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College of Social and Behavioral Sciences

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Holly Curran

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Walden University
2017

Abstract

Facilitating Collaboration Among School and Community Providers In

Children's Mental Health

by

Holly J. Curran

MS, Roberts Wesleyan College, 2007

MA, SUNY College at Brockport, 2005

BS, SUNY College at Brockport, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Educational Psychology

Walden University

February 2018

Abstract

Interprofessional collaboration among school-based and community-based mental health providers in children's mental has been studied in relation to specific providers and as part of program evaluation; however, limited information exists as to how to overcome barriers to collaborative relationships. This study describes the experiences of school and community mental health service providers and those who supervise them. Using phenomenological methodology, three focus-group interview transcripts were analyzed by identifying recurrent themes relevant to the experience of collaboration from school and community providers' perspectives. Although participants viewed aspects of collaboration positively, barriers frequently interfered with collaborative relationships. Support for collaboration from state, district or organization administration was considered necessary for widespread collaboration across settings. To reduce time constraints on existing school staff, school-based professionals suggested it may be necessary to employ additional staff to manage collaborative relationships. Participants' ideas for funding included cutting costs, reducing risks, and grant writing. Jointly developing procedures, increasing accessibility by having services available within the school setting, and collecting outcome data regularly to share with stakeholders were discussed. Understanding the experiences of collaboration among school and community mental health providers has the potential to ignite social change by helping schools and community agencies overcome barriers to collaboration through improved coordination of services for children with unmet mental health needs.

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Chapter 1: Introduction to the Study

Twenty to twenty-five percent of children are estimated to have mental health needs, yet only about one-third of them receive mental health services (Merikangas et al., 2010; Merikangas et al., 2011). The Centers for Disease Control (CDC, 2013) reported that between 13% and 20% of children experience a mental disorder annually. As many as 50% of children ages 13 to 18 were reported have had a mental disorder in their lifetime (CDC, 2013). Of those experiencing mental illnesses, 28% were noted to have a severe impairment (CDC, 2013). Children's unmet mental health needs can have a significant impact on their ability to function. Children with mental health problems have lower levels of academic achievement and educational attainment (Forest, Bevans, Riley, Crespo, & Louis, 2011; McLeod, Uemura & Rhorman, 2012). Additionally, children with mental health problems are more likely to have behavior and conduct problems, including delinquency and school absenteeism (CDC, 2013; McLeod et al., 2012). Rates for the use of alcohol, tobacco, and illicit drugs as well as suicidal thoughts and behavior are also increased among children with mental health problems (CDC, 2013; Heneghan et al., 2015).

Numerous barriers to community-based services exist. Barriers to services are often financial, such as low income or lack of access to public or private insurance (Alexandre, Dowling, Laris & Rely, 2008). The location and availability or the appropriateness of programs or services can also be a barrier (Cummings, Wen & Druss, 2013; Wood, Chiu, Hwang, Jacobs, & Ifekunigwe, 2008). Dissatisfaction with providers, lack of collaboration between community agencies, and the stigma of mental illness also

interfere with help seeking in the community (DeRigne, 2010; Garcia, Circo, Denard & Hernandez, 2015; Thoits, 2011). Community-based mental health services have not been sufficient to meet the mental health needs of children.

Support for expanding school-based mental health services for children has grown, given that children spend the majority of their day in the school setting. Symptom improvement appears to be similar for children receiving school-based and community-based services; however, school-based programs have been found to have significantly lower levels of attrition than community-based programs (Armbruster & Lictman, 1999; Husky et al., 2011). Results from a longitudinal research study indicated that children with mental health problems were more likely to receive services in the education system as opposed to community or medical settings (Farmer, Burns, Phillips, Angold & Costello, 2003). When services were initiated within community mental health, children were more likely to seek services in education and medical settings. However, children who initiated services in the education system were less likely to be connected with services outside the educational setting (Farmer et al., 2003). Given that a school may be the first and only location for mental health service delivery, it is troubling that mental health personnel in the school setting have reported that their numbers are too few to meet demand (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007). They also reported insufficient training to provide mental health services (Brener et al., 2007). Furthermore, collaboration between school and community mental health providers in meeting children's needs has been limited (Walsh, 2013).

The Individuals With Educational Disabilities Improvement Act (IDEA, 2004) requires that schools identify and provide services to children with disabilities. Special education services are necessary when disabilities impact students educationally, causing them to need specialized instruction to make educational progress. Schools have a responsibility to meet the emotional needs of students. Barriers to providing mental health services to students within the school setting include role strain, lack of support from administration, and lack of training in mental health service delivery (Suldo, Friedrich, & Michalowski, 2010). Increasing collaboration between school- and community-based mental health professionals may allow school and community organizations to share responsibility for meeting children's needs.

Even when school-based providers have training in evidence-based mental health practices, implementation often does not occur (Langley, Nadeem, Katoaka, Stein, & Jaycox, 2010). Support from community mental health service providers could help to improve the number of children receiving services, but there is limited collaboration between school and community mental health providers (Brener et al., 2007). Husky et al. (2011) found that a well-developed screening and referral process improved students' likelihood of accessing school-based services. However, community-based mental health services were infrequently sought when students were referred for additional services by school-based providers (Husky et al., 2011). Students appear to be more likely to access and continue services when these services are available in the school setting.

Background of the Problem

Data from the National Comorbidity Survey—Adolescent Supplement (NCS-A), a survey of adolescents aged 13 to 18, indicated that 1 in every 4 or 5 youths met the criteria for a mental disorder (Merikangas et al., 2010). Anxiety disorders were most commonly reported. Behavior disorders, mood disorders, and substance use disorders were also prevalent (Merikangas et al., 2010). Twenty-two percent of survey participants experienced severe impairment. Many of these individuals did not receive mental health services to treat their mental health symptoms. Merikangas et al. (2011) reported that half of individuals with mental disorders who described severe impairment had not received treatment. Service rates were better, about 60%, for those with attention deficit/hyperactivity disorder (ADHD). About one-third of adolescents reporting had accessed services for their mental illness. Black and Hispanic teens were less likely than White, non-Hispanic teens to receive services for anxiety or mood disorders, even when reported impairment was more severe (Merikangas et al., 2011). Based on these data, it appears that the majority of children with mental disorders do not receive any mental health services. The problem is more significant for Black and Hispanic teens than White, non-Hispanic teens (Merikangas et al., 2010). Issues of stigma or negative cultural perceptions of help-seeking behavior or mental health professionals may cause these differences (Merikangas, 2011). Financial costs or problems related to insurance or accessibility of services may also be to blame (Merikangas, 2011).

Given the difficulty children have accessing mental health services, the public school system has been identified and supported as a practical location for the delivery of

mental health services (Soleimanpour, Geierstanger, Kaller, McCarter, & Brindis, 2010). Brener et al. (2007) reported on the CDC's School Health Policies and Programs Survey (SHPPS). This survey is conducted every 6 years in the U.S. with personnel in elementary, middle, and high school. Surveys conducted at the state and district levels address topics including collaboration, provision of services, evaluation of school-based mental health services, and credentials for required personnel. Survey responses indicated that three-fourths of schools had counselors available at least part time. Two-thirds of schools had school psychologists at least part time. Less than half of schools reporting had social workers (Brener et al., 2007). These data were similar to those collected in 2000. Schools were more likely to deliver counseling services than comprehensive assessment or intake (Brener et al., 2007). When schools used community-based providers, services were mostly delivered off of school property. Less than half of the schools that responded to the survey had arrangements with providers of mental health services to provide services to children (Brener et al., 2007). Too few mental health providers were found to be employed by public education agencies, and school professional's connection with outside agencies was determined to be insufficient (Brener et al., 2007). Schools are not able to independently meet the needs of children and frequently do not assist children in accessing community resources.

In a follow-up to the SHPPS completed in 2012, Demissie, Parker, and Vernon-Smiley (2013) reported that improvement in state- and district-level policies had occurred. An increase in the number of policies that support school-based mental health were reported. Greater collaboration between school and community health and mental

health agencies was also reported. However, inconsistency was noted at the state and school district levels, and policies continued to favor separate rather than comprehensive and collaborative support systems for children (Demissie et al., 2013). No quantitative data were available to determine the frequency with which collaboration occurred.

Green et al. (2013) analyzed data from the U.S. National Comorbidity Survey—Adolescent Supplement (NCS-A), in which a small sample of school principals or mental health coordinators responded to surveys about school resources for students with emotional needs. In an analysis of this information in conjunction with reports from adolescent and parent interviews, it was found that almost half of adolescents with a diagnosis from the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) received some school-based mental health service. Identification of less severe mental health problems resulted in greater mental health service use among adolescents with both mild and moderate mental disorders. A higher ratio of mental health providers to students was associated with increases in the use of community-based mental health services among students with DSM-IV diagnoses (Green et al., 2013). Increasing availability of mental health services for children with mental disorders is necessary to improve student outcomes.

Suldo et al. (2010) identified factors related to the delivery of school-based mental health services in schools by school psychologists. Thirty-nine school psychologists in two southern school districts reported on barriers to providing mental health services to children during the school day. Primary barriers to providing school-based mental health services were difficulties in using the school for service delivery,

problems with school district or department support, and problems working with other school staff members (Suldo et al., 2010). Barriers also included inadequate training and role strain. Even when school-based mental health professionals have proper training, barriers to the delivery of mental health services persist. Langley et al. (2010) identified competing responsibilities, problems with parent engagement, logistical issues (e.g., finding space, scheduling, interruptions), and lack of support from school administrators and teachers as barriers to the implementation of a group crisis intervention.

Despite the difficulties that schools have in meeting the mental health needs of their students, they are in an excellent position to identify students in need of mental health services. Identification of children who have unmet mental health service needs has been useful as a bridge to treatment in the school setting. Husky et al. (2011) studied referral processes for identifying students in need of mental health services. To determine if a screening procedure would be more efficient than the usual referral process for identifying students in need of services, the researchers screened randomly assigned students in a public education agency to be part of a screening group. Members of the control group did not participate in screening activities and were referred as usual by school personnel (Husky et al., 2011). Significantly more students were referred based on the screening/interview process than were referred by school personnel. Most of the students were referred through screening and school personnel initiated services in the school setting. Among those who were referred by the school for additional services in the community, very few sought those services (Husky et al., 2011). The screening process was superior for identifying students in need of services, but limited success was

found with referrals to community mental health (Husky et al., 2011). This is consistent with the findings of Farmer et al. (2003) and Tegethoff, Stalujanis, Belardi, and Meinlschmidt (2014). Improved collaboration between school and community-based mental health service providers may improve children's access to services when they are provided in the school setting.

Collaboration in mental health has become a necessity in order to coordinate services. The Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and U.S. Department of Health and Human Services (DHHS; 2013) organized the Children's Mental Health Initiative to improve collaboration and coordinated care in children's mental health treatment. Operated under the Systems of Care Philosophy, the Children's Mental Health Initiative emphasizes several principles for service delivery, including coordinated care though interprofessional collaboration (CMHS, SAMHSA, & DHHS, 2013). Outcome data suggested that the Children's Mental Health Initiative improved access to services for underserved children and youth (CMHS, SAMHSA, & DHHS, 2013). Brannan, Brashears, Gyamfi, and Manteuffel (2012) found that interprofessional collaboration was one of the most difficult aspects of the Children's Mental Health Initiative to realize. Few or no services were available as part of a collaborative, multiagency initiative (Brannan et al., 2012).

Interprofessional collaboration is also referred to as *integrated care* and *multiagency*, *multidisciplinary*, *interdisciplinary*, *cross-disciplinary*, or *interagency collaboration* (Odegard & Strype, 2009). In children's mental health, it refers to multiple

team members from different organizations or professions working together to support children and their mental health needs. Improved interprofessional collaboration among mental health service providers in school and community settings may increase children's access to mental health services and reduce pressure on school mental health professionals to carry the burden of meeting the mental health needs of children. To identify the factors that impact collaboration, Odegard (2005) conducted a qualitative study of interprofessional collaboration in the mental health treatment of children in Norway. Participants were school psychologists, teachers, a psychologist, and a medical doctor, each with experience engaging in collaboration. Having a positive attitude toward other professionals, understanding one another's roles, and having a common understanding of the child's problems were factors identified as helping to facilitate collaborative relationships (Odegard, 2005). Evaluating the collaborative process and having leadership within the collaborative relationship were also reported to improve collaboration (Odegard, 2005). Limiting factors that were noted included poor leadership, unclear aims, different understandings of the problem, different professional backgrounds, limited understanding of one another's roles, time pressures, a heavy workload, and high turnover rates (Odegard, 2005).

Odegard (2006) surveyed Norwegian school and community mental health professionals experienced in collaboration to assess their perceptions of interprofessional collaboration across individual, group, and organizational aspects of the collaborative process. Factors were classified as individual, group, or organizational (Odegard, 2006). Individual factors included motivation, role expectations, personality style, and

professional power. Group factors included group leadership, coping, communication, and social support. Organizational factors included organizational culture, organizational goals, organizational domain, and organizational environment. Collaborating teachers, special educators, psychologists, social workers, primary nurses, medical doctors, child welfare workers, and other professionals working with children were later surveyed. The results suggested that motivation was identified by participants as the most important individual factor in interprofessional collaboration (Odegard & Strype, 2009). Among group factors, leadership and social support were identified as most salient. At the organizational level, the organizational culture was identified as most important to participants' attitudes about collaboration (Odegard & Strype, 2009). Differences were noted based on workplace; school personnel were less likely to view organizational culture as an important factor (Odegard & Strype, 2009).

Despite the establishment of policies that favor collaboration and the body of research in support of collaboration in the delivery of mental health services for children, collaboration between school and community mental health providers continues to be limited in the U.S. Walsh (2013) conducted a national survey of school psychologists and found that 25% reported that they did not engage in any collaboration with community mental health professionals. Fifty percent did collaborate on average about once per month (Walsh, 2013). Twenty percent reported collaboration more than once per month. Barriers reported included time constraints, problems accessing community providers, difficulty obtaining parent permission, turnover among community mental health professionals, and having no information about community providers (Walsh,

2013). School psychologists with a higher number of hours of training in interprofessional collaboration reported higher levels of collaboration with community providers (Walsh, 2013).

Research about collaboration between school and community mental health providers in the provision of services to children has helped to identify factors that impact collaboration. Specifically, it appears that important individual, organizational, and group characteristics can interfere with or support collaborative efforts. Research data have largely been collected from inquiries to a particular group of providers (e.g., school psychologists) or through program evaluation following a specific collaborative initiative. More information is needed to determine what individual and organizational factors are necessary for mental health providers in the school and community settings to *initiate* and sustain collaborative efforts to meet children's mental health needs.

Statement of the Problem

The problem of unmet mental health needs is one of the most critical issues facing the nation's youth (Merikangas et al., 2011). Children with mental health problems have lower levels of educational success and more problems with delinquency, suicidality, and substance use (CDC, 2013; Forest et al., 2012; Heneghan et al., 2015; McLeod et al., 2012). These problems can persist into adulthood. Difficulties exist in identifying youth with mental health needs and in helping those children connect with available services (Farmer et al., 2003; Husky et al., 2011; Tegethoff et al., 2014). Barriers to community-based mental health services particularly impact children from lower income families and those from minority ethnic groups (Alegria et al., 2012; DeRigne, 2010; Kodjo &

Auinger, 2004). Some of these barriers are eliminated when mental health services are available in the school setting; however, too few mental health service providers with adequate training and support are employed by schools to meet the demand (Cummings, Ponce, & Mays, 2010; Slade, 2002; Suldo et al., 2010; Walsh, 2013).

One way to meet the mental health needs of children is to increase collaboration between agencies that support them. Improving collaborative efforts to identify children with unmet mental health needs and increasing the ability to offer services within the school setting has the potential to significantly improve outcomes for children (CMHS, SAMHSA, & DHHS, 2013). Despite this, limited collaboration exists between school and community mental health providers. Much of the information about factors that limit and facilitate collaboration comes from studies that are designed to evaluate a particular program or from studies that focus on information collected from a particular group of mental health providers (Beckles, 2009; Brown, Dahlbeck, & Sparkman-Barnes, 2006; Cross, 2013; Douglas, 2001; Kvarnstrom, 2008; Massey, Armstrong, Boroughs, Henson and McCash, 2005; Walsh, 2013). It is necessary to understand the factors that facilitate collaboration among school and community mental health providers outside of a program evaluation by understanding the experiences of school- and community-based mental health professionals and administrators with various levels of experience building collaborative relationships.

Purpose of the Study

The purpose of this qualitative study was to understand the factors that may improve school and community mental health service providers' ability to initiate and

sustain collaboration in the provision of services to children. The study was primarily phenomenological in nature, and its purpose was to understand the experiences of mental health professionals. For this study, focus groups were made up of school counselors, school psychologists, school social workers, and community-based counselors, psychologists, and social workers. School district and mental health organization administrators were also included in focus groups to develop an understanding of the organizational policies that favored or constrained the fostering of collaborative relationships as well as to understand participants' experiences as leaders, including their understanding of and stances on collaborative relationships. Participants engaged in discussion about the factors involved in collaborating with one another in the provision of services for children. Individual interviews supplemented information obtained through focus groups.

Research Questions

The research questions were the following:

- What are the factors that may facilitate the initiation of collaborative relationships, outside of program requirements or mandates in the provision of services to children?
- How can the known barriers to collaboration be overcome to increase the development of collaborative relationships?
- What differences exist between school- and community-based mental health service providers in how they view collaboration in serving children with mental health needs?

- What differences exist between service providers and administrators in how they view collaboration in serving children with mental health needs?

Theoretical and Conceptual Framework

This investigation is justified by the theoretical framework, which places the development of children's mental health in ecological perspective. Bronfenbrenner's ecology of human development views the child through his or her interactions with the multiple systems and contexts with which he or she comes in contact (Bronfenbrenner, 1979). The *microsystem* consists of those in the immediate environment, including family, peers, neighbors, members of the school community. The *mesosystem* encompasses the interaction of systems (e.g., home and school, school and community, home and community). The *exosystem* includes the environments that impact the child, but in which the child is not directly involved. The exosystem could include the parent's work environment, local politics, social services, and school administration. The *macrosystem* includes the beliefs and values of the culture. Finally, the *chronosystem* involves the passing of time and how historical events outside of all systems can impact development (Bronfenbrenner, 1994). When compatibility exists among systems and contexts, the child's development is even. Difficulties, including the development of mental health problems, may be experienced when expectations among the systems and contexts are inconsistent and goals are not aligned.

This study was primarily concerned with the mesosystem and the interaction of the school and community systems as a way to improve mental health in children. The systems of care model was developed by SAMHSA out of a need to improve mental

health services for children. Class action lawsuits against state agencies including juvenile justice systems, child welfare systems, education systems, and state Medicaid systems became more frequent due to fragmented and delayed services and due to agencies forcing parents to relinquish custody of children in order to access mental health services (Pumariega, Winters, & Huffine, 2003). The establishment of the Children's Mental Health Initiative was intended to improve access and comprehensive mental health treatment to children in need. The key principles of the systems of care philosophy require that the child have access to early identification and intervention, as well as individualized, culturally sensitive, nondiscriminatory, and comprehensive treatment in the least restrictive environment, with case managers serving as advocates who ensure collaboration among service sectors or agencies and families for the planning of services and transition to adult services as needed (Miller, Blau, Christopher, & Jordan, 2012; Pumariega et al., 2003). Outcomes assessed as of 2013 suggested that children with services delivered under a systems-of-care approach improved their ability to develop relationships, manage emotions, function in schools (fewer suspensions and better grades) and at home, and manage anxiety, in addition to decreasing suicide attempts and ideation (CMHS, SAMHSA, & DHHS, 2015). Increasing collaboration among school and community mental health providers has the potential to improve outcomes for children. Understanding the difficulties in initiating and sustaining collaborative relationships outside program requirements and mandates is important to this problem. In order to overcome barriers, it is necessary to develop a better understanding of the factors that can facilitate collaboration.

Significance of the Study

The current view of mental health is that mental health is not merely the absence of mental illness, but a positive sense of mental well-being (Antaramian, Huebner, Hills, and Valois, 2010; Herrman, Saxena, & Moodie, 2005). Flourishing involves accentuating the positive by increasing positive emotions, improving emotional well-being, and increasing satisfaction and success in life (Keyes, 2007). Keyes (2007) noted that it is important that people have a sense of belonging and comfort within their community, that they engage in activities that are valued by others, and that they accept others. For teens, the indicators of flourishing include psychological and social well-being, autonomy, environmental success, self-acceptance, personal growth, life purpose, and positive relationships (Keyes, 2006). Moderately mentally healthy teens have few mental problems but do not have characteristics of flourishing, whereas those who are languishing have mental health problems (Keyes, 2006). It is imperative to have systems in place to identify students with mental health problems as well as those who are not flourishing. Providing interventions for these children can improve their opportunity to thrive, thereby improving lifelong outcomes. Mental health services may improve children's opportunity to achieve a state of well-being.

Barriers to community-based services interfere substantially with children's use of these services. For example, Alexandre, Dowling, Stephens, Laris, and Rely (2008) found that children were more likely to use community-based services if their symptoms were severe, if delinquent behavior was present, and if they had substance use disorders. Children with less serious mental health problems did not receive treatment and may

have been at greater risk for worsening of mental health problems without support (Alenxandre et al., 2008). Children from low-income and ethnic minority groups are disproportionately affected by barriers to community-based services. Parents reported that cost and health insurance coverage problems were primary barriers to mental health treatment (Derigne, 2010). Children were more likely to use services if they came from homes where household income was higher or if they were eligible for Medicaid (Alexandre et al., 2008).

Cultural values and stigma also reduce treatment seeking for psychological problems. African American children use fewer services than Caucasian children with similar needs (Leslie, Hurlburt, Landsverk, Barth, and Slymen, 2004). Mexican American families use fewer services or end treatment sooner due to the stigma within the culture surrounding treatment for mental problems (Wood, Chiu, Hwang, Jacobs, & Ifekunigwe, 2008). It is necessary to improve access to treatment and eliminate barriers to treatment that are present in community-based settings.

One way to eliminate barriers to treatment is to make treatment available where students are—in schools. Outcomes for school-based mental health services have been positive overall. Numerous studies have found that providing mental health services in the school setting resulted in positive outcomes. Participation in school-based mental health services is associated with a reduction in disciplinary referrals, decreased school absenteeism, better grades and fewer course failures (Jennings, Pearson, & Harris, 2000; Kastan, 2003; Walker, Kerns, Lyon, Bruns, & Cosgrove, 2010). Evidence-based therapy provided within the school setting has also been demonstrated to reduce anger and

depressive symptoms, to improve social skills (Flanagan, Allen, & Henry, 2009), to increase frustration tolerance, to reduce irrational thoughts (Vaida, Kallay, & Opre, 2008), and to improve psychosocial competence and resilience (Srikala & Kishore, 2010). Outcomes for school- and community-based mental health services have been found to be similar, with lower levels of attrition noted in school-based programs (Armbruster & Lictman, 1999; Husky et al., 2011). School-based mental health services have been demonstrated to meet children's mental health needs when they are available.

