School-Based Interventions

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Abstract

In this chapter, we provide a brief history of school-based interventions, the connection between mental health and academics, and the provision of school-based mental health services, with a specific focus on immigrant youth. Immigrant youth within the US school system are described, as well as considerations in delivering mental health services to them within the school context. Various approaches to interventions (i.e., universal, selected, and indicated) are reviewed. Case examples of interventions with good outcomes and effectiveness are showcased and professionals within a school system potentially involved in service provision are highlighted. Evaluation and sustainability of school-based mental health interventions are also discussed.

Keywords

Immigrant • School-based interventions • Youth • Children • Students • Mental health interventions • Schools • Service provision • Refugee

History of School-Based Interventions

There is a long history of clinicians working together with schools to improve the well-being of students [1, 2]. The relationship between schools and mental health services in the USA, however, is one that has been long and complex and has ebbed and flowed since the establishment of psychological clinics by academic/medical

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S.G. Patel, D. Reicherter (eds.), *Psychotherapy for Immigrant Youth*,
DOI 10.1007/978-3-319-24693-2_4

Table 1 US historical sociocultural movements and corresponding mental health development in the school setting

Sociocultural movement	Mental health expansion
Community mental health movement after WWII	Schools viewed as appropriate community-based sites for mental health services
Civil Rights Movement of the 1960s	Legislation established that prohibited discrimination against and provided services to those with mental disabilities
Change in social mores from the 1960s through the 1980s	Increased student involvement in risky behaviors and pressure on schools to provide prevention/intervention services
School-based health clinic movement of the 1990s	Recognition of high prevalence of mental health issues in students and need for services

institutions in partnership with public schools in the 1890s [1]. Five historical sociocultural movements in the USA have been identified that all contributed to more awareness of student mental health and the corresponding need for the provision of mental health services in schools [2] (see Table 1). In addition, Sedlak [1] provides a historical perspective on the relationship between the schools and mental health services focusing on different aspects (e.g., service goals, professional roles, funding, etc.) that have presented challenges to this partnership.

Mental Health and Academics

Research on the relationship between mental health and achievement consistently reports that, as compared to youth without mental health problems, youth with mental health problems have lower school performance and attain lower levels of education [3]. Psychological distress may impact a student's ability to pay attention, hinder his or her executive functioning, and interfere with building social relationships among other areas important to immigrant youth. Roeser et al. [4] summarize data on the relationship between a child's emotional distress and achievement; students with internalized distress (e.g., sadness, anxiety, depression) show diminished academic functioning and those with externalized distress (e.g., anger, frustration) show school difficulties including learning delays and poor achievement. Longitudinal research has found that a student's increase in sadness or hopelessness was related to a subsequent decrease or lack of improvement in test scores in reading, language, and mathematics [5]. Hanson et al. [5] also showed that "beneficial influences" or in other words protective factors such as caring relationships in school, high expectations at school, and meaningful community participation were related to increases in test scores. Poor academic performance and inconsistent attendance have been shown to be early signs of emerging mental health problems or of problems that already exist [6]. It has also been demonstrated that over half of adolescents who do not finish high school have a diagnosable psychiatric illness [7]. Of note, immigrant youth and children of immigrants are much less likely to graduate from high school than those children of US born parents, which may be attributable to high rates of poverty and high proportions of parents who did not graduate high school [8, 9].

Immigrant Youth in the School System

Immigrant students are the fastest-growing sector of students in the USA [10], as more and more parents settle here seeking a better future for themselves and their children [9, 11]. Taken together these data underscore the demographic shift occurring in the USA and resulting change in the school landscape. It also highlights the need for schools to be able to respond to the unique needs of their immigrant student population.

Mental Health Interventions in the School Setting

The continued efforts to implement mental health interventions in the school setting derive in large part from the recognition that students with mental health issues have more school difficulties (e.g., school expulsions, absenteeism, etc.) and have poorer outcomes (e.g., lower graduation rates) than those without [3, 12] and that traditional mental health services are underutilized by youth [13]. It has been demonstrated that ethnic minority, youth in particular, underutilize mental health services [13–15] as well as immigrant and refugee youth [16–18]. In addition, research has also shown that limited English proficiency (LEP) is one of the most powerful predictors of lower use of mental health services [19].

