BEFORE STUDENTS HURT:

CURRICULUM SUPPORTS FOR SOCIAL, EMOTIONAL, AND MENTAL DEVELOPMENT, IN PUBLIC SCHOOLS.

A Record of Study

by

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DOCTOR OF EDUCATION

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ABSTRACT

This record of study explored the early identification, intervention, and delivery methods of one remote school district that utilized the Seed Digging (SD) program for their in-house school wide mental health care. Potential outcomes of the research would examine resources that would benefit rural schools in the prevention and provision of social, emotional, and mental health care including curriculum supports. The purpose of this study seeks to understand the reasoning of the administration and the opinions and implications of their stakeholders. The methodology of this study was a qualitative single case study. It involved semi-structured interviews from various stakeholders representing multiple perspectives of school and community members. The findings of this study displayed favorable outcomes of the implementation of the SD program. The program had been in use by the district for over four years. The prognosis for continued use of early identification and prevention strategies using the SD program are highly probable. Students referred to the program saw positive changes in their well-being and academic growth. The implications of these findings could benefit other districts especially in small, remote rural areas with necessary in-house mental health supports.

DEDICATION

I would like to dedicate this work to my father, Capt. Jere Wayne Kelly, class of 1962, the year I was born. He was in the Corps of Cadets and a member of the "Fighting Texas Aggie Band." He had always hoped one of his boys would attend A&M. Sixty years later I am accomplishing the task. Sadly, he passed away on June 26, 2022. He was diagnosed with cancer in April of 2022 and hoped to be able to attend ring day in September but had doubts that he would make it to see me graduate from the doctoral program. Before he passed, he let me borrow his ring until I got my own. I know he is proud, and I will answer "Here" at the Aggie Muster to show that he is still present in spirit.

The work of this Record of Study could not have been accomplished without the love and support from my wife, Vanessa Kelly. God bless her for having to put up with me during this process. I am a blessed man. Gig'em.

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CONTRIBUTORS AND FUNDING SOURCES

Contributors

This work was supervised by a record of study committee consisting of committee chair Dr. Michelle Kwok and committee members Dr. James Laub, Dr. Joanne Olson of the Department of Teaching, Learning, and Culture, Dr. Monica Neshyba of the Department of Educational Psychology, and Claire Katz, chair of the TLAC Department.

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NOMENCLATURE

ACES	Adverse Childhood Experiences
PTSD	Post Traumatic Stress Disorder
TIC	Trauma Informed Care
SD	Seed Digging

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1.1 The Context

1.1.1 National Context

One out of every six children in America, between the ages of two through eight, has been diagnosed with mental health or behavioral disorders. One out of every five children that live in poverty has a mental health diagnosis. Because of their impoverished circumstances, they are less likely to receive treatment for their condition. Behavior disorders, anxiety, and depression tend to increase as the child ages (*Children's Mental Health*, 2020). “Motor vehicle crashes were the leading cause of death for children and adolescents, representing 20% of all deaths; firearm-related injuries were the second leading cause of death, responsible for 15% of deaths. Among firearm deaths, 59% were homicides, 35% were suicides” (Cunningham et al., 2018, p. 2468). According to these statistics, children who were not involved in a tragic accident were more likely to die by being shot by someone else or by shooting themselves. In 2019, sixty-six school shootings occurred in American schools. In twenty-nine of those shootings, people died and 37incured injuries (*Indicator 1,* July 2020). Politicians, educators, and mental health care providers debate the cause and effect of school shootings and mental health concerns with little consensus on a remedy. Children attend public schools, and their burdens of anxiety, fear, and depression come with them.

The social context of school is identified as a common theme in the behavioral manifestations, from minor classroom outbursts to extreme acts of violence towards themselves or others (Metzl & MacLeish, 2015). The number of youths diagnosed with some kind of mental disorder and the number who commit violent, deadly acts is small. School shootings were not as

concerning during the pandemic but now that schools are back open the concern for all types of mental health issues are forefront. What is more concerning is the social effects of isolation and the rise of domestic violence and stress (de Figueiredo et al., 2021). Schools have made a Herculean effort to provide academic progress and lessen the backslide of education during the pandemic. However, little has been done to ready our teachers and serve the children who need cognitive and behavioral intervention now that they have returned to face-to-face learning (Phelps & Sperry, 2020).

Educators have a mandate to provide instruction and learning for children. Teachers do not receive pedagogical preparation as mental health care screeners and providers for their work in the classroom. Researchers have been sharing the need for early identification for school-based mental health screening and embedded curriculum about mental health concerns (Center for Mental Health in Schools et al., 2006). Many children were facing limited access to mental health services before the pandemic and even more limited since schools have returned to face-to-face learning. "One only has to wonder how children with trauma-related issues are coping with our current state of affairs without adequate support" (Phelps & Sperry, 2020, p. S73).

1.1.2 Situational Context

Rural schools have several factors that make it difficult to provide for the mental health needs of students. Education system resources that can sometimes be barriers to providing mental support services are the financing of human capital, additional curriculum instruction for teachers and students, and time to provide the actual services. Texas has 1029 school districts, approximately 80% of those districts serve less than a thousand students per district (*School Data | Texas Education Agency*, 2021). Texas is a large state, and districts can be remote and spread over vast, sparsely inhabited regions. Many districts serve less than a hundred students in grades

K-12. A fair estimate is that 80% of the school districts serve 20% of the student population in Texas, and 20% of the districts serve 80% of the student population (*School Data | Texas Education Agency,* 2021). Educational policies and resources tend to cater to larger districts that service more significant populations of students. Larger school districts are in major urban and suburban areas like Dallas, Houston, and San Antonio. The economy of scale is a term that projects that the larger the population of students served, the less cost it requires to educate them. More students in a district determine the amount of funding generated and more funding per pupil to spend. Providing for students' social, mental, and emotional needs is not about recognizing the necessity of services but the logistics and the economic feasibility of providing services for students.

Small rural schools may require the same number of teachers to provide for student instruction as larger schools, but the cost of funding for smaller schools can be substantial. Rural districts focus their fiscal resources on core academic needs much like medical triage. In the 1980's Texas legislators adopted a funding formula that denied partial State funding to small school districts that have less than 1000 students and occupy less than 300 square miles in their district. This law intended to encourage small districts to consolidate with other small districts and share resources, improving the economy of scale. It was an improbable option for most small districts, and the logistics of busing students to attend other schools were impractical and not as cost-effective as economists hoped. Many schools were already at physical capacity, and the cost of building new school facilities would have been counterproductive (Cooley & Floyd, 2013).

This small school penalty law was only removed just prior to the pandemic. The removal of the old law was an attempt at equity funding, but two new laws were passed in its place. Texas

replaced one bad House Bill and added two equally bad legislative mandates. The first is HB 4545 requiring an additional 30 hours of instruction per child, per each standardized test failed by a student up to 120 hours (*House Bill 4545 Implementation Overview*, 2021). The extra instruction must be provided by a certified teacher in a small group setting outside of regular class times. The second is the requirement for all pre-k through third grade teachers to attend lengthy reading academies even if they are not reading teachers (*HB 3 Reading Academies,* n.d.). These two bills are causing a mass exodus of teachers leaving the profession (Dickerson & Rossatto, 2022). Texas legislature found new ways to limit funding and reduce public school resources especially in rural areas with limited resources.

The highest cost in any school budget is personnel. For most schools, personnel costs are approximately 80% of the budget. When a school must reduce its spending, the predominant place to cut is the staff. School administrators facing personnel hiring decisions must often choose to employ an algebra teacher rather than a mental health provider due to budgetary concerns. Where the legislature cut funding in the past, now legislative mandates have made it difficult to even staff schools let alone provide mental health care (Dickerson & Rossatto, 2022). A school's accountability rating is not measured by its students' social and emotional wellness but by the scores of high stakes standardized tests.

Often rural and urban schools share similar demographics regarding low socioeconomic status and limited diversity. One element that separates the poverty of rural schools from that of urban schools is the availability and proximity of resources (O'Malley et al., 2018). Most rural schools rely on outside sources such as county Mental Health Mental Retardation (MHMR) services. Many of those providers serve multiple counties and schools, decreasing the likelihood of quickly available services for a child who may be experiencing suicidal ideations or other

symptoms. TEA requires teachers to receive professional development annually related to suicide intervention (*Suicide Prevention, Intervention, and Postvention*, 2020). This training is usually in the form of a one-hour video at the beginning of the school year. Recently the TEA has increased the number of mental health resources in various videos. These resources are available for teachers and families but are not required training.

Most attempts to improve education require initiatives that serve as an appendage to the curriculum. Teachers can be overwhelmed with the number of core content standards that must requiring mastery before the end of year testing (*TEKS Review and Revision,* n.d.). Students with emotional and behavioral needs are usually recommended for a special education program referral and out of the immediate care of the classroom teacher. Counselors and diagnosticians seek qualifications for services and an individualized education plan (IEP) to provide modifications that will improve the students' academic outcomes. Teachers already feeling the excessive burden of educating children during a pandemic may require counseling for their mental health needs, much less having the additional training to identify and provide classroom supports beyond the academic needs of children (Christian-Brandt et al., 2020). A student who needs professional counseling can require multiple trips to a provider taking time away from work that most parents cannot afford (Schraeder & Reid, 2014). Providing on-campus mental health experts equipped with early identification tools and curriculum embedded supports for teachers are the first steps to providing for America's public-school children's social-emotional and mental health.

1.2 The Problem

Most school systems in America would not describe their intervention systems as a *wait to fail* model, but that is the functionality of their programs. Response to Intervention (RTI) is a

common term used in public education. It relates to a process of identifying a child with potential learning disabilities and providing accommodations and interventions most identified for reading and math improvement (Reynolds & Shaywitz, 2009). When a child needs RTI in math or reading, the consequences can require a student to be retained a grade level or referred for special education resources. These needs are met internally with school-based resources. Educators have a pedagogy for academic intervention, not cognitive intervention. Social-Emotional Learning (SEL) systems have expanded in public schools over the last decades, and research has shown that SEL programs have a positive benefit in improving academics, reducing out-of-school suspensions and drug use (Weissberg, 2019). Despite the research on the positive impacts of SEL and RTI programs, there has been no significant decrease in students who harm themselves or others. On the contrary, there was a significant increase prior to the pandemic and currently even more so (Rao & Rao, 2021). The current state of mental health care is overwhelming, and there are not enough providers to handle the flood of needy students. Waiting for help often means waiting to fail, and those actions can be fatal (Schraeder & Reid, 2014).

Prior to the pandemic, the floodwaters of mental health needs were rising among students. Now students and teachers alike are wading in those waters. Preventative mental health measures are not new to education. However, even the few schools that utilize early screening methods wait until high school and rely heavily on outside professionals for treatment (Erickson & Abel, 2013). There is little research on schools that combine early mental health detection with in-school treatment (Humphrey & Wigelsworth, 2016). This record of study will conduct a qualitative case study to explore, describe and explain the mental health care, early identification, intervention, and delivery methods of one remote school district with limited resources that is

using the SD program. This study seeks to understand the reasoning of the administration and the opinions and impacts of their stakeholders.

1.2.1 Relevant History of the Problem

It has been over fifty years since a student died in a school fire (*US School Fires, Grades K-12, with 10 or More Deaths*, n.d.). Schools have regular fire drills. Firefighters share fire prevention information and resources as part of school assemblies. Parents are often quizzed by a four-year-old after a fire prevention lesson if the batteries in the smoke detector are refreshed annually. Indoctrination of fire safety and prevention for school children starts as soon as they begin school. Almost six decades later, no fire-related fatalities in our public schools prove that our interventions are working. We have elaborate alarm systems, fire-resistant clothing, early warning smoke detectors, and sprinkler systems to extinguish a fire when no one is present. The construction of our schools and the materials used to build them have fire codes built-in or embedded into the architecture and design of the building.

In March of 2020, the entire country was on lockdown due to the COVID-19 pandemic. The only grocery store in one community burned down. The nearest grocery store was a 45-minute one-way trip. The store owners worked quickly to rent an unused warehouse and set up a makeshift grocery store. In two weeks, they were operational. The community had a need that impacted every demographic in the area. Just as communities need accessible resources for physical needs, schools also need access to resources for mental health needs. A grocery store burning down is something people can relate to and recognize their need for resources. Mental health care is not something people feel comfortable discussing. The importance of the need for mental health can seem insignificant until it is manifest. If the same effort and resources for fire safety and prevention are implemented for mental health education and safety, it would have a

significant impact on our educational system. Texas spends over 90 million dollars annually on standardized testing (*School Data | Texas Education Agency*, 2021). That money could be used to foster the social, emotional, and mental health care needs of students, research has shown that there is a connection to improved test scores and better academic performance (Perry & Daniels, 2016).

From 2013 to 2019 there have been six hundred and twenty-two times a gun has been fired in a school, resulting in over four-hundred student injuries. Of those gun firings, at least two hundred and twenty student deaths, with over 40 of those deaths resulting from suicide or self-harm (2019). It is easy to recognize the mental, physical, social, and emotional devastation resulting from a loss due to fire. Those suffering from mental health issues can suffer the same mental, physical, social, and emotional devastation as similarly from fires. However, there are no elaborate alarm systems or functioning smoke detectors to alert us to school children's problems.

Several curriculums attempt to help students with social, emotional, and mental health support. Social-Emotional Learning (SEL) and Trauma-Informed Care (TIC) are initiatives that are utilized in many school districts. Both programs acknowledge that students need knowledge about their self-awareness and understanding of their traumatic experiences. “Teachers are the engines that drive social and emotional learning” (Schonert-Reichl, 2017, p. 137). We can often overheat the engines that drive learning with added expectations and no compensation. These programs require staff development and clinical professionals to partner with school districts to provide services. Many of these initiatives abide in large urban and suburban areas with local resources nearby, which can be problematic in rural school districts. We know these programs are available for rural school districts, but implementation is costly, and access to clinically trained professionals is limited.

With the issues of school violence and increased mental stress associated with the COVID-19 pandemic, schools in Texas must have a behavioral threat assessment team and complete annual safety audits (*Safe and Supportive Schools Program (SSSP) Updates*, 2021). In small schools, the behavioral threat assessment team consists of the campus principal and counselor. These programs are effective for rural schools because the small staff can communicate regularly about the needs of students and potential threats. These teams also have the freedom to create a plan that works best for their campuses. The behavioral threat assessment teams work much like the fire alarm pulled when a potential threat manifests. The team takes action after an incident, but early intervention and prevention is minimal.

Social and Emotional Learning and trauma informed care are common programs utilized in many schools and may be seen as an attempt at prevention through education about mental health issues. Early intervention screeners for the purpose of detection and prevention are a rarity in public schools based on research or lack of research (Humphrey & Wigelsworth, 2016). The needs are tremendous and growing more necessary every day. It is the hope that this record of study can research methods, tools, and resources used by other schools that can benefit rural schools in the prevention and provision of social, emotional, and mental health supports for rural public schools.

1.2.2 Significance of the Problem

For more than two decades since the school shooting in Columbine, Colorado, law enforcement agencies, politicians, and educators have struggled with how to provide a safe environment for children to attend school. Many solutions have made schools a more challenging target for potential shooters. A harder target means increased security, such as armed school resource officers, school marshals, and trained guardian staff members that are prepared to shoot

back at an active shooter on campus (Silva & Greene-Colozzi, 2020). Some school districts have their own dedicated police departments. The theory ascribes to the same practice of a homeowner who buys a big dog and installs security cameras and special lighting and locks so that a burglar would choose a more accessible home to burgle. The time, money, and effort to enact these safety measures are costly and necessary. The problem is that these measures follow a *wait to fail* model. Many schools use a Response to Intervention (RTI) process to identify students with learning disabilities that rely on a wait to fail model before diagnosis or treatment can begin (Reynolds & Shaywitz, 2009). For many of these students, the RTI can be too late. Much like the old fire alarms that said, in case of emergency, break glass and pull the alarm, our practices wait for the social, emotional, or mental fires to start and then pull the alarm. Our schools are more prepared than ever before to react to a school shooting incident but are ill-prepared to identify and prevent school tragedies.

Making schools harder targets to attack can be pointless if the potential shooters are already in the building. Students with social, emotional, and mental health issues may have struggled with issues as early as kindergarten. Attempts to profile potential shooters are controversial and difficult (Neuman et al., 2015). The social isolation caused by the COVID-19 pandemic has increased the awareness for greater attention to students' social, emotional, and mental health care needs (de Figueiredo et al., 2021). Parents, teachers, and students have more access to videos and resources that help identify and recognize potential students who may desire to harm others or commit self-harm if they had time to watch them.

The problem with a *wait to fail* model is that when children manifest symptoms that may be deemed worthy of help or treatment, the school system support is lacking. Therefore, outside experts in counseling and mental health treatment become the support providers. In many rural

areas, those human resources may be unavailable or overwhelmed, delaying, or denying the treatment a child may need (Schraeder & Reid, 2014). More research is needed to examine resources used in public schools that provide all grade levels of students the opportunity for social, emotional, and mental health care needs at school.

1.3 Research Questions

When this study first began, the primary concern was for the mental health of children that might harm themselves or others related to school violence and active shooter situations. In the months since this study took shape, the world has endured the effects of the COVID-19 pandemic. The ramifications on the mental health of school stakeholders because of the pandemic are unknown. However, the need for mental health care is of a more significant concern than before this research project began. Current teacher training methods and immediate intervention related to public schools' social, emotional, and mental health care have not revealed effective methods for providing immediate identification and provision within the individual public-school systems. The research question for this study involves the reasons, implications, and implementation of school administrators to change from traditional methods to using a novel method of student care called SD. Other factors such as budgetary concerns or contextual factors such as an increase in school violence or suicide attempts might be a source for exploring programs outside of the conventional methods used by most school districts.

RQ: What were the considerations of the district stakeholders for choosing to purchase, implement and continue with a new mental health program called the Seed Digging program?

The study will also address the following sub-research question:

- From the perspective of stakeholders, in what ways has the Seed Digging program had an influence, in terms of student behavior and well-being in the district?