Barriers to implementation of evidence-based interventions within the school day occur due to lack of training among school-based mental health professionals, role strain, and lack of support by school administration (Suldo et al., 2010). Barriers make collaboration with community-based mental health providers necessary to meet the needs of children to improve their opportunities to flourish academically, psychologically, socially, and behaviorally. Improvements in collaboration between school and community mental health professionals can help to bridge gaps in school-based mental health and improve children's emotional health and ability to flourish. In line with the efforts of the CMHS, SAMHSA, and DHHS (2013) to improve children's mental health, Blau, Christopher, and Jordan (2012) and Hodges, Ferreira, and Israel (2012) concluded that in order to meet the needs for children's mental health services, systems-level change is necessary to ensure the provision of comprehensive mental health services. It is necessary to improve school and community collaboration and increase interprofessional collaboration to expand the availability of mental health services for children. It is necessary to understand the factors that facilitate the initiation of sustained collaboration

between school and community mental health providers to improve children's opportunities to flourish.

Summary

Of the 20% to 25% of children who have mental health needs, two-thirds are not accessing mental health services. Community-based mental health services are available, yet barriers to accessing these services include problems with insurance, cost, availability of appropriate services in the community, transportation, culture, providers, and interprofessional collaboration. The use of school-based services has been proposed as an alternative, given that students are present within the school setting. However, barriers such as having too few mental health personnel, inadequate training, lack of support from school district administration, and problems with collaboration between school and community mental health providers have been cited.

Meeting children's mental health needs requires collaboration between school and community mental health providers to provide comprehensive care and improve outcomes for children. Although recent increases in collaboration have been reported (Demissie et al., 2013), it is not clear whether this has improved the comprehensive delivery of services between school and community agencies or what impact it has had on outcomes for children. It could be that collaboration has increased because school-based mental health providers are providing fewer services to children. It is clear that providing a systematic way of identifying children with mental health needs can lead to greater use of mental health services (Husky et al., 2011). When services are available within the school setting, they are accessed more often than when schools refer to

community-based services (Farmer et al., 2003; Husky et al., 2011; Tegethoff et al., 2014). Additionally, having services available in the school setting appears to reduce racial/ethnic disparities in service use (Cummings et al., 2010).

Improving interprofessional collaboration to provide mental health services is a way to remove barriers and reduce the costs associated with the provision of mental health services. Literature on Norwegian interprofessional collaboration suggests that the most salient factors relevant to sustaining collaborative efforts include organizational factors such as organizational culture and organizational goals; group factors, particularly leadership; and individual factors such as professional power and motivation for interprofessional collaboration (Odegard & Strype, 2009). As many as 25% of school psychologists in the U.S. report that they do not engage in any collaborative relationships with community mental health providers (Walsh, 2013). It is necessary to determine the factors that are needed to initiate sustained interprofessional collaboration between school and community mental health providers in order to meet children's mental health needs.

This study was phenomenological and used Bronfenbrenner's ecology of human development as its backdrop. Focusing primarily on the mesosystem, which includes the interaction of systems surrounding the child, such as home, school, and community, the study was designed to identify factors that may encourage sustained interprofessional collaboration and improve systems interactions to better meet the mental health needs of children.

Chapter 2: Literature Review

The New Freedom Commission on Mental Health (2003) assessed the state of mental health in the U.S. and offered this recommendation:

> To transform the mental health care system, the Commission proposes a combination of goals and recommendations that together represent a strong plan for action. No single goal or recommendation alone can achieve the needed changes. No level or branch of government, no element of the private sector can accomplish needed change on its own. To transform mental health care as proposed, collaboration between the private and public sectors and among levels of government is crucial. (p. 86)

This transformation would involve helping Americans understand that mental health and well-being are necessary for overall health. It would also make mental health services consumer and family driven and would aim to eliminate disparities. Implementation of screening, assessment, and referral practices would help in the early identification of mental health needs. Technology would be used to improve access to mental health records and to enhance the dissemination of research-based treatment (New Freedom Commission on Mental Health, 2003). An effort to create a comprehensive system of mental health services would not be complete without consideration of the unique needs of children or without collaboration between school and community mental health providers in their support of children with mental health needs.

The Department of Health and Human Services (2000) suggested that greater collaboration among public organizations was needed to improve the state of children's

mental health. Several goals were identified to improve the ability to meet children's mental health needs (Department of Health and Human Services, 2000). For one thing, there is a need to reduce the stigma of help-seeking behavior by promoting awareness and to eliminating cultural and socioeconomic disparities in access to treatment. Schools are in a position to promote awareness of mental health problems and reduce stigma (Livingston, Tugwell, Korf-Uzan, Cianfrone, & Coniglio, 2013; O'Mara et al., 2013). Further, an overarching goal is to reduce financial costs by increasing coordination of services and improving the public infrastructure to support treatment (Department of Health and Human Services, 2000). There must be efforts to train frontline providers to recognize and manage children's mental health issues, improve assessment and diagnosis, and implement scientifically proven prevention and treatment (Department of Health and Human Services, 2000).

Given the difficulties in meeting children's mental health needs, it is necessary to consider how collaboration between different sectors can reach more children than is currently the case. Schools are well situated to identify students with mental health needs and to provide improved access to evidence-based interventions to improve mental health. In 1975, U.S. Public Law 94-142 was first initiated, which required that children with disabilities have access to a free and appropriate public education. Children with disabilities that impact them educationally have the right to an Individualized Education Program (IEP) identifying goals and services to help them meet educational requirements. Disabilities can include health impairments (including mental health problems) and emotional disturbances. Subsequent reauthorization of the IDEA (2004)

has stipulated that students who fail to respond to research-based interventions may also need supports and services.

There are clear initiatives put forth that indicate the need for greater collaboration in the provision of children's mental health services. The goal of collaboration should be to improve children's ability to access mental health services and improve children's chances to reach a state of well-being. It is necessary to define children's mental health, to assess the impact of children's mental health problems, and to understand how the identification of children's mental health concerns takes place. Next, it is necessary to consider the barriers to community-based mental health services. It is also important to examine the effectiveness of school-based mental health services for children and the barriers to services in the school setting. Finally, it is necessary to determine the state of interprofessional collaboration in the provision of children's mental health services.

Literature Search Strategy

To conduct an exhaustive literature review, I used several research databases available through the Walden Library. These included PsycINFO, ERIC, SAGE Premier, Academic Search Complete, and ProQuest Central. In addition, Google Scholar was linked to the Walden Library and was used to further the search for journal articles. Government sites including those of the CDC, SAMHSA, and DHHS were also used to obtain information on relevant findings and statistics associated with the research topics.

Several search terms were used to identify information on interprofessional collaboration and children's mental health. *Children* and *mental health* yielded many relevant records using the Walden library databases. *School mental health*, *community*

mental health and *children*, *adolescent mental health*, and *expanded school mental health* were all used to find records describing the research in each of these areas. Search terms for interprofessional collaboration also included *interagency collaboration*, *school community collaboration*, *interprofessional collaboration* and *mental health*, and *collaboration* and *mental health*.

Searches were also used to identify sources using phenomenological research and focus groups. The terms *phenomenology* and *focus groups*, *phenomenology* and *interprofessional collaboration*, *focus groups* and *interprofessional collaboration*, and *phenomenology* and *validation of findings* were all used to identify relevant research studies.

Children's Mental Health

The World Health Organization defines *mental health* as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (Herrman et al., 2005, p. xviii). Improving outcomes for children requires not only ensuring the absence of mental health problems, but also assuring a degree of well-being, which is needed to move toward favorable outcomes (Keyes, 2006). This study used the World Health Organization definition of mental health.

Antaramian, et al. (2010) assessed mental health and mental well-being in the school setting. At-risk students (low subjective well-being and few mental health symptoms) and troubled students (low subjective well-being, high mental health symptoms) had lower levels of academic engagement. Students with more mental health

symptoms but high perceptions of well-being performed more poorly than students with both positive mental health and positive sense of well-being (Antaramian et al., 2010). Students who reported high subjective feelings of well-being who were also free from psychological symptoms performed the best academically and were the most engaged (Antaramian et al., 2010). Students with positive well-being, even if they had mental health symptoms, had better social relationships and environmental supports (Antaramian et al., 2010).

It is important to identify those with significant mental health needs as well as those who are at risk for adverse outcomes. Interventions should be considered for students with psychological symptoms and with low subjective well-being. Regular student monitoring for mental health and subjective well-being can occur in schools to identify those students who may benefit from collaborative mental health supports. Lewis, Huebner, Reschly, and Valois (2009) found that increased school satisfaction and school engagement (e.g., family, peer, and teacher support for learning, relevance of school work with future goals) were associated with not only the absence of negative emotions, but also the presence of positive emotions. The presence of positive emotions, but not the absence of negative emotions, was also associated with increased coping skills like seeking social support and problem solving (Lewis et al., 2009). Schools are excellent locations to identify with whom to intervene in order to examine the impact of unmet mental health needs.

Impact of Mental Health Problems

According to the CDC (2013), the prevalence of mental disorders among children is increasing. The type of mental health problems reported differ in terms of gender. Boys are more likely than girls to have a mental disorder. Boys are significantly more often diagnosed with ADHD (12.3% to 5.3%, ever diagnosed; CDC, 2013), behavior/conduct problems (6.2% to 3.0%, ever diagnosed), and cigarette dependence (3% to 2.5%). They are also more often diagnosed with autism spectrum disorder (ASD; 1.7% to .5%, ever diagnosed), anxiety (5% to 4.4%), and Tourette syndrome (0.4% to 0.2%; CDC, 2013). They are more likely to complete suicide (6.54% to 1.83%; CDC, 2013). Girls are more likely than boys to have an alcohol use disorder (4.7% to 3.7%) and depression (18.2% to 7.7%, lifetime; CDC, 2013).

Family and household factors were found to be related to prevalence rates. Diagnoses of ADHD, anxiety, and ASD were more prevalent when health insurance was in place, whereas substance use disorders were more common when health insurance was absent (CDC, 2013). As the educational attainment of the household decreased, the prevalence of behavior/conduct problems, depression, and anxiety increased. As poverty increased, ADHD, behavior/conduct problems, depression, anxiety, illicit drug problems, and cigarette dependence increased (CDC, 2013). The middle-income group had the highest rates of depressed symptoms. The prevalence of certain disorders differed regionally. For instance, the prevalence of alcohol and illicit drugs was high in the west and low in the south. The prevalence of ADHD was greater in the south and lower in the west (CDC, 2013).

Vulnerable groups tend to be at greater risk for mental health concerns. For example, teens in out-of-home placements were more likely to report suicidality when compared with a nonclinical-teen sample (Heneghan et al., 2015). Burton, Marshal, and Chisolm (2014) found that sexual minority youth with depression and anxiety symptoms were more likely to have unexcused absences. Student engagement was observed to be lower for students who had functional limitations or behavior problems. Such students demonstrated poor grades, below average performance on standardized tests, and more disruptive behaviors (Forest et al., 2011). School absenteeism among adolescents increased when they reported symptoms of depression or anxiety (CDC, 2013).

Children with mental health problems are at risk for lower academic achievement and educational attainment. Analysis of data from the National Longitudinal Study of Adolescent Health provided evidence that youth with externalizing behavior problems including attention problems, delinquency, or substance use (especially cigarette use) but not depression were associated with decreased academic achievement in high school (McLeod et al., 2012). The presence of delinquency and substance use disorders lowered educational attainment (highest degree received). Attention problems, alone, were not predictive of lower educational attainment (McLeod et al., 2012).

Child mental illness significantly impacts educational attainment, and lifelong consequences are likely when mental health issues persist. At-risk and vulnerable children are at greater risk for problems including school problems, anxiety, depression, substance abuse, and suicidal thoughts and behavior. It is important to look at how youth

with mental health needs are identified and how increasing collaborative efforts can improve children's access to mental health care.

Identification of Children With Mental Health Needs

Community agencies, schools, and primary mental health may be suitable locations for screening adolescent mental health. Farmer, et al. (2003) evaluated the results of a longitudinal study of children in the southeastern U.S. concerning access to mental health services. They found that children were most likely to receive services in the education system. Specialty mental health and general medicine followed. Significantly less often, services were initiated through child welfare or the juvenile justice system. About 9% of children accessing mental health services were involved with multiple sectors. Simultaneous participation in specialty mental health and education was most common. Mental health and child welfare, and then mental health and general medicine followed (Farmer et al., 2003). Children entering services through education had a lower level of symptoms overall. Children who initiated services through the school system and who had a high level of symptoms often did not access additional services in the community (Farmer et al., 2003). Schools and primary care physicians' offices may be suitable locations to implement screening practices that could result in referrals for mental health services.

School-based screening may improve efforts to identify students in need of referrals for mental health services. Husky et al. (2011) found that using a school-wide screening tool and individual follow-up with school mental health staff effectively increased participation in school-based treatment. A smaller number of students who

were referred for additional mental health support within the community accessed those services (Husky et al., 2011). Although screening procedures improved service delivery in the school setting, students remained less likely to seek recommended community mental health services. Improving collaborative interprofessional efforts may positively impact this problem.

Screening for mental health symptoms can also be completed through interactions with primary care physicians. Gadomski et al. (2015) compared patient/doctor interaction during an annual health exam both with and without the use of a mental health screening tool completed electronically just prior to the visit. Analysis of the interaction suggested that the amount of patient/physician time spent was similar between the group that used the screening tool and the group that did not. Use of the screening tool was consistent with increased discussion of psychosocial issues (Gadomski, 2015). Information obtained from similar screenings completed with the primary care physician could result in follow up with school and community agencies to meet children's mental health needs.

Mental health screening procedures improve the identification of students with mental health needs. Whether in the school or the community setting, mental health screening may be a valuable step forward when collaboration exists among professionals in multiple sectors. At present, community-based mental health and school-based mental health programs separately are unable to resolve unmet mental health needs. An examination of barriers to community-based mental health services follows.

Community-Based Mental Health

Children's mental health needs are not being met with community-based mental health services. Garland et al. (2013) reviewed the literature on the limitations of community-based mental health services for children and identified several targets for improvement. First, they indicated a need for improving access to services. Improvements were deemed necessary in the referral process and in retention in services. A second target was increasing the use of evidence-based practices and increasing the frequency and intensity of delivering these services. A third goal involved measuring outcomes regularly before, during, and after therapy to ensure that interventions are effective (Garland et al., 2013). Barriers to treatment in community-based settings significantly impact both access to services for children and the length of time children spend in treatment.

Barriers to Treatment

Barriers to the use of mental health services have been identified related to availability of services, transportation, health insurance and finances, social and cultural values, and family contextual factors such as social support and family stress (Olin et al., 2010). Barriers can be identified as belonging to the following categories.

Structural barriers. Spears (2010) reported that children without medical insurance are more likely than children with private medical insurance to have unmet mental health needs. DeRigne (2010) found that parents most often reported financial barriers to accessing mental health services for their children. The cost of services and health plan problems constituted the most cited reason for unmet mental health needs in

children. Parents more often reported these problems with a private rather than a public health plan. Families without insurance indicated that cost was the primary barrier to services for their children (DeRigne, 2010). Household income and Medicaid eligibility appeared to increase community-based mental health service use among youth (Alexandre, Dowling, Laris, & Rely, 2008). Curiously, amounts of Medicaid dollars spent on mental health costs for children differ substantially from state to state (Howell & Teich, 2008). Funding is a barrier to developing mental health programs for children. Rarely has research compared the cost of intervention programs with the cost savings if children use fewer government resources across their lifespan (Stevens, Roberts, & Shiell, 2010).

Following cost and health care problems, parents reported barriers such as lack of availability or accessibility of services in their immediate area, transportation issues, problems with appointment times and problems with clinicians (DeRigne, 2010). At the same time clinicians reported limited use of strategies, including appointment reminders, flexible scheduling, and providing transportation to improve accessibility (Watt & Dadds, 2007). Just over 60% of counties in the U.S. have outpatient facilities that provide mental health services to youth. Urban and suburban areas are more likely to have these types of services available with more than 70% of counties serving children. In rural areas, less than half of counties offer mental health services to youth (Cummings et al., 2013). Significantly fewer have special programs designed to treat youth with severe emotional disturbance. Less than half of counties have tailored programs for young people with significant mental illness. Sixty percent of urban/suburban counties have this type of

programming while just over 30% of counties in rural communities have programs designed for mentally ill youth (Cummings et al., 2013). Location and convenience of services significantly impact the use of mental health services for children.

The atmosphere of the clinic (non-sterile, child friendly, privacy), and time issues (timeliness of appointments, phone support between sessions, reminder calls/notices, and follow-up with the family for missed appointments) were also noted (Watt & Dadds, 2007). Convenience (time of available appointments), not getting a referral, and problems getting an appointment time, were also cited as reasons for unmet mental health needs in children (DeRigne, 2010). Garcia et al. (2015) looked at the barriers to effective mental health practices for youth in the child welfare system. They talked with child welfare case managers who are responsible for helping their child clients and families access needed supports. Besides the lack of funding for mental health, case managers reported a lack of knowledge of effective practices. Children and families resistant to treatment and who reenter the system repeatedly were most difficult for case managers to help (Garcia et al., 2015). The proximity of families to mental health services and problems with collaboration between multiple agencies were significant barriers to services for children in the welfare system. Structural factors clearly play a role in facilitating or limiting children's access to mental health services.

Social/cultural barriers. Stereotypes, prejudice, and discrimination associated with mental illness and treatment seeking can reduce the likelihood that children will accept treatment even if it is readily available (Thoits, 2011). Gender differences in attitudes about mental health exist. Eighth-grade girls are more willing than boys to

access mental health services (Chandra & Minkovits, 2006). Perceived parental disapproval and stigma influenced this difference. Parents have also reported dissatisfaction with provider and child refusal to attend services as reasons for unmet mental health needs (DeRigne, 2010).

Cultural values play a role in the likelihood that families will seek out treatment for their children. Some cultural groups hold negative views of mental health services and it may be necessary to make adaptations to traditional therapy to make therapy more relevant for these cultural groups (Wood, Chiu, Hwang, Jacobs, and Ifekunigwe, 2008). Among welfare case managers of children with mental health needs, client engagement problems, including issues related to stigma, and cultural competence were reported (Garcia et al., 2015). For example, many Mexican American families believe that there is a stigma in using mental health services for mental health problems. Mexican Americans use fewer mental health services, and when services are initiated, they tend to end treatment earlier (Wood et al., 2008).

A disproportionate number of children belonging to ethnic minority groups and low-income families face barriers to community-based mental health services. White children were more likely than African-American or Latino children to be in "very good" or "excellent" general health (Stevens, 2006). Developmental delays were more likely for Latino children than White children (Stevens, 2006). Results of the National Longitudinal Study of Adolescent Health indicated that Black adolescents were significantly less likely than White or Hispanic adolescents to receive counseling services regardless of symptom severity (Kodjo & Auinger, 2004). When family income and

educational attainment of parents were accounted for this difference persisted. Referrals for services are also lower for certain ethnic minority groups. African American children with internalizing disorders were less likely than Caucasian or Hispanic/Latino children to seek treatment. They were also less likely to receive referrals and encouragement to seek treatment for mental health problems (Alegria et al., 2012). Social and cultural factors can present barriers to mental health services.

Barriers related to family systems. According to Stevens (2006) developmental delays were more likely to be observed in families with lower social class status and when mothers reported poorer mental health. Children with parents who have mental health problems are not only more likely to be at risk for developmental delay, they are also more likely to have mental health problems themselves. This finding was true when either mothers or fathers had mental health problems (Amrock & Weitzman, 2014). Emotional symptoms, conduct disorder, and hyperactivity increased. Acri and Hoagwood (2014) analyzed studies that contained interventions to treat children's mental health that also offered a parent program. Very few studies included any parent program. The few that included parent programs showed inconsistent results in improving parent mental health.

Certain at-risk groups may be perceived as having greater mental health needs. Fifty percent of foster children ages 2-15 placed for at least 12 months have at least one outpatient mental health service (Leslie, Hurlburt, Landsverk, Barth, and Slymen, 2004). The presence of delinquent behavior, substance use disorders, and a greater severity of symptoms were predictive of mental health service use (Alexandre et al., 2008).

However, African-American children used fewer services than Caucasian children overall despite similar levels of need (Leslie et. al, 2004). Family related issues impact children's access to mental health services.

Community-based mental health services have not been sufficient to meet the demands of children's mental problems. Numerous barriers exist. Structural barriers, social/cultural barriers, and barriers related to the family system continue to impact children's likelihood of accessing mental health services, and disproportionately affect children from low-income or minority groups. Given that children are required to attend school and because mental health problems often impact behavior or performance in the school setting, the next topic to address is school-based mental health.

School-Based Mental Health

The public school system is a practical location to provide mental health services to youth (Soleimanpour et al., 2010). Schools increasingly expected to provide research-based interventions to students who are struggling in the schools setting, including those who have emotional needs (Zigmond, Kloo, and Volonino, 2009). Early identification of students with emotional and behavioral problems through mental health screening can be an effective way of identifying students with mental health needs (Kuo, Vander Stoep, McCauley, and Kernic, 2009). However, the number of school employed mental health providers is not sufficient to meet the needs within the school setting, and collaborative relationships with community providers is limited (Brener et al., 2007).

While two-thirds of schools reported that they employed school psychologists (Brener et al., 2007), these school support staff report that there are significant barriers to

being able to meet the mental health needs of students. These barriers have to do with their primary role in the school setting, problems with using the school to deliver services, lack of support of school faculty, and administrators, and inadequate training in mental health service delivery (Suldo et al., 2010). Given that one in five students may meet the criteria for emotional and behavioral disorders, increased collaboration between school and community-based mental health services is needed.

Effectiveness of School-Based Services

According to Slade (2002), schools that have counseling available increase access to and use of services. This increase occurred across race/ethnic groups. Interestingly, school-based service use did not appear to replace the use of community-based services, except among students with special education classification. Similarly, Cummings, Ponce and Mays (2010) found no differences related to race/ethnicity in service use in the school setting. In contrast, racial and ethnic differences in service use in community settings were noted (Cummings et al., 2010). Schools appear to be in a position to reduce racial and ethnic disparities in access to mental health services.

