Implementation of the Evidence-Based COPE Intervention in an Elementary Classroom to Promote Mental Health

Maria McCormick

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THE IMPLEMENTATION OF THE EVIDENCE-BASED COPE INTERVENTION IN AN ELEMENTARY CLASSROOM TO PROMOTE MENTAL HEALTH

Maria McCormick

A Dissertation Submitted to the Graduate Faculty of

GRAND VALLEY STATE UNIVERSITY

In

Partial Fulfillment of the Requirements

For the Degree of

DOCTOR OF NURSING PRACTICE

Kirkhof College of Nursing

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Dedication

This scholarly project is dedicated to the adolescents who are struggling or have struggled with depression, anxiety, and suicidal ideation and to those who have been impacted by the tragedy of losing a loved one to suicide. And to Jim, my confidant, supporter, and source of motivation.
Acknowledgements

I would like to acknowledge the support, encouragement, and involvement of my scholarly project committee, all of whom helped me complete this project. To Dr. Cynthia Coviak: your wisdom, knowledge, experience, patience, and hours of time that you invested in all stages of this project were key components to my success with the project as well as facilitating my personal growth as an advanced practice nurse. To Martha Hayden: from day one, your whole-hearted belief in me and your unconditional love for your students allowed this project to become an experience that was not only meaningful, but life changing. To Dr. Shawn Bultsma: thank you for your knowledge and understanding of the educational system that helped me to look at aspects of this project from a different perspective as well as your assistance in the shaping of this document. To Dr. Gerri Terry: thank you for your willingness to be apart of this project and for the knowledge and perspective that you provided.

I would also like to acknowledge and thank my family and friends for their love and support throughout this journey. Thank you to my husband, Jim, who kept me believing in myself, ensured that I had the needed supply of chocolate and coffee, and made sure that I kept a healthy balance between school and the rest of life. Thank you to my son, Calvin, who provided comic relief and the purpose to keep moving forward. Thank you to my parents, my in-laws, and my brothers and sisters who believed in me, encouraged me, and were always willing to lend a helping hand. Thank you to all of my classmates, especially Dr. Tiffany Kuipers and Dr. Claudia Turkson-Ocran, for your support, encouragement, times of laughter, and times of tears. I could not have made it without you. And most importantly, a prayer of gratitude to my heavenly Father for grace, patience, and opening all the right doors and just the right time.
Abstract

There is a growing incidence of suicide and suicide attempts in the adolescent population. This is largely impacted by the increasing rates of mental illnesses such as anxiety and depression as well as instigating factors such as negative behaviors and stressful life events. In order to prevent these rates from continuing to rise, it is imperative that mental health promotion interventions be implemented in young children in order to facilitate positive behaviors and coping skills that can be used when stressors occur. The purpose of this scholarly project was to implement the cognitive-behavioral therapy intervention, the Creating Opportunities for Personal Empowerment (COPE) for Children, as a pilot program in a classroom of 2nd grade students.

Twenty-five students, ages six to eight, participated in this project. Sixteen of the participants completed all seven sessions of the COPE intervention. In order to measure effectiveness and feasibility of the program, several measurement tools were used, including a Participant Information Tool, Rating of the Sessions, PBIS Classroom Clip Chart Analysis, information from letters from the students, and immediate and long-term Post-COPE Evaluation Questionnaires. In addition, the staff involved in the classroom provided feedback regarding the program. Analysis of the data showed that there was an increase in positive behaviors in the classroom after the completion of the program that was maintained long-term. In addition, the students provided positive feedback regarding the specific sessions as well as their overall perception of the program. Students stated they would recommend the program to other students and were able to recall specific strategies and skills that they learned during the program immediately after the program and at the long-term evaluation. This project supports the use of the COPE for Children program in an elementary school setting in order to promote mental health and facilitate positive behaviors.
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CHAPTER 1
INTRODUCTION

Identified Concern and Significance to Practice

The incidence of suicide in children continues to be a growing problem. In the most recent report of suicide trends, Sullivan et al. (2015) reported that suicide has become the second leading cause of death among individuals aged ten to twenty-four. In 2007, 15% of high school students expressed a history of suicidal ideations in the last twelve months (Gardner et al., 2010). According to Gilbert, Maheux, Frappier, and Haley (2006), 90% of children who successfully commit suicide have experienced symptoms of a mental illness or have a current mental illness diagnosis. In a study of over 12,000 children Balazs et al. (2013) found that after controlling for age and gender, children with anxiety were two and a half times more likely to have suicidal ideations than those without a history of anxiety. They also found children with depression were nine times more likely to have suicidal thoughts and ideations than those without a history of depression. Twenty-five percent of children will have a diagnosis of conditions such as depression or anxiety by the age of 18. The average age of onset for depression is between 11 and 13 years of age and the average age reported for an anxiety disorder is 12 years of age (Allgaier et al., 2012; Melnyk, Jacobson et al., 2013). Melnyk, Jacobson et al. (2013) reported less than 25% of the 15 million children in the United States with a mental illness receive appropriate treatment.

Depression is often initiated or exacerbated by events such as “early pregnancy, poor academic performance, and impaired work, social, and family functioning during youth” (Kristjánsdóttir et al., 2011, p. 262). Children affected by depression, anxiety or other mental illnesses are at an increased risk for hospitalizations, recurrent or more severe episodes of
depression, psychosocial impairment, alcohol abuse, and antisocial behaviors, all of which positively impact the incidence of suicide ideations and attempts in this population (Zuckerbrot et al., 2007). In addition, depression and anxiety frequently occur simultaneously or sequentially in children, increasing the risk of negative long-term effects (Garber & Weersing, 2010).

**Promotion and Prevention**

According to the World Health Organization (2004), mental illness prevention “has as its target the reduction of symptoms and ultimately of mental disorders” while mental health promotion “aims to promote positive mental health by increasing psychological well-being, competence and resilience, and by creating supporting living conditions and environments” (p. 17). The World Health Organization (2004) recognized that it is common for interventions aimed at promoting mental health to have a secondary impact of decreasing the incidence of mental illness. While it is important to address the instigating events and combat crises when they arise and provide treatment for identified mental illness to prevent their exacerbation, the promotion of mental health and the subsequent prevention of worsening instigating signs and symptoms demand attention. It can be concluded that through the promotion of positive mental health, the incidence and severity of mental illness will be lessened. Therefore, in order to be proactive in the reduction of suicide attempts in children, interventions focused on the facilitation of healthy lifestyle behaviors that promote positive mental health must be implemented. Such interventions will assist in the prevention of depression and anxiety as well as the negative behaviors precipitating these conditions.

**Importance to Health Care**

There is a significant gap in adolescent health care in the promotion of mental health, and the prevention, detection, and treatment of mental illness (Ozer et al., 2009). With 25% of
children being affected with a mental illness and the lack of appropriate access to health promotion and prevention interventions and services, this gap is going to continue to grow and cause long-term consequences. Therefore, it is imperative that health care professionals begin to pay attention to interventions or services that can combat these issues.

The National Research Council (2009) reported patterns of health and behavioral habits, which are formed in adolescence, have significant influence on health, acute and chronic disease, and life expectancy. The promotion of health and well-being in young children will improve immediate health, as well as significantly impacting the ability to thrive as healthy, emotionally resilient adults (Licence, 2004). According to the National Center for Infants, Toddlers and Families (2015), it is never too early to work towards the promotion of mental health and prevention of mental illness. In fact, this center reports there is growing research and an increase in the practice of promoting mental health as early as infancy. The earlier an intervention can be implemented and healthy behaviors can be reinforced, the greater impact it will have on the long-term mental health of an individual. Therefore, effort should be made to provide education and facilitation of positive cognitive skills such as appropriate coping mechanisms, problem solving, goal setting, and positive thinking that will result in improved outcomes during adolescence as well as later in life (Melnyk et al., 2006).

**Rationale for an Intervention in the School Setting**

Implementation of cognitive-behavioral therapy (CBT) for anxious and depressed children in the school setting has been researched and shown to be effective. Mychailyszyn, Brodman, Read, and Kendall (2012) conducted a meta-analysis from which they concluded that the advantages of a school-based mental health intervention included the following: schools provided accessibility to the largest amount of children; the school setting is one of the most
influential aspects of a child’s contextual environment; and mental health concerns are often identified and displayed in the school setting. In addition, Mychailyszyn et al. (2012) reported that there was mild to moderate improvement of anxiety and depression with the implementation of a cognitive-behavioral therapy intervention, recognizing that treatment-based interventions had a larger impact than prevention-based interventions in the population of children targeted for the intervention. The specifics of this meta-analysis as well as details on the use of CBT in children will be further discussed in the literature review. Caldwell (2012) also reported that implementation of an intervention in the school setting which focuses on improving mental health has been associated with lowering obesity, improving grades, decreasing depression, and reducing substance abuse. Research for specific CBT interventions in the school setting is innovative and continues to be developed. One such intervention, which has been heavily researched in the past ten years, is Melnyk’s Creating Opportunities for Personal Empowerment (COPE) evidence-based program (Melnyk, 2007).

**Proposed Intervention**

The COPE program was first created by Bernadette Melnyk, PhD, RN, CPNP/PMHNP, FAAN, FNAP as a health promotion and education program designed to help children in a psychiatric inpatient unit build appropriate coping skills and enhance healthy behaviors (Lusk & Melnyk, 2012). This original program consisted of 15 sessions that align with two different categories. The primary topics addressed in the first seven program sessions focused on promoting mental health and include the following titles: (1) Thinking, Feeling, and Behaving: What is the Connection?; (2) Self-esteem and Positive Thinking/Self-talk; (3) Stress and Coping; (4) Solving Problems and Setting Goals; (5) Dealing with Your Feelings in Healthy Ways; (6) Coping with Stressful Situations; and (7) Pulling it all Together for a Healthy You (Melnyk,
The other eight sessions focused on education and activities that addressed and promoted healthy nutrition and physical activity (Lusk & Melnyk, 2011). After initial development, Melnyk recognized two different adaptations of the COPE program for implementation: the seven-session COPE intervention that focuses on CBT principles, and a 15-session COPE Healthy Lifestyles Thinking, Emotions, Exercise, and Nutrition (TEEN) program that includes the first seven cognitive behavioral therapy-based sessions in addition to education and facilitation of healthy lifestyles behaviors (Melnyk & Lusk, 2013). Both variations of the program have been implemented over the last decade. In addition, the COPE program is available in three variations, which are tailored for specific age groups: children (7 to 11 years), teens (12 to 18 years), and young adults (18 to 24 years). The materials covered in the seven sessions of these different variations are the same and the goals and outcomes of the program are the same; however, the language and the examples used in the exercises are age-appropriate for the specific age group.

The purpose of this scholarly project was to pilot the seven-session COPE for Children program in a classroom of 2nd grade students. This school was chosen after review of the Michigan Profile for Healthy Youth 2013-2014 survey of middle school aged adolescents in Kent County. This survey reported many concerning trends, including rates of depression, anxiety, suicidal ideations and suicide in children in Kent County. These results are summarized in a handout that was presented to the staff at the identified school (Appendix A). In addition to the concerning reports of the overall health of children in Kent County, the identified consists of 500 students (2nd through 5th grade), almost half of whom receive reduced-cost or free lunch and breakfast. This number has increased 20% over the past eight years. Conversation with key stakeholders in the school community regarding the impacts that accompanied this statistic
revealed that there has been an increase in the instability of family units through loss of jobs and the resulting loss/lack of housing. As a result of these factors, student behavior and academics have been negatively impacted. The school has recently implemented the evidence-based Positive Behavior Interventions and Supports (PBIS) (2015) program as a school structure for developing positive behaviors and creating a positive environment for learning. PBIS is a program that focuses on teaching behavioral expectations as a curriculum through a majority of positive reinforcement and a proactive approach with redirection and discipline as needed. While this program focuses on positive behaviors, it does not provide education for the students regarding specific tools and skills that they can use when faced with challenges, problems, or negative behaviors. Therefore, the goal of this project is to augment the PBIS program with the implementation of the evidence-based CBT intervention to improve coping skills and facilitate positive behaviors in order to promote mental health, and decrease the incidence or severity of depression and anxiety. The desired long-term outcome of this intervention is to work towards improved mental health and a reduction in mental illness and/or suicide as the child matures into an older adolescent and young adult.

Evidence-Based Support for COPE for Children

The COPE for Children program is based on evidence-based CBT principles. These principles guide the content of the manuals as well as the structure that is used to implement the program. Significant research has provided support for CBT and has been further used to back the COPE for Children program.

Cognitive Behavioral Therapy

As seen in the previous discussion, CBT is an evidence-based intervention that can be effectively used for children in the school setting. However, it is also important to provide
evidence-based support for the use of CBT for the promotion of mental health in children, regardless of the presence or absence of a mental illness. O’Connell et al.’s (2009) book on the prevention of mental, emotional, and behavioral disorders provides thorough review of a large number of studies addressing the use of a variety of CBTs in children. They conclude current research supports CBT for the successful treatment and prevention of mental illness, while also recognizing that CBT can be used in the promotion of mental health to prevent mental illness for children who may or may not already have a mental illness diagnosis (O’Connell et al., 2009). In his review of the use of CBT in children and older adolescents, Drummett (2010) mentions and provides reference information for 18 studies that have shown the effectiveness of a CBT intervention for the use of a wide variety of issues ranging from mild behavioral concerns to severe mental illnesses in both individual and group settings. McCarty and Weisz (2007), Watanabe et al. (2007), Williams, et al. (2009) and Brent et al. (2008) conducted meta-analyses and systematic reviews regarding the use of CBT in children with depression and found it is efficacious as first-line treatment as well as adjunct therapy to other interventions or medications.

**Seven-Session COPE for Children**

As mentioned above, the first seven sessions of the COPE Healthy Lifestyles Teen Program and the three age-differentiated versions of the COPE program contain the same overall content; however, variations are made in regards to ensuring the information is presented at an age-appropriate level. Therefore, the articles that describe the methodology and the research studies conducted using any version of the COPE program are analyzed in the literature review for information regarding the methodology of implementation and reliability/effectiveness of the program. Review of these studies provides support to conclude there is significant promotion of mental health through education and facilitation of positive healthy lifestyle behavior changes as
well as reported improvement in the symptoms of depression and anxiety (Kozlowski, Lusk, & Melnyk, 2015; Lusk & Melnyk, 2011; Melnyk et al., 2007; Melnyk et al., 2009; Melnyk, Jacobson et al., 2013; Melnyk, Kelly, Jacobson et al., 2013; and Melnyk, Kelly, & Lusk, 2013). Specific information from these studies will be further discussed in the literature review.

**Potential Outcomes**

There are several positive outcomes associated with the use of the COPE for Children program. One of the main variables identified in the studies of the COPE for Children program that encompasses most of the other outcomes is healthy lifestyle behaviors. This construct includes concepts such as positive coping skills, increased self-esteem, and being able to positively address problems and challenges in a way that results in individuals being empowered. For the purpose of this project, these outcomes will be measured through improvement of behaviors at school reported and recorded as part of the PBIS program, and participant report through a post-intervention questionnaire.

The evidence supporting the use of CBT as an intervention as well as the research backing the COPE for Children intervention encourages further implementation of the program. The mental and physical well-being of children is not something to be taken lightly and both can be addressed through this intervention. It is hoped that final evaluation of the pilot program for this scholarly project will provide information to determine whether or not it would be effective and beneficial to implement the COPE for Children program on an annual basis for the 2nd grade classes at the participating school.
CHAPTER 2
LITERATURE REVIEW

The incidence of depression, anxiety, and suicide in children continues to increase while the advancement of treatment and prevention of the symptoms related to these issues fails to counteract such an increase. According to a study that considered a national sample of 10,123 children between the ages of 13 and 18, about 25% of children suffer from a mental illness (Merikangas et al., 2010). According to Gilbert et al. (2006), 90% of children who commit suicide have a mental illness. Anxiety and depression are some of the most common mental illnesses related to the majority of successful and attempted suicides, self-harm behaviors and suicidal ideation (Kristjánsdóttir et al., 2011). Kristjánsdóttir et al. (2011) find depression to be initiated or exacerbated by events such as “early pregnancy, poor academic performance, and impaired work, social, and family functioning during youth” (p. 262). Adolescents affected by illnesses such as depression and anxiety are at risk for increased hospitalizations, recurrent or more severe episodes of depression, psychosocial impairment, alcohol abuse, and anti-social behaviors (Zuckerbrot, et al., 2007). Each of these factors impacts the incidence of suicide in this population (Zuckerbrot et al., 2007). The most recent survey has found suicide to be the second leading cause of death in individuals between the ages of ten and twenty-four (Sullivan et al., 2015). Gardner et al. (2010) reported in 2007 that 15% of high school students stated they had seriously considered suicide in the last twelve months.

All of the above statistics intensify the need for increased awareness, treatment, and prevention of symptoms that can lead to an increased risk of suicide. However, awareness and treatment is no longer enough, as evidenced by the World Health Organization (2004) and Healthy People 2020 recommendations and objectives. These emphasize the need to promote
mental health and well-being and prevent the occurrence and exacerbation of mental illness through evidence-based interventions (HealthyPeople, 2014). The National Institutes for Health have sponsored a significant amount of research and facilitated initiatives that address the importance of promoting mental health during the prenatal period (O’Connell, Boat, & Warner, 2009). Promotion of mental health in parents enables them to successfully transition into parenthood, fosters appropriate parenting skills, and increases overall parental health, thereby promoting the mental health of the child(ren) (Loureiro et al., 2009). Promotion of mental health can begin as early as infancy and is crucial for the impressionable, developing brain of young children (National Center for Infants, Toddlers, and Families, 2015). In the effort to promote mental health prior to negative behaviors and exacerbations of mental illness becoming problematic, it is reasonable to implement interventions at as early an age as the intervention allows. In addition, it is imperative that health care providers recognize the importance of the promotion of mental health and routinely addresses this with their patients and families.

Research has shown that CBT interventions have illustrated effectiveness in promoting mental health in addition to reducing rates of depression and anxiety in children (Melnyk, et al., 2006). The Creating Opportunities for Personal Empowerment (COPE) for Children program is one such evidence-based intervention. This literature review will serve as a foundation for supporting the use of cognitive behavioral therapy for children to promote mental health and prevent the exacerbation of any symptoms of depression and anxiety. In addition, the review will examine the effectiveness of a school-based intervention and the evidence-based support for the efficacy and feasibility of implementing the COPE for Children program.
Methodology

The following research was identified through several search strategies. First, a search was conducted of the CINAHL, PubMed, PsychINFO, Google Scholar, and general Grand Valley State University (GVSU) library databases using multiple combinations of the following search terms: COPE; COPE Healthy Lifestyles TEEN; Creating Opportunities for Personal Empowerment; Creating Opportunities for Personal Empowerment Healthy Lifestyles Thinking, Emotions, Exercise, and Nutrition; intervention; school-based; school; adolescents; children; and teenagers. In addition, a literature search of the GVSU library database was conducted using Bernadette Melnyk’s name in the author category. Due to the recent creation of the selected intervention, inclusion criteria was rather broad and included use of the COPE or COPE Healthy Lifestyles TEEN program as the identified or controlling intervention; implementation of the program in children aged one to eighteen; implementation in any setting; and included any publication year. There is an intervention similar to the Creating Opportunities for Personal Empowerment also entitled COPE (Creating Opportunities for Parental Empowerment) but is geared towards parents of children who are struggling with chronic conditions or long hospitalizations. This intervention was excluded from use in this literature review. After recognizing the inclusion and exclusion criteria, a total of seven studies were identified for review.

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) focuses on the cognitive and behavioral aspects of care by placing emphasis on and investigating the individual’s thoughts, feelings, and behaviors (National Alliance, 2015). According to Spirito et al. (2011), the behavioral aspect of CBT interventions “emphasize various skill deficits in the domains of coping skills, interpersonal
relationships, social problem solving, and participation in pleasant activities” while the cognitive piece “focuses on identifying and challenging schemas, automatic thoughts, and cognitive distortions that cast experiences in an overly negative manner” (p. 193). CBT is designed to help the individual identify destructive beliefs and restructure them into positive beliefs and attitudes (National Alliance, 2015).

Upon initial literature search for this project, there were almost 15,000 studies identified that were conducted using CBT for a variety of problems including obesity, eating disorders, personality disorders, insomnia, substance abuse, and other mental health conditions including depression and anxiety. For the purpose of this project, a literature search was conducted using the databases indicated earlier, for publication dates from 2005 to the present using the following terms: cognitive behavioral therapy, CBT, depression, anxiety, suicide, suicidal ideation. Upon review of these studies, except for a few of the studies using the COPE program that are discussed further in this literature review, the majority focused on the use of CBT for children who had a previous or current diagnosis of depression or anxiety rather than the use of CBT in a group of individuals for whom the main goal was prevention of these concerns. Due to the numerous studies that resulted from this search, it seemed appropriate to narrow the search to meta-analyses that would provide an overview of available studies. Even with these limitations, over 3,000 articles resulted. Therefore, a sample of meta-analysis studies using CBT to promote mental health and prevent the incidence and relapse of depression and anxiety will be presented to demonstrate usability and validity of this type of intervention in children.

