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Education's Role In A System Of Care For Children And Youth With Emotional/Behavioral Challenges: A Mixed Methods Evaluation

Lauryn Young
University of South Carolina

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EDUCATION'S ROLE IN A SYSTEM OF CARE FOR CHILDREN AND YOUTH WITH
EMOTIONAL/BEHAVIORAL CHALLENGES: A MIXED METHODS EVALUATION

by

Lauryn Young

Bachelor of Science
Florida International University, 2012

Master of Arts
University of South Carolina, 2016

Submitted in Partial Fulfillment of the Requirements

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College of Arts and Sciences

University of South Carolina

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Accepted by:

Mark Weist, Major Professor

Kimberly Hills, Committee Member

Cheri Shapiro, Committee Member

Joni Splett, Committee Member

Cheryl L. Addy, Vice Provost and Dean of the Graduate School

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ABSTRACT

Students with more severe emotional/behavioral (EB) challenges have many problems in the school environment and subsequently have significant difficulty making adjustments later in adulthood. Coordinated care systems, such as local system of care (SOC) initiatives, were established in response to a call for reform in youth mental health services as research began highlighting the need for improved access and quality of mental and behavioral services for youth. However, even in communities where SOC initiatives are operating well, school involvement is usually marginal. Therefore, the current study aimed to evaluate education's role in one SOC for children and youth with EB challenges in order to systematically evaluate stakeholder perspectives on a SOC collaboration, specifically the Children's Behavioral Health Collaborative (CBHC) in Palm Beach, FL. A mixed methods exploratory sequential design was used to investigate study aims, which included a focus group, key stakeholder interviews, and a survey. Results suggest that collaboration efforts have been evolving, but the quality and quantity of communication and level of partnership varies by stakeholder and between education/schools and community agencies. Stakeholder perspectives on the CBHC were positive, yet stakeholders identified systematic and interpersonal barriers that could be targeted for quality improvement. provided by stakeholders, with results indicating the top two recommendations as follows: secure additional funding to support existing staff, initiatives, and programming and educate school staff and students on mental and behavioral health. Future directions and implications of results are discussed.

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LIST OF ABBREVIATIONS

ACE.....	Adverse Childhood Experiences Study
ADHD.....	Attention Hyperactivity Disorder
CBHC.....	The Children’s Behavioral Health Collaborative
CD.....	Conduct Disorder
CDC.....	Centers for Disease Control and Prevention
DOE.....	Department of Education
DOJ.....	Department of Justice
DSM.....	Diagnostic and Statistical Manual of Mental Disorders
EB.....	Emotional/Behavioral
ED.....	Emotional Disturbance/Disorder
GTO.....	Getting to Outcomes
IEP.....	Individual Education Plan
ISF.....	The Interactive Systems Framework
LEA.....	Local Educational Agencies
MST.....	Multisystemic Therapy
NCMHJJ.....	The National Center for Mental Health and Juvenile Justice
ODD.....	Oppositional Defiant Disorder
SOC.....	System of Care
SPED.....	Special Education

CHAPTER I

INTRODUCTION

Youth with Emotional and Behavioral Problems

How youth with serious EB problems are defined and identified in the research literature varies from study to study. The literature documents three primary definitions of youth with EB problems. Youth can receive an educational special education (SPED) classification of an Emotional Disturbance/Disorder (ED), a clinical diagnosis of an emotional or behavioral disorder by a clinician using the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM-5*) (American Psychiatric Association, 2013), and/or be identified as a student with severe emotional/behavioral problems as rated by teacher, parent, and/or self-report by a valid and reliable psychological measurement instrument for research study purposes.

Within the educational system, in general, youth with more serious EB problems may qualify as a student with an emotional disorder under SPED. The U.S Department of Education: Individuals with Disabilities Education Act (IDEA) (2004) defines ED as a disorder that negatively interferes with educational achievement due to one or more of the following criteria: “(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors, (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers, (C) Inappropriate types of behavior or feelings under normal circumstances, (D) A general pervasive mood of unhappiness or

depression, or (E) a tendency to develop physical symptoms or fears associated with personal or school problems” (U.S Department of Education, 2016).

DSM-5 clinical diagnoses may also be considered when students present with EB problems (American Psychiatric Association, 2013). These youth may receive the following clinical diagnoses: attention hyperactivity disorder (ADHD), conduct disorder (CD), oppositional defiant disorder (ODD), anxiety, depression, or bipolar disorder. Characteristics of EB problems include antisocial behavior, aggressiveness, impulsiveness, lack of appropriate social skills, inability to manage emotions/behaviors during daily tasks or transitions, obsessive behaviors, attention seeking behavior, depressed mood, withdrawal, anxiety, and mood swings (Special Education Support Services, 2016). Despite receiving a clinical diagnosis as noted here, a student may not qualify under IDEA- ED.

