School-based Family Therapy

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Abstract

School-based Family Therapists are essential for adolescents’ academic achievements, family’s issues affecting the student’s success, and providing psycho-education for the families and educators. Parents and teachers now have a resource to help kids who are hurting emotionally or mentally when a school-based family therapy program is made available. Therapists can help the students with concerns such as depression and diagnosed disorders, along with behaviors due to educational stress, which all can be obstacles to learning. The quality of school-based therapy through the preparation of this program to serve at-risk adolescents and their families, and the steps needed to implement this therapeutic program will be discussed. Alfred Adler’s belief of social interest and Adlerian family therapy will be touched on, as well as how it fits well with a student’s success at school and at home. In addition, the different types of therapies that are used and the methodology of this project including research and a grant proposal, along with the presentation’s outcome will all are discussed.
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School-based Family Therapy

Mental health providers within schools are over-worked and under-staffed in most school districts. School social workers are so busy dealing with crisis management throughout the school day that they have very little time to counsel the student and to be proactive before the behavior occurs. The school psychologist is usually imbedded within the special education department and providing the necessary testing for evaluating the students. Therefore, they have no time to provide guidance for the troubled adolescent. Neither of these school employed staff members are able to work with the entire family, except through phone calls and meetings regarding the student. When the school is continually having problems with the at-risk adolescents, they understand that the majority of times the issues are manifesting themselves at home. This is the gap that a school-based therapist can come in to provide their services.

Implementing a family therapist into a school setting has been found extremely valuable. Schools are an excellent setting to provide an extensive array of mental health services, given that over 77 million students attend elementary and secondary schools (Boyd-Franklin & Bry, 2000). Concerns such as depression and diagnosed disorders, along with behaviors due to educational stress, can be a main obstacle to learning. To intervene early in the student’s time in school, when significant challenges are evident, has been found to deter school failure or even dropping out of school. Since students cannot leave their family problems at home and it is found to affect their academic success, a therapist can be brought in to work with the entire family system, not just the school-age child or “the problem child”. The therapist helps with anger management, conflict resolutions, social skills, anxiety and depression, which all can interfere with the student’s ability to succeed in school.
This project’s general idea is to create a grant proposal to the school board in order to implement a school-based therapy program within their school district. To begin this process is to first prepare a presentation to maintain the need for the proposal using an interview, research and an example of a grant that was already proposed. The presentation consists of a power point given to a panel of educators and then to gather feedback regarding their professional options on this type of program.

**Literature Review**

**Introduction**

The Family Support Network describes a family therapist as someone who offers in-home and school-based parent education, psycho-education, skill-building and clinical interventions to at-risk children and their families. Direct services will be given within a collaborative framework to include the schools, other service providers and community organizations to work together towards service incorporation. They would also be responsible to train school staff to ensure consistency.

The President’s New Freedom Commission on Mental Health’s final report supports focusing on children’s mental health in schools; it concludes “strong school mental health programs can attend to the health and behavioral concerns of students, reduce unnecessary pain and suffering, and help ensure academic achievement” (Christner & Mennuti, 2007, p. 58). Minnesota’s Governor’s Mental Health Initiative was passed in 2007 to improve mental health care for children and adults. The Children’s Mental Health Division revealed that 91,000 children need therapy for emotional disorders. The Minnesota Department of Mental Health (2012) affirmed that it has been approximated that one in five children at one given time have
been affected with challenging mental health issues, yet only 20% of these children will get the professional help they truly need.

The significance of school-based therapy is to conduct therapeutic intervention when the child is not only in school, but also in their homes and in the community. Many current mental health services that are in schools tend to focus just on prevention of behaviors in schools, yet this school-based therapy can concentrate on intensive interventions that include the family and the student’s complete life. Families can now access mental health services more conveniently with the addition of an on-site therapist for their needs that have not been met in the past. This program has been shown to not only increase attendance and improve the student’s grades, but also reduces suspensions and expulsions (Boyd-Franklin & Bry, 2000).

School-based therapists are additionally dedicated to work with the school administration and teachers, along with the families and children, to solve behavioral and mental health issues. A school-based family therapy program can ensure that both parents and teachers have a resource to help kids who are hurting emotionally or mentally. It is important for schools and families to understand that mental health is just as crucial as physical health. A parent or teacher wouldn’t think twice about getting help for a child who has suffered from a physical injury, therefore it is imperative that that they understand that mental health is just as important.