Hofmann et al. (2012) conducted a comprehensive review and survey of meta-analysis studies regarding the use of CBT because of the lack of up-to-date reviews regarding this topic. Prior to Hoffman et al’s (2012) paper, the most recent review only included studies with
publication dates up to 2004. Eight hundred and eight non-duplicative studies were found and examined with the inclusion criteria of a publication date after 2000 and methodology demonstrating a quantitative review of CBT. This resulted in a total of 269 meta-analyses. The authors then categorized the 269 studies into the following groups: substance use disorder; schizophrenia and other psychotic disorders; depression and dysthymia; bipolar disorder; anxiety disorders; somatoform disorders; eating disorders; insomnia; personality disorders; anger and aggression; criminal behaviors; general stress; distress due to general medication conditions; chronic pain and fatigue; and pregnancy complications and female hormone conditions. In addition, the studies were categorized in one of three population groups: disorders in children, disorders in elderly adults, and disorders in adults. Due to the large number of studies for their review and survey, the authors analyzed a representative sample consisting of 106 meta-analytic studies. The number of studies in each of these groupings and the sample sizes in the studies were not reported in this article. For the purpose of the current review, findings in the children-specific population group will be further discussed.

Hofmann et al.’s (2012) review of the meta-analyses involving children reported brief summary results regarding the use of CBT for a variety of issues. The authors concluded the presence of substantial support for CBT use over other treatment approaches for anxiety disorders in children. Improvements in outcomes were found with the use of CBT compared with no treatment, other psychosocial treatment, or medication treatment for obsessive-compulsive disorders. Improvement was also noted in depressive symptoms with the use of CBT. Its effect was similar to the use of other psychotherapies but greater than the effectiveness of medications alone. CBT was effective in improving disruptive classroom behaviors, aggressive/antisocial behaviors, and attention deficit hyperactivity disorder, but was not superior
to pharmacological intervention for these conditions. CBT was inferior to other psychotherapies for smoking and substance use. Finally, while there was limited information present for the use and efficacy of CBT for juvenile sex offenders, childhood sexual abuse survivors, childhood obesity, fecal incontinence, and juvenile diabetes, preliminary results showed that CBT was more effective than no treatment. However, there was no support for CBT over other psychosocial treatment approaches, such as interpersonal therapy and family systems therapy, a finding that is consistent in research.

In consideration to children, Hofmann et al. (2012) concluded that CBT individualized for this specific age group is highly efficacious and more effective than pharmacological therapy for internalizing disorders; however, CBT yielded mixed results for externalizing disorders. One limitation of Hofmann et al.’s (2012) study is that the authors did not present the statistical data regarding the strength and validity of the studies reviewed, or the statistical support for the conclusions given. In conclusion, this review provides overall support for CBT in the promotion of positive mental health behaviors as well as a psychosocial treatment option for a variety of ages and conditions. This meta-analysis is appropriate to consider for implementation of the COPE for Children program, because the sample of children participating in the scholarly project did not have a specific mental health diagnosis.

Watanabe et al. (2007) conducted a systematic review of randomized-controlled trials to determine the benefit, harm, and cost-effectiveness of psychotherapies over no treatment, waiting-list control, attention-placebo, or treatment as usual for children. Recent guidelines from the National Institute of Clinical Excellence supported the use of psychotherapy such as CBT as first-line management of depression in children. The authors conducted this meta-analysis as a
result of these guidelines and because of the lack of up-to-date reviews including randomized controlled trials.

Watanabe et al. (2007) began by conducting a search of the Cochrane Collaboration Depression, Anxiety and Neurosis Registers, which includes the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, CINAHL, PsychINFO, PSYNDEX, and LILACS as well as a variety of psychiatric and medical journals. Inclusion criteria included age between six and 18 years and a diagnosis of major depression, minor depression, dysthymia, or positive scoring on a depression severity scale. Psychotherapies excluded from review included family therapy and counseling. The initial search resulted in 1079 articles, 27 of which were eligible for review after meeting inclusion criteria. These 27 articles included 35 randomized controlled trials (as some of the articles analyzed several studies) comprised of 1744 participants, the majority of which were female (64%); children (81%); recruited in the school setting (54%); and suffering from mild to moderate symptoms of depression (79%). Several of the studies addressed more than one type of psychotherapy in their analysis. Of the psychotherapies included in the overall review, 25 examined CBT; two examined cognitive therapy; three examined behavioral therapy; two examined interpersonal therapy; and each of the following were represented by one study: problem-solving therapy, supportive therapy, and another unidentified therapy.

Results of statistical analysis revealed 49.6% of participants in the psychotherapy group and 34.8% of participants in the control group responded to treatment with a decrease in depressive symptoms. Psychotherapy was superior to the use of the participants’ usual therapy in the control group in reducing depressive symptoms, resulting in a favorable effect of psychotherapy (Relative Risk (RR) 1.39, 95% CI [1.18-1.65], $p = 0.0001$). Studies involving the use of CBT made up the predominant body of evidence for this review. CBT was reported to be
more effective than the control group therapies (RR 1.38 [1.14-1.66], \( p = 0.0009 \)). However, in studies with follow up, there were no significant difference between psychotherapy (including CBT) and control therapies at one to six months (RR 1.19 [0.94-1.47], \( p = 0.15 \)) and at six to twelve months (RR 0.95 [0.82-1.09], \( p = 0.43 \)). Using funnel plot analysis and Egger regression methodology, publication bias was judged as being statistically significant (\( p < 0.001 \)); however, the trim-and-fill adjustment method was applied and resulted in an RR of 1.23, indicating despite publication bias, psychotherapy such as CBT was still superior to the control group.

Watanabe et al. (2007) concluded that psychotherapy, especially CBT, was superior to waiting list, attention placebo, and treatment as usual controls for the improvement of minor and major depressive symptoms. However, while post-therapy results were significantly better for psychotherapy, follow-up evaluation did not reveal psychotherapy to be more effective than control status. Strengths of Watanabe et al.’s (2007) review included the thorough methodology of the literature search. In addition to the organized and methodical process of meta-analysis, the authors provided exhaustive and meticulously appraised evidence. Also, to address the limitation of the publication bias in the study, the authors provided statistical data that counteracted the impact of publication bias on the overall results. Another limitation is some of the psychotherapies and control conditions in this review are not classified as in other reviews that were conducted previously. There is no explanation of why the classification was omitted. Finally, while others acknowledged psychotherapy was no more effective than the controls at follow up, there was no report regarding adverse effects and long-term effects of psychotherapy, although previous research has shown this should be considered. Overall, this meta-analysis provided support to the premise that CBT is effective for improving depressive symptoms, while the authors encouraged further research regarding implementation of psychotherapy.
interventions that have shown significant improvement in the reduction of depressive symptoms upon follow-up.

A second meta-analysis to be considered is an up-to-date review of randomized controlled trials (RCTs) by James et al. (2015) regarding the effectiveness of CBT and/or medication for the treatment of childhood anxiety symptoms and disorders. The authors recognized that anxiety symptoms and disorders are becoming more prevalent and there is often a lack of appropriate diagnosis and treatment provided to these individuals. Therefore, the review was conducted to provide evidence that will guide the treatment of anxiety disorders, because there are no current specific guidelines regarding psychotherapy compared to medication therapy for the treatment of anxiety in children. The meta-analysis also addressed the overarching question regarding the effectiveness of CBT for anxiety, and further explored the efficacy of different types of CBT (e.g. individual, group and parent/family); the value of CBT alone or CBT combined with medication; and the long-term effects of CBT on anxiety.

James et al. (2015) identified RCTs for their review from the studies and references registers of the Cochrane Depression, Anxiety and Neurosis Group. This database holds over 31,500 reports of studies regarding depression, anxiety, and neurosis. In addition, a search of MEDLINE, MEDLINE In-Process, textbooks related to psychiatry and anxiety in children, and a variety of mental-health related journals not published online until 2004 was conducted to complement the above database search. In addition, the reference list of all identified articles were examined for additional findings. Inclusion criteria included the study being a RCT of at least nine sessions of CBT; the CBT included direct contact with the participants; participants’ ages were 5 to 18; and the participants met current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for all anxiety disorders except post-traumatic stress disorder (PTSD);
simple phobias, elective mutism, and obsessive compulsive disorder (OCD) (James et al., 2015). Other comorbidities excluding anxiety-related disorders were allowed, and all research settings were included. Exclusion criteria included the above-mentioned anxiety disorders because PTSD and OCD were addressed in a different Cochrane review, and trials had previously established CBT as effective treatment for simple phobias. Another exclusion was individuals with learning disabilities. The above search produced 41 studies with a total of 1806 participants, 1034 of which were participants in CBT, and 921 controls. Scales and instruments identified in the reviewed articles measuring anxiety symptoms had demonstrated appropriate psychometric validity and reliability (James et al., 2015).

Statistical analysis of several outcomes was addressed. The first group of findings was related to the comparison of CBT to a waiting list control. In regards to remission of anxiety symptoms, 58.9% of participants involved in CBT and 16% of the control participants responded with remission of their anxiety symptoms (OR 7.85, 95% CI 5.31 to 11.60). Seventy-two percent of the studies reported a clear benefit to the use of CBT for anxiety. Evidence of heterogeneity ($I^2 = 33\%, X^2 = 55.24, d.f. = 31, p = 0.04$) was identified with the following variability noted: participant age (1.06%); sex (5.32%); level of comorbidity (6.7%); initial level of anxiety (5.5%); and number of CBT sessions (0.23%). The outcome of reduction in anxiety symptoms also attained statistical significance with a standard mean difference of 0.98 (95% CI -1.21 to -0.74, $Z = 8.20, p < 0.00001$). Similar to the studies reviewed by Watanabe et al. (2007), in the investigations examining long-term follow-up of control and CBT participant individuals there were no significant differences found for the remission of anxiety diagnosis (OR 3.22, 95% CI 0.96 to 10.75, $Z = 1.90, p = 0.06$ ($I^2 = 38\%$) or for reduction in anxiety symptoms (SMD = -
1.55, 95% CI -3.22 to 0.11, \( Z = 1.83, \ p = 0.07 \)). However, there was great heterogeneity (Chi\(^2\) = 49.69, d.f. 3, \( p = 0.00001 \), I\(^2\) = 94\%) (James et al., 2015).

The second comparison in the reviewed literature was CBT compared to active controls. In regards to remission of the anxiety diagnoses (OR 1.51, 95% CI 0.77 to 2.96, \( Z = 1.21, \ p = 0.23 \)), the outcome of reduction in anxiety symptoms (SMD = -0.50, 95% CI -1.09 to 0.09, \( Z = 1.66, \ p = 0.1 \)), and the reduction in anxiety symptoms after long-term follow-up (SMD = -0.92, 95% CI -2.12 to 0.29, \( Z = 1.49, \ p = 0.14 \)), no significant differences were found for CBT over the control groups. However, the use of CBT was more effective than the active controls in eliciting remission of anxiety diagnoses at long-term follow-up (OR 2.03%, 95% CI 1.22 to 3.36, \( Z = 2.74, \ p = 0.006 \)) (James et al., 2015).

The third comparison examined CBT compared to treatment as usual. In this study, treatment as usual could include play therapy, family therapy, and other psychological therapies that did not have any similar methods to CBT. Remission of the anxiety diagnoses (OR 0.53, 95% CI 0.23 to 1.25, \( Z = 1.03, \ p = 0.3 \)) and reduction of anxiety symptoms (SMD = -0.19, 95% CI -0.79 to 0.40, \( Z = 0.64, \ p = 0.52 \)), were not significantly different for CBT over the controls. There were no studies in this comparison group addressing the long-term follow-up component. CBT and medication and CBT and combination treatments were compared because there was only one study addressing these factors (James et al., 2015).

In summary, James et al. (2015) reported that the analysis provided support for the use of CBT in the treatment of anxiety disorders in the pediatric population. They recognized that while CBT was not shown to be more effective than other active controls, it was more effective than waiting list controls, and was effective overall for the treatment of anxiety disorders and symptoms. Strengths of this study include the wide variety of demographic characteristics of the
participants, the realistic inclusion of comorbidities into the analysis, and the extensive and thorough literature search methodology. Limitations of this study included a lack of information allowing comparisons of CBT to medication therapy, and failure to include individuals with learning disabilities (James et al., 2015). This last point is of importance in relation to the scholarly project reported in this document because it is highly likely there will be one or more participants with learning disabilities in the sample of individuals identified for the project. Therefore, it would have been helpful to have support for the use of CBT in children with learning disabilities (James et al., 2015). In conclusion, this review provides support for the use of a CBT program such as the COPE for Children in a group of young children.

**School-Based Intervention**

Rationale and brief literature support for a school-based intervention were included in the introduction to this project report. However, a further summary of the analysis of the efficacy of a school-based intervention will be provided. Mychailyszyn et al. (2012) conducted a meta-analysis in recognition of a gap in care regarding the high prevalence of anxiety and depression in children, strong support of evidence-based treatments for these conditions, a lack in provision of services to these individuals, and a lack of services promoting mental health. While there have been previous meta-analyses regarding the use of CBT in school-aged children, no detailed review had been conducted that was strictly focused on the use of interventions for anxiety and depression in the school-based setting.

Mychailyszyn et al. (2012) searched PsycINFO and PubMed online databases for studies published from 1990 to 2009. The final search was completed on June 1, 2010. The authors addressed publication bias of the “file drawer problem” which refers to “the notion that studies capable of being retrieved and included in a meta-analysis are not likely to be a random sample
of all studies conducted” and worked to counteract this effect by including relevant unpublished
studies and by calculating the appropriate “number of studies with a small magnitude effect size
that would be needed to reduce the mean effect size to a specified criterion level” (Mychailyszyn
et al., 2012, p. 134). Inclusion criteria for identified studies included the use of a CBT
intervention focused on anxiety and/or depression in a school setting; participants had to be in
kindergarten through twelfth grade; there had to be presence of statistical data either in the article
or there was access to the data by contacting the authors of the studies; and the study had to be
written in the English language. Exclusion criteria included the lack of a control group
(Mychailyszyn et al., 2012).

Upon review of the results from the search, Mychailyszyn et al. (2012) identified 63
relevant and appropriate studies, conducted in 11 countries, in which a total of 8,225 participants
received a CBT intervention and 6,986 participants were in comparison groups. Some studies
used interventions addressing both anxiety and depression. Therefore, 7,885 participants took
part in anxiety-focused interventions and 9,727 participants were involved in depression-focused
interventions. In concordance with the above mentioned efforts to prevent publication bias, the
authors conducted subgroup analysis of the standardized mean gain (SMG) effect size because
the homogeneity results revealed that the true effects varied for both anxiety-based studies (Q =
228.73, I² ~ 90%, p < 0.0001) and for depression-based studies (Q = 128.11, I² = 75%, p <
0.001). For assessment of anxiety symptoms in participants involved in a CBT intervention, the
pre-post SMG effect size evaluation of reduction of these symptoms was 0.50 (95% CI 0.40 to
0.60, p < 0.001). This SMG effect size points to a conclusion that individuals involved in a CBT
intervention display a greater improvement in their anxiety symptoms than those in the control
group (Z = 3.50, p < 0.001). Similarly, for assessment of depressive symptoms in participants
involved in a CBT intervention, the pre-post SMG effect size evaluation in the reduction of these symptoms was 0.30 (95% CI 0.21 to 0.40, \( p < 0.001 \)). These statistics indicated individuals involved in a CBT intervention had greater improvement in their depressive symptoms compared to those in the control group (\( Z = 3.56, p < 0.001 \)).

In the studies addressing long-term follow-up, those receiving the CBT intervention had continued improvement of anxiety symptoms at three months (SMG = 0.67, 95% CI 0.43 to 0.91, \( p < 0.001 \)), six months (SMG = 0.57, 95% CI 0.39 to 0.75, \( p < 0.001 \)) and twelve months (SMG = 0.68, 95% CI 0.47 to 0.89, \( p < 0.001 \)). However, CBT interventions were only more effective than the control group therapies for reducing the level of anxiety-symptom at three months (\( Z = 0.68, p < 0.001 \)). Similarly, for studies that explored effectiveness for depressive symptoms, improvement for participants involved in CBT interventions were evident at three months (SMG = 0.44, 95% CI 0.27 to 0.61, \( p < 0.001 \)), six months (SMG = 0.57, 95% CI 0.39 to 0.75, \( p < 0.001 \)) and twelve months (SMG = 0.68, 95% CI 0.47 to 0.89, \( p < 0.001 \)). However, only at six months were the CBT-treated individuals demonstrating greater improvement of depressive symptoms than the control group (\( Z = 2.96, p < 0.01 \)) (Mychailyszyn et al., 2012).

Several other conditions were analyzed and found to yield no differences, but are worth mentioning to further document the strength of the CBT intervention and its relationship to the outcomes for the symptoms of depression and anxiety. No differences in results were found when comparing the facilitators (teachers, research staff, etc.) who conducted the intervention (\( Z = 0.38, p > 0.05 \)). In addition, the authors divided the interventions into low dose and high dose dependent upon the time spent in implementation. Low dose interventions averaged a total of 354.87 minutes and high dose interventions averaged a total of 682.50 minutes. However, comparison of these two categorizations revealed that there were no significant differences in
reduction of symptoms based on the time allocated ($Z = 0.08, p > 0.05$). Finally, neither age ($Z = 0.79, p > 0.05$) nor gender ($Q = 0.08, p > 0.05$) were factors related to improvement of symptoms (Mychailyszyn et al., 2012).

A limitation of this meta-analysis is the lack of specification of the type of trial (such as a RCT) for the studies used. This is common for meta-analyses. In addition, many of the studies had small sample sizes, which provided limitations on the level of evidence produced from these studies. The methods used in analysis and the attention to publication bias were strengths of the research. Mychailyszyn et al. (2012) concluded that this meta-analysis provided moderate support for the use of CBT in the reduction of anxiety symptoms and mild support for the reduction of depressive symptoms when implemented in the school-based setting. Overall, CBT intervention programs in the school-based setting provided improvement in depressive and anxiety symptoms and facilitation of positive mental health behaviors above that of general prevention programs and protocols. In addition, it was a surprise to the authors that the timeframe of the intervention did not alter the effectiveness of the program in reducing anxiety and depressive symptoms. The authors also concluded long-term follow-up after the intervention failed to reveal significant changes in symptoms of depression and anxiety. However, there is a need for continued facilitation of interventions that will promote mental health and keep anxiety and depressive symptoms at the reduced level (Mychailyszyn et al., 2012).

**Background of the Creation of COPE**

Melnyk’s work to develop different variations of the COPE program was the result of several decades of testing CBT interventions with families and children. Initial work in the 1980s included the assessment of coping behaviors and levels of anxiety in hospitalized children and
their parents (Vulcan, 1984; Vulcan & Nikulich-Barrett, 1988). The work evolved into the exploration of strategies and interventions to reduce adverse effects related to the hospitalization of a child (Melnyk, 1994). The first COPE program (Creating Opportunities for Parent Empowerment) was developed and pilot-tested in 1997 and focused on parents who had a child admitted to a hospital (Melnyk et al., 1997). Over the next several years, Melnyk developed three different versions of the Creating Opportunities for Parent Empowerment program: COPE for parents of young hospitalized children ages one to seven; COPE: Pediatric Intensive Care Unit (PICU) for parents of critically ill children aged two to seven; and COPE: Neonatal Intensive Care Unit (NICU) for parents of low-birth-weight premature infants (Melnyk et al., 2006).

According to Melnyk et al. (2006), these programs consist of a theory-based educational-behavioral program that targets the following: parental understanding of their hospitalized child’s emotional, behavioral, and physical response to illness, trauma, and hospitalization; parent and child response to a loss of typical parental role; and recommendations for how to help the parent and child deal with the stressors related to their hospitalization.

Melnyk et al. (2006) put together a summarization and appraisal of two decades of information and evidence that was collected regarding the use of CBT as well as the results of multiple randomized controlled trials providing rationale and support for the use of this type of CBT intervention. These studies reported the improvement of child mental health outcomes with the use of the CBT intervention. Therefore, with the growing prevalence of mental health conditions and symptoms in children, this synthesis supported recommendations for the use of such a program on a routine basis for children, to facilitate the prevention and improvement of these conditions and symptoms (Melnyk et al., 2006).
At the same time that Melnyk was studying and publishing information regarding the Creating Opportunities for Parental Empowerment program, she was involved in publications exploring the growing concern of mental health disorders in children (e.g., Melnyk et al., 2001; Melnyk et al., 2003; DiMarco & Melnyk, 2009) as well as research addressing pediatric overweight and obesity (e.g., Jerum & Melnyk, 2001; Small et al., 2007; Melnyk et al., 2008). It is logical that the work with the COPE programs and the work regarding pediatric mental health would merge. Therefore, while the research specific to the COPE program is relatively recent, Melnyk utilized decades of experience regarding the topic and type of intervention, as well as for support and rationale for the development of the program.

**Creating Opportunities for Personal Empowerment (COPE)**

Several variations of the COPE program have been developed based upon the age of the participant. COPE for Children is for individuals aged seven to eleven. COPE for Teens can be administered to children aged 12 to 18. COPE for Young Adults is designed for use for individuals aged 18 to 24. Finally, COPE Healthy Lifestyles TEEN is an expanded version of the COPE for Teens program, which includes an additional eight sessions focusing on healthy nutrition and physical activity. Currently, the COPE for Teens program is also available in an online self-administered program (COPE, 2015). A thorough description of all studies addressing the above variations of the COPE program will be provided. However, only statistical analysis of the first seven sessions of the program will be reported because they are the only portions of the program used in this scholarly project.

