

Improving Implementation of a School-Based Program for Traumatized Students: Identifying Factors that Promote Teacher Support and Collaboration

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Published online: 31 December 2015

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Abstract The purpose of this study was to delineate the factors that influence teachers' support and involvement in successful implementation of an early intervention, school-based trauma program, Cognitive Behavioral Intervention for Trauma in Schools (CBITS). In schools that had already used the intervention for at least one school year, we interviewed teachers and other stakeholders to understand what factors influence teacher support and clarify the role teachers desire in the implementation process. This paper also illuminates barriers to their support and collaboration and identifies methods to improve future implementation and sustainability. We conducted 40 semi-structured qualitative telephone interviews with school staff across three geographic regions in the USA. Participants were asked about their experiences with CBITS in their schools and asked to share both facilitators and challenges to

implementation. Four key themes emerged: Support for CBITS was related to teachers' perceived need for a trauma program on campus; teachers struggled with the competing priorities of balancing students' social-emotional needs with their missing class to attend CBITS; teachers desired more direct communication with clinicians; and teachers felt they needed more trauma education. Suggested improvements include acknowledging teacher concerns about lost instructional time for CBITS sessions and offering groups during non-core academic instruction, expanding trauma education for teachers, so they can better respond to and connect traumatized students with intervention services, including regular consultation between teacher and clinicians about participating students, and improvements in academic performance following the intervention should be shared with teachers to improve their support.

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Keywords Schools · Mental health · Trauma services · Implementation · Teacher support · Teacher collaboration

Introduction

Despite studies documenting the multi-dimensional and far-reaching impact of exposure to violence and other traumatic events on the social, emotional, and academic development of adolescents (Schwab-Stone et al., 1995; Delaney-Black et al., 2002), few youth, especially low-income minority youth who have often been exposed to high rates of trauma, receive early intervention (Kataoka, Zhang, & Wells, 2002; Jaycox et al., 2002; McKay, Lynn, & Bannon, 2005). To mitigate the long-term effects of trauma, effective psychosocial interventions for trauma-related symptoms in youth have been developed (Cohen,

Deblinger, Mannarino, & Steer, 2004; Stein et al., 2003). However, for the populations most in need of such care, access remains a challenge. The Surgeon General's National Action Agenda for Children's Mental Health (2000) suggests that school-based programs can address the challenges associated with access. School-based services are particularly important for underserved ethnic minority youth who traditionally are less likely to receive services elsewhere (Kataoka et al., 2003; McKay et al., 2005).

Many schools have begun to recognize their significant role in addressing students' emotional and behavioral needs. For example, a recent shift in education policy has led many schools nationwide to begin implementing Multi-Tiered System of Supports (MTSS), a new framework that aligns all school initiatives, supports, and resources to integrate and promote students' academic, behavioral, and social-emotional goals (Averill & Rinaldi, 2011). MTSS's integration of systemwide supports can ensure collaborations across disciplines, particularly between educators and school mental health providers to help students succeed in school (Averill & Rinaldi, 2011). The model includes universal programs (Tier 1), supplemental early and targeted group interventions for those at risk (Tier 2), and services delivered to those in need of intensive individual services/intervention (Tier 3). At a policy level, this system includes psychosocial interventions as consistent with and critical to the educational mission of schools (Averill & Rinaldi, 2011).

Despite this shift in policy, successful implementation of school-based mental health programs can prove challenging. One such study found that evidence-based mental health interventions can "languish" for 15–20 years before becoming common practice in community settings (Balas & Boren, 2000). The field of implementation science has sought to speed up this process by understanding the factors that aid and those that impede integration of evidence-based mental health interventions.

A number of models have emerged (Mendel, Meredith, Schoenbaum, Sherbourne, & Wells, 2008; Aarons, Hurlburt, & Horwitz, 2011; Greenhalgh, Macfarlane, Bate, & Kyriakidou, 2004; Fixsen, Naoom, Blase, & Friedman, 2005) for studying the complex variables that influence whether evidence-based mental health services will be implemented and sustained successfully in community settings. These models posit that there must be buy-in and support from key stakeholders. In the school setting, teachers are key stakeholders and their support is key to facilitating the implementation, success, and sustainability of mental health interventions in schools (Forman, Olin, Hoagwood, Crowe, & Saka, 2009; Lynn, McKay, & Atkins, 2003; Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). For teachers, as well as other stakeholders, it is critical that interventions be framed as supporting the

school's main purpose: educating students (Domitrovich, Bradshaw, Poduska, Hoagwood, Buckley, & Olin (2008), and that the benefits of treatment be evident (Forman et al., 2009; Weist et al., 2012; Flaspohler, Meehan, Maras, & Keller, 2012). Thus, key stakeholders, including teachers, administrators, and school-based clinicians all need to agree beforehand that a particular problem warrants attention and have confidence that the targeted intervention will address the problem they have observed (Fixsen, Blase, Metz, & Van Dyke, 2013; Domitrovich et al., 2008).

It is clear that teacher support is critical: A qualitative study conducted with school-based mental health intervention developers found that 58 % of respondents identified teacher support as a major facilitating factor that made implementation of their intervention successful (Forman et al., 2009). Specifically, Forman and his colleagues refer to the "visible impact of new programs" as the most important factor in eliciting and sustaining teacher support (Forman et al., 2009). Similarly, other studies conducted with school-based clinicians and administrators found lack of support and teachers not allowing students to leave class to be one of the most commonly reported barriers to the implementation of an evidence-based trauma intervention [Cognitive Behavioral Intervention for Trauma in Schools (CBITS)] for middle school students (Langley et al., 2010). Although these implementation studies did not include teachers directly, the stakeholders included suggest that for any intervention to succeed, teachers must see the connection between impairment from trauma-related symptoms and their students' ability to succeed academically and socially. Further, they must observe concrete evidence—such as improvements in their students' behavior and performance following the intervention—if they are to fully support it.