**Alfred Adler, School and Family Therapy**

**Individual psychology in the schools.** Adler considered that the lack of correction in adults could be successfully diminished if the “early mistaken outlook” of the child could be made right (Ansbacher & Ansbacher, 1956). Since he felt that he could not reach all parents, perhaps there was hope in “teaching the teachers”. The schools have the ability to remedy the
misguided styles of life that the family can develop. Adler believed that the main idea in
education is to be able to help the child to be a successful model in society. Encouragement of
the child is the most important task of an educator. Dreikurs & Soltz (1964) found that it was
important to encourage the child needs to be a continuous process aimed at his sense of self-
respect and a sense of accomplishment. School-based therapists can help educate the teachers
that children connect punishment with the feeling that they do not belong at school. Therefore,
they will want to escape attending school, instead of trying to succeed academically. Adler’s
Individual Psychology states, “Everybody can accomplish everything” (Ansbacher & Ansbacher,
1956, p. 400).

The class can be treated as if each student is an equal part of the whole, just as a family is
seen as a unit. When teachers and their students are taught this way, the children will be
interested in one another and then enjoy cooperation within the classroom, which could even
transfer to home. When the class is a unit, the class can perceive the successes of one child as an
advantage to the other classmates. Through the cooperation in the classroom, the process of
social interest can begin (Ansbacher & Ansbacher, 1956). Social interest can be influenced not
only by educational influences, but can also be influenced by the environment, the child’s
internal drive and by the family.

To have social interest means feeling like part of a family, a group, a couple, and the
community. Social interest means to participate, to contribute, to share, to feel accepted,
appreciated and loved as well as accept, appreciate and love others. Social interest is a feeling of
belonging to others and not being on the outside (Oberst & Stewart, 2003). Adler believed social
interest is necessary for healthy functioning. He felt that mental disturbances do not only affect
the individual, but also the entire community. A child will always strive to be worthwhile and on
the useful side of life, as long as the feeling of inferiority is not too great. This child will always be interested in others. Social interest and social adjustment are the “right and normal compensations” (Ansbacher & Ansbacher, 1956, p. 155).

A therapist with social interest has the courage to be imperfect, and also genuine. Adlerian therapy stresses that life goals give direction to behaviors and that all behavior is purposeful and goal oriented. We are all motivated by a sense of belonging, having a place in society, and social interest. The child’s sense of belonging begins within their family. Our unique lifestyles direct everything we do.

Adlerian therapy believes that individuals can become whatever they want to be (Corey, 2009). Collecting early recollections can be a remarkable way to help gain information into the way a client wants or perceives that their life should be. This is where the therapist can then help the client to work toward change and/or their goal.

**Adlerian family therapy.** The illustration of Adlerian ideas in today’s family therapy models comes from the foundational assumptions of Individual Psychology that people (family members) are socially embedded in a network of relationships (with parents, siblings, extended family, spouses and friends) in which we seek to meet the challenges of work, love, and community (Oberst & Stewart, 2003). Families and family life become a key element in influencing how children change themselves towards others to endure their own life tasks. Adlerian therapists believe there are four phases to the intervention process with families: form a relationship with the family; assess the family’s lifestyle; promote the family’s insight about their difficulties; and reorientation of the family’s development and continuation of a healthy and socially interested lifestyle (Oberst & Stewart, 2003).
To begin formulating the relationship with the family, the therapist must clearly communicate how they will work with the family as a whole, as well as with each family member. The therapeutic procedures need to be clearly explained. When the family is told what to expect and what the therapy sessions will strive to obtain, the general trust in the therapist will be built. The assessment of the family’s lifestyle can be attained by completing a genogram, completing the family time lines, discussing the early recollections of the family, analyzing the family member’s birth order and resulting family roles, and any other quantitative measures the therapist feels will be useful (Oberst & Stewart, 2003). Using these assessment techniques will begin to help the family understand the basis and quality of their difficulties.