**Initial Efficacy Studies of COPE Healthy Lifestyles TEEN**

The COPE Healthy Lifestyles TEEN program was initially tested in a two-phase clinical trial conducted by Melnyk et al. (2007). The first portion of the study was a Phase I clinical trial,
which used a pre-experimental design and included a convenience sample of 11 overweight adolescents between the ages of 15 and 18 from an urban high school in New York. The trial was designed to determine whether or not the new intervention was reasonable to implement, as well as the feasibility of the teens providing the necessary measurement outcome data and evaluation information regarding the intervention (Melnyk et al., 2007). All of the adolescents in the Phase I clinical trial were to attend an after-school program. However, over half of the sample did not attend the program regularly or at all, reporting after-school conflicts. Also, none of the parents for this group participated in the COPE Parent Sessions. The Phase I trial findings indicated that the timeline for implementation and the amount of time dedicated to implementing the sessions was feasible to conduct this type of intervention. However, the authors recognized that an after-school program caused attrition due to conflicts of other activities. This trial also supported that the program is appropriate to be used in a group of high-school aged adolescents (Melnyk et al., 2007). Melnyk et al. (2007) also reported positive feedback from the participants of the Phase I trial, providing support for the further use of this program with this population. However, no specific feedback was discussed in the article.

Phase II was a randomized controlled pilot study including a convenience sample of twelve overweight adolescents and their parents from a suburban high school in New York (Melnyk et al., 2007). The research team recruited the participants by distributing brochures describing the program at the school’s cafeteria. Those interested in the study completed screening questionnaires and consents, and parents were contacted to provide consent for the adolescent to participate in the study. Inclusion criteria consisted of age between 15 and 18 years old, and a body mass index (BMI) greater than or equal to 25 (Melnyk et al., 2007). Over a nine-week period, seven of the adolescents received the COPE Healthy Lifestyles TEEN
program while their parents received four sessions providing them with education and information related to the COPE program. During the same period of time, the other five participants participated in a control intervention program while their parents took part in four sessions providing education about adolescent safety (Melnyk et al., 2007). The only measurement variable for the control group was weight change as measured by BMI calculations.

The intervention group reported a total of 32 pounds in weight loss, while the control group reported a gain of 11 pounds after the program. Therefore, the participants in the COPE Healthy Lifestyles TEEN program experienced a decrease in weight and BMI compared to the control program ($p = 0.03$). Six of the seven adolescents in the intervention group completed all of the sessions and responded to the post-intervention survey, and all COPE parents attended the COPE Parent Sessions. The article did not report any specific parent feedback. The researchers found that students felt after-school programs were difficult. However, the program was effective and beneficial to them and other teens, and there was an increase in adolescent-parental dialogue regarding positive, healthy-lifestyle choices. This pilot study helped build a basis for future studies that included this intervention (Melnyk et al., 2007).

While research shows parental involvement increases effectiveness of such interventions, the researchers recognized the difficulty of coordinating parental involvement into a school-based program. They also recognized the difficulty of recruiting adolescents, as well as a need for creative strategies to improve sample size and program completion. While this study does not specifically address outcomes from the first seven sessions of the COPE program, it provides feedback from the adolescents about the program: it helped with “learning how to cope with stress”; it assisted them in “getting tools to make the right decisions” (Melnyk et al., 2007, p.
The students also reported that the program provided an increase in positive cognition and confidence (Melnyk et al., 2007).

Another article providing information regarding the initial efficacy of the COPE program is a 2009 publication by Melnyk et al. The authors provide a report of a two-group cluster randomized controlled pilot study with pre-intervention and post intervention measures. This was the first pilot study of the intervention to provide statistical evidence for the efficacy of the COPE program for improvement and promotion of mental health. Nineteen Latino children with a mean age of 15.5 were recruited from a required health course in a predominantly Hispanic high school located in a metropolitan southwest city in the United States. The students provided assent to participate and provided written consent from their parents for participation in the program. There were two sections of the course provided at the school, and random assignment to groups was conducted by flipping a coin to determine which class received the COPE Healthy Lifestyles TEEN program and which group received the control program. The control program consisted of educational material focusing on health concerns common to the identified population, such as acne, overall safety, first aid, and health-profession career information (Melnyk et al., 2009).

Seventeen of the participants recruited to the study completed baseline and post-intervention data. The overall outcome variables included healthy lifestyle choices and mental and physical health outcomes. Scales used to measure these outcomes included the Healthy Lifestyles Beliefs Scale (HLBS) (Melnyk, Kelly, & Belyea, 2010), Nutrition Knowledge Scale (Dickson-Spillmann et al., 2011), Healthy Lifestyles Choices Scale (HLCS) (Kelly et al., 2010), Beck Youth Inventory, 2nd ed. (BYI II) (Beck et al., 2005), anthropometric measures and
laboratory work. Statistical analysis was comprehensive. Results specific to the first seven sessions of the COPE program are discussed further.

Recognizing the small sample size, and in order to emphasize the aspects of the program that were potentially worthwhile, a p-value < 0.10 was used for gauging statistical significance. This is one of the only COPE Healthy Lifestyle Teen intervention studies analyzed in this literature review that showed no improvement in depressive symptoms as measured by the BYI-II in either of the intervention groups (COPE: Pre-test mean = 53.25, SD = 13.06; Post-test mean = 50.64, SD = 9.87; Cohen’s d -0.32, p = 0.11) (Control: Pre-test mean = 51, SD = 11.06; Post-test mean = 52.17, SD = 15.33; Cohen’s d 0.15, p = 0.20). Therefore, in this study, the COPE intervention was not effective in decreasing depressive symptoms. However, Melnyk et al. (2009) reported a greater increase in healthy behaviors on the Choices Scale (COPE: Pre-test mean = 54.5, SD = 5.84; Post-test mean = 58.91, SD = 10.25; Cohen’s d 0.48, p = 0.07) (Control: Pre-test mean = 57.14, SD 9.97; Post-test mean = 61.83, SD 12.51; Cohen’s d 0.41, p = 0.20) and decreasing anxiety (COPE: Pre-test mean = 54.83, SD = 12.45; Post-test mean = 50.64, SD = 8.72; Cohen’s d -0.56, p = 0.03) (Control: Pre-test mean = 50.14, SD 13.46; Post-test mean = 48.33, SD 10.41; Cohen’s d -0.20, p = 0.20) for the COPE program over the attention control group.

Considering the initial findings, it would have been appropriate for the researchers to conduct a longitudinal study to determine if there were any changes in the depressive symptoms over time. This would have been possible because Melnyk et al. (2009) report that other research suggests that an increase in healthy lifestyle behaviors and beliefs will improve depressive symptoms over time. Limitations in this pilot study, including a small convenience sample, cluster randomization and the method with which the researchers randomized, and
limiting assessment to short-term outcomes suggest that there is an indication for further study of the intervention in the Latino population. In addition, this was only the second research study of the COPE intervention. Considering the newness of the intervention, there may have been some inexperience by the researchers in implementing the interventions. If the study would have been conducted again after the researchers had gained more experience using the intervention, there may have been different results. On the positive side of the findings, no risk or harm came to the participants as a result of the intervention.

**Continued Research Supporting the COPE Program**

After the initial pilot studies reported successful use of the COPE program as a CBT intervention, Lusk and Melnyk (2011b) conducted a study to determine whether or not COPE was feasible and effective in other settings. Therefore, the researchers used a one group pre-experimental pre- and post-test design with follow-up assessment to determine if it was possible to implement the seven-session COPE intervention to depressed children in a community mental health clinic during their 30-minute outpatient visits (Lusk & Melnyk, 2011b). This study was innovative because many providers are unable or unwilling to complete appropriate CBT interventions during short patient visits. As with other studies using this intervention, the authors provided theoretical support for this intervention using Beck’s Cognitive Behavior Theory (Lusk & Melnyk, 2011b).

Fifteen Caucasian children between the ages of 12 and 17 were recruited during their initial face-to-face intake assessment and interview at a community mental health center. If the teen reported any symptoms of depression, the recruiter invited him or her to participate in the study. If there was interest in the program, education was provided to the teen and his/her parent(s). Due to the lack of cultural diversity in the sample of 15 white, non-Hispanic
participants, the researchers conducted a local community high-school demographic analysis, finding that 85% of the community’s students were white, non-Hispanic. This analysis provided explanation of the lack of cultural diversity in the recruited sample (Lusk & Melnyk, 2011b).

The overall outcome variable for the study was improvement in depressive symptoms, which included depression, anxiety, anger, destructive behavior, self-concept, and personal beliefs. Scales used included the Personal Belief Scale-Teens (PBS) (Embree & Embree, 1993), Beck Youth Inventory 2nd ed. (BYI-II) (Beck et al., 2005) and post-COPE program evaluations. A p-value of 0.05 was used for determining statistical significance. Participants showed a significant decrease in scores on the depression subscale of the Beck Depression Inventory (BDI) from pre-COPE ($M = 58.33$, $SD = 11.80$) to post-COPE ($M = 46.13$, $SD = 7.47$) with a mean decrease of 12.20 in overall score ($95\%$ CI 6.69 to 17.71, Cohen’s $d$ 0.53, $p < 0.005$). In addition, a decrease in scores on the anxiety subscale of the BDI from pre-COPE ($M = 55.20$) to post-COPE ($M = 49.13$) and a mean of 6.07 decrease in overall score (Cohen’s $d$ 0.27, $p = 0.018$) were obtained. Scores on the PBS increased from pre-COPE ($M = 34.73$) to post-COPE ($M = 43.07$), along with a mean increase in overall score of 8.34 (Cohen’s $d$ 0.67, $p = 0.001$). In addition, there was significant improvement in symptoms as evidenced by the scores on all of the subscales (Lusk & Melnyk, 2011b).

Finally, all 15 participants reported in the post-COPE survey that this program was helpful for them in that it helped them focus on positive strengths and less on weaknesses. In addition, the program gave them techniques and skills for dealing with difficult situations and emotions, and helped them improve their relationships. Parents also observed their child to be more positive, confident, and able to handle difficult situations effectively (Lusk & Melnyk, 2011b).
Limitations of this study included the small sample size, lack of cultural diversity of the sample, and the lack of clinic time available to implement the study as a randomized controlled trial. However, this study provides evidence supporting the effectiveness and feasibility for implementation of the COPE intervention in an outpatient setting (Lusk & Melnyk, 2011b). In a follow-up article providing more in-depth information regarding this study’s implications to practice, the authors reported that the advance practice registered nurse (APRN) who conducted this study as part of her Doctor of Nursing Practice (DNP) degree project is in a leadership position at the health center where this study took place (Lusk & Melnyk, 2011a). As a result of the findings of the study, the COPE program has become a standard of care for children who are treated for mental illness such as depression and anxiety in this health center (Lusk & Melnyk, 2011a).

Around the same time, another DNP student was conducting a study for her scholarly project work using the COPE Healthy Lifestyles TEEN program in a rural high school health class (Ritchie, 2011). This pre-experimental study with pre- and post-testing examined the feasibility of using the COPE Healthy Lifestyles TEEN program as an intervention to increase healthy lifestyle behaviors, facilitate stronger beliefs regarding the ability to engage in positive practices, boost self-esteem, increase physical activity, and decrease weight in those who were initially overweight (Ritchie, 2011).

Fifty-five students of an average age of 14.67 years old from a ninth grade health class were enrolled in the program initially, and 49 of those students completed all 15 sessions. Inclusion criteria included obtaining assent from the student as well as written parental consent. Attrition was a result of two students being dismissed from school, two students moving to a
different school, and two students who dropped out because they did not want to continue to participate (Ritchie, 2011).

The measurement tools included in this study to determine outcomes related to the first seven sessions included the following self-report questionnaires: Healthy Lifestyle Behavior Scale for Teens (Kelly et al., 2010); Healthy Lifestyle Belief Scale (Melnyk, Kelly, & Belyea, 2010); Healthy Lifestyle Perceived Difficulty Scale (Kelly et al., 2010); and the Rosenberg Self-esteem Scale (Rosenberg, 1965). Ritchie (2011) used paired sample t-tests to determine the change in outcomes from pre- to post-measurement. The author reported that there was an improvement in healthy lifestyle behaviors as indicated by a 6.13 point increase (t (43) 3.93, 95% CI: 9.28 to 2.99, \( p = < 0.001 \)) in scores on the Healthy Lifestyle Behavior Scale for Teens from pre- (\( M = 51.32, SD = 11.5 \)) to post-program (\( M = 57.45, SD = 9.71 \)) (Ritchie, 2011). In addition, there was a mean increase of 1.13 (\( p = 0.010 \), effect size 1.48) in the level of self-esteem in scores for those who initially scored as low level of self-esteem on the Rosenberg Self-esteem Scale pre- (\( M = 20.41, SD = 5.98 \)) to post-program (\( M = 21.54, SD = 5.63 \)). While there was an improvement on all of the other scales, none of the findings were statistically significant (Ritchie, 2011).

The study was limited by a small convenience sample that was not ethnically or culturally varied. In addition, this study was a one-group pre-experimental study causing for threats to internal validity and a Hawthorne effect. Finally, students in the sample were enrolled in a health class, creating a bias that they were being influenced by other specific health-related topics and education during this program (Ritchie, 2011). However, this study provided support for the scholarly project as it produced evidence that it is feasible to implement the COPE program into the curriculum of a public school in the limited time frame.
Melnyk, Kelly, Jacobson et al. (2013) continued to look into the effectiveness of the COPE program by conducting a four-year prospective randomized controlled trial comparing the short and long term effects of the COPE Healthy Lifestyles TEEN intervention and the Healthy Teens program, both of which address healthy lifestyle habits. The COPE Healthy Lifestyles TEEN intervention is focused on interactive learning and involvement in activities while the Healthy Teens intervention is strictly a distribution of education regarding health information. As a CBT intervention, the authors hypothesized that the COPE intervention would “first strengthen the teens’ beliefs/confidence in their ability to engage in healthy lifestyle behaviors, manage their negative emotions, perform well academically and lessen their perceived difficulty performing healthy behaviors, which in turn, will result in more healthy behaviors, less depressive and anxiety symptoms, and higher social skills” (Melnyk Kelly, Jacobson et al., 2013, p. 42). The authors’ initial article published in 2013 strictly reports the details of the programs, baseline findings, and the method for implementation of the program, while their following article (Melnyk, Jacobson, et al., 2013) reports the overall findings of the study.

Researchers recruited individuals for the study through an invitation to children between the ages of 14 and 16 who were enrolled in a health education course in 11 different high schools located in two districts in the southwestern United States. In addition to the characteristics above, self-assent to the program, consent from a parent or guardian, ability to read and speak English, and parents who could speak and read either English or Spanish were inclusion criteria. The only exclusion criterion beyond the bounds of the inclusion criteria was the presence of a medical condition hindering the individual from taking part in the physical activity portion of the program (Melnyk, Kelly, Jacobson et al., 2013).
The sample included 779 culturally diverse children. Each of the schools was randomly assigned either the COPE Healthy Lifestyles TEEN Program, or the control program, both of which lasted for 15 weeks. Each group of students participated in 15 sessions that lasted 50-57 minutes with the COPE program being comprised of 30 minutes of education and skills building and 20 minutes of physical activity. The Healthy Teens program consisted of 50 minutes of educational content with no interactive or physical activity component (Melnyk, Kelly, Jacobson et al., 2013). Outcome measurement variables identified include healthy lifestyle behaviors, depressive and anxiety symptoms, and social skills. The researchers controlled for acculturation. The scales used to measure the outcome variables included The Acculturation, Habits, and Interests Multicultural Scale for Adolescents (AHIMSA) (Unger et al., 2002); the Healthy Lifestyle Beliefs Scale (HLBS) (Melnyk, Kelly, & Belyea, 2010); the Perceived Difficulty Scale (Kelly et al., 2010); the subjective measurement of healthy lifestyles behaviors; pedometer measurement; Beck Youth Inventory, 2nd ed. (BYI-II) (Beck et al., 2005); BMI (height and weight); Social Skills Rating System (SSRS) (Gresham & Elliot, 2008); Nutrition and Activity Knowledge Scales (Dickson-Spillmann, et al., 2011); Cholesterol measurement; Demographic questionnaire; and the individual's health course grade (Melnyk, Kelly, Jacobson et al., 2013).

Baseline findings reported by Melnyk, Kelly, Jacobson et al. (2013), included the following: (a) more than 40% of the sample was overweight or obese; (b) 15.78% were between mildly and extremely depressed; and (c) 21.57% had mildly to extremely elevated anxiety scores. Limitations of the study included that individuals who were implementing the intervention were teachers of the class who had been trained by the healthcare professionals, rather than the healthcare professionals themselves. Also, only 44% of the children eligible for
the study had parental consent. However, the sample of children who had consent was large in size and culturally diverse (Melnyk, Kelly, Jacobson et al., 2013).

In the article that followed the report of the baseline findings, a dependent variable of substance use and academic performance were added for outcome measurement as well as the Youth Risk Behavior Survey (Centers for Disease Control and Prevention, 2015). Extensive statistical analysis of the outcome measurements was conducted and is available for review in the published article. In alignment with the scholarly project, the details regarding the first seven sessions will be discussed in more depth (Melnyk, Jacobson et al., 2013).

Significant differences were found between the COPE and Healthy Teens program in regards to cooperation, assertion, academic competence, and overall grade in the health course. The adjusted means and 95% confidence intervals of these variables were collected from the article and placed in Table 1 to facilitate understanding of the findings (Melnyk, Jacobson et al., 2013). Due to some of the students not fulfilling all aspects of the programs at the initial post-intervention follow-up, this table includes data from the 320 students who participated in COPE and 377 students who participated in Healthy Teens.

Individuals in the COPE program recorded a reduction in their scores on the depression (pre-intervention $F = 49.00 \, [10.51]$, post-intervention $F = 46.91 \, [8.29]$) and anxiety scales (pre-intervention $F = 46.55 \, [10.20]$, post-intervention $F = 46.57 \, [8.07]$). While these overall scores were not significantly different compared to these in the Healthy Teens program, individuals with elevated depression scores pre-intervention showed greater improvement in the COPE program compared to those in the Healthy Teens program ($F_{1,12} = 6.98, p = 0.02$). There were no significant differences in anxiety or depression between the two programs at the six-month follow-up; however, the COPE program produced positive long-term increases in healthy
lifestyle behaviors regarding weight and reduction in alcohol use. Finally, at the end of the program, 92% of the participants’ parents reported the program was helpful for their child and 94% stated they would recommend the program to others (Melnyk, Jacobson et al., 2013).

Table 1

Comparison of Means and Confidence Intervals of Students in COPE Versus Healthy Teens Program

<table>
<thead>
<tr>
<th>Variable</th>
<th>COPE Adjusted Mean</th>
<th>Healthy Teens Adjusted Mean</th>
<th>COPE 95% Confidence Interval</th>
<th>Healthy Teens 95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperation</td>
<td>15.50</td>
<td>14.59</td>
<td>14.93 to 16.06</td>
<td>14.07 to 15.11</td>
</tr>
<tr>
<td>Assertion</td>
<td>13.30</td>
<td>10.41</td>
<td>12.67 to 13.93</td>
<td>9.81 to 11.02</td>
</tr>
<tr>
<td>Academic</td>
<td>97.97</td>
<td>95.69</td>
<td>96.35 to 99.59</td>
<td>94.21 to 97.18</td>
</tr>
</tbody>
</table>

Overall, this study revealed the feasibility and effectiveness of the COPE program in a large sample of children compared to another program focused on improving healthy lifestyle behaviors. One limitation of the study included a difference of variables such as weight and TV viewing time at baseline, resulting in the authors using these variables as covariates during analyses. Another limitation was that the teachers at the school were implementing the intervention with guidance from the researchers, rather than the researchers personally implementing the intervention. The researchers reported there were occasional instances where
the teachers strayed from the exact program, which may have impacted the results (Melnyk, Jacobson et al., 2013). However, having the teachers implement the COPE program in the school setting has the potential of increasing the number of students who can be impacted by this program.

The teens of this study were once again followed-up with 12-months after the program was completed (Melnyk et al., 2015). The primary outcomes measured at this point in time were BMI and depressive symptoms; however, only the findings related to depressive symptoms will be further discussed here. The researchers found that while scores on the Beck Depression Scale were one point higher for COPE participants than Healthy Teens participants, the average scores for both groups were in the normal range. In addition, for teens that had scored as extremely depressed prior to the start of the program, the Beck Depression Inventory scores of those who participated in COPE were in the normal range at the 12-month evaluation point. Participants in the Healthy Teens program with extreme depression still had scores in the depressed range at 12 months (COPE M = 42.39; Healthy Teens M = 57.90; p = 0.03). Finally, when interviewed 12-months post-intervention, 69.6% of the participants reported that they found the information from the program helpful, 48% reported continued changes in behavior as a result of COPE, and 22.6% reported that their family had made long-term changes as a result of COPE (Melnyk et al., 2015). Limitations of this study included the self-reported data on depression and the fact that only about 50% of the eligible teens participated in the long-term follow up. However, the researchers conclude that the COPE program is effectively implemented by teachers at the school and may be more effective at sustaining the longer-term positive outcomes because they are aware of the concepts addressed in the program and can reinforce these concepts throughout the year in their classroom.
As a follow up, in order to determine the fidelity of this study and the impact that the methodology had on the results, Kelly et al. (2014) conducted research involving the thirty teachers who were involved in the implementation of the COPE and Healthy Teens programs. They reported that there was less fidelity in the COPE teachers than the Healthy Teens teachers, possibly impacting the results of the study (Kelly et al., 2014). The authors contribute this difference in fidelity to the unfamiliarity of the teachers with cognitive behavioral skills building, and the unfamiliar intervention. Kelly et al. (2014) concluded that it is important to assess knowledge and skill development in individuals involved in the program prior to the implementation, as well as to provide constructive feedback during the implementation of the program. As a result, recent adjustments have been made in the rigor of the training to be able to ensure strict adherence to the evidence-based program (COPE, 2015).

