses, 2009).

Families. The impact of stigma on families, at the microsystem level of interaction and development for children, is substantial. Family members experience a range of feelings and consequences when caring for children and adolescents with mental health issues. Not only are routines interrupted, time off from work may be needed for managing crises, attending meetings and appointments, and advocating for their children, all while they are dealing with the stigma

and blame that is often associated with these conditions (Hinshaw, 2005; WHO, 2013). Furthermore, when parents or caregivers also suffer from mental illness, issues from stigma may greatly impact their parenting behaviors and in turn, their developing children. There is a growing body of literature on the process and implications of caregiver strain and coping with children with emotional and behavioral conditions. Many families rely on support from their extended family, folk and community healers, and churches, especially when existing mental health services are perceived to be inaccessible or lacking an adequate cultural understanding and fears of stigmatization exist (Mukolo et al., 2010). Beyond this, families face additional burdens associated with accessing mental health services for their children, including practical, logistical, and financial burdens which diminish the accessibility of mental health resources.

Families are burdened with more than the tremendous emotional and physical aspects of caring for a child with mental illness. Financial costs, especially when insurance does not sufficiently cover mental health treatment, complicate the matter. Even for parents and children who qualify for Medicaid, they must carefully monitor their financial situation to stay within income limits for the program (Kaiser Commission on Medicaid and the Uninsured, 2015). Often the gap between the earned income cap to qualify for Medicaid and social services and the costs associated for those same services without a subsidy are too great for any promotion or second job to cover (Koyanagi & Semansky, 2003).

Teachers and schools. At the next level of interaction within the microsystem is the role of teachers in children's education and development as a resource given the percentage of students who first seek mental health services in the school setting. In the findings of the pilot study (Foxley, Heitz, McNichols, & Brashear, 2014) that preceded the current dissertation and consistent with nationally reported statistics, teachers and school staff reported that a significant

number of students have experienced or are currently dealing with a mental health issue. While most teachers want to do their best for all students, many teachers remain uncomfortable with adapting their teaching and classrooms and would prefer to refer children out of their classrooms, a vestige of the stigmatizing mindset of exclusion and the expectation that children behave and respond to authority uniformly. Unfortunately, many interventions and programs have been too complex for teachers to implement and manage independently or are too distinct from their standard practices for them to embrace them, often resulting in teachers being perceived as resistant, uncooperative, or ineffective (Dougherty, 2014; Gonzalez, Nelson, Gutkin, & Shwery, 2004). Fantuzzo and Atkins (1992) proposed that this was not as much the issue as the teachers were not considered or consulted with in the development of the interventions.

When teachers are adequately supported, trained, and able to manage the pressures they face, such as state tests and their student's performance, they may begin to mitigate the ways in which school environments can negatively impact a student's mental health due to the pressures of academic achievement. One way to enhance academics and classroom management is to design instruction to account for a wide range of individual differences in learning and challenges (Adelman & Taylor, 2006). Teachers consistently report that even though mental health issues are known to exist, mental health awareness and issues of stigma are still not talked about routinely though many would welcome the opportunity to initiate discussions on mental health issues (Dougherty, 2014).

Mental health professionals. As part of the exosystem for the child, mental health professionals can provide an important support for a child's healthy development. A great many professionals in the mental health field are genuinely committed to the clinical assessment, care, and recovery of their clients and patients. However, Wahl and Harman (1989) posited evidence

from a systematic United States survey that mental health professionals are one of the primary

sources of stigmatization perceived by people with mental illness and their family members.

Overton and Medina (2008) indicated provider attitudes and beliefs are often no different, or

even more pessimistic, than the general public. Continued research has confirmed this finding

(Charles & Bentley, 2017). Contributing factors to provider stigma include professional

trainings that convey a superior attitude (i.e., an "us versus them" mentality; Hinshaw &

Cicchetti, 2000). According to these authors, when mental health professionals maintain

demeaning attitudes or low expectations for improvement, particularly regarding those with

severe mental health conditions, their clinical choices are directly influenced. The ways in

which the attitudes of mental health professionals stigmatize children and adolescents may be

similar to adults though remains to be investigated. From this limited research, it is logical to

assume that at least some mental health professionals may inadvertently imbue stigmatizing

attitudes through their language, theory, and treatment modalities that decontextualize and

blame children and adolescents, and their families.