When youth do utilize services, it is oftentimes in the school setting [20, 21]. Thus, schools and educators have much to gain from students receiving appropriate mental health treatment because when mental health needs go unaddressed, academic performance suffers. At the same time, mental health practitioners recognize that offering school-based interventions holds the potential to address both mental health barriers to academic success and structural barriers to youth accessing mental health services. This is particularly relevant for schools with immigrant students given that immigrant students account for growing numbers in the US school system, present with unique mental health needs, and have higher high school dropout rates than US born youth.

Despite the many advantages of school-based mental health services, successful implementation of these services faces a number of challenges [22, 23]. There are standard challenges such as funding concerns, lack of adequately trained mental health school-based professionals, and lack of school administrator or staff buy-in [22, 23] that impact the implementation of school-based mental health programs. Two educational policies also shape the landscape in which school-based mental health programs operate: (1) the Individuals with Disabilities Education Act (IDEA) of 1994 (reauthorization in 2004) and (2) the No Child Left Behind Act (NCLB) in 2002. (For a more comprehensive history of education policy and its interface with mental health, please see Kataoka et al. [12].) In addition, the implementation of school-based mental health programs with immigrants faces its own unique challenges. The remainder of this chapter focuses on school-based mental health interventions that address the unique challenges and needs of immigrant and refugee youth.

Considerations in Delivering Mental Health Services to Immigrant Youth

We highlight here several considerations in implementing school-based mental health services with immigrants: heterogeneity of immigrant populations, confidentiality, family involvement, and the importance of the socio-ecological framework. Immigrant youth and families represent a multitude of different backgrounds and experiences including reasons for migration, experience of migration, languages, and cultures. This heterogeneity can prove challenging to schools, as youth and their families vary in the amount and types of mental health support they need to make a successful transition to school and the community. In addition, there is a large need to service the variety of languages spoken by immigrant families but a shortage of translators and limited language and cultural resources available to schools to help communicate with youth and families. Schools are challenged to have the cultural and linguistic capacity needed to keep up with the increasing numbers of immigrant youth, and there is a real need to provide adequate culturally appropriate training of school personnel to attend to immigrant youth and their families [24, 25].

An important consideration when delivering mental health services to an immigrant population is keeping confidentiality. Confidentiality is of particular concern both within the school setting and within ethnic communities. It is mandated in mental health services so that one's personal information cannot be shared without permission [22]. Issues of confidentiality become particularly salient in immigrant communities where there is stigma around mental health and mental health services [26]. Relatedly, legal issues must be considered when working with immigrant communities. For example, immigrants who have arrived in the USA without sufficient legal documentation or those in the midst of legal procedures related to immigration status may be less likely or worrisome to convey personal information to anyone at a public institution including a school. Given the tight-knit nature of some immigrant communities, some families may also fear that information about their child will be shared with other community members. This is prominent among immigrant communities where translators are often people from within the same community. The concern of private information being shared may also be increased or intensified for those who are representatives of more rare cultures/languages within a given community. Ellis and colleagues [26] assert that "in some instances, community members may be concerned that if a child is known to be receiving mental health care, the stigma he or she may experience would be more damaging than receiving no care at all" (p. 71). Thus extra care must be taken to ensure confidentiality. This is especially true in a school setting where students may be aware of when another student is being pulled out of a class for services. A balance must be struck between sharing student information in the service of improvement or student success, sharing clinical information about a student (e.g., safety concerns), and sharing information about the youth that does not need to be shared within the school or with others in the immigrant community [22, 26].

Another consideration for service delivery with immigrant youth is family engagement, both with the school system in general and with mental health services. Immigrant parents may have varying knowledge of the US school system or of schooling in general [27] or at times due in part to their own lack of educational attainment. Even if they are familiar with the institution of school, culturally they may have different expectations of the role of the school, the teachers, and/or themselves in their child's education [25]. These challenges to engage immigrant families in the school system can be compounded by the difficulty that immigrant children and families have in accessing mental health services, including the stigma of mental health across various cultural groups [11, 13, 28]. Although parents may be concerned with behaviors at home or in school, they may not understand the psychological sequelae to these behaviors [29]. This may reflect different cultural understandings of mental health issues [16]. Alternatively, these symptoms might be seen as less important relative to other factors; the acculturative stress experience by immigrant families may have more prominence in daily life as they struggle to meet their housing, healthcare, and employment needs [30]. Schools need to take these challenges into consideration in engaging immigrant families in the school system and mental health services.

