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The Impact of Alternative Calming Spaces on Students with Mental Health Needs in a School-Based Setting: A Collective Case Study

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Abstract: Students with identified mental health needs frequently experience challenges in emotional regulation that affect academic engagement, behaviour, and overall school functioning. This collective case study examined the impact of a structured alternative calming space (the therapy room) within a school-based Mental Health Program. Nine secondary students participated across two six-week grading periods, fall 2025 (pre-intervention baseline) and spring 2026 (post-intervention). Data were collected using behavioural incident logs, off-task behaviour tracking, staff observation rubrics, therapy room frequency records, and academic and attendance records. Findings revealed a notable reduction in behavioural incidents (3.11 to 1.75) and off-task behaviour (3.11 to 1.88), alongside notable improvements in emotional awareness, independent regulation (1.67 to 3.25), attendance, and academic performance. Students consistently used the therapy room to de-escalate and returned to the classroom ready to engage in learning, suggesting the space functioned as a productive bridge between dysregulation and academic participation. Contextual data from student self-reports indicated that in prior years, the same room, used without clear structure, resulted in unproductive use and extended loss of instructional time. Results

suggest that an alternative calming space, when supported by clear rules, expectations, and a structured re-entry protocol, can serve as an effective, low-cost intervention for students with mental health needs. This article discusses implications for school counsellors, special educators, and administrators implementing similar spaces.

Keywords: alternative calming space, therapy room, self-regulation, mental health, school-based intervention, emotional regulation, collective case study, special education, trauma-informed practice.

Introduction

The increasing prevalence of mental health challenges among students has become a significant concern in educational settings. Schools are now serving a growing population of students who experience anxiety, emotional dysregulation, trauma-related responses, and other mental health-related difficulties. These challenges often manifest in behaviours such as withdrawal, non-participation, task avoidance, and classroom disruptions, which can negatively impact both academic performance and the overall learning environment.

Traditional classroom management strategies often focus on compliance and behavioural control, relying on consequences and disciplinary actions. While these approaches may temporarily address observable behaviours, they often fail to address students' underlying emotional needs. In some cases, punitive measures may even exacerbate emotional distress, leading to increased behavioural challenges. Despite a marked increase in the use of zero-tolerance and exclusionary discipline procedures in schools, there is little evidence that these approaches improve school safety or student behaviour; a preventive, early-response disciplinary model has instead been proposed to expand the range of effective options available to general and special educators alike (Skiba & Peterson, 2000).

In response to these concerns, educational frameworks such as Social-Emotional Learning (SEL) and trauma-informed practices have emphasised the importance of supporting students' emotional and psychological needs within the school environment. Central to both frameworks is the concept of self-regulation — an individual's ability to manage emotional responses, control impulses, and maintain focus on goal-directed tasks. Students with strong self-regulation skills are better equipped to navigate academic challenges, maintain engagement, and interact positively with peers and teachers.

Research Problem

Despite the growing recognition of the importance of self-regulation, many school programs lack structured environmental supports that allow students to actively practice these skills in real time. Students are often expected to regulate their emotions without access to a designated physical space where de-escalation can occur safely and productively. Critically, when such spaces do exist, they are not always implemented with the intentionality required to produce meaningful outcomes. Prior to the launch of the Mental Health Program described in this study, students at this school site reported that the therapy room was frequently closed or access was significantly restricted. In years when the room was accessible without clear guidelines, students used it unproductively—sleeping, avoiding academic tasks, and spending extended periods outside the classroom without structured support or a plan to return. Without clear rules and expectations, the space, rather than supporting regulation, inadvertently reinforced avoidance behaviour and further loss of instructional time.

Research Focus

This study explores the implementation of a designated alternative calming space — referred to throughout as the therapy room — within a Mental Health Program operating in a school-based setting serving secondary students with identified mental health needs. The therapy room was designed as a low-stimulation environment specifically structured to support emotional de-escalation and self-regulation, to promote student independence and reduce reliance on reactive disciplinary measures. The critical question is not simply whether a therapy room exists, but whether it is implemented with clear expectations, time limits, and a deliberate re-entry protocol that returns students to the classroom prepared to learn.