     Mass and social media. Social media, as part of the exosystem of the child, directly and

inadvertently exposes children to real life and fictional depictions of stereotypes, negative

descriptions, and inappropriate humor about people with mental illness. Such pervasive images,

and messages can be seen in children's cartoons, memes, commercials, and mainstream music

and dramas portraying characters and people with mental illness as violent, dangerous,

unpredictable, or grossly disturbed and at fault for their condition and status (Wilson, Bonevski,

Jones, & Henry, 2009). This may be improving however, due perhaps in part to people sharing

their stories and struggles with mental illness on social media platforms and finding informal

support groups. Perhaps it is also in part due to celebrities who have revealed their mental health

diagnoses and openly discussed their struggles and experiences of stigma-related shame and why it has been difficult to go public. On January 14, 2018, *Harper's Bazaar* online presented a slideshow with a photograph and brief statements from 39 celebrities regarding their mental health including Adele, Kerry Washington, and Jared Padalecki to name a few, with the tagline "Proof that anxiety and depression can affect anyone" (Roberts, 2018). Of note, the main title uses the phrase "mental health" rather than mental illness or condition; an illustration that language, on its own, can further contribute to or reduce stigmatization.

Community Psychology

Community psychology has a long history of identifying, studying, and addressing disparities. The goal of community psychology "is to optimize the well-being of communities and individuals with innovative and alternate interventions designed in collaboration with affected community members and with other related disciplines inside and outside of psychology" (Moritsugu, Vera, Wong, & Duffy, in press). Community psychology recognizes the diverse community and cultural contexts in which research and interventions are conducted. As such, the community psychologists strive to recognize and understand that diverse subgroups may be defined by race and ethnicity, sexual orientation, gender, geography, disability, socioeconomic status or other characteristics with shared interests, values, experiences, or traditions. Accordingly, approaches, discourse, interventions, and the like should be adapted or developed specifically for them and with them.

The Concept of Spirit from Community Psychology: Relationship to Stigma

Spirit in community psychology is a multifaceted and multidimensional concept that varies across and within settings and culture. The engagement of spiritual concepts, while often shied away from in research and psychology in general, are in alignment with the guidelines

presented by the APA regarding "Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (APA, 2002). In order to better address issues of stigma and barriers, it is necessary for those involved in the practices of community psychology and mental health care to adhere to these ethical practices and guidelines, but also bring ourselves back into this spirit and the heart of human relationships, which should be reflective and respectful of the context and cultures the community psychologist encounters and is working from.

In 1978, community psychologists Goodstein & Sandler provided perspectives on how their field can be used to promote human welfare. Specifically, they identified differences between the targets and philosophies of community-based mental health services and community psychology, spurring a much-needed conversation on how to lessen the gap. More than two decades later, The Power of Collaborative Solutions (Kelly, 2002) brought the "spirit of community psychology" into the conversation. To be clear, the term "spirit" here is used not in association to religion; Kelly (2002) considered the concepts related to the spirit of community psychology to include "passion, personal vision, ideology, empowerment, resilience, persistence, and Seymour Sarason's concept of transcendence [Hill, 2000; Sarason, 1994]. Plus a sense of humor" (p. 45).

Wolff, another community psychologist, also wrote about engaging spirituality. Wolff highlights four ways diverse ideas of spirituality converge despite differences in cultures and religions as: appreciation, interdependence, acceptance, and compassion (2010, p. 199). By recognizing and practicing these qualities in ourselves, others, our work, and communities, we may also begin to recognize the deeper sources of both problems and change. In further support of bringing spirituality into the conversation, a survey from Mathai and North (2003) found that

the vast majority of parents reported spirituality to be of some importance and reported that mental health professionals should consider their spiritual beliefs in the management of their child's problems.

There is often discomfort associated with the engagement and use of the term spirituality within mental health in both clinical practice and empirical research. Within empirical literature there is a large-scale avoidance of spirituality as a term and topic. Linguistic and scientific vernacular inform varied perceptions of spirituality, and as such, in this context as it is defined within community psychology has relevance to this endeavor. As a result of this discomfort and avoidance, stigmatizing beliefs and experiences pertaining to spirituality and the engagement thereof are allowed to continue to both large- and small-scale detriment. On a microsystem level, this avoidance of spirituality can impact and impede mental health care for children because parents report a desire for mental health professionals to consider their spiritual beliefs (Mathai & North, 2003). At the macrosystem level, this impacts empirical literature, general knowledge, and, ultimately, policies and procedures that govern mental health care service provision.