Studies have also pointed out advantages of teacher buy-in and collaboration that are unique from other stakeholder groups. Teachers spend the most time during the school day with their students, often know them the most intimately, and, with psychoeducation, may be able to integrate the coping strategies and insight provided by interventions in ways that directly improve academic performance (Adi, Killoran, Janmohamed, & Stewart-Brown, 2007; Feinstein, Fielding, Udvari-Solner, & Joshi, 2009; Diekstra & Gravesteyn, 2008). These studies point out important benefits of including teachers in the implementation of mental health interventions, particularly because mental health professionals have substantially less access to students.

While previous research has highlighted the importance of garnering teacher support and the need for collaboration with teachers for successful implementation and sustainability, few studies have interviewed teachers directly about factors that influence their support and role in

implementation. Those studies that have interviewed teachers have mostly explored their attitudes toward and understanding of students' mental health needs in general. These studies suggest that teachers are invested in their students' mental health, including the health of students exposed to traumatic stress (Alisic, 2012; Alisic, Bus, Dulack, Pennings, & Splinter, 2012; Graham, Phelps, Maddison, & Fitzgerald, 2011; Reinke, Stormont, Herman, Puri, & Goel, 2011; Williams, Horvath, Wei, Van Dorn, & Jonson-Reid, 2007; Walter, Gouze, & Lim, 2006). In the study conducted by Alisic (2012), they found that elementary school teachers would like to provide additional support for traumatized students, but feel limited by their lack of relevant knowledge about mental health issues. These findings have not been replicated in middle or high school. Similarly, evidence suggests that support from teachers can improve psychological adjustment in students. Reddy and colleagues found that those students who perceive their teachers as supportive of their mental health issues experience a decrease in depressive symptoms and an increase in general self-esteem (Reddy, Rhodes, & Mulhall, 2003). Though it is clear that teachers recognize that their students have mental health needs and would like to help, studies have not interviewed teachers directly about a specific mental health intervention that has already been implemented in their schools. Do they see this intervention as filling an existing need, do they see its value to their students, and were there factors that limited their support and collaboration?

The intervention in our study, Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, 2004), was created in partnership with school staff and administrators to maximize sustainability (Wong, 2006). CBITS can be delivered by existing school clinicians, rather than requiring outside resources, and is designed to work within the confines of schools without overburdening teachers. A school community-research collaborative team designed CBITS sessions to be offered during the school day when school counseling usually occurs and to fit within one class period "bell-to-bell." By "fitting" within the framework of the school environment, CBITS has characteristics that have been found to facilitate adoption of new innovations (Rogers, 1995) such as relative advantage over usual care practice, and compatibility with other behaviorally oriented practices in schools. Overall, clinicians have described CBITS with a high level of acceptability and feasibility, with "user-friendly materials" and a "well-defined" curriculum (Langley et al., 2010).

CBITS is delivered to students who have been exposed to trauma and exhibit symptoms of PTSD in the clinical range (see Stein et al., 2003 for details). During 1-h weekly group sessions over the course of about 10 weeks, students learn the core components of cognitive behavioral skills. CBITS has been studied in a quasi-experimental trial

(Kataoka et al., 2003) and randomized controlled trial (Stein et al., 2003), both delivered by school-based clinicians. Findings have demonstrated improvements in post-traumatic stress disorder (PTSD) and depressive symptoms among late elementary and middle school students exposed to violence who received CBITS compared to those on a waitlist. Preliminary findings also suggest that this program may have effects on school performance, with students who receive CBITS early in the school year doing better in math and language arts grades than students who receive the intervention later that same academic year (Kataoka et al., 2011). CBITS, a Tier 2, targeted group intervention within the MTSS framework, has now been disseminated in schools across the USA, with some districts being able to sustain implementation over several years. Others have had less success with long-term sustainability (Langley et al., 2010). One common challenge, even in schools that successfully implemented CBITS, was coordinating the delivery of this mental health program with teachers.

In an effort to improve this coordination and better understand implementation challenges, this exploratory study interviewed teachers. We asked them about their role in facilitating and supporting CBITS implementation and to identify barriers to their support. We also interviewed other key stakeholders to understand their perspectives on the role teachers play in CBITS implementation. Specifically, this study aims to identify teachers' attitudes and beliefs about their experience with CBITS, how they would best like to participate in implementation, any challenges they perceive to the program's sustainability, and their suggestions for improvement.

Method

Participants and Procedures

We conducted a qualitative study with a broad set of school stakeholders to examine what factors influence the role of teachers in the implementation of CBITS. The primary inclusion criteria were that a region had to have successfully implemented CBITS in its schools for a minimum of 2 years. Of the three regions selected, each had varying funding and implementation approaches. Table 1 describes the funding sources, policies, and implementation strategies for CBITS in each region. Utilizing a community-partnered research approach (CPPR) (Wells & Jones, 2009), the research team collaborated with CBITS community partners in each region to identify specific schools for the study. The final sample included a total of 11 schools: 4 schools in the Western region, 4 schools in the Midwestern region, and 3 schools in the Southern region (see Table 2).

Table 1 Funding sources, CBITS policy and implementation strategies by region

	Funding sources	CBITS policy	Implementation strategy
Western region	Federal grant dollars District funds, Medicaid billing	Centralized: Training and supervision provided by the district Mental Health Unit Decentralized: Decision to implement CBITS made at the individual school level	Individual district clinician
Midwestern region	Federal grant dollars Private charity	Centralized: Training and implementation decisions made at the district level	Colocation: Community mental health agency clinician partner with onsite school clinician
Southern region	Federal grant dollars	Centralized: Training and supervision provided by local community mental health agency Decentralized: Decision to implement CBITS made at the individual school level	Colocation: Community mental health agency clinician partner with onsite school clinician

From these schools, a convenience sample of 71 potential participants was identified by the community partners: 51 (72 %) completed interviews, 15 declined participation, and five could not be contacted. Participants were eligible for the study if they had been involved in the implementation of CBITS in the past year; the teacher sample included those whose students participated in CBITS. CBITS was typically implemented in grades 5–9 in participating schools. Across all schools, interviews were conducted with a total of 51 participants: 11 teachers, 15 clinicians, 9 school administrators, 11 parents, and 5 regional administrators (e.g., funding administrators, regional mental health coordinators). Participants were evenly distributed across regions and schools. For the purposes of this study, we omit the parent

interviews since they did not include discussion of the teachers’ role, so our final sample includes 40 participants. See Tables 2 and 3 for a complete summary of participant characteristics and school demographics.