1.4 Personal Context

1.4.1 Researcher's Roles and Personal Histories

My interest in conducting this research began the Friday morning of December 14th, 2012. I was a new elementary principal in a small rural school in Texas with about 150 students, pre-K through fifth grade. In Newtown, Connecticut, a young man entered the Sandy Hook elementary school and killed twenty students and six adults. As I read the description of the events on the internet, I looked out my office door into the front hallway of my school and thought, "What if that was me? What would I do?" The shooter began his killing spree at the front office. He killed the principal and began going down the hallways room by room. My emotions and thoughts were troubled. The most formidable weapon I saw on my desk was a paperweight with "What would Jesus Do?" The image of me chasing a shooter down the hall and throwing a paperweight at him only increased my level of frustration and concern. I was not alone, and the nation began to examine, blame, and search for answers and solutions.

My first reaction was the desire to have the ability to shoot back at someone who was shooting my students. Many in our state had the same sentiment, and in May of 2013, Texas approved House Bill (HB) 1009, known as the "The Protection of Texas Children Act" (*School Marshal | Texas Commission on Law Enforcement*, 2013). This act made provision for approved academic staff to receive training from the Texas Commission on Law Enforcement on the use of deadly force in the case of active shooters on school campuses. The people who completed the 80 hours of training would be known as school marshals. I was part of the second group of educators to go through the training and became a school marshal. Tactical weapons and terror

specialists taught the training. Like firefighters who run into a burning building, we were trained to engage the shooter or shooters and immediately eliminate the threat. Before going into the training, I only had one question that I needed to answer: "could I pull the trigger on a perpetrator of violent, deadly acts on a child?" Answering this question was a significant part of our instructors' training and a goal to make us, as they said, "trigger pullers."

We were prepared by participating in many simulated real-life scenarios. We shot over a thousand rounds of live ammunition and spent twelve-hour days enduring stress-inducing situations. We also studied the nature of school shooters and were told that when the time came to look down the gunsight, we would probably know the shooter by name, and they would be a teenager. By the end of the training, the instructors had done well. I received the answer to my question; I could pull the trigger without hesitation. The sad reality is that I fully believe that the training I received if ever tested, will save lives, but it will not eliminate the loss of life. The use of deadly force is only authorized when there is an imminent threat, usually beginning with the phrase, "shots fired." The quicker a school marshal or police officer engages an active shooter, the less opportunity the shooter has to take other lives. In most cases, the gunman is often killed or takes their own life.

As an administrator, at both a campus and district level, there was exposure to situations with students that had the potential to be deadly. Text messages and various social media postings will often reveal the social, emotional, and mental anguish students are going through. In one instance, a fourteen-year-old boy's girlfriend broke up with him. This young man was a good student, but there was no way for him to express the pain he was experiencing. His main desire was to end his own life, but his religious views would have him go to hell if he took his own life. His solution would be to have someone else kill him, preferably the police. He had a

methodical plan and a list of names. He would begin killing students in his classroom who had offended him first and then continue to kill students one at a time until the police came and ended his life. He did not have access to a gun and planned to use the arm of a paper cutter in his classroom as a machete. He was intercepted before he carried out his plan.

Incidents like this are becoming all too common (Whelan et al., 2021). Intervening with a student before they hurt themselves or others is fortuitous but having no intervention can have fatal consequences. Law enforcement officials and now educators have the training for use of lethal force. Deadly incidents may be avoided but the mental health care provided after an incident is seldom sufficient (Selwyn et al., 2019). School protocols often mandate that students must be placed in an alternative education setting and/or receive professional counseling until a social worker deems them safe to return to their regular classroom schedule. A high school in Oxford, Michigan began their protocols when red flags of behavior prompted a parent conference requiring their student to seek professional counseling within 48 hours. The student was returned to class with the promise of counseling. Two hours later the student began a shooting spree killing several students and wounding others (Sullivan, 2022). Students who seek to harm themselves or others do not discriminate based on school size, location, or socioeconomic status.

1.4.2 Journey to the Problem

The law has given me the tools, training, and authority to protect my schools even at the risk of my own life. My campuses are more complex targets for someone who fears reprisal. I am convinced that arming educators for small schools is necessary. If the goal is to save lives and limit the loss of life, then we should not wait until a child has a weapon in their hand before we go into action. Part of my routine every morning is to make sure my pistol and extra

ammunition are in my concealed carry. I am diligent in making sure I do what is required to defend my students, but I am an educator first and foremost. My job is to educate and advocate for kids, but education means more than a core curriculum. Parents and teachers should not be surprised when their students make failing grades. We provide intervention and support to ensure their academic success. Grades are not a measure of social, emotional, and mental health. Waiting for a child to fail on these issues can have deadly consequences.

We often see a child in distress and notify the school counselor. The counselor calls the parents, and a referral is made to offsite mental health services. Academic counselors rely on trained mental health professionals to provide services. Mental health services for rural students are often in another town over an hour away. Most parents can barely afford time off from work for one visit to a professional counselor, let alone several. The children return to school with little to no support.

I have been an educator for over twenty years. I was a campus principal for four years and a superintendent of schools for five. I never dreamed that part of my professional development would include training to search down dark hallways and classrooms with a weapon to eliminate a troubled child seeking harm using deadly force. Education is a life-giving force that can transcend poverty and abuse. Instead of a pistol, I would like to arm our teachers and counselors with embedded curriculum supports that speak the language of mental health as soon as children enter the public school system. There is no age limit for children who suffer abuse or Adverse Childhood Experiences (ACES). The current COVID 19 pandemic has exacerbated the need for more mental health solutions.

The safest place for children is in face-to-face classrooms with teachers and students that provide for their social, emotional, and mental health needs (Soneson et al., 2020). Early

identification is an overlooked aspect of mental health care. Teachers and school counselors need more training to identify needy children. An investigation of research is needed to determine the attempts that are being made by school districts to remedy the lack of necessary in-house mental health supports, and how they could benefit small schools with limited resources to help students before they hurt.

1.4.3 Significant Stakeholders

Shawna Burns started her career as public-school special education teacher. Her passion for children and their needs motivated her to become a licensed professional counselor (LPC). As an LPC, she worked with special needs children outside the school setting. She desired to equip others to help students at school and not have them wait for referrals for off-campus counseling. Mrs. Burns has taken the skills of an LPC and used them to equip critical stakeholders in the public-school setting. Her method is called SD, which focuses on getting to the troubling root or seeds that have grown in a child's thinking and planting healthy seeds of thought instead. This model works well with very young children and can aid in early detection of mental issues. Administrators in charge of mental health with the State Department of Education took notice of SD programs related to suicide prevention and intervention and have encouraged other districts to consider her programs.

Key stakeholders are school administrators and their school board at one public school district who took the time to review her novel methods and endorse their use among their campuses. Local school counselors embraced the concepts and began implementing them with children manifesting emotional and behavioral episodes. These counselors are reaching out to their colleagues at other schools and are encouraging them to utilize the techniques of SD. Teachers and students are the stakeholders who reap the benefits of SD with early

identification of social, emotional, and mental health concerns. The results of this study have the potential to qualify methods that can be transferred to other schools and help students before they hurt.

1.5 Important Terms

Adverse Childhood Experiences (ACES) - "Adverse events in childhood are of great public health concern given the evidence of their long-term impact on health" (Boullier & Blair, 2018, p. 132). ACES is a foundational term in identifying students with all levels of health concerns.

Seed Digging - A program developed by Licensed Professional Counselor Shawna Burns for use in public schools to identify students who seek self-harm and determine root causes. The program uses a garden approach to replace weeds or bad seeds (thoughts) with healthier seeds of thought and techniques to grow better social, emotional, and mental health (*Home | Seed Digging, Pllc*, n.d.).

Transferability - The feasibility that a program used at one school district can be used at another school district considering its human resources and budgetary limitations.

Universal Screeners - An assessment instrument administered to all students for the determination of their level of self-esteem and potential for emotional and academic stability (Houri & Miller, 2019).

1.6 Closing Thoughts on Chapter I

The COVID 19 pandemic has caused a worldwide crisis. The impact on public education may take years to understand and quantify the effects caused by the disruption of everyday pedagogical practices. Teachers and students alike have had to adjust to the change from in-person face-to-face instruction to a virtual or blended teaching platform. Social isolation has left educators wondering where their students are. Some students have physically left their schools or

cities to different areas or with different parents. Educators are unsure of where students are with academic success. Many schools went to a pass or fail system to reward students for attempting an assignment or simply logging in to online classes. The most important question may be, where are students regarding their social, emotional, and mental health? Prior to the pandemic, these were serious concerns among educators, and now more than ever, research for solutions to help students deal with their adverse childhood experiences is necessary.

In this Record of Study, a case study of one school's attempts to utilize and in-house mental health early identification method along with teacher and curriculum supports using the SD program. Public school counselors and teachers use these techniques and support systems in several state school districts. The gathering of qualitative data will be obtained from the creator of the SD program and current stakeholders participating in the program. An attempt to gauge the effectiveness and transferability to small rural schools with limited human and financial resources will be a potential outcome. Chapter 2 will look more closely at the current research on the effects of adverse childhood trauma and how public-school systems can provide support and treatment for troubled students. Chapter 3 will consider solutions and methods, Chapter 4 will provide results and analysis, and Chapter 5 will yield the conclusions.

CHAPTER II

REVIEW OF SUPPORTING SCHOLARSHIP

2.1 Introduction

The typical training for the American public-school teacher involves lesson planning, outcome-based learning objectives, assessments, teaching techniques and a myriad of other skillsets to provide instruction for children. Results and performance are often measured with standardized testing (Ballou & Springer, 2015). Educators have made provisions for a child's physical needs in terms of free lunch programs and physical exercise. The social, emotional, and mental well-being of children are issues, most teachers are ill equipped to diagnose and treat. Often it is difficult to know the severity of a child's adverse experiences until the student manifests inappropriate behaviors in the classroom like outbursts of anger or severe mood swings. Children who are victims of Adverse Childhood Experiences (ACES) especially those in rural America have extremely limited availability to mental health care (Schraeder & Reid, 2014). It is often too far away, too expensive, and too difficult to maintain consistent treatment. The learning process of a child of ACES must overcome a great amount of emotional noise of the mind to focus on the academic lessons at hand. Through my ROS I will examine methods being used to provide for early identification of children with mental health needs and the feasibility of providing mental health care on campuses by existing staff members.

This chapter is a comprehensive inquiry of scholarly articles that address the needs, techniques, tools, and guidance of interventions related to children experiencing ACES and the need for Trauma Informed Care. Research articles are presented that show the effectiveness of some programs related to early detection of social, emotional, and mental health concerns that impact learning and behavior. Presentation of the reviewed literature shows historical

background, impact on children, educators and society and long-term consequences of nonintervention. The need for adolescent mental health intervention has long been established but the recent shift in education because of the COVID-19 pandemic only accelerates the need for early intervention and assessments of school aged youth (Pfefferbaum & North, 2020). The Texas A&M library system and Google scholar provided the online data bases producing timely scholarly articles for this review. Keywords related to the problem of study were, trauma, Adverse Childhood Experiences (ACES), Post Traumatic Stress Disorder (PTSD), depression, suicide, school violence, neglect, self-esteem, and relationships.

2.2 Relevant Historical Background

Psychiatrists, physicians, and researchers have acknowledged for hundreds of years that children who suffer maltreatment are affected emotionally, mentally, and physically by their experiences (Parkinson, 1800). As long as there have been vulnerable populations the vulnerable have been abused. ACES and Trauma Informed resources are common terms in the educator's vocabulary for discussing the needs of today's youth (Aponte, 2020). The effects of trauma and ACEs can have problematic impacts on student learning. Trauma experienced by students often manifest behaviors that lead to a desire to harm themselves or others (Van der Kolk, 2014). These manifestations and others can affect a child's inability to experience academic success. Educators need resources that can provide early intervention and curriculum supports to aid students and create a safe and healthy educational experience. Our nation's greatest struggle and challenge of public health is childhood trauma (Nicholson et al., 2018, p. viii).

Before a solution can be found it is important to first recognize that a problem exists. Eighteenth century London England was home to the Royal Humane Society which awarded medals to physicians and others who made notable contributions to society. James Parkinson was

one such recipient of a silver medal in 1777 (Parent, 2017). Parkinson is most noted for the discovery of the disease that bears his name, but Parkinson was one of the first to make mention in his medical journals about the effects of abuse on children and the need for reform and care of mental health patients (Parkinson, 1800). Because of his desire to help the underprivileged he was often known as the "madhouse doctor" (Parent, 2017, p. 86), due to his frequent visits to care for those sentenced to the mental institutions of the period. Parkinson may have been the first author to ever point out the need for mental health care for children and that the trauma and ACES need attention to insure their healthy development. Research literature also concurs that for children to achieve academic success the social, emotional, and mental health of a child must not be ignored (Seiff, 2015). At a time in history when the value of a child was for what they could provide in terms of labor, Parkinson saw the need for provision of care when he said ", Expect not duty from a child, if you have not yours towards him" (Parkinson, 1800, p. 64).

Physical abuse can leave physical scars which can heal quickly but the mental scars left by those experiences may need a lifetime of healing (Selwyn et al., 2019). Physical pain can impact mental health, but the reverse can be true. Mental pain can impact one's physical health. Wilhem Wundt was a pioneer of modern psychiatry and is credited with making the connection with emotions and physiological effects (Wassmann, 2008). In his book, *Principles of the Physiological Psychology*, Wundt says "the last most important question for the relationship of nervous process to the processes of the physical life" (Wundt, 1902/1904, p. 38). Over a hundred years later Van Der Kolk confirms Wundt's work in his book *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (Van der Kolk, 2014). The author stated that "It takes tremendous energy to keep functioning while carrying the memory of terror, and the shame of utter weakness and vulnerability" (Van der Kolk, 2014, p. 2). A child in the classroom who has

been exposed to trauma must go above and beyond to concentrate on a lesson when their mind and body is expending this energy of dealing with ACES (Herrenkohl et al., 2019).

In the last several decades attention has been given to soldiers returning from battle with the condition known as Post Traumatic Stress Disorder (PTSD). This disorder can also be prevalent in children (Selwyn et al., 2019). A child may not have experienced the trauma of the military battlefield but may have experienced adolescent exposure to violence (AEV) (Covey et al., 2017). This exposure to violence can be experienced by parental violence in the home and violence in the neighborhood. Children can manifest symptoms of "maladaptive cognitive coping strategies such as avoidance, rumination, and self-blame" (Ross & Kearney, 2015, p. 3767). To help identify these children with PTSD and AEV it is recommended for "collaboration among criminal justice, child welfare, educational, and mental health agencies in ensuring that once AEV is identified, the resulting mental health needs of adolescents are addressed" (Covey et al., 2017, p. 198). ACES are not just problematic during adolescence but can impact victims long into adulthood. Children with exposure to violence have been linked to adult depression, anxiety, and PTSD. "Research suggests that sophisticated mental health diagnosis is warranted for children who come to the attention of the justice and human services systems as a result of AEV" (Covey et al., 2017, p. 198). It is not just the children who sit in police stations while their parents are processed but children who sit in classrooms that come to the attention of their teachers that warrant mental health services (Herrenkohl et al., 2019). Realizing that children in our schools have had these traumatic experiences, it is important to know some of the manifestations that may be present in classroom behavior.

2.3 Alignment with Action Research Traditions

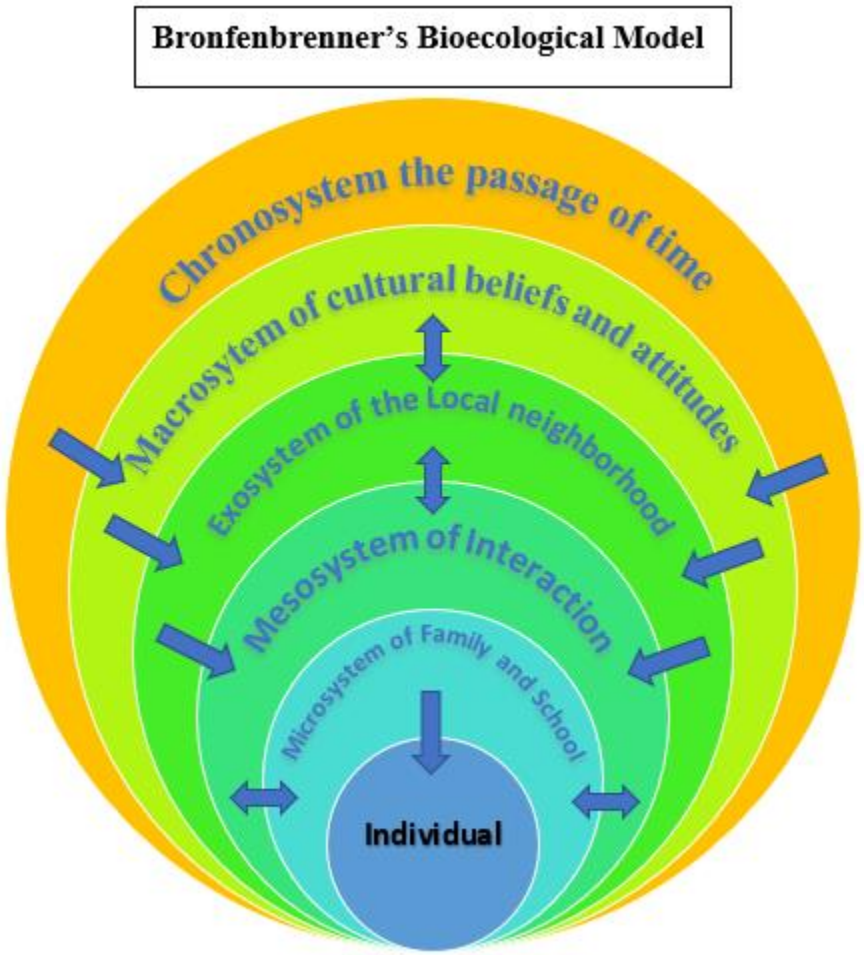
Working with a group of people who are looking to solve a problem at their local level can experience phenomena that might be beneficial for others experiencing similar problems. Studying the reasonings of school administrators in one rural school district to implement a novel method of providing mental health solutions for students in public school is the basis of this record of study. **"**Action research is research with people, rather than on people" (Coghlan & Shani, 2005, p. 544). Studying the stakeholders involved with the SD approach aligns with the premises of action research that Lewin established that there must be "the active participation by those who have to carry out the work in the exploration of problems that they identify and anticipate" (Adelman, 1993, p. 9). A single case study related to the implementation of the SD program by this school district will seek to understand the problems of mental health needs that have impacted their stakeholders.