Melnyk, Kelly, and Lusk (2013) conducted another school-based study; however, this study was strictly focused on the seven-session program. The study design was a one-group pre-experimental pre- and post-intervention study with a four-week follow-up to assess the feasibility and effectiveness of the COPE for Teens program. Sixteen youth, aged 14 to 17, from two different schools, were referred to the program by a school-based family nurse practitioner after being identified as having depression and/or anxiety. Identified subjects met with the individual conducting the intervention prior to implementation, and were educated regarding the specifics of the group program. If the recruit was interested in the program, he/she signed an assent form as well as provided written consent from a parent (Melnyk, Kelly, & Lusk, 2013).

Outcome measurement variables included depression, anxiety, and belief and confidence about the ability to manage stress and cope with stressors. The scales used to measure the outcomes included the Personal Beliefs Scale: Teens (PBS) (Embree & Embree, 1993); Beck
Youth Inventory II: Depression and Anxiety (BYD: II) (Beck et al., 2005); and a post-COPE program evaluation form. Statistical analysis was conducted with the significant p-value set at < 0.10 due to the small sample size. Participants exhibited an increase in scores on the PBS (pre-intervention: $M = 32.9$, $SD = 3.9$; post-intervention $M = 37.3$, $SD = 6.2$; $p < 0.005$) with a positive moderate effect as evidenced by the Cohen’s $d$ statistic of 0.83. In addition, a decrease in depression scores was reported on the BYI II: Depression immediately post-intervention (pre-intervention: $M = 58.5$, $SD = 7.2$; post-intervention $M = 54.1$, $SD = 8.8$; $p = 0.068$) and at the four-week follow-up ($M = 53.5$, $SD = 8.4$; $p = 0.024$) with a moderate effect (Cohen’s $d$ statistic of 0.56) at the immediate post-intervention assessment, and large positive effect as evidenced by Cohen’s $d$ statistics of 0.83 four weeks post-intervention. In addition, the authors reported a decrease in anxiety scores on the BYI II: Anxiety (pre-intervention: $M = 55.5$, $SD = 9.6$; post-intervention $M = 49.9$, $SD = 9.4$; $p < 0.063$) with a positive moderate effect (Cohen’s $d$ statistic of 0.59). There were no significant findings from the pre-intervention findings to the four-week follow-up on the PBS or the BYI II: Anxiety (Melnyk, Kelly, & Lusk, 2013).

In addition to the measured outcomes of the program’s effectiveness, the post-intervention survey yielded positive comments from all of the participants. Some of the main topics identified by the survey included an increase in developing skills to change overall thinking, manage stress, appropriately cope with life problems, use relaxation techniques such as deep breathing and imagery, and increase emotional regulation. Specific comments from participants included “It helped me think more positively and that helped a lot”, and “I learned how to cope with stress” (Melnyk, Kelly, & Lusk, 2013, p. 9).

Limitations of the study include a small sample size, lack of ethnicity-specific demographic data, and a lack of a control group, which can threaten internal validity. The
authors also recognized follow-up greater than four weeks post-intervention would have been appropriate and helpful in determining the long-term effects of this program. The outcome measurements are simple and specific, which can be a strength for data analysis. Overall, this study provided evidence-based support for the use of a group-implemented version of the seven-session COPE program.

Another recent study published regarding implementation of the COPE program was conducted in a rural primary care clinic as a result of a provider feeling helpless while seeing children with symptoms of anxiety (Kozlowski et al., 2015). The provider wanted to know what cognitive behavioral interventions were available for a pediatric nurse practitioner without psychotherapy training to effectively implement into the usual clinic schedule. Upon review of the literature, the COPE for Children program was identified as being effective and feasible for a pediatric nurse practitioner to implement (Kozlowski et al., 2015). Therefore, the first author conducted a pre-experimental, one-group, pretest and post-test design to determine whether or not the COPE for Children program would fit the needs of the children she was caring for (Kozlowski et al., 2015).

Fourteen children ages 8 to 13 were selected as a convenience sample to participate in the program. Children with a current diagnosis of anxiety recorded on their medical record or meeting DSM-V criteria for an anxiety disorder at the time of their visit to their pediatric health care provider were included (Kozlowski et al., 2015). After individuals were identified as potential candidates for the study based on the above criteria, they were administered the Screen for Child Anxiety Related Disorders (SCARED) (Birmaher et al., 2015) tool to complete alone or with the help of a parent. A score of higher than 25 on the SCARED tool identified the children as having current anxiety symptoms and they were included as participants in the study.
Exclusion criteria included the presence of mental retardation, psychosis, or current suicidal thoughts. Almost half of the participants were below the age of 10 and there were more females than males. The identified individuals and their parents met with the pediatric nurse practitioner and were given information and education regarding the program. If they voiced interest, the child signed an assent form and the parent signed a consent form. The practitioner then set up weekly appointments with the child for each session and administered the pre-intervention measurement tools. The child attended the session with the practitioner, and the parent was present for review of the homework/skills building assignments (Kozlowski et al., 2015). Of the 14 participants, eight had a current diagnosis of generalized anxiety disorder and six were identified through a visit with their primary care provider. In addition, eight of the individuals had current pharmacological treatment that continued during the study while six participants did not. Unfortunately, only eight participants completed the program in its entirety (Kozlowski et al., 2015).

Outcome measurement variables included symptoms of anxiety and feelings about the COPE for Children Program. In addition, a demographic data questionnaire, pre- and post-intervention content quiz to assess the cognitive skills knowledge, the SCARED tool, and the Clinical Global Impression Scale (CGI-1) were completed (Kozlowski et al., 2015). Of the eight individuals who completed the entire program, there was an average improvement of 13.88 points on the SCARED tool with the scores before the intervention ranging from 23 to 69, and the post intervention scores ranging from 17 to 44 ($p = 0.07$, SD = 17.96, 95% CI -1.13 to 28.89). At the end of the program, all of the participants reported being much improved (37.5%) or very much improved (62.5%) on the CGI-1 (Kozlowski et al., 2015).
Pre- and post-intervention content quiz showed an average increase of 2.27 points ($p < 0.001$), suggesting “that these children learned the skills necessary to help manage their anxiety, hopefully for the long term [as] literature states that improvement in anxiety symptoms after treatment has been followed up longitudinally up to six years” (Kozlowski et al., 2015, p. 280). In addition, at the end of the program, 50% of the individuals no longer met DSM-V criteria for an anxiety disorder diagnosis. Finally, the authors reported several comments from both children and parents regarding the success and helpfulness of the program. A few examples of these comments included: “It helped me to calm down and think better”; “[I] learned how to handle things”; and “I think in the present now, not in the past or the future. I worry less” (Kozlowski et al., 2015, p. 280). All of the participants and their parents reported positive thoughts about the impact of the healthcare clinic as well as reporting that the COPE for Children program was helpful in teaching how to positively think, feel, and behave (Kozlowski et al., 2015).

Internal validity threats limiting the study include a small sample size and the attrition rate of 43%. The authors reported that the program fit well into the fast-paced environment of a pediatric health care setting, while also producing high levels of reimbursement due to the amount of time spent in counseling. In addition, the pediatric nurse practitioner at this clinic continues to deliver the COPE for Children program to her patients, averaging four sessions a week. She continues to receive positive feedback and similar results as were reported in the above study (Kozlowski et al., 2015). This study provided evidence-based support for the scholarly project, as there was successful use of the COPE for Children in a sample of children of similar ages (eight to ten year-olds) to those who were included in this DNP student’s project.
Synthesis of Literature Review

As demonstrated by the above synthesis of literature, it is apparent that there is significant evidence-based support for the use of CBT interventions when implemented in the school setting. In regards to the COPE for Children program itself, while the published, peer-reviewed articles regarding research of this program are limited in number, the COPE/COPE Healthy Lifestyles TEEN program is being implemented as an evidence-based intervention in many settings, including large school districts. For example, several classrooms consisting of around 100 students each at Huntington Middle School in Chillicothe, Ohio have gone through the program as part of their school curriculum (Pyle, 2013). Strengths of the published studies regarding the COPE/COPE Healthy Lifestyles TEEN program included the consistency of the researchers as well as the creator of the intervention being a member of each research team. This may also be seen as a limitation, as there could be some bias as a result of her frequently being involved in the studies. Further implementation of this intervention by varied project teams may prove additional insight into this possible bias.

As seen by the above evaluations and statistical data analysis, there is a significant improvement in symptoms of depression and anxiety with the use of CBT in the majority of the studies. The variety of study designs also provides support for the COPE/COPE Healthy Lifestyle TEEN program above other various interventions. The clinical trial and pilot study for the intervention were not convincingly strong in support of the use of the intervention; however, further studies helped to resolve several concerns identified in the pilot study (Melnyk et al., 2007). One study did not show improvement in depressive symptoms; however, the limitations and the sample need to be recognized before disregarding the intervention as a result of that study (Melnyk et al., 2009). The measurement scales used to measure the outcome variables
were valid and have been proven reliable over the years; therefore, their use strengthens the statistical results. Later studies report that a large number of children can be effectively impacted through implementation of this intervention. Successful use of a large sample size provides reassurance of increased accessibility through the use of COPE for Children in the school setting. In addition, recent studies have supported the use of the COPE for Children in eight to ten year olds, which is the age group of children included in the scholarly project. Finally, large school districts, such as the one in Chillicothe, Ohio have implemented this program on a large scale with positive comments from teachers and children as well as a lack of evidence of harm to the participants (Pyle, 2013).

Summary

The studies identified through this literature review provided an evidence base to support the continued implementation of the CBT-based COPE 7-Session Program for Children in an outpatient setting such as a school. The majority of research has been conducted in school settings, validating the feasibility and effectiveness of the use of COPE for Children by the original creator and researchers as well as trained school staff or health care professionals. As seen through the statistical data and evaluations above, implementation of this program fosters the promotion of mental health, thereby decreasing the incidence of symptoms of depression and anxiety. As stated above, these symptoms often lead to mental health conditions and increased suicide ideations and attempts.
CHAPTER 3

CONCEPTUAL FRAMEWORK

The overall goal of this scholarly project was to promote mental health in order to prevent mental illness and decrease the incidence of depression, anxiety, and suicidal ideation and attempts in children. Therefore, the purpose of the intervention was the facilitation of healthy lifestyle behaviors such as appropriate coping skills, problem solving, emotional regulation, positive thinking, and effective communication. The Essentials of Doctoral Education for Advanced Nursing Practice (American Association of Colleges of Nursing [AACN], 2006) are foundational competencies that guide the scholarly project and are required to prepare the Doctor of Nursing Practice (DNP) graduate to collaboratively and innovatively practice in an advanced practice role. The third, fourth, fifth and sixth Essentials of doctoral education for advanced nursing practice incorporates the application of clinical scholarship and evidence-based practice (EBP) to improve and transform healthcare (AACN, 2006). These Essentials can be exercised through the application of evidence-based conceptual frameworks to guide the proposed intervention and effectively impact the health of children.

Beck’s Cognitive Behavioral Theory (Butler & Beck, 1995) is the conceptual framework that is frequently used to provide evidence-based support for the use of the COPE Program, as noted in the above literature review. The Transtheoretical Model provides the framework for the implementation of the intervention and facilitation of the change of an individual’s beliefs and behaviors (Prochaska, Johnson, & Lee 2009). Finally, the Promoting Action on Research Implementation in Health Services (PARIHS) model is used to guide the manner in which such an intervention is effectively translated into practice (Kitson et al., 1998).
Beck’s Cognitive Theory of Depression

Aaron Beck’s Cognitive Theory of Depression, also known as the Cognitive Theory of Psychopathology, was developed in the 1960s and is the basis for the implementation of CBT (Butler & Beck, 1995). Melnyk (2007) used Beck’s framework of the Cognitive Theory of Depression and his work with development of CBT as a basis for the COPE program. According to Beck et al. (1979), the use of CBT is hypothesized to be more beneficial than pharmacological treatment for mental health conditions – specifically depression. This is due to the fact that the long-term effects of this therapy allows the individual to learn from the therapeutic experience, enabling him/her to effectively cope in the moment of a stressor, abort a stressor prior to it becoming problematic, and even prevent the negative behavior or attitude from happening (Beck et al., 1979). Therefore, the cognitive model is founded on three specific concepts: (a) the cognitive triad, (b) schemas, and (c) cognitive errors – otherwise known as faulty information processing.

Cognitive Triad

The cognitive triad is made of the relationship between and interaction of self, experiences, and the future. Beck et al. (1979) supported the thought that individuals’ views of themselves will impact the manner with which they interpret the experiences and events around them, and define their expectations and the attitude with which they view the future. This can be applied to a negative view of oneself as well as a positive view of oneself, both situations resulting in an outcome that is consistent with the initial belief and attitude. For example, if children have low self-esteem and self-worth as a result of an unhealthy home environment or negative peer influence they will have a negative view of themselves. This will result in their
feeling undesirable and worthless; decrease their confidence in current abilities; and adversely affect the ability to foresee success in the future.

**Schemas**

Beck et al. (1979) defined the second concept of schemas as the “stable cognitive patterns [that] form the basis for the regularity of interpretations of a particular set of situations” (p. 12). The schema that is activated when a situation presents itself will determine how the individual responds. If a negative, depressive, or destructive schema, then the individual will respond in a manner that fits the schema (Beck et al., 1979). Over time and with persistent stimulation of specific schemas, destructive responses can become consistent and will occur with a wider range of incidents or stimuli, even if the response is not logical, appropriate, or ‘normal’ for the situation. Eventually, the individual will lose intentional control over his or her thinking patterns and processes, and the negative and/or inappropriate schemas will become the standard response for both negative and positive stimuli (Beck et al., 1979). Therefore, continuing from the example above, if the children have frequent stimulation of negative schemas through events and the environment, their negative self-thoughts and reactions will become normalized for all situations. Over time, they will respond negatively and at times even self-destructively to all stimuli, whether positive or negative. This vicious cycle will continue until their self-worth and belief for self-success is very minimal unless measures are taken to reverse the developed response.

**Cognitive Errors/Faulty Information Processing**

The final main concept of cognitive errors results in the individual believing that the negative view and manner of thinking is valid despite any evidence that is contrary to that belief. This will result in relatively primitive patterns of thinking that manifest as broad judgments of
events causing conclusions that are extreme, negative, categorical, absolute, and judgmental (Beck, et al., 1979). Life experiences will be perceived as deprivations and defeats that are irreversible, dooming the individual to be disregarded, unpopular, and unsuccessful. If children in the example above continue through adolescence with these negative schemas and perceptions, they will fall into a pattern of negativity for all situations, which will impact their ability to take chances, persevere through failures and setbacks, and abilities to strive to dream and succeed in adulthood.

With consideration to the above concepts, Beck developed CBT to be “an active, directive, time-limited, structured approach...designed to identify, reality-test, and correct distorted conceptualizations and the dysfunctional beliefs (schemas) underlying these cognitions” (Beck et al., 1979, p. 3-4). The techniques utilized in this type of therapy focus on targeting, identifying, and challenging current misconceptions and assumptions, and assisting individuals in assessing their beliefs for validity. Individuals are guided through this process in order to allow them to discover the false beliefs that they have and identify strategies that will help successfully combat the stimulation of the negative schemas (Beck et al., 1979). With time and practice, individuals will learn how to master events, complications, and situations that were previously regarded as impossible and destined for failure.

Melnyk’s (2007) COPE for Children program teaches skills that can be used in situations that may have resulted from negative beliefs and attitudes. The coping skills that are developed throughout the seven sessions help restructure negative schemas that the children may be experiencing, and they prevent the development of an increased incidence of negative responses by increasing self-esteem and empowering an attitude of success. These skills will promote
mental health, thereby combating and preventing the incidence of depression, anxiety, and negative lifestyle behaviors that may contribute to these conditions.

**Developmental Considerations**

Prior to delving into the concepts of a behavior change theory, it is important to lay the groundwork for the developmental environment for which the scholarly project intervention is intended, and to provide rationale for implementation of a behavior change intervention at this point in childhood. According to Romer (2010), recent advancements and findings of developmental neuroscience have suggested that “early manifestations of impulsivity and experience during childhood, especially various forms of stress, may predispose some youth to engage in risky activity…as a result of impaired impulse control that precedes the adolescent period” (p. 264). In addition, Romer (2010) reported that a large amount of evidence suggests that impulsive and risky behaviors, which often manifest as acting without thinking and sensation seeking, are present as early as age three and are strongly positively correlated to negative behaviors throughout adolescence and young adulthood. Finally, another substantial indicator of risky and negative behaviors during adolescence and young adulthood is the presence of physical and emotional stressors during early childhood (Romer, 2010). Therefore, it is imperative to give children tools and guidance regarding how to respond to impulsivity, negative behaviors, and emotional and physical stressors.

With many change interventions, there is a need to determine the individual’s readiness for change. Therefore, consideration should be given to the developmental stage of the group of children for the scholarly project. According to Erikson, school aged children between the ages of five and twelve are in the industry vs. inferiority stage (McLeod, 2013). During this stage, children accomplish many new skills and learn at a very rapid pace. In addition, they are very
social; relationships with peers are being established and are of increased importance; and how others think of them is important to them. When there is failure with skills and tasks or perceived failure in relationships, children will feel inferior (McLeod, 2013). Piaget (n.d.) proposed that young school-aged children are in the concrete operations stage during which their logical thought processes are beginning to develop; however, to apply logic, they need concrete or physical objects and examples. With attention to these developmental considerations, it is imperative that cognitive behavioral interventions address the importance of children feeling industrious with tasks and relationships while providing concrete examples and skills that they can apply to daily proceedings. The COPE for Children version of the program was chosen because it addresses promotion of mental health through increasing healthy behaviors and facilitating coping skills at a developmental level that is appropriate for children aged seven to eleven.

**Transtheoretical Model**

In addition to developmental consideration of participants, it is important to have a framework to guide the implementation of the intervention. An intervention based on promotion of mental health will largely include efforts towards making physical or psychological lifestyle changes. According to Prochaska, Johnson, and Lee (2009), the transtheoretical model is based on psychotherapy and behavior change theories and consists of an integrative framework that defines and guides how an individual works towards embracing and maintaining a change in a belief or a behavior. The model consists of five stages that an individual will journey through when attempting to change an old behavior or embrace a new behavior. These are precontemplation, contemplation, planning or preparation, action, and maintenance. Other core
concepts of the model include decisional balance, self-efficacy and temptation (Prochaska et al., 2009).

**Stages of Change**

The first stage of change, precontemplation, occurs in the timeframe of at least six months prior to the individual considering a change in behavior (Prochaska et al., 2009). This lack of desire or initiative to change can be due to being uninformed or having a lack of understanding regarding the consequences of a behavior (Prochaska & Velicer, 1997). As mentioned above, the level of brain development of the proposed population most likely does not recognize the need for change or the intervention. Therefore the students will be in this stage until someone educates them regarding the benefit of making behavior changes to promote healthy lifestyle behaviors, and assists them to work towards avoiding negative behaviors that can lead to problems in the future.

The second stage is the contemplation stage and involves the individual seriously thinking about making a behavior change in the next six months. The third stage is the planning or preparation stage and is comprised of the individual seriously considering and taking small steps towards the change (Pender et al., 2011). In this project, these two stages were considered to be brief and to happen relatively concurrently because the participants had the program introduced to them and were given only a short amount of time to decide whether or not they wanted to participate. During the preparation stage, the individual weighs the pros and cons, and makes the initial commitment to the change (Prochaska & Velicer, 1997). The concept of decisional balance is applied during this stage and involves the process of determining whether or not the pros outweigh the cons (Pender, 2011). Because the COPE program involved a group
of peers and the commitment required minimum involvement by the participant, this stage did not require much time or cause any duress to the students.

The fourth stage was the most labor intensive for the individual as it involved a time period (less than six months) during which there was active involvement in making a behavior change (Prochaska & Velicer, 1997). To account for this, the intervention was administered over a time period of a few months and the success of the change was identified, observed, and monitored through the use of previously identified measurement tools. The ability to attain a specific criterion to determine success is an important part of this stage; therefore, the data from the measurement tools were important for motivating the individual to continue making and/or maintaining the changes that they attempted (Prochaska & Velicer, 1997).

The final stage is the maintenance of the behavior modifications during which the individual works to prevent relapse to previous behaviors but does not apply change processes as frequently as in the action phase (Prochaska & Velicer, 1997). During this time period, it is important to decrease temptation, which is a core concept that consists of urges and desires to engage in a negative behavior (Pender et al., 2011). Maintenance is most effective when there is a high level of self-efficacy, which is the final core concept that involves a “situation-specific confidence people have that they can cope with high risk situations without relapsing to their unhealthy or high risk habit” (Prochaska & Velicer, 1997, p. 40). Self-efficacy can be facilitated during the intervention by having participants engage in and celebrate their successful behavior changes and involvement in coping skills.

The transtheoretical model has been used successfully in many studies that include the implementation of an intervention to facilitate a behavior change to improve the mental, physical, or emotional health of an individual (Pender et al., 2011). Di Noia and Prochaska
(2009) reported the use of this model for a dietary intervention program that was implemented in a group of children and found that the transtheoretical model helped facilitate the positive effects of the program and guide the overall implementation. As described in the previous chapters, the scholarly project was the implementation of an evidence-based intervention that assists with the promotion of mental health through the development, practice, and maintenance of behavior changes to improve healthy lifestyle behaviors and decrease behaviors that will have a negative impact on the mental and physical health of children. Therefore, this model was appropriate to use to guide the implementation of the scholarly project.

