Guidelines for Adapting Mindfulness-Based School Interventions with Underserved Youth

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Abstract

Low-income and ethnically diverse youth in the United States have unmet needs for mental health services; however, these same youth are unlikely to be connected with high-quality mental health care. Promoting social-emotional competencies through school-based service delivery is one potential solution for improving the accessibility and quality of care for diverse youth facing mental health disparities. Mindfulness, conceived as a set of practices to cultivate social-emotional competencies, can therefore be useful for improving the accessibility and quality of care for diverse youth facing mental health disparities. Given the growing interest in MBSIs and the need to enhance equity in youth mental health services more generally, we provide guidelines to help practicing clinicians successfully adapt and implement MBSIs with underserved youth. First, we offer recommendations for clinicians to enhance underserved youths' engagement with MBSIs. Next, we overview implementation approaches that clinicians could use for increasing access to MBIs in school settings. Following, we discuss strategies clinicians might employ when working with teachers to effectively implement MBSIs with underserved youth in their classrooms. Ultimately, we hope the guidelines offered in this paper might help inform better practice—as well as motivate further, better research—that advances equitable mental health care in schools with underserved youth.

Keywords: mindfulness; school-based interventions; youth mental health; school mental health; evidence-based practice

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Mental health issues are increasing among adolescents since 2005, with as many as one in five youth suffering from mental illness and many more experiencing psychological distress (Molavi et al., 2018; Twenge et al., 2019). Despite this elevated general prevalence rate of mental health problems among children and adolescents, 7.5 million low-income and ethnically diverse youth in the United States have an unmet need for mental health services (Hodgkinson et al., 2017; Kataoka et al., 2002). Additionally, low-income and ethnically diverse youth who experience chronic environmental stressors (e.g., stressful life events, daily hassles, ambient stressors) and persistent poverty face significant challenges to healthy development (Guski, 2001). Practical barriers (e.g., insurance coverage) and cultural barriers (e.g., beliefs about care) have been shown to disproportionately affect service use among ethnically diverse youth (Gudiño et al., 2008). Furthermore, low-income and ethnically diverse youth exposed to chronic environmental stress have been shown to have higher rates of internalizing and externalizing disorders (Grant et al., 2006) relative to their economically advantaged peers (Keenan et al., 1998). Environmental stressors have also contributed to higher rates of poor academic performance, school dropout, and negative social outcomes (e.g., juvenile arrests) among socioeconomically disadvantaged youth (Reynolds et al., 2001).

Despite their need for mental health services, low-income and ethnically diverse youth are unlikely to be connected with high-quality mental health care (Hodgkinson et al., 2017). Barriers to seeking and accessing high-quality mental health care for underserved youth include the stigma associated with help-seeking (Abdullah & Brown, 2011), differences in ethnic and linguistic backgrounds between clinicians and clients (Bauer et al., 2010), clinic staff turnover and burnout leading to poorer quality services (Aarons & Sawitzky, 2006), as well as the

availability (or lack thereof) of state and federal funding initiatives that determine what kind of services are available (Aarons et al., 2011). In addition to these structural and cultural barriers, there are also perceived challenges by clinicians working with low-income and ethnically diverse youth. For example, clinicians have indicated that low-income and ethnically diverse youth are sub-optimally engaged in treatment (Merikangas et al., 2011). A study also showed that clinicians were unable to identify solutions to reduce mental health disparities among low-income and ethnically diverse youth, which emphasizes the continued need to develop and disseminate solutions for engaging and providing effective mental health care with this population (Park et al., 2019).

We suggest that promoting social-emotional competencies through school-based service delivery is one potential solution for improving the accessibility and quality of care for diverse youth facing mental health disparities. Since mental health disparities exacerbate economic inequities, building social-emotional competencies at the level of the whole-school population could be a pivotal approach for improving the wellbeing of youth from disadvantaged backgrounds (Jagers et al., 2018). Although there are various ways to operationalize social-emotional competencies, one of the most common models is the five-factor framework comprised of self-awareness, self-management, social awareness, relationship skills, and responsible decision making (Collaborative for Academic, Social, and Emotional Learning, 2012). Meta-analyses show that school-based interventions targeting these five domains of social-emotional competencies yield meaningful, sustained improvements in youths' academic and mental health outcomes (e.g., Taylor et al., 2017). Thus, school-based interventions targeting social-emotional competencies could effectively promote the well-being of youth from communities of color and under-resourced backgrounds, helping to remedy current disparities

(Jagers, 2016). In this paper we propose that *mindfulness*, conceived as a set of practices for cultivating social-emotional competencies, can be useful for improving the accessibility and quality of care for diverse youth facing mental health disparities.

Mindfulness for Underserved Youth

Mindfulness is defined as the process by which we "pay attention in a particular way: on purpose, in the present moment and nonjudgmentally" (Kabat-Zinn, 2003, p. 145). Based on research conducted with adults, yoga, meditation, and other mindfulness-based interventions (MBIs) promote increased attention and awareness, which have beneficial effects on the ability to respond to stress without adverse psychological outcomes (Brown & Ryan, 2003). Meta-analyses have shown that MBIs with adults are effective for a broad range of chronic disorders and problems, such as anxiety, depression, pain, and stress (Eberth & Sedlmeier, 2012; Grossman et al., 2004). Likewise, several meta-analytic reviews have shown multiple benefits of MBIs with youth, such as improving psychological outcomes, disruptive behavior, academic achievement, externalizing problems, internalizing problems, negative and positive emotions, physical health, and social competence (Kallapiran et al., 2015; Klingbeil et al., 2017; Zoogman et al., 2015).

Despite extensive empirical support for MBIs with adults and emerging, promising support for MBIs with youth, there is sparse evidence for the effectiveness of MBIs with low-income and ethnically diverse youth (DeLuca et al., 2018). MBIs with this population have received minimal attention, even with encouraging preliminary evidence that MBIs may be particularly beneficial for chronically stressed youth (Mendelson et al., 2010). Similarly, the National Health Interview Survey suggested that underrepresented populations with low education levels are less likely to engage in MBIs (Olano et al., 2015). Survey data found that

education beyond high school was significantly associated with increased engagement in mindfulness-based practices. Although the reason for such differences remains unclear, we suggest that those who have higher levels of education may have more exposure, knowledge, and opportunities to engage with MBIs—and, thus, mere exposure effects could account for the lack of engagement among underrepresented populations. Furthermore, given the context of the evidence-based practice movement, DeLuca et al. (2018) suggested that the underdeveloped status of evidence supporting the use of MBIs with low-income and ethnically diverse youth could itself limit the frequency with which MBIs are provided to this population.