The trend towards considering the school setting as a location for mental health service delivery appears to be occurring worldwide. This trend is being observed in the United Kingdom (Rait, Monsen, & Squires, 2010), in Scotland (Lauder, Burton, Roxburgh, Themessl-Huber, O'Neill, & Abubakari, 2008), and in India (Srikala & Kishore, 2010). Efforts to improve measurement of students' psychosocial health, and to identify therapeutic techniques for use in schools to increase resilience and improve coping skills, social skills, self-esteem and adjustment issues, have been reported.

In the U.S., schools that implemented focused learning lessons to improve social and emotional learning had fewer problems with externalizing or internalizing student behavior and improved achievement test performance (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011).

Barriers to School-Based Services

Despite their willingness to engage in mental health service delivery, school counselors, school social workers and school psychologists face barriers (Burton, 2013). Brown et al. (2006) surveyed school counselors about their perspectives on collaboration with non-school mental health providers to meet student mental health needs. Most school counselors agreed that collaborative efforts could help to provide services to students. The number of students needing support in comparison to the number of counselors, misunderstandings by administrators about their training in mental health service delivery, and role strain due to their other duties interfere with schools taking on mental health service delivery (Brown et al., 2006). School counselors, who view their role as a guidance counselor rather than a mental health professional, are less likely to provide mental health services in the schools (Beckles, 2009). Cross (2013) found that about half of school psychologists indicated that they were qualified to identify and counsel students with behavior and mood issues in both elementary and secondary. They were also more likely to use evidence-based cognitive behavior therapy and solution focused therapy than other types of therapy with students (Cross, 2013). Although substance use in youth predicts learning, and behavior problems, school mental health professionals frequently reported that they were unfamiliar with evidence-based

interventions (Evans, Koch, Brady, Meszaros, & Sadler, 2012). Training issues impact school-based professional's ability to provide needed services.

Training alone does not result in the successful implementation of mental health services. Although a number of school sites received training for delivering a school trauma intervention, many of the schools did not implement the intervention when school trauma was present (Langley et al., 2010). Factors that facilitated implementation included, organizational structure for delivering school-based services, a social network of clinicians implementing the program, and administrative support. Grant funding or funding set aside by the administration was more likely in the schools where implementation was successful. Barriers were similar for schools that were successful in the implementation and those who were not successful. For those who did not implement the program, competing job responsibilities were cited as the primary barrier. Lack of parent engagement, logistical barriers (e.g. scheduling problems), and lack of support from school administrators and teachers, did follow. Those who successfully implemented the program were most likely to cite lack of parent engagement as the primary barrier. Competing responsibilities, logistical barriers, and lack of support from school administrators and teachers, followed (Langley et al., 2010).

School mental health providers' job responsibilities are largely determined by finances (Bailey, 2005). When schools make referrals to community-based services, schools can become financially responsible for those services. Special education categories of eligibility do not align with DSM categories that allow for billing and insurance reimbursement. Schools located in poorer areas may have fewer financial

resources. Children with more severe symptoms and needs were more likely to be serviced by non-school employed providers, with less experience, working for less money (Bailey, 2005).

For a school system to consider expanding school-based mental health services, school administrators must understand the need to allocate funding for this purpose. School administrators do not appear to be well informed of the problems with children's mental health and need for school mental health services to improve academic performance (Caparelli, 2012). Lack of information and training among administrators is a barrier to children having access to mental health services in schools (Caparelli, 2012).

Schools have the responsibility to provide mental health services to children who need them. Although the costs associated with having a greater number of mental health providers present in school are a consideration, so should be the costs related to educating children with emotional and behavioral problems. School-based services are effective and provide opportunities for students from lower income and minority race/ethnic groups to increase use of services. Schools are an appropriate place for services in the U.S. and worldwide. Barriers to school-based services include inadequate training, competing responsibilities, logistical barriers (e.g. scheduling), and lack of support by administrators (e.g. lack of understanding, funding).

Improving interprofessional collaboration between school and community based mental health providers has the potential to alleviate barriers to mental health services for children. Partnerships between schools and community organizations can improve identification and referrals for early intervention. When schools allocate the necessary

funding, space, and time for mental health services, many barriers to traditional community- and school-based services can be eliminated.

Interprofessional Collaboration in Children's Mental Health

Support for collaboration in children's mental health has grown in recent years. The CMHS, SAMHSA, and DHHS (2013) organized the Children's Mental Health Initiative. Using the Systems of Care Philosophy, the Children's Mental Health Initiative emphasizes the need for systems surrounding children to come together to provide coordinated care though interprofessional collaboration (CMHS, SAMHSA, & DHHS, 2013). Outcome data suggested that the Children's Mental Health Initiative improved access to services for underserved children and youth (CMHS, SAMHSA, & DHHS, 2013). However, in a large multisite analysis of funded programs, interprofessional collaboration was one of the most difficult aspects of the Children's Mental Health Initiative to achieve (Brannan et al., 2012). Few services were available as part of a collaborative, multi-agency initiative (Brannan, et al., 2012).

With improved interprofessional collaboration among service sectors in meeting children's mental health needs, reduced costs, and increased availability of services to children have been noted. Sebian et al. (2007) reviewed the research on the systems of care approach and reported that it resulted in reduced costs, fewer inpatient days, reduced number of arrests, sustained mental health improvements, decreased suicide-related behaviors, improved school attendance, improved school achievement, and reductions in juvenile detention. Sebian et al. (2007) emphasized the need for a school component to improve the coordinated care model and also noted the need to enhance communication

and collaboration, identify stakeholders, and increase technical resources to improve collecting and sharing information across systems.

In contrast, Hamner, Lambert, and Bickman (1997) and Bickman, Lambert, Andreade, and Penaloza (2000) found the coordinated care model to increase costs with no apparent benefit to children over the traditional approach. The Fort Bragg demonstration was an interdisciplinary effort to provide mental health services to children at Fort Bragg (Hamner et al., 1997). Outcomes were compared with two other US. Army locations who received traditionally delivered services at 18 months and 5 years. Compared to traditional outpatient treatment, they found the continuum of model to be more expensive with similar outcomes (Hamner et al., 1997; Bickman et al., 2000). No information was presented on the identification and referral processes for program candidates so it is not clear how children were identified for participation. Attrition was reported to be high for both traditional and coordinated services.

What is not known is how the population being served, military families, differs in their likelihood to seek treatment for their troubled children. A quasi-experimental design was employed and random assignment was not used for placement in either the continuum of care or traditional outpatient therapy (Hamner et al., 1997). Information on the traditional services provided in the comparison group was also not available as part of the report. Finally, no school-based component was offered in this continuum of care model (Hamner et al., 1997). The literature demonstrates lower levels of attrition when services are available in the school setting (Armbruster & Lictman, 1999; Husky et al., 2011). Children participating in the Fort Bragg model were reported to have increased

access to services, which was one of the primary goals. They also had a greater number of services, adding to the cost of treatment (Hamner et al., 1997; Bickman et al., 2000).

DHHS (2000) created a national action agenda to address children's mental health needs. Overarching goals of this agenda were to increase children's access to services and to reduce costs by coordinating services through the collaborative efforts of multiple agencies (DHHS, 2000). Several objectives were identified. Training frontline providers to recognize and manage mental health issues, promoting awareness of children's mental health issues, reducing the stigma associated with children's mental health, and help-seeking behavior, eliminating racial and ethnic disparities in accessing mental health care, increasing interprofessional collaboration, improving assessment, and identification of children's mental health needs, providing evidence-based prevention, and intervention strategies, (DHHS, 2000). The final goal was to engage in ongoing monitoring of access to treatment and the coordination of care (DHHS, 2000). Schools are on the frontlines and as noted in several places within this review, have the potential to collaborate with community mental health to identify and provide access to treatment for children with unmet mental health needs.

Tegethoff et al. (2014) found that the link between school and community-based mental health service utilization was not significant. Traditional separation of practices in children's mental health most often does not result in referrals, or follow-through with referrals, from school to community-based services. Yet schools alone have not been able to meet the needs of all or even most children. Building partnerships with mental health service providers could streamline services and may avoid unnecessary duplication of

services. Utilizing the school as a primary location for service delivery has been demonstrated to reduce attrition and stigma (Armbruster & Lictman, 1999). Limited information exists as to the factors that improve the initiation of interprofessional collaboration between school and community agencies. However, there is research that identifies factors that are important to collaborative relationships, generally, and in mental health service delivery specifically.

Factors In Interprofessional Collaboration

Interprofessional collaboration has many names. It has been referred to as integrated care, multiagency, multidisciplinary, interdisciplinary, cross-disciplinary, or interagency collaboration (Odegard & Strype, 2009). Team members from multiple mental health organizations or professions work together to meet children mental health needs (Odegard & Strype, 2009). Improved interprofessional collaboration among mental health service providers in school and community settings may increase children's access to mental health services and to reduce the pressure on school mental health professionals to carry the burden of meeting the mental health needs of children.

Studies of interprofessional collaboration tend to focus on specific program evaluation and the factors necessary to improve collaborative experiences once they have been established. Mattessich and Monsey (1992) surveyed the research literature and identified factors that were found to sustain collaborative relationships. Six categories of factors were identified as important to collaborative relationships; environment, membership, process/structure, communications, purpose, and resources (Mattessich & Monsey, 1992). Factors that related to the environment included; having a history of

collaboration in the community, having a leadership role in the community, and the favorability of the political or social climate for the collaborative efforts. Factors related to membership characteristics in collaborative efforts included; mutual respect, understanding, and trust; appropriate stakeholders chosen for membership; members believe benefits outweigh costs; and having the ability to compromise. Factors related to process/structure included; members share stake in the process and outcome, a need for multiple layers of decision making, the collaborative group is flexible, and adaptable, although clear roles and policies should be developed. Factors related to communication included the need for frequent and open communication, and both informal and formal communication links. Factors related to purpose included having concrete goals and objectives, a shared vision, and a unique purpose. Finally, collaboration issues related to resources included having sufficient funds to support its operations, and having a skilled leader (Mattessich & Monsey, 1992).

Studies of interprofessional collaboration have often been conducted as part of specific program evaluation or team participation. Interprofessional team experiences in healthcare were examined. Interprofessional teams in Sweden were interviewed about their experiences with working in collaborative teams to meet patient needs. Participating health care team members included occupational therapist, registered nurse, physiotherapist, medical social worker, administrative assistant, physician, practical nurse, psychologist, and speech therapist (Kvarnstrom, 2008). Difficulties were generally related to the team dynamic, the contribution of knowledge by professionals and the influence of organizational variables (Kvarnstrom, 2008). Problems with role conflict,

unequal responsibility for making decisions, value or usefulness to the team, lack of consensus, unequal knowledge, hierarchical valuations, changes in organization or setting, and lack of correct resources (i.e., wrong professionals on the team) (Kvarnstrom, 2008). In some cases, teams reported that they were able to discuss and/or resolve some of the issues, but often times they were not able to either discuss or resolve the issues (Kvarnstrom, 2008).

Related to children, interprofessional collaboration has been assessed to measure perceptions of interagency relationships when providing services to children. Child protection workers and mental health workers were surveyed regarding their perceptions of one another and inteprofessional collaboration (Darlington, Feeney & Rixon, 2005). Several factors were noted. Mental health providers and child protection workers have positive regard for one another and do not mistrust one another but perceive lack of training in one another's disciplines as being a barrier (Darlington et al., 2005). Barriers to collaboration were reported to include inadequate resources, issues related to confidentiality and interagency processes, unrealistic expectations, and professional boundary issues (Darlington et al., 2005).

On a larger scale, the interprofessional collaboration of community development teams that were part of a randomized controlled trial the Cal-40 study aimed at improving the treatment of children in foster care revealed several factors, were measured for relevant factors (Palinkas et al., 2014). Factors found relevant for collaboration were classified as external; availability of funding, county size, shared clients, and government mandates (Palinkas et al., 2014). Factors classified as internal related to participating

organizations included common language, common recognition of the problem, commitment, accountability, or individual characteristics such as interpersonal relationships and social ties, collaboration facilitator, supportive leadership, and personal qualities (honesty, credibility, trust and respect) (Palinkas et al., 2014). Collaboration characteristics that facilitated collaboration included having a broader focus, less formality, and greater frequency of interaction. The function of the collaboration was also important. Examples of function include information exchange, pooling of resources, service delivery (Palinkas et al., 2014).

To measure perceptions of collaboration in collaborative school teams, Mellin et al. (2010) surveyed school professionals participating in interprofessional school teams. Participants included members of interprofessional school teams across the U.S.. Responses were based on the type of team in which they collaborated. Most often these included school mental health teams, individual education program (IEP) teams, and student support teams (Mellin et al, 2010). A survey was developed to measure elements of interprofessional teams. This survey assessed team interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process (Mellin et al, 2010). Through factor analysis, four factors emerged; need for reflection on the collaborative process, need for flexibility in the professional role, creation of new professional activities needed for better program functioning, and interdependence among team members (Mellin et al, 2010).

Specific to the mental health needs of children, Mendenhall and Frauenholtz (2014) evaluated the process of implementing a large-scale community-based

comprehensive system of care to support mental health for children with serious emotional and behavioral disorders. Collaboration between various systems was necessary for program implementation to be successful. Despite support at the systems level, several barriers were discussed through the implementation process. A lack of knowledge between systems as to how each system worked resulted in communication issues (Mendenhall & Frauenholtz, 2014). Additionally, resentment, resistance, and power imbalances resulted when relevant stakeholders were excluded from the planning and implementation process. Stakeholders also had difficulty reaching consensus and some issues were not resolved (Mendenhall & Frauenholtz, 2014). Including a representative from the agencies involved as well as state and family representatives were found to be an important step toward improving collaboration (Mendenhall & Frauenholtz, 2014). There were also many benefits of collaboration. Having members of various systems work together led to improved sense of trust and willingness to help. They developed creative ways to ensure communication such as video conferences for meetings to reduce the need for travel (Mendenhall & Frauenholtz, 2014).

Many studies have looked at interprofessional collaboration through specific program evaluation and looking at how groups of professionals perceive their experiences with collaboration. Factors that are relevant to collaboration can be external, such as the political climate and funding, internal, such as organizational characteristics and personal characteristics, or they can be related to the process of collaboration. Little attention has been given to the initiation of collaborative efforts outside of program

mandates. However, several studies have evaluated collaboration among school- and community-based mental health providers.

Collaboration Between School and Community-Based Mental Health Providers

Several studies have looked at the issues involved in school-community relationships in the treatment of children's mental health. Related specifically to the collaborative efforts of school and community mental health professionals, Odegard (2006) used surveys to examine collaboration among Norwegian school and community professionals. When Odegard (2006) assessed their perceptions of interprofessional collaboration across individual, group, and organizational aspects of the collaborative process, six factors emerged. These factors included; the interprofessional climate, the cultures of both organizations, the goals of the organizations; professional power, the leadership of the group, and the motivation to engage in interprofessional collaboration. An investigation of the perceptions of interprofessional collaboration among school and community mental health professionals located within the U.S. is needed to identify ways to improve collaborative efforts and improve mental health services for children

Establishing partnerships with community agencies can help to meet the emotional needs of children. Duchnowski and Kutash (2011) assessed the effectiveness of schools in the delivery of supports for students with Emotional Disturbance. Participants were recruited from 37 schools in 13 states and whittled down to seven schools meeting study requirements for having a sufficient number students with emotional disabilities, having established high levels of reform for meeting student emotional needs, and having diverse student bodies (Duchnowski & Kutash, 2011).

Seven comparison schools with low levels of reform were identified within the school districts serving the seven schools identified. Surveys were given to assess school reform. Parents reported on student demographics and answered surveys about their child's mental health service use (Duchnowski & Kutash, 2011). Student functioning was measured through achievement tests, and behavior rating scales. Parent involvement was also measured through survey data. Schools embracing the collaboration between education and mental health systems were identified as high-reform schools while low-reform schools were those with little collaboration. Schools with high-reform had more direct instruction for students with emotional disturbances to promote reading and math and had a proactive approach to discipline rather than a punitive approach. They spent more time in the general education setting and improved overall math performance (Duchnowski & Kutash, 2011). Additionally, procedures were put in place to include more stakeholders in planning and monitoring objectives and goals. Mental health services were provided equally as often in both the high and low reform schools. However, services were more frequently provided by community agency personnel with services delivered in the school setting in high reform schools (Duchnowski & Kutash, 2011). Collaborative efforts were more frequent in high-reform schools to increase capacity to provide mental health services. Although schools did not report differences in parent involvement, parents in the high-reform schools reported lower levels of participation than those in low-reform schools (Duchnowski & Kutash, 2011). Administrators reported that parent time spent in low-reform schools was typically

negative as a result of their student's problems and discipline issues (Duchnowski & Kutash, 2011).

Program evaluation has been done with regard to community-based mental health staff providing services within the school setting. Douglas (2001) investigated collaborative efforts among agency-employed and school-employed providers working together within the public school setting. School employed personnel were less supportive of collaboration than agency staff and expressed a desire to have more school-based mental health professionals (Douglas, 2001). Both school and agency employed mental health providers expressed concern about the number of mental health providers being too few. They also expressed concern about the need for more support by the school administrators and governing boards to increase the number of mental health providers available to help students (Douglas, 2001). Agency-employed staff reported that teachers were often reluctant to allow students to leave instruction to receive intervention services. There were also issues with funding. Administrators acknowledged that collaborative efforts were affordable but expressed concerns about agency-employed staff and their understanding of the school culture and adherence to agreements made about service delivery (Douglas, 2001). School and agency employed providers reported the need for relationship building and planning in the referral process and for the provision of services. Benefits of collaboration included aiding families in accessing mental health services (Douglas, 2001). Similarly, Kindall (2009) found that school districts could save money by contracting agencies to provide school-based mental health services. However, school district personnel were more satisfied with district employed

mental health staff. Additionally, agency employees reported spending more time engaged in indirect services than school employees (Kindall, 2009).

Many problems with collaboration seem to have to do with communication and building cooperative relationships. Massey et al. (2005) completed a qualitative analysis of collaboration as part of a program evaluation of several prevention/intervention programs that focused on reducing violence in schools. Both community-based and school-based implementation of prevention and intervention programs occurred. Program members from twelve programs were part of focus groups to gain an understanding of the issues related to comprehensive program implementation (Massey et al., 2005). Service providers, senior program supervisors, social workers, counselors, and school psychologists were included in the focus groups (Massey et al., 2005). They reported several themes regarding the implementation process that are relevant to interprofessional collaboration. Community-based practitioners reported concerns about feeling accepted in schools and recalled difficulties building relationships with school people. In contrast, having a good relationship with school administrators aided in community providers integrating with school personnel (Massey et al., 2005). Communication problems were noted by both school and community-based providers. Another concern conveyed by the external service providers surrounded parental consent and confidentiality. Community-based providers felt limited in discussing children with teachers and other school personnel without obtaining parental consent to share information (Massey et al., 2005). Teachers and other school personnel were said to have little understanding of those limitations. Community-based providers also felt that the

task of sustaining the program by seeking additional funding fell on them and often did not feel that the school districts were working to keep programs going (Massey et al., 2005).

Opinions about interprofessional collaboration were gathered from a small sample of school counselors and the principles/vice principals involved in hiring staff to understand their perceptions of contracting community mental health professionals to provide mental health services, their views on interprofessional collaboration among school counselors, and community mental health professionals as well as their thoughts about the school counselors' role (Brown et al., 2006). Survey questions were developed and four open-ended questions were posed. School counselors largely reported that they were trained to provide counseling, that they could identify students in need of counseling, and that they considered themselves to be mental health professionals (Brown et al., 2006). Administrators were less likely to report that their school counselors were competent in these areas. Many counselors and administrators agreed with contracting community mental health professionals. Counselors noted the greater student need, school counselor's role, competing responsibilities in schools, and low counselor to student staffing ratios (Brown et al., 2006). Administrators noted the growing responsibility for schools to meet children's mental health needs. Counselors who had reservations or disagreed with hiring community mental health professionals reported concerns about the qualifications of community mental health professionals and their frustration over having clerical duties that interfered with their own ability to deliver services (Brown et al., 2006). Administrators with reservations or who disagreed with

hiring community mental health providers indicated that the outside providers would need to have an understanding of school operations, or that it was simply not affordable to consider (Brown et al., 2006).

Walsh (2013) conducted a national survey of school psychologists and found that all respondents reported communicating with community-based mental health providers (psychiatrists, pediatricians, neurologists, psychologists, social workers, counselors/therapists, or case managers). With regard to collaboration, nearly 20% reported collaboration with community mental health providers at more than once a month. Nearly half of respondents reported less than 10 instances of collaboration in the previous school year, while almost a quarter reported no collaboration at all.

Most school psychologist reported benefits to collaborative efforts such as improving student mental health, behavioral or academic outcomes for students were improved (Walsh, 2013). Many reported that it provided an opportunity for cross-disciplinary problem solving. A little over half of respondents reported that collaboration would help with assessing student progress across settings, would increase parent involvement, and would provide a chance to share resources. Just under half perceived that it would be beneficial in avoiding duplication of resources. About a third believed that it would provide an opportunity to learn different methodology and techniques. About a quarter thought they would feel valued for their expertise to other professionals, or it would improve a student's physical health. Less than 1% reported no benefit to collaboration (Walsh, 2013). Barriers to collaboration were reported as time constraints, accessibility of community providers, obtaining parent permission to collaborate with

community providers, turnover in the community, and some reported that they did not have information about providers that were working with students (Walsh, 2013). Some respondents indicated that they thought that views on mental health services and child development were too different. Almost 5% reported no barriers to collaboration.

Professional development in mental health was a significant predictor of collaboration (Walsh, 2013). For those who had over 10 hours of training in youth mental health, the amount of communication and collaboration with community-based providers increased. The primary role of the school psychologist was also a factor in collaboration. For school psychologists whose primary role was student-focused or system focused consultation, collaboration was significantly higher than those who saw their primary role as special education evaluation. Collaboration was also lower for those who saw their primary role as intervention planning and implementation. School factors such as the number of students served by the school psychologist and the socioeconomic status of the school were not significant predictors of the amount of collaboration (Walsh, 2013).

Outcome data appear to support collaborative school/community endeavors. When implemented in conjunction with school systems, the systems of care approach has resulted in reduced costs, fewer inpatient days, reduced number of arrests, sustained mental health improvements, decreased suicide-related behaviors, improved school attendance, improved school achievement, and reduced juvenile detention (Sebian et al., 2007). Expanded School Mental Health in the Minneapolis Public Schools is a collaborative effort that utilizes collaboration with private non-profit agencies to place mental health providers in school settings. In four years, there was a reduction in the

number of mental health systems, and an increase in access to mental health services for low-income and minority populations. Increasing access to mental health services reduced suspension rates (Everts. 2011). When family members participated in therapeutic efforts, teachers tended to have more positive ratings of student symptoms, and reading scores were higher.