Research Aim and Research Question

This study aimed to examine the behavioural, emotional, and academic impact of providing secondary students with structured access to an alternative calming space within a school-based mental health program. The following research question guided it: How does access to a designated alternative calming space (therapy room) impact the behavioural, emotional, and academic outcomes of secondary students with mental health needs enrolled in a school-based mental health program?

Literature Review

Self-Regulation and Academic Outcomes

A growing body of research supports the importance of self-regulation and emotional support in improving student outcomes. Self-regulation is a critical component of academic success, and students who can effectively manage their emotions and behaviours are more likely to achieve positive academic outcomes (Zimmerman, 1990). Self-regulated learners are better able to sustain attention, persist through challenges, and utilise effective learning strategies.

Social-Emotional Learning and Emotional Competence

Social-Emotional Learning (SEL) frameworks reinforce the role of emotional competencies in education. Students who receive explicit instruction in emotional awareness and regulation demonstrate improved academic performance, better social interactions, and reduced behavioural problems (Collaborative for Academic, Social, and Emotional Learning [CASEL], 2020). A meta-analysis found that SEL interventions significantly enhance students' emotional skills, attitudes, and academic achievement (Durlak et al., 2011).

Trauma-Informed Practice and Environmental Supports

Trauma-informed education highlights the importance of addressing students' emotional needs through structured, predictable, and supportive environments. Students who have experienced trauma often require environmental conditions that promote safety and trust, and without such supports may struggle with emotional regulation and exhibit behaviours that interfere with learning (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Trauma-informed practices have been found to improve student engagement, reduce behavioural incidents, and strengthen relationships between students and educators (Brunzell et al., 2016).

Alternative Calming Spaces in School Settings

Self-regulation is not an innate ability but a skill that must be taught and supported through environmental design and structured opportunity (Shanker, 2016). Environmental modifications and

designated spaces for reflection have been advocated as ways to help students regulate their emotions effectively. Alternative calming spaces — also referred to in the literature as regulation stations, sensory rooms, or calm-down corners — represent one such environmental modification. Structured calm-down spaces in school settings have been shown to reduce behavioural escalation and support students' return to productive academic engagement (Diliberto & Brewer, 2012). Critically, this research emphasises that the effectiveness of such spaces is contingent not merely on their physical design but on the protocols governing their use, including clear behavioural expectations, time-limited visits, and structured re-entry procedures that facilitate a student's return to the classroom in a regulated and academically ready state.

Research on the unintended consequences of unstructured withdrawal spaces further supports the importance of structured protocols. When students access calming or sensory spaces without clear guidelines or expectations, such environments can inadvertently reinforce avoidance behaviour, enabling students to escape academic demands without developing regulation skills and resulting in extended loss of instructional time (Diliberto & Brewer, 2012). This distinction between structured and unstructured calming space use is directly relevant to the present study, which examines a program context in which a previously inaccessible and unstructured therapy room was redesigned under a new set of clearly defined rules and expectations. Despite these findings, there remains a gap in research documenting the comparative outcomes of structured versus unstructured calming space implementation within secondary school-based mental health programs, particularly with student populations presenting complex mental health profiles.

Recent work reinforces this pattern. In a controlled behavioural study, autistic children given control over sensory equipment in a multi-sensory environment showed increased attention and reduced repetitive and sensory behaviours compared with when the same equipment changed passively, underscoring the importance of structured, self-directed use rather than unstructured access alone (Unwin et al., 2022). A 2025 systematic scoping review of sensory rooms in mental health settings likewise found that protocol design — including clear entry and exit procedures and staff involvement — was consistently identified across the reviewed studies as central to positive outcomes, echoing the present study's emphasis on structure over mere access (Doroud et al., 2025). Emerging qualitative research on school-based multi-sensory environments has similarly found that self-directed, individualised use supports emotion regulation and readiness to learn, even where the population and setting differ from the present study (Dyer et al., 2026).

Trauma-Informed Approaches: Evidence and Limitations

Trauma-exposed youth are at elevated risk for deficits in executive functioning, difficulty regulating emotions and behaviour, and academic and behavioural difficulties at school (Perfect et al., 2016). Trauma-informed schools have been defined as educational environments that respond to the needs of trauma-exposed youth through effective practices and system-change strategies (Overstreet & Chafouleas, 2016). However, a Campbell systematic review examining the effects of trauma-informed approaches in schools on trauma symptoms, academic performance, behaviour, and socioemotional functioning found that, despite widespread adoption, rigorous evaluation studies meeting the review's inclusion criteria were not yet available (Maynard et al., 2019). This gap underscores the importance of practitioner-generated evidence, such as the present case study, in documenting outcomes of specific trauma-informed structures as implemented in real school settings.