Finally, when implementing mental health services, it also important to understand a youth's immigration experience from a socio-ecological framework [31]. Assessing a student within his or her individual, familial, societal, and cultural contexts is critical to addressing the mental health and overall well-being of immigrant youth [32–34]. These issues related to the socio-ecological context (e.g., ethnic identity, gender, trauma exposure, community violence, poverty, discrimination) can have an impact on the overall well-being of students, contributing to learning, socio-emotional, and behavioral problems [35, 36]. Pumariega and Rothe [18] provide a comprehensive overview of the unique challenges of immigration (e.g., migration experience, acculturative stressors, etc.) and discuss factors such as acculturation status that may minimize risk of poor mental health in immigrant youth. Of note, they report that the less acculturated an individual, the better his or her mental health profile; first-generation immigrants fare better than 1.5[1] or second-generation immigrants in terms of psychopathology [18]. Similarly, Ellis et al. [33] provide a thoughtful overview of the unique challenges of refugees and broaden the understanding of the refugee experience to include core stressors of trauma, resettlement, isolation, and acculturation.

Rationale for School-Based Mental Health Intervention

The school system is a promising setting to increase access to mental health services [37], particularly for immigrant youth [26, 38, 39]. Schools are uniquely poised to meet the aforementioned considerations for a few key reasons: schools are gateway

[1] The term 1.5 generation describe people who were born in another country and arrived in the USA as children and adolescents.

providers that allow for the engagement of immigrant youth and families, schools allow for early identification of mental health need among immigrant students, and school-based interventions can address the socio-ecological framework that is critical to these youth.

Stiffman and colleagues [40] describe how a child's mental health is determined by key individuals, or gateway providers, who both have the ability to influence decisions about help seeking and the information related to available resources. School-based staff (e.g., teachers, coaches, front desk administrators, etc.) represent gateway providers for immigrant youth and families since schools are a key part of the resettlement experience. Schools provide a shared and common context for those whose environments and experiences have been disrupted by trauma and displacement, such as refugee and immigrant youth. They are one of the earliest systems that are introduced in resettlement and are often highly respected institutions by these families. School-based staff can help parents navigate what is initially an unfamiliar school system and at the same time expose them to mental health services and resources available. As schools develop trust and relationships with these families, the process of referral or integration into mental health services is more easily facilitated. Schools therefore play a key role in decreasing the stigma of mental health services among immigrant populations [32, 41]. Finally, the transportation barriers that are endemic to the underutilization of mental health services (in clinic settings) by immigrant populations are not usually involved in accessing schools. This context of familiarity, de-stigmatization, and access becomes a unique opportunity to deliver mental health services to refugee and immigrant youth [41–43].

The school environment also provides for the early identification of immigrant youth in need of services. Teachers and auxiliary school staff have the unique perspective of being able to observe children in a number of different settings and activities during the school day, over different periods of time, and with different individuals such as other students, friends, and adults [44]. Teachers, school administrators, and other school staff are able to observe these children in a non-stigmatizing manner, providing information related to needed mental health services that might not be available otherwise.

Finally, school-based intervention has the potential to address the broader socio-ecological context that is critical to serving the mental health needs of immigrant youth. The process of acculturation, which often integrates multiple levels of the socio-ecological context, is a defining feature of an immigrant youth's experience [39, 45]. This process may be particularly prominent in the school setting as youth navigate daily intercultural interactions with their peers and teachers outside of their familial and cultural contexts. The combination of the process of acculturation with the developmental transition that these youth are going through makes them especially amenable to supportive interventions [42, 43]. It has therefore been suggested that the school context, where immigrant children are navigating acculturation and striving for overall adjustment, is the appropriate place to provide mental healthcare [46, 47]. Addressing acculturation as part of a mental health intervention can help how youth learn and how they relate to other students and youth [48]. Thus, school-based interventions are well positioned to provide timely mental health services that incorporate a focus on the broader social context that immigrant youth are experiencing.

Approaches to School-Based Mental Health Interventions

Schools can provide mental health services to immigrant youth through a number of different approaches. There are a number of practical considerations when designing school-based services such as the demographics of the population (ethnicity, age, and gender), the setting in which the school is located (i.e., urban vs. suburban), and when services will be offered (integrated as part of the regular academic curriculum, offered during electives, or held after school). For example, the demographics of the population will affect the curriculum/content being offered (e.g., boys versus girls) and whether any group services are mixed-group or a single ethnicity, gender, or grade level. Another example is the setting of the school and availability of transportation, which may impact how children get home or when services can be offered. Similarly, the timing of services during the school day will impact what other content the children will miss and how singled out they feel/appear to others when receiving services.