Nonetheless, it is noteworthy that studies have also indicated that MBIs are acceptable and engaging for underrepresented populations, showing higher program completion rates than other evidence-based treatments (Dutton et al., 2013; Roth & Robbins, 2004). Given that many MBIs are comprised of packages of simple, portable exercises (e.g., mindful breathing and body scan), we further suggest that the very nature of this approach to intervention may help reduce the stigma associated with mental health care—by not necessarily requiring a mental health professional nor a formal mental health treatment setting for effective delivery—thereby increasing acceptability among underrepresented populations. Furthermore, MBIs are financially low-cost (Miller et al., 1995) and mindfulness exercises, once learned, can be practiced anytime and anywhere—making them a flexible and feasible approach with diverse populations.

In order to expand MBI use among underserved youth, it is critical to increase the accessibility and feasibility of mental health care more generally. School-based interventions are considered key to improving the accessibility of youth mental health care, especially because low-income and ethnically diverse students are more likely to seek and receive school-based supports compared to clinic-based treatments (Jaycox et al., 2010). In addition, schools offer an

ideal setting for prevention, intervention, and wellbeing promotion that can be supported by regular school–home communication. School-employed healthcare professionals (e.g., school psychologists, counselors, social workers, and nurses) also have a relationship with the students, parents, and other staff, which adds to the accessibility of mental health services (National Association of School Psychologists, 2016). Based on a similar line of reasoning, Fung et al. (2016) propose that MBIs might be an effective means to reduce observed racial disparities in mental health service utilization and to promote overall student wellness in school settings. Given that mindfulness is a key social-emotional competency that can be trained universally in schools to reduce problems and improve well-being (Klingbeil et al., 2017), we propose that mindfulness-based school interventions (MBSIs) can play a pivotal role in increasing the accessibility and feasibility of mental health care for underserved youth.

MBSIs generally involve 4–24 weeks of instruction in the cultivation of mindfulness, consisting of three components: (1) *didactic instruction* related to mindfulness, meditation, yoga, and the mind-body connection; (2) *experiential practice* of various mindfulness meditations, mindful yoga, and the mindful body scan within the classroom; and (3) *classroom discussion* focused on the application of mindfulness to everyday situations as well as problem-solving barriers to effective practice (Grossman et al., 2004; Kabat-Zinn, 1990). MBSIs can play a critical role in improving students school attitudes, behavior, and performance because school-based prevention and intervention have shown to effectively enhance social, emotional, and academic outcomes (Eva & Thayer, 2017). Low-income and ethnically diverse students could especially benefit from MBSIs since they experience higher levels of stress and social pressures compared to their advantaged peers (Jackman et al., 2020). Also, given that youth spend a significant portion of their time attending school, MBSIs are likely to be more feasible and

accessible for improving the social-emotional competencies of underserved youth compared to most other community-based mental health services, which are not naturally embedded within youths' everyday environment.

Although studies have found that MBIs are beneficial in addressing emotional and behavioral problems for underrepresented youth in a clinic-based setting—by reducing attention-related problems, anxiety symptoms, and behavior problems (Semple et al., 2010)—results have yet to be replicated in larger samples of minoritized and disadvantaged youth in real-world, public-school settings (Black & Fernando, 2014). Indeed, a systematic review conducted by Felver et al. (2016) revealed that 71% of MBSI studies did not report any details on socio-economic status, suggesting more research is needed with this population. Despite the lacking research with underserved youth specifically, we echo others who suggest that MBSIs could be useful for enhancing equity in mental health care for low-income and ethnically diverse youth because they are more affordable (i.e., free to clients and their families) and more accessible (i.e., embedded within the everyday environment) compared to MBIs offered outside of schools (Juszczak et al., 2003).

Given the growing interest in MBSIs and the need to enhance equity in youth mental health care more generally, the purpose of the remainder of this paper is to provide guidelines to help practicing clinicians successfully adapt and implement MBSIs with underserved youth. First, we offer recommendations for clinicians to enhance underserved youths' engagement with MBSIs. Next, we overview implementation approaches that clinicians could use for increasing access to MBIs in school settings. Following, we discuss strategies clinicians might employ when working with teachers to effectively implement MBSIs with underserved youth in their classrooms. Ultimately, we hope the guidelines offered in this paper might help inform better

practice—as well as motivate further, better research—that advances equitable mental health care in schools with underserved youth.

Enhancing Engagement with MBSIs

Since clinicians indicated that low-income and ethnically diverse youth are sub-optimally engaged in treatment (Merikangas et al., 2011), it is important to adapt MBSIs to be applicable for the youth seeking treatment by increasing engagement with intervention activities. We suggest using qualitative data and being flexible with minor curriculum adaptations in order to meet youths' needs. To best develop and refine MBSIs, it is critical to explore the stressors experienced by underserved youth and whether mindfulness practice can help them better navigate these stressors. There is research showing that youths' perceived stressors differ in early, middle, and late adolescence, and that such stressors are usually situation specific (Seiffge-Krenke et al., 2009). Previous studies on MBSIs have measured stress levels and related outcomes via quantitative measures (Biegel et al., 2009; Schonert-Reichl & Lawlor, 2010; White, 2012). However, using qualitative data as a touchstone of treatment planning—outside of outcome assessment—has the additional advantages of informing the way clinicians design interventions and how, in turn, they can engage underserved youth with MBSIs. Specifically, we recommend that clinicians qualitatively evaluate how underserved youth define their stressors, the sources of their stressors, and the applicability of MBSIs to their stressful experiences. A good example of this recommendation in practice has been incorporated by Dariotis and colleagues (2016), who emphasized their approach to asking youth to define stress and stress-management (e.g., "What does stress mean to you", "What do you think other youth should know about youth and stress", "What did you learn about stress in the program", and "Have you used what you learned in the program outside the program to help you with stress?").

When interviewing youth about their understanding of their stress, there are a few guiding principles to keep in mind. First, some youth may have a hard time distinguishing anger and other negative emotions from stress. A qualitative study showed that underserved youth defined their stress as unpleasant emotional experiences, which included minor annoyances, irritations, and frustrations that were beyond the current situation affecting their lives (Dariotis et al., 2016). Likewise, youth may not properly recognize stress as a state of feeling overwhelmed and unsure of how to cope, which could lead to negative emotions (Dariotis et al., 2016). As a result, we recommend clinicians discuss stress as separate from negative emotions, highlighting that more positive emotional outcomes may be possible depending on how one responds to their stress. Focusing on this distinction—clarifying one's experiences of subjective distress in relation to their ability to respond effectively to stressful situations—could help promote a sense of empowerment in underserved youth, especially when emphasizing how mindfulness is beneficial for both purposes.

Furthermore, it is critical to recognize the socioeconomically disadvantaged environments that youths may live in, which could involve circumstances that require the youth to assume adult-like responsibilities in their family. For example, Dariotis et al. (2016) found that disrupted or insufficient sleep resulting from tiredness was a common source of stress for youth, yet this problem often stemmed from expectations to care for younger siblings. Although reducing financial hardship and structural inequalities are extremely difficult to achieve without system-level changes, helping youth change how they manage stressful experiences is likely to increase their sense of empowerment, agency, and hope. School-based interventions, like MBSIs, could therefore help underserved youth better manage the adult-like stressors they experience.