Adlerian therapists can actively intervene through confrontation of the family’s dynamics and symptom prescription techniques. Lastly, as the family begins to give up some of their dysfunctional traits, they begin to develop new behaviors and new ways to relate to each other through reorientation. A few of these techniques that can first be practiced in the therapy sessions are family council meetings, effective communication skills, and developing caring behaviors (Oberst & Stewart, 2003).

Preparing for a School-based Program

It is challenging to approach schools since they already have their system of mental health providers established. The school psychologists and social workers are employed to be responsible for the all the student’s emotional and mental health needs. Some schools may hinder the idea of having a family therapist intervene in a preventive program.

Boyd-Franklin & Bry (2000) established that there a certain conditions that can be put into place to make the family therapist’s entrance more acceptable to the school. First, if a trusted school principal or superintendent introduces this new school-based therapist and program, it can
go much smoother. The relationship of the therapist and the school staff must be sustained as positive and will be changing through the implementation of this new program. They must be seen as an asset to the school and understood that the school staff will be working with the therapist collaboratively. Next, the school administrators must be prepared to admit to the idea that some of the student’s needs are not being met by the resources that they already have in place. Lastly, once the family therapist is allowed into the school, the school staff must be satisfied that the therapist’s work is affecting their work positively instead of making their work more difficult. It will be a detriment to the program if the staff is seeing that they have to do more work instead of feeling relief that the therapist has come to help. The therapist is there to tackle the student’s needs that the staff was unable to deal with or maybe even have the time to do so before.

**Population Intended for School-based Program**

The population that is targeted through this school-based therapy program is at risk adolescents and their families. Early warning signs such as truancy, poor grades, conduct problems, and family conflict have a better likelihood of developing severe problems later on. Schools have identified high-risk students as ones who are showing signs of academic failure, drug and alcohol abuse and juvenile delinquency (Boyd-Franklin & Bry, 2000). Often parents of these high-risk adolescents feel incapable to help their children that have behavior problems and are failing in school. Identifying these students and intervening early can help parents minimize the risk factors that affect their children’s lives.

Working with schools is an ideal setting since the schools can recognize which students need help, it is where the students already are, school staff can influence the parents to permit the intervention, and the schools can offer feedback when evaluating the effectiveness of the mental
health services. The schools can identify such warning signs in the high-risk students as: increase in absences and suspensions; an increase in school failure as a result of low grades or little motivation to finish school work; more reprimands from school staff; and lack of involvement in after school activities.

**Steps Required for Implementation**

After the school consents to implementing a school-based therapy program, the family therapist would first discuss with the school staff the risk factors and the importance of confidentiality of the referred students. The staff goes through the school records to find which students are at risk. Then they would have to contact these students and their families to get permission to be seen by the family therapist, since the therapist is not an employee of the school district. The ideal way is to have the principal write a letter explaining the program and then perhaps the social worker or guidance counselor making a follow-up call. When a trusted school staff contacts the parents, there is a better acceptance rate since they do not know the family therapist yet (Boyd-Franklin & Bry, 2000). The best way for the school staff to introduce this new type of approach for high-risk adolescents is for them to give the message that the therapist can help the student do better in school. To highlight a positive implication to this program by staff can only encourage the parents to see hope for their troubled child.

In 2000, Boyd-Franklin & Bry found that high-risk adolescents and their parents agree to this intervention at the very high rate of 88%, and 100% of those stay in the program. Many people are quite surprised at this figure, since many of those families have not gone before when mental health services have been recommended to them. The family therapist will usually meet with the student first for a few weeks at school to gain their trust and then will call the parents to
meet with them. This service is then offered by the therapist to meet with the family either at school, in their home or perhaps at an agreed location in the community.

At-risk Adolescents and Psychotherapy

**Cognitive Behavior Therapy (CBT).** To examine the treatment process for depression, specific attention is given to the coping skills of the adolescent and to also see how they respond to stress (Gudmundsen, 2008). In a 2008 study, Bernstein followed students from an earlier study to compare three school based CBT interventions for children that suffered from anxiety to find out whether long term post-treatment was beneficial. A three month, six month, and then twelve month follow up interventions were held. The results indicate school-based CBT decreases anxiety symptoms up to 12 months post treatment.