Systems of Care and Community Psychology

As mentioned previously, SOC is:

a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them function better and home, in school, in the community, and throughout life. (Stroul & Friedman, 2011, p. 13)

In recent years, community psychologists (Cook & Kilmer, 2012; Hodges, Ferreira, & Israel, 2012) wrote about the systemic change needed in children's mental health using the SOC concept. Systems of care were conceived as a values-based organizational philosophy that also focuses on systemic change by building collaborations across the child-serving sectors, for improving access to a growing array of coordinated community-based services. The SOC was developed to serve children with more severe social-emotional disturbances (Stroul & Friedman, 2011).

The SOC integrated model aligns well with the values and principles central to community psychology, specifically; empowerment, collaboration, an emphasis on strengths, and focus on multi-system level change. The SOC philosophy, on which the CMHI is based, incorporates the following core values: (1) services and supports are child focused and family driven; (2) collaborative with effective communication in a culturally and linguistically competent manner; (3) employ strengths and evidence based service plans; (4) family and children are involved in planning, service delivery, and evaluation; (5) focused on prevention, early identification and intervention; (6) provided in the least restrictive and most accessible environment possible; (7) coordinated through an interagency network; and (8) protective of human rights and advocacy (Cook & Kilmer, 2012; Stroul & Friedman, 2011; see Table 2).

Communities that undertake change in accordance with the SOC philosophy commit to developing integrated services for children, adolescents, and their families that are dictated by the needs and strengths of the child and family, are community-based, and culturally competent (SAMHSA, 2015). The aim of this SOC framework is for children and families to have access to a continuum of appropriate services and supports unencumbered by multi-agency jurisdictional fragmentation (Cook & Kilmer, 2012). The SOC model seeks to be

comprehensive and recognize the ecological levels of intervention required for change to occur. Bringing about positive change for children's mental health through SOC involves both the family and school, and community resources in recognition of the need for intervention at all of these levels. In considering ways to address stigma, the role of spirituality as identified in community psychology, will be discussed in the Summary and Discussion.

Table 2

Community Psychology and Systems of Care Values Relevance for Addressing Issues of Stigma

Community psychology	Systems of care	Relevance for addressing issues of stigma
Empowerment	Child and family focused (driven); power and choice lie with family; families are actively involved in planning and evaluation of services	Address issues of blame and responsibility for mental illness. Avoid top down hierarchy of power and authority. Consider language use, labels, and titles that may affect or illicit power differentials.
Collaboration	Collaboration and effective communication between family members and professionals of varying disciplines; smooth transitions among agencies, providers; integrated services with coordinated planning across child-serving systems	Form a coalition specifically for the review and adaption of multi-systems/wraparound service models that are working well to directly question and review possible barriers related to issues of stigma. Adolescents should have direct involvement at every step. People & perspectives from all involved positions are key.
Emphasis on strengths	Emphasis on strengths	Address issues of stigma related to deficit-based approaches by focusing on strengths, existing resources and resiliency.
Citizen participation	Family participation in planning, service delivery, and evaluation	Not equalization, rather attempts to deconstruct top down power and "expert" knowledge imparting. The service team is accountable to the families and children in every aspect from development to evaluation. This applies to teachers and school staff as well.
Social change	Targets change of service delivery for children and their families; goals include a children's mental health system that offers a comprehensive array of services and support	Tracking of progress and outcome monitoring for accountability and transparency in reporting to families, communities, funding, and policy sources. Tracking progress can help to maintain hope, efficacy, and cohesiveness as well as provide recommendations for social policy development and change. Recognition of differing and multilevel approaches needed in settings due to culture, service availability, rural, etc. Consider use of telehealth & technological supports.
Prevention, early intervention, wellness promotion	Early identification and intervention, preventative approaches	Related issues from stigma and self-stigma usually increase with age. Universal intervention programs can help reduce stigma while specific treatment targets and contingency based strategies work well imbedded in normal academic instruction. Combine duplicate efforts and resources to decrease stigma for mental health services and increase accessibility.
Social justice	Human rights protection and advocacy	Develop & evaluate specific efforts for efficacy and reduce barriers to access mental health services. Work to influence social policy toward a more meaningful & comprehensive mandate for children's mental health services.
Ecological perspective	Attempt to build connection between family and community; families help to shape the system and community	Recognition of the contextualized child and the importance of their interactions in their environments.