School-based mental health services vary, both in terms of focusing on prevention versus more acute intervention and also in terms of who provides these services (see below for a discussion of individuals involved in service provision). We adapted the following table from the American Academy of Pediatrics [22] to provide an overview of how a school or school district can configure mental health services using a three-tiered model of services [2, 22] (see Table 2). The configuration of services should depend upon the refugee or immigrant population in the school, the broader school population, existing mental health capacity in the school, and partnerships with agencies outside of the school. Multiple tiers of services can be combined into one program, along the lines of a public health prevention model that includes a spectrum of activities across different levels of prevention and intervention. Comprehensive services that address multiple layers of intervention may be the most successful for immigrant youth [49, 50], and schools are key settings to provide this range of prevention, early identification, and treatment [28, 44, 51].

Table 2 Overview of school-based services, targeted participants, and overall focus of intervention

Services	Target participants	Overall focus
Universal services: preventive mental health programs and services	All children in all school settings	Decrease risk factors (e.g., risk-taking behaviors) and build resilience (e.g., school connectedness)
Selected services: group or individual therapy	Students who have identified mental health needs or risks	Individual students' identified emotional or behavioral issues
Indicated services: multidisciplinary team services including but not limited to special education services, individual and family therapy, pharmacotherapy, and school and social agency coordination	Students with mental health diagnoses	Individual students' identified needs in multiple areas of functioning

A universal intervention is delivered to the whole school or classroom and usually involves a transformation of the school environment as opposed to implementation of a specific treatment modality. One of the most common types of a school-based mental health universal intervention is social and emotional learning (SEL) that focuses on the relationship between social and emotional competencies, the development of character, and a core set of life principles and academic achievement [52]. Durlak et al. [48] did a meta-analysis of 213 school-based, universal SEL programs and found that these programs improved socio-emotional competencies, attitudes, academic performance, and pro-social behaviors [48]. SEL programs have been adapted for Latino immigrant populations with favorable results [53]. Another example is the Cultural Adjustment and Trauma Services (CATS) model, a comprehensive program for first- and second-generation immigrant children with significant trauma exposure and/or cultural adjustment needs [46]. At the universal level, CATS provides relationship building between school personnel and immigrant students, coordination services aimed at reducing stress in the school environment, and supportive resources for families and outreach services [46]. A third example of a universal intervention is creative expression workshops that involve music, creative play, drama, and drawing. These workshops have been used to address general adjustment issues and have been shown to increase feelings of integration as well as decrease levels of emotional and behavioral symptoms [54].

Case Study

Project SHIFA (Supporting the Health of Immigrant Families and Adolescents), a multitiered model that involved a universal component, was developed to specifically address challenges to engaging Somali youth and families in services, as well as problems associated with traumatic stress [26, 55]. It was developed through a partnership between agencies with specific expertise in mental health, education, and Somali culture. Project SHIFA was based in a middle school in the Boston Public School District and provided secondary prevention and intervention services to Somali English language learner (ELL) middle school students and their families.

Project SHIFA is a four-tiered integrated and comprehensive model of prevention and intervention. Tier one is community outreach and engagement, which seeks to address the challenge of parent and community engagement as well as address the barrier of stigma around mental illness and treatment. Tier two is comprised of school-based nonclinical skill-building groups, which seeks to teach emotion regulation and coping skills as well as provide a safe space for youth to discuss acculturation issues. Stigma of services is reduced by inviting all Somali ELL students to join the groups. In addition, the groups provide a method for monitoring individual youth, which aids in the collection of diagnostic information, especially in reference to their peers, who may

need more targeted or intensive services. Tier three is individual outpatient/school-based therapy, which targets the specific needs of the child. Tier four is home-based therapy, which enables more intensive work with families. The evidence-based model implemented in Tiers three and four is trauma systems therapy (TST). TST is a treatment model that views the development of traumatic stress in children as resulting from two main elements: (1) a traumatized child who is not able to regulate emotional states and (2) a social environment or system of care that is not sufficiently able to help the child contain this dysregulation [56].