After the known stressors are established from the youth's perspective, it is important to be flexible to minor curriculum adaptations in order to best meet youths' needs (Bluth et al., 2016). One key area of adaptation is changing the language used throughout the curriculum (Sibinga et al., 2011). Knowledge of the students' developmental level and vocabulary is critical for informing effective communications with them, especially when introducing a new intervention like MBSIs (Dariotis et al., 2016). For clinicians, modifications in language can involve simplifying the language used to describe mindfulness practice and activities. For example, when talking to youth about decentered observation of thoughts, the clinician can adjust the language to describe how one can get "hooked by thoughts" and "stuck in their head" (Coyne et al., 2011), which are more colloquial and memorable phrasings than traditional mindfulness terminology. We also recommend that clinicians make frequent use of stories, metaphors, and real-life examples that relate directly to underserved youths' lived experiences and help ground mindfulness exercises in relatable events (Miller et al., 2006). For instance, it may be helpful to pick something the client loves or expressed interest in, such as a sport or music, and then use that context to explore what really "being in the moment" with that thing feels like for them.

Increasing Access to MBSIs

Although individual MBI sessions with youth are helpful for improving their mental health (Kallapiran et al., 2015), we strongly encourage clinicians expand their application of MBSIs to classroom and school-wide settings that may allow them to reach more underserved youth in need of services (Fung et al., 2016). In order to understand the specific cultural considerations related to implementing MBSIs as a clinician in a school setting, we recommend using the Community-Based participatory Research (CBPR) principles (Israel et al., 1998).

These principles serve to co-implement the process of adaptation with participation from local community leaders, stakeholders, and beneficiaries of the intervention. When using CBPR methods in a school setting, it is important that clinicians meet with the school administrators, teachers, other staff, and parents to learn about all stakeholders' perspectives on having MBIs in the classroom. Furthermore, connecting with these stakeholders allows for the possibility to form real relationships and to gain insight into how to help an MBSI become more population-specific (Blum, 2014). Furthermore, we recommend that clinicians conduct qualitative interviews with school staff to generate knowledge about potential facilitators and barriers to implementing MBSIs at the local level. According to Boothroyd et al. (2017), obtaining the perspective, priorities, and preferences of the target community and stakeholders is essential to successful implementation and sustainability of interventions. Based off the findings from the qualitative interviews, clinicians may adapt and modify the intervention to better fit the needs of the school, capitalize on existing strengths and facilitators, and directly address concerns and potential barriers. Ultimately, applying CBPR principles should lead to increasing rapport, trust, and buy-in from stakeholders for MBSIs.

Additionally, we recommend careful consideration regarding how MBSIs will be implemented to ensure program fidelity and sustainability within the classroom. Key components for successful classroom implementation include, but are not limited to, high-quality implementation and ongoing evaluation of intervention effectiveness (Bond & Hauf, 2004; Elias et al., 2003; Greenberg, 2010). Regarding high-quality implementation, instructor competence should be at a professional standard to preserve the integrity of MBSIs (Crane et al., 2012; Kabat-Zinn, 2011). Research indicated that students had more positive outcomes with mindfulness interventions when their implementers attended more trainings, taught more

mindfulness lessons, and were classified as moderate or high-quality implementers (Collaborative for Academic, Social, and Emotional Learning, 2012). As for ongoing evaluation, progress monitoring of the intervention's effectiveness (i.e., strength, capacity, and resources) is needed in order to achieve successful student outcomes (Bond & Hauf, 2004). Moreover, successful interventions tend to incorporate findings from the ongoing evaluations—using a problem-solving oriented feedback loop—to improve the efficacy of the intervention components and ongoing delivery (Bond & Hauf, 2004).

Besides intervention delivery by trained clinicians, having MBSIs paired with young adult community members may be beneficial in utilizing community resources to enhance the cultural relevance of the intervention. According to data from a study conducted by Mendelson and colleagues (2020), involving young adult community members as co-facilitators of an MBSI increased student buy-in for the program—providing real-world examples of skills use from individuals who were both closer in age and more familiar with their cultural context than the primary interventionists. This community-engagement approach has shown to promote behavior change (Cuijpers, 2002a, 2002b) as well as offer training and workforce development for the young adults involved (Mendelson et al., 2020). In line with the CBPR principles, we suggest this model not only shows potential for improving underserved youth outcomes but can also enhance dissemination opportunities for MBSIs in public school settings.

Working with Teachers to Implement MBSIs

Since clinicians may not have the bandwidth to implement MBSIs in classrooms themselves, this last section will discuss how they can provide strategies when consulting (or providing other forms of indirect support) with teachers to implement MBSIs and work effectively with underserved youth in their classrooms. We should start by saying that all of the

recommendations we have already made in the previous sections—on enhancing engagement with and increasing access to MBSIs—are just as applicable to working with teachers. Instead of reiterating those points here, however, we consider a few new inroads for supporting MBSIs implemented by educators: (a) discussing how mindfulness benefits teachers personally, (b) addressing potential barriers in teacher uptake of mindfulness practice, and (c) providing strategies for teachers to build rapport with underserved youth.

Before implementing MBSIs with underserved youth, Crane et al. (2010) highlight the importance of mindfulness embodiment by the teacher, which not only requires adequate training but also an intensive personal practice of mindfulness in daily life (Crane et al., 2012). The emphasis on mindfulness embodiment is mentioned in other literature about the teaching of mindfulness and is seen as a prerequisite for being an adequate mindfulness teacher (McCown et al., 2010; Santorelli et al., 2017). Besides developing competence with intervention delivery, cultivating a personal mindfulness practice allows teachers an opportunity to engage in a process of examining their own experience on an ongoing basis, which they can then more authentically relay to their students (Crane et al., 2010). Additionally, there are multiple potential mental health benefits for teachers who practice mindfulness themselves. Studies have shown that mindfulness interventions enhance teacher wellbeing by reducing stress, burnout, anxiety, and depression (Beshai et al., 2016; Franco et al., 2010; Kemeny et al., 2012; Roeser et al., 2013) as well as by increasing mindfulness, self-compassion, and emotion regulation (Jennings et al., 2011, 2013). Indeed, a meta-analysis conducted by Klingbeil and Renshaw (2018), which included 29 studies and 347 effect sizes, found that MBIs with teachers consistently improved mindfulness, increased well-being, and decreased psychological distress.

Clinicians can help teachers get acquainted with mindfulness practice by guiding them with the following two-step instruction. The first step is to slow down and notice what they (i.e., teachers) are experiencing in the present moment, which enables enhanced awareness, acceptance, and emotion regulation to take hold. The second step is to practice acceptance toward these experiences, which includes at least two sub-processes: the realization that being emotional and experiencing failure is part of being human, along with a capacity to separate the stable experience of oneself from one's fleeting feelings and thoughts (Hwang et al., 2019). The literature with teachers indicates that being aware and accepting one's own painful thoughts and emotions, making distinctions between self and emotions, and applying self-compassion were all instrumental processes for teachers to realize the need for and benefits of mindful practice (Hwang et al., 2019). Furthermore, there is growing evidence that teachers influence their students not only by how and what they teach but also by how they relate, teach, and model social-emotional competencies in the classroom (Jennings & Greenberg, 2009). If clinicians' sense that teachers are hesitant on practicing mindfulness, we suggest it may be helpful to remind them that enhancing their own mental health is likely to make them better teachers, which, in turn, is likely to result in improved student outcomes.