Key Considerations for Collaborative SBMHS

Key Consideration Development

Using the key concepts of community psychology and systems of care as well as the literature on stigma and children's mental health the following methodology is proposed to develop key considerations for collaborative SBMHS implementation models. This model uses an adaption of the Bronfenbrenner bioecological framework to address stigma and barriers to accessibility to mental health services for children at each system level, from the microsystem through the broader macrosystem. Six objectives with tangible steps, tasks, and considerations are presented: (1) convene a school & community coalition; (2) assess mental health service needs and resources; (3) develop an implementation plan; (4) monitor and address challenges; (5) create and carry out a communications plan; and (6) build sustainability. While there are sequential steps for some objectives, each objective is meant to be engaged in a manner that is relevant for adaption with existing resources and structures. For example, a school may already have established communication protocols the coalition can employ, or community mental health partnerships they can partner with.

Objective one: Convene a school and community coalition. Building and fostering respectful relationships between participants on all levels is key to developing a meaningful SOC. The establishment of a coalition that includes key members from all levels and groups surrounding and including the children is an important initial step. Key members can be individuals who influence opinions, are directly involved in the service delivery and support, as well as those in formal organizational leadership roles. This will require an investment and commitment of time and energy to the process. The facilitator or group of identified leaders

should hold to the principle of fostering empowerment as an important aspect of coalition formation and member support.

As a first step, the facilitator can informally engage in meetings and conversations that explore interest and gauge readiness for participation. Relative to addressing and reducing stigma, children, adolescents, and their families are invited as coalition participants. In a practical way, this means addressing issues of blame or responsibility for mental illness by their inclusion full participants in the coalition. Additionally, this means being considerate of language use; using labels can be largely stigmatizing for children and their families. In practice, this means adapting people-first language (i.e., "individuals with autism" versus "autistic"). For all participants, within schools and at the community level, equalizing the power differential by acknowledging the authority of every voice can be another way to reduce potential feelings of stigma. Additionally, the exploration of self-stigma versus stigmatization of others is crucial.

Wolff's 2010 book, *The Power of Collaborative Solutions*, provides additional guidelines and tools on forming coalitions. Once the coalition is formed, an initial in-house assessment should be conducted to evaluate of the school's current mental health services functioning and service population including identifying issues related to stigma and barriers when developing and accessing mental health services. This could be done through informal fact-finding and quantitative measures. It is also the role of the coalition to develop a shared vision that mobilizes the school and community to promote and protect children's mental health as the coalition functions as the leading body for the project development and implementation.

Objective two: Assess mental health service needs and resources. After the coalition has developed a vision and gathered initial information, a comprehensive assessment of the current and future mental health services is conducted. Existing data should be included to help

identify problems, analyze risk and protective factors in the school and community, and determine gaps between the current services and coalition's vision as a strength-based approach. After the assessment is completed, the coalition provides a report of the findings to the community to seek input on the information and collaboratively develop proposal recommendations. The recognition of community strengths and resources is key to this step.

Additional considerations relative to reducing and addressing stigma at this level, are role of the coalition and "experts" (i.e., mental health providers in schools or in the community) and the engagement of families in assessing the needs of children with mental health concerns. For example, when disseminating findings of this assessment to families and communities, it is important for the coalition to present data in an accessible way, using language that is appropriate for the audience. Further, it would be important to emphasize strengths as well as areas of growth to reduce feelings of stigma which may ultimately inhibit service-seeking behavior for mental health concerns (i.e., if a family feels marginalized by the service providers, they may choose not to seek care for their child due to perceived stigma). The use of a logic model from program evaluation methodology may be helpful early on. A logic model is a tool to map and organize the coalition's planned work and intended goals. Next, the coalition will need to develop a budget and secure financial resources, which may require the formation of a subcommittee.

Objective three: Develop an implementation plan. Following the logic model creation and community meeting, the coalition will explore the activities and efforts toward addressing stigma. These activities should align with the vision and continue to build on the strengths and resources identified from the readiness assessment. For example a teacher could take on leadership supporting her peers for the implementation of a universal, school-wide intervention.