A lesson learned from the implementation of Project SHIFA, Boston, is that inclusivity and flexibility are key to engaging refugee families in a mental health program [57]. A clear example of the flexibility and responsiveness to the community needed in implementing a program in a refugee community is highlighted by the following. In Project SHIFA, Boston, community outreach and anti-stigma efforts, in combination with parent engagement during the time their children participated in the school-based groups, resulted in exceptionally high success rate with referrals for individual and family mental health services. As school was not viewed as a comfortable, accessible place for some families to meet with clinicians, Project SHIFA partnered with a home-based agency to provide in-home services.

Selected school-based interventions for immigrant youth are designed to target mental health symptoms more directly and are delivered to those who have been identified as at risk for or as having mental health needs. Selected interventions for immigrant youth have the goal of preventing and/or improving functioning and often employ therapeutic components eclectically rather than as part of a structured protocol. Selected interventions for immigrant youth are often delivered as part of a multitiered program that incorporates universal and/or targeted services. An example of a selected mental health intervention is one tier of the aforementioned CATS program. Supportive therapy, psychoeducation, and cognitive behavioral therapy (CBT) techniques are provided to a subset of the immigrant children in response to clinical presentation and/or cultural adjustment needs [46].

Targeted school-based interventions for immigrant youth focus on populations with a specific diagnosis. These interventions usually involve a therapeutic component focused on the verbal processing of past experiences and are often targeted toward PTSD or depression. The CATS program employed trauma-focused CBT (TF-CBT) to treat children with PTSD or if they identified a specific traumatic event as related to their current problems [46]. A second example of a targeted intervention for immigrant youth is Cognitive Behavioral Intervention for Trauma in Schools (CBITS) [38, 58]. CBITS was designed for a multicultural population in an inner city school in response to community violence exposure. CBITS has since been

adapted for American Indian adolescents who presented with symptoms of PTSD and depression [38, 59]. CBITS is comprised of teacher psychoeducation, a 10-week CBT group therapy (focused on anxiety, PTSD, and depression symptoms), as well as individual youth and optional parent sessions [59]. Finally, the Mental Health for Immigrants Program (MHIP) [38] is based on the CBITS program and is offered to newly immigrated Latino children. Youth who screened positive for exposure to violence and clinically significant symptoms of PTSD and/or depression received eight sessions of CBT group therapy.

The aforementioned universal, selected, and targeted school-based interventions have been effective with the specific populations for which they were developed. In some cases, i.e., CBITS with Latino children, as well as (nonimmigrant) Native American Indian adolescents, the intervention has been adapted for multiple populations with success [38, 59]. A review of the literature shows a lack of school-based interventions that have been used with multiple populations, especially with various cultural groups; the approach has been to demonstrate effectiveness with one group. The next step would be to determine if the principles of the intervention are generalizable to other cultural or ethnic populations. In the case of TST-R (the in-depth case study above), the intervention was developed and evaluated with Somali refugee youth and is currently being implemented and evaluated with Bhutanese refugee youth, with considerations for expanding the model to mixed-ethnicity groups (M. A. Benson, personal communication, May 20, 2015).

Individuals Involved in the Provision of School-Based Mental Health Services

Given the limited resources and high demand for provision of mental health services in the school setting, clinicians should be prepared to work in collaboration with existing school resources and personnel [60]. According to the *National Association of School Psychologists* (www.nasponline.org), most school-based mental health services will be provided by school-employed professionals such as guidance counselors, psychologists, and social workers. These professionals will have training in learning and mental health within the school context and can contribute to academic and school success. Community-employed professionals also may provide mental health services in schools and/or across school districts through intra-agency agreements. In this case, mental health providers from the community agency deliver services within the school setting. These professionals usually focus on the global mental health of students and how it impacts the students' functioning in the contexts of family, community, and work. The AAP [22] also offers a way to understand the various mental health service delivery models that are utilized by schools or school districts (see Table 3). The identified models and model components are not exclusive and schools may offer one or more components of these models [22].