Similarly, Mancoske (2013) assessed children's outcomes while involved in a comprehensive system of care model after six months to 1 year of services in a low-income, primarily African American sample. Outcome data suggested less substance use, depression, and anxiety were evident when treatment was in place. Additionally, increased school attendance, fewer disciplinary actions at school (suspensions, expulsions) and better grades were noted. Cultural competencies have also been found to be important. Providers that demonstrate an understanding family cultural values and beliefs, understand family beliefs about mental health, religion and family needs, speak the family's primary language, or know when an interpreter was needed, were more effective. When service providers were viewed as more culturally competent, outcomes were statistically better than when service providers were not rated as culturally competent (Mancoske, 2013).

Despite the potential value of collaboration, efforts to implement comprehensive interprofessional collaboration have not become the norm. It is necessary to investigate the phenomenon of interprofessional collaboration and the factors that facilitate and limit school and community collaboration in the provision of children’s mental health services. Most mental health professionals see the value in collaborating with community-based

mental health providers, yet there are significant barriers that reduce collaborative efforts. Barriers to collaboration between school and community mental health most often reported in the literature include; time constraints, role strain, role differences between school and community mental health providers, acceptance of community providers in the school setting, and communication difficulties. For school psychologists, increased training in mental illness was related to a greater collaboration with community mental health providers.

Although these efforts to identify issues related to collaboration between school and community-based providers are a good start, it is necessary to understand the experiences of school-based mental health providers and community-based mental health in collaboration. The information that is obtained through the use of focus groups and interviews will be used to determine strategies for improving school and community collaboration in meeting children's mental health services. In contrast to previous studies that tend to identify issues presented as part of particular program evaluations or that focus on particular groups separately (e.g., school psychologists, community providers, school counselors), this study proposes to include both school and community-based mental health providers with various levels of experience in collaboration. Given that most mental health professionals see the value of collaboration, it is necessary to gain their perspective on what factors are involved in facilitating collaborative efforts.

Summary

Roughly two-thirds of children who have mental health needs do not access mental health services. There is a need for a comprehensive and collaborative approach

to children's mental health treatment. Children's mental health problems significantly impact lifelong outcomes. At-risk and vulnerable children are more likely to have school problems, lower educational attainment, anxiety, depression, substance abuse, and suicidal thoughts or actions.

Community-based mental health services have not been sufficient to meet the demands of children's mental health problems. School-based mental health services have also not been sufficient to meet children’s mental health needs. Comprehensive and collaborative approaches to mental health care have resulted in improving children's access to services and building long-term success. School and community collaborations lead to improvement in student outcomes. Many factors are known about collaborative relationships generally, and about school and community collaborations specifically; however, two little collaboration occurs to meet the mental health needs of children.

The current study proposes to identify those factors that are related to initiation of sustained collaboration between school and community mental health providers. Much of the information obtained about the factors that limit and facilitate collaboration among this group has been obtained through program evaluation based on specific or established collaborative relationships, or through surveys of individual groups of providers. Efforts to obtain qualitative information about the factors important to initiating collaborations from the perspective of both school-based and community-based mental health providers do not currently exist. An effort to understand the experience of collaboration through school and community mental health professionals is necessary in order to improve the likelihood that these groups will engage in collaboration and to identify the reasons they

may avoid these types of interactions. This study proposes to obtain information from both school-based, and community-based mental health providers as well as administrators in schools and mental health agencies. Collaborative focus groups consisting of members of the community and the school will be utilized to optimize the exploration of these factors from both perspectives.

Chapter 3: Research Method

Introduction

The previous chapters have provided a detailed discussion of the unmet mental health needs of children, the barriers to both community-based and school-based mental health services for children, and the current state of collaboration between mental health providers in community and school settings. Children may experience negative outcomes as a result of having unmet mental health needs. Problems with school discipline, school achievement, peer relationships, and mental illness can be overcome with access to mental health services. Even children who are not experiencing significant mental health problems but who do not identify aspects of well-being or flourishing have lower engagement and achievement and are at greater risk for negative outcomes. Improved collaboration and partnerships between school and community mental health providers may increase children's access to mental health services. However, limited collaboration exists at this time.

Collaborative efforts between community agencies and school-community partnerships have yielded some assessment of the factors that limit and facilitate collaboration. An assessment of factors important to interprofessional collaboration between school and community mental health professionals in Norway indicated several important aspects of their collaborative experiences (Odegard, 2006). Individual factors included motivation, role expectations, personality style, and professional power. Group factors included group leadership, coping, communication, and social support. Organizational factors included organizational culture, organizational goals,

organizational domain, and organizational environment (Odegard, 2006). Leadership, social support, motivation, and organizational culture were identified as the most important (Odegard & Strype, 2009). In the U.S., there have been efforts to examine interprofessional collaboration in relation to specific programs and initiatives, or with specific groups regarding the amount of collaboration they engage in and/or their feelings about the need for collaboration. To date, there has been no attempt to understand the experiences of both school and community mental health professionals with varying levels of experience with collaboration to identify the specific factors that increase the likelihood of initiating collaborative relationships outside of program mandates.

This chapter outlines the qualitative method and design that were used to assist in understanding this phenomenon from the perspectives of both school and community mental health providers. It includes the profile of prospective participants and how they were recruited for the study. Specific information is provided as to the procedures were used and how the ethical protection of participants was ensured. The procedures are listed as to how the data were collected and analyzed and how the verification of findings was handled.

Research Methodology

This topic can best be explored through qualitative methodology. Although some information on this topic has been gleaned as part of other studies, the specific factors that are necessary for initiating collaboration between school and community mental health providers, outside of program mandates, have not yet been fully explored, requiring a qualitative method of inquiry (Creswell, 2013). This study explored the

phenomenon of interprofessional collaboration through the experiences of school and community mental health providers. This study was primarily phenomenological and was necessary to study the experiences of mental health professionals in collaborative efforts. Participants' experiences were described and analyzed using Moustakas's (1994) transcendental phenomenology. In transcendental phenomenology, knowledge of a phenomenon can only be perceived through human experiences. In order to look at the problem with minimal bias, the researcher must set aside his or her own perception of the problem and look at the problem anew through the eyes of the study participants (Mustakas, 1994). This strategy was employed.

This investigation was justified by the theoretical framework, in which the development of children's mental health was seen through an ecological perspective. Proponents of Bronfenbrenner's ecology of human development view children through their interactions with the multiple systems and contexts in which they come in contact (Bronfenbrenner, 1979). This study was primarily concerned with the mesosystem, which involves the interaction of systems in the child's microsystem or immediate environment (e.g., school and community). To a lesser degree, the exosystem, which involves the surrounding environment (local services, school board, political arena); the macrosystem (cultural values); and the chronosystem (passing time and historical events; Bronfenbrenner, 1994) were also considered. As goals align within and between these systems, child development occurs with less disruption.

Ensuring that children have access to comprehensive systems of mental health care when it is needed can improve children's ability to reach a state of mental well-

being. The key principles of the systems of care philosophy require that a child have access to early identification and intervention, as well as individualized, culturally sensitive, nondiscriminatory, and comprehensive treatment in the least restrictive environment, with case managers serving as advocates who ensure collaboration among service sectors or agencies and families for the planning of services and transition to adult services as needed (Miller et al., 2012; Pumariega et al., 2003).

Research Design

In transcendental phenomenology, it is necessary to understand the essence of the human experience of a phenomenon (Moustakas, 1994). To do this requires the researcher to identify and set aside personal biases about the phenomenon in order to see the information anew. This was explained by Moustakas (1994) as Husserl's concept of *Epoche* or bracketing. One method that Moustakas described involves using reflective meditation in which preconceptions are allowed to enter and leave consciousness and are eventually written out. The list is then reviewed and released from consciousness until the researcher is receptive to new experiences of the phenomenon (Moustakas, 1994). Creswell (2013) described a procedure in which the researcher presents his or her own personal experiences with the phenomenon in the methods section under the "role of the researcher" (p. 82). This strategy was employed.

Phenomenological investigation is typically associated with in-depth interviews with individuals who have experienced the phenomenon of interest (Creswell, 2013). In this case, focus groups were used to help uncover factors that influence interprofessional collaboration. Bradbury-Jones, Sambrook, and Irvine (2009) concluded that focus groups

can be advantageous for understanding the essence of a phenomenon because they may help a researcher to bracket preconceptions as they are challenged by group members. A focus group study is a series of discussions conducted with groups of 4 to 12 people with some commonality (Krueger & Casey, 2015). Focus groups, when conducted in a relaxed, nonthreatening environment, promote self-disclosure through the use of group processes (Krueger & Casey, 2015). Because focus groups consisted of both school and community mental health providers, there was the possibility that the discussion would be enriched and that participants would be able to identify additional factors. In-depth interviews were used to supplement focus group discussions. This helped with verification of results through triangulation of data, which involves making use of multiple sources of data, multiple methods, and/or multiple investigators, or using theories to provide corroborating evidence (Creswell, 2013). Data were analyzed using Moustakas's method of data analysis (described under Data Analysis, below) and the meaning or essence of participants' experiences was formed.

The purpose of this study was to identify the factors that facilitate collaboration between school and community mental health professionals. It was necessary for participants to have had some experience with collaboration, communication, or consultation with other mental health professionals. School professionals must have had some experience working with community professionals. Community professionals must have had some experience working with school-based professionals. It was not necessary for the participants to be involved in active or sustained collaborative relationships. Participants took part in focus groups that were led with a semistructured set of interview

questions (Appendix B; p. 87). Focus groups were videotaped and audiotaped for later analysis. The broad research questions are listed below.

Participants

Focus groups consisted of at least 4 or 5 but no more than 10 members. Large groups with more than 10 participants can be difficult to control (Krueger & Casey, 2015). Groups that are too large can also limit individuals' opportunities to share experiences (Krueger & Casey, 2015). At least three groups were planned. Additional interviews with group participants were added to ensure saturation had been reached. Groups consisted of school psychologists and school counselors, as well as community-based counselors and social workers. Administrators who oversaw the provision of mental health services were also invited to participate.

Participants were recruited from local school districts and community agencies or private practice in the greater Phoenix, AZ area. A letter describing the proposed study was sent to local school districts and community agencies/providers to recruit potential volunteers. Additionally, nominations were be taken from neutral parties or from other nominees. Letters are included in Appendix A (pp. 85-86).

Research Questions

The research questions were as follows:

- What are the factors that may facilitate the initiation of collaborative relationships, outside of program requirements or mandates in the provision of services to children?

- How can the known barriers to collaboration be overcome to increase the development of collaborative relationships?
- What differences exist between school- and community-based mental health service providers in their view of collaboration in serving children with mental health needs?
- What differences exist between service providers and administrators in how they view collaboration in serving children with mental health needs?

Ethical Protection of Participants

The participants were adult male and female mental health professionals. They participated on a voluntary basis. In transcendental phenomenology, participants are thought of as coresearchers and are fully informed of the true nature of the study (Mustakas, 1994). Given this, there was no expectation of harm related to participants' involvement in this study. Had any of the participants experienced harm related to their participation in this study, a referral would have been made to local services. This was not necessary. Each participant signed consent for participation. Confidentiality was maintained by storing all files, audiotapes, and transcripts in a locked cabinet in my home office.

Procedures

In order to recruit study participants, local school districts, community mental health agencies, and professionals in private practice were contacted by phone to provide information about the study. Follow-up letters were sent to these organizations to provide details about the study and request assistance in recruiting school and

community-based mental health providers. Once potential participants were identified, in-person or phone meetings with school and community-based mental health providers were scheduled in order to describe the study and screen candidates. Letters were sent to provide details about the study. Viable candidates were those who had experienced the phenomenon of collaboration between home and community mental health. Candidates were contacted to schedule participation in focus groups. The consent form was sent for participant review prior to participation in the focus group.

During focus groups, each participant were provided with an informational letter describing the study, and participants were asked to sign the consent form. A set of questions were used to guide the discussion in the focus group (Appendix B; p. 87). Videotapes and audiotapes were transcribed verbatim and analyzed as described later in the chapter.

Once the qualitative data had been initially analyzed, participants were contacted to assist in validating themes extracted from transcripts of their focus group. Participants were sent a summary of the thematic analysis. Participants were asked to examine the themes and provide any additions or corrections. A follow-up meeting or phone call was scheduled individually with those who responded to review the themes and any concerns the participant had about the thematic analysis.

The Researcher's Role

As the human instrument of data collection, I reflected on personal experiences so that personal biases could be examined. As a school psychologist, I found that personal experiences had engendered strong positive perceptions about interprofessional

collaboration between school and community mental health providers and the need for it. Preconceptions about the barriers to school-community collaboration were also held. It was necessary to bring all of these biases to light so that the phenomenon could be seen from a fresh perspective. Additionally, member checks were used to give participants an opportunity to reflect on any potential biases that resulted from my experiences during the analysis. Member checking occurs when a researcher takes the findings of research to the participants, giving them an opportunity to make corrections or additions (Creswell, 2013).

Data Collection

Data were collected primarily through the use of focus groups. Focus groups are essentially group interviews that allow for interaction and have the potential to provide a safe environment and a sense of cohesion among group members (Sim, 1998). Several qualitative studies of interprofessional collaboration have successfully used focus groups to identify factors important to collaborative efforts. Focus groups have been used to look at collaboration in health and social care (Hudson, 2002; King & Ross, 2003) and to examine the experiences of healthcare team members (Kvarnstrom, 2008; Sargeant, Loney, & Murphy, 2008), and intensive care unit teams (Lingard, Espin, Evans, & Hwryluck, 2004). They have been used to look at barriers to collaboration among community pharmacists and general practitioners (Hughes & McCann, 2003) and in evaluating collaborative experiences in school mental health (Massey et al., 2005). McLafferty (2004) evaluated the use of focus group interviews as a method for collecting qualitative data in healthcare and determined that although focus groups that include

strangers require a greater degree of moderator interaction, focus groups are dynamic and can be an efficient way of collecting rich data. Focus groups were interviewed using the interview guide (Appendix B; p. 87) and were videotaped and audiotaped to aid in phenomenological analysis. Group interviews were transcribed for subsequent analysis.

Interviews were used to supplement and verify the data collected in the focus groups. Participants were interviewed at a time and location that was convenient for them or by phone using the interview guide. Interviews were transcribed to use in data analysis.

Data Analysis

Data were analyzed using Moustakas's (1994) procedures with the adaptation recommended by Creswell (2013) to bracket out personal biases at the outset. Once biases had been set aside (Epoche) and data had been collected and transcribed, phenomenological reduction was applied. In this step, significant statements were identified to build an understanding of how the participant experienced the phenomenon. In the process of horizontalization, statements have the same value unless they are identified as repeated ideas or as being irrelevant to the individual's experience of the phenomenon (Moustakas, 1994). Overarching clusters or themes were identified from the horizons. Textural descriptions of the participants' experiences were written based on the statements and themes identified.

Moustakas's (1994) next step, imaginative variation, requires the researcher to consider the conditions surrounding the experience of the phenomenon. Structural themes were considered in terms of time, space, causality, etc., and structural descriptions of the

context of the phenomenon were written. In the final step, the textural and structural descriptions were used to identify the essence of the experiences of the participants. The collective perceptions of the participants were synthesized.

Verification of Findings

Verification of research findings in qualitative research is completed as a validation process to ensure the trustworthiness and credibility of the findings (Creswell, 2013). Of the eight methods that Creswell proposed, clarifying researcher bias, triangulation and member checks were used.

Clarifying Researcher Bias

As part of the process of transcendental phenomenology, I must set aside preconceptions and biases. This was done prior to the collection and analysis of data and was presented under the heading The Researcher's Role. Personal experiences and biases that are relevant to the study and the analysis of data collected in the study were explained. My experiences as a school psychologist and with interprofessional collaboration between school-community mental health providers are relevant because my strong positive feelings about collaborative mental health and the need for more frequent efforts to collaborate have been shaped through my experiences. I have strong presuppositions about the reasons that collaborative efforts are difficult from the perspective of school-employed staff. Time constraints, role strain and a lack of support from school administrators are among those preconceptions. These experiences were bracketed and set aside to reduce the likelihood of bias in interpretation.

Triangulation

A second strategy that will be employed for validation will be triangulation. Use of multiple sources of information can help to corroborate findings (Creswell, 2013). In this study, there was an opportunity to compare data obtained from participants based in the community setting with those based in the school setting. Additionally, both focus groups and in-depth interviews were used to compare the responses of members in a group as compared with their responses in an individual setting. During a focus group study, the opinions of more dominant and outspoken members of the group may overshadow the opinions of more reserved participants and their voices may not be heard in this forum (Krueger & Casey, 2015). In-depth interviews were held in addition to participation in the focus groups when possible to ensure that all members had an opportunity to share their experiences with facilitate school-community collaboration.

Member Checks

Participants were contacted to review the study findings and to correct or add to the analysis of the data. This was done by contacting participants individually and conducting the check by phone or in person.

Summary and Conclusions

Children spend a large portion of their day within the school setting. Often, schools are the first and only location in which children seek mental health services, yet school professionals are limited in their training and the time they have to engage in providing mental health services. Although collaborative efforts between community agencies and between schools and communities have had a positive impact on children's

mental health and well-being, barriers to interprofessional collaboration reduce the likelihood that these types of collaborations will occur. Studies published previously have surveyed or interviewed mental health providers who have participated in specific programs or have focused on the experiences of one group or another (e.g., social workers, school psychologists, school social workers, etc.).

This study proposes to gather information based on the experiences of both school and community based social workers, counselors and psychologists, outside of participation in specific programs that focus on interprofessional collaboration. Learning about the experiences of mental health professionals in this way allowed for the development of new insights as to why interprofessional collaboration is limited and what may be necessary to encourage mental health professionals to seek these types of collaborations.

Chapter 4: Results

Introduction

Collaborative relationships between schools and community-based mental health services have become an ideal way to meet children's mental health needs, yet these collaborative relationships too often remain the ideal and do not translate into practice. Many barriers exist to initiating and sustaining collaborative relationships; however, few studies have reflected on how mental health providers believe that these barriers can be overcome. This study fills a void in the literature by facilitating a better understanding of the collaborative experiences of mental health providers in both settings and how they believe that known barriers can be overcome. In this study, focus groups were used to interview mental health providers working both inside and outside the school setting regarding their experiences. This chapter details how participants were recruited; the profile of each participant; how data were collected, stored, and analyzed; verification procedures; and themes identified.

Recruitment

Participants were recruited by word of mouth in day-to-day interactions within the professional helping community, by email invitation, and through calls to local schools and community mental health organizations. Participants were part of school and community organizations that had experience with collaborating to support children's mental health needs. Emails to organizations largely went unanswered or were rejected by members of the organizations. For example, a local mental health organization sent the following rejection via email: "We don't do this kind of work. I'm sorry but we can't

help you." In other instances, a gatekeeper, such as a secretary or even a director of clinical programming and education for the organization, responded that he or she would pass along information about the study. However, future attempts to follow up with the organization were met with no response. School-based mental health providers were much easier to recruit and were much more likely to respond and be interested in participating. In-person and word-of-mouth recruitment efforts were most effective for both community-based providers and school-based providers.

Of the 20 participants recruited, 13 were found in schools, one was found in an institute of higher learning where she was my fellow adjunct faculty member, one was referred by another participant, and five volunteered after being given a recruitment letter (Appendix A) by a program director recruited by word of mouth. Of those found in schools, three were certified school psychologists, one was a lead school psychologist, and nine were school guidance counselors. The participant recruited from an institute of higher learning was a licensed clinical psychologist. Six of the participants were part of a community behavioral health organization. Two of them were program directors, and the other four were master's or doctoral level school-based clinicians in partnerships with local education agencies. Eighteen participants were women, and two were men.

Participant Profiles

Participant 1, "Sara," was a 25-year-old Caucasian woman. She was a master's-level behavioral health professional who had been working as a school-based clinician for a local behavioral health organization for 2 years. She was placed within the school setting and delivered therapeutic services in a school-based model.

Participant 2, "Lynn," was a 38-year-old Caucasian woman who was a master's-level behavioral health professional with 9 years of experience. She was employed by a

local behavioral health organization and had been working as part of a school-based model of service delivery for 2 ½ years.

Participant 3, “Jenny,” was a 39-year-old Hispanic woman who was the program director for a local behavioral health agency. She initiated a school-based therapy program that had been in place for the past 4 years.

Participant 4, “Chrissy,” was a 40-year-old Caucasian woman who was a school psychologist. She had 13 years of experience working in both elementary and high schools in public school settings. She was currently employed by a contract company and placed in the public school setting.

Participant 5, “Maria,” was a 29-year-old Caucasian woman who was employed as a behavioral health professional for a local behavioral health organization. She was currently placed in a school setting where she was working in a school-based model of mental health service delivery.

Participant 6, “Jan,” was a 42-year-old Caucasian woman who was a program director for a local behavioral health agency. She led the school-based therapy program for the eastern part of the area.

Participant 7, “Gloria,” was a 29-year-old Hispanic woman who was a behavioral health professional for a local behavioral health organization. She had been placed in the school-based program for 2 years.

Participant 8, “Tara,” was a 40-year-old Caucasian woman who was the lead school psychologist for a local public school. She had 12 years of experience as a school psychologist.

Participant 9, “Yolanda,” was a 35-year-old Hispanic woman. She was a licensed clinical psychologist and was employed in a local school district. She had 9 years of experience as a psychologist.

Participant 10, “Mabel,” was a 38-year-old Caucasian woman. She was a certified school counselor working in a local high school, where she had been a counselor for 4 years.

Participant 11, “Megan,” was a 35-year-old Caucasian woman who worked as a school psychologist in a local high school. She had 5 years of experience.

Participant 12, “John,” was a 35-year-old Caucasian man. He was a certified school counselor working in a local high school. He had 5 years of experience in his position.

Participant 13, “Marletta,” was a 48-year-old African American woman. She was a certified school counselor and had 20 years of experience. She was employed by a local school district where she was a high school guidance counselor.

Participant 14, “Rita,” was a 53-year-old Hispanic woman. She was a certified school counselor working in a local high school. She had 20 years of experience.

Participant 15, “Genevieve,” was a 30-year-old Caucasian woman. She was a certified school counselor for a local high school. She had 1 year of experience.

Participant 16, “Tom,” was a 45-year-old Caucasian man. He was a certified guidance counselor with 13 years of experience.

Participant 17, “Nicole,” was a 35-year-old Hispanic woman. She was a certified high school guidance counselor with 9 years of experience.

Participant 18, “Donna,” was a 45-year-old Caucasian woman. She was a certified guidance counselor with 8 years of experience.

Participant 19, “Riley,” was a 32-year-old Caucasian woman. She was a certified school psychologist with 4 years of experience.

Participant 20, “Stella,” was a 50-year-old Caucasian woman. She was a certified guidance counselor with 4 years of experience.