Self-Regulation, Executive Function, and Emotion Regulation Processes

Self-regulation is closely linked to executive function, the set of top-down cognitive processes, including inhibitory control, working memory, and cognitive flexibility, that allow individuals to manage

impulses, sustain attention, and adapt to changing demands (Diamond, 2013). Emotion regulation itself has been conceptualised as a multi-stage process through which individuals influence which emotions they have, when they have them, and how they experience and express them, encompassing strategies that operate before an emotional response fully develops as well as strategies that modulate the response after it occurs (Gross, 1998). Structured calming spaces such as the therapy room examined in this study can be understood as environmental supports for these antecedent- and response-focused regulation strategies, giving students a designated point to interrupt escalation before it fully develops.

For students served under the Other Health Impairment (OHI) category, a classification that commonly includes attention-deficit/hyperactivity disorder (ADHD), difficulty with behavioural inhibition has been theorised to disrupt four executive functions that subserve self-regulation: nonverbal working memory, internalisation of speech, the self-regulation of affect, motivation, and arousal, and reconstitution (Barkley, 1997). This model suggests that the emotional dysregulation frequently observed in students with OHI-related conditions is not a separate deficit but a downstream consequence of impaired inhibitory control, an insight with direct implications for a structured calming space that offers a designated point of interruption before dysregulated affect fully develops. Students with specific learning disabilities (SLD) also frequently present with co-occurring executive function difficulties, including challenges with cognitive flexibility, organisation, and self-monitoring, that vary in profile depending on the specific area of academic difficulty (Khan & Lal, 2023). This body of research supports the inclusion of structured, low-stimulation regulation spaces as an appropriate accommodation within programs serving students with OHI-related and SLD-related executive function challenges alongside students with emotional and anxiety-related needs.

School-Wide and Tiered Behaviour Support Frameworks

Structured calming spaces align conceptually with school-wide Positive Behavioural Interventions and Supports (PBIS) and Multi-Tiered Systems of Support (MTSS), frameworks that emphasise prevention, explicit teaching of expected behaviour, and increasingly individualised, data-based supports for students who require more than universal, school-wide practices (Sugai & Horner, 2009). A randomised, wait-list controlled effectiveness trial found that school-wide positive behaviour support was associated with improved outcomes when implemented with fidelity (Horner et al., 2009), and subsequent reviews have continued to find evidence supporting the framework's effectiveness for improving behavioural and academic outcomes at scale (Horner et al., 2010; Sugai & Horner, 2020). The therapy room protocol examined in the present study reflects a Tier 2/Tier 3-aligned individualised support: a targeted, structured intervention layered on top of the Mental Health Program's broader supportive climate for students whose needs were not fully met by universal classroom supports alone.

Relational and Structural Supports for Regulation

The quality of the relationship between a student and the adults supporting them has also been shown to shape self-regulatory development. Early teacher-child relationship quality has been found to predict students' behavioural and academic trajectories across subsequent school years (Hamre & Pianta, 2001), suggesting that structured spaces such as the therapy room are unlikely to be effective as a stand-alone physical resource; their impact is inseparable from the relational quality of the check-in and check-out process that staff provide. Commercially developed self-regulation curricula, such as the Zones of Regulation, similarly combine a structured conceptual framework for identifying emotional states with adult-supported instruction in strategy selection (Kuypers, 2011), reinforcing the broader pattern in this literature that structure and relationship, not access to space alone, drive outcomes.

Social-Emotional Learning: Long-Term Evidence

Social-emotional learning has been framed as a guiding process through which students acquire and apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, and establish and maintain supportive relationships, with explicit guidelines developed early on to help educators embed this instruction into daily practice (Elias et al., 1997). As the field has matured, SEL has been increasingly understood not as a supplementary program but as a foundational element of school improvement in its own right, with implementation quality and integration into the broader school environment identified as key determinants of program impact (Weissberg et al., 2015). Beyond immediate post-intervention effects, school-based social and emotional learning interventions have been shown to produce benefits that persist well beyond the intervention period. A meta-analysis of follow-up effects across 82 school-based, universal SEL interventions found that participants continued to outperform control groups in social-emotional skills, attitudes, and indicators of well-being for months to years after the intervention ended, with post-intervention social-emotional skill development emerging as the strongest predictor of later well-being (Taylor et al., 2017). This finding lends weight to the present study's emphasis on independent regulation as a particularly important outcome, since gains in this domain may be the most likely to persist beyond the study's two-semester window.