After obtaining informed consent, participants took part in a semi-structured qualitative phone interview and received a \$20 merchandise gift card for participation. The interview was designed to examine the implementation process from the perspective of multiple key stakeholders at the school, district, and regional levels. Interview questions were adapted from a conceptual framework proposed by Mendel et al. (2008) that identifies key characteristics as contextual factors that influence implementation. Mendel’s model describes particular contextual factors: policies and

Table 2 Participant demographics

Participant demographics (<i>N</i> = 40)	Clinicians (<i>N</i> = 15)	Teachers (<i>N</i> = 11)	School/regional administrators (<i>N</i> = 14)
<i>Gender</i>			
Male	1 (7 %)	4 (36 %)	3 (21 %)
Female	14 (93 %)	7 (64 %)	11 (79 %)
<i>Age</i>			
Less than 25 years old	2 (13 %)	0	0
25–34	6 (40 %)	4 (37 %)	2 (14 %)
35–44	5 (33 %)	4 (37 %)	4 (29 %)
45–54	1 (7 %)	3 (27 %)	3 (21 %)
55–64	1 (7 %)	0	4 (29 %)
65 years of age or older	0	0	1 (7 %)
<i>Race/ethnicity</i>			
African-American, Black	0	1 (9 %)	3 (21 %)
Hispanic, Latino	6 (40 %)	2 (18 %)	2 (14 %)
White	8 (53 %)	7 (64 %)	8 (57 %)
Other	1 (7 %)	1 (9 %)	1 (7 %)
<i>Highest level of education</i>			
Bachelor’s degree	2 (13 %)	6 (55 %)	0
Master’s degree	13 (87 %)	4 (36 %)	11 (79 %)
Doctoral degree	0	1 (9 %)	3 (21 %)

Table 3 School demographics

School (<i>N</i> = 11) ^a	A	B	C	D	E	F
Region	Western	Western	Southern	Southern	Midwestern	Midwestern
Enrollment	2117	771	183	398	671	431
School type	Public	Public	Charter	Private	Public	Public
Grades	K-12	K-5	9–10	K-8	6–8	6–8
Teachers	2	1	1	1	1	1
Clinicians	2	1	1	1	1	1
Administrators	0	1	0	1	1	1
Race/ethnicity						
African-American, Black (%)	<1	6	93	7	14	26
Hispanic, Latino (%)	98	94	6	3	6	11
White (%)	1	–	<1	89	76	57
Students with free/subsidized lunch (%)	100	97	84	NA	30	48
School	G	H	I	J	K	
<i>Region</i>	Western	Western	Southern	Midwestern	Midwestern	
Enrollment	428	1340	460	389	535	
School type	Public	Public	Charter	Public	Public	
Grades	6–8	9–12	K-8	6–8	6–8	
Teachers	1	0	1	1	1	
Clinicians	1	2	1	2	2	
Administrators	1	1	1	1	1	
Race/ethnicity						
African-American, Black (%)	3	3	97	33	31	
Hispanic, Latino (%)	93	89	1	13	19	
White (%)	–	<1	<1	40	42	
Students with free/subsidized lunch (%)	87	86	97	58	56	

^a Data source: National Center for Education Statistics: US Department of Education (2010–2011 school year)

incentives; resources, networks, and linkages; organizational structure and process; media and change agents; and norms and attitudes that impact the implementation process (Mendel et al., 2008). Specific questions were designed to elicit information about participants' beliefs and attitudes regarding school-based mental health services and CBITS (What do you think are the benefits and disadvantages associated with providing CBITS in your school?) and how the organizational structure and process affected implementation strategies (Have there been any challenges to having students take time out of class to attend CBITS groups?) and future sustainability of CBITS (How can CBITS be changed or improved to better suit the needs of students and staff at your school?). The study was conducted in compliance with the university IRB. Complete interview guides are available upon request.

Analysis

All interviews were audio-recorded and transcribed by members of the research team. The data were entered into

ATLAS.ti 6.2 (Muhr, 2010) to organize and facilitate team-based analysis. Using grounded theory techniques (Corbin & Strauss, 1990), twenty percent of transcripts were corated/reviewed by at least two members of the research team for accuracy of content and broad themes. A ninety-percent inter-rater reliability was established before remaining transcripts were independently coded. Any discrepancies in coding were discussed until consensus by the team was reached. The research team met on a weekly basis to discuss the themes and representative codes in an effort to interpret the data through collaboration and group consensus. First codes were developed based on large themes across stakeholders and then distilled further into subcodes to represent emergent themes among stakeholders. Codes were redefined or collapsed when determined necessary and subthemes were identified. For this analysis, we focused on codes specifically related to teachers including their norms and attitudes about the role/relevance of mental health services in schools, involvement with implementation, perceived benefits and disadvantages of the CBITS program, and suggested improvements to program implementation.

Results

Four key themes regarding teachers' responses to CBITS implementation emerged from the interviews: (1) Support for CBITS was related to teachers' perceived need for a trauma program on campus; (2) teachers, though aware of their students' social-emotional needs, expressed concerns about how to best balance those needs with academic goals, given that CBITS participation required students to miss class time; (3) teachers desired better channels of communication between themselves and clinicians regarding student progress in CBITS; and (4) teachers desired more psychoeducation about trauma. These themes were consistent across sites.