In order to directly increase teacher wellbeing—and thereby indirectly improve youth outcomes—it is important to first address potential barriers in teacher uptake with mindfulness practice. When incorporating MBSIs, teachers may be resistant to change, resistant to taking on more work, and in some circumstances, mindfulness might not align with their personal religious beliefs or cultural values. Additionally, it is important for teachers to perceive that the intervention is not mandated by the clinician, since they may see it as an additional task that detracts from their already scarce time and resources in the classrooms (Grant, 2017). Teachers

also reported that authentic experiences with mindfulness is what makes the intervention effective so personal practice and interest is needed before successful implementation (Grant, 2017). In order to help teachers build their authenticity in mindfulness, we suggest clinicians invest in a personal mindfulness practice themselves—and then share their own authentic experiences with teachers about how mindfulness practice has made an impact on their personal wellbeing. Moreover, if teachers express interest in mindfulness but show hesitance due to time restraints, we suggest it might be useful for the clinician to encourage the teacher to engage in experiential mindfulness activities, such as guided meditation sessions or app-based exercises, to increase their exposure to MBIs.

Along these lines, research has found that teachers preferred to connect deeply with mindfulness practices, before implementing the intervention in the classroom, by taking a personal mindfulness journey (i.e., reflecting on a mindfulness texts, theories, and practices; taking the time to connect with their own personal wisdom; Albrecht, 2018). A recent study found that it was valuable for teachers to be surrounded by a mindful culture and to have the support of their colleagues, parents, local school leadership, families, and community organizations such as universities and health agencies (Albrecht, 2018). When teachers feel a lack of support from key personnel in this area, the implementation of MBSIs may result in discouragement and therefore resistance to uptake. Furthermore, it is noteworthy that Albrecht (2018) found that rushing to integrate MBSIs was perceived as problematic for teachers. Instead, teachers preferred that mindfulness training and practice proceeded at a slow and gradual pace pre-implementation. Given these findings, it is essential for clinicians to intentionally address and balance teachers' concerns when implementing MBSIs. Thus, we recommend that clinicians be sensitive to teacher variables pre-implementation, then continue to encourage and support

teachers in their implementation throughout the duration of the intervention. Ultimately, with the approval and enthusiasm of teachers, uptake and implementation of MBSIs will be more successful and, therefore, more likely to benefit underserved youth.

Finally, we turn to the topic of strategies clinicians might employ for helping teachers promote youths' engagement with MBSIs. In order to connect and build trust with underserved youth, it is crucial for teachers who do not identity as a person of color to be aware of their own whiteness and to avoid falling into the "white savior" mindset. This mindset is geared towards those with privileged identities (e.g., white, mid-high socioeconomic status), in which they think they know what those with target identities (e.g., youth of color or with low socioeconomic status) need and deliver it in one-way (Matias, 2016). According to Blum (2014), teachers are advised to have training—beyond mindfulness—in practices and competencies that support their sensitivity and efficacy in working with diverse populations of youth (i.e., anti-racism training, class awareness, feminism, and non-violent communication). Having additional training in these areas may better prepare teachers to understand and empathize with their students while implementing MBSIs to underserved youth (Blum, 2014). Clinicians may want to recommend these trainings if teachers express challenges in building a connection and trust with underserved youth. For example, members of the Insight Meditation Community of Washington (IMCW) formed a group in which participants meet monthly to examine the history of white privilege and its manifestation on their lives. Participants reported supporting each other in "actively dissolving systemic racism" (Blum, 2014). Other programs such as Insight Meditation Center of Pioneer Valley (IMCPV, 2021) and New York Insight (NYI, 2021) also offer these trainings to build authentic relationships across race.

When working with underserved youth, we recommend that teachers reframe from common misconceptions and stereotypes about underserved youth, which could negatively affect mindfulness implementation in the classroom. Bryan and Atwater (2002) noted the two most common and problematic beliefs held by teachers about underserved youth are: students from culturally diverse backgrounds are less capable than other students, and teachers should treat all students the same, regardless of their class, gender, or race. Teachers who hold the belief that culturally diverse students are less capable than other students tend to have less ambitious learning goals, provide students with less autonomy, allow less interaction between students, and rely more heavily on passive teaching methods (Bryan & Atwater, 2002). To counteract these tendencies when implementing MBSIs, teachers should encourage group discussions of the intervention and allow their students to have some degree of control and freedom over the structure (Moll et al., 1992). If students refuse the intervention from perceiving it as being imposed on them, allowing them to maintain self-determination and participate whenever they are ready may improve the quality of student-teacher relationships, which, in turn, promotes better student outcomes (Bryan & Atwater, 2002). Teachers may demonstrate challenges to these adjustments, which could provide clinicians with an opportunity to offer classroom observations to provide supportive feedback. Promoting youths' self-determination in engaging with MBSIs is also consistent with ethical guidelines regarding obtaining minors' assent for participating in psychological interventions generally (American Psychological Association, 2002) as well as school-based interventions specifically (National Association of School Psychologists, 2020). Given the flexibility required of MBSI classroom implementation to underserved youth, we suggest it is worthwhile for clinicians to check in with teachers regularly to formally evaluate

their implementation challenges and provide consultation and support for resolving any pressing concerns.

Likewise, teachers who treat all students the same regardless of their class, gender, or race are likely to employ teaching methods that do not take into account the heterogeneity of educational and cultural backgrounds among underserved youth (Bryan & Atwater, 2002). Treating all students the same also ignores cultural variations in learning-related social interactions. Instead of a one-size-fits-all approach, teachers implementing MBSIs with underserved youth are encouraged to use several potentially helpful strategies to improve engagement, including (a) using illustrations to aid comprehension with English language learners, (b) allowing for choice among mindfulness activities (e.g., mindful breathing vs. walking vs. eating vs. yoga), (c) emphasizing how mindfulness is helpful in youths' day-to-day lives using culturally relevant exemplars, (d) allowing opportunities for students to converse with each other related to mindfulness practice, and (e) providing students with the option to practice mindfulness in groups or as individuals (Bryan and Atwater, 2002).

Conclusion

Given the need to enhance equity in youth mental health care, the overarching purpose of this paper was to provide guidelines to help practicing clinicians successfully adapt and implement MBSIs with underserved youth. Specifically, we overviewed strategies for clinicians to increase underserved youths' engagement with MBSIs, implementation approaches for clinicians to employ for increasing access to MBIs in school settings, and strategies for clinicians to use when working with teachers to effectively implement MBSI with underserved youth in their classrooms. Although some evidence-based interventions, including MBIs, were not originally developed with sufficient inclusion of underserved youth, we echo others who propose

that cultural and contextual adaptation research offers a useful framework within which MBSIs can be designed, modified, and implemented to have a positive impact with underserved youth (Bernal et al., 2009).