The psychologists and mental health providers can organize and present a review of evidence-based practices and interventions that are in alignment with the desired goals and relevant outcomes for the specific school population, community, and identified needs. In congruence with current research, both universal and targeted programs that address stigma should be included. By implementing specific programs to increase the awareness of stigma, efforts can be made to reduce the effects of stigma in both clinical, school, and community settings from the microsystem to the ecosystems

The coalition must continually evaluate their process and each planned step for alignment with SOC values and community psychology principles. For example, the following questions are proposed as areas of exploration: How will this coalition be held together and be accessible for all stakeholders and informants to participate? Will there be regular meetings that are informal, formal, or a combination thereof? How will transparency and clear communication be maintained with attention and adjustments made to empower? Then, trainings and implementation strategies can be developed for programs that include specifics and timelines for achieving goals. After this is completed, a program evaluation plan needs to be identified to monitor program implementation, effectiveness, and outcomes in the following years.

Objective four: Monitor and address challenges. The objective of monitoring and addressing challenges is conducted throughout the program development, implementation, and evaluation. Challenges can be expected to arise along the way as a natural part of the change process. The coalition and those involved in implementation should remain vigilant for assumptions and expectations that may only be made evident when challenges arise. Implementation will be hampered, and even potentially halted, if issues are not explored and addressed. In particular, the existing effects from stigma may impact the way interventions can

be carried out and how effective they can be. Planning for, monitoring, and addressing these stigma-based barriers as they arise is imperative in successful implementation.

When school and community partners approve the plan and it is ready for implementation, the coalition will identify the school staff who will receive training and create a plan for supporting and guiding their efforts. Relationship building, rapport, and buy-in from the school and its staff is key for success. Careful monitoring for resistance in individual staff and strategies to deal with resistance is required. Successes and emergent issues need to be noted and tracked methodically for fidelity. This includes, though is not limited to, identifying, documenting, and addressing in a timely manner challenges such as resistance, cultural competence issues, stigma, and confidentiality concerns.

Objective five: Create and execute a communications plan. Throughout the program development and process, coalition, school, and community participants will need to regularly receive information. One goal of the communications plan is to ensure inclusiveness, access, respect, and transparency. This helps to build trust in the working relationships. Several avenues of communication and contact with the coalition should be available to the participants. The coalition should also conduct situational analyses to identify communications goals, target audiences, and their characteristics (i.e., diversity, culture, preferred communications style and modality), and the available assets for creating and implementing the communications plan. This is another area in which to be mindful of the impact of stigma. When communicating with stakeholders, community members, children and their families, and others it is important for the coalition to be aware of the ways that communication, including humor, may be used to reduce or worsen stigma. In particular, this is another opportunity to use inclusive, people-first language when discussing mental health conditions. In this way, even though this objective is

broad in scope, it is adherent to SOC values and community psychology principles at the mesosystem level of interaction. Communication messages should define both the problems, and how the program's efforts address them. Furthermore, the coalition should evaluate efforts to determine how to refine the communications plan to reach the agreed upon goals.

Objective six: Build sustainability. When undertaken in a truly collaborative spirit, with adherence to the principles, values, and ethics of community psychology and SOC, the change process can enhance relationships and empower communities at the micro and mesosystem levels and beyond. This is the embodiment of the bioecological perspective. Throughout program development and implementation of the mental health services model it is important to identify and prioritize the practices and activities that are the most effective as well as identify those which will require support beyond the current funding and capabilities of the community and school. With regard to mental health stigma prevention, intervention, and awareness promotion, the coalition should ensure they have identified the key functions of each practice and activity (i.e., the screening and assessment of children for issues related to stigmatization). By using a variety of multisystem level approaches, such as a wraparound team, strategic planning, community partnerships, and capacity-building, the programs can function and be sustained in a way that promotes enduring positive outcomes.

Summary. The proposed objectives use an adaption of the Bronfenbrenner bioecological model as a framework for improving SBMHS for children and adolescents. Within these objectives, the aim is to directly address and reduce stigma to promote better outcomes and successful mental health service provision. This begins with the microsystem for the individual and their immediate mesosystem (i.e., family, teachers, etc.), and extends through the

macro-level, where the aim is to address stigma at a broader level with policy-makers and in the larger culture.

Summary & Discussion

Summary of findings. This dissertation identified problems with stigma in current mental health services and SBMHS programs and implementation models through employing community psychology principles partnered with SOC values. The focus of this dissertation is on the expansion of mental health services in schools through collaboration with community-based program methodology from SOC and community psychology. As such, a thorough and critical review of the current state of children's mental health services, with particular attention to model and program components that are successful and accessible for students was provided. Stigma related barriers that are insufficiently addressed in extant SBMHS delivery and the associated literature, were reviewed. The concept of spirituality from community psychology was introduced to the process of coordinating and navigating change related to stigma in children's mental health across the ecological systems.