2.4 Theoretical Framework

The theoretical framework for this study is based on the bioecological theory made popular by Urie Bronfenbrenner. The bioecological model is based on a series of concentric circles as systems with the child being at the center. The Inner system is referred to as the microsystem that includes elements that are in direct contact with the child such as parents and school. These strong relationships can have positive and negative influences. The mesosystem builds on the interconnectivity of the relationships within the child's microsystem such has the parent's relationship with the school. The exosystem goes beyond the child's inner systems such as mass media, extended families, neighbors, schools, and government agencies. The macrosystem comprises ideologies, social media influences, attitudes, poverty, race that form cultural expectations. The outer layer is referred to the chronosystem that adds the element of

time and situation that can affect society (Bronfenbrenner, 1981). Figure 1 is an illustration of Bronfenbrenner's basic model.

Figure 1. Bronfenbrenner's Bioecological Model



Bronfenbrenner's basic model is like an onion. The layers of the model are peeled back exposing levels of influence. Firefighter's approach a burning building in much the same way. They start with where they see the smoke and begin working through the structure looking for the source of the fire. The smoke exiting the roof may have a source in the basement. A child's behavior may manifest in the classroom, but the source of the actions may be from a different level of influence. The child's belief system is formed by bioecological factors and must be

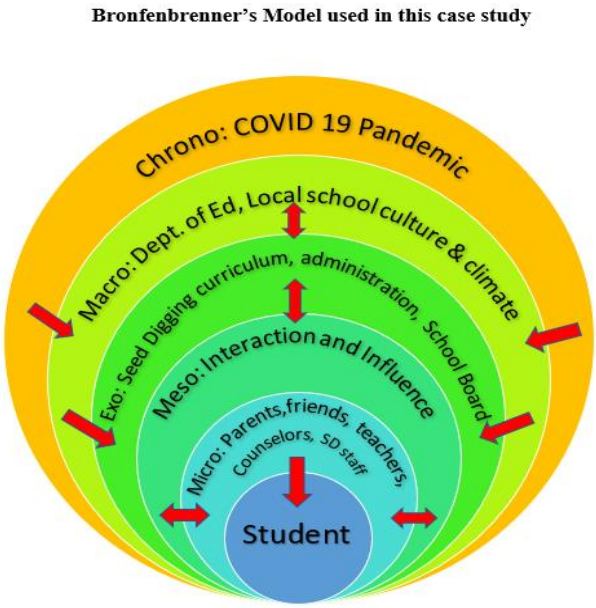
addressed from that perspective. Sturgeon premised that mental illness and mental health issues encompass the individual's physiological, societal, and social interactions (Sturgeon, 2006). These factors can come from a post on social media urging a student to commit suicide or parent calling their child useless or worthless or possibly a history of mental illness in the child's family. The bioecological model has been used by other researchers to help guide public policy relating to mental health (Eriksson et al., 2018), and is a suitable framework for this study.

The bioecological theory provides a lens which reveals the interconnectivity of factors that can influence a child's social, emotional, and mental well-being. The SD method utilized by the school district exemplifies the foundation of this theory and is similar to a concept of bioecological counseling (Richardson et al., 2019). The interaction of the bioecological systems can illustrate possible factors that influence a child's desire to hurt themselves or others (Richardson et al., 2019). The SD model seeks to identify negative influences and provide interventions by exposing the roots or issues of the student.

Figure 2 illustrates the bioecological model used to guide the collection of data and its relativity to participants. This case study will involve stakeholders that occupy every system of Bronfenbrenner's model (Crawford, 2020). For example, when a teacher requests a conference with the parent, the child is at the center of the discussion. The parents influence the child from the microsystem and the school's protocols influence the exosystem of curriculum and intervention. The point of interaction with teacher, parent and student is a work of the mesosystem. In the exosystem, the curriculum tools used in the SD program like the Self-Esteem Questionnaire, children's book and book for older students can move from an indirect relationship to a direct relationship when introduced to the student. The macrosystem can represent the culture of the school with regards to violence, bullying or compassion. The

macrosystem factors can influence the teacher's, counselor's, and administration's attitudes and actions when working with students. The chronosystem shows the work of time's influence on the system. The COVID 19 pandemic exemplifies how fast a culture can traverse from the macrosystem of beliefs and norms to the indirect environment of the macrosystem with elements of social media, religion, and politics. The mesosystem interacts with these systems and moves ever closer to the microsystem of teachers and parents. In the center of this bioecological model lies the student, absorbing these influences, both positive and negative. These influences will ultimately form the student's belief system about themself and their environment.

Figure 2. Bronfenbrenner's Modified Model used in this case study



2.5 Most Significant Research and Practice Studies

Reaction to Manifestations of Trauma in Children

Social needs and interactions can also devastate students' emotional needs and manifestations. Much of the protocol for reacting to mental health issues in public schools began after the Columbine shooting in 1999. "Regardless of how Columbine is memorialized, when we

speak about “Columbine,” we are not talking about what happened in that incident in 1999, but rather its reverberations that continue to this day” (Muschert, 2019, p. 358). The reverberations are zero-tolerance policies, hardened schools, armed staff, and active shooter drills that may help prepare for disaster but increase students’ mental health and stress issues (Huskey & Connell, 2020).

Texas responded to the public outcry for safer schools by passing HB1109, which allowed public schools to train school personnel to act as School Marshals (*School Marshal | Texas Commission on Law Enforcement*, 2013). This program mandates that participants receive eighty hours of law enforcement training in using deadly force to eliminate the threat of a violent, deadly act that might occur on a school campus. The use of deadly force is an extreme reaction to a social, emotional, or mental health manifestation. Many police incidents that end in using deadly force are with people suffering from mental illness (Chambers, 2021). Some educational policies may contribute to the increase of violent or unstable acts. “Research has tied exclusionary practices to a host of negative outcomes including lower levels of attendance, self-esteem, academic performance, graduation, and higher levels of anxiety, dropout, delinquency, victimization, and arrest” (Hemez et al., 2019). Unintended consequences of zero tolerance policies are that students who would benefit from a mental health referral instead are dealt with by law enforcement. The focus becomes on the infraction, and the mental health need goes undiagnosed (Mitchell, 2014). Students who often need the most significant help manifest poor behavior that results in some form of incarceration but not the social, emotional, and mental help that they need.

Alternatives to Violent or Punitive Solutions

In 2019 Texas Senate Bill 11 was passed in response to the deadly school shooting in Sante Fe, Texas. The bill's passage allowed public schools to increase the number of school marshals and a more comprehensive look at threat assessments and trauma-informed teacher preparation (*School Safety | Texas Education Agency*, 2020). "The Texas Youth Risk Behavior Survey (YRBS) reflects an almost 20-year trend of rising rates of sadness, hopelessness, and suicide attempts among Texas students, highlighting that suicide prevention, intervention, and postvention is a key area of concern for schools" (*Suicide Prevention, Intervention, and Postvention,* 2020, p. 1). Senate Bill 11 has expanded the role of mental health support, but because it is new to Texas public schools, implementation is in its infancy. Many teacher preparation programs focus on pedagogy, classroom management, and curriculum presentation. Nicholson, Kurtz, and Perez express the need for early educators to be trauma-informed in the classroom (Nicholson et al., 2018). The authors of this article created a landmark project in exploring the effects of ACES in early childhood and strategies to change the school environment and enhance learning through better teacher-to-student relationships. There are consequences when our educational system ignores the mental health needs of children. Keeping educators informed about trauma attempts to prepare teachers beyond curriculum and instruction. "The COVID-19 pandemic has changed the norms of society and brought instability, deepening the symptoms of complexly traumatized adolescents" (Aponte, 2020, p. 125). Aponte recommends instructing educators in neuroeducation and seeking public resources to utilize trauma-informed strategies for adolescents. Trauma-informed strategies and neuroeducation can be intimidating for teachers who have enough challenges teaching their introductory coursework.

A solution for helping ACE victims may be as simple as building healthy relationships with students.

Students need an outlet for their experiences, and teachers may be the only trusted available option. “The single most common factor for children who end up doing well is having the support of at least one stable and committed relationship with a parent, caregiver, or other adult” (Aponte, 2020, pp. 134–135). Just as soldiers returning from battle with PTSD need intervention from VA hospitals, the classroom may be the frontline intervention for children who have PTSD. Trauma-focused cognitive behavioral therapy (TFCBT) is an option that has shown to be effective (de Arellano et al., 2014). Trained administrators of trauma-focused programs may be an essential need at public schools. However, the cost of such programs and specifically trained personnel may be a burden that public schools cannot afford (O’Malley et al., 2018). A key element of TFCBT is the initial assessment given to students to determine the level of trauma and depth of treatment a child may need. Some researchers state that “childhood trauma has been called “the hidden epidemic,” (Gerson & Rappaport, 2012, p. 137). An epidemic signal that the need is often greater than caregivers can supply. Assessing the need is a beginning, but getting students to trained therapists is problematic, especially in rural areas.

Teachers as Therapists

Most teachers begin their classroom instruction guided by a lesson plan template focused on a learning objective. Classes are often less than an hour, and the emphasis is to cover the essential knowledge and skills that require mastery on year end high stakes testing. Knowing their pupils’ social, emotional, or mental condition is not part of the curriculum (Herrenkohl et al., 2019). Students with behavioral or discipline issues often visit a school counselor for a referral. Finkelhor explores the effectiveness of screeners or ACE inventories for school-age

children and adolescents. He contends that "the potential is great. The key challenge is to figure out how to use health visits to find the patients who will benefit from such effective services and get them connected while minimizing unnecessary costs and harms" (Finkelhor, 2018, p. 177). Researchers try to pair ACE screeners with medical professionals because of the connection between ACES and physical health conditions. The likelihood of a child developing negative health conditions including diabetes, stroke, cancer, alcoholism, substance abuse, and depression throughout their lifetime is in direct relationship to the scores on ACE screeners (Frampton et al., 2018).

Other researchers have suggested practitioners in the medical community should incorporate the use of PTSD screeners in primary pediatric care facilities. They feel that providing this service to children is attainable "even in under-resourced settings" (Selwyn et al., 2019, p. 64). The evidence is clear that ACES leads to numerous mental and physical health issues. A connection to medical clinics seems logical, except that the experience must be severe enough to require a doctor's visit. Public schools are often under-resourced settings.

Compassion Fatigue and Secondary Trauma

Regardless of the job description, teachers will reach out with compassion to students' needs, sometimes to the detriment of their own health. It is often the teacher who first notices a change in a child's health or behaviors. From 2012 to 2016, there was almost a 10% increase in child abuse reporting by teachers. Those reports listed six-hundred and seventy-six thousand child abuse cases, and one-thousand, seven hundred and fifty children died because of maltreatment (Hupe & Stevenson, 2019). Teachers' care and caring can have a cost (Christian-Brandt et al., 2020). Teachers become distressed when they incur daily experiences with children undergoing the trauma of homelife. Divorce, abuse, neglect, poverty, and violent situations

suffered by students are often shared with the teacher leaving the teacher to feel helpless and frustrated leading to a concept of compassion fatigue (Hupe & Stevenson, 2019). The cost of caring through secondary trauma is often job burnout. Teachers are helping professionals, and teachers who work in underserved and low-income schools come into more frequent contact with traumatized children. There is growing attention to the need for teachers to be instructed in Trauma-Informed Care (TIC). However, little has been researched on the teacher's impact and quality of life when interacting with trauma children (Christian-Brandt et al., 2020).

School Based Interventions

Most school-based mental health interventions begin with a referral to an academic school counselor. School counselors receive little training in licensed professional counseling interventions. The average ratio for school counselors is about one counselor for every four hundred and fifty students (*Ratioreport*, 2015). Because most academic school counselors are overwhelmed with other duties, outside mental health professionals see a child with behavioral anxiety or suicidal ideations (Hugh-Jones et al., 2020). Small rural communities seldom have adequate mental health providers, and students in need of therapy or intervention must travel more than an hour to a treatment facility. Time away from work and the cost of treatment for low socio-economic families is a deterrent to treatment (O'Malley et al., 2018). "Globally, approximately 117 million children and young people are affected by anxiety disorders [1]. Fewer than 20% of young people with anxiety disorder access support [2], and of those that do, a significant minority end treatment prematurely or do not benefit" (Hugh-Jones et al., 2020, p. 1). Available help for most students is not convenient, practical, or sustainable. Researchers in the UK have titled this a *wait to fail* model that involves children and young people's MHD coming to the attention of education, care and or health service professionals as the result of events that

reflect deeply entrenched problems (e.g., being permanently excluded from school or coming into contact with the criminal justice system)," (Humphrey & Wigelsworth, 2016, p. 24).

A possible start for school-based intervention can begin with the school environment. Studies have shown a correlation between the school environment and the probability of school violence. "Violence in US schools is hindering the educational, psychological, and social development of students. Students who are victimized are more likely to report feelings of social isolation, depression, frustration, and poorer school attachment" (Johnson et al., 2011, p. 331). The local school should be a place of safety for children, but often it is not. A conscious effort to establish a safe environment at school is a beginning intervention. Just as the school environment is a crucial element of school safety, intervention relationships are common among researchers. Professional development programs like Capturing Kid's Hearts (CKH) emphasize equipping teachers to establish healthy relationships with their students. "Capturing Kids' Hearts is a management model that involves building community and relationships within the classroom to help students take responsibility for their actions" (Burgess, 2017, p. 62). Burgess focused her research on the impact of classroom management issues on novice teachers. Quite often, novice teachers responded to classroom disruptions with only punitive responses, but the CKH training taught them how to look for the underlying contributors to disruptions. Nicholson, Perez, and Kurtz completed research that focused on relationship-based trauma-informed practices for early childhood teachers. Their book has become a resource for educators that train in-house staff with skills to build relationships with children and families that are strength-based and encourage healing and support (Nicholson et al., 2018).

A group of Canadian researchers looked at the importance of mental health literacy. This concept promotes a curriculum-based approach to mental health literacy to expose students to a

greater familiarity with mental health issues, terms, and treatment (Mcluckie et al., 2014). If knowledge and beliefs about mental health are present, then students can aid in preventing, identifying, and managing mental disorders, quite possibly their own (Mcluckie et al., 2014). Their research revealed improvement in early diagnosis but a decrease in mental health attitudes toward destigmatizing related to students struggling with mental health issues.

Universal Screeners in Early Intervention

Universal mental health screeners have been used effectively in clinical and medical settings. There is evidence for their use on the frontlines of public schools, but it is not without opposition. The primary opposition, according to Humphrey and Wigelsworth is the labeling of children as a mental health risk and the bias that children might receive from educators and society based on an initial diagnosis (Humphrey & Wigelsworth, 2016). Combatting the fear of stigmatization may be done through increased societal awareness. Awareness can be grown through the screening process itself. The Canadian study showed a connection between improved mental literacy lessons stigmatizing students and paving a path for the use of universal screeners (Mcluckie et al., 2014). Parent fears are well warranted because of the vocabulary associated with mental illnesses such as suicide ideation, depression, and anxiety. Other terminology used in the screening process can make the process more palatable with less stigmatism for caregivers. Screening regarding a child's self-esteem and self-image can be revelatory regarding cautionary elements of a child's social, emotional, and mental health needs (Barry et al., 2003). "The key step in reform is to move school-based psychological services from the back of the service delivery system, in which only students at the highest level of risk receive services, to the front of service delivery through the use of universal, proactive screening" (Dowdy et al., 2010, p. 174). Universal screening seems to have advantages over other types of screenings. Most

screeners are reactionary, whereas universal screening would be proactive and given to all students promoting early identification (Soneson et al., 2020).

Two groups of researchers in the UK conducted separate studies on school-based universal screening, and both studies considered the feasibility of implementation. One group of researchers reviewed 33 different universal screening studies. It analyzed the cost of implementation, staff training, additional personnel, parental consent, student acceptance, and time of administration of screeners. Seven of the studies were curriculum-based, and most of the teachers involved felt that they were beneficial and appropriate. Some teachers were concerned about acceptance or rejections by parents, but most found it relevant, important, useful, and interesting (Soneson et al., 2020). Of the thirty-three studies completed by the group led by Emma Soneson, no evidence of harm resulting from screening students was manifested (Soneson et al., 2020). Humphrey's and Wigelsworth's research conclude with, "We envisage a secure online screening system underpinned by high-quality training for teachers (and other stakeholders) that provides a solid baseline of mental health literacy, the technical process of screening and clarification of its purpose, goals, and role within the broader system" (Humphrey & Wigelsworth, 2016, p. 36). The researchers lend hope to the feasibility of creating in-school early interventions instead of waiting for the behavioral manifestation to outside professionals with poor histories of patient follow-up. The mindset among mental health professionals and school-based practitioners regarding early intervention is gaining popularity. School resources are limited, and mental health needs are rising. A shift from individualized therapy to universal and preventive approaches is warranted (Dowdy et al., 2010).

2.6 Closing Thoughts on Chapter II

Research on mental health care for children of trauma and ACES produced several different focus areas. Several studies involved care for children from highly trained mental and medical health professionals (Strand et al., 2005). The problems with these programs are the access and availability of treatment to the needy—many children who have had ACES come from low socio-economic situations. The time, transportation, and expense of treatment prevented children identified for therapy from receiving any follow-up after an initial diagnosis (Hugh-Jones et al., 2020). Not a single research article downplayed the need for early intervention or denied that mental health needs are growing. The unknown implications of the ongoing COVID 19 pandemic have created a heightened sense of need regarding school-aged children's mental health issues (Aponte, 2020). Several aspects of helping students with social, emotional, and behavioral needs can be implemented by elements already available to schools through training teachers on healthy teacher/student relationships (Honsinger & Brown, 2019) and improved campus environments to reduce school violence (Johnson et al., 2011). Fears of labeling or profiling students can be addressed by universal screening because it would be a regular part of school assessments, much like mandatory hearing and vision screening (Humphrey & Wigelsworth, 2016). Research is minimal regarding long-term follow-up of diagnosed and treated individuals. Research showed little connection between early intervention and improved academic performance, higher attendance, and decreased discipline referrals. There were direct correlations between numerous societal maladies related to poor mental and physical health and decreased educational outcomes (RB-Banks & Meyer, 2017).