Teacher Perceptions About the Need for CBITS

A significant majority of teachers (9/11) recognized the need for a trauma program such as CBITS, on their campus. They were well aware of the high levels of trauma exposure among their students and a pressing need for more mental health services offered in the school setting. As one teacher said, "... for a long time I had seen students who have problems with emotional or physical violence in their lives, wishing that there were programs in the school...for kids to go and get help and support...CBITS has taken that place." At a school which had implemented a universal trauma screening process for all students, a teacher endorsed its value, "...we are a fairly large school with a fairly small staff...so if it was left up to the kids to speak up that they've had a problem, there would be a lot of kids that were missed unless screening [was conducted]. I guess I'm always a little bit surprised with who has qualified because I wouldn't have ever known... that they were struggling with something." A clinician reiterated this observation; screening students made teachers more aware of the prevalence of trauma among their students and the need for treatment. "I think that doing the screening and doing the CBITS groups has heightened their [teachers'] awareness of trauma." The implementation of CBITS on campus improved overall trauma awareness on campus and reframed some teachers' perceptions of problem behaviors. A clinician said: "I think [teachers] are better able to see when students are having a difficult time so [they]...don't just primarily think oh well they're just acting out." A teacher described this increased awareness as: "I am just... more aware of emotional signs that the kids is struggling, and I'm...more sympathetic to emotional issues." Another teacher discussed the relief that came with knowing that there was a targeted resource on campus since she often felt out of her depth when confronted with her students' emotional problems: "Let's say I have a student and I tried all my interventions, and I don't see any improvement. Or I have

suspicion that this student might have experienced trauma. Now I know where to go and look for help; that's a huge relief as a classroom teacher. And also we are dealing with adolescent psychology here, and I am not an expert on this." The implementation of CBITS on campus helped another teacher to make the connection between trauma and decreased academic engagement: "We have kids who just put their heads down, and it's very difficult to get them involved in anything. I don't know specifically what's going on to have them react that way, but I'm pretty sure it's...stressful and traumatic events that they're experiencing at home."

A few interviewees (2/11 teachers; 3/15 clinicians) acknowledged that some of the teachers were less supportive of CBITS. One teacher spoke of her colleagues this way: "There were just teachers who...didn't support it and felt like it was a waste of time...most of them are just not believers in PTSD...[and think] that's not our job. If you need counseling, go somewhere else."

As part of the interview, we asked teachers to describe their beliefs about the benefits and the disadvantages of having CBITS at their school. The majority of teachers (9/11) described treatment benefits including improved social-emotional functioning, classroom behavior, and academic engagement among students who received the intervention. While not asked about the classroom climate specifically, teachers (7/11) volunteered that their students seemed calmer and more confident than prior to CBITS, with some improvement also in their peer relations. Teachers (6/11) also observed improvement in their students' ability to concentrate and participate in the classroom. One teacher commented, "What I see in academics is they take more pride in their work. And if they are taking more pride when in the classroom, they do better." Similarly, an administrator commented, "We did see a marked increase in their ability to go with the flow and listen to rules and do the things that they needed to do to be good students." Teachers (4/11) felt that these improvements in students' behavior and functioning led to overall improvements in the classroom climate. They perceived CBITS as having benefits to the classroom community that extended beyond those received specifically by the students who received the intervention. "[CBITS] gives students a chance to get centered and in doing so, the rest of the students are centered, and then their academics go up. It's a ripple effect. If you have a student or a couple of students in your class who have some issues and can't handle different conflicts or situations very well, then they can bring a whole class of thirty students off task. Whereas when they are really centered and focused, then you've got thirty centered and focused students." When asked specifically about improvement in grades, most teachers (9/11) reported they could not accurately provide this data because they had not actively tracked students' grades pre- to post-CBITS.

Given their observations of improved student academic engagement and classroom behavior, teachers said that they would have also liked to know more about changes in academic performance/grades.

Balancing Students' Social-Emotional Needs with Missed Class Time

Although teachers reported a number of benefits associated with students' participation in CBITS, most (8/11) regarded the loss of instructional time to attend CBITS sessions a disadvantage. One teacher explained, "There were some issues as far as missing out of instructional time and some teachers who were a little bit more apprehensive than others. However, in general, I think we all agreed that we needed some major psychological help for many of our students." While attending CBITS sessions remained the priority, teachers still struggled to balance their students' psychosocial and academic needs, particularly for those students at risk of failing courses. While they saw the benefits of their intervention, they worried about the added stress on students' whose participation resulted in their getting even further behind in their studies. One teacher described the problem, "I had kids [who] would miss my entire geography class that day. And...the concern was that some of these students are failing geography and though I understand that they need to be treated for...trauma that they are going through, they also need to pass world geography."

Administrators (school: 5/9 and regional: 1/5) and clinicians (8/15) also recognized this problem. A clinician offered this perspective, "...I think that scheduling is always difficult...a lot of kids come into our school behind, so it's kind of like...trying to balance between academics and these supportive services." To compensate for lost instructional time, some teachers (4/11) reported re-teaching lessons after school, allowing makeup work, providing extra time to complete missed assignments, and rescheduling tests to minimize the impact on academics.

Despite overall recognition of the benefits associated with CBITS, a minority of participants (1/11 teachers; 3/15 clinicians; 1/9 administrators) described teachers who openly objected to students' missing classes. One administrator described, "...a teacher didn't want a student taken out of class 'for this purpose.'" Another clinician observed that teachers "are not so happy to see us pulling them out [of class] and have given some of the students...a hard time."

Mindful of teachers' concerns, clinicians (7/15) reported several ways they worked with teachers to minimize loss of instructional time and improve teacher support of CBITS. Clinicians found that simply acknowledging teacher concerns about missed academic time, particularly for students struggling academically, was an important starting point to a positive working relationship and critical to gaining

teacher support. For instance, one clinician described her experience scheduling CBITS groups as, "...we have to be creative [because] no one wants to lose the students out of class, but...I find with good communication with the teachers, we are able to make it happen." Other clinicians reported that it was helpful to include teachers in their scheduling decisions because of the creative options these collaborations achieved. At some schools teachers preferred to alternate the classes that would be missed (2/11), while at others CBITS could be implemented during lunch (4/11) or during non-academic classes (4/11). Clinicians (7/15) cited this collaborative approach as a factor that strengthened teacher support of CBITS. The majority of teachers (8/11) acknowledged clinicians' efforts to work with them in scheduling to minimize the loss of instructional time.

Communication with Teachers about Program Implementation

Another key factor thought to influence teacher support was the quality of communication between teachers and staff (clinicians and administrators) involved with program implementation. Although a fair number of teachers and clinicians described working well together to coordinate students leaving class to attend CBITS sessions, other aspects of communication were less consistent. The frequency and quality of teacher-clinician interactions about students participating in CBITS were often limited and varied across schools. A clinician stated, "From what I've seen, the more the teachers are informed, the more they are reminded, the better the turn-out, the better the participation rate we get [in group]."