**Group therapy.** The effectiveness of Trauma and Grief Component Therapy (TGCT) was tested by Ritschel in 2011 on a sample of at-risk adolescents who had grown up in Bosnia during wartime to see if they would develop PTSD, depression, and grief. A group of at-risk adolescents for depression was evaluated in another study by holding a six session of Cognitive Behavioral Prevention Intervention. Both of these studies’ findings implied that school based interventions signify a practical procedure for providing group psychotherapy for at-risk adolescents.

**Family therapy.** Targeted Family Intervention (TFI) was given to one of two groups of comparable students who had a mean grade of GPA of 69, over one year. Alexander (2001) found that the results showed that there was no considerable difference that first year between the TFI and the non-TFI groups as far as there school performance. Yet in the second and third year follow-up, there was a significant increase in the TFI group of passing GPA grades than with the non-TFI group. Initially parents had the perception that the TFI would simply give their
child a person to talk to. Instead, they were surprised at how much support and help with emotional issues the therapist was able to help them with. The parents also commented on how they felt they had a “good relationship” with the family therapist and that they also saw a big improvement on their student’s academic success. They also shared how helpful it was to receive the TFI weekly report cards and how they preferred the home based therapy over office visits (Alexander, 2001). In short, this study confirms that preventive family interventions can affect school success over a period of time.

Functional Family Therapy (FFT) is a family-based prevention and intervention program that has been found to be successful in treating at-risk adolescents and their families (Sexton & Alexander, 2000). This model permits intervention to be accomplished for difficult problems within clinical practice that is both sensitive to cultural differences and is adaptable to youth, families, and the community. FFT is a multisystemic and many tiered intervention program that works to strengthen family member’s functioning and to give them a sense that their current situation can improve.

Summary

As the number of students dropping out and failing in schools increases and the current school mental health providers are overwhelmed, the need for a school-based therapist has been shown to be extremely valuable. A main obstacle to learning can be depression and diagnosed disorders, along with behaviors due to educational stress. A therapist can be brought in to work with the entire family system, not just the school-age child or “the problem child”, since their family problems at home can affect their academic success. The therapist can also help with anger management, conflict resolutions, social skills, anxiety and depression, which all can impede with the student’s success in school.
The great thing about school-based therapy is that the therapist can also conduct therapeutic intervention in the student’s homes and in the community, not just in school, whatever works best for the family. Many of the current school mental health providers only have time to focus on prevention of behaviors that are showing up in school. This school-based therapist can concentrate on intensive interventions that include the family and the student’s total life. Families would now be able to access mental health services more suitable to the entire family system when this on-site therapist can attend to their needs that have not been met in the past. This program reduces suspensions and expulsions and also increases attendance and can improve the student’s grades.

School-based therapists also work with the school administration and teachers to resolve any behavioral and mental health issues that they are seeing in the schools. A school-based family therapy program can make sure that both the parents and school staff have a resource that helps these troubled students, both emotionally and mentally.

Adler believed that social interest meant feeling like part of a family, a group, a couple, and the community. Social interest means to participate, to contribute, to share, to feel accepted, appreciated and loved as well as accept, appreciate and love others. Social interest is a feeling of belonging to others and not being on the outside (Oberst & Stewart, 2003). Adler’s focus on social interest was pertinent to healthy functioning. He felt that mental disturbances do not only affect the individual, but also the entire community. We are all motivated by a sense of belonging, having a place in society, and social interest. The child’s sense of belonging begins within their family. This is why it is so important for a therapist to intervene with the whole family, to be able to have all the family members have this sense of belonging.
Methodology

This project is to ultimately propose that Edina Public Schools adopt a school-based family therapy program. The current school mental health providers are primarily employed to work with the students that are showing behaviors at school that are interfering with their academic success. The school staff recognizes that they are able to only work with the students and attempt to just inform the parents on the difficulties the student is having within the school day. The family therapist through this school-based program would now be able to work directly with the family system as a whole. This project was designed to show how a school-based therapist could benefit the Edina schools through an interview, research and a grant proposal all of which support the idea that students can be successful in this program. A presentation was then given to a select group of educators at Edina High School.

Interview with Washburn

An interview was arranged with Christina Gonzalez, LICSW, who is the School Based Mental Health Program Supervisor with Washburn Center for Children. She shared that Washburn has been employing school-based therapists for 5 years in the Minneapolis area. This program started with two schools and now has grown to be in 18 schools; all located in Minneapolis, Bloomington, and Eden Prairie school districts. Minneapolis and Bloomington school districts employ 10 therapists and there are 7 therapists employed in the Eden Prairie school district.