**PARIHS Model**

The Promoting Action on Research Implementation in Health Services (PARIHS) framework is a multidimensional model that provides guidance for the complex process of implementing EBP to promote change. It was initially published in 1998 by Kitson, Harvey, and McCormack (Rycroft-Malone, 2004). Kitson et al. (1998) built this framework to fill the need for a process and model that would address the multiple factors that impact and influence practice change in a successful manner. Since the creation of this model, research and development teams have collaborated to continue to improve the framework (Rycroft-Malone, 2004). While there are several other frameworks that could be implemented for a project such as this, the PARIHS model was chosen because it is a concrete, realistic, and easy-to-use tool for practitioners at the local level (Kitson et al., 2008). At this time, there are three main concepts and their sub-concepts that make up the PARIHS model: (a) evidence, (b) context, and (c) facilitation.
Evidence

Kitson et al. (1998) defined evidence as the combination of research, clinical expertise, and patient choice. Rycroft-Malone (2004) furthered this definition by reporting that Higgs (2000), stated that the evidence in EBP is defined as “knowledge derived from a variety of sources that has been subjected to testing and has found to be credible” (p. 298). In regards to the sub-concept of research, there is high-level research such as quantitative or qualitative analysis, and low-level research such as widely divided or unsystematic professional consensus, or opinion and feedback from patients (Rycroft-Malone, 2004). The sub-concept of clinical expertise includes high levels such as professional critique, critical reflection, and debate that are consistent in their views, and low levels such as divided expert opinion (Kitson et al., 1998). Finally, the sub-concept of patient choice or patient experience is high when patients are involved and their wishes are made known through partnerships and are considered low when there is no input from patients (Kitson et al., 1998). While the ideal situation would be that all of these sub-concepts would be judged in the “high” level, each specific situation in which the model is applied is unique. In addition, if there is a significant amount of support through one of the above-mentioned sub-concepts, a lower level of clinical expertise on one of the other sub-concepts may not negate the usefulness of the practice (Kitson et al., 1998).

For the sake of this scholarly project, the literature review provided information that was applied. There is a moderate amount of quantitative and qualitative work supporting the use of the COPE for Children intervention, providing a high level of research evidence. In addition, the individuals who are involved in the creation of the COPE for Children program and those who have implemented it are experts in their field and have contributed similar thoughts and support for the program. While the number of experts involved and the number who have published
reports of the program are limited, this can be regarded as moderate to high level of clinical expertise. Finally, both parents and participants involved in the program itself had positive reports regarding the effectiveness and results of the program, providing high patient choice/experience.

**Context**

According to Kitson et al. (1998), context is defined as “the environment or setting in which the proposed change is to be implemented…[and is composed of] three core elements: an understanding of the prevailing culture, the nature of human relationships as summarized through leadership roles, and the organizations approach to routine monitoring of systems and services – that is, measurement” (p. 150, 152). As with the sub-concepts above, these core elements of environment are considered to have both a high and low level that will influence the evaluation of the proposed change. A culture considered to be on the low level for readiness for change will be task-driven, have low morale, and low regard for the individuals involved in the organization (Kitson et al., 1998). A high level of readiness evident in a culture that exhibits a drive to learn, has a high value for individuals, provides education, and is centered on the patient/participant (Kitson et al., 1998). A low level of leadership will be evidenced by a lack of team roles, poor organization and management, and poor leadership, while a high level of leadership is the opposite, as there will be clear, defined roles, effective team work, appropriate organizational structure, and definite leadership. Finally, the level of measurement of leadership that is in place at an organization will impact the process or implementation of change. Low levels will be evidenced by an absence of feedback and reviews while a high level of measurement will include internal and external reviews, and frequent feedback at the ground and upper levels (Kitson et al., 1998). Overall, this concept can be summarized to say that if the
organization is comprised of individuals who are driven and highly valued, where roles are clearly defined, and where exposure or access to information and feedback is available, practice change will be welcomed and effective.

**Facilitation**

The last concept to consider is facilitation, which, according to Kitson et al. (1998), is defined as “a technique by which one person makes things easier for others” (p. 152). The facilitator helps set goals, encourages movement towards these goals, and provides opportunities for success and action. The three key factors that can be addressed when evaluating how to be an effective facilitator include characteristics, role, and style. Characteristics that make for an effective and successful facilitator include “openness, supportiveness, approachability, reliability, self-confidence, and the ability to think laterally and nonjudgmentally” (Kitson et al., 1998, p. 152). The role of the facilitator will largely depend on the change that is taking place; however, regardless of the specifics, there needs to be access to the facilitator. In addition, the facilitator needs to provide the materials and information needed as well as the agenda for the change so that the individuals who will be affected and driving the change will have the tools they need (Rycroft-Malone, 2004). Finally, the style with which the facilitator addresses the change as well as the level of skills and attributes that is brought will affect success (Rycroft-Malone, 2004). Therefore, an effective style would include flexibility, consistence, appropriate presence and support, and the knowledge and abilities that are needed to facilitate the change.

**Summary**

The conceptual models and theories described above guided and facilitated the successful implementation of the scholarly project. Beck’s Cognitive Theory of Depression and CBT guided the development of the intervention itself and provided a basis for its implementation,
while also guiding the assessment of the impact of the intervention on the participants and selection of the measurement tools. Understanding of the developmental stage and brain environment of the participants guided the selection of the intervention and impacted the method/manner in which it was implemented. Theorists such as Erikson and Piaget help provide understanding and knowledge to guide teaching and facilitation on an age-appropriate level for second graders. The stages of the Transtheoretical Model were applied to assess readiness and facilitate the promotion of mental health through a change of negative behaviors and enabling of healthy lifestyle behaviors. Finally, the overall elements, concepts, and sub-concepts of the PARIHS model provided guidance for the implementation of the COPE for Children program as a therapeutic intervention to stimulate a change in the beliefs and behaviors of children in the school setting. In addition, the involvement and interaction of the key staff members at the school during the preparation for and process of implementation of this project provided education and resources for the continued development of skills facilitated by the COPE for Children program.

Thoughts, beliefs, attitudes, and behaviors are developed early in life and will be impacted either positively or negatively by situations, events, and interactions with others. It is crucial to assist in establishing healthy beliefs and positive lifestyle behaviors at a young age in order to facilitate success and combat the presence of depression, anxiety, and suicidal ideations and attempts in children. Through the implementation of the COPE for Children program, the participants were provided with tools and skills that they can use to empower them to be successful throughout adolescence and into adulthood.
CHAPTER 4
METHODOLOGY

The purpose of this doctoral scholarly project was the implementation of a pilot implementation of an evidence-based, school-based CBT program, with the goal of promoting mental health by working to improve coping skills and enhancing healthy behaviors. It was desired to see an increase in positive behaviors and verbal acknowledgement of positive coping skills that can be used when faced with challenges or problems. After thorough consideration of the literature regarding existing evidence-based programs targeting the facilitation of behavioral health skills, Bernadette Melnyk’s Creating Opportunities for Personal Empowerment (COPE) for Children 7-session cognitive-behavioral therapy based intervention was chosen. This program was delivered to a pilot 2nd grade classroom of 25 students. A variety of tools were used to evaluate the outcomes. Effectiveness and acceptability were evaluated based on the pre- and post-behavior ratings as measured by the Positive Behavioral Interventions and Supports (PBIS) rainbow stick behavior measurement tool and a pre- and post-program questionnaire. Feasibility was measured by the completion of all seven sessions, adequate time and space to deliver each session, and perceptions from the staff. This chapter will describe the completed project plan and the phases of implementation.

Procedures

Permission from Melnyk

The first step in this project was gaining permission for the use of the COPE for Children program. Dr. Melnyk was contacted through phone and email correspondence and she provided verbal and written permission for the use of her program (See Appendix A). As instructed by the COPE2Thrive organization and correspondence team, the DNP student participated in instructor
training for implementation of this program (See Appendix B). The workbook manual for the COPE for Children program was provided to the DNP student as part of the instructor training. New instructor training expectations were later added that included implementing the program in a test run with an individual who would not be a part of the project. In order to comply with the new guidelines and ensure good understanding of the program, the DNP student administered the program to her 12-year old brother. He was able to provide feedback regarding the content, what was helpful, what areas were not as applicable, and tips for how to implement the program with students who were younger than him. Also, throughout the implementation of this project, the DNP student became knowledgeable of and frequently reviewed the COPE manual. In addition, the DNP student corresponded occasionally with Dr. Melnyk and members of her support staff for guidance regarding implementation, and to stay up-to-date on other current COPE projects being implemented. All of these activities and the information-gathering process align with the PARIHS model’s concept of evidence. Accessing the original source of the program information provided the DNP student with access to a high level of clinical expertise that could be used as a resource as needed during implementation.

**Selection of Site**

Before the project was initiated, data from the Michigan Department of Education (MDE), which conducted the Michigan Profile for Healthy Youth (MPHY) 2013-2014 survey of 9th to 12th graders to identify the areas of major concern in regards to the mental health and well-being of children in Kent County were examined (Michigan School Health, 2015). The survey demonstrated the presence of use and easy access to alcohol and drugs, physical and emotional bullying at school, avoidance of school as a result of bullying, risky sexual behaviors, and signs and symptoms of depression and anxiety (See Appendix A) (Michigan School Health, 2015). It
is imperative to intervene and facilitate healthy behaviors and coping skills at an early age in order to facilitate better outcomes throughout adolescence and into early adulthood. Evidence indicates that an overall approach to promoting mental health, especially self-esteem, self-concept, and coping skills, is more effective in young children than focusing on specific topics (Victorian Government DHS, 2006). In addition, programs and interventions for children preschool aged through 15 have been shown to be more effective in the long-term than interventions for children aged 15 to 19 (Victorian Government DHS, 2006; Rigby, 2002). Therefore, the target population for this program was a sample of students in a 2nd grade classroom.

The first step in implementing this project in the school setting was to meet with key stakeholders and ascertain the level of interest and share the idea for the project. Therefore, the DNP student set up an initial meeting with the initial contact person at the identified school. This individual was the teacher of a 2nd grade classroom, the age of which was the target population for this project. The DNP student met with this teacher on March 30th, 2015 to introduce the project. The teacher voiced interest and granted the DNP student permission to use her classroom to implement this pilot program. The teacher informed the DNP student at this time that approval would need to be obtained from the principal and superintendent of the school and provided email introductions to these key stakeholders.

A brochure of the program that was mailed to the DNP student from the COPE2Thrive organization as well as the documents depicted in Appendix A were provided to these key stakeholders for review. In addition, these individuals were able to review the COPE for Children workbook that would be used for the pilot program. All three of these key stakeholders approved the implementation of this proposed scholarly project on April 2nd, 2015 pending the
approval by the district team at their meeting on May 13\textsuperscript{th}, 2015. The district team met on May 13\textsuperscript{th}, 2015 and voiced strong interest and approval of the implementation of the COPE for Children program in identified classroom in the 2015-2016 school year. Several other school staff members, including members from the middle school voiced interest in the program and its outcomes.

In addition, during this time period, it was agreed that there would be further collaboration with the teacher, principal, and superintendent regarding the draft and distribution of a letter (Appendix D) that would inform parents of the opportunity for their child to participate in the program as well as offering them an opt-out option. This letter was drafted by the DNP student and approved by the teacher and principal. It was also agreed upon that meetings would be established with these three key stakeholders based on the needs that arose during the planning and implementation stages. During the planning and implementation phase, the DNP student met several times in person with the teacher and principal to discuss specifics of implementation and areas that needed adjusted during the implementation of the program. During implementation, the student also communicated with other staff members at the school regarding the specifics of the program and a brief verbal report was provided about the program’s progress. No other official meetings with the key stakeholders were required during the planning and implementation phase.

A high level of support and acceptability of the project was demonstrated throughout the planning and implementation process. In addition, all the staff members at the school demonstrated a significant level of investment and interest in the students’ overall well-being, including their mental health. Finally, the strong leadership provided by the principal and the 2\textsuperscript{nd} grade teacher during all aspects of the scholarly project provided the DNP student with an
appropriate level of support, presence, and knowledge regarding how to most effectively implement the project. All of these factors align with a positive context and an effective level of facilitation, as described by the PARHIS model, creating an environment of success for the implementation of this scholarly project.

**Human Subjects**

The project was submitted to the Human Research Review Committee (HRRC) as an evaluation project for an evidence-based project implementation that was not research. The determination that it was not research was based on the fact that the project implements an intervention that has been determined by review of the literature to be a widely accepted evidence-based practice for the identified population; the focus was on quality improvement through promotion of mental health and evaluation of the program; all identifying personal information collected was permanently encrypted during collection, transmission, and storage; there were minimal identified risks to the participants involved; and the project was implemented in an established education setting. Despite the determination that the project was not research, utmost care was taken to protect the participants from risk. When the project was implemented, the DNP student had the skills and training to recognize child distress as well as signs and symptoms of anxiety or depression. It was decided that in the event that the DNP student identified any of these concerns, she would contact the school social worker, and/or the school psychologist. The DNP student would then collaborate with these school staff members to determine the next steps that need to be taken to ensure that appropriate intervention or referral occurred. During the implementation of the intervention, the DNP student, along with the teacher, and/or the principal effectively addressed all behavioral concerns.
Human Subjects Protections and Ethical Practices Adherence

There was no compensation or incentive for participating in this pilot program for the students or their families. There was no compensation or incentive given to the school, the principal, or the teacher of the 2nd grade classroom where the program was implemented. In addition, there were no financial benefits for the DNP student.

Study Population and Sample

Participants

Students in the selected 2nd grade classroom ranged from six to eight years of age. Age and gender characteristics are described in Table 2. Ethic background characteristics are described in Table 3. The mean age of the participants was seven years (SD = 1). The class consisted of 48% males and 52% females.

Table 2
Age and Gender of Participants

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Male (n = 12)</th>
<th>Female (n = 13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 3

*Ethnic Background of Participants*

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Male ((n=12))</th>
<th>Female ((n=13))</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>13</td>
</tr>
</tbody>
</table>

Initially, there were 26 students in the 2\(^{nd}\) grade classroom; however, one student moved to a different school after participating in the first two sessions. The data from that student’s participant information tool is not included in the data analysis. In addition, nine students were absent for one of the seven sessions, and one student was absent for two of the sessions. The session missed by the nine students was variable, depending on the student and the date that they were absent. The students who were absent were encouraged to read over the session that they missed on their own. Overall, 16 students completed the entire seven sessions. Because anonymity was maintained for responses on the Participant Information Tool and The Post-COPE Evaluation tool, it is not known which evaluations students attending all seven sessions completed. However, it is recognized that due to the repetitive nature of the activities addressing key concepts in the program, the students were able to practice and remember the activities for the key concepts. Students verbally acknowledged their understanding of the key concepts to the DNP student during the wrap-up session.

**Staff Participants**

During the first 12 weeks of the school year, the DNP student’s mentor (the teacher of the 2\(^{nd}\) grade classroom) was not able to be in the classroom because of unforeseen
circumstances. A long-term substitute teacher took the teacher’s place during these 12 weeks. The DNP student and the mentor met with the long-term substitute prior to school starting, to discuss the project and the role that the long-term substitute would play in encouraging the students’ participation and in reinforcing throughout the week the concepts learned during the session. The long-term substitute showed understanding of the program and facilitated the DNP student’s involvement in the classroom. In addition to these two teachers, the principal was very visible and involved with the students on a daily basis. The principal was present for the implementation of the fifth session in order to observe how the instruction occurred, and the impact that it was having on the students as evidenced by their verbal participation during the session. In her daily announcements, the principal also reinforced the positive behaviors that the students were learning, as they aligned with the PBIS program. The final key staff member involved in the implementation of the program was the paraprofessional educator who assisted the teachers part-time in the classroom. This individual was present for all of the sessions and was able to encourage the students to use the skills that they learned in the sessions throughout the week.

**Intervention: COPE for Children**

The COPE for Children program has been used in a variety of settings with diverse participants for multiple reasons including treatment of mental health conditions as well as promoting healthy lifestyle behaviors. For this project, the COPE for Children program was used as a tool to promote mental health through teaching and facilitating the use of cognitive behavioral therapy strategies such as problem solving, positive self-talk, and behavior changes. While the COPE for Children program can be implemented in either one-on-one sessions or group sessions, it is most effective to use the group-setting format in order to impact the largest
number of students in a school setting. As the DNP student learned in the training session, the COPE for Children program is to be delivered exactly as printed in the manual, following the script exactly, while allowing the participants to interject their own personal experiences related to the concepts being discussed.

Each of the sessions in the program begins with a review of principles learned in previous sessions and ends with a homework assignment for the participants to focus on during the upcoming week. The goals of the homework are to restate and reinforce the concepts learned in the lesson and help the students apply them to daily life. Finally, at the end of each session, there is a brief letter for the parents of the participants that describes the skills and concepts that were addressed in the session. This letter was sent home with the students in their homework folder at the end of each session and the students were encouraged to discuss the concepts that they learned with their parents.

The program started with an introduction session in which the participants and the DNP student had the opportunity to get to know each other through the use of several guided “ice breaker” questions. In addition, this session introduced the concept of the Thinking-Feeling-Behaving Triangle, the model used throughout the program to help the participants make connections regarding the concept of “how you think affects how you feel and how you act or behave” (Melnyk, 2007, p. 3). The participants are given an example to apply the model to, and are also given an exercise that helps them identify the differences between a thought, feeling, and action/behavior. Finally, the homework for the introduction asked the students to draw the Thinking-Feeling-Behaving triangle in order to imprint this concept in their minds.

Session one revisited the concept of the Thinking-Feeling-Behaving triangle in greater depth in order to make the connection between these concepts and to help the participants
recognize how to impact various aspects of the triangle. The participants learn about trigger events that may result in negative thinking and are given several examples in which they can identify the trigger events and the consequential behaviors or feelings. The participants are then given the opportunity to think of two trigger events – one that made them happy, and one that made them sad – and to apply the Thinking-Feeling-Behaving triangle to these situations. Finally, the concepts of positive self-talk and staying in the moment were introduced and discussed and applied to examples used previously.

Each student was given a 3x5 notecard on which they wrote one to three positive self-talk statements. They were encouraged to reference these at least once a day, and more if they were struggling with negative thoughts. This session helped the participants learn how to identify negative triggers and their consequences, as well as to apply helpful strategies to counteract the negative thoughts. For the homework assignment, participants were encouraged to identify a negative situation in the upcoming week and recognize the feelings and behaviors that went along with that negative situation.

In session two, the concept of self-esteem was introduced along with the impact of positive self-talk on self-esteem. Several examples of bad/low self-esteem and good/high self-esteem were discussed as well as unhealthy ways to cope with low self-esteem and healthy ways to build high self-esteem. One healthy self-esteem exercise provided in the manual is identifying individuals that the participants are thankful for, and recognizing how other people can positively impact negative thoughts or triggers. Finally, this session introduced the COPE game that provided participants with a strategy to changing negative thoughts or feelings. The strategy of capturing a thought, overturning it to a positive thought to emotionally feel better was practiced.
The homework for this session helped the participants identify aspects of themselves that they liked as well as having them practice telling people that they were thankful for them.

Session three focused on the concepts of stress and coping. Both of these concepts were defined, and several examples of stressful situations were discussed. In addition, the physical and emotional consequences of stress as well as the potential negative or unhealthy resulting behaviors were reviewed and/or acted out by the participants and the DNP student. Finally, the session ended with a discussion of what it means to cope with stress in a healthy way. Several coping strategies were provided and discussed and the students identified a few strategies that would be the most beneficial for them to practice. The homework for the week asked the students to identify a stressful situation in which they were able to apply the positive coping skills and reduce the potential for a negative effect of stress.

Session four addressed how to solve problems and set goals. Each of the participants were asked to identify a goal or a dream that they had and to discuss steps that they could take (such as positive self-talk) to facilitate reaching the goal or dream. In addition, the participants were educated regarding a four-step problem solving strategy, and given several case-study examples for applying this process. For the homework activity, the participants were asked to identify a problem that arose during the following week and apply the four-step problem solving process to it. In addition, the students were encouraged to identify something positive that they did during the week.

In session five, the concept of dealing with feelings in healthy ways was addressed. Strategies that were taught and discussed included mental imagery, guided imagery and relaxation techniques, self-control activities, and good communication. Specific activities based on these strategies were discussed with the participants and included going to a happy place in
their mind; positive thinking and self-talk; counting to 100 or saying the ABCs; using deep breathing; talking to a trusted family member or adult; and using active listening, appropriate body language, and choosing words carefully. For the homework, the participants were given the opportunity to draw a picture of their happy place and identify a self-control strategy that they used during the week when they were feeling upset.

Session six brought many of the previous concepts together in order to discuss coping with stressful situations. During this session, the participants reviewed the COPE game, the Thinking-Behaving-Feeling triangle, self-control activities, and the power of positive self-talk. They were then able to practice using these strategies with several case examples. The homework provided two other case examples that the participants could practice on their own and asked them to identify a time when they used the COPE game to positively deal with a negative situation during the following week.

The final session is entitled “Pulling it All Together for a Healthy You!” and reviews all of the concepts and key strategies identified throughout the program. The participants were given the opportunity to identify situations in the past seven weeks where they applied the skills that were taught throughout the program. Finally, encouragement was provided to the participants to continue to use these strategies and skills as well as continuing to add to and reference their positive self-talk statements. Following this session, the participants were allowed to take their COPE for Children program manuals home with them to share with their families, if desired.