The literature review for this topic supports further investigation of the implementation of universal mental health screeners by school personnel for early intervention to better students'

overall health. Educating the world's children has become much more than providing for academic success but providing for the whole child's needs in mind, body, and soul. Equipping schools with the resources necessary for early detection and providing on-site treatment for mental health care needs is essential to combat the growing concerns of children with ACES. This ROS will attempt to explore one school district's attempt to use early identifiers, and embedded curriculum supports to aid educators in preventing, detecting, and treating the social, emotional, and mental needs of school-aged children in public schools.

CHAPTER III

SOLUTION AND METHOD

3.1 Outline of Proposed Solution

This research explored the considerations and factors that lead administrators to choose a mental health care program in one school district for proactive and preemptive measures to reduce the incidence of student self-harm or the harm to other students. There are multiple problems when providing mental health care for children, including early identification, accessibility, affordability, effectiveness, transferable, and deliverable care system to children. The stigma associated with mental identification can be problematic in program implementations (Barry et al., 2003). Therefore, I studied a public school that utilizes early detection methods and provides staff support systems to intervene and help students with potential social, emotional, or mental health concerns. This researcher researched one rural public school district using the SD approach for providing mental health care for their students.

3.2 Justification of Proposed Solution

Suicide prevention and mental health awareness training are mandated for most educators before the school year starts, and it is difficult to determine their effectiveness or success (*Suicide Prevention, Intervention, and Postvention*, n.d.). A societal increase in suicides and active shootings would contradict the current school-based methodology's effectiveness. Due to the pandemic, current mental health situations are an unknown and emerging factor (Aponte, 2020). Most programs used in schools can be considered a *wait to fail* model that attempts to deal with the student's mental health after a problem has manifested (Humphrey & Wigelsworth, 2016). A possible solution for providing effective mental health support is through a program known as SD. SD is a remedy that utilizes outside mental health experts to provide services and

train local school counselors in SD techniques and early intervention (*Seed Digging: Achieve Incredible Inner Peace*, n.d.). Rural schools can be hours away from resources that often operate at capacity. A real-time phenomenon addressing public school students suffering from mental health issues will be a valuable source of information for effective future methodology. Early identification of students can improve academic outcomes and future behavior disruptions in the classroom (Finkelhor, 2018).

3.3 Study Context and Participants

This qualitative record of study is "generally characterized by the inductive approaches to knowledge building aimed at generating meaning and is generally appropriate when your primary purpose is to explore, describe, or explain" (Leavy, 2017, p. 9). When looking for professional learning opportunities for educators regarding suicide prevention and mental wellness, the SD program was utilized in several school system. The developer of the SD Wellness Center program comes from an education background, as well as has a collegial relationship with the researcher. Information became available that the SD program was branching out beyond suicide prevention to school-based models of early identification and school-based mental health counseling. As a researcher, insight could be gained into the program and what guided other district leaders to make their decisions and to continue with the program. The knowledge gained would allow decisions to be made that could positively impact other school districts. Several schools have seen the merit of the SD approach and are adopting the program in their schools. The SD program has been in place for almost four years in one State School District. This case study explored a school district's decision to implement the SD program and explain their rationale and describe the perceptions and impressions of the stakeholders.

Interviews began with the superintendent (n=1). Approval to conduct research and interviews with district employees was granted. Interviews included three academic school counselors (n=3), two classroom teachers (n=2), two parents (n=2), Sarah from the SD Wellness center (n=1), a former student (n=1) and a community nurse practitioner (n=1) for a total of (n=11) interviews. This process aligned with the bioecological framework that included perspectives that impacted the levels of influence on children's developmental and decision-making processes (Crawford, 2020). Participants were given the opportunity to describe their experience with the SD program.

Table 1. Initial Participant Guide

Participant Interview	**System Location**	**Use of Reflecting Tools**
Administrator (n=1)	Exosystem/ Macro	SD Program Information
Counselor (n=3)	Micro/Exosytem	Self Esteem Questionnaire, SD Books other
SD staff (n=1)	Micro/Exosystem	Curriculum Developer
Parent (n=2)	Microsystem	Home use if any.
Teacher (n=2)	Micro/Exosystem	Questionnaire, SD Books, directives from counselors or staff
Nurse Practitioner (n=1)	Exosystem/ Macro	Community physician that makes SD referrals for adult patients
Former Student (n=1)	Microsystem	First recipient of SD therapy in the school community.

3.4 Proposed Research Paradigm

This was a qualitative case study as opposed to a quantitative approach which "seeks to identify factors ahead of time and then seeks to measure the prevalence and strength of each factor, qualitative researchers are interested in knowing how people understood and experienced their world at a particular point in time" (Merriam et al., 2019, p. 4). Therefore, I employed a case study illuminating why decisions were made, how they were implemented and what were

the results or impacts of those decisions (Yin, 2017). In particular, the research questions for this study focus on "why" and "how" of administrators' considerations for implementing the SD program in response to students' mental health needs, requiring an extensive explanation of a circumstance or phenomenon. This case study allowed the researcher to ask why some participant's chose the SD program and how others can explain their level of participation in the program. Once an understanding was gained into their reasonings then knowledge was added on how they were able to accomplish the change from their former mental health system to a novel mental health care program.

Other research methods were not appropriate for this study for several reasons. The nature of incidents of self-harm and active shooters are difficult to quantify. Quantitative studies seek to test theories, relationships and variables using measurable instrumentation (Creswell & Creswell, 2018). Statistical data can be found in large studies showing national and worldwide increases of mental health incidents. This data addressed the increase but not the emotions and experiences of participants in a single community. Suicides and school shootings are rare and random occurrences and difficult to pattern (Paez et al., 2021). Documentation of potential and intervention successes are difficult to quantify. A qualitative case study analyzed the mental health, early identification, intervention, and delivery methods of one remote school district with limited resources.

This qualitative case study provided the opportunity to create themes, and findings from holistic data (Leavy, 2017). The SD Wellness Center's mental health program entails a counseling method that explores the root of mental and psychological issues in children and youth. Bronfenbrenner's bioecological model explored the levels of interconnectivity in the micro and macro areas of childhood influences. An inquiry of a school using the SD program

allowed the study of the program's development and access to phenomena that focus on mental health issues in school-age students. Researching one school district that is implementing these new and innovative methods of mental health provision was beneficial in providing transferable resources. Counselors and participants who are currently treating school-age clients with differing levels of mental distress provided considerable information on their impressions of effectiveness and value of the program. Examining the treatment provided by the counselors and their use of mental health screening for school-age children improved understanding into methods of early detection for troubled students.

3.5 Data Collection Methods

Approval was granted by the International Review Board (Appendix A) and successful completion of the preliminary defense of chapters 1-3 by my committee, I began to secure permissions and suggestions for possible school district (D1) interview participants. I reached out to the D1 superintendent for permission to conduct research in the district and for his consent to participate in an interview (Appendix B & C). The list of the semi structured questions for the different participants is found in Appendix D.

The grounded theory approach for participant interviews relied on inductive or ground up coding to see where the data would lead. All interviews were conducted using the GoToMeeting program. GoToMeeting provides users the ability for audio, video, and detailed written transcripts identifying the main speaker and the interviewee.

Once all eleven interviews were complete the initial coding began using Delvetool qualitative research software. Transcripts were read manually and checked for accuracy and initial codes were created. After reviewing initial open coding, axial coding showing

connectivity lead the creation of four themes. A coding matrix is provided in Appendix E detailing themes, codes, and examples.

Interviews were the primary mode of data collection for this case study. The interviews were semi-structured and informal. The SD director provided introductions with the District Superintendent. Arrangements for interviews and permission to interview school personnel was the purpose of this meeting. Once the district superintendent granted permission, communication was sent via email to participants, followed by phone contacts with the recommended participants. A letter explaining the authorization from district administration, the nature of the interview, and assurances of confidentiality for the research was given to potential participants (Appendix B).

The SD Wellness Center provides their clients with several resources for student's use and are considered artifacts for this study. The *Self-Esteem* questionnaire is used as their early screening tool. For the elementary aged children, the book, *Charlie, and the yucky, stinky, no-good fruit* (Burns, 2015) is used as a counseling tool. The book, *Seed digging: A simple technique that leads to incredible inner peace* (Burns, 2014), is used for older students and adults to understand the program and help them deal with trauma.

The in-depth/informal interviews included a list of starter questions appropriate for their involvement with the program. For example, I asked counselors to bring a completed, anonymous Self-Esteem questionnaire and/or any other SD resources they used while working with a student. They explained their decision-making processes and explained its influence. ""Interviews can especially help by suggesting explanation (i.e., the "how's" and "whys") of key events, as well as the insights reflecting participant's relativist reflections"" (Yin,2017,

p.118). Specific interview starter questions related to each participant's involvement with the program are available in Appendix D. After the starter questions, the format was informal, allowing the participants to interject or comment as they wish.

3.6 Justification of the Use of Instruments in Context

Researching the preventive measures of mental health care using a qualitative research method allowed for the examination into the emotions, social influences and phenomenon that might influence self-harm, or harm to others. A great deal of data exists regarding suicidal and school shooter incidents, but variables needed to test an objective theory using a quantitative approach would be problematic due to the need to measure the emotional nature of the variables (Creswell & Creswell, 2018). Students with mental health issues are phenomenological in nature. Incidents such as suicides or school shootings become newsworthy when they occur, but many attempts are thwarted before deadly outcomes are experienced. The bioecological framework combined with a qualitative case study approach to the research permitted the examination of the reasoning of use, by various staff in the field of education, for their willingness to use the SD program on their campuses.

3.7 Data Analysis Strategy

A grounded theory of qualitative analysis was used to code the data. Open coding broke down the data into smaller parts for labeling and creating the initial codes. After the coded information was collected, axial codes across sources of data were made from the first pass of coding to create group categories (Corbin & Strauss, 1990). From open coding to axial coding a final selective coding process brought the data to a narrative that told the story of the research.

The grounded theory strategy allowed the collection of real-world data and data analysis that was done iteratively (Shenton, 2004). These strategies have an inductive element that Yin considers as "working your data from the ""ground up"" (Yin, 2017, p. 169). A computer software program called Delvetool collated data and codes for each data source. Collected and collated research increased the understanding and insight into the phenomena studied.

3.8 Timeline

Proposal of study- Spring 2021

Submit IRB Proposal- Spring 2021

Completion of Chapter One and Two- Spring 2021

Begin Writing Chapter Three- Summer 2021

Chapters 1-3 proposal defense- Spring 2022

Begin data collection and interviews- Spring 2022

Begin analysis of data- Spring/Summer 2022

Submit draft of Chapters 4&5 – Fall 2022

Submit Final Copy of ROS to Committee- Fall 2022

Oral Defense of ROS to Committee - Fall 2022

Graduation from Program- December 2022

3.9 Reliability and Validity Concerns or Equivalents

This ROS is a qualitative study that seeks to be a credible work of research. Credibility, dependability, confirmability, and transferability were the guiding factors for ensuring trustworthiness (Shenton, 2004). Credibility was attributed to multiple voices and sources to confirm or disprove the authenticity of the interpretations. The use of recording devices, interview transcripts, computer software to aid coding, and participant feedback provided

dependability (Leech & Onwuegbuzie, 2007). These findings were limited to the context researched and may or may not be generalizable or transferable. Triangulation across data sources and reflection conducting member checks during data analysis provided confirmability (Leavy, 2017). Together these elements produced trustworthy research.

3.10 Closing Thoughts on Chapter III

This chapter presents the research method and design for this qualitative study. The study focused on the considerations of administrators in one school district and its participant stakeholders, and the factors that influenced administrators to implement the SD Program. The protocols, methods for participant interviews, data collection, and theoretical framework were presented. Chapter 4 will focus on conducting the research, collecting data, analyzing evidence, and interpreting the findings.

CHAPTER IV

ANALYSIS AND RESULTS/FINDING

4.1 **Introducing the Analysis**

The case for this research is one rural school district of over four thousand students in a rural community of over 18,000 residents. Over 70% of all the students qualify for free and reduced federal lunch programs. This study examined the multiple perspectives of various stakeholders in their experiences with a mental health program called "Seed Digging" that was introduced to the school district in 2017. The qualitative data was collected using semi-structured interviews with multiple participants representing all levels of the bioecological framework.

The bounds of this case study are significant because it involves the first school district (D1) to adopt the SD program. D1 supplies and cares for student mental health care needs predominantly in-house by the D1staff. Since its inception, many other districts in multiple states have adopted the SD program but D1 has longevity as an innovator of this novel mental health care program.

The research questions that guided this study were:

RQ: What were the considerations of the district stakeholders for choosing to purchase, implement and continue with a new mental health program called the SD program?

The study will also address the following sub-research question:

SQ: From the perspective of stakeholders, in what ways has the SD program had an influence, in terms of student behavior and well-being in the district?

4.2 **Presentation of Data**

In the following, I will present my findings in two sections. The first section addresses the RQ: "What were the considerations of the district stakeholders for choosing to purchase,

implement and continue with a new mental health program called the SD program?" I detail stakeholders' considerations, organizing the data by the bioecological framework. I start with the level of the student, who was the catalyst for an accelerated positive acceptance of the SD program. From the student level of the framework, I will show the outward influence of each system on participants' decisions and opinions. The bioecological model reveals the interactions between the systems.

In the second section of the findings, I address the SQ: "From the perspective of stakeholders, in what ways has the SD program had an influence, in terms of student behavior and well-being in the district?" This section represents my axial coding of the data which produced four themes: perceptions, transferability, empathy and understanding, and implementation. The thematic development from the data provides more insight into individual participant perspectives.

4.2.1 Participant Sample

Participants for this single case study were purposefully selected stakeholders that provided an understanding of the research questions and problem of practice (Creswell & Creswell, 2018). The first participant was the school superintendent. As the top official for the district, they are responsible for any new curriculum or service purchases. The school administrator's decisions have a top-down impact on all school stakeholders implementing a new schoolwide program. The school administration occupies the macro level as an indirect element of the bioecological model. The superintendent guided the researcher for approved and appropriate participants.

Sarah, from the SD Wellness Center, was a macrosystem participant that has significant involvement in the mesosystem of influence across multiple realms of micro, macro and

exosystems. Sarah had an indirect relationship with the students; she provided the curriculum and instruction for the counselors and teachers who are directly involved with the students.

Parents, teachers, and counselors are microsystem participants that had the most direct contact with the students. School counselors provided the most intimate perspective of this case study. School counselors were the resource that most teachers used when they did not know what to do with a child. They are the ones who hear the child's stories. Teachers had the perspective of student behavior and the observations that something may be out of normal developmental manifestations. Parents may not always make the connection with home behavior versus school behavior.

Two interview participants were referred to this research for interviews that were unexpected and solicited using a snowball participant sampling approach (Rahi, 2017). One interviewee was a former student of the district who received counseling directly from the SD wellness center after their parent heard about the program during a district staff development. The parent did not wait for the district to adopt the program but immediately sought counseling for their adult child. The perspective of the former student represented the microsystem but could also touch on all elements of the bioecological model all the way to the chronosystem of time.

In addition, a nurse practitioner in the community also agreed to be interviewed. She represented the exo- and macrosystem of the model. She had no formal affiliation with the school district but had an indirect relationship because some of her patients were school district employees. These patients would discuss with the nurse practitioner about their physical and mental needs. The patients told of their positive experiences with SD in their school and the nurse practitioner felt it was something that could benefit them. They received counseling directly from the SD Wellness center and later went on to refer their own patients to the center

for patients in need of mental health care. All interview participants were given pseudonyms to maintain confidentiality.

Table 2. Participant List with Details

Participant/ Pseudonym	Role in the District	System Location	Background Information	Use of Reflection Tools during Interview, if Any
Mr. Johnson	Superintendent/ Administrator	Exo/Macrosystem	District superintendent with 15 years in the district and role of superintendent for the last 7 years.	SD program information
Maggie	Counselor/ Administrator	Micro/ Exosystem	Mental Health Coordinator and Behavioral Support Specialist for the entire district. It was a new position 4 years ago.	Self-esteem questionnaire, SD curriculum supports
Sarah	SD Consultant	Micro/ Exosystem	Main support and contact person for D1. She is a licensed professional counselor and former special education classroom teacher.	
Martha	Middle School Counselor	Micro/ Exosystem	Middle school counselor with 5th and 6th graders and has 17years in working for D1.	Self-esteem questionnaire, SD curriculum supports
Cathy	Elementary Counselor	Micro/ Exosystem	Counselor for K- 4 grades and has been with the district many years.	Self-esteem questionnaire, SD curriculum supports
Katy	Kindergarten Teacher	Micro/Exosystem	Kindergarten teacher with over 20 years of experience in D1.	Self-esteem questionnaire, SD curriculum supports, directives from counselors
Ellie	Elementary Teacher	Micro/Exosystem	Elementary Teacher/ Math coordinator with	Self-esteem questionnaire,

			many years in D1. As a math coordinator they can work with larger student populations.	SD curriculum supports, directives from counselors
Pam	Parent	Microsystem	Parent of younger children in multiple grades and has firsthand SD experience.	Home use of SD programs
Paula	Parent	Microsystem	Parent of multiple children in the district in various grade levels. Children have experienced SD firsthand and is also the parent of Sally.	Home use of SD programs
Nancy	Nurse Practitioner in the community	Exo/Macrosystem	Nancy is not directly affiliated with D1 but serves patients in the community. Nancy had personally participated in the Seed Program as a client and now makes referrals to SD for clients needing mental health care.	
Sally	Former student	Microsystem	First recipient of SD therapy in the school community. Sally was possibly the catalyst that gave credence to the SD program. She was a former student of the district and the first person in the community to experience SD as a client. Sally is the child of Paula. Sally was known to many teachers and staff in D1 as a lifelong student and resident. The SD program was credited with saving their life. Many of the D1 staff were familiar with Sally	

			before and after SD experience and this gave trust to the SD program.	

4.3 Results of Research

The concentric circles of Bronfenbrenner's bioecological model provided a framework to address RQ1. The influence and interaction between the students at the center to the societal and cultural opinions on the fringe guided this research. To examine the results of the research in relation to the framework, the heart or center of the model, the students, will be discussed first in Section 1 and the thematic relationship in Section 2.