For several decades, schools have become the de facto mental health system for children, with teachers often in the position of being the person who may first identify or receive information from students having mental health concerns (Taylor et al., 2012). At the same time, issues of stigma associated with mental illness have emerged as an important topic for the field of mental health internationally (Cicchetti & Cohen, 2006; U.S. Department of Health and Human Services, 1999; WHO, 2013). Separately, federal and state initiatives and programs such as SOC and localized wraparound services have focused on serving the most severe child and adolescent mental health conditions. Unfortunately, the statistics reflect the current capacity and efficacy of these efforts remain inconsistent and insufficient. Additionally, despite the increased

focus on integrating various components of child and adolescent mental health care in the last three decades, specific implementation models for ongoing collaboration between schools and communities with schools are lacking. Furthermore, issues and barriers related to stigma are not addressed as key components.

Approximately 17 million children and adolescents nationwide are currently suffering from mental illness (CDC, 2013). Some mental health conditions last only a short time while others are potentially lifelong. Nearly half of adult mental health conditions begin in adolescence and carry the potential to interfere with an adolescent's development of self, resulting in both short- and long-term impacts (Merikangas et al., 2010). Symptoms of mental illness can produce impairment and suffering along with limiting the attainment of developmental milestones and competencies in children and adolescents. Social disapproval and the various forms stigma children and adolescents experience greatly compounds these problems. The emerging body of research consistently indicates stigmatization precludes access and opportunities for treatment, with estimates of up to 75% of children and adolescents with mental health issues in the United States not receiving evaluation or treatment services (Merikangas et al., 2010; Olfson, Druss, & Marcus, 2015).

However, mental health conditions are treatable. Early intervention is an important predictor for positive responses to treatment and sustained recovery (Calear & Christensen, 2010). Many children and adolescents can recover from mental illness and grow up to lead healthy and productive lives. Of course, the chances for improved outcomes are much better with appropriate, accessible, and affordable mental health services free from the barriers stigma, in its various forms, can create.

Given that mental health services are often delivered through grant-funded programs, they are susceptible to funding changes and often are short-lived. In schools and communities, and at the state and national levels, separate but related and overlapping initiatives exist. While many mental health service models and programs have been successfully developed and executed, research regarding their stability and long-term impacts along with components which directly address issues of stigma is notably lacking. Access to mental health services is often impeded by complicated and multiple pathways to treatment, multiple and siloed funding streams for services provided and received, and stigma.

While it is indeed a slow-moving, complex, and challenging undertaking to address the varied and increasing mental health needs of children and adolescents, it is imperative to increase recognition of the need for services as it pertains to issues of stigma as a barrier. Community partnerships stand to benefit from further developed applications of community psychology principles and SOC values. A unification of these efforts could reduce the duplication of resources and streamline pathways to services that lead to confusion and further stigmatization especially for low socioeconomic, immigrant and refugee populations, among others. Importantly, this integration can directly benefit the mental health and wellbeing of children and adolescents and their associated systems and communities.

Strengths and limitations. The present critical review contributes to the existing clinical and empirical research in that it specifically addresses issues of stigma related to children's mental health. The applications and objectives aim to augment existing frameworks with the goal of directly benefitting children with mental health difficulties, their families, communities, and greater systems. While sometimes acknowledged within research, stigma is rarely the focal point of investigation or the driver for intervention within SBMHS research.

Another primary strength of the present study is the role of community psychology and SOC. These areas helped to inform concrete objectives to implement change, improve outcomes and accessibility, reduce stigma-related barriers, and increase awareness of stigma beginning with SBMHS systems. This represents a novel contribution to the existing literature, and informs both clinical and empirical practices. At a microsystem level, the objectives described in this dissertation can be implemented directly with existing schools and communities and further evaluated. At a macrosystem level, the implementation of the objectives should be evaluated in research to determine its efficacy, which would ultimately inform future policy and procedure.

This investigation is an early effort to raise awareness about stigma in children's mental health bringing stigma more prominently into the development of SBMHS and more broadly children's mental health services. This is an area that is underrepresented within empirical literature. This is an increasingly relevant issue for children and adolescents at the microsystem level, their families and communities at the exosystem level, and within the larger culture at the macrosystem level.