**Instruments**

There were several tools used to measure the effectiveness and feasibility of the project. These tools included the Participant Information Tool, Rating the COPE Sessions, the PBIS Classroom Clip Chart, and the Initial and Long-Term Post-COPE Evaluation Questionnaire. The
PBIS Classroom Clip Chart and the Clinical Global Impressions Scale on the Initial Post-COPE Evaluation Questionnaire were the only standardized measurement tools used. The DNP student developed the other measurement tools that were utilized. Finally, information from letters that the students wrote the DNP student was included in the data analysis. While these letters were not an expected source of data, they provided significant responses from the students regarding their perceptions of the COPE program and the DNP student was given permission to use them in the analysis of the COPE program.

**Participant Information Tool**

The Participant Information Tool (Appendix D) was administered to obtain information regarding the characteristics of the sample. The information collected by this tool included the following: age, gender, ethnicity, family members, and information regarding relationship with friends, parents, and adults at school. The students filled out the tool with the assistance of the teacher and the DNP student during the initial introduction session in order to help guide them through filling out the questionnaire and answering any questions they may have regarding the questions.

**Rating of COPE Sessions**

In order to gauge the helpfulness and applicability of each COPE for Children session, the students were asked to rate each session on a rating scale of zero to two. A rating of zero meant that the session was not helpful at all or the student did not learn anything new. A rating of one meant that the session was “kind of” helpful, and the student might apply the skills over the next week. A rating of two meant that the session was very helpful and the student learned new information and skills that he or she planned on using over the next week. After each session, the students were reminded of what each number on the rating scale represented, and
were given a 3 by five inch notecard on which to write their chosen rating. The teacher collected the cards so that the students would not feel obligated to give the DNP student a favorable rating.

**PBIS Classroom Clip Chart**

As part of the evidence-based PBIS program, one of the behavior strategies used is the classroom clip chart. The goal of this chart is to focus on positive behavior that is noticed throughout the day, rather than only addressing negative behavior. This chart consists of a yardstick that is painted from top to bottom: red (parent contact), orange (think about it), yellow (slow down – chance to regroup), green (ready to learn), blue (great job) and purple (superstar). A clip for students with their name on it is attached to the yardstick. The students begin each day on the green section of the yardstick and the clips can be moved up for good behaviors (positive actions, efforts, self-control, and responsibility) and down for negative behaviors. Students are able to “turn their day around” at any point and are recognized for making the change from negative to positive choices. At the end of the day, the color on which the student’s name is located is recorded on a log. There are monthly behavior celebrations for students whose names are on green or above at the end of every day during the month.

Years of research and continued evaluation of outcomes has supported the concepts of the PBIS program (including the classroom clip chart) as successful, reliable, and valid. The PBIS program initially began as a substitute to punishment-based interventions for those with developmental disabilities (Sailor, Dunlap, Sugai, & Horner, 2008). However, educators recognized that when the entire school system focused on reinforcing positive behaviors, individuals with developmental disabilities thrived even more. Therefore, the PBIS structure progressed towards school-wide implementation and support to facilitate a positive environment at all times (Sailor et al., 2008). The U.S. Office of Special Education Programs (OSEP) provides
evidence-based trainings and multiple evaluation tools that are used to ensure that the schools implementing the concepts of the PBIS program do so in a valid, reliable, and efficient manner (PBIS, 2015). In addition, the OSEP provides checklists and guides for teachers to reference and use as evaluation tools to ensure that they are appropriately using the strategies of the PBIS program. Many of these tools and references address the classroom clip chart in some manner.

**Post-COPE Evaluation – Initial and Long-Term**

The Post-COPE Evaluation questionnaire (Appendix E) consists of a checklist of recent life stressor events, close-ended questions to provide feedback of the programs use and usefulness, and open-ended questions to allow the individuals to evaluate their perceived effectiveness and helpfulness of the program. In addition, the evaluation questionnaire provided information regarding aspects of the program that were and were not helpful as well as the students’ recommendation of the program to other students. Two peers of the DNP student administered this questionnaire to the students in an interview format the week following the last session. These DNP students were instructed on a systematic and uniform way to administer the questionnaire to the students in order to avoid bias.

The Long-Term Post-COPE Evaluation questionnaire (Appendix F) is a shortened and slightly modified version of the Post-COPE Evaluation questionnaire. The goal of this questionnaire was to evaluate the long-term impact of the program on the students, and their ability to recall key concepts of the program. The DNP students who were involved in administering the Post-COPE Evaluation were also involved in collecting information for the Long-Term Post-COPE evaluation.

The Clinical Global Impressions (CGI) Scale, tailored for the COPE for Children program, is included on both of these questionnaires. This scale is easy to use and has been used
frequently in many settings and situations to provide reliable and valid assessment of the efficacy of an intervention. For example, Zaider et al. (2003) conducted a study to determine if this tool was effective to be used for measuring the effectiveness of a treatment for anxiety disorders at different points in treatment compared to clinician-measured levels of anxiety for the individual. Zaider et al. (2003) found that the CGI accurately determined the improvement in symptoms with the use of an intervention ($p < 0.005$).

**Letters from Students**

At the end of the program, the students wrote the DNP student letters to thank the DNP student and express what they thought of the program. The DNP student asked the students if she could share these letters and the information in them anonymously as part of the scholarly project. The students were in unanimous agreement. Therefore, some of the qualitative information gleaned from these letters is shared in the results section.

**Feasibility of COPE in the Chosen Setting**

To assess for feasibility of the ongoing use of COPE in the school, adherence to the specific aspects of delivery of the intervention given in the instructor training class, as well as the students’ successful completion of the program, were evaluated. Other aspects of the COPE program’s feasibility were evaluated in addition to the outcomes measured by the instruments described above. These include the facilitators and barriers for attendance of participants who were able or unable to complete the entire program, as well as the facilitators and barriers to implementing the program in a group of 2nd grade students.

It is recognized that there are other factors that may have impacted the results of the project. The similarities in concepts between the COPE for Children program and the PBIS program help reinforce and facilitate mental health promotion. It was not possible to
differentiate if the COPE program improved the positive behaviors and effects above that of the PBIS program. In addition, the presence of the long-term substitute for the beginning of the program and the presence of the original teacher (the DNP student’s mentor) for the end of the program and the long-term evaluation may have been a source of bias or error in the evaluation data obtained from the Rainbow Scale of Behavior, as each teacher had her own adherence to the method as well as her individual ethical principles. However, it is hoped that the standard training given to teachers for the PBIS program would decrease this source of bias or error.

**Implementation Design**

The following timeline for the implementation of this pilot program was used. First, an opt-out letter (Appendix G) was sent home with the students for the parents to read during the first week of school. This notified the parents that the DNP student would be present in the classroom and gave the parents 25 days to determine whether or not they wanted their children to participate, or to opt out their children. If a parent did not want his or her child to participate, and alternate activity, such as going to the library to read, would be provided for the student. Upon consultation with the school staff, it was decided that there would not be a parent meeting held prior to the implementation of the pilot program, unless there was strong interest voiced by the parents to have more information regarding the program. There were no objections to any of the students participating in the program, and there were no concerns voiced by the parents regarding the program to either Ms. Hayden or the DNP student.

In addition, the DNP student and Ms. Hayden collaborated and determined that the DNP student would be present in the classroom for four Tuesdays prior to implementation of the program to facilitate familiarity with the students and establish rapport as well as become familiar with other staff members at the school. These initial dates of involvement in the
The DNP student then used the next eight Tuesdays to continue to be a presence in the classroom and implement each session, including the introductory session, of the COPE for Children program. Initial Post-COPE Evaluation data were collected the week after the program was finished, and Long-Term Post-COPE Evaluation data were collected six weeks from initial Post-COPE Evaluation.

**Data Analysis**

The data collected from the instruments listed above was transferred to an Excel spreadsheet and analyzed to determine if the program was effective and feasible in the identified setting. The information from the Participant Information Tool was categorized and used to describe the demographic and baseline information of the students. In addition, the information obtained from this tool assisted the DNP student in identifying the presence of significant events in the group of students as well as their comfort level with talking to adults. This qualitative and quantitative information impacted the manner with which the DNP student interacted with the students. The Rating of the COPE Sessions data were used to provide quantitative information regarding the students’ perceptions of each session. It was used to compare the ratings with the content of the program that was taught to the students. In addition, this information was analyzed to determine how it impacted future implementation of the program in the school setting. The PBIS Classroom Clip Chart provided quantitative data that were grouped and analyzed to determine the program’s impact on daily behaviors. These data were presented in chart format to visualize the group’s change in behaviors over time. The Post-COPE Evaluations, both Initial and Long-Term, provided qualitative and quantitative information regarding the overall helpfulness of the program, areas for improvement, and aspects of the program that were especially beneficial or impactful to the students. This information was analyzed for common
themes and implications. Finally, the Letters from the Students provided qualitative data that were analyzed for common themes related to the effectiveness and helpfulness of the COPE for Children program. All of the data analysis mentioned here is discussed further in Chapter 5 and Chapter 6.
CHAPTER 5

RESULTS

The results of this pilot implementation of the COPE for Children program in a 2nd grade classroom, as reported in this chapter, reflect the information provided by the Participant Information Tool; the PBIS Classroom Clip Chart; the students’ rating of the COPE sessions; the initial and Long-Term Post-COPE Evaluation Tool; and the perceptions and overall assessment provided by the two key teachers in the 2nd grade classroom.

Data Analysis

Participant Information Tool

The Participant Information Tool is depicted in Appendix E. Age, gender, and ethnic background characteristics are described in Table 2 and Table 3 in the previous chapter. This information was confirmed with the teacher, because only 22 students filled out the Participant Information Tools. Information regarding the individuals the student lives with was collected. Of the 22 students who completed the forms, 19 lived with both their mother and father, two students lived with their mother, and one student lived with his mother and foster grandparents. The Participant Information Tool also addressed perceptions of the number of friends the student had, and whether or not the students felt as if they could talk to parents or an adult at school. These responses are summarized in Table 4 and Table 5.
Table 4

*Student Perceptions of Number of Friends*

<table>
<thead>
<tr>
<th>What Answer Describes You Best</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I have lots of friends at school.</td>
<td>13</td>
</tr>
<tr>
<td>I have one or two good friends at school.</td>
<td>8</td>
</tr>
<tr>
<td>I don’t have any friends at school.</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 5

*Student Perceptions of Ability to Talk to Adults When Upset*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel like you can talk to your mom or dad when you are sad or upset?</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>Do you feel like you can talk to an adult at school when you are sad or upset?</td>
<td>13</td>
<td>9</td>
</tr>
</tbody>
</table>

In addition, a question regarding significant events that occurred in the students’ lives in the past 12 months was originally a part of the Participant Information Tool. However, this question was confusing for students to complete on their own. Since the Participant Information Tool was filled out independently by the students, and the Post-COPE Evaluation Questionnaire was filled out in an interview format, this question was moved to the Post-COPE Evaluation Questionnaire so that the students could have assistance in understanding the question. Because their responses are more appropriate to discuss in regards to general participant information, the results are presented here (see Table 6). All 25 students were present for the Post-COPE
Evaluation Questionnaire interview. From zero to four significant events were reported by the students. Four students reported two of these events, two students reported three significant events, and three students reported four significant events.

Table 6

*Significant Events Reported as Occuring in the Last Twelve Months.*

<table>
<thead>
<tr>
<th>Question</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>No significant events</td>
<td>7</td>
</tr>
<tr>
<td>Parent/Step-parent separated (no longer living together).</td>
<td>1</td>
</tr>
<tr>
<td>Parent/Step-parent divorced.</td>
<td>1</td>
</tr>
<tr>
<td>Birth of a sibling.</td>
<td>3</td>
</tr>
<tr>
<td>Your parent got a new job.</td>
<td>6</td>
</tr>
<tr>
<td>Your parent is working different hours at a job.</td>
<td>6</td>
</tr>
<tr>
<td>There was a death of an immediate family member.</td>
<td>5</td>
</tr>
<tr>
<td>There was a death of a family pet.</td>
<td>5</td>
</tr>
<tr>
<td>An immediate family member had to be hospitalized or is significantly ill.</td>
<td>3</td>
</tr>
<tr>
<td>You moved to a new location.</td>
<td>4</td>
</tr>
<tr>
<td>A family member is in jail or prison.</td>
<td>2</td>
</tr>
<tr>
<td>Total number of significant events.</td>
<td>36</td>
</tr>
<tr>
<td>Number of Students =</td>
<td>25</td>
</tr>
</tbody>
</table>
Rating of Sessions

After the teaching portion of each lesson, the DNP student asked the students to rate each session’s helpfulness based on a scale of zero to two, as described above. Because one to three students were missing for each session, the ratings of helpfulness are reported as percentages of the students who were present (See Figure 1). In addition, the overall average rating for each session is provided in Figure 2.

Figure 1

Student Ratings of Session Helpfulness

Key: 0 = not helpful at all; 1 = a little bit helpful; 2 = very helpful
As seen in Figure 1, as the students became more familiar with the terminology of the program and the concepts that were revisited multiple times, a higher percentage of the students ranked the session as being very helpful. While only 50% of the students rated the first session as very helpful, and 27% of the students rated the first session as not helpful at all, 75% of the students rated the last session as very helpful, and only 5% of the students rated the last session as not helpful at all. At least 50% (Session 1) and a maximum of 75% (Session 7) of the students rated the sessions as very helpful. A rating of a little bit helpful was given by 16.67% (Session 6) to a maximum of 30.43% (Session 2) of the students. Finally, A rating of not helpful at all was given by 4.35% (Session 2) of students to a maximum of 27.27% (Session 1) of the students. As seen in Figure 2, the average overall rating of each session was relatively consistent between 1.5 and 1.7 except for Session 1 and Session 3, both of which were rated around 1.25.
PBIS Classroom Clip Chart

It was the school’s practice that at the end of each day, the teacher would record the color corresponding to the student behavior ratings on the PBIS Classroom Clip Chart. This record was obtained and the data documenting the color rating of each student for a two week period before the implementation of the COPE for Children program, a two week period at the end of the program, and a two week period beginning six weeks after the end of the program were recorded. The average rating associated with the placements of the clips for each day are noted in Figure 3 for each of the two-week time-periods. Because an average rating for the group was used for these analyses that could account for individuals student absences, the total class size (N=25) is used for all reported PBIS results.

Figure 3

Average Daily Ratings of Behaviors on PBIS Clip Chart

Key: 1 = Red 2 = Orange 3 = Yellow 4 = Green 5 = Blue 6 = Purple
As seen in Figure 3, the average clip placement for the Post-COPE timeframe was higher than the Pre-COPE daily average for the timeframe 80% (8 out of 10) of the recorded days. The average clip placement for the Long-Term Post COPE was higher than the Pre-COPE average placement 80% (8 out of 10) of the recorded days and was higher than the Post-COPE average placement 70% (7 out of 10) of the recorded days.

**Repeated measures ANOVA.**

The overall average clip chart ratings for the three two-week timeframes are depicted below in Table 7.

Table 7

*Average Student Behavior Ratings by Timeframe*

<table>
<thead>
<tr>
<th>Measurement Period</th>
<th>Mean</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-COPE</td>
<td>4.26</td>
<td>4.12</td>
</tr>
<tr>
<td>Post-COPE 1</td>
<td>4.67</td>
<td>4.51</td>
</tr>
<tr>
<td>Post-COPE 2</td>
<td>4.77</td>
<td>4.55</td>
</tr>
</tbody>
</table>

Repeated-measures ANOVA, which met the sphericity assumption for multivariate tests (Mauchly’s W = 0.957, p = 0.603), determined the mean PBIS Classroom Clip Chart Placements to be significantly different between assessment stages (pre-COPE, initial post-COPE, and long-term post-COPE) (F = 13.101, df = 2.000, p < 0.0001; Wilks Λ 0.467, p < 0.001; partial η² 0.533). The pairwise comparisons for the main effect of the COPE for Children program
corrected using Bonferroni adjustments are shown below in Table 7. This table indicates a significant difference ($p = 0.001$) between levels 1 and 2 (Pre-COPE and Initial Post-COPE) and levels 1 and 3 (Pre-COPE and Long-Term Post-COPE) but not between levels 2 and 3 (Initial Post-COPE and Long-Term Post-COPE). This lack of significance between the two post-COPE timeframes was expected, and desired, and the fact that the students maintained a similar level of behavior was encouraging and significant for the long-term impact of the COPE for Children.

Table 8

*Pairwise Comparisons for the Main Effect of the COPE for Children Program*

<table>
<thead>
<tr>
<th>Measure: time</th>
<th>(I) factor1</th>
<th>(J) factor1</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>p-value</th>
<th>95% Confidence Interval for Difference&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>-0.408*</td>
<td>0.093</td>
<td>0.001</td>
<td>-0.647 to -0.169</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>-0.504*</td>
<td>0.102</td>
<td>0.000</td>
<td>-0.766 to -0.242</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1</td>
<td>0.408*</td>
<td>0.093</td>
<td>0.001</td>
<td>0.169 to 0.647</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>3</td>
<td>-0.096</td>
<td>0.085</td>
<td>0.812</td>
<td>-0.315 to 0.123</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>1</td>
<td>0.504*</td>
<td>0.102</td>
<td>0.000</td>
<td>0.242 to 0.766</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>2</td>
<td>0.096</td>
<td>0.085</td>
<td>0.812</td>
<td>-0.123 to 0.315</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Based on estimated marginal means

* The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Bonferroni.
**Information from Letters from Students**

All 25 of the students reported positive feelings regarding the implementation of the COPE for Children program in their classroom in the letters that they wrote to the DNP student upon completion of her immersion in their classroom. Table 9 gives a sampling of the comments regarding the COPE for Children program taken from the letters that the students wrote. The DNP student, for the sake of understanding, corrected spelling errors in the excerpts taken from these letters.

Table 9

*Comments from Students Regarding COPE for Children Program*

<table>
<thead>
<tr>
<th>Comment</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Thank you for helping me with my feelings and how I act.”</td>
<td></td>
</tr>
<tr>
<td>“I learned that I can take a deep breath and think of a good time.”</td>
<td></td>
</tr>
<tr>
<td>“You taught me a lot. How to deal with bullies is really helpful.”</td>
<td></td>
</tr>
<tr>
<td>“I like the part when we got to think of a happy place.”</td>
<td></td>
</tr>
<tr>
<td>“My favorite part is positive self-talk. I used it when me and my brother were fighting.”</td>
<td></td>
</tr>
<tr>
<td>“Thank you for teaching me about positive self-talk. I use it every day. I look at the card that you gave me.”</td>
<td>(In reference to the positive self-talk statement that the students wrote on a card during Session 1).</td>
</tr>
<tr>
<td>“You taught me a lot. You have made my life a lot better than before and the program is amazing. I think it is the best thing I have ever done in my entire life”</td>
<td></td>
</tr>
<tr>
<td>“Thank you for teaching me about COPE! You should teach it to other kids.”</td>
<td></td>
</tr>
</tbody>
</table>
Initial Post-COPE Evaluation

The initial Post-COPE Evaluation Tool allowed the DNP student to assess the overall helpfulness of the program and any aspects that were especially impactful, or not helpful. In regards to the overall helpfulness of the COPE for Children program, 24 (96%) of the students stated that it was helpful overall and 23 (92%) of the students stated that they would recommend the program to other kids their age. Only one student (4%) voiced uncertainty that the program was helpful overall and two students (8%) stated that they did not think that other kids their age should do the program. When asked to expand on why they felt this way, one student stated “I did not feel like I learned much” and the other stated, “I don’t really think it would help them.” However, these two students reported that the overall program was helpful to them.

Another question addressed on the initial Post-COPE Evaluation tool was in regards to the students’ perceptions of the impact of the program on their home and school life (Table 9). Sixty percent of the students reported some level of improvement in their home and school life, while 40% voiced that there was no change. None of the students reported that there was a decrease in their perception of their home and school life after the program.
Table 10

Student Perceptions of Home and School Life Post-COPE

<table>
<thead>
<tr>
<th>After going through the COPE program, how is your home and school life?</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much improved.</td>
<td>8</td>
</tr>
<tr>
<td>Much improved.</td>
<td>2</td>
</tr>
<tr>
<td>A little bit improved.</td>
<td>5</td>
</tr>
<tr>
<td>No change.</td>
<td>10</td>
</tr>
<tr>
<td>A little bit worse.</td>
<td>0</td>
</tr>
<tr>
<td>Much worse.</td>
<td>0</td>
</tr>
<tr>
<td>Very much worse.</td>
<td>0</td>
</tr>
</tbody>
</table>

When asked if they were able to deal with problems or concerns that come up at home or at school better after than before the program, all of the students responded positively. Examples of the comments voiced included: “It solves problems at home when I fight with my brother” and “I say ‘please stop’ and I am able to deal with my problems better.” When asked if there was anything in the sessions that was not helpful, only two students responded negatively. One student stated that the only things that were not helpful were things that he/she already knew, and the other student stated that one session was not very helpful but was not able to remember
which session that was exactly. When considering these two responses with the question regarding the overall helpfulness of the program, both of these students responded that the overall program was helpful.