The school districts effectively prepare for school based therapy through early warning signs of mental health issues and/or behaviors, which then turn into referrals by the school staff to the therapist. Since the therapist is not an employee of the school district, confidentiality of the any student’s name and situation is discussed in “code”. The parents would have to agree to
authorize to release any information before any of the specifics of the child or circumstance can be communicated between the school staff and the therapist. This agreement is usually in a legal form that is signed by the parent, so there is documentation of this arrangement.

When asked about how the school district initiates the school-based program, Christina answered that the expansion has been slow and intentional, usually in only one school for the first year. It is determined by each school district whether this program begins in the elementary or secondary levels. For example, Eden Prairie began its therapist in one elementary school where it was noticed the higher need in comparison to the other schools in that district.

The school usually writes a grant proposal to start the therapist to cover the costs to office within the school. When the district is ready to expand the school based therapy program, some schools will give this funding. The funding source can be broken down by the state, the city, then the school district and lastly third party billing.

Research from Minneapolis Public Schools

Expanded school mental health (ESMH) refers to programs that represent partnerships between schools and community organizations to provide a full array of therapeutic service to young people in school settings. There is a lack of research on the impact of school-based mental health (SBMH) on the social and emotional that SBMH is designed to address. Research on SBMH has focused on number of clients served and types of services provided a lack of consensus on which social, emotional and academic outcome variables are important to target or to study (Sander, Everts & Johnson 2011). More consistent and theoretically driven evaluation procedures are needed to advance the field of SBMH, and ESMH in particular. ESMH programs need to develop the infrastructure to collect and analyze program data to clinicians, supervisors,
and program administrators the ability to monitor the impact of their programs at multiple levels (individual student, school, and agency).

The Minneapolis ESMH program was started in 2004 as part of the Safe Schools Health Students federal grant. At each school, a mental health agency placed a full-time professional to practice clinical mental services and supports to students. This program started with five kindergarten through fifth grade or kindergarten through eighth grade schools working with two mental health agencies. Currently, the program is working with four mental health agencies, one being Washburn Center for Children, in fifteen Minneapolis schools (Sanders, Everts & Johnson 2011).

Sanders, Everts and Johnson (2011) discovered that this ESMH program was able to develop a minimum set of variables critical to evaluate the outcomes identified by stakeholders, which is an organization or system that affects, or can be affected by, an organization's actions. This minimum set of variables included: demographic information on each student; service data as recorded for third-party reimbursement; data on additional services such as meeting with teachers and organization of the student’s treatment; a standard mental health outcome measure, and individual student suspension, attendance and academic achievement records.

The research and data collection happened within three phases. In the first phase, the initial program assessment was conducted in the summer of 2006 partnering with University of Minnesota researchers (Sanders, Everts & Johnson, 2011). The evaluation focused on four main areas: the student’s and families’ access to services, the parents’ and then the teacher’s reports on mental health indicators, and fourthly, measurement of the occurrence of both clinical and ancillary services.
The evaluation data for one and a half years of the program showed that 346 students have been identified for services by the school staff. Sanders, Everts and Johnson’s findings were that 82.7% of these students had been seen face-to-face at least once by a clinician. Then 66.5% of these students were seen within 14 days of the referral. Subsequently, an incredible 63.7% of those students, this occasion was the very first time that they had ever received any type of mental health services.

In this first phase, the introductory data showed an increase in the access of services, which for the Minneapolis stakeholders, was an important finding to prove that this school-based mental health provider was utilized. This evaluation also confirmed that the mean number of clinical visits during the school year was 12, supplying evidence that the students and families not only used the therapist, but also continued to keep using the services throughout the year. Both parents and teachers took the Strengths and Difficulties Questionnaire (SDQ), and after examining their responses, it showed a decrease in both emotional and behavioral problems since the beginning of the student’s treatment (Sanders, Everts & Johnson, 2011). The amount of these mental health services that were offered per month also increased. Over the year, the study of this data also found an interesting tendency for the school staff to refer students for services.