Given the increasing numbers of immigrant students in the school system, it is important for schools, teachers, and other school staff to provide culturally and linguistically appropriate services in response to the needs of their immigrant

Table 3 Mental health models and corresponding model components

Mental health model	Components of model
School supported	Providers are employees of the school system: Social workers Guidance counselors School psychologists Separate mental health units exist within the school system School nurses serve as a major portal of entry for students with mental health concerns
Community connected	A mental health agency or individual delivers direct services in the school part time or full time under contract Mental health professionals are available within a school-based health center or are invited into after-school programs Formal linkage to an off-site mental health professional and/or to a managed care organization
Comprehensive, integrated	A comprehensive and integrated mental health program addresses prevention strategies, school environment, screening, referral, special education, and family and community issues and delivers direct mental health services School-based health clinics provide comprehensive and integrated health and mental health services within the school environment

students and families. As such, in the process of implementing a school-based mental health program with immigrant youth, it would be beneficial to provide on-going professional development opportunities to teachers and school staff [23, 61] across varying domains relevant to the provision of services and mental health of immigrant students (e.g., evidence-based interventions, emotion science, reasons for migration, etc.). It has been recommended, however, that professional development opportunities should not be prescribed or regulated but that a more flexible approach be taken [61]. An approach that is responsive to the needs of the school, the teachers themselves, as well as the needs of the students [61].

Evaluation

Evaluation of school-based mental health programs for immigrant youth is important, as the research base for what is known to be effective for these populations is limited. As part of this evaluation, outcomes must be measured in order for an intervention to be considered either efficacious or effective. Efficacy is defined by how well an intervention performs under ideal and controlled conditions, such as in an academic research center, whereas effectiveness is defined by how well an intervention performs under real-world conditions like in a school context [60]. Outcome targets of interest may differ for different stakeholders such as schools, parents, and mental health systems. As such, it is important to define what is meaningful when considering evaluation or outcome measures [60]. It may be beneficial for program evaluators to consider what outcomes may be meaningful to different stakeholders such as school administrators (e.g., attendance, GPA, standardized test scores,

graduation rates), teachers (e.g., reductions in stress, opportunities for professional trainings), students (e.g., increased sense of school belonging, acculturation), parents (e.g., academic performance, reduced disciplinary measures), and the researcher/clinician (e.g., improvement in mental health symptoms). Program evaluation is not only essential to demonstrate a program's effectiveness but also can provide invaluable information about the quality and perceived value of the program. The collection of outcome data can lead to improved and meaningful outcomes for participants and may also be leveraged to obtain funding for the program in the future [60].

Sustainability

Once a school-based mental health program for immigrant youth has been developed, implemented, and shown to be effective, the question turns to how to sustain or maintain it. In addition to the standard barrier of funding, sustaining school-based mental health programs for immigrant youth involves the unique challenge of obtaining buy-in from multiple stakeholders, including school and community. Integration of services within the school context is crucial to gaining school administrator and staff buy-in, but the program must also be flexible and responsive to the needs of the community it serves. Just as it is paramount that school administrators and staff view mental health services as not only worthwhile but also critical to the well-being and adjustment of their immigrant students, it is also paramount for the immigrant community. One means of accomplishing this may be making explicit the connections between mental health services, improved academic success, and increased parent engagement to school administration and staff and creating a mechanism of providing positive feedback to immigrant parents. Another may be to provide professional development opportunities to teachers and school staff on topics integral to the program (e.g., cultural presentations of the targeted ethnic community, presentation of the consequences of mental health disorders like PTSD on academic learning in youth, etc.). It may also be beneficial to offer needed or desired services to immigrant parents in the school setting (e.g., English as a second language class, navigating the US school system 101, etc.). Activities such as these contribute to program ownership by and engagement of key stakeholders [26, 55].

In addition, the development of school-based mental health intervention in consultation and collaboration with key partners like community leaders, parents, and the school is critical for sustainability [10, 26]. Partnership with the community is essential to develop a school-based mental health program that is consistent with community needs, priorities, values, and culture [26, 62]. Partnership with the school is critical to cultivate buy-in and accountability as well as to address practical issues of implementing services such as space and time and obtaining consent [22]. It has also been recommended that interventions be grounded in strength-based approaches [10] that acknowledge, leverage, and view as an asset the diverse cultural factors of immigrant communities.

Conclusion

Immigrant youth represent an increasing population in US schools. In order to best service these students, we must be able to attend to their overall well-being and adjustment to the USA, which may include responding to their socio-emotional needs. Schools are uniquely poised to deliver mental health services to refugee and immigrant youth, as they address structural barriers to accessing mental health services. Embedding culturally appropriate mental health services in the school provides an invaluable opportunity to overcome mental health barriers in order to promote academic and life success of immigrant youth in the USA.

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