Data Collection and Storage

All participants were part of in-person focus groups, as described in Chapter 3. A total of three focus groups were formed. Two focus groups were held at participants’ high school work settings and were composed of school-based mental health professionals. One of these groups contained six participants; the other had five. One focus group, with nine participants, was held at a local behavioral health organization and was composed of a mix of school and community mental health professionals. Focus groups lasted between 1 hour and 1 ½ hours. Consent forms were reviewed at the beginning of each focus group, and each participant was offered a copy to keep. Interviews were recorded using a digital video recorder. Recordings have been filed and saved in a secure database on my personal computer. I transcribed each focus group and stored these documents in a password-protected document on my home computer. Identifying information was removed from transcripts.

Data Analysis

Data were analyzed using Moustakas’s (1994) procedures, with the adaptation recommended by Creswell (2013) to bracket out personal biases at the outset.

Transcripts were read, and significant statements were identified to build an understanding of how each participant experienced collaboration. Analysis was first completed in relation to each participant to better understand each individual's experiences. Analysis was then completed in relation to each of the research questions. Overarching clusters or themes were identified. Contextual factors including job description were considered, along with participants' experiences, to identify individual and group descriptions of participants' experiences.

Data Verification

Data verification procedures were completed following individual analyses. Interviews were transcribed and analyzed. Three techniques were used: clarifying researcher bias, triangulation, and member checks.

Clarifying Researcher Bias

As discussed in Chapter 3, researcher bias and assumptions can affect data collection and analysis. Researcher bias was identified at the outset to guard against bias during the analysis of the data. I expected to find that both school- and community-based mental health providers would have generally positive feelings regarding collaboration and would express a desire for greater collaboration. Participants were aware of my biases and experiences with collaboration as a school psychologist and were invited to challenge my assumptions and address concerns about potential risks associated with collaboration both during the initial focus group and during member checks.

Triangulation

Data were collected through two methods to corroborate the information obtained through each method. Focus groups were held, and follow-up interviews were conducted with those participants who agreed to take part to share their experiences. During follow-up interviews, participants were offered an opportunity to add to or change their initial responses. There were some participants who had been very quiet during the focus groups who were able to answer more freely in the individual interviews.

Data were analyzed in three ways. Data were coded and statements were analyzed to identify overarching themes. Data were also analyzed by research question. Finally, data were analyzed in relation to participants' job descriptions to determine whether similarities in experiences and views were held in relation to participants' roles as community-based administrators or mental health providers, school psychologists, school counselors, or school-based administrators.

Member Checks

Following analysis of each participant's statements, participants were contacted in person, by phone, or by email. Eleven participants responded, participated in member checks, and were provided with my conclusions about their statements. Each participating member was given an opportunity to correct or expand upon the interpretation of their statements. The remaining participants did not respond to attempts to schedule checks. Subsequently, they were emailed a statement containing the themes identified through the analysis and were provided an opportunity to respond. Each

document was protected with a password. Passwords were sent to the participants in a separate email so that they could unlock and open the document.

Themes Identified

Benefits of Collaboration

Study participants were largely in favor of collaboration between school and community mental health. This was likely because they self-selected for participation because they were interested in or believed in the idea already. They were able to present many benefits of collaboration, particularly pertaining to cases in which community mental health providers are able to provide services at schools.

Accessibility. Participants noted that when community mental health has a presence on a school campus, barriers preventing children from receiving mental health services may be eliminated. Families do not have to worry about transportation, money, or taking time off work to take their children to a facility. Participants felt that this type of collaboration improves accessibility. Jan, a community agency program director, said,

> It's an accessibility piece. We're supporting a model that allows children to be seen very, very frequently. There's collaboration with the family and there's collaboration with the school and we're all coming together. Families don't have to worry about taking an hour out of work or driving to pick up their child, going to an appointment; doing all that first if they have childcare issues, transportation issues or financial issues. That outpatient appointment can become very stressful and may become less of a priority. Being on school campuses, neighborhood school is usually within walking distance or relatively short drive. That's a

> significant accessibility piece and I think that does help to manage the risk. It's that wrap-around model, very supportive-type collaboration.

Several participants, like Yolanda, a school-employed licensed clinical psychologist, noted that stigma can be reduced by having programs available at school. Yolanda explained,

> If I'm going to the school to get mental health services, I'm not going to a clinic or hospital, so it's a lot safer if we're working with diverse students or just students who don't want that stigma. If I go the psychiatrist today, people are going to think that I'm going to leave because I am mentally ill, as opposed to I just need some extra support.

The theme of safety and reduced stigma came up several times in relation to having services available at school. Jan felt that parents may be more willing to accept services if they are available in the school setting: "Parents often see their neighborhood school as a safe place. They're more likely to accept mental health services if they have a connection with somebody on a school campus."

Improved student mental health. Some participants thought that having collaborative relationships between school and community mental health professionals can help to meet students' needs before they get to the point of crisis. There was also some discussion that suggested that when community mental health is available in the school, it can help to manage the level of risk and the costs associated with helping higher need students. Participants thought that community mental health services in schools might lead to a decline in depression and suicidality. With services available,

students' problems might not have to escalate to that level before mental health services were accessible to students. Jenny, a community agency program director, suggested that collaborative relationships that include having a community mental health staff member located on a school campus can improve outcomes for students.

> We have the highest percentage of reliable change with our services. The model works and we have the data as an organization. We are more effective than any other program in the agency and that says a lot about what we're doing with schools.

Improved relationships. The idea that collaboration can improve relationships between school and families was also mentioned. Sara said,

> Benefits of working in the school are that it can help change a family's relationship with the school. If you have a family that might think the school is always against them or just giving them a lot of resistance, Community Mental health can be a great bridge to help build those relationships. They are getting everyone to the table for CFTs and working more closely with teachers.

Education, training, and sharing of resources. Yet another perceived benefit to collaboration was that community mental health could provide training to teachers and help them to better understand and work with students who have mental health problems. Lynn mentioned that she can go over with teachers what she is working with on students and a lot of times they take the strategies and use them with other kids. She said that they can also help teachers and staff to accept new approaches to working with difficult students and that this may change the future for the student.

> We have a role in the trajectory of success of that child. Oh, that kiddo, he has been a terror for 10 years, or that's the reputation and so with us being in the school introducing new language about the child and maybe what's going on with those behaviors and helping the school understand, accept and embrace maybe a new approach and that child no longer becomes the terror passing from third to fourth grade and from fifth to sixth grade.

Collaboration was said to help administrators, staff and parents better understand how providing mental health services to children in schools can help to improve academic outcomes that schools care about, like academic performance and attendance. This is welcomed by overwhelmed, school-employed, mental health staff, like school psychologists and counselors who don't feel that they have the time or training to address student needs on a regular basis. John said that when children have immediate mental health needs he does what he needs to do to respond but that he is not prepared to treat mental health problems.

> I'm triaging the severity, referring out and notifying parents. It's the confidence I have in my skills in that area. I don't feel confident in my skills. I'm not a mental health professional. With more collaboration, we could have resources available on campus.

There was also some ambivalence that came from school guidance counselors with regard to the benefit and need for collaboration. Although they were glad to know that certain students were receiving services, they were not sure if they should be

engaged in a more collaborative relationship in some cases, but wanted it in others. Donna explained,

> To be able to call and have a [crisis] team come out who does know what they're doing and they can talk [to the student] and determine what needs to happen. That is huge for us. So, I've been a part of that multiple times. I have had a student who had a counselor come meet with her here [at school] but I was completely unaware of that. The only reason I knew was that because she was getting pulled into the library and I happened to see her. So, there was no collaboration and I'm OK with that because I'm her guidance counselor and I'll support her whenever she wants to share with me but if she's receiving that counseling for a personal reason I think that's appropriate for it to stay separate but just knowing that she was receiving that was comforting to me because I can't provide that for her. The struggle we have if the kid goes to [the hospital] for a week or whatever and then returns to school its super difficult to get any kind of information. Our assistant principal wants like a safety plan or something like that and you can't get really anything if a parent doesn't bring it in. So that does not really feel collaborative.

Risks of Collaboration

There were some risks presented to collaboration. The main risks identified were related to liability, adversarial relationships, confidentiality and consent, eligibility for services, and privatization of public school funds.

Liability. Another concern was the idea presented by some school counselors that the school may not want to get involved in the liability that they might take on if they begin to provide mental health services. Tom said,

> I'm not so sure that it isn't … the expense of it. There's other districts that are pretty close to us like [school district] has social workers. I talked to a coach whose wife was one on campus. I don't know for sure but I'm not sure our district is not OK with those things being separate there's a liability that comes with it when you start getting involved in those areas and I think that's one of those things for us as guidance counselors. And that's where collaboration is tough because we can get a lot of information from outside resource about a student but to be quite honest, our supports are going to be what we're trained in, what we feel skilled in, because the minute you step out of your area… Let's be honest if we step out of an area and we start counseling, that's not what we're trained to do. Our employers know that's not what we're trained to do. If it ever went to litigation or anything like that were going to be standing our own. So, you have to be very cautious, fully knowing that you may not be supported on that other end.

Another concern about the liability had to do with the trust that families have in the school staff and guidance counselors and worry about the services being provided by the outside agency and that if the community agency was not providing the kinds of services or supports that the child needed that the parent might stay with that agency based upon the word of the school counselor. Stella said,

> I would worry if it were my responsibility to set up the connections, is it really reputable? Are they doing justice with my kids? I send them to good hands am not sure their qualified and I don't have time to vet then ahead of time that a time that would be my fear.

Tom added,

> To some parents our word is golden. As a parent, I am aware that if something doesn't work for my child, I'm gonna keep trying. And it's scary that your opinions are held in that prestige that, my gosh, they may stay in that situation and it's not working. And that would break my heart.

Adversarial relationships. Although some of the participants suggested that improving relationships with families was a potential benefit, there was some dissent. Cindy was concerned that there could be times when community providers may be more of a support to the parent and may not help them to understand the school's position. She said, "Sometimes they (community providers) can become adversarial. We're trying to prepare students to stand on their own feet, expand their comfort zone. Sometimes parents and advocates view that as being disrespectful of their disability."

Service eligibility. Another concern that was mentioned had to do with student's eligibility for services. One school psychologist explained that the alternative school she works with had decided not to collaborate with a community agency because they would only see students who were Medicaid eligible or who agreed to private pay. The school was not willing to fund services for students with private insurance who could not afford to pay for services. She also felt that in this case it would be appropriate for her school to

hire a school social worker to provide the services to students. In describing her experiences, Riley said,

> One of the reasons we're not doing the [community organization] thing is because I told our K12 [administrator] that I don't think it's appropriate for us to be denying service to some kids. I've been in meetings with people talking about mental health support at [the campus] and I am used working in residential treatment facilities and working in an alternative school. If really, it's going to be an alternative school, it's missing a key component; Mental Health Service. There's nothing there. And no matter how much we keep knocking on that door… they tried to get us a .5 nurse. It's like, NO not a nurse! I just don't understand it. Maybe they're afraid to bring them because they're like if one school has a social worker, that all the schools are going to want a social worker.

Privatization of public school funds. Some participants were concerned about the costs that may be associated with collaborative partnerships with community mental health and the appropriateness of using public school funds to pay for services from for profit agencies. Riley stated, "I think that we're getting so focused on bringing in private for profit companies into education and it really could have lasting harmful effects…Since being here I have been surprised that the amount of privatization that goes on in public education."

Confidentiality and consent. There was some concern about parental consent and confidentiality issues. Donna was concerned that a parent may not allow a student to access needed services. She said,

> I wonder how much of a barrier mental support would be even if we did bring it to the school because of the stigma. The kids who need it, their parents may say I don't want my kid to be that kid and not want the school to know what's going on. I wonder how many of those kids we want to receive the services would be denied because their minors. I can think of some family that would say, "Nope, there's nothing wrong with him."

Similarly, Tara said that as a school psychologist, she had difficulty figuring out how much collaboration about a student was appropriate without parental permission. She said, "I could see we run into it a little bit not so much not wanting to collaborate but figuring out how much we can collaborate; how much information can we share? Where is that line of what is OK without specific permission?"

Barriers to Collaboration

Study participants identified several barriers to initiating and sustaining collaborative relationships. They identified barriers related to time, communication, funding, and different agendas.

Time. Study participants from both school and community-employed settings shared concerns about time as a major barrier to collaboration. Lynn explained that high caseloads can make it difficult to take advantage of opportunities to collaborate.

> I think it's harder when the problems are the lower level. When you have someone with a lot of needs, big crisis, its collaborative and they have smaller caseloads and are mobile and they can be more involved with schools, have the time and energy to devote. But if you have lower level kids on your caseload

> with small problems they could become facility based. People have a caseload that bigger. If I go to a school, then that's like 3 times for kids that I am missing for one child so I don't have the time to do it. There becomes a disconnect between facility based services and schools. Yes, I understand that you're the teacher but there's no relationship. Maybe you send me a copy of the IEP, if I have an ROI (release of information). It's the constraints of having a big caseload. With a smaller caseload, there is the time and opportunity to create those relationships.

School-employed participants agreed that in schools, time constraints and high caseloads may result in collaboration being most likely to occur for higher needs students. Chrissy said,

> In the schools, my experience has been that our higher needs students, we do a really amazing job with that collaboration piece, but that's exactly it. The mid-level, low-level need, fall back. The students that do best in that situation are the students that have parents that are good advocators and are informed.

Marletta was also concerned about the amount of time needed to spend with those students whose needs were the highest, "We just pour, pour, pour into them. It goes back to the bigger mental health picture. We can only do so much. We don't have the resources here."

Communication. Participants reported difficulty initiating and sustaining communication. It can be difficult know who to contact and what information can be

shared, legally. From Yolanda's perspective, communication is vital, but it is necessary to have parent permission to release information.

> I don't know maybe in an idealic society we could have a mutual or an Ongoing release of information where if they are working we can share information easily. I think that's a barrier. You have to get parent permission not only to sign the HIPPA form for the community mental health but then the FERPA form and not only is it one way but you have to have two FERPA forms to have, you can talk to me but I might not be able to talk back until you sign the second form. If there were a universal release of information to talk with community mental health, again in a utopian society, is it ever gonna happen? But that communication is so vital.

Following from a previous discussion about the importance of school people to be involved in Child Family Team (CFT) meetings with community organizations, Yolanda shared,

> I have never been invited to a CFT and I don't know what students have one. And so, a lot of times its, 'well we had this meeting and now we are going to need this from the school.' It's like it would have been nice to know and parents may not share that information.

Megan shared her experiences trying to connect to community organizations to get information she might be able to share with children and families. She expressed a desire to have regular contact with community organizations.

> Last year I spent one or two days contacting places that I saw in the community. When I actually got to talk to someone they were more than willing to send me some things for sure. And then someone called us last year and said I'm your liaison to your, you know, organization. I'm just calling to see if you have any needs or whatever and actually did help me with a student here who had been depressed or whatever. And then after that they never called again. They disappeared. They were probably overworked and underpaid and just didn't have the resources. I think that it would take not just that person calling monthly but setting foot on campus and scheduling an hour here and there to speak to you know school mental health people on the campus to check in. And if they were doing that regularly, if we can get someone on campus to do that, that would be huge bridge to services.

Inconsistency in community mental health was shared by several school mental health professionals in terms of turnover. Marletta suggested, "I think its turnover. I mean you make a relationship, you know you make a connection with someone and it's like 'Hi, I remember working with [name]...' and 'Oh, she's no longer here."' Riley also expressed concern about this, "I feel like there is so much turnover that the kid will get established with someone and then they'll leave so there's not really any consistency."

Funding. Several participants raised concerns about how funding can be barrier to collaborative relationships. There were concerns about how schools could attract mental health organizations and how the community agencies may not find schools to be a profitable market. Mabel wondered,

> How are they going to be compensated for their efforts? You have to make a dollar and the district is probably not going to fund, am I wrong in assuming they're not going to fund something like this? It has to be lucrative. If there were a lucrative market, there would be people who were starting to build up a clientele, tapping into a market that's not been tapped into. It's not lucrative because there is no money here.

John agreed that it was unlikely that the school board would be willing to fund a collaborative program that placed mental health professionals from the community on school campuses.

> What kind of federal grants are out there for stuff like this? Everything that takes place outside of straight education and even within straight education, any service that is research based that indicates increased academic performance does not typically come on the local taxpayer's dime. Free/reduced lunch, title 1 after school intervention, so I think the extent to which those opportunities could be thought out, researched and utilized. you took the words out of my mouth earlier you're not going to convince the board elected from a primarily like wealthy District that this is like most parents want to do it they're going to go out and see a therapist. That's just not gonna compute. If you look at the way we fund education it would just be asinine that we would help support someone. On paper, a billable hour for mental health, that's insane, it's just so off the charts of what we, how much we value each kid per dollar. And the staff members that work

with them all the time, it's totally inverted so it would have to be some kind of outside funding and compensation, which I know is not a surprise I'm sure but …

The sustainability of programs was also questioned by Chrissy,

I am in a position now that I am in a district now that values mental health services that are school-based and are employed by the district. That has not been my experience up to this point. It's that financial piece. Schools face a lot of pressure financially. When we go through these budget decisions, mental health is one of those things that seems to go.

Similarly, Marletta discussed cutbacks that had eliminated her job as an intervention specialist on an elementary school campus. Due to budget cuts, she felt that they just kept "peeling back" layers of support for students until the "bridges kind of collapse".

Different agendas. Differences also emerged in how school and community mental health professionals view student problems. Schools and community organizations may have a different focus and may be working on different goals with the student. There is a perception from school staff members that community agencies may be working to appease the parent and may not understand the role of the school, and the process by which services become eligible for special education services. There is a perception from community staff that their role may not be valued by the school. Rita said of community providers that they don't necessarily think that the school understands the child's disability.

They're just looking at this IEP meeting. They're not thinking long term. I'm always thinking long-term and I have no problem saying that might work for

> today but how are we going to get them through to the end where they leave us and they can function?

Along those same lines, Yolanda felt that there was a lot of confusion about what an IEP is for on the part of community mental health. She felt that parents can sometimes be misinformed by community health who may not understand specially designed instruction, “kids are resilient, they might not show these behaviors at school”.

Many of the school-based providers indicated that they thought there may be a misperception about what they were doing with students in terms of therapy. Megan was concerned that community mental health providers may not understand that schools are not doing therapy. “School mental health providers are helping students access the curriculum, not creating a therapeutic relationship.” Similarly, Rita was concerned that parents do not understand the difference between what they do and what a community mental health professional does: “When the Spanish-speaking parents come in and hear, ‘consejero,’ the Spanish word for counselor, and they’re like, ‘yeah’ and I’m like, ‘no, not that kind. I don’t do therapy.’”

John was concerned that there may be questions about who is in charge and that the community organization may have a different agenda from the school. Tom was more concerned about what his role should be as a school counselor and was conflicted about the academic goals of education for students struggling with mental health issues. Tom said,

> I think maybe it’s just the way you look at education in general and what our role is because we catch so many different things coming down the pipe how to

> educate kids in and we're doing a poor job of educating kids. I mean you hear about it in the news all the time and the things that were talking about now about the support and the mental health issues, they're really not prioritized. We really need to find the balance and reestablish what the role is because I'm torn in two worlds. I mean I have a heart for people. And my heart gets broken when I see people like the young lady that we talked about and we all have them….It gets frustrating I guess my point on that is that they need to work together somehow. That you have to reestablish what education's role is that is because again what we've been dealing with when she's [a student] missed fifth hour every day the last week and she goes into this mode and she comes to visit with me and she finds a safe haven in the nurse's office and again education's not getting done here. It's almost like they need to bring the organizations in but they still need to be two separate entities. Right now, we're dabbling into too many things and not doing one thing very well it seems like sometimes.

Sara suggested that community mental health understands how important a role the school plays in the Child Family Team (CFT) process but schools do not always understand how big of a role they play: "Those that get it are trying to teach everyone, but if you don't have someone in the district and the school it's difficult to get their buy-in."

Overcoming Barriers to Collaboration

Study participants had many suggestions for overcoming the barriers to collaboration. Problems addressed included initiating relationships, funding problems,

leadership and communication issues, accessibility issues, and sustaining collaborative relationships were all addressed by the participants.

Initiating collaborative relationships. Participants suggested several possibilities for facilitating collaboration; needs assessments to demonstrate the need for services, program initiatives at the state or district level, word of mouth from school to school about partnerships, and getting administrator buy in. The idea that schools needed a school social worker or someone whose job it was to manage those collaborative relationships.

Several participants felt that a top-down approach to collaboration would be most effective. Community-employed providers working in the schools found that they had the most success when their role was understood and welcomed by the building or district level administrators. Lynn suggested that the statewide behavior health leaders should meet with the department of education should work together to expand collaborative efforts.

> The way to facilitate would be at the top. Mercy Maricopa and the Department of Education sitting down and talking about it, and have a trickledown effect so that the Department of Education can go to all the districts and say, ‘this is an availability,’ and identifying organizations under Mercy Maricopa, and creating those partnerships.

Jenny agreed that top down coming from the district level was beneficial. She also thought word of mouth was important:

> It's really word of mouth, having a champion in the district. I never would have developed a partnership with [school district] had a principal from another district not met the principal at [school district] at a conference. They're talking sand she says, 'Oh my God, you have what at your school? And that led her to call me and so when we have school administrators and staff who are really in tune to wanting support on their campus they're very, very motivated."

Educating decision makers was also proposed as a way to help facilitate the development of collaborative relationships. Chrissy said,

> Educating our administrators as to what this is, a lot of these decisions are made by the [school] board and they're just regular people who don't know. Your board, as you know, those people are doing it because they care and they can only work with the information they have, so making sure that they have the information. If they don't know what we do and how important it is bring it back to the student performance and attendance and things that make people understand that it is important.

Funding. Another theme for overcoming barriers was the idea that costs can be decreased in other areas by building and funding partnerships like these. Jenny felt that risk management was a compelling argument and could persuade school districts that funding partnerships could save money in other places.

> We tend not to have as many high needs kids in the school setting because we're able to work with the school to manage the level of risk and need. It costs more money to have the high needs kids. It's beneficial for both. Having a high-risk

> student, it costs more money to have these kids… We can manage those risks by establishing these partnerships.

The idea that building partnerships could reduce costs by minimizing risks was popular, but difficult to demonstrate what the benefits would be on a day to day basis. Chrissy said,

> Schools may think about the threat of lawsuit. What happens if we don't do it- to the extreme? But I think benefitting us day to day; I think it is hard for schools to see. I would also be interested in finding ways to better demonstrate how important what you all do for our kids is.