Comprehensive School-Based Mental Health Systems

School-based mental health programs have historically proliferated in a narrow and piecemeal fashion, with limited coordination across school and community-based supports (Adelman & Taylor, 2010). Adelman and Taylor (2010) argued for moving beyond fragmented, categorically funded interventions toward a comprehensive, unified system of learning supports that addresses barriers to learning as a core and essential component of school improvement rather than an auxiliary service. The therapy room examined in this study, situated within the Mental Health Program's broader multidisciplinary team spanning mental health therapy, behaviour support, speech therapy, and academic and wellness counselling, reflects this comprehensive systems orientation: the calming space functions not as an isolated resource but as one coordinated component within an integrated program of student support.

Legal and Programmatic Context for Special Education Behavioural Supports

All participants in this study were served under Individualised Education Programs pursuant to the Individuals with Disabilities Education Improvement Act of 2004, which requires that students with disabilities receive a free appropriate public education in the least restrictive environment appropriate to their needs (Individuals with Disabilities Education Improvement Act, 2004). Structured behavioural and mental health supports, such as the therapy room, align with this legal mandate insofar as they are designed to maintain students within their placement and reduce reliance on exclusionary responses to dysregulation, supporting continued access to instruction rather than removal from it.

Materials and Methods

Research Design

This study employed a collective case study design as conceptualised by Stake (1995), wherein multiple cases are examined together to better understand a shared phenomenon. The collective case study approach was selected because it preserves the contextual richness of individual student experiences while enabling the identification of cross-case patterns. Consistent with established case study protocols emphasising systematic data collection and triangulation across multiple sources of evidence (Yin, 2018), this study drew on behavioural incident logs, off-task behaviour tracking, staff observation rubrics, therapy room frequency records, academic records, and attendance records to construct a comprehensive account

of each case. The phenomenon of interest was the school-based use of an alternative calming space (therapy room), and the cases were nine secondary students with documented mental health needs who were provided structured access to this intervention. Data were collected across two six-week grading periods: fall semester 2025 served as the pre-intervention baseline, and spring semester 2026 served as the post-intervention data collection period.

Sample and Participants

Participants included nine secondary students enrolled in a school-based Mental Health Program. All students were served under Individualised Education Programs (IEPs) reflecting a range of disability classifications relevant to emotional and behavioural regulation, and required structured support for both academic and behavioural needs. During the spring semester, one student (Participant 4) withdrew from the program; therefore, post-intervention data reflect eight participants. All data analysed in this study were drawn from existing behavioural, academic, and program records collected in the ordinary course of the author's professional duties as case manager and lead teacher of the Mental Health Program, rather than from a separate research protocol. Pseudonyms are used throughout, and identifying details have been generalised or omitted to protect student confidentiality.

The Intervention: Alternative Calming Space (Therapy Room)

The alternative calming space, referred to by students and staff as the therapy room, was a designated area within the Mental Health Program's classroom environment purposefully designed to provide students with a low-stimulation setting for emotional de-escalation. The space was equipped with sensory-supportive materials including soft lighting, comfortable seating, visual calming prompts, and structured activity options to support regulation. Critically, the therapy room operated under a revised set of clearly defined rules and expectations developed during the program's inaugural year. These included time-limited visits, a structured check-in process upon entry, and a mandatory re-entry protocol upon exit designed specifically to help students transition back to the classroom in a calm, focused, and academically ready state. The re-entry protocol included a brief staff check-out in which the student confirmed their readiness to return, identified what they needed to re-engage with their learning, and was supported in making a purposeful, productive transition back into the classroom environment.

This structured approach represented a deliberate departure from prior practice at the school site. Student self-reports during routine programmatic check-ins indicated that, in previous years, the therapy room was frequently closed or access was significantly restricted. When the room was accessible without clear guidelines or expectations, students reported using the space unproductively, sleeping, avoiding academic tasks, and spending extended, unstructured time outside the classroom with no plan for return. Rather than supporting regulation, the unstructured space inadvertently reinforced avoidance behaviour and compounded academic loss. The Mental Health Program's revised framework, emphasising purposeful, time-limited use and a supported, structured return to learning, directly addressed these prior limitations and constitutes the defining feature of the intervention examined in this study.