Teachers (7/11) described a number of factors that contributed to effective communication and enhanced their support. When educators felt comfortable approaching the clinician, clinicians made themselves accessible and actively developed relationships with educators; the teachers felt included in the process and more supportive of the intervention. One teacher commented on the importance of a clinician's approachability, "I think what stands out is the personality of the individual [clinician] and her interpersonal skill...which makes her very approachable." Clinicians (6/15) also highlighted rapport building. Given current budgetary and staffing constraints, there can be logistical obstacles to this kind of consistent outreach. As one clinician shared, "I was only on campus for the group so it was harder for me to have access to teachers...but there was a liaison [co-facilitator] at the school...who I did speak to regularly and who was able to work with the teachers."

An administrator and clinician from another school described having biweekly "kid-talk" meetings, a method they used to communicate about students that created a

collaborative working environment with teachers. “It allowed us to be more proactive and the staff could bring up their concerns and what things were done already. We discussed students in CBITS groups, and teachers could become more aware of how to talk to the students.”

Clinicians and teachers also described barriers to communication. One important barrier to clinician/teacher communication was a concern about the parameters of student confidentiality. Teachers (5/11), clinicians (4/15), and administrators recognized the need to maintain student confidentiality and perceived how concerns about confidentiality presented challenges in communicating with teachers. An administrator noted, “[CBITS] it’s kind of private. I don’t know if that was the right way or the wrong way but it’s been very private. There’s just not a whole lot of information about the group that I feel like the whole staff [teachers] know about.” One clinician reported, “...we really don’t know [how] information is going to be handled...[so] how do you include school staff and what does it look like?” In response, another clinician noted, “Even though there is confidentiality, I think there is some collaboration we can do...It gives them [teachers] the sense of relief to know what all I am doing. So even though it’s in general terms...they really like knowing either what’s happening or even that something is happening.”

Nearly half the teachers (5/11) described an absolute absence of communication about CBITS implementation. Others (3/11) described the primary mode of communication as indirect correspondence such as informational letters, e-mails, and written referrals. When clinicians were asked about the extent of communication with teachers, they (7/15) mostly reported minimal indirect contact. A clinician stated, “We didn’t have much [communication] actually...which is probably an important component that we should’ve done but wasn’t done...there was not much communication at all.” Another clinician described the consequences of failing to communicate with teachers as “...we need to improve our teacher awareness of CBITS first, because otherwise it’s harder to collaborate...I don’t think they are really aware of what’s going on with their students.” One clinician summarized the indirect methods of communicating with teachers consisting of, “...just a lot of communication...via email and paper throughout the whole process.”

Teachers described their desire for more information from clinicians. The majority of teachers (7/11) expressed the desire to be more informed about the students’ attending CBITS sessions, while maintaining student confidentiality. While discussing the role of teachers in the implementation process and how information is disseminated across stakeholder groups, teachers (4/11) wanted more information about student progress in CBITS and as one teacher stated, “I think that [it would be helpful] if

CBITS [clinicians]...met with the teachers occasionally, did some check-ins to let the teachers know what was going on and how different students were progressing.” “More communication...to help me understand what I should’ve been looking for in kids...,” described a second teacher. Similarly, another teacher stated, “...if there was an issue [about a student] that the teacher really needed to know [about] that would be helpful...it would even change your language in how you would say something in class if you knew this child had a problem.”

Teacher Education on Trauma

The large majority of teachers (10/11) stated that they need more trauma education as part of their own professional in-service training. One teacher specified, “There’s an estimate that perhaps 80 % of our students are suffering with PTSD, we have to start to include that as our focus and professional development,” and another teacher suggested “I would recommend twice a year [trauma education sessions], and the reason for this is we do have a lot of movement within our school. Some teachers leave and others come and it’s good to be updated.”

The majority of clinicians (10/15) echoed a similar belief and acknowledged the need for more trauma-informed teacher training. While describing the importance of devoting more time and resources to improve teachers’ understanding of the effects of trauma on students, a clinician commented, “I do think there is a huge gap with teachers and their understanding of trauma.” As one clinician stated, “Importantly...how to deal with [trauma] when it comes up in the classroom is something that isn’t really touched upon.” A second clinician stated, “I think...if [trauma education] were...built into the school year, to talk to [teachers] about trauma and how it affects the students, and how it fits into...the whole big academic picture, this would improve CBITS implementation.”

Teachers (7/11) also would like more training in identifying traumatized students and trauma reactions, and some methods to improve the way they work with traumatized students in the classroom. One teacher stated, “I think part of the development [has] to be...teaching us how to recognize [trauma]...that we are aware that it exists...sometimes I feel like I’ve just overlooked some kids who have real issues and just wrote it off as ‘Oh, they are just misbehaving.’” Teachers also expressed a need for help in defining their own roles vis-à-vis their students’ emotional needs: “I would be interested in hearing how we should balance...[students] needing emotional support and needing kind of a sympathetic adult versus an adult that holds them academically accountable...”

Clinician’s described some of the challenges surrounding implementation of teacher in-services and training.

Clinicians (8/15) cited a lack of both their own time and teachers' time as a barrier to increasing teacher trauma education. A clinician stated, "Well, I would have had the interest [to provide additional teacher education about trauma], but I had no ability to do that. No time, no space." Another clinician recalled, "My experience with teachers is that...they're all so pressed for time." Although teachers did not explicitly share their own concerns about the lack of time for trauma in-services, some teachers and administrators suggested alternative strategies to providing trauma education. One teacher suggested "...maybe some practice or some handouts of how to deal with...students that are confrontational [trauma-related behavioral problems] and [how] to decompress the situation." An administrator suggested, "...An overview of quick tips that you can give the teachers to recognize when trauma is probably occurring or has occurred...what to do and how to navigate it would be helpful for busy teachers."