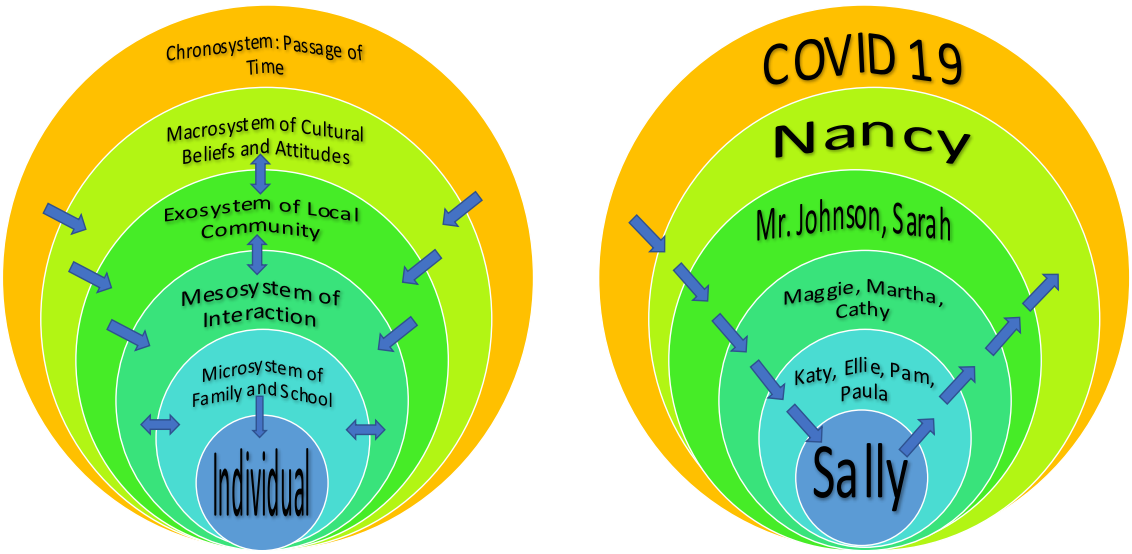
4.3.1 Section 1- Research Question 1

This section addresses the first research question, "What were the considerations of the district stakeholders for choosing to purchase, implement and continue with a new mental health program called the SD program? The results are organized by the levels of the bioecological model, starting with the level of the students.

4.3.1.1 *The Students*

Bronfenbrenner's original framework shows the influence of society bearing onto the student only. However, I found that students can have a profound influence on their surrounding society (see Figure 3). Sally, who participated in SD, radiated influence on other systems of the model.

Figure 3. Bioecological Systems in Context



Original Bioecological Systems Model *Bioecological Systems Model in Context*

The Catalyst: Sally. Based on my interview with Mr. Johnson his main consideration for the implementation of SD was a result of the lifesaving change that occurred with a staff member's child, Sally. Most of Mr. Johnson's counseling staff had attended a statewide counselor's conference. Sarah was one of the presenters on suicide prevention. The D1 counselors felt that their entire staff would benefit from her presentation. A request was made to D1S by the district mental health coordinator for a staff professional development (PD) at the beginning of the new school year. Mr. Johnson shared that allowing a SD staff development was an easy decision because of some grant money specifically allotted for student mental health care and positive recommendations from the counseling staff. The cost of the program was affordable, and at the time, SD implementation would be a one-time professional development

opportunity for the staff. I was curious about any phenomena that might have influenced their decision besides a favorable request from the counselors, and according to the interview, there was.

One of the teachers, Paula, attending the D1 initial PD was so moved by the presentation that the next day they made an appointment with the SD Wellness Center and drove their adult child, Sally, six hours one-way to receive therapy for some life-threatening mental issues. Several months and multiple therapy sessions resulted in a dramatic change in their child. Years of traditional therapy had not produced any results, but now the family finally had progress, freedom, and peace. After the teacher had their SD experience, they made a presentation to the staff requesting the district to implement the SD program. It was after this presentation and the success of the teacher's child that Mr. Johnson decided to move to a full-on implementation and additional training for school counselors. According to Mr. Johnson their decision to move forward with SD was a "no brainer." They had also known of the teacher's child's long-term struggle with mental illness.

In the original considerations for choosing participants for this study, the idea of interviewing a student(s) was not a possibility due to age and permission limitations. Sally is the exception. Sally is the child of Paula and was an adult when they experienced SD firsthand. Sally began having issues as a 14-year-old. A friend's family member had committed suicide and Sally was exposed to the gory details of the suicide. Those details of trauma began to weigh heavy on her. Fears, nightmares, depression, and anxiety began to take their toll. Most of the time she could mask her emotions and most people were unaware of her deep-rooted fears and thoughts of her own suicide.

After years of off and on counseling, band-aid type fixes, and anxiety medication, the stress of college and working a full-time job came to a head. Sally was at home and confessed to her parents.

> My brain is telling me to commit suicide, and I know that's not something I want to do, but like I need help right now, because I know I don't want to do this, and so, like, I don't care whatever it takes, I feel like I need to be sent to the mental ward, because I don't know what I'm gonna do. I can't be helped by myself. I don't trust myself. My mom started crying and was broken down, she called my dad, and he came home from work. She immediately contacted the counselor at her school and that's how I got referred to Sarah. (Interview, June 6, 2022)

Sally is well now, but her story gave credence to the SD program. Sally has since learned the techniques and strategies provided by this program, and now she also makes referrals to help others who are struggling with mental health issues.

4.3.1.2 Microsystem and Mesosystem: Parents, Counselors, and Teachers

Parents. Parental influence within the framework was the most dichotomous of participants. Some students in the research experienced trauma outside of the family setting and others their family setting was the source of the trauma. Parents who recognized trauma in their child were quick to secure help for their children. Parents who were the cause of the trauma were less likely to reach out for help for fear of consequences. Trauma is still trauma for a child regardless of the source. Parents who saw success in their children because of the SD program became great advocates of SD. Other children received the benefits of SD with little to no support from parents. The two parents for this interview were also teachers in the district. Both have students in differing grade levels and campuses. Paula is a teacher in D1. She is also the

parent who attended the district PD and made the six hour drive the next day after she heard Sarah's testimony. When I began my interview with Paula, I was able to make the connection through her story and the stories of others I had interviewed but it was not apparent at first. Other participants had made references to this one parent and how in desperation for their older child, made multiple long-distance trips for therapy. Paula's dedication made an impact on the district not because of her devotion but because of the results. This was Paula's response when asked how she felt about her experiences as a parent who participated in SD as it might help other parents:

> Well, it is scary, and I can totally empathize and sympathize with how they feel because that was definitely the scariest thing I've ever dealt with in my life. Because when you jump out and you don't really know what the outcome will be. For me, it was control, you know, like, it was something I couldn't control. I think it opened my eyes. Everybody needs, in my opinion, some counseling to deal with trauma. We would probably all have trauma, and we might not call it that, but in the way it affects different people. So just because your child goes to therapy or counseling, doesn't mean that there's something wrong with them. Actually, to me, I think if anything, it shows they are strong and that they are willing to get help and to know, to be better, a better person. (Interview, July 7, 2022)

Paula's experience with SD and her child may have begun in desperation but it ended in hope and advocacy. Paula's entire family experienced a positive change in their attitudes and perceptions towards mental health. The SD experience for them enabled them to have more conversations with each other but also with friends and colleagues going through similar

circumstances. Pam was one such parent whose child was also struggling with mental and emotional issues.

Pam is a parent and the newest teacher in the district and had only been teaching for one year. She had been a substitute teacher before becoming a teacher in D1. She found out about the SD program by asking their younger child's school counselor about dealing with some trauma their high school child was experiencing. Pam said.

> The counselor's opinion mattered a ton, and just hearing her talk about going to the root of the problem, rather than, you know, trying to fix the surface problems was really intriguing to me. Because I knew that where my kids, or the place of hurt was deeper than just what I was seeing on the surface and experiencing, so that intrigued me. But then when I got on the SD website and I read everything and saw Sarah's testimony of how she got started with the program, in the end, just reading some of the information on there, like I said, I just, I thought, this is the best thing for my child to be able to move forward. (Interview, July 6, 2022)

Pam's child was a high school student at the time, so she made the referral directly to the SD Wellness Center. The SD staff worked with her child who was struggling with depression and eating disorders. According to Pam, her child is a different person now and has overcome depression, anxiety and eating disorder. Much of what SD does for the parents is that it normalizes mental health and helps remove the stigma associated with mental illness.

Counselors. Counselors are the engines that drive the SD program in D1. The counselors were the first in the district to enquire, request and implement the SD program. From inquiry, to training, to implementation, the counselors have maintained fidelity to the program. The counselors have also customized the original program to meet their own needs. D1 counselors

use SD strategies to help students impacted by trauma. Because the program has been in place for over four years, they are able to monitor student results over time and the success of transient students who leave the district for a time and then return. The first part of my ROS title is "Before Students Hurt," because I wanted to know what D1 was doing for preventative measures. From the interviews and my interactions, I can see that the counselors at D1 gathered skills and tools they received from the SD initial training and took them to a new level of prevention and curriculum support for teachers and students. Because the counselors are central to the implementation of the SD program, I have identified three themes that resonate in their responses in particular: early identification, therapy vs. strategies, and "good work."

Early Identification

Originally, SD provided a universal screener (*Seed Digging: Achieve Incredible Inner Peace*, n.d.) (Fig.3). One counselor, Maggie, took the SD screener and modified it through Google forms, so that it could be accessed easily by other counselors and teachers and given to all students at different times of the year. The screener is based on the seven innate needs of Maslow's hierarchy of needs, and those needs are posted on the walls, in the classrooms, on posters, newsletters and repeated in the daily announcements.

Figure 4. SD poster of 7 Innate Needs

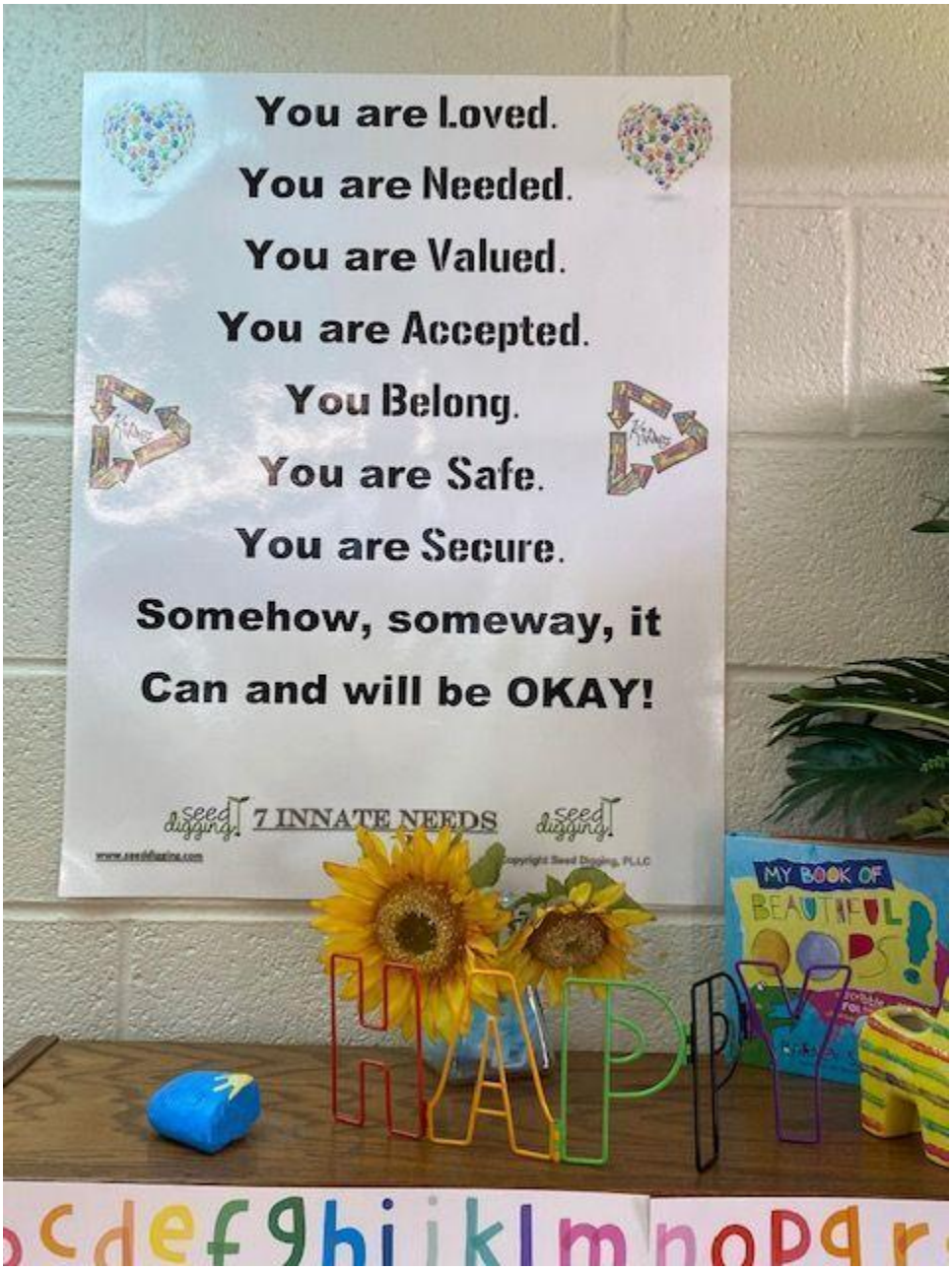
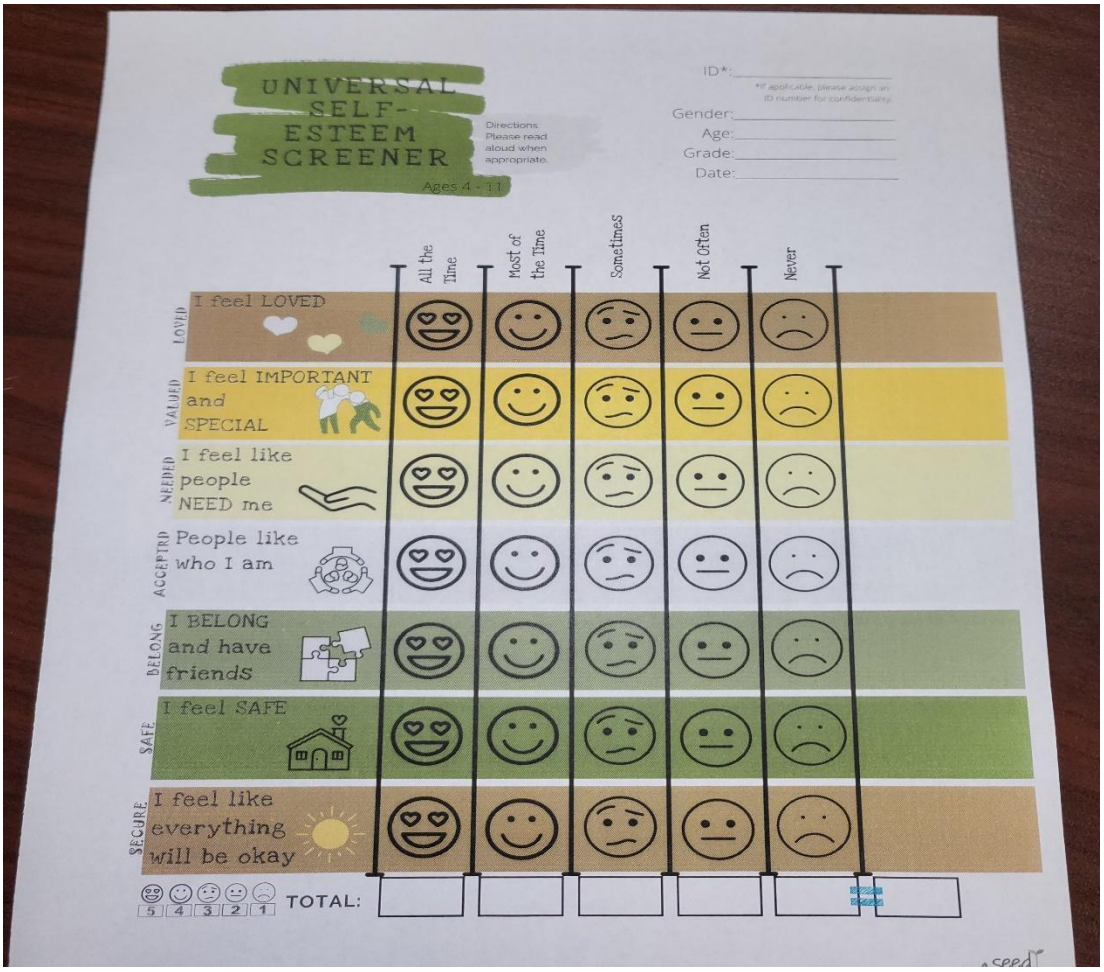


Figure 5. Seed Digging Self-esteem Universal Screener



The universal self-esteem screener is given to every child at least twice a year. Because the Google forms scoring of the screeners was faster, the identification of students indicating a low score and needing therapy could be addressed quicker. Along with the screeners Maggie also created a mental health Google form that any teacher, or administrator could fill out online. The form goes directly to Maggie, and she can quickly identify if it is a discipline, counseling, or a mental health issue. Maggie said, “schools are no longer just places where kids are educated. We really have to treat the whole child, and I think we're really trying hard to take those steps to meet those needs, and seed digging is definitely part of that.” (Interview, June 17, 2022)

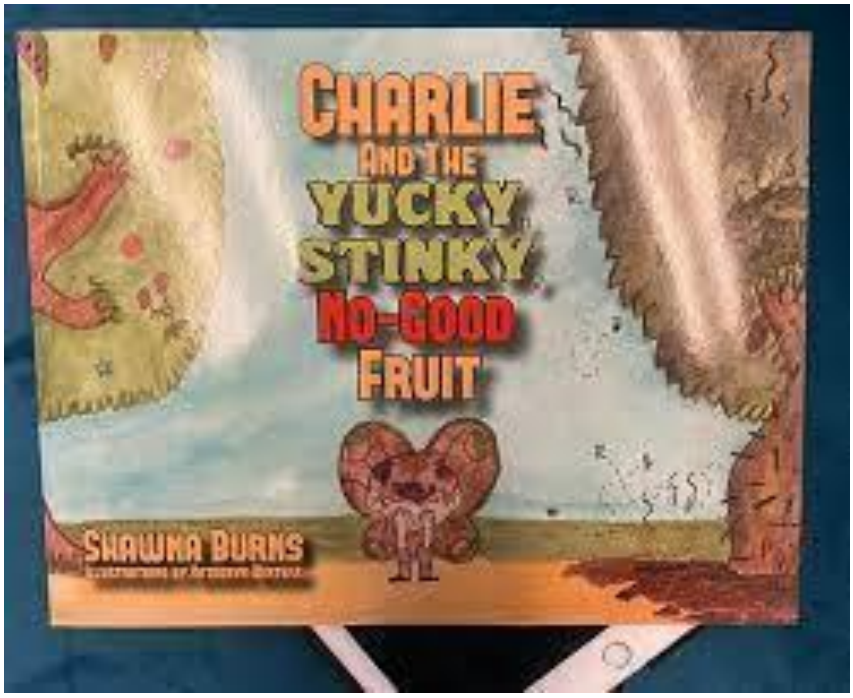
Therapy vs. Strategies

All four counselors that were interviewed touched on the idea of therapy versus strategies. In the state that this case study occurred, only licensed professional counselors could provide therapy for students or clients, but anyone could provide, use, implement and teach self-help strategies including student to student. Cathy, who has been with D1 for over 20 years and an educator for 28 years, felt that in the last 10 years the need for counseling has gotten greater and especially after COVID. She indicated that people seem more willing to talk about their mental health needs. Cathy referenced the need "especially with elementary, you just need a wide variety of things in your toolbox." (Interview, June 22, 2022). Those tools are the strategies taught by SD.