The possibility of looking for grants was also considered, but there was concern about what happens to programs once the grant funding is gone. There was consensus that convincing decision makers would take presenting information on outcomes to help them understand and support collaborative partnerships. Jenny said,

> We talked to our supervisor recently and you inspired me to look at the organization doing a Needs Assessment in schools that we are currently in, doing focus groups, doing informant interviews and looking at those outcome data and presenting that as a tool to Mercy Maricopa because we have been meeting with them to expose the work we've been doing in school, but also then taking that data to school districts so that they know that they need partnerships like this. School services in a community-based organization and the thing that we're doing together this is something that could be really powerful for future collaborations. We're kind of excited, very preliminary conversation.

Cost savings was another potential source of funding. Specifically, participants suggested that savings on the school side could be as simple as reducing outplacements. In order to hire a school social worker, for example, Riley suggested,

> And if it's a cost thing, because I have been working a lot with [school] in terms of let's conceptualize what why are they doing this that you know I mean not sending one kid to [private placement] covers the cost of that person.

Additionally, managing risk and need was identified as a measure of potential cost savings. Jenny noted,

> We tend not to have as many high needs kids in the school setting because we're able to work with the school to manage the level of risk and need. It costs more money to have the high needs kids. It's beneficial for both. Having a high-risk student, it cost more money to have these kids, and more insurance and expenses. It's beneficial to both. They work with the school's school psychologist administrators and assess risk. It's a huge responsibility...We can manage those risks by establishing these partnerships.

Seeking federal grants for funding was also suggested.

Leadership/communication. With regard to leadership and communication schools felt that it would be important to hire a professional like a social worker to be in the role of leading collaborations. Donna said,

> We first need someone on our campus who is not the school psychologist who is trained in some of those techniques. Because you can tell me what's going on or while you're working with the kid on but I still am not trained to be able to add

> anything to that other than, "Keep it up. Good job." So I think having someone here who could work with those outside agencies in supporting the kids. With our caseload and the number of students we have the number of IEPs the number of 504s the testing all of these things that is just not something I mean that's a time consuming thing you have the kid going through and I mean there's a lot of hours that you're talking about for those kids and it's just not a priority in our district that's for sure. Not when you're cutting counselors and increasing caseloads and responsibilities. You would have to have another staff member who was role that was.

Riley added,

> And I know we fought really hard to get a behavior interventionist on our campus. It was just me doing a lot of work and we'd have someone come for a day here and a day at [school] then we got one fulltime. Don't get me wrong I love that we have a Full-Time BI but I think that we could have a social worker doing what she does with the kids and then taking on those extra things. The amount of kids are being seen are able to be covered in about three days and then there's two days of doing other things like meeting with kids that aren't scheduled on things like that were crisis management or whatever but the skill set that you need for the BI would be encompassed in a social worker so I just don't really understand why they're not behind doing that.

Agenda. To overcome concerns about having different goals within each organization, it was indicated by participants that developing a common agenda with

common goals was important. School psychologists did not see the goals as all the different and also felt there was an adequate understanding by community mental health about what was happening in the schools. Megan said,

> I feel like I've had a good experience with mental health professionals from the community. They're usually an agreement and it's extremely helpful to have them there because they know what they're really targeting out there. Or when they call and they're asking about a student check in more tell me more. We're not really doing therapy here we're trying to ask to help them access their curriculum. Therapeutic environment is very different than what we're doing in school. I feel like I don't know if it's a misconception but I feel like I'm desperate for that. I want them to be here I want them to be involved and I feel like maybe they have so much business out there they don't need that.

Community mental health providers felt that building a common understanding alleviated issues related to agenda. Gloria said,

> Talking about schools really getting it I've had a completely different experience in the school I'm in where the administration truly does understand my role. It's really effective to where we're starting to get the referrals from the staff after they do their interventions first and if they're not effective they refer them to me.

Gloria also mentioned the importance of demonstrating an understanding of the school’s role. She said,

> Being respectful of teachers and their time plays a big role in it. Explain to them how the process will be when do they want to work with your 7th and 8th graders.

They're doing testing, there are certain times to avoid they're very clear about that, but they realize that if there's an emergency situation. it's whatever time it's necessary to be effective so I think that's it helpful and they work with you better.

Accessibility. Participants working for community agencies who delivered services to students in a school-based model made the case for school-based service delivery as a way to overcome barriers and increase collaboration. Having staff present in school allowed opportunities for greater collaboration. According to Maria, “integrating yourself into the school environment” provides opportunities for school staff to approach community professionals about possible referrals. Having community providers in schools reduces the concerns about time for collaboration and provides more opportunities for communication. Lynn expressed how much easier communication is in this model.

We play so much of a role within the school. I can run over to Sean’s classroom and talk to his teacher and we can go over those coping skills that he learned. And the teacher, things I was working on with an individual kiddo, the teacher brings in her own and is using them in the classroom for all students.

Jan also explained how the school-based model can improve collaboration. She also noted that this model may not work for every therapist.

Our model eliminates the barriers. It is in our procedures that we will talk to teachers and administrators as part of the collaborative team. Ongoing collaboration is happening all the time in this model. Not every clinician can be a school-based clinician. You have to be willing to go to the classroom and talk to

teachers and share information. Same with school psychologists, and bring parents and teachers together.

Sustaining collaboration. Jenny, a program director, suggested that looking at outcome data and presenting that information could help support collaborative efforts in the long term. She said,

> We talked to our supervisor recently and you inspired me to look at the organization doing a needs assessment in schools that we're currently in. Doing focus groups, doing informant interviews and looking at those outcome data and presenting that as a tool to [state organization] because we've been meeting with them to expose the work we've been doing in school. But also then taking that data to school district. so that they know they need partnerships like this, school service in a community-based organization and the thing that we're doing together. And this is something that could be really powerful for future collaborations. We're kind of excited very preliminary conversation.

Summary

Analysis of these qualitative data was completed to identify benefits and risks associated with collaboration between school and community mental health providers, and to identify factors that facilitate collaboration, barriers to collaboration, and ways that barriers may be overcome. Benefits of collaboration included; removing barriers to services for children, increasing accessibility of services, particularly if services were available as a school-based model, improved student mental health, and improved relationships between school and families. Mutual benefits to collaboration included;

education, training, and sharing of resources that have the potential to reduce costs. Risks of collaboration included; the liability the school may take on by getting involved in children's mental health, relationships with families and community agencies that may become adversarial, problems with parental consent, and confidentiality. Barriers to collaboration were related to time, communication, funding, and differing agendas of the school and community organization. Most school-based professionals believed that it was necessary to employ a mental health professional such as a social worker, whose job it was to establish and maintain collaborative relationships. Both school and community mental health providers indicated that establishing relationships was a process that worked best from the top down. Participants proposed ideas for funding that included; cutting costs, reducing risks, and finding grants. Jointly developing procedures, increasing accessibility by having services available within the school setting, and collecting outcome data regularly to share with stakeholders, were discussed. Understanding the experiences of collaboration among school and community mental health providers has the potential to help schools and community agencies overcome barriers to collaboration, and improve the coordination of services for children with unmet mental health needs.

Chapter 5: Interpretations and Conclusions

Introduction

As many as one quarter of children have mental health needs, yet only about a third of them receive mental health services (Merikangas et al., 2010; Merikangas et al., 2011). Community- and school-based mental health services, independently, have not been sufficient to meet children's mental health needs. Most students with mental health needs initiate services in the educational setting (Farmer et al., 2003). However, there is little evidence to support that services carry over from school to community-based mental health or vice versa.

Barriers to community-based services disproportionately impact children from lower socioeconomic levels and from minority ethnic backgrounds (Alegria et al., 2012; DeRigne, 2010; Kodjo & Auinger, 2004). In schools, services are impacted by too few providers, role strain, and inadequate training (Suldo, Friedrich, & Michalowski, 2010). Increasing collaboration between school- and community-based mental health professionals may allow school and community organizations to share the responsibility of meeting children's mental health needs.

Recent legislative updates to the Elementary and Secondary Education Act of 1965, known as the Every Student Succeeds Act (ESSA, 2015), require schools to address the mental health needs of students, including early identification of mental health problems, coordination of services, and the use of partnerships to expand access to or coordinate services for students in order to improve school safety and increase the likelihood that at-risk students will complete their education. Barriers to collaboration

have been identified, but little information is available to determine how school and community mental health providers can initiate and sustain collaborative relationships or how they may overcome barriers to collaboration to meet children's mental health needs.

A phenomenological approach to this inquiry was used to understand the experiences of school and community mental health providers with varying levels of involvement in collaborative relationships. This method was chosen to capture the lived experiences of mental health service providers with initiating and sustaining collaboration in the provision of mental health services for children. Understanding their experiences can help in the effort to identify ways in which barriers may be overcome for collaborative relationships to flourish.

The findings from the focus groups and interviews revealed that participants' views of collaboration were generally positive, but school-based providers overwhelmingly suggested that it was difficult to initiate and maintain collaborative relationships at the level of the mental health provider. A few providers also noted risks related to collaboration. Benefits of collaboration included the ability to remove barriers and to increase accessibility of services, particularly if services were available within a school-based model, as well as improvements in student mental health and relationships between schools and families. Further, mutual benefits included education, training, and sharing of resources, which had the potential to reduce costs. Risks of collaboration included concerns about the liability the school might take on by getting involved in children's mental health, especially if some students with needs were not eligible for services through the community mental health agency; concerns that relationships

between families and community agencies might become adversarial; and problems with parental consent and confidentiality.

Barriers to collaboration were related to time, communication, funding, and differing agendas of the school and community organization. Ideas for overcoming barriers to collaboration included initiating collaborative relationships with a top-down approach, identifying a leader who could be responsible for maintaining communication, developing common goals and a common agenda by increasing parental involvement, respecting teachers' time and establishing a culture of collaboration, increasing accessibility by providing services through a school-based model, and sustaining collaboration by collecting outcome data to educate administrators and school boards as to the effectiveness of the collaborative efforts and reductions in costs associated with risk management and outplacements. A consensus of the school-based professionals was that it would be most beneficial for schools to have a person, such as a school social worker, who could take on the responsibility for leading collaborative efforts on the school side.

Interpretations

The intent of this study was to provide insight into the experiences of school and community mental health providers in collaborative relationships to support children's mental health needs. The results of this study suggest that mental health professionals on both sides do see the benefits of a collaborative relationship, but, especially among school professionals, do not feel that there is much that they as professionals can do to initiate and maintain such relationships. Despite feeling that they had limited control

over establishing collaborative relationships, they could identify barriers as well as ways in which those barriers could be overcome. Professional experiences related to the benefits and risks of collaboration, the barriers to collaboration, and overcoming those barriers were identified. The position of the mental health provider as a school- or community-employed professional, is a point of consideration when interpreting the findings of this study, particularly given the low number of community mental health professionals who agreed to participate in this study. Additionally, few participants identified themselves as administrators.

Facilitating Collaboration and Overcoming Barriers

Study participants identified benefits and risks for initiating and sustaining collaboration. Issues related to initiating collaboration included improving accessibility, navigating confidentiality and consent, dealing with family relationships, managing district risks and liabilities for student outcomes, and improving training, education and sharing of resources. Sustaining collaboration was associated with overcoming barriers related to time and role conflict, identifying leadership to manage the collaborative relationship, building a common agenda, and identifying sources for sustained funding. Benefits, risks, barriers, and ways to overcome these barriers are discussed in greater detail below as the two primary goals of this study, initiating and sustaining collaboration.

Initiating Collaboration

School and community providers agreed that initiating collaboration was most likely to occur with program initiative, beginning at the state or district level. This was

felt to provide the best understanding by both organizations as to what the expectations of the collaboration would be. Participants suggested that the “top-down” approach is needed in order for administrators to buy into and support the program. Another suggestion was to conduct an assessment to document student needs. Finally, word of mouth was identified as a way to gain acceptance for collaborative models, particularly from administrator to administrator. A tool that has the potential to assess readiness for collaboration at the school level is the Expanded School Mental Health Collaboration Instrument (School Version). The scale addresses several factors related to collaboration, including interpersonal processes, buy-in, outreach by community agencies, school environment, and administrative support (Mellin, Taylor, & Weist, 2013). Three main factors related to collaboration were types of, influences on, and benefits of collaboration (Mellin et al., 2013). From a planning perspective, the results of this type of school- or district-wide assessment may help school professionals better understand what needs to be done to prepare for coordinated and collaborative relationships with community mental health.

Accessibility. There was a lot of support among participants for the idea that collaboration between school and community mental health providers could improve access to mental health services for students, particularly when services were delivered as part of a school-based model. Participants also expressed concerns about whether parents would follow through on referrals. Accessibility and availability of services in terms of time and location have been identified as significant barriers to children receiving needed mental health services (Cummings et al., 2013; DeRigne, 2010). Problems have also

been noted by school mental health providers regarding accessibility of community mental health providers for collaboration (Walsh, 2013). Housing community mental health providers within the school building can help to eliminate this barrier. Community providers in this study working within the school setting reported improved accessibility, both in terms of children accessing services and in terms of school personnel accessing clinicians. Jenny and Jan, program directors for a school-based program in a community agency, shared that having clinicians located within the school works. Jenny stated, “We have the highest percentage of reliable change with our services,” and Jan said, “Our model eliminates the barriers.” This is an important consideration for ways in which barriers to services can be overcome. Students are able to be seen more frequently, and communication and collaboration between community and school staff are built into the model.

Consent and confidentiality. Some participants shared concerns about sharing too much information with collaborative partners without specific permission, and others were concerned that parents might not consent for their children to receive services due to stigma. School and community mental health partnerships are required to abide by the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) to protect the confidentiality and privacy of children (Klontz, Bivens, Michels, DeLeon, & Tom, 2015). FERPA allows for disclosure of mental health records to health care professionals providing treatment to the student with the student’s permission, or with the guardian’s permission if the student is a minor (U.S. Department of Health and Human Services [DHHS] & U.S. Department of

Education [DOE], 2008). Once the record is in possession by the healthcare organization, the healthcare organization is required to protect the information according to HIPAA privacy rules. At that point, the mental health record can be disclosed to prevent an immediate threat to health or safety (for the patient or another party) or to lessen the threat, including to law enforcement, the target of the threat, family, or others who might lessen the threat. Otherwise, consent by the patient or guardian (for a minor child) is necessary (DHHS & DOE, 2008). The key to maintaining appropriate privacy and confidentiality is to develop procedures for how these issues will be managed (Klontz et al., 2015). Consent forms should be used for evaluation and treatment that satisfy both FERPA and HIPAA requirements, permission should be obtained early in the process, and it should be identified as part of the procedure how records will be stored and managed (Klontz et al., 2015).

Family relationships. Study results suggested that some school-employed staff felt that relationships with families could become adversarial if the community provider did not understand the school's agenda. On the other hand, many school- and community-based providers felt that working collaboratively with community mental health could help to improve family relationships as grades or discipline improved and school staff gained a better understanding of children’s struggles. Schools and families may have issues that include distrust or disconnection, especially when cultural differences are perceived between teachers and students (Mellin, Belknap, Brodie, & Sholes, 2015). Families may not be available to be involved in the way that schools would like, due to long work hours or feeling unwelcome in school (Mellin et al., 2015).

This can extend to mistrust by schools of community organizations or mistrust in families concerning community organizations (Mellin et al., 2015). In contrast, when school-family relationships are strong, they may facilitate trust (Bryan & Henry, 2012). Establishing partners with organizations that are also trustworthy may help to facilitate the likelihood that families will follow through with mental health referrals for services.

Participants also thought that these types of collaboration could improve relationships between schools and families. When providers understand social and cultural family values and beliefs, improvements for children are greater (Mancoske, 2013). Additionally, when discipline problems negatively impact their children, parents often find the time that they spend at school to be negative due to these problems (Duchnowski & Kutash, 2011). Community providers felt that once they became involved, the school had a better understanding of students' problems, children showed improvements academically or in relation to discipline, and families experienced relief, helping to improve family-school relationships (Duchnowski & Kutash, 2011).

Student outcomes. Another theme identified was improved student mental health. Administrators from the community agency reported that their program was more effective than center-based programs without school collaboration within the same organization. Community providers also indicated that they could see students more frequently and when problems were present at a lower level. Children who receive services under a coordinated systems of care approach demonstrate improved relationships, emotions, school functioning (improved attendance, fewer discipline referrals, better grades), and functioning at home, as well as decreased substance abuse,

depression, anxiety, and suicidal thoughts and attempts (CMHS, SAMHSA, & DHHS, 2015; Mancoske, 2013). Under the current version of ESSA (2015), schools are responsible for identifying and coordinating services for students with mental health problems.

Training and sharing of resources. The idea of that collaboration could result in more training opportunities for teachers and school staff and that collaboration results in a sharing of resources and responsibilities was identified. Some concerns were also noted. All school counselors indicated that they felt that they were not trained to provide mental health services. Interdisciplinary collaboration is associated with an array of competencies (communication skills, collaboration skills, relationship-building skills, team participation skills, consultation skills, group process skills, identifying and understanding roles and responsibilities, collaborating effectively across systems, values input from stakeholders, participating in planning, needs assessment and resource mapping, knowledge of available community supports and when they are needed, etc.) that must be learned and practiced in order to support collaborative relationships (Michael, Bernstein, Owens, Albright, & Anderson-Butcher, 2014). School and community mental health professionals can use effective relationships to provide training opportunities to one another and to create an understanding of the goals of each system to more effectively coordinate care for students.

Several participants suggested that educating teachers to better understand and respond to children's mental health problems could have a positive impact not just on students in service, but on other students as well. All states require some level of mental

health training in teacher preparation programs (Ball et al., 2016), and teachers have reported concern for student mental health (Moon, Williford, & Mendenhall, 2017). However, teachers have also reported a need for further mental health training (Moon et al., 2017). Compared with school mental health professionals and administrators, teachers are less likely to believe that addressing mental health issues is part of their job (Moon et al., 2017).

Collaborative relationships provide additional sources for ongoing professional development that can be beneficial to key collaborators including teachers and other school support staff who work with students from day to day. Mental health first aid training can improve teachers' knowledge and beliefs about treatment, but it may not result in any significant change in their efforts to support individual students (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010). Collaborative partnerships may improve teachers' ability to address mental health needs by providing an opportunity for teachers to learn through training, collaboration, and interactions with community and school mental health providers. Feedback and training can improve the delivery of interventions at earlier stages and may reduce the need for more intensive supports.

Risk management. Results from this study suggest that some school-based professionals were concerned that by initiating collaboration, the district would become liable for student outcomes. Other school-based providers were concerned that parents held their recommendations in too high regard, which they felt could be a problem if the organization was not properly vetted. Several community and school professionals felt that, in contrast, having mental health services available could manage the risks

associated with children's mental health problems by establishing partnerships. As was reported by participants in this study, school counselors and school psychologists may not have needed time or training and are often not set up with student-to-provider ratios for diagnosing and treating mental illness (LaFee, 2013). Lafee (2013) recommended coordinating collaborative services in the form of mental health clinics on campus. The argument for this is that when the school takes on the task of mental health diagnosis and treatment, it also takes on liability risks. By implementing mental health procedures and collaborating with community mental health, schools can build connections with external mental health providers while protecting themselves from liability risks they would face if they were to diagnose and treat students themselves or if they were to do nothing (LaFee, 2013).

Sustaining Collaboration

Ideas for sustained collaboration included minimizing barriers to collaboration including time and role strain by; increasing training in mental health, hiring school staff to lead and manage collaborative relationships, building a common agenda by setting clear rules and boundaries, developing common goals and common language, establishing a referral process, frequent meetings, and evaluation of collaborative efforts. Conducting assessments to document student need, and collecting outcome data to share with educators, administrators, schoolboards, and state organizations may help to justify financial needs to potential sources of funding. Completing a cost benefit analysis and demonstrating how costs can be reduced across several systems may help to make the

case that paying for some services are affordable. Strategies are discussed in greater detail below.

Time and role strain. Time was identified by most of the participants employed by schools as a major issue. Mental health professionals in schools and in the community, each felt that high caseloads left little time for collaboration. Participants also felt that high needs students received the most support; with community-based mental health professionals and school psychologists indicating that collaboration was better with these students. School counselors reported that the high needs students took most of their time, but often they did not feel that the time was a good investment. Students fell behind in their school work and sometimes left without school counselors feeling that they had made a difference. Time constraints and heavy workloads are noted as barriers within the literature (Odegard, 2005; Walsh, 2013).

Additionally, school counselors expressed difficulty identifying themselves as mental health professionals. They expressed concern about parents thinking they could provide ongoing therapeutic counseling and they reported that they lacked the necessary training to act in the capacity of a counselor. One group member said she felt that the word counselor should be removed from her job title. This is consistent with the research literature suggesting that those who identify primarily as a guidance counselor are less likely to provide mental health services (Beckles, 2009). School psychologists in this study indicated that their training supported them in the role of mental health provider but that time constraints were the major barrier. Walsh (2013) found that school psychologists whose primary role was evaluation for special education eligibility,

engaged in less collaboration. For school psychologists, number of professional development hours in mental health was related to amount of time in collaboration (Walsh, 2013). For those with more than 10 hours of training, both communication and collaboration with community mental health increased. Increasing training opportunities for school professionals in youth mental health may be a way to increase collaboration. Additionally, school professionals suggested schools hire a school social worker whose job it would be to lead and manage these types of relationships (discussed further below).

Identifying leadership. Many school-based providers felt that leadership and communication issues could be addressed by hiring someone whose primary role it is to initiate and maintain collaboration and communication. School mental health providers suggested hiring a social worker at the school to manage the relationships with community organizations. Identifying leadership in the community may also help to avoid confusion given that school mental health professionals indicated that high levels of turnover within community mental health are a significant barrier to collaboration and communication. Concern about high turnover in community mental health is consistent with previous research (Mellin & Weist, 2011). Community organizations involved in collaborative partnerships may also look at improving retention by providing incentives for continuing with the organization to ensure that there is investment in school-community relations (Mellin & Weist, 2011). When changes are expected, communication about these changes from the community-based leader may help to support efforts to sustain relations.

Building a common agenda. Creating specific procedures and outlining a common agenda was identified by school-based providers as a way to ensure that schools and community organizations established rules and common goals. They also felt that it would be necessary to provide training to staff and establishing a culture of collaboration. One school counselor suggested that when community mental health providers come to school meetings they don't understand the role of the school and the focus on academics and educational issues, while another school counselor felt that for some students there was a conflict between academic goals and mental health goals. Community-employed therapists, in contrast, suggested that collaboration, whether they attend an IEP meeting or schools staff attend a CFT, was beneficial. They felt that it could be difficult to get school buy-in. School psychologists did not see the goals of school and community mental health as being very different while community mental health providers felt it was important to build common understanding and goals so that admin and school staff understood their role and could aid in making referrals for services. Community mental health providers also felt it was important for them to demonstrate understanding of the school's role. Specifically, they suggested having clear guidelines about when to see students and how to be respectful of teachers when pulling students. Developing a positive attitude toward one another's roles and a common understanding of the child's problems can help to facilitate collaboration (Odegard, 2005). Having a common language, a sense of commitment and accountability and greater interaction were also found to facilitate collaboration (Palinkas et al., 2014). Frequent meetings and ongoing

assessment of the collaborative process may help to keep community and school staff engaged.