Discussion

Previous research has shown how instrumental teacher support can be to the implementation, success, and sustainability of mental health interventions offered in schools (Forman et al., 2009; Lynn et al., 2003; Langley et al., 2010). Yet, there is an absence of research to guide practitioners in how to develop and sustain this support. Few qualitative studies have interviewed teachers on this subject following the implementation of an intervention in their schools. Without teacher support, even effective interventions can fail to improve student outcomes (Fixsen et al., 2013).

Overall, teachers in this study support school-based mental health programs like CBITS, but they identify an important struggle between meeting the social-emotional needs of students and the loss of instructional time when CBITS is offered during class time. Past studies have described the lack of treatment received by traumatized youth in low-income neighborhoods when treatment does not occur at school (Jaycox et al., 2010) or when school interventions are provided after school hours (Kataoka, Santiago, Jaycox, Langley, Stein, & Vona 2014). Teachers also report feeling more invested in programs when they have regular communication with clinicians about students participating in CBITS. Teachers recognize the importance of receiving trauma education, which leads to greater identification of traumatized students and referral for trauma-related services. By providing teachers with coping strategies that they can use in the classroom to support students, teachers can also reinforce the gains of treatment. We also found that the majority of other stakeholders, including clinicians and administrators, validated teacher reports.

We explored teacher knowledge of and attitudes about trauma and their perceptions of the relevance of offering trauma services in school. Our sample of teachers who had been exposed to CBITS in the past recognize that a large number of students have been impacted negatively by trauma. Teachers also describe the social-emotional benefits that they observed in students who attended CBITS sessions. Some teachers describe witnessing firsthand that CBITS results in improvements in students' classroom behavior. Teachers' understanding of trauma and appreciation of the benefits of an intervention are critical for students. Studies have shown that middle school students who perceived an increase in teacher support of their emotional needs showed significant declines in depressive symptoms and an increase in self-esteem scores (Reddy et al., 2003). Similarly, Klem & Connell (2004) found that students who perceive teachers as caring are more engaged in school, which, in turn, is positively associated with attendance and test scores.

During pre-implementation planning, schools can build on teachers' general awareness of their students' need for trauma-informed care to a deeper appreciation of the benefits of the particular intervention offered. It is important to assess teachers' preexisting awareness and attitudes about trauma and mental health services so that schools can build on the values that teachers already hold, dispel any misinformation, and identify other areas for further psychoeducation.

Teachers uniformly reported wanting more trauma education and better tools to recognize the effects of trauma so they can identify traumatized students earlier. They believe that concrete strategies to manage trauma-related behavior in the classroom will allow them to better support their students and improve the classroom environment. Studies have shown that teachers are more likely to support their students if they feel competent in meeting their needs (Alisic, 2012; Kos, Richdale, & Hay, 2006). Clinicians and administrators should share evidence-based resources such as Listen, Protect, Connect–Model and Teach, Psychological First Aid for Students and Teachers (Schreiber, Gurwitch, & Wong, 2006) published by the US Department of Homeland Security. It includes teacher-friendly information on traumatic stress and step-by-step instructions for ways teachers can support students following a traumatic event (www.ready.gov). Equipping teachers with better skills to accurately recognize trauma will improve referrals to school-based mental health programs, reduce disciplinary responses, and increase support for programs like CBITS.

Despite their support of CBITS, teachers reported challenges in balancing academic goals and students' emotional needs, particularly in students at risk of academic failure. In a time when teachers are being held accountable for meeting rigid academic standards,

students' repeatedly missing class to attend treatment sessions is a valid concern that should not be minimized during the implementation process. Therefore, clinicians should collaborate with teachers to find the best solutions for scheduling. These may include offering CBITS during lunch or non-academic periods. Including teachers in scheduling and other aspects of decision making can contribute significantly to teacher buy-in and a smooth and sustainable implementation (Langley, Santiago, Rodriguez, & Zelaya, 2013).

Once a program is in place, it is important that teacher buy-in is sustained by keeping teachers aware of its benefits in the form of concrete outcome data. Program implementers and district officials will need to collect and disseminate social-emotional and academic-outcome data to reassure teachers of a program's benefits. If teachers can see the link between CBITS and improvements in students' academic performance, their concerns about missed class time and other challenges to student participation will likely be minimized. To assist clinicians with this effort, manualized treatments should include materials, such as a weekly progress report card to be shared with teachers. If teachers are updated about intervention progress, they can be more aware of classroom behavior and academic performance before and after CBITS. Written updates that summarize the skills students are learning each week with practical recommendations for reinforcing those skills in the classroom would assist teachers in reinforcing skills in the classroom. Such materials would help clinicians keep teachers updated and supplement more direct communication. It will also reinforce the mission, scope, and benefits of these programs and how they help to achieve alignment and integration of systemwide goals—a priority of the new MTSS framework being implemented in many schools nationwide.

The desire to be more informed about how students are progressing in CBITS and more involved with their treatment was expressed by a majority of teachers in the sample. The lack of direct communication with clinicians contributed to teachers feeling “left out of the loop.” In our sample, teachers seemed to value direct communication with clinicians. They found this to be the most effective mode of communication and saw less value in methods such as e-mail and newsletters. Thus, to improve the frequency and quality of communication with teachers, clinicians should make themselves accessible and recognize the importance of building rapport with teachers to insure teachers are included in the implementation process and thus able to be more supportive of the intervention. One such strategy for enhancing communication as discussed earlier is the use of weekly progress reports and general intervention updates to teachers. Previous research supports our findings of the importance of teacher–clinician

communication in the success of school-based interventions. Langley and colleagues also described the value of teachers' being given updates on student progress and provided with strategies on how best to support the skills learned in the program (Langley et al., 2013). Of course, clinicians need to balance confidentiality about treatment with teachers' desire to be more informed. It is important to lay out the parameters so that both can feel comfortable in sharing information. From the clinicians' perspective, regular communication with teachers was hindered by lack of time. Building this time into class schedules and budgets will be a challenge for many schools, but future efforts to implement effective school-based mental health programs will be most successful if there is a true partnership in both the pre-implementation planning stages and the actual implementation process.