The D1 counselors and teachers commented on the simplicity of the SD tools. For example, the language of the garden in the heart, how things grow, and not all things that grow are good, are simple ideas that children can understand. Sarah with SD said multiple times during the course of the interview that this is not "rocket science." It works because it is simple. Most of the participants alluded to the simplicity of the SD program and the ease of communicating the principles. From the superintendent, counselors, and teachers many of them used the same expressions that to adopt the SD program was a "no brainer," "it just made sense," "it was easy to explain," "everybody can relate to a garden."

Some of the tools can also be considered curriculum supports. SD provides several story books for different age groups. The counselors take time every year to go into every classroom and read the stories. For example, every student in the lower grades has been read the book, *Charlie and the Yucky, Stinky, No-Good Fruit,* by Shawna Burns.

Figure 6. Curriculum Support



Maggie also makes sure that all students in K-6th grades have a cup, some dirt, and a seed they can plant and grow. What was once used as a tool for teaching biology is now used to teach mental health. Some teachers have their classes plant flowers. The counselors also have a sandbox or garden box in their office where students can describe their garden by placing certain toy figures and plants in the box and tell the counselor their stories, fears, emotions and often the trauma they have experienced (Figure 7). These curriculum supports and strategies are tools that all the counselors can use on a regular basis.

Figure 7. Counselor's Sand Box

"Good work."

All the counselors interviewed had specific stories of "good work" but also of long-term improvement in all levels of academics and social interaction. In the four years of SD implementation, they could see the change in a once traumatized second grader to a now functioning well adjusted sixth grader. Martha, the middle school counselor, used the term "doing good work with the child," several times during the interview. I asked Martha to define what they meant by "good work."

> Good work for a middle schooler is boosting that self-esteem, boosting the idea of self-worth and those innate needs. Ensuring like, if they really struggle with that sense of belonging, the good work there is improving that and helping them understand where their worth comes from. (Interview, June 20, 2022)

One aspect of doing "good work" was the concept of helping the child help themselves. For example, Martha, in talking about the SD Pro training she received, shared that.

> It helped me a lot to build that relationship with that student, and then see the process at work and it really helped the child do some good work within themselves, you know, to, to kind of work on those innate needs. (Interview, June 20, 2022)

This idea of helping the child take ownership is related to Sarahs's approach to "good work." Sarah referred to Aaron Beck, who was a pioneer in cognitive behavioral therapy, and who recommended that every child should, or every person should become their own therapist. Sarah expanded on the science and psychology of what happens in the mind of a child by using the SD approach.

> I am teaching them through mindfulness, to rewire the neural connections in their brain to hear thoughts of love and affirmation and to know how to counteract shame and all the horrible thoughts that usually drive that child to harm himself or others. (Interview, June 21, 2022)

The science informs the foundation of the SD program, and through this, children are able to do "good work."

Sarah is a SD staff member, and a licensed professional counselor and former special education classroom teacher. The interview with Sarah lasted 90 minutes. The transcript was very detailed in the science behind SD along with many analogies. Sarah provided the initial

professional development for the D1 staff and later the district hired her to train the counselors who wanted to become SD Pro Level trainers. SD terminology and methodology was conveyed consistently with all the counselors interviewed. Sarah can also be a counselor to the counselors. SD is now in use at some level, in 40 different schools and in 3 states. Counselors call her or one of her trained SD licensed therapists for help with students who have unique or extreme situations.

Due to the intense support and training received by SD, Maggie felt that at least 80% of all student's mental health care was provided in-house or within the confines of the school setting. Maggie also stated that if a student needed outside care from local state therapists that the wait for treatment was usually over a month.

Teachers- Teachers received an initial SD professional development several years ago but currently are given frequent guidance from school counselors on the basics of SD and how to identify and refer students to the program. The counselors and administration have intentionally removed the major aspects of SD implementation from teachers so that they could focus on their classrooms. Teachers that were interviewed related that they could see the before and after improvements from students in their classroom behavior and in their academics. Because of noticeable changes in their students, they are willing to support and encourage the use of SD in their classrooms.

What became evident through the interviews was that teachers have very limited training other than the initial PD four years ago. The counselors were the main trainers of the teachers. Otherwise, the school principals and counselors provide daily saturation and promotion of the SD ideas and vocabulary. The counselors also provide refreshers during regular PD's mostly on what teachers should observe and report. Rather, the teacher's main role in the SD progress is to

make referrals to the counselors because the counselors want to relieve as much of the work of SD from them as possible. In the referral process, the teachers have learned the SD language and communicate with students using those terms to discern the nature of the student's needs. The teachers refer and confirm with the counselors of students' needs and progressions.

Two teachers were interviewed, who had taught most of the students who participated in the SD program. Katy is a kindergarten teacher with over 20 years of experience with the district and Ellie was a second-grade teacher but is now the math coordinator for the K-4 campus. Both teachers had only positive experiences with students and their interactions with the SD program. Katy was able to make connections between her students' participation in SD and improvements in their emotional well-being and academics. Katy said that "Seed Digging definitely comes across in academics as well, just because whatever's going on in their little hearts and minds will definitely come across in their schoolwork." Katy, when asked if there was anything they disliked about SD, responded that "they wished they could get it to more students."

4.3.1.3 The Macrosystem: Local Community

During my doctoral internship program, I participated in some shadowing of an on-line counselor training from the SD Wellness Center. I became familiar with the process and strategies that counselors used to help students but as a school superintendent I was curious on how a district could introduce, promote, and sustain a SD program. My first interview was with the District Superintendent Mr. Johnson. As leader of the district, I needed his permission to conduct research in the district, but I also needed his perspective on the how's and why's of adopting the SD program for their stakeholder's mental health care needs. When asked about School Board approval and parental input, he was doubtful that most people outside of the school had any idea about the program. However, I had the opportunity to interview someone who

showed me that the SD program was reaching people outside of the school and district. Nancy was recommended by others who had been interviewed. She has been a nurse practitioner for over 17 years mostly in D1. Based on the recommendation of teachers and counselors I thought Nancy worked for the district. During the interview I discovered that she provided a private practice for adults. Nancy did not work with children or have any affiliation with D1. She did however "treat patients" who were teachers at the school. In communicating with patients about their physical ailments, patients would also share their emotional ailments. Some of Nancy's patients were teachers and they started sharing about how SD was helping their children. Nancy was going through some emotional issues of her own and thought she would experience the SD program for herself. Her personal experience with SD became something she would refer her patients for when they discussed and needed mental health care. Nancy said:

> I think the sooner we are upfront and honest about our issues; I mean everybody's got something really, I mean, people come in and out of these doors all day long, and everybody's kind of got something. So, the more that we can make that thing normal, where people embrace the bad, and come and deal with it, and move through it, the better our mental health will be. (Interview, July 22, 2022)

Although this chance to interview Nancy came as a surprise, it showed how far-reaching the SD program was having an impact in the area. Nancy is a prime example of the interaction of the framework. Nancy was not affiliated with the school and provided treatment only for adults. Nancy became influenced by relationships with patients and friends in D1 that had discussed their successes and opinions of SD. The explanation and positive comments encouraged her to seek personal counseling from the SD Wellness Center. Her own experience with SD led the way for her to refer adult patients struggling with mental issues for SD counseling. Nancy reminded

this researcher that the whole body suffers physically, emotionally, and mentally when dealing with trauma. Other potential outside influences such as the school board were not included in the initial decisions and adoption of SD by the administration and therefore, they only experienced the positive outcomes of SD.

4.3.1.4 The Chronosystem: Time and COVID-19

The question about the impact of the COVID pandemic was put to every participant. The answers were consistent in that the need for addressing mental health needs has increased which is a negative consequence. If there is anything positive to come from the pandemic it is that people have a greater realization of mental health. The other is an increase in telehealth services. Telehealth became an essential part of counseling. Parents could now use a telehealth therapist for their children without driving six hours to seek help. Not all strategies work on-line but many do. Sadly, the residual effects of the pandemic are still rising and though most of the world is attempting to return to normal physical aspects of life, the social, emotional, and mental healing part of life may take quite some time. The chronosystem provided a window of observation from the beginning of the SD program in D1, the interruption of services due to the pandemic, and the resilience of people and programs to continue.

4.3.2 Section 2- Sub-question

This section addresses the sub-question, “From the perspective of stakeholders, in what ways has the SD program had an influence, in terms of student behavior and well-being in the district?” All the interviews conducted, except for Sarah, were new encounters. Every interview created a trail of breadcrumbs leading to inductive discoveries related to the research questions. The initial codes were a product of all eleven transcripts. They were grouped as commonalities arose and placed in a Delvetool database that would group common codes from all transcripts.

There were 22 initial codes and axial codes revealed connections across participant groups. Four predominant themes emerged from the findings: perceptions, transferability, empathy/understanding, and implementation.

4.3.2.1 Theme 1: Perceptions

Perceptions allow people to see the view of phenomena from their position and understanding. The participant interviews were purposeful in seeking a variety of perceptions from the people of the community. Participant selection was based on their role and position in D1, but also participants were recommended by their peers and colleagues. Introductions were made by email and each interview was an enlightening experience, exposing me to their perceptions and interactions with SD. An initial code for this theme related to stories or testimonies from people unfamiliar with SD. Other codes are challenges and flaws in the traditional system.

Stories. Every participant indicated the influence of someone's story. Sally commented, "I tell everyone my story." Relatedly, it was Sally's story that influenced Mr. Johnson to buy into the SD program. He said, "the testimony of a teacher that had experienced it firsthand with her teenage daughter really made an impact and made for a good sale." Almost all interviewees for this study also made some reference to Sarahs's relatability and her personal stories. Cathy remarked that "Sarah's personal story sold me on it from the get-go." Many of the stories and videos are found on the SD website (*Seed Digging: Achieve Incredible Inner Peace*, n.d.). Sarah feels that her mission is to

> Help teachers see behind the scenes that this child is acting the way that he's acting for a specific purpose. When the teacher begins to understand what's going on behind the scenes, and that this child really, just has an unmet need, it seems to create a different

approach to discipline and how to handle that child in the classroom. The overall effects that I have seen is just more empathy and understanding with students, which I believe is the key. One of our main goals is to help teachers see the student through the eyes of love and compassion. (Interview, June 21, 2022)

Challenges. The perception of those who faced various challenges were also contributors to this theme. Some stakeholders in the community or individuals in families had negative experiences and predetermined ideas related to mental health. Some challenges were from family members with mixed feelings related to mental health. The challenges of parental involvement and societal opinions still exist but the SD program flourishes because the stories are from people in the school and community of whom they are familiar. Paula said, "my husband thought that the mental health thing was a joke." Sally said, "they have friends whose parents think that mental health issues are for the weak and counseling is not needed. I help my friends realize that mental health issues are real." Cathy mentioned that even in their own district and with all the success that other counselors have experienced, the high school counselors do not want to participate because they feel it will take too much time from the academics.

Flaws in the system. Perceived system failures may be a contributor to the challenges, doubt, and skepticism related to people's perceptions of mental health programs. Societal attempts to aid people with mental health issues still conjure up images of mental health wards. Sally suffered for many years with mental issues and made numerous attempts with a variety of mental health care providers for help. It was not until SD that she found relief. Sally shared:

I think they just want to use medication instead of getting to the root of the problem. Sometimes traditional counseling is just a ranting session to help you cope with the

problem but not solve it. My friend tried 20 different counselors. (Interview, July 25, 2022)

Sarah shared that during her time as a school based mental health therapist, she saw many flaws in the system. She made an analogy of therapists being like lifeguards watching a few kids in a pool. In the past there were only a few kids in the pool and now there are thousands of kids in the same pool and only a few lifeguards. With so few resources, Maggie shared that when she made an outside referral to community-based counseling, it usually took a month or more to get approved for traditional counseling.

4.3.2.2 Theme 2: Transferability

Often when any organization sees the success of other entities, they will seek to duplicate their success. In the process of attempting to replicate the results of others it seems that key ingredients in the recipe are left out. Considerations of finances, leadership, trust, and staff buy-in can impact results. A novel program like SD is like a pebble in a pond with concentric circles going outward. Transferability is "how" to keep expanding out from the initial start-up. Two codes are included in this theme: language and sustainability.

Language. Both teachers, Katie, and Ellie, talked about the effectiveness of a common language to talk about emotions. They both shared a story about a student who was going through SD and later left the district. They were concerned about the student losing gains that they had made. Some students who left eventually came back, and because of the self-help strategies they learned, they were able to minimize the loss of academic and emotional gains. The teachers accredited some of this with the early intervention of SD vocabulary that made it easy for even the youngest of students to talk about their emotions. Katy said:

> You know it’s funny to hear kindergarteners talk about their emotions, but you know, they'll say, well, that makes me feel left out, you know, usually kindergarteners don't talk like that. But once they've been given that vocabulary, and can express their feelings, I think that sticks with them and they're going to be able to take that with them throughout all of their age levels. (Interview, July 6, 2022)

Ellie commented several times about students learning to communicate with themselves:

> Everything that we're seeing with kids today since COVID, you know, the depression and suicide rates and all the different things that the kids face because they need to have the opportunity to get to the root of the trauma and get those seeds out and replace them with good seeds. (Interview, July 20, 2022)

In learning the language of SD the child also learns the source of their issues and often it is the voices they hear in their minds saying, “I can’t do math because I’m stupid, or nobody likes me.” The students can remember the innate needs they are taught and counter those voices with, “I am not stupid, I am loved and accepted.” Things that might make a child happy or sad can be explained in the garden they describe to their teachers. The vocabulary of emotions for a child may sound like, “Miss I think I have a bad seed in my garden, and I don’t know how to dig it up.” Now the teachers and counselors have a place to start with a child who is expressing their emotions.

In speaking with Sarah, she explained that this teaching of a common language was intentional:

> We train the concepts at a very early, early, level, preferably at preschool, when they're the youngest so that we learn verbiage and we learn ways to pull seeds from a child's heart and not plant them, because sometimes with our words and actions, we, though not

> intentionally, but we can, as educators, plant seeds in their heart. So, our goal is to train teachers with a language to sow happy seeds and counteract those negative seeds that they may be picking up from home. Then the ultimate goal of SD is not only helping teachers to learn the strategies to plant happy seeds in a child's heart and pull those negative sad seeds, but that we're constantly equipping the child with the same language to do it for themselves. So, we're teaching students through mindfulness, through visualization, through the concepts of, you know, just connection activities and affirmation that they are worthy, and that they are loved and that they are valuable. The goal is to reset the mind with positive affirmations of the self. I believe I have failed the child if I have not trained them to take care of their own garden. (Interview, June 21, 2022)

Part of what distinguishes SD from other types of mental health programs is that it can begin at the earliest stages of public-school learning, so that children are learning how to express their emotions at an early age.

One of the most significant influences of the SD program was the development of a common mental health language. Many SEL programs have this as an element of their curriculum to normalize the use of mental health terms (Mcluckie et al., 2014). The language of SD was not the language of mental health but the language of the garden. The garden analogy was universal, simple, relatable, and non-threatening. The language of the garden helped remove the stigma associated with mental health terms. The commonality of the garden also made it easier for participants to understand that everyone has a garden, and everyone has weeds in their garden that need to be pulled up from the roots. As Martha said, “it works because our teachers, admin, counselors, and kids have the cohesiveness of the language, we are all on the same page.”

Sustainability. Sustainability is also a key factor. Many new programs or initiatives, if not met with quick success, may not last and the district may move to another initiative. Eventually, staff members can suffer from initiative fatigue or whiplash. How did SD survive for four years and a pandemic and still continue to grow? The answer was a surprise in that it teaches a self-therapy concept. In the initial stages, people need a counselor, but eventually they can help themselves and others and become less dependent on therapy and counseling. Paula shared how she had used the SD techniques with her friends and had already referred others to the SD program. Sarah related that:

> If you have teachers who are sowing seeds into a child's heart and pulling weeds and then you have counselors doing one-on-one sessions, if a child is actually taking those concepts and learning to rewire their brain themselves, that's where we get the sustainability factor. (Interview June 21, 2022)

The concept of the garden is something that always needs tending to. The "good work" concept can come in the form of recognizing the weeds when they start to sprout in their garden. It is nice to have help in the weeding process but being able to identify the good from the bad is the first step in recovery. For the teachers and counselors of D1 they can hear the change in how students talk about themselves, but they can also see a change in how the students feel about themselves.

4.3.2.3 Theme 3: Empathy and Understanding

This theme collected more initial codes than all the rest. Those codes were consolidated further to find the emerging theme. Childhood behavior and emotional outbursts can sometimes be seen as a sign of disrespect or a cry for help. Learning how to differentiate between the two takes empathy and understanding. In addition, trauma is a term that many do not understand.

Perhaps it is easily understood when a major accident happens, and people are rushed to a trauma ward. However, emotional, and mental trauma occurs in the mind and is not readily visible like a broken bone or severe cut. The codes for this theme are trauma, improvement, preventative, and emotional needs/wellbeing.