Access to the therapy room was primarily student self-initiated, reflecting the program's emphasis on building self-awareness and independent regulation. For two students (Participant 5 and Participant 9), access also occurred through staff direction and crisis-based referral, consistent with their higher baseline dysregulation. For Participant 2, scheduled sessions were incorporated alongside self-initiated use. All therapy room visits were time-limited and paired with the check-in and check-out procedures described above.

Instruments and Procedures

Multiple data sources were used to ensure a comprehensive analysis of student outcomes:

- Behavioural Incident Logs: Recorded frequency of disruptions, emotional outbursts, and non-compliance, averaged per week.
- Off-Task Behaviour Tracking: Measured student engagement during instructional time, averaged per week.
- Staff Observation Rubrics: Used a 5-point scale to assess emotional awareness and independent regulation.
- Therapy Room Frequency Records: Documented each student's number of therapy room visits per week, total visits per six-week period, and mode of access (self-initiated, staff-directed, scheduled, or crisis-based).
- Academic Records: Monitored subject completion and performance across both semesters.
- Attendance Records: Tracked consistency of school attendance, averaged per week on a 5-point scale.
- These instruments provided both quantitative data and qualitative insights into student progress.

Data Analysis

Descriptive statistics were used to analyse the quantitative data, including mean comparisons between pre- and post-intervention measures across behavioural, emotional, and academic domains. Group means were calculated for each measure across all nine participants at baseline ($n = 9$) and across the eight remaining participants post-intervention ($n = 8$). Therapy room frequency data were analysed to identify patterns in use across the two semesters and to examine relationships between visit frequency, access type, and student outcomes. Qualitative staff observations and student self-report data were analysed thematically, following established procedures for identifying and organising patterns of meaning across qualitative data sources (Merriam & Tisdell, 2016), to provide contextual understanding. Triangulation across data sources was employed to strengthen the credibility and completeness of the findings.

Ethical Considerations

This study drew exclusively on behavioural, academic, and program-monitoring records maintained by the author in the ordinary course of her professional duties as case manager and lead teacher of the Mental Health Program; no additional testing, interviews beyond routine programmatic check-ins, or procedures outside standard case management practice were introduced. Accordingly, the study is best characterised as a retrospective analysis of existing program-monitoring data rather than an intervention study requiring a separate research protocol.

Consistent with this retrospective, practice-embedded design, this study did not seek a formal Institutional Review Board (IRB) protocol. The retrospective analysis of existing, de-identified educational and program-monitoring records — collected by a practitioner in the ordinary course of their professional duties and without the introduction of new testing, assessment, or intervention — falls within the category of activity that the author's affiliated institution treats as exempt from full IRB review under applicable federal human-subjects research guidance governing existing data and records. This study introduced no procedures beyond standard case management practice.

As the case manager and lead teacher of the Mental Health Program described in this study, the author held a dual role as both practitioner and researcher. This positionality provided direct, sustained

access to program records and a detailed contextual understanding of each participant's needs that would not typically be available to an external researcher. At the same time, this dual role introduces the potential for observer bias, including personal investment in demonstrating the program's success. To help mitigate this risk, the study relied on structured observation rubrics and dated incident logs completed contemporaneously with events, together with pre-existing therapy room, academic, and attendance records maintained independently of the study's aims, rather than on retrospective recollection alone.

Student confidentiality was protected throughout. Pseudonyms are used in place of student names, and identifying details, including exact demographic combinations and information unique to a single student, have been generalised or omitted from reporting. Data are presented in pseudonymized or aggregate form to reduce the likelihood that school personnel or other readers familiar with the program could identify individual students. All data handling and reporting practices were consistent with applicable federal and state student privacy protections governing educational records.