Finally, the initial Post-COPE Evaluation questionnaire asked the students to describe what was most helpful or what they enjoyed most about the program. Of the 25 students, 20 of them were able to give specific examples of what was helpful or what they enjoyed. A few of the students were unsure or unable to give specific examples. Examples of the positive remarks regarding what was most helpful from the students are as follows: “The positive self-talk”; “Learning ways to deal with problems”; “Learning how to express my feelings better”; “That it’s good to take a deep breath and think about good thoughts”; “You can solve problems better if you are nice and talk appropriately”; “Writing about my dreams”; and “How to talk to someone when you have a problem”.

Long-Term Post-COPE Evaluation

The two questions on the Long-Term Post-COPE Evaluation addressed the students’ recollection of the concepts that were taught in the COPE program as well the tools and skills that they continue to use. This evaluation allowed the DNP student to assess whether there was long-term retaining of concepts of the program and a long-term impact on the students. Twenty of the 25 students were able to verbalize aspects of the program that they remembered from the COPE program. The majority of the students remembered the concepts of positive self-talk and stress-relieving techniques such as deep breathing, counting, and singing the ABCS when upset or worried. Other comments regarding concepts remembered and those that continued to be exercised included “Treating others how I want to be treated”, “How to control my emotions around bullies”, and “Walk away when people are being mean and tell the teacher if they don’t
stop.” In addition, several students gave real-life examples during which they were able to use the skills that they learned in the COPE program. For example, one student stated, “I go outside and take a deep breath.” Another student stated, “I put my hand on my belly and take a deep breath.”

**Perceptions of Key Staff**

The principal, long-term substitute, and paraprofessional present in the classroom during implementation provided letters of support for the program (Appendix H). Each of these individuals had positive comments regarding the program. In addition, these individuals stated that this program would be beneficial for other students in the future.

**Conclusion**

Each of the tools used for measuring the helpfulness and feasibility of implementing the COPE for Children Program in the elementary school setting resulted in data that allowed the DNP student to draw meaningful conclusions. The students’ overall impression was that the COPE for Children program was helpful in giving them tools and skills to improve their behaviors and responses to stressful situation, and the teachers’ ratings of behavior were of improvement. In addition, other key stakeholders, such as the principal and other school staff reported that there was an observable improvement in the behaviors of the students that participated in the program. These conclusions will be further described and addressed in the following chapter.
CHAPTER 6
DISCUSSION

This chapter includes a discussion of the overall findings of this scholarly project and its implications to advanced nursing practice. It also addresses the limitations that were discovered during implementation of the COPE for Children program at the participating school and the evaluation of its effectiveness. In addition, the chapter provides recommendations for future implementation of this program in a similar setting and group of participants. Finally, the role of a doctorally prepared nurse in the implementation of an evidence-based project is discussed with reference to this DNP’s role in the scholarly project described in the previous chapters.

Overall Summary of Findings

As stated previously, 25 students in a 2nd grade classroom participated in the COPE for Children program over a seven-week period. Sixteen students completed all seven sessions, and the students who missed a session were encouraged to review the session and participate in the homework activity. In retrospect, it would have been beneficial for the DNP student to teach each missed session to the student at a later time in order for each student to benefit from being actively taught the program in entirety. However, the DNP student was only in the classroom one day a week, and the DNP student and the mentor had agreed upon an allotted amount of time on that day of the week for the implementation of the program. In order to teach absent students the session that they missed, the students would have missed other regularly scheduled classes or events, putting them behind in their normal coursework. Therefore, the fact that nine of the students were unable to be actively taught the COPE program in entirety is a limitation that comes with implementing this program in the school setting.
Conclusions regarding the effectiveness and feasibility of the COPE for Children program in this age group and setting were made based on data collected and described in the previous chapter. Discussion of the implications of these data are addressed further.

**Participant Information Tool**

According to Umberson and Montez (2010), a lack of supportive adult relationships in childhood can lead to an increased risk for depression, lack of personal control, poor health habits, and an inability to have supportive relationships across the lifespan. Therefore, the students’ comfort level in talking to and having a supportive relationship with an adult either at home or at school is important. It will be helpful for the teacher or principal to have an understanding of the students’ perceptions of their abilities to communicate with an adult. In the event that students do not feel as though they have an adult that they can talk to, the teacher and/or the principal can work towards providing a mentor or trusted adult for this student to facilitate trust and provide a resource for guidance or advice. Drury (2003) reported that there are several factors that negatively impact communication between children and adults. Barriers to communication include the children’s perceived imbalance of power in relation to the authority figure; the children feeling as though the adult is being patronizing; and the children feeling as though the adult will not be able to understand their position or feelings. Therefore, by acknowledging these potential barriers, staff at the school can strive to be approachable and facilitate a positive child-adult relationship with students, especially those who are at risk for not having that relationship in their home environments.

As stated earlier, the information regarding significant events that happened in the child’s life over the previous 12 months was moved from the Participant Information Tool to the Post-COPE Evaluation questionnaire. However, the data are more relevant to discuss in relation to
other risk factors for compromised mental health. Eighteen of the 25 students reported at least one significant event in the last 12 months. In addition, 10 students reported more than one significant event in the last twelve months. All of these significant events are potential threats to children’s mental health. The frequency of these events in children’s lives supports the benefit of a mental health promotion program.

A limitation of the Participant Information Tool and the Post-COPE Evaluation questionnaire was recognized during the analysis phase. Because these were completed anonymously, the information in the forms could not be correlated with the individuals’ previous behaviors or improvements in behaviors. However, the information obtained is relevant in that it provides further rationale and support for the need of a mental health promotion program in this group of children in order to counteract risk factors for compromised mental health. In addition, this information is helpful to provide to the key staff at the school in order to help them recognize that there may be a need to assess perceived student support from teachers or gaps in the home setting that may need to be addressed by the school staff.

Rating of Sessions

Figure 1 documents the percentage of students rating the session as not helpful at all, a little bit helpful, and very helpful. The higher percentage of rating the session as very helpful was consistent for the majority of the sessions. Following the third session, the percentage of students who found the sessions very helpful increased with each session. In addition, Figure 2 depicts the average rating of each session and demonstrates that all of the sessions were rated in a relatively similar (1.5 to 1.7) manner except for Session 1 and Session 3 (rated around 1.25). It was not a surprise that Session 1 had a lower rating because of the initial introduction of new concepts and information that was potentially confusing or novel to the students. However, the
lower rating in Session 3 demanded some attention. Upon reviewing content of the program, it was noted that the third session introduced the topics of stress and coinciding coping techniques, which were confusing to the students at first and became clearer as they were revisited in the rest of the program sessions. In addition, many of the positive comments on the Post-COPE Evaluation questionnaire and the letters written by the students discussed how the coping techniques introduced in Session 3 were some of the key aspects of the program that they were exercising after finishing the program. Therefore, it can be assumed that these concepts and skills became clearer with the revisiting of them throughout the following sessions. It is recommended that acknowledgement be given verbally to the participants regarding the complexity of the concepts addressed in Session 3. In order to prevent the students from getting frustrated if they do not understand the concepts right away, they can be told prior to these sessions that these concepts introduced will be revisited in future sessions.

Upon evaluation of this information, it is apparent that each of the sessions was beneficial to a large majority of the students. Because the individual session evaluations were not matched to maintain anonymity, it is unclear if the same students were consistently rating the sessions as not helpful at all. This prevented the DNP student from identifying particular students who may have benefited from a one-on-one type of implementation or further clarification of certain concepts. During the implementation of the project, there were times when it was apparent that the students were not completely grasping the concepts, or that some of the terms were above their current knowledge or understanding. While this program has been implemented previously in seven-year olds, there were some aspects of the program, such as the concept of mental imagery and self-esteem, which seemed advanced for them in the manner in which they were presented and described in the workbook. In addition, many of the exercises in the COPE for
Children manual included exercises that asked the students to write down thoughts or feelings. Many times the students had many questions on how to spell certain words or were unable to finish an exercise in the time allotted to that exercise, signaling that their writing and language abilities were somewhat challenged by the standardized content.

According to Piaget, seven-year old children are nearing the end of the preoperational stage of development and moving toward the concrete operational stage of development (McLeod, 2015). This transition is significant in that children are able to move from an inability to use logic and combine ideas or concepts, to a more organized and rational thought process. However, according to Piaget, their ability to think abstractly is still limited. Comparatively, Vygotsky (1978) introduced several thoughts that suggested that Piaget’s theory was limited and did not give proper attention to several other contributing factors to learning.

According to McLeod (2014), Vygotsky theorized that there is more fluidity to the cognitive development of children in that their social interactions and guidance provided from a “more knowledgeable other” allows them to understand concepts or solve problems that would otherwise be too difficult for them to accomplish on their own. Vygotsky (1978) also suggests that children have a zone of proximal development, which is defined as “the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance, or in collaboration with more capable peers” (p. 86). Being in this zone of proximal development, with the help, guidance, and encouragement of the “more knowledgeable other” allows the children to develop and exercise skills or concepts that are too difficult to master on their own. In addition, when Vygotsky’s theory is applied directly to the classroom setting, the process of reciprocal teaching evolves, which includes a collaboration of the teacher and students.
summarizing, questioning, clarifying, and predicting in order to grasp a concept or skill. During this cycle, “scaffolding” and “apprenticeship” are used through which the teacher introduces, arranges, or structures a skill, concept, or task so that the less competent student can grasp it more successfully (McLeod, 2014). As time goes on and the students’ competence increases, the teacher’s role in this cycle decreases. Therefore, while grasping some of the concepts addressed in the COPE program may be more challenging than the usual cognitive development of a seven-year-old by Piaget’s standards, Vygotsky argued that a knowledgeable individual, such as a teacher, can help guide and encourage the child towards understanding concepts such as mental imagery and self-esteem.

Therefore, for future implementation in this age group in this type of group setting, it would be helpful for the instructor to understand that there may be some confusion regarding terminology or concepts in the beginning, and to provide support and reassurance to the participants that these concepts will be further addressed and explained. This may help decrease the potential for the participants to feel overwhelmed or frustrated if they do not understand the concepts with the first explanation. Other limitations that need to be addressed if this program is repeated is the need for more time for each session and an understanding that children seven and eight years of age have a limited ability to spell the words that they want to use to complete the exercises.

In addition, it may be helpful to utilize a reading ability, language comprehension, and spelling ability screening tool in order to gauge where the group of students are prior to implementing the program. This will also help identify students who may need more explanation or direction with comprehension or exercises that include spelling. Once such screening tool is the PALS tool (Center on Response, 2015). This tool has been shown to have
high levels of classification accuracy (Sensitivity 0.922, Specificity 0.702); reliability (Chronbach’s alpha for spelling and word recognition 0.81-0.99); construct validity (determined through principal component analysis; coefficient range 0.81-0.85), as well as moderately high generalizability. This computerized screening tool takes 23-43 minutes to complete and has been widely used nationally (Center on Response, 2015).

In the participating school, the students participate in Accelerated Reader (AR) and are given scores based on reading comprehension tests that they take after reading specific books throughout the school year. The initial reading levels of the students are obtained at the beginning of the year through taking a computerized test. In the future, these scores could be analyzed prior to the implementation of the COPE program in order to gauge the comprehension of the students who will be participating.

**PBIS Classroom Clip Chart Analysis**

As depicted in Figure 3 (Chapter 5), the daily average PBIS Clip Chart behavior ratings improved both initially and long-term following the implementation of the COPE program. In addition, the average of the behaviors from each timeframe significantly increased initially and again upon long-term evaluation, as seen in Table 7 and Table 8. These data further support the effectiveness of the COPE program in positively impacting students’ daily behaviors and their coping abilities immediately after the program and long-term.

It could be argued that because there was a change in the teacher between the pre-COPE and post-COPE PBIS Clip Chart analysis, there was not consistency in the manner with which the teachers used the PBIS Clip Chart. This, therefore, is a limitation of the data collected from the PBIS Clip Chart. However, this potential limitation is lessened in that both teachers were given the same training on the use of the PBIS Classroom Clip Chart and use the PBIS teacher
manual. In addition, the DNP student met with both teachers to discuss how the PBIS Clip Chart would be used in the analysis process of the program implementation in order to ensure that there was understanding and consistency in the use of the chart.

**Information from Letters from Students**

All of the letters from the students expressed positive feelings regarding the implementation of the COPE for Children program and the concepts and lessons that they learned. In addition, many of the students reported specific examples of using the skills that they learned during the program, as seen in Table 9. Several students expressed a desire to continue using the skills and lessons that they learned during the COPE for Children program in the future. Others wrote that they felt participation in the program was important for other students as well (see example in Table 9). These comments from the students further support the effectiveness and the benefit of this program, as the participants perceived that it was helpful and a positive experience overall.

**Initial Post-COPE Evaluation**

Each of the aspects of the Initial Post-COPE Evaluation questionnaire consistently resulted in many positive comments and perceptions from the students. Almost all of the students reported that they felt that the program was helpful overall and that they would recommend the program to other students. Fifteen of the students reported that there was an improvement in their home and school life after participating in the COPE for Children program. In addition, 20 of the 25 students were able to recollect specific strategies and skills that they learned and put into practice that were helpful in their daily life.

The information gleaned from this questionnaire further supports the benefits gained from the implementation of the COPE for Children program. However, some students did not
have as positive perceptions of the program. Students who stated that there were aspects of the program that were not helpful, or who would not recommend the program to others, may have had greater understanding and perceived greater benefit if adjustments were made during sessions for understanding of advanced concepts, and if there had been longer class sessions to accommodate spelling abilities for the writing exercises.

**Long-Term Post-COPE Evaluation**

As stated above when discussing the Long-Term Evaluation, 20 of the students (80%) were able to recall key concepts of the program and name specific tools or real-life examples in which they used the skills learned in the COPE program. This is the same number of students who were able to recollect concepts in the Initial Post-COPE Evaluation. This supports the likelihood that students who were able to solidify concepts during the program were able to retain information regarding those tools and skills in the long-term. Further, information gathered from the Long-Term Evaluation supports the continuing effects of positive coping skills and healthy lifestyle behaviors that are taught and reinforced during the COPE program. If adjustments had been made regarding increased explanation of advanced concepts and longer class session times to accommodate spelling abilities for the writing exercises, students who were unable to recall key concepts, or who did not report continuing to use skills or concepts learned in the COPE program, may have had increased long-term recollection and application of the concepts and skills learned during the program.

**Perceptions of Key Staff**

The positive comments provided by the principal, long-term substitute, and paraprofessional further support the continued use of the COPE program in the elementary school setting. These individuals reported that they saw an increase of positive behaviors and
coping skills in the students who participated in the program. In addition, the staff members reported that not only was this program helpful to the students who participated in the scholarly project, but that it would also be beneficial for all grade levels and students in the elementary school.

**Recommendations**

**Sustainability**

The findings of the scholarly project implementing the COPE for Children program in the pilot classroom of 2nd grade students support the feasibility and effectiveness of this mental health promotion program in this setting with this age group of children. In order to facilitate sustainability of this program at the participating school, there are several actions the DNP student will take. First, the student will set up a meeting with the key staff, especially the teacher and the principal, in order to give a formal report of the findings of the project. The report will include recommendations for continued implementation of this program for a designated age group of students at this school on an annual basis. The DNP student will also provide further dissemination of the project findings and plan for sustainability to other teachers at the school, the district curriculum committee, and the school board, as desired by the teacher and the principal.

In addition, the DNP student will create a pamphlet (Appendix I) that will be distributed to the parents of the 2nd grade student who participated in the pilot program. This pamphlet will include the findings of the project regarding the improvement in behaviors in the classroom as well as the positive comments and responses of the students to the COPE for Children Program. This pamphlet will also encourage parents to continue to facilitate and support the use of the skills that the students learned in the COPE for Children program to further promote mental
health. This is feasible for the parents to do, as they received the weekly summary of what the students learned throughout the implementation of the program. Therefore, they are knowledgeable of the skills to facilitate and support.

**Further Implementation of COPE for Children**

It is recommended that the participating school integrate the COPE for Children program into the curriculum of either the 2nd or the 3rd grade. If the school staff prefers to keep the program in the 2nd grade classroom due to schedule or curriculum needs, it may be necessary to increase the amount of time from 30 minutes to 45 minutes for each session to allow further expatiation of advanced concepts and to allow the students to have more time for the writing exercises. This extended time period may require there to be some time taken away from the independent reading portion of the day. However, it could be argued that this additional time would only be needed once a week for a limited period of time, and the benefit of the program would outweigh the 15-minute decrease in time for independent reading.

If it were felt that the 3rd grade classrooms would be more appropriate for this program because of an increased spelling and comprehension ability, then it would be recommended that the COPE program be piloted next year in all the 3rd grade classrooms during 30 minutes sessions. If the students who participated this year want to repeat their participation of the program, their participation would be acceptable. If not, an alternate activity could be provided for them during the teaching of the sessions. The individual who implements the program, and the students, can provide feedback regarding their perceptions of the helpfulness and feasibility of the program in the 30 minute sessions. These data can be compared to the perceptions of the pilot classroom that completed the program during this DNP scholarly project. The use of the
program in the school can then be reevaluated and the desire for and benefit of long-term sustainability can be further addressed at that time.

In regards to future measurement tools, it is recommended that the tools previously discussed be used to continue to provide rationale of the effectiveness and feasibility of the program. In addition, it is recommended that participant code numbers be used so that the data from these tools can be more richly utilized. An example of a personal identifier that could be anonymously used would be having the students use the numbers from their birth month and date, followed by the number of how many brothers they have, followed by the number of sisters they have, followed by what grade they are in. This number would allow the implementing individual to correlate data from the measurement tools without identifying which student was responding. Important correlations that could be made would include information such as the impact of the program through the PBIS Classroom Clip Chart data compared to the number of significant events reported by an individual.

Another measurement tool that could be used for future implementation that was a missed opportunity in this scholarly project is the use of the stress thermometer at the end of each session. While students were encouraged to “color in” their level of stress on the thermometer each week to help them personally gauge if their levels of stress were improving throughout the program, the DNP student did not collect this information. It would have been helpful to have yet another indicator of the impact of the program on the mental health of the students, and the stress thermometer would have provided that information.

In order for this program to be sustainable long-term, it would be necessary for a staff member at the school to receive the training and be able to implement the COPE for Children Program. There is a social worker and a behavioral specialist who could implement this program
in a specific grade, or the teachers for a specific grade level could receive the training. This is an aspect of sustainability that will be discussed with the principal, who may also have other ideas regarding staff members who would be the best fit for training and implementation of the COPE for Children Program. The one potential barrier to training staff members is the cost of $250 dollars for the training. However, the DNP student has information for the staff regarding grants that may be available for this training. A grant similar to the one that the student received for the implementation of this project from a local community organization would be a potential funding source. In addition to the training, the time required for one of the school staff to implement the program would have to be considered. The average pay for a school staff member with a Master’s degree and several years of experience is around $40.00 per hour. There would be an added one-time cost of around $80 for the staff member to be trained. In addition, the time required to implement the program would be 3.5 hours ($140.00) if done on an annual basis, and seven hours ($380.00) if done on a biannual basis.

Another cost that would have to be addressed for the future implementation of the program is the cost of the COPE for Children manuals that are given to the students. These manuals cost $20 each. The benefits of the required use of these manuals as part of the program are that the students are able to use them during the program and then take them home to share with their parents and family; are able to reference them; or can continue to work in them long-term. Again, a grant could be applied for in order to help with the cost of these manuals on an annual basis. In addition, the cost of these manuals could be addressed with the district curriculum committee or the school board. With the positive results of this pilot program as well as the long-term impact that promotion of mental health has on the overall wellbeing and health
of children and adolescents, these manuals could be added to the curriculum annually, for a designated grade.

While the initial cost of sustaining the COPE for Children program through obtaining the needed training may seem significant, and there is a continued annual cost for the manuals, the benefits of mental health promotion far outweigh the costs. O’Connell, Boat, and Warner (2009) report that in 2007, the annual costs related to the treatment of mental, emotional, and behavioral disorders and issues in young people totaled approximately $247 billion dollars. The annual national costs of treatment for mental health disorders in the United States for children ages 6 to 11 is $163 per child. In addition to these costs, mental, emotional, and behavioral disorders “decrease productivity and significantly increase the utilization of services, thus reducing economic resources available to society for other purposes” (O’Connell, Boat, & Warner, 2009, p. XX). The average cost of the impact of mental illness on health, productivity, and crime-related costs for individuals aged 0-24 was roughly $2,380 per person in 2007. Therefore, recognizing the impact of the cost of mental, emotional, and behavioral concerns in the adolescent population, it is reasonable to spend the money for training staff to implement the COPE program as well as the $20 per student for the COPE for Children manual.

Limitations

As mentioned previously, the challenges/limitations during this specific implementation of the COPE for Children Program included that the concepts seemed too advanced for these students at times, and that they required more time on the written exercises than the 30-minute time-frame allowed. These limitations may have been behind the number of students who reported a lack of effectiveness of the program and a lack of ability to recall the key concepts or use the skills after completing the program. An increase in the time allotted for each session
would possibly address these limitations. Another strategy to address these limitations may include splitting the classroom into smaller groups to implement each session; however, there are several other time factors in regards to the school day schedule as well as the time required of the person implementing the program, that need to be considered when looking at implementing in smaller groups. In addition, since both the teachers and the students found the program so beneficial in this age group, it may be helpful to create another version of the program with language that is more understandable for seven to eight-year old children. The program could be adapted to use exercises that include expression of thoughts in drawings, or through the use of music, rather than writing. While there may be a tendency to want to change some of the verbiage, examples, or exercises given in the manual in order to address the barriers that were found in this age group of students, it is imperative to recognize that the fidelity of the program is maintained through the strict adherence to the training received on how to implement the program, including the adherence to the script in the manual. When fidelity is compromised, the program’s effectiveness may also be lessened.