Funding. Another concern noted by participants was that some children may be denied services that they need due to funding issues. Community providers in this study responded to concerns about denying children needed services and indicated that community organizations may be able to provide services on a sliding scale or lower fees for children who were not eligible for Medicaid. Funding to sustain mental health collaborative partnerships can come from Medicaid, private insurance, state health departments, fee-for services, nonprofit companies, community coalitions, grants, social services or mental health government organizations, and community funding sources (Klotz et al., 2015). Additionally, use of volunteers or use of interns through partnerships with university programs may help to sustain mental health service accessibility for students (Klontz et al., 2015).

Local funding sources are also an option. Sources may include child welfare, juvenile justice, health organizations, and school districts (Weist et al., 2003). However, one participant shared concerns that if schools and other public organization fund services in partnerships with private, for-profit agencies, that the effects could be harmful. Exogenous privatization utilizes the private, for-profit, sector to provide education services (Ball & Youdell, 2007). Contracting services for transportation, cleaning, food services and building maintenance are common practice for schools (Ball & Youdell, 2007). Most participants in this study felt that benefits outweighed the risks and that it was possible to put procedures in place to ward off any ill effects of such

relationships. Recently, federal, state and local governments have enacted policies that provide funding for charter schools, voucher programs and open enrollment to foster competition and innovation in academically underperforming areas (Roda & Wells, 2013). These policies can result in increased racial/ethnic segregation (Roda & Wells, 2013) and change the way education is managed, how curriculum is delivered and how performance is measured (Ball & Youdell, 2007). Identifying the benefits and risks of the specific policies and how they are implemented should be considered when analyzing outcomes of such policies.

Soliciting funds from private donors and private foundations may also be an option (Cammack, Brandt, Slade, Lever & Stephan, 2014). Coordinated care has been associated with reduced inpatient services by 42%, ER visits by 57%, juvenile arrests by 38%, retention rates, school dropout rates, and parent absences from work and increased parental employment (Stroul, Pires, Boyce, Krivelyova, & Walrath, 2014). One study participant noted that cost savings could be found in schools through fewer outplacements. Cost-benefit analyses across multiple systems can help support the need for integrated collaborative approaches to children's mental health.

Schools and communities may have to become increasingly creative in how they find and allocate financial resources in the current political climate where the Affordable Care Act is in danger of being repealed and replaced with a healthcare bill that significantly reduces funding to Medicaid and leaves mental health care benefits up to each state to decide (Grayson, Hurt, & Kodjak, 2017). Proposed changes in federal funding for education, expanding school choice, may result in decreased funding for

public schools in favor of public and private charter schools (U.S. DOE, 2017). Finally, the U.S. DHHS (2017) is anticipating $374,000,000 budget decrease, with reduced funding in community mental health, certain mental health programs, substance abuse prevention, health surveillance and program support. While children's service funding is proposed to remain unchanged, reduced funding for mental health services, substance abuse prevention, program support and monitoring of mental health needs is likely to have a negative impact on children and their families.

Collecting and sharing outcomes. Although it continues to be reported that the literature is scant in terms of student outcomes related to collaboration, the information that exists suggests that coordinating systems has been effective in improving school attendance and grades, decreasing emotional and behavioral problems, decreasing suicidality, lowering rates of substance abuse and reducing involvement with the juvenile justice system (Stroul et al., 2014). In low income, African-American populations, coordinated care was associated with better attendance and grades, fewer disciplinary referrals, less substance use, and reduced mental health symptoms (Mancoske, 2013). When at risk students access available mental health services in a school setting, academic outcomes improve (Walker et al., 2010). Community-based mental health directors in this study have identified the importance of collecting and sharing outcome data in order to continue to build relationships with school. They indicated a desire to conduct needs assessments, interview focus groups, use informant interviews and collect information on therapeutic and educational outcomes. These participants identified

sharing this information with state departments of mental health and education and local school districts as crucial for expanding their school-based program.

Theoretical Considerations

The systems of care model developed by SAMHSA out of a need to improve mental health services for children (Pumariega, Winters, & Huffine, 2003) continues to support collaboration as a worthwhile initiative. The establishment of the children's mental health initiative endeavored to improve access and comprehensive mental health treatment to children in need. Outcomes assessed as of 2013 suggest that children with services delivered under a systems of care approach improved their ability to develop relationships, manage emotions, improve functioning in schools (fewer suspensions and better grades) and at home, improved anxiety, and decreased suicide attempts and ideation (CMHS, SAMHSA, & DHHS, 2015).

Bronfenbrenner's ecology of human development is discussed earlier in this review and reappears here as a way of looking at how interactions between systems can affect the developing child (Bronfenbrenner, 1979; 1994). Adding to this, resilience is a theoretical construct from which collaboration in mental health can be viewed. Ungar, Ghazinour & Richter (2013) analyzed resilience in the context of Bronfenbrenner's ecology of human development and found it fitting. A social-ecological view of resilience emphasizes the role of systems in facilitating positive child development. This view looks at the adaptations needed in each system to support desired outcomes. At the micro level resilience is impacted by individual factors including; biology, personality, and temperament, but also the family, the neighborhood, school, and religious

organizations, of which the child is a part (Ungar et al., 2013). Making changes in any of these systems can affect the child's development and can impact the child's ability to be resilient. At the level of the mesosystem, resilience is an outcome of interactions between the microsystems to which the student belongs. When microsystems form complex interactions, they can exchange resources that enhance the growth of the child (Ungar et al., 2013). Little research has been done to examine the effect of intervention at this level on resilience. The exosystem is the social networks that indirectly affect the child, but that affect those in the child's microsystem or mesosystem (Bronfenbrenner, 1994; Ungar et al., 2013). Thus, increasing supports for parents; social supports, parent training, and support for working parents can positively impact children. Similarly, increasing supports for teachers; training in mental health, social supports, team building activities, supportive administrators, and well-trained support staff, can also have a positive impact on children's ability to be resilient. In the school system, having a well-developed character education plan and integrated collaborative mental health supports can positively affect not only the child but the other students who can affect the resilience of the child (Bronfenbrenner, 1994; Ungar et al., 2013). The macrosystem includes cultural factors and values that affect child development. This can include the impact of values transmission that occurs in subcultures. Thus, as criminal behavior or drug use is normative within the subculture, this can have an impact on the child's resilience. Families that reinforce adherence to the majority culture standards have children who are less likely to have problems with criminal behavior or drug use (Ungar et al., 2013). Finally, the chronosystem includes the impact of historical events and time on resilience.

Events such as the attacks on the World Trade Center and the Capital building on September 11, 2011 have a lasting impact on the macrosystem due to changes in public policies, legal and political platforms that in turn affect the exosystem, the mesosystem, and the microsystem, to impact resilience.

Finally, the current view of mental health is that mental health is not merely the absence of mental illness, but a positive sense of mental well-being (Antaramian et al., 2010; Herrman et al., 2005). Flourishing involves accentuating the positive by increasing positive emotions, improving emotional well-being, and increasing satisfaction and success in life (Keyes, 2007). Keyes (2007) noted that it was important that people have a sense of belonging and comfort within their community, that they engage in activities that are valued by others, and that they accept others. For teens, the indicators of flourishing include; psychological and social well-being, autonomy, environmental success, self-acceptance, personal growth, life purpose, and positive relationships (Keyes, 2006). Moderately mentally healthy teens have few mental problems but do not have characteristics of flourishing, while those who are languishing have mental health problems (Keyes, 2006). It is imperative to have systems in place for the identification of students with mental health problems as well as to identify those who are not flourishing, and therefore at-risk. Providing interventions for these children can improve their opportunity to thrive, improving lifelong outcomes. Mental health services may improve children's opportunity to achieve a state of well-being.

Implications for Social Change

Hess, Pearrow, Hazel, Sander, & Wille (2017) made the argument that school mental health is a public health issue and deserves the attention of the larger healthcare system. Healthcare has long been provided in the school system, yet this has gone unrecognized, despite carrying a price tag greater than $10 billion annually (Hess et al., 2017). In fact, mental health treatment is most often initiated in the school setting (Farmer et al., 2003). Efforts to expand mental health services in schools and to establish collaborative relationships with community mental health agencies can best be construed as a cry for help. Approaches to public health emphasize prevention, positive practices, widespread assessment, intervention, and comprehensive service delivery, which coincides well with a multitiered system of supports. Tier 1 of a multitiered system of support involves universal strategies appropriate for all students (Desrochers, 2014). Tier 2 includes targeted interventions for students at risk of mental health problems. Finally, Tier 3 involves intensive intervention for student currently experiencing mental health problems (Desrochers, 2014).

School psychologists, school counselors and school social workers are in a position to garner support for improved mental health support from school district and school building administrators. Universal, school-wide strategies and social emotional learning can be taught and implemented by teachers and school staff. When used as part of a multitiered system of support teachers implementing social emotional learning curricula to teach class wide strategies for social competence and resilience and positive behavioral interventions and supports, a schoolwide approach to teaching, modeling,

cueing, and reinforcing appropriate behavior either individually or together, resulted in improvements in student mental health functioning when compared with business as usual (Cook et al., 2015). For students at Tier 2, consultation and collaboration between school and community mental health providers can provide opportunities for more focused and targeted interventions for at-risk students, preventing more significant school and mental health problems from developing, while students at Tier 3 are likely to require more intensive behavior health supports (Hess et al., 2017). Within this model, collaborative relationships between school and community mental health are not just ideal, but necessary to provide the supports needed. A greater understanding of school mental health as a public mental health problems is needed.

Data obtained through this qualitative inquiry corroborates and extends previous research on collaboration. Problems with initiating and sustaining collaborative relationships among school and community mental health professionals continue to prevent worthwhile partnerships from improving children's ability to receive needed mental health services, despite a recognition of the benefits that these types of relationships. New information garnered from this study suggests that support for collaborative partnerships is expected to have the greatest effect when high level administrators at state departments of education and mental health and school district leadership champion the cause, implementing collaborative practices from a top-down approach. Additionally, many participants suggested that providing community mental health services within the school setting could eliminate barriers, improve access to services, and improve children's ability to build resilience to mental illness. By

intervening at the lowest levels of need, within the school setting, where children spend much of the day, it is possible to affect outcomes and improve children's wellbeing.

School and community mental health professionals involved in collaborative relationships are in a position to advocate for policies that can help to sustain collaborative practices. Eliminating barriers at the school level to reduce time constraints and role strain by identifying leaders to manage collaborative partnerships may help to improve the ability to apply school mental health in a multitiered system of support. School and community mental health professionals can help to conduct needs assessments and collect student outcome data to share with state and school level officials to identify and secure sources of funding. Resilience can be achieved in an ecological model when public policy changes encourage interaction among the systems to support children's mental health needs.

Limitations

The limitations for this study include difficulty with recruitment of community mental health providers. Although many community mental health agencies were contacted and offered the opportunity to participate in focus group or interviews, many these organizations and providers did not engage in collaboration with schools and did not feel that they had anything they could add to the discussion. Others indicated that they did not have time or were not willing to make time to participate in this research. Just six of the twenty participants were community-based mental health providers, and two of those participants were in a supervisory role and were not providing direct services to children. Two of the community participants were willing to participate in

more in depth follow up to ensure that as much information as possible could be obtained from the perspective of community-based mental health providers. It does appear that the information collected is sufficient for making some general interpretations.

A limitation among the school-based providers was recruiting participants in an administrative role. Only one of the fourteen school-employed mental health providers interviewed was in a supervisory role. School administrators contacted did not feel that they had enough experience with school-community collaboration, were not available to participate in focus groups, or were not interested in participating in the study.

Another possible limitation was gender. Of the twenty participants in this study, only 2 (10%) were male. None of the community-based providers were men. Women do tend to dominate the fields of community and school mental health. About 77% of school psychologists are women (Castillo, Curtis, & Gelley, 2013), 73% of counselors are women (Evans, 2010), and 77% of school counselors are women (Bridgeland & Bruce, 2011). A somewhat smaller percent of males participated in this study than is observed in these fields.

Another limitation is the somewhat small sample. Recruiting school-based mental health providers was relatively easy and they were generally willing to participate. Given the limited number of community-based mental health providers, it was determined that continuing to recruit school-based participants would skew the results. Additionally, when analyzing data, it became clear that saturation of the data had been reached. Participants' descriptions became repetitive and confirmed previously collected data.

Recommendations

School district and state mental health agencies should consider the results of this study. School professionals experience stress related to their inability to meet children's mental health needs. Community agencies in partnership with schools can identify needs early and reduce the level of risk management needed in the school setting. Reducing outplacements by minimizing children's level of behavioral difficulty can reduce costs and provide a source of funding for school districts to hire support staff whose role it is to initiate and sustain collaborative relationships. Adequate planning for early intervention at the highest levels can reduce costs for high needs students by eliminating the costs involved in high needs case management and reduce the need for services in multiple sectors.

Conclusions

Viewing school mental health as a public mental health issue and utilizing a multitiered systems of support approach to support the need for collaboration between school and community mental health may result in a program with an emphasis on prevention and promoting resilience. A systems of care approach to meet children's unmet mental health needs can be viewed through an ecological model of resiliency. According to Zimmerman (2013), a strengths-based approach to intervention supported by resiliency theory may be best to promote mental health in adolescents. Promotive factors include; individual factors or assets and supportive resources, including parents, other adults, and programs for learning and practicing skills (Zimmerman, 2013). Promotive factors or assets can mitigate the risk factors present in the adolescent's life.

As noted in the experiences of participants in this study, Lee et al. (2013) found that collaboration between systems for children with emotional disturbance helped to reduce the severity of problems and improved the child's ability to function. Parents also demonstrated increased competence in handling their child when systems collaborated with one another to support children (Lee et al., 2013). Weist et al. (2012) noted that mental health initiatives often get lost within the schools. Schools are held accountable for academic rather than mental health outcomes. Recognizing that barriers to student learning can be academic and nonacademic can be reduced by promoting student wellness can help mental health and wellness initiatives survive (Weist et al., 2012). Developing relationships among school and community professionals to support children's mental health is necessary in order to understand the resources available within the community and to develop partnerships to increase the coordination of services.

Within the literature are numerous suggestions for improving the process of collaboration. The results of this study are consistent with those recommendations. To increase coordination of services among school and community mental health professionals, organizational supports may be needed. IEP team meetings, CST meetings and CFT meetings are effective ways to stay in communication and to coordinate care (Weist et al., 2012). Collaborative team member should include school and community employed mental health staff, educators, health staff (school and community), family members and family advocates (Weist et al., 2012). They should meet regularly and choose a leader to facilitate meetings. Evaluating the team's work should occur regularly. Policies and procedures and services offered should be outlined in a written agreement

(Weist et al., 2012). Community mental health staff involve parents as much as possible in the child's mental health services. Approaches to resilience that strengthen the family can be very effective in improving the functioning of individual and the family (Walsh, 2002). Community mental health staff may be able to help promote resilience not just within the student, but for the entire family (Walsh, 2002).

Browne, Gafni, Roberts, Byrne, & Majumdar (2004) concluded that that school-based services provide easy access and encourage participation while community programs provide a greater opportunity for confidentiality but reach a smaller number of children. Confidentiality issues can be reduced by obtaining a release of information from the family (Weist, et al, 2012). When mental health services are available in a school health center, accessibility is improved and barriers to services are eliminated (Bains & Diallo, 2016). Building collaborative partnerships in which community mental health services are available within the school setting, as part of a multitiered system of support, within a larger public health model is necessary to promote resilience, and is achievable when adequate supports for the collaborative process are in place.

References

Acri, M. C., & Hoagwood, K. E. (2014). Addressing parental mental health within interventions for children: A review. *Research on Social Work Practice*. Published online before print August 11, 2014. doi:10.1177/1049731514546027

Alegria, M., Lin, J. Y., Green, J. G., Sampson, N. A., Gruber, M. J., & Kessler, R. (2012). Role of referrals in mental health service disparities for racial and ethnic minority youth. *Journal of the American Academy of Child and Adolescent Psychiatry, 51*(7), 703-711. doi:10.1016/j.jaac.2012.05.005

Alexandre, P. K., Dowling, K., Stephens, R. M., Laris, A. S., & Rely, K. (2008). Predictors of outpatient mental health service use by American youth. *Psychological Services, 5*(3), 251-261.

Amrock, S. M, & Weitzman, M. (2014). Parental psychological distress and children's mental health: Results of a national survey. *American Pediatrics, 14*(4), 375-381. doi:10.1016/j.acap.2014.02.005

Antaramian, S. P., Huebner, E. S., Hills, K. J., & Valois, R. F. (2010). Dual-factor model of mental health: Toward a more comprehensive understanding of youth functioning. *American Journal of Orthopsychiatry, 80*(4), 462-472.

Armbruster, P., & Lichtman, J. (1999). Are school based mental health services effective? Evidence from 36 inner city schools. *Community Mental Health, 35*(6), 493-504.

Bailey, A. M. (2005). School-based mental health providers: Characteristics, tasks and job responsibilities (Doctoral dissertation). *Dissertation Abstracts International Section A: Humanities and Social Sciences, 65*(10-A), 3988.

Bains, R. M., & Diallo, A. F. (2016). Mental health services in school-based health centers: Systematic review. *Journal of School Nursing, 32*(1), 8-19. doi:10.1177/1059840515590607

Ball, A., Iachini, A. L., Bohnenkamp, J. H., Togno, N. M., Brown, E. L., Hoffman, J. A., & George, M. W. (2016). School mental health content in state in-service K-12 teaching standards in the United States. *Teaching and Teacher Education, 60,* 312-320.

Ball, S. J. & Youdell, D. (2007). *Hidden privatisation in public education*. London, England: Education International.

Beckles, J. N. T. (2009). *Middle school counselors' perceptions of the experiences of juvenile delinquents with school-based mental health services* (Doctoral dissertation). Riverside, CA: La Sierra University.

Bickman, L., Lambert, E. W., Andrade, A. R., & Penaloza, R. V. (2000). The Fort Bragg continuum of care for children and adolescents: Mental health outcomes over 5 years. *Journal of Consulting and Clinical Psychology, 68*(4), 710-716.

Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2009). The phenomenological focus group: An oxymoron? *Journal of Advanced Nursing, 65*(3), 663-671. doi:10.1111/j.1365-2648.2008.04922.x

Brannan, A. M., Brashears, F., Gyamfi, P., & Manteuffel, B. (2012). Implementation and development of federally-funded systems of care over time. *American Journal of Community Psychology, 49,* 467-482. doi:10.1007/s10464-011-9472-8

Brener, N. D., Weist, M., Adelman, H., Taylor, L., & Vernon-Smiley, M. (2007). Mental health and social services: Results from the school health policy and programs study 2006. *Journal of School Health, 77*(8), 486-489.

Bridgeland, J., & Bruce, M. (2011). *2011 national survey of school counselors: Counseling at a crossroads*. New York, NY: College Board.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1994). Ecological models of human development. *In T. Husen & T. N. Postlethwaite (Eds.). International encyclopedia of education, Vol. 3* (2nd ed., pp. 1643–1647). Oxford, England: Elsevier.

Brown, C., Dahlbeck, D. T., & Sparkman-Barnes, L. (2006). Collaborative relationships: School counselors and non-school mental health professionals working together to improve the mental health needs of students. *Professional School Counseling, 9*(4), 332-335.

Browne, G., Gafni, A., Roberts, J., Byrne, C., & Majumdar, B. (2004). Effective/efficient mental health programs for school-age children: A synthesis of reviews. *Social Science & Medicine, 58,* 1367-1384. doi:10.1016/S0277-9536(03)00332-0

Bryan, J., & Henry, L. M. (2012). A model for building school-family-community partnerships: Principles and process. *Journal of Counseling and Development, 90*, 408-420.

Burton, C. M., Marshal, M. P., & Chisolm, D. J. (2014). School absenteeism and mental health among sexual minority youth and heterosexual youth. *Journal of School Psychology, 52,* 37-47.

Burton, D. L. (2013). *School mental health: Views of services integration and attitudes toward evidence-based practice among multiple levels of school personnel* (Doctoral Dissertation). Retrieved from ProQuest (UMI Number 3590277).

Cammack, N. L., Brandt, N. E., Slade, E., Lever, N. A., & Stephan, S. (2014). *In M. D. Weist, N. A. Lever, C. P. Bradshaw, & J. S. Owens (Eds.). Handbook of school mental health: Research, training, practice & policy (2nd ed.).* New York, NY: Springer

Caparelli, S. M. (2012). *School leadership and school mental health: An exploratory study of SMH content in the preparation of principals* (Doctoral Dissertation). Retrieved from ProQuest. (UMI Number 3532779).

Castillo, J. M., Curtis, M. J., & Gelley, C. D. (2013). Gender and race in school psychology. *School Psychology Review, 42*(3), 262-279.

Centers for Disease Control and Prevention (2013). *Mental health surveillance among children-United States, 2005-2011*. Atlanta, GA: Author.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, & U.S. Department of Health and Human Services. (2013). *Comprehensive community mental health services for children and their families. Evaluation findings: Annual report to congress 2011.* Rockville, MD: Author.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, & U.S. Department of Health and Human Services. (2015). *Comprehensive community mental health services for children with serious emotional disturbance. Evaluation findings: Report to congress 2012-2013.* Rockville, MD: Author.

Chandra, A., & Minkovits, C. S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health, 38(6)*, 754.e1–754.e8.

Cook, C. R., Frye, M., Slemrod, T., Lyon, A. R., Renshaw, T. L., & Zhang, Y. (2015). An integrated approach to universal prevention: Independent and combined effects of PBIS and SEL on youth's mental health. *School Psychology Quarterly, 30*(2), 166-183.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches (3rd ed.)*. Thousand Oaks, CA: Sage Publications, Inc.

Cross, A. Y. (2013). *School Psychologists' report of school-based mental health service programs across Pennsylvania school systems* (Doctoral Dissertation). Retrieved from ProQuest. (UMI Number 3604278).

Cummings, J. R., Ponce, N. A., & Mays, V. M. (2010). Comparing racial/ethnic differences in mental health service use among high-need subpopulations across clinical and school-based settings. *Journal of Adolescent health, 46*, 603-606.

Cummings, J. R., Wen, H., & Druss, B. G. (2013). Improving access to mental health services for youth in the United States. *Journal of the American Medical Association, 209*(6), 553-554. doi:10.1001/jama.2013.437

Darlington, Y., Feeney, J. A., & Rixon, K. (2005). Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers. *Child Abuse & Neglect, 29*, 1085-1098.