In examining strategies to increase engagement for undeserved youth, we discussed the importance of clinicians understanding what stressors are taking place with this population by using qualitative interviews and being flexible to minor curriculum adaptations. Next, we discussed key considerations for clinicians when implementing mindfulness interventions in schools, including the cultural adaptation process that involves incorporating feedback from key stakeholders as well as considerations for how to support intervention implementation to ensure program fidelity and sustainability. Our last section reviewed strategies that clinicians can employ when consulting with (or providing other indirect services to) teachers, emphasizing the value of encouraging teachers to incorporate their own mindful practice, helping them resolve potential uptake barriers to their personal engagement with mindfulness, and supporting them in working to engage underserved youth with MBSIs in culturally and contextually relevant ways.

In closing, we reiterate our hope that school-based mindfulness programs may be one viable solution for increasing the affordability and accessibility of mental health care for underserved youth. The field of MBSIs is promising yet still emerging, both in practice and research, and best practices are not yet fully vetted. More research is needed to establish a robust selection of high-quality, evidence-based mindfulness programming that is intentionally optimized for school settings (Renshaw, 2020). Toward this end, we recommend that future work on MBSIs should investigate—and integrate—the quality of factors known to impact implementation in schools (cf. Renshaw & Cook, 2017) as well as with diverse populations (cf. Fuchs et al., 2013). To achieve effective implementation and sustainment of MBIs in school

settings, it is important to consider a multilevel approach. Given the complexities working in school settings, multilevel approaches provide advantageous perspectives that are closer to real-life circumstances. Using guidelines from Emerson et al. (2019), we recommend the following directions for future work on MBSIs:

1. Specify the theoretical underpinnings of MBSIs, including contemplative theory and theory relevant to understanding human development, distress, and wellbeing.
2. Train implementers of MBSIs to have the appropriate level of knowledge and competence prior to delivering the intervention.
3. Explore the compatibility of MBSIs with the broader values, goals, and infrastructure of the school culture and environment.
4. Establish the effectiveness of MBSIs and the core components that makes it effective.

Moreover, we recognize that the inequalities and disparities that underserved youth experience in educational settings are complicated by systemic political, social, economic, and cultural barriers. By taking up the project of adapting mindfulness practices for use with underserved youth in school settings, clinicians can join in mental health equity work that provides more opportunities for more students to develop social-emotional competencies that facilitate their personal wellbeing and academic success. That said, despite the benefits that MBSIs may have with underserved youth, we clearly acknowledge that there is currently little research guiding how clinicians should be working with this population. To address this knowledge disparity around how to best address mental health care disparities, we urge researchers interested in MBSIs to empirically investigate our recommendations to advance diversity, equity, and inclusion for underrepresented youth.

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The authors declare no conflicting or competing interests related to the work presented herein.

References

Aarons, G. A., & Sawitzky, A. C. (2006). Organizational climate partially mediates the effect of culture on work attitudes and staff turnover in mental health services. *Administration and Policy in Mental Health and Mental Health Services Research,33*(3), 289–301. https://doi.org/10.1007/s10488-006-0039-1

Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(1), 4–23. https://doi.org/10.1007/s10488-010-0327-7

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review, 31*(6), 934–48. https://doi.org/10.1016/j.cpr.2011.05.003

Albrecht, N. J. (2018). Teachers teaching mindfulness with children: Being a mindful role model. *Australian Journal of Teacher Education, 43*(10). http://dx.doi.org/10.14221/ajte.2018v43.n10.1

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*(12), 1060–1073.

Balfanz, R., & Vaughn, B. (2012). *The importance of being in school: A report on absenteeism in the nation's public schools*. Johns Hopkins University Center for Social Organization of Schools. https://www.attendanceworks.org/wp-content/uploads/2017/06/FINALChronicAbsenteeismReport_May16-1.pdf

Bauer, A. M., Chen, C., & Alegría, M. (2010). English language proficiency and mental health service use among Latino and Asian Americans with mental disorders. *Medical Care, 48*(12), 1097–1104. https://doi.org/10.1097/MLR.0b013e3181f80749

Benn, R., Akiva, T., Arel, S., & Roeser, R. W. (2012). Mindfulness training effects for parents and educators of children with special needs. *Developmental Psychology*, *48*(5), 1476–1487. https://doi.org/10.1037/a0027537

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice*, *40*(4), 361–368. https://doi.org/10.1037/a0016401

Beshai, S., McAlpine, L., Weare, K., & Kuyken, W. (2016). A non-randomised feasibility trial assessing the efficacy of a mindfulness-based intervention for teachers to reduce stress and improve well-being. *Mindfulness*, *7*(1), 198–208. https://doi.org/10.1007/s12671-015-0436-1

Biegel, G. M., Brown, K. W., Shapiro, S. L., & Schubert, C. M. (2009). Mindfulness-based stress reduction for the treatment of adolescent psychiatric outpatients: A randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *77*(5), 855–866. https://doi.org/10.1037/a0016241

Black, D. S., & Fernando, R. (2014). Mindfulness training and classroom behavior among lower-income and ethnic minority elementary school children. *Journal of Child and Family Studies*, *23*(7), 1242–1246. https://doi.org/10.1007/s10826-013-9784-4

Blum, H. A. (2014). Mindfulness equity and Western Buddhism: Reaching people of low socioeconomic status and people of color. *International Journal of Dharma Studies*, *2*(1), 1-18. https://doi.org/10.1186/s40613-014-0010-0

Bluth, K., Campo, R. A., Pruteanu-Malinici, S., Reams, A., Mullarkey, M., & Broderick, P. C. (2016). A school-based mindfulness pilot study for ethnically diverse at-risk adolescents. *Mindfulness*, *7*(1), 90–104. https://doi.org/10.1007/s12671-014-0376-1

Bond, L. A., & Hauf, A. M. C. (2004). Taking stock and putting stock in primary prevention: Characteristics of effective programs. *Journal of Primary Prevention*, *24*(3), 199–221. https://doi.org/10.1023/B:JOPP.0000018051.90165.65

Boothroyd, R. I., Flint, A. Y., Lapiz, A. M., Lyons, S., Jarboe, K. L., & Aldridge, W. A., II. (2017). Active involved community partnerships: Co-creating implementation infrastructure for getting to and sustaining social impact. *Translational Behavioral Medicine*, *7*(3), 467–477. https://doi.org/10.1007/s13142-017-0503-3

Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology*, *84*(4), 822–848. https://doi.org/10.1037/0022-3514.84.4.822

Bryan, L. A., & Atwater, M. M. (2002). Teacher beliefs and cultural models: A challenge for science teacher preparation programs. *Science Education*, *86*(6), 821–839. https://doi.org/10.1002/sce.10043

Butler, E. A., Lee, T. L., & Gross, J. J. (2007). Emotion regulation and culture: Are the social consequences of emotion suppression culture-specific? *Emotion*, *7*(1), 30–48. https://doi.org/10.1037/1528-3542.7.1.30

Collaborative for Academic, Social, and Emotional Learning. (2012). *2013 guide: Effective social and emotional learning programs—Preschool and elementary school edition.* Author.