This research emerges at a pertinent time given the current socio-political climate within the United States. Children are impacted by significant macrosystem-level events and circumstances that influence their mental health and development. There are current cultural burdens faced by children today that are unique to our current generation and socio-political climate. Policies surrounding immigration, families, and minority-status individuals likely promote a sense of cultural unease, which contributes strain on the microsystem for individual children. Specifically, if a child is affected by turmoil within their family due to national-level

policies, this is a unique stressor impacting their mental health that may not be present for other children.

The subject of this dissertation was originally conceived as an in-vivo application of the proposed objectives for addressing stigma and barriers in mental health services for children. The pilot study that preceded this dissertation explored how SBMHS were experienced by staff and caregivers at a non-profit elementary school primarily for children of families dealing with homelessness. Although mental health service providers were on-site at the school several days a week and part of the wraparound service model, the staff survey results included variable understandings of the role of mental health services. Many of the families were immigrants or refugees and they all had experienced adversity. In reflection upon the pilot study in light of this dissertation, stigma around mental health services was likely a factor in the lack of surveys returned by caregivers. This suggests that research which endeavors to develop measures for possible or highly stigmatized populations and individuals is inherently problematic. When children and families are dependent upon systems, such as schools for educational and support services, concerns about involvement in these systems or issues of self-stigma may prevent them from seeking mental health services. Furthermore, as described in the key considerations, it is important to define the role of mental health services as collaborators in addressing stigma as a barrier.

Stakeholder involvement at every level is crucial (i.e., children and their families, schools and districts, mental health service providers, policy-makers, etc.) work to increase accessibility to mental health services and decrease stigma and related barriers of this type of care, especially for children and adolescents. This, however, also represents a broader limitation of this type of research. In some contexts, evidence-based practices can be directly applied in the clinical

setting at the discretion of the qualified clinician; in this case, SBMHS interventions require involvement and buy-in from stakeholders at each level of involvement. The proposed objectives and critical evaluation of literature can be directly applied to improve mental health services. Other barriers such as policies, procedures, and funding complexities that may stand in the way of progress, need to be addressed.

This research represents a novel effort in the field; little existing research directly addresses stigma as a barrier to accessing mental health services among children. Further, stigma research is still relatively new, with many measurements still in development. It is also important to note that little is currently known about the long-term impacts of stigma among children. This may be partially due to the primary avoidance of this topic in the body of research; it can be uncomfortable and painful acknowledge and address the presence, development, and impacts of stigma. Because of this, caution must be taken not to draw firm conclusions within this research. Rather, the focus can be directed to increasing awareness of (1) stigma as an under-addressed topic in empirical research and clinical practice, and (2) stigma as a multifaceted barrier to pursuing or accessing mental health services for children.

Future research. Investigations focused on stigma, as well as its development and impact on and among children, are sparse. As noted previously, there is discomfort associated with acknowledging and reflecting on stigma, and this discomfort leads to an avoidance of systematically investigating stigma and its impact in empirical research. Because of this, there is relatively little understood about stigma. Earlier we noted the cyclical process and impact of stigma: individuals with mental health problems avoid seeking mental health care due to stigma, individuals who have untreated mental health problems may exhibit stereotypical behavioral symptoms associated with mental illness which promote stigmatized ideas (i.e., aggression,

emotional dysregulation, etc.), and in turn, this reinforces broad and false ideas about individuals with mental illnesses, which increases stigma and leads to care-avoidance. Further, this cyclical process remains unexamined because of the discomfort associated with confronting stigma.

Returning to the Bronfenbrenner bioecological framework (2004), the problem of stigma is present at each level and system. Within the microsystem and mesosystem, stigma and self-stigma may prevent children and adolescents from accessing and receiving proper mental health services, due to fears of negative perception from others, or fear of being stigmatized by a provider. At the level of the exosystem, stigma is broader, and also influences subcultures and media. At the macrosystem level, the cyclical process of stigma is observed at the level of cultural expectations or ideals as well as legislature and policy, which then inform the ways in which mental health services can be accessed and by whom (i.e., insurance coverage policies not covering mental health services, inability of socioeconomically disadvantaged individuals accessing care, etc.). The bidirectional interaction across and between systems can further promote stigmatization of those with mental health conditions. Examining the cycle of stigma in a systematic way through research is a crucial step in eventually reducing the impact of stigma, and more specifically related to the focus of the present investigation, the impact of stigma on access to mental health services for children and adolescents.