Demissie, Z., Parker, J. T., & Vernon-Smiley, M. (2012). Mental health and social services. *In Results from the school health policies and practices study 2012*. Atlanta, GA: Centers for Disease Control and Prevention.

DeRigne, L. (2010). What are the parent-reported reasons for unmet mental health needs in children? *Health & Social Work, 35*(1), 7-15.

Desrochers, J. E. (2014). The best mental health programs start with all students. *Learning and Mental Health, 96*(4), 34-39.

Douglas, L. S. (2001*). A study of mental health collaboration in Colorado's schools* (Doctoral Dissertation). Retrieved from ProQuest (UMI Number 9999871)

Duchnowski, A. J., & Kutash, K. (2011). School reform and mental health services for students with emotional disturbances educated in urban schools. *Education and Treatment of Children, 34*(3), 323-346.

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*(1), 405-432.

Evans, M. (2010). Men largely MIA from counseling. Retrieved from https://ct.counseling.org/2010/08/men-largely-mia-from-counseling/

Evans, S. W., Koch, J. R., Brady, C., Meszaros, P., & Sadler, J. (2012). Community and school mental health professionals' knowledge and use of evidence based substance use prevention programs. *Administration and Policy in Mental Health, 40*, 319-330. doi: 10.1007/s10488-012-422-z

Everts, J. C. (2011). *Minneapolis public schools expanded school mental health program: Outcomes from the first four years* (Doctoral Dissertation). Retrieved from ProQuest (UMI Number 3457064).

ESSA (2015). *Every student succeeds act of 2015*, Pub. L. No. 114-95 § 114 Stat. 1177 (2015-2016).

Farmer, E. M., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services, 54(1),* 60–66

Flanagan, R., Allen, K., Henry, D. J. (2009). The impact of anger management treatment and rational emotive behavior therapy in a public school setting on social skills, anger management, and depression. *Journal of Rational-Emotive Cognitive-Behavioral Therapy, 28*, 87-99.

Forest, C. B., Bevans, K. B., Riley, A. W., Crespo, R., & Louis, T. A. (2011). School outcomes of children with special health care needs. *Pediatrics, 128*, 303-312.

Gadomski, A. M., Fothergill, K. E., Larson, S., Wissow, L. S., Winegrad, H., Nagykaldi, Z. J., ... Roter, D. L. (2015). Integrating mental health into adolescent annual visits: Impact of previsit comprehensive screening on within-visit processes. *Journal of Adolescent Health, 56*, 267-273.

Garcia, A. R., Circo, E., DeNard, C., & Hernandez, N. (2015, in press). Barriers and facilitators to delivering effective mental health practice strategies for youth and families served by the child welfare system. *Children and Youth Services Review*. doi: 10.1016/j.childyouth.2015.03.008

Garland, A. F., Haine-Schlagel, R., Brookman-Frazee, L., Baker-Ericzen, M., Trask, E., & Fawley-King, K. (2013). Improving community-based mental health care for children: Translating knowledge into action. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(1), 6-22. doi:10.1007/s10488-012-0450-8

Grayson, G., Hurt, A., & Kodjak, (2017). Chart: Who wins, who loses with senate health care bill. Retrieved from http://www.npr.org/sections/health-shots/2017/06/22/533942041/who-wins-who-loses-with-senate-health-care-bill.

Green, J. G., McLaughlin, K. A., Alegria, M., Costello, J., Gruber, M. J., Hoagwood, K., ... Kessler, R. C. (2013). School mental health resources and adolescent mental health service use. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*(5), 501-510.

Hamner, K. M., Lambert, E. W., & Bickman, L (1997). Children's mental health in a continuum of care: Clinical outcomes at 18 months for the Fort Bragg demonstration. *The Journal of Behavioral Health Services & Research, 24*(4), 465-471.

Heneghan, A., Stein, R. E. K., Hurlburt, M. S., Zhang, J., Rolls-Reutz, J., Kerker, B. D., ...Horwitz, S. M. (2015). Health-risk behaviors in teens investigated by U.S. child welfare agencies. *Journal of Adolescent Health, 56*, 508-514.

Herrman, H., Saxena, S., & Moodie, R. (2005). *Promoting mental health: Concepts, emerging evidence, practice.* Geneva, Switzerland: World Health Organization.

Hess, R. S., Pearrow, M., Hazel, C. E., Sander, J. B., & Wille, A. M. (2017). Enhancing the behavioral and mental health services within school-based contexts. *Journal of Applied School Psychology, 33*(3), 214-232.

Hodges, S., Ferreira, K., & Israel, N. (2012). 'If we're going to change things, it has to be systemic:' Systems change in children's mental health. *American Journal of Community Psychology, 49*(3-4), 526-537. doi:10.1007/s10464-012-9491-0

Howell, E. M., & Teich, J. (2008). Variations in Medicaid mental health service use and cost for children. *Administration and Policy in Mental Health, 35,* 220-228.

Hudson, B. (2002). Interprofessionality in health and social care: the Achilles' heel of partnership? *Journal of Interprofessional Care, 16*(1), 7-17.

Hughes, C. M., & McCann, S. (2003). Perceived Interprofessional barriers between community pharmacists and general practitioners: a qualitative assessment. *British Journal of General Practice, 53*, 600-606.

Husky, M. M., Kamplan, A., McGuire, L., Flynn, L., Chrostowski, C., & Olfson, M. (2011). Identifying adolescents at risk through voluntary school-based mental health screening. *Journal of Adolescence, 34*, 505-511.

IDEA (2004). Individuals with Disabilities Education Act, 20 U.S.C. § 1400 (2004).

Jennings, J., Pearson, G., & Harris, M. (2000). Implementing and maintaining school-based mental health services in a large, urban school district. *Journal of School Health, 70*(5), 201-205.

Jorm, A. F., Kitchener, B. A., Sawyer, M. G., Scales, H., Cvetkovski, S. (2010). Mental health first aid training for high school teachers: A cluster randomized trial. *BMC Psychiatry, 10*(51), 1-12.

Kastan, J. (2003). School-based mental health program development: A case study of interorganizational collaboration. *Journal of Health Politics, Policy and Law, 25*(5), 845-862.

Keyes, C. L. M., (2006). Mental health in adolescence: Is America's youth flourishing? *American Journal of Orthopsychiatry, 76* (3), 395-402.

Keyes, C. M. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist, 62*(2), 95-108. doi:10.1037/0003-066X.62.2.95

Kindall, A. E. (2009). *School based mental health service modalities and program effectiveness* (Doctoral Dissertation). Retrieved from ProQuest (UMI Number 3357433).

King, N., & Ross, A. (2003). Professional identities and interprofessional relations: Evaluation of collaborative community schemes. *Social Work in Health Care, 38*(2), 51-72.

Klontz, B. T., Bivens, A., Michels, S., DeLeon, P. H., & Tom, L. (2015). The Mokihana program: The effectiveness of an integrated Department of Education and Department of Health school-based behavioral health approach. *Psychological Services, 12*(2), 101-111.

Kodjo, C. M., & Auinger, P. (2004). Predictors for emotionally distressed adolescents to receive mental health care. *Journal of Adolescent Health, 35*, 368-373.

Krueger, R. A. & Casey, M. A. (2015). *Focus groups: A practical guide for applied research (5th ed.).* Los Angeles, CA: Sage Publications, Inc.

Kvarnstrom, S. (2008). Difficulties in collaboration: A critical incident study of Interprofessional healthcare teamwork. *Journal of Interprofessional Care, 22*(2), 191-203.

LaFee, S. (2013). The school's role in students' mental health. *School Administrator, 7*(10), 24-30.

Langley, A. K., Nadeem, E., Kataoka, S. H., Stein, B. D., & Jaycox, L. H. (2010). Evidenced-based mental health programs in schools: Barriers and facilitators of successful implementation. *School Mental Health, 2*, 105-113.

Lewis, A. D., Huebner, E. S., Reschly, A.L., & Valois, R. F. (2009). The incremental validity of positive emotions in predicting school functioning. *Journal of Psychoeducational Assessment, 27*, 397-408. doi:10.1177/0734282908330571

Lingard, L., Espin, S. Evans, C., & Hawryluck, L (2004). The rules of the game: Interprofessional collaboration on the intensive care unit team. *Critical Care, 8*(6), R403-R408.

Livingston, J. D., Tugwell, A., Korf-Uzan, K., Cianfrone, M., & Coniglio, C. (2013). Evaluation of a campaign to improve awareness and attitudes of young people towards mental health issues. *Social Psychiatry and Psychiatric Epidemiology, 48*, 965-973.

Massey, O. T., Armstrong, K., Boroughs, M., Henson, K., & McCash, L. (2005). Mental health services in schools: A qualitative analysis of challenges to implementation, operation and sustainability. *Psychology in the Schools, 42*(4), 361-372.

Mancoske, R. J. (2013). Cultural competency, children's mental health, and school performance. *Race, Gender & Class, 20*(1-2), 307-325.

Mattessich, P. W., & Monsey, B. R., (1992). *Collaboration: What makes it work*. Saint Paul, MN: Amherst H. Wilder Foundation.

McLafferty, I., (2004). Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing, 48*(2), 187-194.

McLeod, J. D., Uemura, R., & Rohrman, S. (2012). Adolescent mental health, behavior problems and academic achievement. *Journal of Health and Social Behavior, 53*(4), 482-497. doi:10.1177/0022146512462888

Mellin, E. A., Belknap, E. E., Brodie, I. L., & Sholes, K. (2015). Opening school doors to communities and families: A social capital perspective for multiparity collaboration. *Journal for Social Action in Counseling and Psychology, 7*(1), 1-18.

Mellin, E. A., Bronstein, L., Anderson-Butcher, D., Amorose, A. J., Ball, A. & Green, J. (2010). Measuring Interprofessional team collaboration in expanded school mental health: Model refinement and scale development. *Journal of Interprofessional Care, 24*(5), 514-523.

Mellin, E. A., Taylor, L., & Weist, M. D. (2013). The expanded school mental health collaboration instrument [school version]: Development and initial psychometrics. *School Mental Health, 6*(3), 151-162.

Mellin, E. A., & Weist, M. D. (2011). Exploring school mental health collaboration in an urban community: A social capital perspective. *School Mental Health, 3*(2), 81-92. doi:10.1007/s12310-011-9049-6

Mendenhall, A. N., & Frauenholtz, S. (2014). System of care development in children's mental health: Lessons learned from a process evaluation. *Journal of Child and Family Studies, 23*, 157-168.

Merikangas, K. R, He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S.

adolescents: Results from the national comorbidity survey – adolescent supplement (NCS-A). *Journal of the American Academy of Child Adolescent Psychiatry, 49*(10), 980-989).

Merikangas, K. R., He, J. P., Burstein, M., Swendsen, J., Avenevoli , S., Case, B., Georgiades, K., Heaton, L., Swanson, S., & Olfson, M. (2011). Service utilization for lifetime mental disorders in U.S. adolescents: Results of the national comorbidity survey-adolescent supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry, 50*(1), pp 32-45.

Michael, K. D., Bernstein, S., Owens, J. S., Albright, A., & Anderson-Butcher, D. (2014). Preparing school mental health professionals: Competencies in Interdisciplinary and cross-system collaboration. *In M. D. Weist, N. A. Lever, C. P. Bradshaw, & J. S. Owens (Eds.). Handbook of School Mental Health: Research, Training, Practice & Policy (2nd ed.).* New York, NY: Springer

Miller, B. D., Blau, G. M., Christopher, O. T., & Jordan, P. E. (2012). Sustaining and expanding systems of care to provide mental health services for children, youth and families across America. *American Journal of Community Psychology, 49*(3-4), 566-579. doi:10.1007/s10464-012-9517-7

Moon, J., Williford, A., & Mendenhall, A. (2017). Educators' perceptions of youth mental health: Implications for training and promotion of mental health services in schools. *Children and Youth Services Review, 73,* 384-391.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage Publications, Inc.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: transforming mental health care in America. Final report.* Rockville, MD: Department of Health and Human Services.

Odegard, A. (2005). Perceptions of interprofessional collaboration in relation to children with mental health problems: A pilot study. *Journal of Interprofessional Care, 19*(4), 347-357.

Odegard, A. (2006). Exploring perceptions of Interprofessional collaboration in child mental health care. *International Journal of Integrated Care, 6*(18), 1-18.

Odegard, A. & Strype, J. (2009). Perceptions of interprofessional collaboration within child mental health care in Norway. *Journal of Interprofessional Care, 23*(3), 286-296.

O'Mara, L., Akhtar-Danesh, N., Browne, G., Mueller, D., Grypstra, L., Vrkljan, C., & Powell, M (2013). Does youth net decrease mental illness stigma in high school students? *Canadian Journal of Community Mental Health, 32*(4), 9-22.

Palinkas, L. A., Fuentes, D., Finno, M., Garcia, A. R., Holloway, I. W., & Chamberlain, P. (2014). Inter-organizational collaboration in the implementation of evidence-based practices among public agencies serving abused and neglected youth. *Administration and Policy in Mental Health and Mental Health Services Research, 41*, 74-85.

Pumariega, A. J., Winters, N. C., & Huffine, C. (2003). The evolution of systems of care for children's mental health: Forty years of community child and adolescent psychiatry. *Community Mental Health Journal, 39*(5), 399-425.

Roda, A., & Wells, A. S. (2013). School choice policies and racial segregation: Where white parents' good intentions, anxiety and privilege collide. *American Journal of Education, 119*(2), 261-293.

Sargeant, J., Loney, E., & Murphy, G. (2008). Effective Interprofessional teams: "Contact is not enough" to build a team. *Journal of Continuing Education in the Health Professions, 28*(4), 228-234.

Sebian, J., Mettrick, J., Weiss, C., Stephan, S., Lever, N., & Weist, M. (2007). *Education and System-of-Care Approaches: Solutions for Educators and School Mental Health Professionals.* Baltimore, MD: Center for School Mental Health Analysis and Action.

Sim, J. (1998). Collecting and analysing qualitative data: Issues raised by the focus group. *Journal of Advanced Nursing, 28*(2), 345-352.

Slade, E. P. (2002). Effects of school-based mental health programs on mental health service use by adolescents at school and in the community. *Mental Health Services Research, 4*(3), 151-166.

Soleimanpour, S., Geierstanger, S. P., Kaller, S., McCarter, V., & Brindis, C. D. (2010). The role and value of school-based health care. *American Journal of Public Health, 100*(9), pp 1597-1603.

Srikala, B., & Kumar, K. K. V. (2010). Empowering adolescents with life skills education in schools - School mental health program: Vidas it work? *Indian Journal of Psychiatry, 52*(4), 344-349.

Stevens, G. D. (2006). Gradients in the health status and developmental risks of young children: The combined influences of multiple social risk factors. *Maternal and Child Health Journal, 10*(2), 187-199.

Stevens, M., Roberts, H., & Shiell, A. (2010). Research review: Economic evidence for interventions in children's social care: revisiting the what works for children project. *Child & Family Social Work, 15*, 145-154.

Stroul, B. A., Pires, S. A., Boyce, S., Krivelyova, A., & Walrath, C. (2014). *Return on Investment in Systems of Care for Children with Behavioral Health Challenges.* Washington, DC: National Technical Assistance Center for Children's Mental Health.

Suldo, S. M., Friedrich, A. L., & Michalowski, J. (2010). Personal and systems-level factors that limit and facilitate school psychologists' involvement in school-based mental health services. *Psychology in the Schools, 47*(4), 354-373.

Thoits, P. A. (2011). Resisting the stigma of mental illness. *Social Psychology Quarterly, 74*(1), 6-28. doi:10.1177/0190272511398019

Tegethoff, M., Stalujanis, E., Belardi, A., & Meinlschmidt, G. (2014). School mental health services: Signpost for the out-of-school service utilization in adolescents with mental disorders? A nationally representative United States cohort. *PLOS One, 9*(6), 1-8.

Ungar, M., Ghazinour, M., & Richter, J. (2013). Annual research review: What is resilience within the social ecology of human development? *Journal of Child Psychology and Psychiatry, 54*(4), 348-366.

U.S. Department of Education (2017). Fiscal Year 2018 Budget: Summary and Background Information. Retrieved from https://www2.ed.gov/about/overview/budget/budget18/summary/18summary.pdf

U.S. Department of Health and Human Services (2000). *Report of the surgeon general's conference on children's mental health: A national action agenda.* Washington, DC: Author.

U.S. Department of Health and Human Services & U.S. Department of Education (2008). Joint guidance on the application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to student health records. Retrieved from https://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf

U.S. Department of Health and Human Services (2017). HHS FY2018 Budget in Brief- SAMHSA. Retrieved from https://www.hhs.gov/about/budget/fy2018/budget-in-brief/samhsa/index.html

Vaida, S., Kallay, E., Opre, A. (2008). Counseling in schools. A rational emotive behavior therapy (REBT) based intervention- A pilot study. *Cognition, Brain, Behavior, 12*, 57 - 69.

Walker, S. C., Kerns, S. E. U., Lyon, A. R., Bruns, E. J., & Cosgrove, T. J. (2010). Impact of school-based health center use on academic outcomes. *Journal of Adolescent Health, 46*, 251-257.

Walsh, A. S. (2013). *Interdisciplinary collaboration for youth mental health: A national study [Doctoral Dissertation].* ProQuest. UMI: 3557785.

Walsh, F. (2002). A family resilience framework: Innovative practice applications. *Family Relations, 51*(2), 130-138. doi:10.1111/j.1741-3729.2002.00130.x

Watt, B. D. & Dadds, M. R. (2007). Facilitating treatment attendance in child and adolescent mental health services: A community study. *Clinical Child and Adolescent Psychology and Psychiatry, 12,* 105-116. doi:10.1177/1359104507071089

Weist, M. D., Goldstein, J., Evans, S. W., Lever, N. A., Axelrod, J., Schreters, R., & Pruitt, D. (2003). Funding a full continuum of mental health promotion and intervention programs in the schools. *Journal of Adolescent Health, 32*(S), 70-78.

Weist, M. D., Mellin, E. A., Chambers, K. L., Lever, N. A., Haber, D., & Blaber, C. (2012). Challenges to collaboration in school mental health. *Journal of School Health, 82*, 97-105.

Zimmerman, M. A. (2013). Resilience Theory: A strengths-based approach to research and practice for adolescent health. *Health Education & Behavior, 40*(4): 381–383. doi:10.1177/1090198113493782

Appendix A: Letters

Letter to Organization

Date:
Name of Organization
Address

My name is Holly Curran and I am a doctoral candidate at Walden University. I am conducting dissertation research on the factors that limit and facilitate school and community collaboration in the provision of mental health services for children. There have been numerous studies of interprofessional collaboration. What is not known are the factors that are specific to initiating and sustaining collaboration among mental health professionals in school and community settings. This research will provide insight into the experiences of mental health professionals working in both school and community settings. This study is not being conducted by your organization and has not been endorsed by your organization. Rather, I am interested in recruiting mental health professionals who are willing to participate voluntarily in this study.

Your assistance in conducting this research is requested. If willing, you will simply pass along the enclosed “letter to potential participants” to mental health professionals and administrators in your organization. Passing along this information to mental health professionals and administrators within your organization will provide an opportunity for professionals who are interested in participating voluntarily in this study to contact me and express their interest. Specifically, I am interested in working with administrators, counselors, psychologists and social workers. Once they contact me, I will provide additional details about this study. Professionals appropriate for participation in this study include agency administrators, licensed psychologists, licensed counselors or licensed social workers or school administrators, school psychologists, school counselors or school social workers. The potential participants are free to choose whether or not to participate and can discontinue participation at any time. Information provided by the participants will be kept strictly confidential.

I would welcome a telephone call from you to discuss any questions your organization may have concerning this study. I can be reached at (XXX) XXX-XXXX, or emailed at XXX.XXXX@waldenu.edu.

Sincerely,

Holly Curran
Doctoral Candidate
Walden University

Letter to Potential Participants

My name is Holly Curran and I am a doctoral candidate at Walden University. I am conducting dissertation research on the factors that limit and facilitate school and community collaboration in the provision of mental health services for children. There have been numerous studies of interprofessional collaboration. What is not known are the factors that are specific to initiating and sustaining collaboration among mental health professionals in school and community settings. This research will provide insight into the experiences of mental health professionals working in both school and community settings. This study is not being conducted by and has not been endorsed by your organization. Rather, I am interested in recruiting mental health professionals who are willing to participate voluntarily in this study.

I realize that your time is important and I appreciate your consideration to become a participant in this study. In order to fully understand your experiences, you would participate in a focus group with other professionals in the school or community setting for approximately one hour. Some of the specific questions that will be asked include:

- What are the factors that may facilitate the initiation of collaborative relationships, outside of program requirements or mandates in the provision of services to children?
- What collaborative experiences have you have with members of the mental health profession in the school or community setting in the provision of mental health services to children?
- How can the barriers to collaboration be overcome to increase the development of collaborative relationships?
- What differences exist between how school and community based mental health service providers view collaboration in serving children with mental health needs?

Focus Groups will be held at XXXXXXX XXXXXX. You will not be required to do anything you don't feel comfortable doing. Given the voluntary nature of your participation, you may withdraw your consent for participation at any time before, during or after your scheduled focus group. All information gathered during our meetings will be kept strictly confidential.

Please contact me at your earliest convenience to complete a preliminary screening to determine if you are a candidate for participation. If you meet the criteria for participation, we will then schedule a date and time that is convenient for you. My telephone number is (XXX) XXX-XXXX. You can also email me at XXX.XXXX@waldenu.edu. I look forward to hearing from you.

Holly Curran
Doctoral Candidate
Walden University

Appendix B: Focus Group/Interview Protocol

Date:____________________________

Location:_________________________

Guiding Questions

1. What are the factors that may facilitate the initiation of collaborative relationships, outside of program requirements or mandates in the provision of services to children?

2. What collaborative experiences have you have with members of the mental health profession in the school or community setting in the provision of mental health services to children?

3. What situations have influenced your experiences of this collaboration?

4. What factors have you experienced that limit collaboration between school and community mental health providers?

5. How can the barriers to collaboration be overcome to increase the development of collaborative relationships?

6. What differences exist between how school and community based mental health service providers view collaboration in serving children with mental health needs?

7. What differences exist between how service providers and administrators view collaboration in serving children with mental health needs?

8. What are the benefits of community and school mental health professionals engaging in collaborative efforts for children?

Appendix C: Phone Screening Protocol

1. What is your highest degree?
2. What is your current age?
3. What is your current position?
4. Do you work with and/or service children?
5. Have you ever collaborated with a client or students school or community mental health service provider?
6. Are you available to participate in a focus group designed to discuss collaboration between school and community mental health providers?
7. Would you be willing to be videotaped or audiotaped as part of your participation in the focus group? The purpose of this would be to improve our accuracy in recording your experiences with collaboration.