Coyne, L. W., McHugh, L., & Martinez, E. R. (2011). Acceptance and commitment therapy (ACT): Advances and applications with children, adolescents, and families. *Child and Adolescent Psychiatric Clinics*, *20*(2), 379–399. https://doi.org/10.1016/j.chc.2011.01.010

Crane, R. S., Kuyken, W., Hastings, R. P., Rothwell, N., & Williams, J. M. G. (2010). Training teachers to deliver mindfulness-based interventions: Learning from the UK experience. *Mindfulness*, *1*(2), 74–86. https://doi.org/10.1007/s12671-010-0010-9

Crane, R. S., Kuyken, W., Williams, J. M. G., Hastings, R. P., Cooper, L., & Fennell, M. J. V. (2012). Competence in teaching mindfulness-based courses: Concepts, development and assessment. *Mindfulness*, *3*(1), 76–84. https://doi.org/10.1007/s12671-011-0073-2

Cuijpers, P. (2002a). Peer-led and adult-led school drug prevention: A meta-analytic comparison. *Journal of Drug Education*, *32*(2), 107–119. https://doi.org/10.2190/LPN9-KBDC-HPVB-JPTM

Cuijpers, P. (2002b). Effective ingredients of school-based drug prevention programs. A systematic review. *Addictive Behaviors*, *27*(6), 1009–1023. https://doi.org/10.1016/s0306-4603(02)00295-2

Dariotis, J. K., Cluxton-Keller, F., Mirabal-Beltran, R., Gould, L. F., Greenberg, M. T., & Mendelson, T. (2016). "The program affects me 'cause it gives away stress": Urban students' qualitative perspectives on stress and a school-based mindful yoga intervention. *Explore*, *12*(6), 443–450. https://doi.org/10.1016/j.explore.2016.08.002

DeLuca, S. M., Kelman, A. R., & Waelde, L. C. (2018). A systematic review of ethnoracial representation and cultural adaptation of mindfulness- and meditation-based interventions. *Psychological Studies*, *63*(2), 117-129. https://doi.org/10.1007/s12646-018-0452-z

Dutton, M. A., Bermudez, D., Matás, A., Majid, H., & Myers, N. L. (2013). Mindfulness-based stress reduction for low-income, predominantly African American women with PTSD

and a history of intimate partner violence. *Cognitive and Behavioral Practice*, *20*(1), 23–32. https://doi.org/10.1016/j.cbpra.2011.08.003

Eberth, J., & Sedlmeier, P. (2012). The effects of mindfulness meditation: A meta-analysis. *Mindfulness*, *3*(3), 174-189. https://doi.org/10.1007/s12671-012-0101-x

Elias, M. J., Zins, J. E., Graczyk, P. A., & Weissberg, R. P. (2003). Implementation, sustainability, and scaling up of social-emotional and academic innovations in public schools. *School Psychology Review*, *32*(3), 303–319. https://doi.org/10.1080/02796015.2003.12086200

Emerson, L. M., de Diaz, N. N., Sherwood, A., Waters, A., & Farrell, L. (2020). Mindfulness interventions in schools: Integrity and feasibility of implementation. *International Journal of Behavioral Development*, *44*(1), 62–75. https://doi.org/10.1177%2F0165025419866906

Epstein, J. L., & Sheldon, S. B. (2002). Present and accounted for: Improving student attendance through family and community involvement. *The Journal of Educational Research*, *95*(5), 308–318. https://doi.org/10.1080/00220670209596604

Eva, A. L., & Thayer, N. M. (2017). Learning to BREATHE: A pilot study of a mindfulness-based intervention to support marginalized youth. *Journal of Evidence-Based Complementary & Alternative Medicine*, *22*(4), 580–591. https://doi.org/10.1177/2156587217696928

Felver, J. C., Celis-de Hoyos, C. E., Tezanos, K., & Singh, N. N. (2016). A systematic review of mindfulness-based interventions for youth in school settings. *Mindfulness*, *7*(1), 34–45. https://doi.org/10.1007/s12671-015-0389-4

Franco, C., Mañas, I., Cangas, A. J., Moreno, E., & Gallego, J. (2010). Reducing teachers' psychological distress through a mindfulness training program. *The Spanish Journal of Psychology*, *13*(2), 655–666. https://doi.org/10.1017/s1138741600002328

Fuchs, C., Lee, J. K., Roemer, L., & Orsillo, S. M. (2013). Using mindfulness- and acceptance-based treatments with clients from nondominant cultural and/or marginalized backgrounds: Clinical considerations, meta-analysis findings, and introduction to the special series. *Cognitive and Behavioral Practice*, *20*(1), 1–12. https://doi.org/10.1016/j.cbpra.2011.12.004

Fung, J., Guo, S., Jin, J., Bear, L., & Lau, A. (2016). A pilot randomized trial evaluating a school-based mindfulness intervention for ethnic minority youth. *Mindfulness*, *7*(4), 819–828. https://doi.org/10.1007/s12671-016-0519-7

Grant, K. C. (2017). From teaching to being: The qualities of a mindful teacher. *Childhood Education*. https://www.tandfonline.com/doi/full/10.1080/00094056.2017.1300493

Grant, K. E., Compas, B. E., Thurm, A. E., McMahon, S. D., Gipson, P. Y., Campbell, A. J., Krochock, K., & Westerholm, R. I. (2006). Stressors and child and adolescent psychopathology: Evidence of moderating and mediating effects. *Clinical Psychology Review*, *26*(3), 257–283. https://doi.org/10.1016/j.cpr.2005.06.011

Greenberg, M. T. (2010). School-based prevention: Current status and future challenges. *Effective Education*, *2*(1), 27–52. https://doi.org/10.1080/19415531003616862

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology*, *85*(2), 348–362. https://doi.org/10.1037/0022-3514.85.2.348

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research*, *57*(1), 35–43. https://doi.org/10.1016/S0022-3999(03)00573-7

Gudiño, O. G., Lau, A. S., & Hough, R. L. (2008). Immigrant status, mental health need, and mental health service utilization among high-risk Hispanic and Asian Pacific Islander youth. *Child & Youth Care Forum*, *37*(3), 139–152. https://doi.org/10.1007/s10566-008-9056-4

Guski, R. (2001). Environmental stress and health. *The International Encyclopedia of the Social and Behavioral Sciences.* Oxford & Elsevier. https://doi.org/10.1016/B0-08-043076-7/03832-8