Results

Behavioural and Emotional Outcomes

Table 1 presents pre- and post-intervention mean scores across behavioural and emotional outcome measures for the study cohort. (Table 1)

Table 1

Pre- and Post-Intervention Behavioural and Emotional Outcomes (5-Point Scale)

Measure	Pre-Intervention Mean (n = 9)	Post-Intervention Mean (n = 8)	Change	Direction
Behavioral Incidents	3.11	1.75	↓ 1.36	Decrease
Off-Task Behavior	3.11	1.88	↓ 1.23	Decrease
Emotional Awareness	2.11	3.38	↑ 1.27	Increase
Coping Strategy Use	1.78	3.38	↑ 1.60	Increase
Independent Regulation	1.67	3.25	↑ 1.58	Increase
Attendance	3.33	4.00	↑ 0.67	Improvement

Note. All scores are based on a 5-point scale. Pre-intervention data reflect all nine participants (n = 9) collected during the fall semester of 2025. Post-intervention data reflect eight participants (n = 8) following one student withdrawal in spring semester 2026. Means are rounded to two decimal places.

As shown in Table 1, meaningful improvements were observed across all measured domains. Behavioural incidents decreased from a group mean of 3.11 to 1.75, and off-task behaviour declined from 3.11 to 1.88, indicating a substantive reduction in disruptive and disengaged classroom behaviours. Emotional awareness increased from 2.11 to 3.38, reflecting growth in students' capacity to recognise and name their emotional states. Independent regulation showed the largest gain in the dataset, rising from 1.67 to 3.25 (an increase of 1.58 points), suggesting that students progressively developed the capacity to self-manage their emotional responses without adult prompting. Attendance also improved, from a group mean of 3.33 to 4.00.

Therapy Room Use

Table 2 presents individual and group-level data on therapy room use across both semesters, including average weekly visits, six-week totals, and mode of access. (Table 2).

Table 2

Therapy Room (Alternative Calming Space) Use by Student — Fall 2025 and Spring 2026

Student	Access Type	Fall Avg/Wk	Fall Total (6 wks)	Spring Avg/Wk	Spring Total (6 wks)	Trend
Participant 1	Self-initiated	2/5	~12	3/5	~18	↑
Participant 2	Self-initiated; Scheduled	1/5	~6	2/5	~12	↑
Participant 3	Self-initiated	1/5	~6	2/5	~12	↑
Participant 4	Self-initiated	2/5	~12	—	—	—
Participant 5	Self-initiated; Staff-directed; Crisis	5/5	~30	4/5	~24	↓*
Participant 6	Self-initiated	1/5	~6	1/5	~6	→
Participant 7	Self-initiated	2/5	~12	2/5	~12	→
Participant 8	Self-initiated	1/5	~6	1/5	~6	→
Participant 9	Self-initiated; Staff-directed; Crisis	2/5	~12	3/5	~18	↑
Group Mean		1.89/5	~11.3	2.25/5	~13.5	↑

Note. Fall data reflect the six-week pre-intervention baseline period (fall semester 2025). Spring data reflect the six-week post-intervention period (spring semester 2026). The 'X/5' figures in the Avg/Wk columns indicate the number of school days, out of a five-day school week, on which a student accessed the therapy room; this is a count of days per week, not a rating on a five-point scale. Totals are approximate based on weekly averages across six weeks. The Group Mean row reports the mean of the individual Avg/Wk values (expressed in the same X/5 units) and the mean of individual six-week totals across participants. ↓* for Participant 5 indicates a decrease in total visits alongside an increase in independent regulation, suggesting reduced need for crisis-based access. Participant 4 withdrew in the spring semester.

Therapy room use data reveal several notable patterns. Across the cohort, the group mean weekly use increased from 1.89 out of 5 school days per week in the fall to 2.25 out of 5 school days per week in the spring, and the average total number of visits per student increased from approximately 11.3 to 13.5 per six-week period. For most students, access was entirely self-initiated, which is a meaningful indicator of growing self-awareness and independent regulation.

Participant 5 presented the highest frequency of therapy room use in the fall (5 out of 5 days per week), with access occurring through self-initiation, staff direction, and crisis-based referral. By the spring semester, total use decreased to 4 out of 5 days per week, a reduction that, when viewed alongside the student's improvement in independent regulation (1/5 to 3/5) and decrease in emotional outbursts (4/5 to 2/5), suggests a shift from crisis-driven access toward more proactive, self-regulated use of the space. Similarly, Participant 9, who accessed the room through staff direction and crisis referral in addition to self-initiation in the fall, showed increased total use in the spring (2/5 to 3/5) alongside improvements across all behavioural and emotional measures.