In keeping with the spirit of this investigation, and in an effort to directly address the discomfort associated with evaluating stigma, several specific directions for future research are provided. Echoing the persistent framework of the Bronfenbrenner model (2004), research can be pursued using a systems-based approach. At a microsystem level, research on the impact and development of stigma among children, families, and communities is necessary. Implicit association tests may be investigated as a useful tool in identifying and beginning to address the

roots of stigma early on (Rudman, 2011). Future research focused on children and adolescents could employ mental-health specific implicit association tests to gain a greater understanding of stigma, self-stigmatizing beliefs, and stigmatizing behavior. Additionally, examining various media (i.e., social media, music, advertisements, movies, etc.) portrayals of mental illness can be useful in characterizing sources of stigmatization. This understanding could then inform the development of better assessment and intervention tools for measuring and reducing stigma. Of note, it may be particularly valuable to evaluate the way social media portrays mental illness and how this impacts care-seeking behavior among children and adolescents who experience mental health symptoms and conditions. As we begin to understand more about the nature of stigma, its development, and its impact for children and adolescents, it is hoped that this knowledge will ultimately influence broader social change and policy. As an illustration, cigarette policies in the United States (i.e., advertisements, required warnings, where and how cigarettes can be sold, etc.) changed significantly after the revelation that smoking is a causal factor for lung cancer (Liu & Hsieh, 1995). Similarly, as we learn more about stigma as a barrier to seeking or accessing mental health services, we may see changes in the way mental health services are broadly perceived and managed at the governmental level.

Stigmatizing ideas about mental illness are embedded throughout the history of the mental health field. Stigma-related barriers are present at all system levels; at the microsystem level this directly impacts mental health care access and outcomes, which is carried out through the mesosystem and ultimately impact the broad macrosystem informing cultural attitudes toward mental illness and mental health care. Relatively few resources have been developed and little literature is written on the topic of stigma in children and adolescents' mental health. The emerging studies are promising for improving our understanding of the mechanisms, levels,

interactions, and developmental factors associated with stigma. These efforts may provide insight into developing collaborative and spirited mental health services that make specific efforts to destigmatize mental illness, including making recommendations for change in social policy. A next step in furthering the application of this critical review would return to the original idea: implementation and evaluation of the proposed objectives in a school-based setting at the exosystem level. Attention to the issues of stigma in implementation could provide a better understanding of the role of stigma in systemic change.

Collaborative research that includes children and adolescents as informants and stakeholders can help build on what is working well, or not, and to better understand why, from their perspective. Current research identified gender differences in self and societal stigma indicating stigmatization reduction efforts may need to include varied approaches. Issues related to stigma for children and adolescents who are transgender, living in remote or rural locations, and from military families warrant specific investigation. Furthermore, the conversation around stigma stands to benefit from a hermeneutic reflection that allows for situating the issue further within the relevant historical, cultural, and sociopolitical context, specifically examining the use of language used (e.g., for labels and positions in the mental health field to make recommendations for adaptions). Case studies and qualitative studies specific to programs and settings are warranted and can be used to inform larger studies and be more broadly incorporated.

The predominant body of research and literature on mental health service implementation models, programs, and frameworks include issues of stigma and potential barriers as cursory mentions, noted as a limitation, or simply left as recommendations for further research to improve outcomes for students. School-based mental health services and programs for children

and adolescents developed in partnership with communities for children and adolescents are necessary to begin to more comprehensively and efficiently address the prevalent fragmentation and often stigmatizing issues that persist. For lawmakers, policy analysis of child and adolescent mental health is often neglected, though the need for review and revision is widely recognized. Changes in social policy, programming, and funding often follow dominant cultural shifts, further emphasizing the need to better understand and address issues of stigma across the ecological systems in which children develop.

Returning to the community psychology concept of spirituality, collaborative efforts undertaken with passion, vision, ideology, empowerment, resilience, and persistence can help to propel the work forward (Kelly, 2002). A collaborative spirit is also respective to the diverse communities and schools within which children thrive. When we acknowledge our interdependence, while holding appreciation, acceptance, and compassion for our diverse contexts (Wolff, 2010), we can meet ourselves, each other, and our work, more fully.

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Appendix A

Permissions

Appendix A: Permissions

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From: **permissions (US)** <permissions@sagepub.com>
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To: Brittany

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Also, to clarify, the colored image is my creation. The black and white image is Bronfenbrenner's original bioecological model (image provided for reference from readily available google image search).

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Citation below model in text:

Figure 1. Adapted from Urie Bronfenbrenner's Bioecological Model (2004)

Reference citation:

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Brittany Foxley

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