Hwang, Y.-S., Noh, J.-E., Medvedev, O. N., & Singh, N. N. (2019). Effects of a mindfulness-based program for teachers on teacher wellbeing and person-centered teaching practices. *Mindfulness*, *10*(11), 2385–2402. https://doi.org/10.1007/s12671-019-01236-1

Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving mental health access for low-income children and families in the primary care setting. *Pediatrics*, *139*(1). https://dx.doi.org/10.1542%2Fpeds.2015-1175

Insight Meditation Center of Pioneer Valley. (2021). *Winter/Spring 2021 offerings*. https://www.insightpv.org/offerings.html

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing Partnership Approaches to Improve Public Health. *Annual Review of Public Health*, *19*(1), 173–202. https://doi.org/10.1146/annurev.publhealth.19.1.173

Jackman, K., Kreuze, E. J., Caceres, B. A., & Schnall, R. (2020). Bullying and peer victimization of minority youth: Intersections of sexual identity and race/ethnicity. *The Journal of School Health*, *90*(5), 368–377. https://doi.org/10.1111/josh.12883

Jagers, R. J. (2016). Framing social and emotional learning among African-American youth: Toward an integrity-based approach. *Human Development*, *59*(1), 1–3. doi:10.1159/000447005

Jagers, R. J., Rivas-Drake, D., & Borowski, T. (2018). *Equity & social and emotional learning: A cultural analysis.* CASEL Assessment Work Group Brief series. https://measuringsel.casel.org/wp-content/uploads/2018/11/Frameworks-Equity.pdf

Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., Scott, M., & Schonlau, M. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress*, *23*(2), 223–231. https://doi.org/10.1002/jts.20518

Jennings, P. A., Frank, J. L., Snowberg, K. E., Coccia, M. A., & Greenberg, M. T. (2013). Improving classroom learning environments by Cultivating Awareness and Resilience in Education (CARE): Results of a randomized controlled trial. *School Psychology Quarterly*, *28*(4), 374–390. https://doi.org/10.1037/spq0000035

Jennings, P. A., & Greenberg, M. T. (2009). The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. *Review of Educational Research*, *79*(1), 491–525. https://doi.org/10.3102/0034654308325693

Jennings, P. A., Snowberg, K. E., Coccia, M. A., & Greenberg, M. T. (2011). Improving classroom learning environments by Cultivating Awareness and Resilience in Education

(CARE): Results of two pilot studies. *Journal of Classroom Interaction*, *46*(1), 37–48. https://doi.org/10.1037/spq0000035

Juszczak, L., Melinkovich, P., & Kaplan, D. (2003). Use of health and mental health services by adolescents across multiple delivery sites. *Journal of Adolescent Health*, *32*(6, Supplement), 108–118. https://doi.org/10.1016/S1054-139X(03)00073-9

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. Pain, and Illness. Bantam, New York. https://doi.org/10.1037/032287

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice*, *10*(2), 144–156. https://doi.org/10.1093/clipsy.bpg016

Kabat-Zinn, Jon. (2011). Some reflections on the origins of MBSR, skillful means, and the trouble with maps. *Contemporary Buddhism*, *12*(1), 281–306. https://doi.org/10.1080/14639947.2011.564844

Kallapiran, K., Koo, S., Kirubakaran, R., & Hancock, K. (2015). Review: Effectiveness of mindfulness in improving mental health symptoms of children and adolescents: A meta-analysis. *Child and Adolescent Mental Health*, *20*(4), 182–194. https://doi.org/10.1111/camh.12113

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. Children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, *159*(9), 1548–1555. https://doi.org/10.1176/appi.ajp.159.9.1548

Keenan, K., Shaw, D., Delliquadri, E., Giovannelli, J., & Walsh, B. (1998). Evidence for the continuity of early problem behaviors: Application of a developmental model. *Journal of Abnormal Child Psychology*, *26*(6), 441-452. https://doi.org/10.1023/A:1022647717926

Kemeny, M. E., Foltz, C., Cavanagh, J. F., Cullen, M., Giese-Davis, J., Jennings, P., Rosenberg, E. L., Gillath, O., Shaver, P. R., Wallace, B. A., & Ekman, P. (2012). Contemplative/emotion training reduces negative emotional behavior and promotes prosocial responses. *Emotion*, *12*(2), 338–350. https://doi.org/10.1037/a0026118

Klingbeil, D. A., Fischer, A. J., Renshaw, T. L., Bloomfield, B. S., Polakoff, B., Willenbrink, J. B., Copek, R. A., & Chan, K. T. (2017). Effects of mindfulness-based interventions on disruptive behavior: A meta-analysis of single-case research. *Psychology in the Schools*, *54*(1), 70–87. https://doi.org/10.1002/pits.21982

Klingbeil, D. A., & Renshaw, T. L. (2018). Mindfulness-based interventions for teachers: A meta-analysis of the emerging evidence base. *School Psychology Quarterly*, *33*(4), 501–511. https://doi.org/10.1037/spq0000291

Matias, C. E. (2016). "Why do you make me hate myself?": Re-teaching Whiteness, abuse, and love in urban teacher education. *Teaching Education*, *27*(2), 194–211. https://doi.org/10.1080/10476210.2015.1068749

McCown, D., Reibel, D. K., & Micozzi, M. S. (2010). *Teaching Mindfulness: A Practical Guide for Clinicians and Educators*. Springer-Verlag. https://doi.org/10.1007/978-0-387-09484-7

Mendelson, T., Clary, L. K., Sibinga, E., Tandon, D., Musci, R., Mmari, K., Salkever, D., Stuart, E. A., & Ialongo, N. (2020). A randomized controlled trial of a trauma-informed school

prevention program for urban youth: Rationale, design, and methods. *Contemporary Clinical Trials*, *90*, 105895. https://doi.org/10.1016/j.cct.2019.105895

Mendelson, T., Greenberg, M. T., Dariotis, J. K., Gould, L. F., Rhoades, B. L., & Leaf, P. J. (2010). Feasibility and preliminary outcomes of a school-based mindfulness intervention for urban youth. *Journal of Abnormal Child Psychology*, *38*(7), 985–994. https://doi.org/10.1007/s10802-010-9418-x

Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B.,… Olfson, M. (2011). Service utilization for lifetime mental disorders in U.S. adolescents: Results of the national comorbidity survey-adolescent supplement (NCSA). *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(1), 32–45. https://doi.org/10.1016/j.jaac.2010.10.006

Milkie, M. A., & Warner, C. H. (2011). Classroom learning environments and the mental health of first grade children. *Journal of Health and Social Behavior*, *52*(1), 4–22. https://doi.org/10.1177/0022146510394952

Miller, J. J., Fletcher, K., & Kabat-Zinn, J. (1995). Three-year follow-up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. *General Hospital Psychiatry*, *17*(3), 192–200. https://doi.org/10.1016/0163-8343(95)00025-m

Miller, A. L., Rathus, J. H., & Linehan, M. M. (2006). *Dialectical Behavior Therapy with suicidal adolescents*. Guilford Press.