Trauma. Many participants talked about trauma by using the metaphor of a garden. For example, Ellie said:

> I think there's a lot of people that don't understand that, especially educators, that sometimes, he had acted that way, because of trauma, and it's some kind of bad seeds they have. And we just say they were misbehaving intentionally and all that, but they don't really understand how. (Interview, July 2022)

In addition, Sarah noted that, "some children enter the school system with fields and fields and fields of weeds and thorn bushes because of all the trauma that they've encountered."

Understanding the language of trauma can be difficult for all stakeholders because of a lack of understanding. An element that aids in the understanding is improvement. When someone experiences improvement or shows progress, they are more than likely willing to continue in the process especially if it is their own success. Nancy saw how a patient who was an emotionally distraught 18-year-old is now a happy young woman. Katy saw one of her students started out at a low academic level and could barely recognize her ABCs and is now progressing at an accelerated rate after her SD referral. Cathy shared her confidence in SD because she could see a before and after difference in students who entered the program in crisis mode and then see them flourish afterwards.

Improvement. Seeing improvement provides energy and encouragement for stakeholders. Much of our past attempts revolved around a custodial model of wait to fail. Empathy becomes sympathy when we work with the survivors of abuse and trauma.

Prevention. Being intentional in our prevention efforts is critical if we are to help people before they hurt themselves or others. SD is purposefully creating early screeners and curriculum supports that can be understood by children before they can read. Martha shared that:

> The counselor does an excellent job of getting into classrooms and starts laying that groundwork laying that language down, they'll talk, they'll do the screener at a level the kid understands. We use the screener and use the feedback from that screener to kind of find our kids that we want to keep on a watchlist, and we keep on checking the list. (June 20, 2022)

Maggie shared that there is a lot of trauma in their district because of poverty. The screener became an early intervention process because it stimulated the trauma conversation. Pam's experience with her child affected her whole family. What they learned through SD helped their younger siblings how to deal with their own struggles. Katy said, "Some kids just need extra love" (Interview, June 17, 2022).

Well-being. Prevention and improvement lead to emotional health and well-being. That is the desired outcome we would hope for any individual regardless of age or place in the bioecological framework.

4.3.2.4 Theme 4: Implementation

Implementation and potential can be related terms. Potential alludes that all the elements are present for implementation, but nothing has occurred. It is one thing to have great ideas and it is another to implement those ideas. Some of the coding for this theme are virtual counseling, referrals, and training.

Virtual Counseling. Prior to 2020, the technology existed for virtual interaction, but few were using it in education unless it was a distance learning program. A conference call was popular but lacked the facial cues and connection of a face-to-face meeting. However, the pandemic lock-down forced educators to use programs that could mimic face-to-face, one-on-one interaction. Virtual counseling became the new thing. It created more opportunities for people to get help without having to drive long distances for counseling appointments. Cathy commented that all of the counselors were able to complete their SD Pro Counselor training on-line with other counselors from around the state. Virtual counseling also broadened the available resources. For instance, Maggie said that "students that need counseling beyond what we can provide have the opportunity for telehealth" (Interview, June 17, 2022).

Referrals. Sales people often pay big commissions for customers who make referrals. A referral introduces the provider to someone who was previously unknown to them for something they need. The referral process used in SD helps connect people who have a need of counseling that was probably unknown to them. Katy explained that when a difficult situation arose with a child that they had a referral form that would facilitate a quick response from a campus counselor. Maggie said that "we try to create a lot of exposure with the kids and teachers. That exposure then plants a seed for the teacher to make a referral when they notice something."

Training. Just as referrals help funnel students to the right service, proper training aids all participants. A district wide training is an introduction for all staff members to be aware of foundational SD principles. District wide training exposes all school stakeholders to the possibilities of effective help for their students. The training for SD occurs at multiple levels. At the highest level are SD staff members that are licensed professional counselors highly trained in SD methods. Below that are school counselors who choose to become a SD pro. These school counselors are the ones who provide one-on-one counseling for students who have been referred by teachers and possibly parents. Martha shared that:

> SD helped me a lot to build that relationship with that student, and then see the process at work and really helps the child do some good work within themselves, you know, to, to kind of work on those innate needs. (Interview, June 20, 2022)

Ultimately the client is trained to incorporate SD training to help children maintain their own mental health.

4.4 Interaction Between the Research and the Context

The subject for this record of study was created at the beginning of the doctoral program while the SD program was in its early stages of implementation into public schools. My initial questions the SD Wellness Center was for a recommendation of a school district that was implementing the SD program the longest and with fidelity. At first, they were hesitant to recommend D1. In the four years since they had completed their initial professional development with the district and training of the counselors, their contacts had been limited to a few individuals conducting one-on-one counseling. The interruption of the relationships due to COVID also cast doubt on how effective the program in D1 was performing. The Sd Wellness Center had other schools post pandemic lockdown that were implementing SD with great fidelity

and the SD program had also evolved with more tools and resources for staff and students. I felt that for the trust and reliability of my research questions that D1 would provide a non-biased case study and be authentic to the nature of my research question.

4.4.1 How did the Context Impact the Results?

The school district for this case study created a unique context. The size of the district (4000 students) was larger than I had hoped, but also much smaller than many urban schools. The staff and parents that participated in the interviews were all familiar with one another and most had been in the community for 15-20 years. The community is very old and located in a somewhat isolated part of the state. It has a population of 18,000 but is close knit. I was an outsider and a stranger with only one connecting relationship at the SD Wellness Center. Once the purpose of my research became clear the participants were eager to tell their stories. They were proud of the work they are doing.

The impact on the results I feel makes for genuine, authentic, and trustworthy results. The average interview lasted 37 minutes. The information shared in that short time was personal, and vulnerable. I was surprised by the details of their stories that they were willing to share with a stranger doing research on a mental health topic about them. At times the data seemed overwhelmingly positive with little to no push back. There were detractors at the high school level who chose not to participate despite all the positive affirmations of the program. Even though the SD program was not promoted at the high school, parents still found a way to get their children help through the referral systems active on other campuses. These examples contribute to the authenticity of the research.

Multiple participant voices, perspectives, and artifacts contributed to the authenticity and trustworthiness of the research gathered. The use of video, audio, and written transcripts using

the GoToMeeting format allowed for review and accuracy of the results. The Delvetool qualitative research software provided analysis support of almost seven hours of recorded interview data.

4.4.2 How did the Research Impact the Context

The participants in this ROS were eager to share their story. The stakeholders of D1 have taken ownership of their mental health program. The interviews were conducted during the participant's summer break. For participants to take time away from family to sit for an interview indicated their desire to share with others. Some of the conversations were very personal but the strides made in D1 allowed participants to share freely and unembarrassed. The context of mental health is at a forefront in the world today. We know the impact of the COVID-19 pandemic has been devastating worldwide, but the depth of devastation is still unknown. It is hopeful that the SD strategies that are in place at D1 can serve as a model for other organizations. These participants are speaking a new mental health language that is so easy to learn that even a child can speak it. This ROS will serve as an artifact that has the potential to aid countless school districts in providing a model of mental health care for their stakeholders. The findings of this research are an exhibit of how implementation of the SD program was credited for making a difference in the social, emotional, and mental wellbeing of their students. The hope is that the positive results experienced by D1 can serve as encouragement for implementation in other districts.

4.5 Summary

This chapter took on the exploration of a qualitative single case study of one school district in rural America. The public-school setting was important because public schools work with all levels of students, often with limited resources. What ended up being a partial snowball

participant sampling approach (Rahi, 2017) allowed for discovery of data as it was revealed and then led to other participant's perspectives. Two participant perspectives that were not anticipated were the viewpoints of a community nurse practitioner and a former student of D1. These two adult participants were not directly involved with D1 but had family members and patients that were. They were able to experience the SD program firsthand as clients. Their connection to SD was a direct result of D1's implementation in their schools.

The major themes are, perceptions, transferability, empathy and understanding, and implementation. These follow a progression from the initial perspectives and viewpoints. Perceptions often make it difficult to discuss or acknowledge in relation to mental health. Transferability had a strong connection with the language and vocabulary of mental health. The language of the garden provides young children and adults the ability to communicate feelings and emotions related to trauma. Being able to communicate those emotions is essential for providing help. Transferability is more than just transferring ideas from one group to another but the experiences of one individual to another. Empathy and understanding are the vehicle of transferability. Children seem to have the empathy and understanding of pain and trauma. It is often the adults that forget that education involves the whole child and all of their experiences. If a new initiative is costly, complicated, confusing, or time consuming, implementation can be short-lived and ineffective. SD provides a simple inexpensive process that puts little strain on teacher's workload and creates effective means for counselors to identify and provide for needy students.

Chapter V will provide a summation of findings, lessons learned, implications of practice, discussion of the results, future research, and conclusions.

CHAPTER V

DISCUSSION

5.1 Summary of Findings from Chapter IV

The recent school shooting in Uvalde, Texas once again brought to the forefront the tragedy of how to care for students with mental health needs. Another tragedy exists in the reality that during the time it took to conduct this research and by the time it will be published, multiple school shootings will have occurred, and more students will have taken their own lives. While local, state, and federal authorities are trying to build a better lock for school doors, a better solution may be the focus on early intervention, diagnosis, and in-school supports for the socially, emotionally, and mentally struggling students. The negative effects of the pandemic are increasing (Aponte, 2020). School shootings and suicides are no respecter of age, location, academic success, or socio-economic status. In addition, rural school systems often face more challenges in meeting the needs of students and teachers dealing with trauma. Availability of resources, funding, and societal perceptions can limit the effectiveness of any program. The goal of this research was to find in-school curriculum supports to provide mental health care before students hurt themselves or others. These findings show the perceptions of stakeholders, and phenomena that influenced implementation and the general well-being of students in a school district who have been using a school based mental health program called SD for the last four years.

5.2 Discussion of Results in Relation to the Extant Literature or Theories

The use of the bioecological framework for this record of study showed the connectivity of participants to the cultural, social and time influences related to mental health. The relevant

literature studied for this research highlighted various elements of the bioecological model but not the interaction between systems.

Research related to early identification revealed the need for universal screeners but were not able to connect to functional in school or in-house counseling supports (Humphrey & Wigelsworth, 2016). One aspect of Humphrey and Wigelsworth's research was that they found that no harm was experienced by children who were given a universal screener. This was a similar experience encountered by D1 in that no negative outcomes were experienced by children given a screener for early identification.

Secondary trauma along with teacher and mental health care provider fatigue was common in the literature reviewed but lacked the remedy for resources for the caregivers (Christian-Brandt et al., 2020). The D1 community of students, teachers, parents, and health care providers benefitted from the SD program. In teaching the language of SD to students, other stakeholders were able to do self-reflection on their own mental health needs and found an avenue for help and encouragement.

The nature of the local school environment was a consideration of research and its relationship to violence. The feelings of safety and fear impacted student success and the school environment could be a source of trauma for many students (Johnson et al., 2011). The daily affirmation of the innate needs of students are prevalent in schools using SD. It is one thing to acknowledge the impact of school-based violence and trauma, but another to provide a source of remedy.

Mental health literacy was prominent in many articles and foundational in some SEL programs. The idea is to have students become familiar with mental health vocabulary, treatments, and concerns (Mcluckie et al., 2014). In these studies, consistency was started at

early grade levels, but was still in the adult language of mental health. SD uses the language of the garden that transcends all age groups and grade levels. The mental health garden becomes relatable to all participants.

Throughout this research a triangle of interaction was exposed but not the connectivity for provision of care. There seemed to be a passing of responsibility of care from one source to the next. Law enforcement might have an encounter with a victim of trauma and refer them to a medical provider (Chambers, 2021). A medical provider may have a patient who exhibits physical symptoms but are the results of trauma and refer them to a mental health provider (Van der Kolk, 2014). The mental health provider has been so overworked that they may be in need of care themselves (Selwyn et al., 2019). The school system was often a common element in this triangle but the question of who can or who will provide care was missing. The bioecological model used in this study revealed a connectivity of entities that created a circle of care and influence found in the school district.

5.3 Discussion of Personal Lessons Learned

The lessons learned while completing this Record of Study come not only from the results of research but lessons from the journey. From the initial broad topic ideas to the narrow focus of inquiry, knowledge has been acquired from beginning to end. The purpose of this research is steeped in the hope that some form of social, emotional, and mental health help could be discovered at a local and immediate level for young victims of trauma and ACE's. The personal nature of this study is likened to the perspective of watching someone drown and the lifeguard not being able to swim or have a lifeline to throw. The focus of a single case study provided this researcher the opportunity to talk to the lifeguards and the survivors of trauma. To

hear the stories, opinions, and emotions of participant's mental health experiences was an invitation to experience the phenomena as it occurred to them.

The most disheartening experience during this case study came at the revelation that the high school at D1 had not embraced the SD approach because of a prioritized need on academics, despite SD successes on other D1 campuses. Our school systems nationwide still have priority and role issues. In the past the role of the school was mainly on education and academic success. Ignoring the mental health needs of students is not an option if there is any hope in reducing school shootings and student suicides.

5.4 Implications of Practice

When district leaders consider the implementation of a new program there are several questions, "How much does it cost? How much time will it take to train staff? What are the perceived needs and perceptions of staff and community? Is it effective?" The outcomes from this single case study research of D1 revealed that other school districts of any size could benefit from using the SD program. The cost for a SD one day professional development was a one-time affordable fee. Additional training for counselors to advance to the SD Pro level was as affordable as most dual credit courses offered to high school students. Costs of books and other materials were comparable to other curriculum resources. The universal Self-Esteem Screener was available at no cost. The time to train staff was minimal and continuing. The need for mental health supports should not be a question, but perceptions often drive needs. The appeal of a common, simple, garden language will help with initial delivery to younger students, but participants of all ages found it identifiable. The increased use of the SD program over four years in D1 is testimony to effectiveness.

SD shows promise for early intervention and identification of students with social, emotional, and mental health care needs. For example, one aspect of this study was the concept of early identification. Trying to profile a potential school shooter or identifying a student considering suicide is lucky at best. Addressing the effects of trauma on school children at the earliest possible time, in school, with people they trust, and are familiar with, is a proven concept that D1 is showing to be possible. For the SD program, a simple Google form served as a tool for early identification, and this is something that could be easily implemented at other schools.

The curriculum supports provided by SD allow for school staff to create embedded lessons into courses of study rather than an appendage or additional lesson to be taught. The innate needs are incorporated into daily activities and announcements. School newsletters share mental health strategies. Teachers will read SD books to their students. The curriculum becomes a tool to teach mental health concepts congruent with the subject area being taught. The SD vocabulary becomes an everyday communication and produce a common language of empathy and understanding. Teachers also incorporate other books and materials that include language and concepts like the SD principles. Other research related to this study dealt with fragments and compartmentalization of mental health care provision, most of it outside of the public school (Selwyn et al., 2019). Curriculum in its essence is what we intentionally teach in hopes that students actually learn.

5.4.1 Connect to the Context

The context and size of one rural school district may not be relatable for all schools but the context of mental health needs is an identifiable context for all educational entities. Because of the size of this district, I was able to make connections of phenomena that influenced the considerations of district stakeholders. These connections also corresponded to the concentric

circles of influence incorporated in the bioecological framework. Like a pebble in a pond the arrows of influence traveled from the center of the circle to the outside and back again. A macrosystem decision by the State Department of Education to include SD for a statewide counselor conference, reverberated to the microsystem of counselors, to students and parents and then back to local administration.

If this study would have been conducted at larger or more urban districts, I feel the results would have been similar. A rural district may seem more familial but large school districts that serve tens of thousands of students are still broken down into campus levels of community. Campus and class sizes are often similar even though the demographics may not be. Not all the campuses in D1 chose to participate in SD, and other districts could experience similar situations. Even though not all campuses chose to participate, students from those campuses were still impacted because of bioecological connections. The ability for counselors to have the freedom and are encouraged by the administration to utilize SD may be a more significant consideration rather than size of the district.

A phenomenological event was catalytical for wide acceptance of the SD program in D1. If a positive phenomenon is absent at a district, it could also have influence on wide acceptance of a SD initiative. D1 is an innovator in the adoption of SD. Their experiences could be the phenomenological evidence that another district could value.

5.4.2 Connect to the Field of Study

A case study seeks to know the how's and why's of phenomena that occurred to specific people at a specific time (Yin, 2017). This study revealed that the SD program gained its initial success because of a phenomenon. The desperation of a parent for the life of their child and the involvement of the SD program provided a successful remedy. The success of the SD approach

to counseling turned what could have been a tragedy into an experience of hope and promise. The SD program at D1 had a catalytic start from one success story which led to more success stories from children and adults. The more positive outcomes encountered by participants the greater the sustainability of the program. The use of language and changes in people's lives created a greater capacity for empathy and discussion of mental health.

This study was limited to one school district with a historical use of the SD program. The results of this study were favorable and encouraging. Now that SD is being used in more school districts, possible research might include multiple case studies involving several school districts that are implementing SD. A mixed methods study could also provide research that includes quantifiable data related to participation in SD and academic performance. A comparison of the number of disciplinary referrals withs districts of similar size and demographics could also be a source of study.

5.5 Lessons Learned

I am an educational leader who is responsible for the safety and well-being of many students. The lessons learned from this research are personal and functional. In the inner circle of Bronfenbrenner's model is a child. They are the center of the bull's eye and the target of our concerns. They come to our schools with many weeds in their garden. Weeds can choke the life of a garden and in the same way the wellbeing of a child. Showing a person how to pull weeds is an educational process. Rather than looking to outside sources for care of our students, we educators should provide that care. School is supposed to be a safe place to learn and not a place of violence and trauma. SD exemplifies that place of love, care, education, and provision in multiple ways:

- The best student care happens where the students spend most of their time with adults they can trust. In-school care becomes convenient and does not rely on parents or other entities to make time in their schedule for travel and appointments.
- Communication is consistent and simple.
- Training and support for counselors and teachers is applicable, available, and effective.
- Caregivers and those needing care experience benefits.

The lessons learned through the exploration of this case study and the use of SD are an exercise of hope and promise. I had hoped to find a program that could be utilized by small rural school districts with limited resources. The SD program experienced by D1 displayed positive characteristics that it was transferable and sustainable for use in other small districts. The functionality of the SD program showed that it could be utilized by districts of any size or location. The proof of the effectiveness of SD may not be a universal solution for all educational institutions but it is a start. Our current methods of mental health care do not exhibit in our nation a decrease in violence to self or others, or the betterment of children of trauma.