Participant 2 was the only student with a scheduled therapy room component in addition to self-initiated access, which may have contributed to the consistency of outcomes observed for this participant. Participant 6 and Participant 8 maintained stable, low-frequency use across both semesters (1/5 per week), consistent with their moderate baseline profiles and incremental progress.

Academic Outcomes

Table 3 presents individual academic performance and attendance data across both semesters. (Table 3)

Table 3

Academic Performance and Attendance by Student — Fall 2025 and Spring 2026

Student	Fall Subjects Passed	Spring Status	Fall Attendance (avg/wk)	Spring Attendance (avg/wk)	Change
Participant 1	5 passed; 1 incomplete	6 on track	3/5	4/5	↑
Participant 2	6 passed	6 on track	4/5	4/5	→
Participant 3	6 passed	5 on track; 1 in progress	4/5	4/5	→
Participant 4	0 passed	Withdrew	2/5	—	—
Participant 5	6 passed	6 on track	4/5	5/5	↑
Participant 6	0 passed	2 on track	0/5	2/5	↑
Participant 7	6 passed	6 on track	4/5	4/5	→
Participant 8	6 passed	6 on track	5/5	5/5	→
Participant 9	6 passed	6 on track	4/5	4/5	→

Note. Fall data reflect completed grades at the end of the Fall 2025 semester. Spring data reflect current academic status at the time of data collection (spring semester 2026). Attendance is reported as average days present per school

week on a 5-point scale. Participant 4 withdrew in the spring semester. Participant 6 had 0 subjects passed and 0 attendance days in the fall, reflecting significant absenteeism at baseline.

Academic outcomes reflected positive trends across the cohort. Seven of the eight remaining students were on track to pass all or most of their subjects in the spring semester, compared to six of nine at fall baseline. The number of students with incomplete or failing grades decreased from three (Participant 4, Participant 6, and Participant 1) to one (Participant 6), with Participant 6 showing notable improvement from 0 subjects passed and 0 attendance days in the fall to 2 subjects on track and an attendance average of 2/5 in the spring, a meaningful shift despite remaining below cohort norms.

Discussion

The findings of this study indicate that the implementation of a structured alternative calming space (therapy room) was associated with meaningful and multidimensional differences in student outcomes across behavioural, emotional, and academic domains. The reduction in behavioural incidents and off-task behaviour suggests that students were better able to manage emotional responses before reaching escalation, consistent with research emphasising the role of environmental supports in interrupting the stress response cycle (Shanker, 2016). Importantly, these improvements were not simply a reflection of students spending more time outside the classroom. Rather, the data indicate that students used the therapy room to de-escalate and returned to the classroom more regulated and better prepared to engage in learning, a pattern corroborated by the study's attendance and academic performance data.

This outcome stands in direct contrast to the prior-year pattern described in students' self-reports, in which access to the therapy room without clear structure led to extended, unproductive absences from the classroom and no meaningful improvement in regulation. The comparison underscores a critical finding of this study: the physical existence of a calming space is insufficient on its own. Meaningful change came from the combination of access and structure: clear rules and expectations governing use, time limits that prevented avoidance, and a deliberate re-entry protocol that returned students to their learning environment with intention and support. In this model, the therapy room was never an endpoint; it was a regulated bridge back to the classroom.

The increase in independent regulation, the largest gain observed across all measures (1.67 to 3.25), is particularly notable in this regard. As students internalised the structure of the therapy room, they demonstrated a growing capacity to recognise early signs of dysregulation, decide to seek support, use the space purposefully, and return to class ready to participate. This sequence reflects a developmentally meaningful progression toward autonomous self-regulation, a core goal of SEL frameworks (CASEL, 2020) and a critical life skill for students with mental health needs.

The case of Participant 5 illustrates this trajectory compellingly: despite entering the fall semester as the highest-frequency user, with access driven largely by staff direction and crisis referral, this student's use became more self-directed and less crisis-based by spring, accompanied by notable improvements in emotional awareness (2/5 to 4/5), behavioral regulation (4/5 to 2/5 incidents), and independent regulation (1/5 to 3/5). This shift suggests that for students with the most intensive needs, consistent access to a structured calming space can gradually shift the locus of regulation from external (staff-managed) to internal (student-managed).