Molavi, P., Mohammadi, M. R., Nadr Mohammadi Moghadam, M., Khaleghi, A., & Mostafavi, A. (2018). Prevalence of psychiatric disorders in children and adolescents in Ardabil

province: A population-based study. *Journal of Ardabil University of Medical Sciences*, *18*(2), 240–51. https://doi.org/10.29252/jarums.18.2.240

Moll, L. C., Amanti, C., Neff, D., & Gonzalez, N. (1992). Funds of knowledge for teaching: Using a qualitative approach to connect homes and classrooms. *Theory into Practice*, *31*(2), 132–141. https://doi.org/10.1080/00405849209543534

National Association of School Psychologists. (2016). *School-based mental health services: Improving student learning and well-being*. https://www.nasponline.org/resources-and-publications/resources-and-podcasts/mental-health/school-psychology-and-mental-health/school-based-mental-health-services

National Association of School Psychologists. (2020). *The professional standards of the National Association of School Psychologists.* https://www.nasponline.org/standards-and-certification/professional-ethics

New York Insight. (2021). *We teach what the Buddha taught*. https://www.nyimc.org/sangha-diversity/

Olano, H. A., Kachan, D., Tannenbaum, S. L., Mehta, A., Annane, D., & Lee, D. J. (2015). Engagement in mindfulness practices by U.S. adults: Sociodemographic barriers. *The Journal of Alternative and Complementary Medicine*, *21*(2), 100–102. https://doi.org/10.1089/acm.2014.0269

Park, A. L., Boustani, M. M., Saifan, D., Gellatly, R., Letamendi, A., Stanick, C., Regan, J., Perez, G., Manners, D., Reding, M., & Chorpita, B. F. (2019). Community mental health professionals' perceptions about engaging underserved populations. *Administration and Policy in Mental Health and Mental Health Services Research*, 1–14. https://doi.org/10.1007/s10488-019-00994-3

Proulx, J., Croff, R., Oken, B., Aldwin, C. M., Fleming, C., Bergen-Cico, D., Le, T., & Noorani, M. (2018). Considerations for research and development of culturally relevant mindfulness interventions in American minority communities. *Mindfulness, 9*(2), 361–370. https://doi.org/10.1007/s12671-017-0785-z

Renshaw, T. L., & Cook, C. R. (2017). Mindfulness in the schools—Historical roots, current status, and future directions. *Psychology in the Schools*, *54*(1), 5–12. https://doi.org/10.1002/pits.21978

Renshaw, T. L. (2020). Mindfulness-based intervention in schools. In M. Bray & C. Maykel (Eds., pp. 145–160), *Promoting mind–body health in schools: Interventions for mental health professionals.* Washington, DC: American Psychological Association. https://www.apa.org/pubs/books/4317526.

Reynolds, A. J., Temple, J. A., Robertson, D. L., & Mann, E. A. (2001). Long-term effects of an early childhood intervention on educational achievement and juvenile arrest: A 15-year follow-up of low-income children in public schools. *JAMA, 285*(18), 2339. https://doi.org/10.1001/jama.285.18.2339

Roeser, R. W., Schonert-Reichl, K. A., Jha, A., Cullen, M., Wallace, L., Wilensky, R., et al. (2013). Mindfulness training and reductions in teacher stress and burnout: Results from two randomized, waitlist-control field trials. *Journal of Educational Psychology, 105*(3), 787–804. https://doi.org/10.1037/a0032093

Roeser, R. W. (2014). The emergence of mindfulness-based interventions in educational settings. In Advances in Motivation and Achievement (pp. 379–419), *Motivational interventions*. Emerald Group Publishing Limited. https://doi.org/10.1108/S0749-742320140000018010

Roth, B., & Robbins, D. (2004). mindfulness-based stress reduction and health-related quality of life: Findings from a bilingual inner-city patient population. *Psychosomatic Medicine, 66*(1), 113–123. https://doi.org/10.1097/01.PSY.0000097337.00754.09

Santorelli, S. F., Kabat-Zinn, J., Blacker, M., Meleo-Meyer, F., & Koerbel, L. (2017). *Mindfulness-based stress reduction (MBSR) authorized curriculum guide. Center for Mindfulness in Medicine, Health Care, and Society: University of Massachusetts Medical School*.

Schonert-Reichl, K. A., & Lawlor, M. S. (2010). The effects of a mindfulness-based education program on pre- and early adolescents' well-being and social and emotional competence. *Mindfulness, 1*(3), 137–151. https://doi.org/10.1007/s12671-010-0011-8

Seiffge-Krenke, I., Aunola, K., & Nurmi, J. E. (2009). Changes in stress perception and coping during adolescence: The role of situational and personal factors. *Child Development, 80*(1), 259–279. https://doi.org/10.1111/j.1467-8624.2008.01258.x

Semple, R. J., Lee, J., Rosa, D., & Miller, L. F. (2010). A randomized trial of mindfulness-based cognitive therapy for children: Promoting mindful attention to enhance social-emotional resiliency in children. *Journal of Child and Family Studies, 19*(2), 218–229. https://doi.org/10.1007/s10826-009-9301-y

Sibinga, E. M. S., Kerrigan, D., Stewart, M., Johnson, K., Magyari, T., & Ellen, J. M. (2011). Mindfulness-based stress reduction for urban youth. *Journal of Alternative and Complementary Medicine, 17*(3), 213–218. https://doi.org/10.1089/acm.2009.0605

Soto, J. A., Perez, C. R., Kim, Y.-H., Lee, E. A., & Minnick, M. R. (2011). Is expressive suppression always associated with poorer psychological functioning? A cross-cultural

comparison between European Americans and Hong Kong Chinese. *Emotion*, *11*(6), 1450–1455. https://doi.org/10.1037/a0023340

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). Wiley.

Taylor, R. D., Oberle, E., Durlak, J. A., & Weissberg, R. P. (2017). Promoting positive youth development through school-based social and emotional learning interventions: A meta-analysis of follow-up effects. *Child development*, *88*(4), 1156-1171. https://doi.org/10.1111/cdev.12864

Twenge, J. M., Cooper, A. B., Joiner, T. E., Duffy, M. E., & Binau, S. G. (2019). Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset, 2005–2017. *Journal of Abnormal Psychology*, *128*(3), 185–199. https://doi.org/10.1037/abn0000410

White, L. S. (2012). Reducing stress in school-age girls through mindful yoga. *Journal of Pediatric Health Care: Official Publication of National Association of Pediatric Nurse Associates & Practitioners*, *26*(1), 45–56. https://doi.org/10.1016/j.pedhc.2011.01.002

Zoogman, S., Goldberg, S. B., Hoyt, W. T., & Miller, L. (2015). Mindfulness interventions with youth: A meta-analysis. *Mindfulness*, *6*(2), 290–302. https://doi.org/10.1007/s12671-013-0260-4