After examining the assuring findings from the initial phase, the second phase examined the program’s most impacted school variables, particularly out-of-school suspensions. The students that were studied were the ones that were seen by the provider at least four times and who had also had one or more suspensions. In this study, Sanders, Everts and Johnson (2011) found that 82 students from the 2006 school year whose suspensions had reduced, now in the school year of 2007 established that fifty percent of them had one to six fewer suspensions.
Phase three, during the school year of 2008-2009, found that the treatment group of students substantially decreased their mean number of out-of-school suspensions. This program also showed the accomplishment of helping the low-income and under-served minority people. The researchers showed the fact that 72.3% of all students referred obtained four or more face-to-face services, which indicated that there was a large number of mental health services being used (Sanders, Everts & Johnson, 2011).

**Grant Proposal from a Minnesota School**

The State of Minnesota has offered grant money to increase the availability of both school-based mental health services (SBMHS) and crisis services. Shockman (2009) found in the Crookston, Minnesota area that the local collaborative joined with Northwestern Mental Health Center (NWMHC) to be able to secure state grant funding to improve Children’s Therapeutic Services and Supports (CTSS) services in the region. This replaced the Local Collaborative Time Study (LCTS) funding with other money which helped maintain the School Social Worker (SSW) positions in all schools in the six-county region. As the only full CTSS provider in this region, NWMHC served as the host for the SBMHS grant, and then supported and supervised the actions provided by the grant-funding. (Shockman, 2009)

Shockman (2009) obtained that current funding for school-based mental health positions usually depends on a combination of LCTS, School District, SPED, and possibly some direct County Social Services money. The State of Minnesota is gradually reducing LCTS money, exposing these mental health positions to significant cut in funding.

To maintain funding for the school the following goals would need to be established:

- Expand mental health and skills building services to more children and families in every community in the area.
• Provide expanded crisis services to children throughout the region.

• Allow school social workers to continue serving students and families in their schools.

• Give school social workers the opportunity to advance to Mental Health Practitioner or to Mental Health Professional status, such as a family therapist (LMFT), to be able to properly develop the clinical supervision which is available with these grants.

This grant funding is different because the State will propose that the money is acquired by a “fee-for-service” basis only (Shockman, 2009). This means that the funding is available only through a billing process for submitted services, which intensifies the paperwork load for local insurance providers. The good news is that the bulk of the services to be billed are services that are already being provided by the local SSW.

Other services provided for in the SBMHS grant include clinical supervision for achieving MH Practitioner status and for medical assistance billing and support for training SBMHS mental health providers. The training will include strategies for maximizing the funding available through effective billing practices. The Crisis Services grant offers support for crisis intervention activities on a “fee-for-service” basis as well, but with reduced paperwork requirements for school-based mental health providers.

The Child and Adolescent Service Intensity Instrument and the Strengths and Difficulties Questionnaire are outcome measures to be used with all children ages 6 - 21 receiving mental health services which are paid for through Minnesota Health Care Programs, Children’s Mental Health Infrastructure Grants, and the Children’s Mental Health School-Linked Mental Health Grants. (Shockman, 2009)
**Description of Project Implementation**

To propose the implementation of a school-based therapy program, the project was presented to a panel of educators. The panel included a school social worker, a school psychologist, general education teachers, special education teachers, a guidance counselor and a parent. Initially twelve people were asked to be a part of the panel, but only these eight people were available to attend. It was determined that this would be a good sampling of the school staff that would be most likely that the family therapist would be collaborating with. A parent was also invited to offer feedback of how parents might react to this new mental health provider.

The presentation included an arrangement of a power point slide show and also a scheduled question and answer period. To respect the time of the panel, it was arranged to have the slide show last about thirty minutes and then another thirty minutes for the questions and answers. This total time of one hour was held after school hours and agreed in advance to not run any longer than that.

**Summary of Presentation’s Outcome**

**Personal Assessment**

I learned a great deal from researching, interviewing and presenting this project; a great deal more than I could have ever imagined. I had talked to some Eden Prairie teachers a few years ago that currently have a school-based therapist employed in their school. These conversations triggered my interest to execute this project. They shared the big difference the therapist’s presence made with their students and also how the collaboration impeded the teacher’s success within their classroom.