Improvements in attendance and academic performance further reinforce the connection between emotional regulation and classroom readiness. Students who can de-escalate, process their emotional state, and re-enter the classroom with support are more likely to attend consistently and engage meaningfully with academic content, consistent with research on trauma-informed practice and the relationship between emotional safety and academic participation (Brunzell et al., 2016).

Limitations

While this study's findings offer meaningful insights into the impact of a structured alternative calming space on students with mental health needs, several limitations should be considered when interpreting the results.

First, the study employed a small, purposive sample of nine secondary students enrolled in a single school-based program within one school district in California. The specificity of this sample, students with IEPs enrolled in a Mental Health Program at Jefferson Union High School District, limits the generalizability of findings to other school contexts, grade levels, student populations, or geographic regions. Replication across larger and more diverse samples is necessary before broader conclusions can be drawn.

Second, the study design did not include a control group. Without a comparison group of students with similar profiles who did not have access to the therapy room, it is not possible to attribute all observed improvements solely to the intervention. Other factors, such as the program's supportive climate, relationship-building with staff, or natural developmental progression, may have contributed to the outcomes observed.

Third, the prior-year contextual data relied exclusively on student self-reports shared during routine programmatic check-ins rather than archival behavioural or academic records. While these accounts provide valuable qualitative context and add meaning to the current findings, they are subject to recall bias and should be interpreted with appropriate caution. Future studies would benefit from systematic comparative data collected across academic years.

Fourth, the data collection period spanned two six-week grading periods, which, while sufficient to capture short-term trends, does not allow for conclusions about the sustainability of outcomes over time. Longitudinal follow-up would be needed to determine whether the improvements in self-regulation, attendance, and academic performance observed in this study are maintained beyond the intervention period.

Finally, the study's primary outcome measures relied on staff-completed rubrics and observational logs, which may introduce observer bias. Future research would benefit from including validated, standardised instruments for measuring emotional regulation and behavioural outcomes, as well as student self-report measures that triangulate staff observations with student perspectives.

Conclusions

This collective case study demonstrates that providing secondary students with structured access to an alternative calming space (therapy room) within a school-based mental health program can be associated with meaningful improvements in behavioural, emotional, and academic outcomes. The intervention was associated with reductions in behavioural incidents and off-task behaviour, notable growth in emotional awareness and independent regulation, increased student-initiated therapy room use, and positive trends in attendance and academic performance.

A central and distinctive finding of this study is that the therapy room's effectiveness was not attributable to the space itself, but to the structured framework within which it operated. Student self-report data describing prior-year experiences, in which the same physical space, used without clear rules or a re-entry protocol, produced no meaningful benefit and in some cases increased academic loss, provide a compelling comparative context. The Mental Health Program's implementation of defined expectations, time-limited visits, and a purposeful check-out and return-to-learning protocol transformed the therapy

room from a passive escape into an active, productive component of students' emotional regulation and academic engagement.

These findings carry important implications for school counsellors, special educators, school psychologists, and administrators who are considering or currently implementing calming spaces in their programs. The evidence from this study suggests that a calming space without structure may be as ineffective as no calming space at all, and that the design of the protocol governing the space is as important as the design of the space itself. Schools are encouraged to adopt clear guidelines, staff-supported re-entry procedures, and data monitoring practices as essential components of any calming space implementation.

The alternative calming space, when implemented with fidelity and intentionality, represents an accessible, scalable, and evidence-aligned strategy that can be integrated within Multi-Tiered Systems of Support (MTSS), Positive Behavioural Interventions and Supports (PBIS), and trauma-informed school frameworks.

Suggestions for Future Research

Future research should examine the long-term effects of structured calming space interventions across diverse settings, grade levels, and student populations. Studies using control or comparison groups would help isolate the therapy room's specific contribution from other supportive elements of a program's overall climate. Larger, multi-site samples would strengthen generalizability beyond a single school district, and longitudinal designs extending beyond a single academic year would clarify whether gains in independent regulation, attendance, and academic performance are sustained over time. Future work should also further investigate the specific components of the re-entry protocol, such as check-in structure, time limits, and staff check-out procedures, that most contribute to productive classroom reintegration, and should incorporate validated, standardised instruments alongside student self-report measures to reduce reliance on staff-completed observational tools.

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Conflict of Interest

The author declares no conflict of interest.

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