Administrators can also support this planning by prioritizing time in the academic calendar to implement teacher in-service education on trauma that includes a learning module for teachers that describes the effects of trauma on learning. These in-services would increase teachers' understanding of the effects of trauma on students, including on their behavior and academic performance, describe the fundamentals of evidence-based trauma treatment in schools, and give more specific information about the methodology of CBITS and how it has been shown to help students improve in the classroom environment. Communication and collaboration between clinicians and teachers can be best facilitated by bringing teachers and clinicians together before implementation. In this way, teachers may subsequently feel more invested in the program's success. During this period, they can discuss their role in the implementation process, gain more trauma awareness, and map out parameters of student confidentiality. It is clear from our study that concerns about student confidentiality can hamper effective communication between clinicians and teachers. It is important to lay out the parameters so that both can feel comfortable in sharing information without violating students' rights.

Although our study contributes to a better understanding of teachers' roles in the implementation of CBITS in a variety of academic environments, it has several limitations. This qualitative study included a relatively small sample of teachers. Our sample was well distributed across regions of the USA, and we also validated what we heard from teachers in interviews with a similar number of other stakeholders (clinicians, administrators). This study focused on one school-based program, and some of its findings may not be generalizable to other school mental health programs. While some recommendations (e.g., more regular communication with clinicians) would apply to most school-based interventions, other interventions may warrant unique strategies of their own. Also,

this was a convenience sample for which the research team worked with community partners who identified the participants, which likely led to participants with more favorable views of CBITS and more positive relationships with their school-based clinicians. Still, our interviewees were forthcoming about barriers to implementation and their own reservations and also described their observations of teachers with less favorable views. Data from this study also point out the need for future research that improves our understanding on how to engage teachers who have negative perceptions of mental health services in schools. In addition, we were not able to measure the quality of implementation and how this impacted teacher support and collaboration within schools. Additional research is needed to assess the quality and fidelity of implementation. This was an exploratory study and should be used as a guide for future studies that examine these factors using quantitative approaches to better assess the degree to which a teacher support impacts implementation and related student outcomes. Despite limitations, this study's exploration of teachers' perspectives after implementation of this school-based trauma intervention provides important insight into how best to build teacher buy-in and partner with them to increase support for school-based mental health programs.

Conclusion

By increasing teacher participation in school mental health programs, teachers can support positive student mental health outcomes and treatment implementation success. Feeling like partners in the process can raise teacher morale and improve the overall climate in the classroom. Teachers can collaborate and feel more invested in school-based mental health programs when they have a part in the early identification of students with social and emotional issues, and when the program provides them with tools to more competently manage classroom behaviors of students with mental health issues.

Teachers are central to the school ecosystem. They not only represent the majority of school stakeholders, but also have the most direct daily access to students. In addition, teachers are a crucial link in identifying and connecting students with trauma services, as they are in a unique position to see the negative impact of trauma and traumatic stress reactions on their students' emotional, academic, and social lives. Students often confide in their teachers, and teachers are significant adult figures in many students' lives. That circumstance offers a unique perspective that is unavailable to most school-based mental health providers. Therefore, to further improve student outcomes, it is essential to devote resources toward developing teacher support, collaboration, and their long-term buy-in of school-based mental health

(trauma) services. In particular, a partnership with teachers prior to and during the implementation process for any in-school mental health program should focus on increasing awareness of the impact of trauma on students, make the benefits as visible as possible to teachers, and encourage ongoing communication between clinicians and teachers. Further exploration of teachers' perceptions of school mental health programs, such as CBITS, can lead to a better understanding of how best to include teachers in these programs and increase every school's capacity to expand school-based mental health programs.

Acknowledgments This work was supported by the UCLA Center for Health Services and Society (NIH1P30MH082760) and Substance Abuse and Mental Health Services Administration (SAMHSA) (SM59285, SM57283). The authors would like to thank Pia Escudero, Douglas Walker, and Mary Sue Roberts for their partnership, guidance, and support.

References

- Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(1), 4–23.
- Adi, Y., Killoran, A., Janmohamed, K., & Stewart-Brown, S. (2007). *Systematic review of the effectiveness of interventions to promote mental wellbeing in children in primary education: Report 1: Universal approaches non-violence related outcomes*. National Institute for Health and Clinical Excellence.
- Alisic, E. (2012). Teachers' perspectives on providing support to children after trauma: A qualitative study. *School Psychology Quarterly*, 27(1), 51–59.
- Alisic, E., Bus, M., Dulack, W., Pennings, L., & Splinter, J. (2012). Teachers' experiences supporting children after traumatic exposure. *Journal of Traumatic Stress*, 25(1), 98–101.
- Averill, O. H., & Rinaldi, C. (2011). Multi-tier system of supports. *Essentials on Education Data and Research Analysis*, 91–94.
- Balas, E. A., & Boren, S. A. (2000). Managing clinical knowledge for health care improvement. *Yearbook of Medical Informatics*, 2000(2000), 65–70.
- Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2004). A multi-site, randomized controlled trial for children with abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(4), 393–402.
- Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, 13(1), 3–21.
- Delaney-Black, V., Covington, C., Ondersma, S. J., Nordstrom-Klee, B., Templin, T., Ager, J., et al. (2002). Violence exposure, trauma, and IQ and/or reading deficits among urban children. *Archives of Pediatrics and Adolescent Medicine*, 156(3), 280–285.
- Diekstra, R. F., & Gravesteyn, C. (2008). Effectiveness of school-based social and emotional education programmes worldwide. *Social and emotional education: An international analysis*, 255–312.
- Domitrovich, C. E., Bradshaw, C. P., Poduska, J. M., Hoagwood, K., Buckley, J. A., Olin, S., et al. (2008). Maximizing the implementation quality of evidence-based preventive interventions in schools: A conceptual framework. *Advances in School Mental Health Promotion*, 1(3), 6–28.