The biggest thing that I learned is how successful students can become when a therapist offices right in their school. I found a good amount of literature that discussed how the school’s
suspensions and expulsion percentage decreased for the at-risk adolescents, along with the increase of their academic achievement. I was thrilled to discover the parent’s response was very positive, seeing a change in their child’s mental health status and the ability to access a therapist within the school for the entire family.

I feel the presentation of my project went very well. A lot of nerves were felt initially, but once I got into the flow, the nerves subsided. I had note cards to help keep me on track of the information and also to help me remember some of the important facts. I thought I used the note cards more in the beginning when my anxiety was more present. I tried to keep it interesting to keep the panel’s attention. I did this by connecting some of the new therapist’s role into how it would benefit their educator’s role in their current role in the school.

I have a passion for this idea of putting a family therapist into practice within the schools. I tried to illustrate this by sharing how a therapist could be used in the schools and also the promising data of the success that the therapist can have on the student’s achievements. The school-based therapy program seemed like a perfect match when I combined the many years of experience within the school system along with my graduate program in Marriage and Family Therapy.

I would say the only thing that I wish went better is to be able to have the video I had arranged to show them work. I decided to show them the video at the end, after the period designated for questions and answers, instead of at the end of the actual power point. I wanted to make sure I was respectful of their valuable time, and gave them the option to stay and watch the video or leave. Surprisingly all participants elected to stay. I made sure at home that I was able to open up the website for the video, by opening a hyperlink. The location of the presentation had a Smart Board to use to illustrate the power point. As I attempted to open the website, the
curser turned into an eraser and made it impossible to open up the video. I apologized profusely. A few of them asked me if I could send them the link so they could watch the video later. Of course, I agreed and sent them the entire power point by email that same evening.

**School Staff’s Evaluation**

The school staff shared that they felt that an important part of the school-based therapist’s job would be the power to support the school staff to help them know how to better handle certain behavioral matters that they do not personally feel qualified to address with the student. Presently when a student is seeing an outside therapist, it is very difficult to get the parents to authorize them to be able to share their concerns they are observing at school. Another gap they see is the lack of knowledge of mental health concerns that the staff as a whole has. The therapist’s capability to also educate them regarding the ways to assist the student’s mental health issues would be extremely helpful.

All of the educators saw the collaboration with this family therapist to be extremely helpful. The capability to be able to give the therapist a “heads up” when the teacher sees a problem within the classroom is greatly appreciated. The staff saw this collaboration as a great asset to feeling like they are a part of the team and their time as a teacher valued as an intricate piece to the therapeutic plan. Most comforting for the majority of these educators was having the therapist right on site to be able to give them the ability to express their concerns and then be able to have the therapist give them suggestions on how to handle this current concern.

Many of the educators communicated that they see this therapist’s most important role is the ability to work with the total family, not just the student. They understand that many of the behaviors that are exhibited at school are a direct result of the problems the adolescent is experiencing at home. Another important feature is to be able to work with the family assisting
them to define such things as what is each family member’s role within the family, what are healthy boundaries, how to schedule homework and computer time to benefit the family as a whole, were just a few examples.

The parent who attended the presentation commented how she would have liked this program when her child was having issues as a junior in high school. She said that it was very difficult to pick her up from school and bring her to the therapist’s office. It was not only disruptive to the parent’s schedule, but more importantly to her daughter’s school schedule. This parent felt that taking her daughter out of school put her through more anxiety than what she was already trying to deal with. It would have been less invasive to both of their schedules and less back and forth to the off-site therapist’s office, if a school-based therapist would have been available.

**How Project Could be Better Developed**

The project could have been presented to the school board instead of a group of educators and counselors. Usually a grant proposal and/or a new implementation of services would need to officially be presented to the board. The school board would then assess whether or not they would implement this new mental health provider into practice. I felt that it would benefit the school staff to initially hear this presentation since they would be the ones actually working and collaborating with this school-based therapist.

**Future Plans**

It is my aspiration that this presentation gave these educators the awareness and understanding of how beneficial and valuable a school-based family therapist would be to their students, families and the entire staff within the Edina Public School system. The fundamental goal is that there will be a presentation offered to the school board and eventually a grant
proposal to implement this school-based therapy program into the high school in Edina, and then later into all of the schools within Edina School District.
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