5.6 Recommendations

Not all districts will experience the phenomenon of dramatic familiar life-saving success at the onset of implementation. Having SD staff members tell their stories are important for counselor and staff buy-in. The possibility of including counselors that are using SD in other districts to share their stories and strategies could be helpful in creating confidence in using a new system of mental health counseling. A peer element of training and an immediate network of veteran users would aid in the transferability of the program. It may be easier for districts to follow the example of D1 and have a one-day district wide PD for staff, but their initial PD was

prefaced by a positive counselor experience and recommendation from their statewide training. A key element of success would be a multistage approach of counselor training and then an introductory training to include all staff. Knowing that a foundation for success was preemptively laid will help in providing resources and answers for stakeholders who are early in their understanding of the program. An element that may not be expressed enough in this study is a sense of urgency. Most school models are a *wait to fail* model, where SD would provide the district a preventative plan of action.

5.7 Closing Thoughts

Mental illness is highly personal. Stigma is a term that was a consideration from the very first undertakings. Before this research began, an informal poll was taken from several staff members at a district where I served as superintendent. The question was put forth to staff members who were authorized to conceal carry a weapon on campus. They were trained in the use of deadly force in case of an active shooter on campus. The question was regarding the use of universal screeners to help determine the mental health needs of students. All answers were against the use of a universal screener. The fear was the stigma that their child might be identified as someone with mental health needs. Fears of others' perceptions of someone with mental health issues was their concern and especially if it was their child.

The misconceptions that our society faces are that only certain people have mental health issues and to have them is abnormal. The psychological testing and analysis that most school marshals and concealed carry school guardians are required to take is a snapshot of a person's mental health status at the time of testing. Trauma can come at any time, in many forms. Once we realize that everyone has issues, and it is okay to talk about them, the quicker the seeds of trauma can be dug up and seeds of hope planted in the garden of our life.

One element missing in most school curricula is how to teach about trauma and how to help those who suffer from it. Mental health needs have traditionally been an issue to be dealt with by experts outside of the education system. The need for student mental health care was growing before the pandemic and the needs are now greater than ever. As a result, the existing outlets for treatment are full and wait times are months not hours. Sarah commented that most children in need of counseling will never receive the therapy they need. The protocol in most educational systems has been a *wait to fail* model resulting in tragedy. But there is hope.

The findings of this study revealed four themes: perceptions, empathy and understanding, implementation, and transferability. These four themes like education can follow a natural progression. When the perception of society changes regarding mental health, a flood of empathy and understanding can follow. With understanding comes the desire to implement programs that can provide remedy for the victims. With successful implementation a resource is created that can be transferred to other institutions. The mental health program created by Shawna Burns and the SD Wellness Center provides schools and individuals a simple natural process to process trauma and improve a person's well-being. In my own gardening experience, I found that if I did not pull the weeds when they first came up that my garden would quickly be overrun. Cutting the weeds back was not the solution but pulling the weeds up by the roots would allow the good things in my garden to grow.

School shootings have become so common that many are only on a 24-hour TV news cycle. One school counselor said that conversations with second graders considering suicide was not unusual. When one teacher was asked if there was anything negative that they had experienced with SD, the response was that they wished they could help more people. The findings of this single case study share the experiences and perspectives of a small group of

individuals. Though small they represent a school of more than 4000 students and community of over 18,000 residents. The participants credit the SD program with saving at least one life. We may not know how many other lives have been saved through early intervention, but this is a good place to start.

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APPENDIX A

LETTER OF DETERMINATION

NOT HUMAN RESEARCH
DETERMINATION

February 25, 2021

Dear Mary Margaret Capraro:

The Institution determined that the proposed activity is not research involving human subjects as defined by DHHS and FDA regulations.

Further IRB review and approval by this organization is not required because this is not human research. You have indicated that the results of the activities described in the application will not be generalized beyond a single school system and will not be published. This determination applies only to the activities described in this IRB submission and does not apply should any changes be made. If changes are made you must immediately contact the IRB about whether these activities are research involving humans in which the organization is engaged. You will also be required to submit a new request to the IRB for a determination.

Please be aware that receiving a 'Not Human Research Determination' is not the same as IRB review and approval of the activity. IRB consent forms or templates for the activities described in the determination are not to be used and references to TAMU IRB approval must be removed from study documents.

If you have any questions, please contact the IRB Administrative Office at 1-979-458-4067, toll free at 1-855-795-8636.

Sincerely,

IRB Administration

APPENDIX B

ADMINISTRATOR APPROVAL FOR DISTRICT PERSONNEL PARTICIPATION

I _____ Superintendent of XXXXXXXXXXXXX district do allow Patrick Wayne Kelly to interview selected personnel in the district during the course of conducting research for the Record of Study titled, BEFORE STUDENTS HURT: CURRICULUM SUPPORTS FOR SOCIAL, EMOTIONAL, AND MENTAL DEVELOPMENT, IN PUBLIC SCHOOLS.

Research participation is strictly on a volunteer basis. Your approval of this research does not mandate or require XXXXXXXXXX employee to participate.

Thank you for your support of this study.

Sincerely,

Patrick Wayne Kelly

APPENDIX C

PARTICIPANT INFORMED CONSENT FORM

INTRODUCTION

Welcome, this form is to inform you about the research study being conducted and to document your consent should you choose to participate.

RESEARCHER

Patrick Wayne Kelly (a doctoral student at Texas A&M University)

STUDY PURPOSE

The purpose of this research is to inquire about your experiences regarding your involvement, participation, and implementation of the Seed Digging program in your district.

DESCRIPTION OF RESEARCH STUDY

This action research project is an unfunded study. The protocol for this research includes the following commitments and your consent.

1. To conduct one GoToMeeting/Zoom interview with you at your convenience.
2. To be recorded in an individual interview using video and/or audio recording with a transcription of the interview.
3. To have access at your discretion for artifacts/documents that are related to the research topic.

RISKS

There are no known risks associated with this study. It is difficult to guarantee complete confidentiality there is some possibility that you may be subject to risks that have not yet been identified. The sample size for this study is small and it is difficult to guarantee absolute anonymity. It is possible that others may recognize part of your experience. Every effort will be made to keep research confidential. It is possible that questions asked during an interview may cause some discomfort and your continuation is at your discretion. You will be free to strike data or information from the record, should you feel concerned about any adverse impact on you.

BENEFITS

There is no financial benefit to the participation in this study. The potential benefits for participation in this study is to inform others in the education community about the impact either good or bad regarding your experiences with the Seed Digging program in your district.

CONFIDENTIALITY

The results of this research study may be used in reports, presentations, and publications. The researcher will not identify you or your school by name. Patrick Wayne Kelly will assign you a pseudonym in working with and discussing the data. Patrick Wayne Kelly will not share any information gleaned from interviews, classroom observations, and artifacts/documents with

any individuals. All the information will be kept safe and confidential. Only Patrick Wayne Kelly and his doctoral committee chair Dr. Michelle Kwok will have access to the information. Data from interviews, recordings, artifacts, and raw data will be destroyed three years following the completion of this research.

WITHDRAWAL PRIVILEGE

Your participation in this study completely voluntary. There is no pressure for you to participate or adverse consequences if you choose not to. You are free to withdraw consent at any time before, during or after the study.

COSTS AND PAYMENTS

There is no payment for your participation in the study.

VOLUNTARY CONSENT

Any questions you have concerning the research study will be answered by Patrick Wayne Kelly (361-701-2610). Your signature below indicates that you consent to participate in the above study. By signing below, you are granting to the researcher the right to use information gathered during the recorded interview to be included in the presentation and publication of this research.

Participant's Signature_____

Printed Name_____ Date_____

APPENDIX D

PARTICIPANT INTERVIEW STARTER QUESTIONS

Superintendent-

1. [Macro/Exosystem] How did you become informed about the Seed Digging Wellness Centers?

2. [Macrosystem What were the motivators or influences that prompted you to implement the program in your district?

3. [Mesosystem/ Exosystem] What were some of the challenges to "buy in" from your staff and/or Board of Trustees?

4. [Chronosystem] How has the COVID-19 pandemic influenced the use of the Seed Digging program in your district?

Counselor- All of the above questions with the addition of:

1. [Mesosystem]What was your part in implementing the Seed Digging program in your district?

2. [All levels] Can you tell me how the Seed Digging program interacts with students, parents, teachers, Seed Digging staff and administration.

3. [Macrosystem] What were some of the tools that the Seed Digging program provided and how did you use them? Example: Self Esteem Questionnaire, Books etc…..

4. [Chronosystem]Has COVID-19 pandemic affected implementation of the Seed Digging program?

Teacher-

1. [Mesosystem] How were you informed about the use of the Seed Digging program in your school?

2. [Macrosystem]What kind of training, if any, were given to inform you of the program and how to refer students?

3. [Microsystem]What kind of interaction did you have with the counselors and parents?

4. [Chronosystem] What kind of benefits or changes have you seen in the students who have utilized the program?

5. [Macrosystem]What do you like or dislike about the program?

6. [Meso/Microsystem] What advice would you give to other teachers who are not familiar with the program?

Parent-

1.[Mesosystem]How were you informed that your child would be involved with the Seed Digging program?

2. [Micro/Mesosystem] What were your first reactions when you were informed that your child would be involved in the Seed Digging program?

3. [Chronosystem]What if any benefits did you notice because of your child's participation with the Seed Digging program?

4. [Meso/Microsystem] What would you tell other parents who might have fears related to their child having emotional, behavioral, or mental needs?

5. [Meso/Microsystem] What kind of interaction did you have with the counselors and teachers?

Seed Digging Staff-

1. [Exo/Macrosystem] How did you become involved with the Seed Digging Wellness Center?

2.[Exo/Meso/Microsystem] How was your presence on campus perceived by school personnel?

3. [Chronosystem]What changes have you seen evolve over time on the campus you serve?

4. [Meso/Exo/Macro/Microsystem] What kind of interaction did you have with administration, parents, counselors, and teachers?

APPENDIX E

THEMES AND CODING MATRIX

Theme	Codes	Definitions	Examples
Perceptions- The point of view from various stakeholders	Stories	Influence of Testimonials	"They gave testimonies about other people who'd been there, and they'd cure people from schizophrenia." Sally "I tell everyone my story" Sally -I was able to witness the growth of this young person who had been crippled emotionally. Nancy "I had seen their success stories, and that, from the PD" Ellie "Her personal story sold me on it from the get go." Cathy "The testimony of a teacher that has experienced it firsthand with her teenage daughter really made an impact and made for a good sale." Mr. Johnson
	Challenges	Negative experiences and predetermined ideas related to mental health	"I have friends whose parents think that mental health issues are for the weak and counseling is not needed. I help my friends realize that mental health issues are real." Sally "I didn't really understand the whole scope of it." Paula "My husband thought that the mental health thing was a joke." Paula "The HS does not want to participate because it takes too much time from the academics." Cathy

	Flaws in the Traditional system	Negative of ineffective effects using traditional methods of counseling or programs.	"I think it is our health care system, it just wants to mask over the issues." Sally "My friend tried 20 different counselors." Sally "I truly believe medicine made things worse for me." Sally -I felt like seed digging was the only thing that could get to the source of my child's problem- Paula "I do not think traditional therapy works." Ellie -Medicaid usually takes a month or more to get approved for traditional counseling. Maggie "Sometimes children will never see the therapy world." Sarah "Therapists used to be like lifeguards watching a few kids in a pool, now there are a thousand kids in that pool and only one lifeguard." Sarah

Theme	Code	Definition	Example
Transferability- Ability to go from grade to grade, campus to campus and district to district.	Mantra/Language	Consistent repeatable and understandable district wide communication.	"We have posters on the wall, and we recite the 7 innate needs every day." Ellie "The innate needs are part of our everyday announcements." "The kids repeat the 7 innate needs, and it has become our mantra." Cathy "Once they've been given that vocabulary, they can express their feelings." Katy "She does an excellent job of getting into classrooms and laying that groundwork laying that language down, and they'll do the screener at their level." Martha -it works because our teachers, admin, counselors, and kids have the cohesiveness of the language, we are all on the same page- Martha
	Sustainability	What keeps the SD program growing from year to year?	"She's able to use the seed digging techniques with her friends and she's already referred people." Paula "Our school based mental health; I'd say probably 80% is taken care of in-house." Martha "And it's very important for us to equip that child with those tools of healing, because that, child may be in trauma until they're 18, but at least they'll have the tools to know how to pull those seeds out." Sarah
Theme	**Code**	**Definition**	**Examples**

<u>Empathy and understanding</u>- A byproduct of Seed DiggingSD for all participants	Trauma	The base for most of the seed digging language.	"Everything that we're seeing with kids today since COVID, you know, the depression and suicide rates in just all the different things that they face because they need to, um, have that opportunity to get to the root of it to get those seeds out and replace them with good seeds and stuff like that." Paula "I think there's a lot of people that don't understand that, especially educators, that sometimes, he had acted that way, because of trauma, and it's some kind of bad seeds they have. And we just say they were misbehaving intentionally and all that, but they don't really understand how." Ellie "There is a lot of drugs and crime, and so, we have, we have a lot of trauma in the district and so, I wanted to do something preventative." Maggie
	Improvement	Successes people saw in their own life or others and in academics.	"I mean it changed my life. I just learned so much about me as a person." Sally "Working through the things has allowed her to grow into this young woman who was crippled as an 18-year-old if emotionally." Nancy "And we have not seen the level of depression, she's happy, she's cheerful, she's eating. She had gotten to where she was withdrawn, wouldn't leave her room, now she's outgoing, she participates with youth group, she participates with friends.

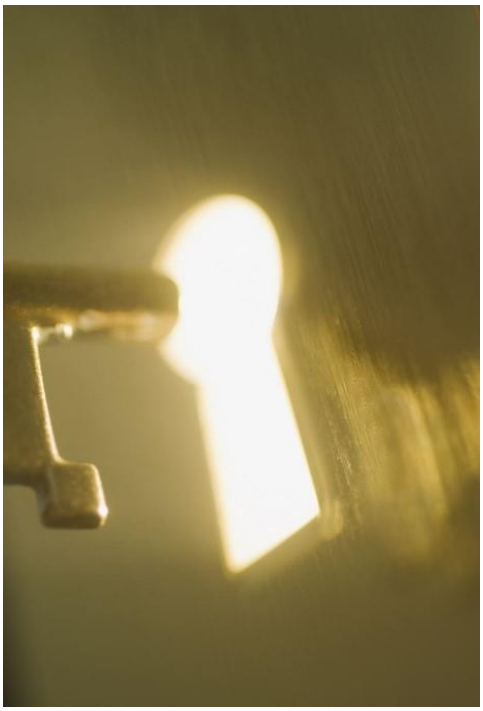
			This was very effective" Pam "When you have a student that goes from being in crisis to coming out on the other side, you just know it's works." Cathy
	Preventative	What is done before a child hurts.	The counselor does an excellent job of getting into classrooms and starts laying that groundwork laying that language down, they'll talk, they'll do the screener at a level the kid understand." Martha "The screener is an early intervention process because it stimulates the conversation." Maggie "We have a lot of trauma in the district and so, I wanted to do something preventative." Maggie
	Emotional needs/well being	It is the recognition of needs beyond the physical	"Because mental health can be one of those things that people are skeptical about. They're hesitant to open up the kinds of things that you know, everybody has had struggles. I've had people, people will if I am just crazy like it's a lot. People say you're gonna think I'm crazy or something like that and I say, everybody's probably crazy just in their own way, like, everybody's got something different, so it's OK, you know." Nancy "Just because your child goes to therapy or counseling, doesn't mean that there's something wrong with them." Paula "One of our major strategies is

			to create empathy.” Sarah
Theme	**Code**	**Definition**	**Example**
Implementation- How seed diggingSD is put into practice	Virtual Counseling	On-line counseling	“We were able to do our suicide prevention training on-line.” Ellie “All of our counselors were able to do the SD Pro Counselor training on-line with other counselors from around the state.” Cathy “One of the benefits during that time, was that many insurance companies recognized the need for virtual counseling and telehealth. Because of that we are able to help more people. Most of our counseling now is virtual.” Sarah
	Referrals	Sending people who need services to get the help they need.	“I have referred my boyfriend, other friends, you know lots of people to Seed Digging.” Sally “So during our visits something will come up and I will get a clue and I will make a referral.” Nancy “As teachers we refer the kids to the counselors.” Ellie We try and create a lot of exposure with the kids and teachers. That exposure then plants a seed for the teacher to make a referral when they notice something.” Maggie
	Training/PD	What equips the school staff	“Our superintendent wanted us to go to the advanced training.” Cathy

			"Seed Digging helped me a lot to build that relationship with that student, and then see the process at work and really help the child do some good work within themselves, you know, to, to kind of work on those innate needs." Martha "They absolutely loved the program and were using just bits and pieces in her elementary school, and I wanted to get more folks trained, so that we could implement it, and spread it more widely throughout the district." Maggie

APPENDIX F

ARTIFACT FOR DISTRICT



What's your plan to deal with rising suicides and active shooters?

- **More security?**
- **Better locks?**
- **Do the best you can and hope it doesn't happen to you.**
- **Most plans are a *wait to fail* model.**

Nobody wants to hear!

- **Shots fired! Shots Fired!**
- **911 What is your emergency?**
- **Lockdown.**
- **Funeral services will be held…..**

What if there was something you could do before students hurt themselves or others?

- There is a new approach to providing mental health education starting with Pre-K.
- It provides universal screeners that help students identify and communicate their own social, emotional, and mental health needs.
- Your own staff will be trained to handle needs "in -house," rather than making outside referrals that are often backlogged for weeks or months.
- Schools using this approach are experiencing
- "good work" and progress with struggling students.

seed digging

Seed Digging is a compassionate approach that blends evidence-based counseling models and techniques together in a simple language to help individuals understand how emotional and behavioral issues develop and how to overcome them. Seed Digging uses a garden analogy to explain how negative and positive thoughts (seeds) can deeply impact emotions and behaviors; through simple strategies, negative seeds can be "uprooted" and replaced with positive ones through building self-confidence, love and inner healing connection. Seed Digging incorporates current neurological research and concepts and techniques from Person-Centered Therapy, Psychodynamic Therapy, Play Therapy, Cognitive-Behavior Therapy, Attachment Therapy, mindfulness, and Maslow's Hierarchy of Needs.

Seed Digging also offers several programs and services including a school -based trauma informed model, with 5-layers of care, a wellness & counseling clinic, books and resources, live trainings and online training programs (www.seeddigging.com)