- Feinstein, N. R., Fielding, K., Udvari-Solner, A., & Joshi, S. V. (2009). The supporting alliance in child and adolescent treatment: enhancing collaboration among therapists, parents, and teachers. *American Journal of Psychotherapy*, 63(4), 319.
- Fixsen, D., Blase, K., Metz, A., & Van Dyke, M. (2013). Statewide implementation of evidence-based programs. *Exceptional Children*, 79(2), 213–230.
- Fixsen, D. L., Naoom, S. F., Blase, K. A., & Friedman, R. M. (2005). *Implementation research: A synthesis of the literature* (No FMHI Publication #231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, National Implementation Research Network.
- Flopspohler, P. D., Meehan, C., Maras, M. A., & Keller, K. E. (2012). Ready, willing, and able: Developing a support system to promote implementation of school-based prevention programs. *American Journal of Community Psychology*, 50(3–4), 428–444.
- Forman, S. G., Olin, S. S., Hoagwood, K. E., Crowe, M., & Saka, N. (2009). Evidence-based interventions in schools: Developers' views of implementation barriers and facilitators. *School Mental Health*, 1(1), 26–36.
- Graham, A., Phelps, R., Maddison, C., & Fitzgerald, R. (2011). Supporting children's mental health in schools: Teacher views. *Teachers and Teaching: Theory and Practice*, 17(4), 479–496.
- Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *Milbank Quarterly*, 82(4), 581–629.
- Jaycox, L. H. (2004). *CBITS: Cognitive behavioral intervention for trauma in schools*. Longmont, CO: Sopris West Educational Services.
- Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., & Schonlau, M. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress*, 23(2), 223–231.
- Jaycox, L. H., Stein, B. D., Kataoka, S. H., Wong, M., Fink, A., Escudero, P., et al. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant school children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(9), 1104–1110.
- Kataoka, S., Jaycox, L. H., Wong, M., Nadeem, E., Langley, A., Tang, L., et al. (2011). Effects on school outcomes in low-income minority youth: Preliminary findings from a community-partnered study of a school trauma intervention. *Ethnicity and Disease*, 21(3 Suppl 1), S1.
- Kataoka, S. H., Santiago, C. D., Jaycox, L. H., Langley, A. K., Stein, B. D., & Vona, P. (2014). Cognitive behavioral intervention for trauma in schools: Implementation and dissemination of a school-based intervention. In R. S. Beidas, P. Kendall (Eds.), *Dissemination and implementation of evidence-based practices in child and adolescent mental health* (p. 294).
- Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., et al. (2003). A school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(3), 311–318.
- Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among US children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159(9), 1548–1555.
- Klem, A. M., & Connell, J. P. (2004). Relationships matter: Linking teacher support to student engagement and achievement. *Journal of School Health*, 74(7), 262–273.
- Kos, J. M., Richdale, A. L., & Hay, D. A. (2006). Children with attention deficit hyperactivity disorder and their teachers: A review of the literature. *International Journal of Disability, Development and Education*, 53(2), 147–160.
- Langley, A. K., Nadeem, E., Kataoka, S. H., Stein, B. D., & Jaycox, L. H. (2010). Evidence-based mental health programs in schools: Barriers and facilitators of successful implementation. *School Mental Health*, 2(3), 105–113.
- Langley, A., Santiago, C. D., Rodriguez, A., & Zelaya, J. (2013). Improving implementation of mental health services for trauma in multicultural elementary schools: Stakeholder perspectives on parent and educator engagement. *The Journal of Behavioral Health Services & Research*, 40(3), 247–262.
- Lynn, C. J., McKay, M. M., & Atkins, M. S. (2003). School social work: Meeting the mental health needs of students through collaboration with teachers. *Children & Schools*, 25(4), 197–209.
- McKay, M. M., Lynn, C. J., & Bannon, W. M. (2005). Understanding inner city child mental health need and trauma exposure: Implications for preparing urban service providers. *American Journal of Orthopsychiatry*, 75(2), 201–210.
- Mendel, P., Meredith, L. S., Schoenbaum, M., Sherbourne, C. D., & Wells, K. B. (2008). Interventions in organizational and community context: A framework for building evidence on dissemination and implementation in health services research. *Administration and Policy in Mental Health and Mental Health Services Research*, 35(1–2), 21–37.
- Muhr, T. (2010). Atlas.ti GmbH v 6.2 [Computer software]. Berlin, Germany: Atlas.ti.
- Reddy, R., Rhodes, J. E., & Mulhall, P. (2003). The influence of teacher support on student adjustment in the middle school years: A latent growth curve study. *Development and Psychopathology*, 15(1), 119–138.
- Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly*, 26(1), 1.
- Rogers, E. M. (1995). *Diffusion of innovation*. New York: Free Press.
- Schreiber, M., Gurwitsch, R., & Wong, M. (2006). *Listen, protect, connect—model & teach: Psychological first aid (PFA) for students and teachers*. Washington, D.C.: US Department of Homeland Security.
- Schwab-Stone, M. E., Ayers, T. S., Kaspro, W., Voyce, C., Barone, C., Shriver, T., et al. (1995). No safe haven: A study of violence exposure in an urban community. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(10), 1343–1352.
- Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., et al. (2003). A mental health intervention for schoolchildren exposed to violence. *JAMA*, 290(5), 603–611.
- U.S. Public Health Service. (2000). *Report of the surgeon general's conference on children's mental health: A national action agenda*. Washington, DC: U.S. Department of Health and Human Services.
- Walter, H. J., Gouze, K., & Lim, K. G. (2006). Teachers' beliefs about mental health needs in inner city elementary schools. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45(1), 61–68.
- Weist, M. D., Mellin, E. A., Chambers, K. L., Lever, N. A., Haber, D., & Blaber, C. (2012). Challenges to collaboration in school mental health and strategies for overcoming them. *Journal of School Health*, 82(2), 97–105.
- Wells, K., & Jones, L. (2009). "Research" in community-partnered, participatory research. *JAMA*, 302(3), 320–321.
- Williams, J. H., Horvath, V. E., Wei, H.-S., Van Dorn, R. A., & Jonson-Reid, M. (2007). Teachers' perspectives of children's mental health service needs in urban elementary schools. *Children & Schools*, 29(2), 95–107.
- Wong, M. (2006). Commentary: Building partnerships between schools and academic partners to achieve a health-related research agenda. *Ethnicity and Disease*, 16(1), S149–S153.