Another impact and potential limitation mentioned previously, was the change in teachers. Because of an unforeseen situation, the second graders experienced changes in teachers from a long-term substitute, to the original classroom teacher (the DNP student’s mentor) during the implementation of the program. As was mentioned, measures were taken to combat the effects that this change may have had on the results of the program. The DNP student ensured that both of the teachers received the same information regarding the implementation of the COPE for Children program as well as the use of the PBIS Classroom Clip Chart as a measurement tool. The student had a discussion with both of the teachers to work towards a consistent use of the PBIS Classroom Clip Chart. In addition, it was beneficial
that the same teacher was in the classroom for the initial post-COPE collection as the long-term post-COPE collection of PBIS Classroom Clip Chart data.

Another limitation that was recognized during the implementation of the program is the likelihood of several students being absent for one or more of the session implementation days or times. Because each session was only taught once during the week, if students were absent for that specific date and time either due to illness or an appointment outside of school, they did not receive the benefit of the concepts and information shared during that session. As the school setting is an ideal place for the implementation of the COPE for Children program since it allows a significant number of students to be impacted at one time, this limitation could be addressed in the future. A time could be set aside later in the week so that students who missed the initial implementation of the session could be taught the session that they missed. In the participating school, this time could be either during the morning independent reading portion of the day, or during the afternoon recess period.

In addition, a limitation recognized during data analysis was the lack of participant identifiers on the measurement tools, which therefore hindered the ability to recognize potentially significant correlations, as mentioned previously. For example, it would have been helpful to be able to compare the impact of the program on students who potentially had a higher risk for decreased mental health and coping skills, to those who had a lack of risk factors. The Participant Information Tool data could be associated with the information from the Rating of Sessions, PBIS Classroom Clip Chart data, and Post-COPE Evaluation Questionnaires.

The final limitation of this pilot project was the lack of standardization of the measurement tools that were used for evaluation of the feasibility and effectiveness of the program. While the pre and post COPE questionnaires were modeled after previously used
questionnaires in similar types of pilot programs, these specific versions had not been previously used in this age group. The DNP student was not certain that the questions used would result in the information needed to analyze the feasibility and effectiveness of the program. After doing this pilot program, the DNP student became aware of some small things that should be changed in regards to the questionnaires, such as the fact that they should all be administered in interview format, because some of the language used was above the comprehension level of the 2nd graders in this project. These modifications could be made and trialed in a follow-up pilot program with a new group of students.

**Anecdotal Findings**

While it was desired that there would be improvement in the measureable behaviors of the students (as portrayed by the PBIS Clip Chart), the teacher in the classroom, as well as the other key staff members involved, were very impressed by the overall impact that the program had on the students. All of the students voiced support of and appreciation for the program at some point to either the DNP student or the teacher of the classroom. Students were able to verbalize skills and strategies that they learned throughout the program as well as give examples of instances in their lives where they were using these skills. A few of the support staff at the school who were involved with behaviorally or emotionally challenged students voiced strong support for the program and an appreciation of the effects that they saw it having on these students. These findings further support the recommendation for sustainability of the COPE for Children program at the participating school. As alluded to above, the steps that would be taken by the DNP student and key staff members at the school in order to facilitate sustainability would include the following: (a) have a discussion with the key staff members regarding what grade level this program will be used for and the desired method of funding for purchasing the COPE
manuals on an annual basis; (b) identify key staff members that will be trained to implement the program in the future; (c) search for and apply for grants to fund the training for these staff members as well as funding for the COPE manuals if they are not added to curriculum budgets; and (d) begin the annual implementation of the COPE for Children Program.

**Doctor of Nursing Practice Role**

The DNP prepared provider is expected to be able to fulfill and practice in a multitude of roles in order to facilitate the evolvement of advanced practice nursing and improved patient care. These roles include being a clinician, a scholar, a leader, and an educator. Not only are these roles dynamic, they are also flexible and adaptable for a variety of settings. During the implementation of this scholarly project, this DNP student utilized and demonstrated each of these roles.

**Clinician**

As a nurse who currently works in a pediatric emergency room setting, this DNP student observed an increasing number of children and adolescents presenting with depression, anxiety, suicidal ideations and suicide attempts. These children and adolescents ranged from six years old to 17 years old, and each had a unique story. However, the one consistent theme that this DNP student observed was the need to address risk factors and promote positive mental health before the individual experienced a level of crisis and required emergency services. This observation as a clinician served as an inspiration for this project.

Therefore, the DNP student used a knowledge base regarding the ability to integrate nursing science with knowledge from psychosocial, analytical, and organizational sciences as well as the use of science-based theories in order to develop and evaluate a new practice approach that would address the lack of mental health promotion in adolescents. Clinical
expertise in understanding childhood and adolescent development, both physical and psychological, was used in order to select a specific program for the new practice approach as well as the measurement tools that would be used to analyze the effectiveness of the program. Finally, clinical leadership skills were used in order to advocate for the mental health needs of the students, to communicate interprofessionally and influence leaders in the school to recognize this need, and to collect and evaluate the information received throughout the implementation of the program in supporting the importance and impact of mental health promotion.

Scholar

The role of the scholar was greatly exercised during the information gathering and project planning phases of this scholarly project. Beck’s Cognitive Theory of Depression was used to support the selection of the COPE for Children program as a beneficial and evidence-based mental health promotion program. In order to select an appropriate age for the program implementation, the developmental considerations of children and adolescents were evaluated along with the understanding that mental health promotion is most beneficial the earlier it can be facilitated. The Transtheoretical Model was then used to guide the implementation of an intervention that focused on behavior change in order to provide understanding of where the participants may have been in their desire to change as well as their ability to change. Finally, the DNP student applied the concepts of the PARIHS Model to assess the physical and psychosocial environment at the participating school in order to determine if this setting would be ready for change and the implementation of an evidence-based intervention.

In addition, scholarship was demonstrated through the collection and analysis of information in order to measure the usefulness and benefit of this pilot program. The DNP student collected the information, organized it in spreadsheets and statistical packages, and
proceeded to look for significant outcomes and patterns. Other data were represented on charts and tables.

Throughout this process, the DNP student combined the application of theoretical concepts and the integration of current, evidence-based research to critically identify and assess a current gap in the delivery of mental health promotion. Then, this information was used to translate current evidence into practice through the implementation of the COPE for Children Program in a school-based setting with a group of children in order to promote mental health and facilitate healthy lifestyle behaviors. The Transtheoretical Model and the PARIHS model mentioned above were used to guide this process. During this time, the DNP student participated in interdisciplinary collaboration in order to develop a plan for implementation that would be successful. Finally, the DNP student scheduled several opportunities for dissemination of the results of this scholarly project with the school staff, the dissertation committee, and interested GVSU staff, GVSU students, and community members.

Leader

Throughout the implementation of this DNP scholarly project, the DNP student demonstrated leadership through being the director of the project and the individual teaching the COPE for Children program to the participants. Throughout the planning and implementation phases of this project, the DNP student served as a liaison between the GVSU College of Nursing and the participating school; organized and attended meetings regarding this project with key stakeholders at the school; provided significant research and evidence for the implementation of this project; and coordinated with the key stakeholders in order to facilitate a smooth implementation of the pilot of the COPE for Children program. In addition, the DNP student applied for and received a local community grant and the Grand Valley Presidential
Research Grant. This application process provided the DNP student with knowledge and skills that will be useful as a DNP leader in the future.

There were several other leadership skills that were exercised throughout the implementation of this project. Throughout the entire process, the DNP student had to ensure that there was cultural sensitivity demonstrated towards the organization as well as the staff and students who were involved in the project. The DNP student had to be aware of the potential ethical dilemmas and challenging situations that may arise during the implementation of the project and be able to provide leadership in addressing concerns or challenges. In addition, the DNP student was able to provide leadership in advocating for increasing mental health promotion in the participating school as well as advocating for specific students’ needs as they were brought to the attention of the DNP student. Finally, the DNP student was able to guide, mentor, and support the students as they participated in the COPE for Children Program, as well as being able to be a consultant to the school staff regarding mental health promotion strategies.

**Educator**

During the planning and implementation of this project, the DNP student was able to demonstrate the role of the educator. First, the DNP student provided education and instruction to the key stakeholders, including board members, administrative staff, and teachers, regarding the need to address and facilitate the promotion of mental health in the school setting as well as education regarding the COPE for Children program specifically. The DNP student then provided education to parents and other staff at the school regarding the COPE for Children program and the benefit that mental health promotion has for young children. Finally, the DNP student was able to further evolve in the role as an educator through implementing the COPE for Children program with the group of 2nd grade students in the pilot classroom.
There were many skills that were used during the education aspects of the scholarly project. First, it was imperative that the DNP student use advanced communication skills and processes to lead this implementation. In addition, the DNP student had to have an extensive understanding of the economic and financial implications of the implementation and sustainability of the COPE for Children Program in order to educate the key stakeholders involved in all aspects of this scholarly project.

**Conclusion**

The multiple roles of the DNP prepared nurse can be practiced, demonstrated, and further evolved through the implementation of an evidence-based scholarly project. The implementation of the evidence-based COPE for Children program, as a means to promote mental health and healthy lifestyle behaviors, helped this DNP student develop and practice these roles. In addition, this program provided significant benefit to the students who participated, as evidenced by the discussion of the findings in the previous chapters. It is desired that this project can demonstrate the need for, as well as the benefit of, mental health promotion programs. It is hoped it will inspire others to integrate mental health promotion into practice that can prevent mental health illness and situations of crisis.
May 11, 2015

Ms. Maria McCormick, RN, BSN
Kirkhoff College of Nursing
Grand Valley State University
Cook DeVos Center for Health Sciences
301 Michigan St. NE, Suite 300
Grand Rapids, MI 49503-3314

Dear Maria,

This letter is to verify that you have permission to use the COPE 7-Session Cognitive Behavioral Therapy program as part of your DNP scholarly project. I look forward to the outcomes of your project.

Please let me know if you have any questions or require anything further.

Warm regards,

Bernadette Mazurek Melnyk, PhD, RN, CPNP-PMHNP, FAANP, FNAP, FAAN
Owner
COPE2Thrive
Good Morning Everyone,

I am looking forward to speaking with you all tomorrow and hearing more about how you plan to use COPE in your practice!

I wanted to share some information for the COPE Training tomorrow, May 28, at 4:30pm EST. You should have received a invitation to join the training from the joinme.com website. You will be able to access the training from this screen sharing website. There will be a conference number listed on the invitation. We have found it is best to use this number with a cell phone or another phone that is able to be muted. Please make sure you use a phone with a mute option, in order to eliminate background noise.

I have attached the COPE Training Manual, COPE Training PPT and 2 COPE manuals to this email. We will use the COPE Training PPT tomorrow during our session.

You will soon receive two hard copies of the manuals at the address you previously provided.

If you have any questions or need anything else, please let me know. Again, I look forward to the training tomorrow afternoon and having the opportunity to speak with everyone!

Thank You,

Caroline B. Graham, MS.Ed. LPC
Mental Health Counselor
Director of COPE Programs
APPENDIX C
Handouts for the Participating School

## Kent County: Rationale for Intervention

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<th>ENGAGE</th>
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Anonymous survey of middle school aged adolescents in Kent County. Some of the major concerns identified included the following:

- Between 8.5% and 11.5% of adolescents surveyed reported that they believed that some of their friends had used alcohol, or tobacco recently.
- The average age of first alcohol use in middle school aged adolescents is 10.7 years old.
- One in five students reported riding in a car that was driven by someone who had been drinking alcohol.
- More than one in four students reported that they have easy access to alcohol, one in five reported easy access to cigarettes, and one in nine reported easy access to drugs such as marijuana.
- Six to eight out of ten students have seen various methods of physical bullying at school. 50% of students have heard a student threaten physical violence to another student more than one time in the last twelve months and/or have seen other student’s personal things wrecked or damaged more than once in the last twelve months.
- One out of ten students reported avoiding going to school because they felt unsafe on the way to school or at school on one or more of the past 30 days.
- One out of four students reported feeling sad or hopeless almost every day for two weeks or more in a row during the past 12 months to the point that it affected their normal activities.
- One in five students reported seriously considering suicide, one in six reported making a plan about how they would attempt suicide, and almost one in ten students reported attempting suicide. Half of those who attempted suicide required medical treatment as a result of their attempt.
- Almost one in ten middle school students report having sexual intercourse, while only 57% of these reported condom use.
- More than one in ten students reported that their parents would not know if they did not come home in time.
Timeline of Proposed Intervention

- Initial Meeting: March, 2015
- By May 15th, 2015
  - Meet with other key staff for education.
  - Determine specific dates of implementation
- By November 25th, 2015
  - Complete implementation of intervention
- By January 31st, 2016
  - Complete reevaluation of intervention
- By March 30th, 2016
  - Report project effectiveness and findings to Cherry Creek staff and/or families

Other Considerations:
- What classroom/teacher would this intervention fit best?
- Where would this fit in the school day/curriculum?
- What dates are school breaks?
- What days are testing?
It’s a fact that right now in the U.S., children, teens, and young adults are not getting the mental health treatment they need. Many are on long waiting lists, and fewer than 25% are receiving help. According to the latest research, at least 5% of children and 9-20% of all adolescents suffer from depression, and the risk is even higher if their parents experience depression as well. And those numbers are even higher in minority populations.

Faced with these facts, it’s clear that timely, evidence-based prevention and treatment for depressed and anxious children and teens is an absolute must. That is why the COPE program was created. COPE understands young people’s needs and offers access to education and skills-building to help prevent and manage negative emotions while enhancing healthy behaviors.

Through a series of brief, easy-to-follow sessions, complete with skills-building activities, the COPE Program conveys that there is hope for change, and that both depression and anxiety are treatable.

COPE recognizes that we can’t control trigger events, but we can control our responses to them. For less than the cost of just one session with a therapist, the COPE Program teaches children and teens how to recognize and stop automatic negative thoughts and replace them with positive thoughts instead. The result is feeling emotionally better and behaving in healthy ways.
Discover the COPE Program

How You Think Affects How You Feel and Behave: The Science Behind the COPE Program

The COPE Programs are based on a Cognitive-Behavioral Therapy-based skills-building approach that includes reducing negative thoughts, increasing healthy behaviors, and improving communications and problem-solving skills.

When a person learns to COPE in positive ways, the brain lays down new pathways, helping him or her grow new neuronal connections and deal with stress, anxiety and depressive symptoms in healthy ways.

By helping individuals change their thoughts from negative to positive, their feelings and behaviors naturally follow suit.

By convincing children and teens that they can accomplish whatever it is that is important to them, and reinforcing that what their minds believes that they can achieve, COPE helps them face their fears and take control of their emotions.

The Proof is in The Positive Outcomes:
COPE Gets Real Results

COPE has been used effectively in clinics, schools, and office practices in individual, group and classroom formats. Several separate studies have shown that the COPE Programs results in reduced depressive and anxiety symptoms, as well as improved self-concept.

In a large High School-based COPE Trial, teens that participated in the program in comparison to teens who did not receive COPE had:

- Higher average scores on the social skills specifically cooperation, assertion, and academic competence
- Higher academic performance
- Less alcohol use
- Less depression
- Greater healthy lifestyle behaviors
- Less overweight/obesity
APPENDIX D

Participant Information Tool

Participant Information

Directions: Please fill in the blank, or circle the answer that best answers each question.

1. Your age in years: ________

2. Gender:
   Male
   Female

3. What is your ethnic or racial background? (check all that apply)
   White, not of Hispanic origin
   Black, not of Hispanic origin
   American Indian/Alaskan Native
   Asian/Pacific Islander
   Hispanic
   Multiracial
   Other ___________________

4. Whom do you live with? _______________________________________

5. How many brothers and sisters do you have? _____________________

6. What answer described you the best?
   I have lots of friends at school.
   I have one or two good friends at school.
   I don’t have any friends at school.

7. Do you feel like you can talk to you mom or dad when you are sad or upset?

8. Do you feel like you can talk to an adult at school when you are sad or upset?
APPENDIX E

Post-COPE Evaluation Questionnaire

Please respond to the following questions to help Maria McCormick, BSN, RN, DNP Student improve the COPE program for other students.

Check if any of the following events have happened to your family in the past 12 months.

- Parent/Step-Parent/ separated (no longer living together)
- Parent/Step-Parent divorced
- Birth of a sibling
- Your parent got a new job
- Your parent is working different hours at their job
- There was a death of an immediate family member
- There was a death of a family pet
- An immediate family member had to be hospitalized or is significantly ill
- You moved to a new location
- A family member is in jail or prison

Overall, did you find the 7 COPE sessions helpful?

- Yes
- No

After going through the COPE program, how is your home and school life? (Circle One)

- Very Much Improved
- Much Improved
- A Little Bit Improved
- No Change
- A Little Bit Worse
- Much Worse
- Very Much Worse
Do you feel like you are able to deal with problems or concerns that come up at home or at school better now than before you did this program?

What did you find most helpful or what did you enjoy most about this program?

Was there anything in the sessions that was NOT helpful to you? How was it NOT helpful?

Would you recommend the COPE program to other students? If no, why not?
APPENDIX F

Long-Term Post-COPE Evaluation Questionnaire

Please respond to the following questions to help Maria McCormick, BSN, RN, DNP Student improve the COPE program for other students.

What are some of the things that you remember from the COPE program?

Are there any tools that the COPE program taught you that you continue to use? If so, what are they?
August, 2015

Dear Parents & Guardians,

Hello! My name is Maria McCormick and I am a nurse who is in graduate school at Grand Valley State University. This fall, I am working with the elementary school in their work with a positive behavior model for the students. With the help of your child’s teacher, we will be starting the Creating Opportunities for Personal Empowerment (COPE) program for Children. This program teaches children valuable strategies such as positive self-talk and helpful stress management techniques.

If you do not want your child to participate in this program, please either contact the teacher or me directly (616-987-6033). If you have any further questions about this program, please feel free to contact me, as I am happy to answer them.

I hope you and your child had a wonderful summer and I look forward to working with your child in this important program.

Thank you,

Sincerely,

Maria McCormick, RN, BSN

Grand Valley State University Graduate Nursing Student

Kirkhof College of Nursing
November 5, 2015

Dear Educator,

We are thrilled to have second grade students participate in the COPE (Creating Opportunities for Personal Empowerment) program with Mrs. Maria McCormick. The program supports our efforts to teach children useful strategies to utilize when dealing with stress and life challenges.

The COPE program underwent a review by our Superintendent and Area School's District School Improvement Team in May, 2015. It was enthusiastically endorsed. Our elementary has a school social worker only two days each week, and there is a need for additional emotional support and educational opportunities for children.

is a rural school. The numbers of students in poverty here has risen, as evidenced by free/reduced lunch increases of 20% over the past eight years. With this we have seen instability with family units (housing, loss of jobs). Student behavior and academics have been impacted by family stability as well. As a response, we have adopted Positive Behavior Interventions and Supports (PBIS) as a school structure. The COPE program goals correlates with PBIS ideas, teaching children healthy life-style strategies and encouraging positive choices.

Mrs. McCormick is a wonderful resource for us. She is an active participant in the classroom where COPE is being piloted, and has built relationships with the children. Her skills and understanding of the children has enabled a high-quality implementation.

Thank you for bringing COPE to

Sincerely,

[Signature]
Principal

We Value: Responsibility • Integrity • Compassion • Honesty • Respect • Character Counts
The COPE program is an awesome introduction to children to help them understand and think about their emotions. Many kids at this age do not have the perceptions yet to develop the idea that they can actually control and or change the outcomes of negative situations by thinking through and possibly deciding to react in a less impulsive way.

It has been interesting to see how the students have reacted to the program. At first many seemed mystified by the concept of the program. But gradually, as time and repetition on a weekly basis took place, many seemed to understand that they did have the power to change the way that they reacted or how a situation would take place.

Maria did a wonderful job teaching the program. She has the patience and right temperament to work with young children. All through her time with the class she was very intuitive with meeting the students' needs. She was able to interact with kindness and encouragement. At the same time she held the students to an appropriate standard for their ages and actions. We were lucky to have her!

Sincerely,
The Cope program was a great useful tool for the majority of our students. They learned so much. I feel this needs to be implemented in our school in all grade levels. They learned to turn around bad behaviors into good, how to handle anxiety and stress. What to do with a bully. Mrs. McCormick did a fabulous job with the kids!! 😊

[Signature]
APPENDIX I

Parent Information Pamphlet

COPE
Creating Opportunities for Personal Empowerment

DISCOVER THE POWER TO COPE
Over several weeks during the first half of the year, your child participated in the COPE for Children Program, during which weekly letters were sent home to help keep you informed on what was being taught. This program taught the students valuable strategies such as positive self-talk, capturing and overturning negative emotions and thoughts, as well as helpful stress management skills. I would like to share some of the responses that I got from your children regarding this program and the things they learned. In addition, I kept track of the students placement on the color clip chart at the end of the day before and after the program to see if their positive behaviors in the classroom improved – which they did! Please continue to reinforce these skills in your children, as

Comments from Students:

- Thank you for helping me with my feelings and how I act.
- I learned that I can take a deep breath and think of a good time.
- Learning how to deal with bullies is really helpful.
- My favorite part is positive self-talk. I used it when me and my brother were fighting.
- Thank you for teaching my about positive self-talk. I used it every day.
- You taught me a lot. You have made my life a lot better than before and the program is amazing. I think it is the best thing I have ever done in my entire life.
References