Risk factors for the development of EB problems.

Epidemiological studies aim to elucidate the determinants, development, progression, and treatment of childhood disorders (Cicchetti & Toth, 1995). Research has documented that experiencing risk factors increases the likelihood of negative outcomes, such as developing a psychiatric disorder (Patterson, Reid, & Dishion, 1992). The number of risk factors, length of exposure, and the presence of compound risk factors (i.e., physical impairment while experiencing neglect) contribute to increased risk of negative outcomes (Cicchetti & Toth, 1995).

The Adverse Childhood Experiences Study (ACE) was initiated by collaborative efforts between Kaiser Permanente (San Diego, CA) and the Centers for Disease Control and Prevention (CDC) (CDC, 2016; Edwards, Holden, Felitti and Anda (2003). Results

from the ACE study indicated that an emotionally abusive family environment has a significant impact on a child's mental health. Their investigation revealed that lower mental health scores were related to a higher number of exposures to sexual abuse, physical abuse, and witnessing maternal battering (CDC, 2016; Edwards, Holden, Felitti & Anda, 2003). Additionally, Dube, Felitti, Dong, Giles, and Anda (2003), examined the relationship between ACE scores and the risk of health problems. Results suggest that experiencing ACEs increased the risk of developing multiple health problems beyond the influence of social or secular changes across time. Individual, familial, and environmental risk factors are discussed below.

Risk factors for developing EB problems operate at multiple levels of the social ecology. These levels include individual, family, school, and community-level risk factors. Being male, exhibiting externalizing behaviors, demonstrating poor problem-solving skills, experiencing high frequency of physical illness, using substances, and having internal feelings of stigmatization have all been identified as significant individual level risk factors for developing EB problems (Morgan & Farkas, 2016). Additionally, being raised in a single-family home, having infrequent contact with parents or relatives, being admitted into institutional care due to suspected neglect and abuse, moving between two or more institutions, lacking regular contact with teachers and institutional staff, and low academic achievement were all found to be significantly associated with an increased probability of developing EB problems (Morgan & Farkas, 2016). Nelson, Stage, Duppig-Hurley, Synhorst, and Epstein, (2007) found that a child's temperament, the parent's behavior management skills, and the interaction between the two were significant predictors of developing EB problems, further reinforcing the integral element

of parenting skills and the home environment as factors that influence the onset of these problems. Socioeconomic factors such as poverty, neighborhood crime, ecologic factors (i.e., lack of community/school support), and cultural factors have also been identified as potential risk factors (Lyons, Baerger, Quigley, Erlich, & Griffin, 2001).

Prevalence rates of EB problems

According to the National Mental Health Association (2007) 3-6% of school-aged students (i.e., 4-6 million students) have a severe emotional/behavioral disorder that impact successful functioning in daily living within the home, school, and community settings (Quinn, 2004). Garland et al. (2001) investigated prevalence rates of mental disorders within youth aged 6-17 in the US. Results suggested that within five public youth-serving sectors, 42% of youth from families in the Child Welfare system had mental disorders, however this prevalence rate was relatively smaller in comparison to the rates found in other public youth-serving sectors. A prevalence rate of 60% was found among alcohol and drug service centers, 52% in the juvenile justice facilities, 61% within the mental health system, and 70% in public school services for youth with severe emotional disturbances (Garland et al., 2001). Caucasian youth have a greater likelihood of being identified as having an emotional or behavioral disability as compared to youth of other ethnicities as noted by teacher or parent report (Morgan & Farkas, 2016). Morgan, Farkas, Hillemeier, and Maczuga (in press) found that racial, ethnic, and language minority youth were less likely to receive special education services for an emotional/behavioral disorder compared to white youth when academic achievement, gender, and socioeconomic status were similar.

Challenges for schools

Youth with severe EB problems present with significant academic needs, have high rates of absenteeism, and may engage in aggressive and disruptive behavior. The presentations of such behaviors can detract from quality instruction within the classroom (Herron & Martin, 2015). Classroom and school disruptions occur frequently when educating a student with EB problems (Bradley, Doolittle, & Bartolotta, 2008). Students with more serious EB problems are more likely to receive detentions, suspensions, and expulsions due to behaviors that are not conducive to the educational environment. This is especially true when students are being served in the general education classroom (Bradley et al., 2008). Not surprisingly, the Special Education Elementary Longitudinal Study data revealed that ED youth have a suspension and expulsion rate approximately three times higher than students in any other special education eligibility category (Bradley et al., 2008).

Educational settings

Special education definitions and classifications can differ between the federal and state level, such that additional inclusivity can be instituted by the state (Becker et al., 2011). Becker et al. (2011) found that the majority of states adhered to the federal definition of ED, however 20% of states employed a broader definition for inclusivity purposes. Interestingly, states that used more inclusive definitions did not differ in their rates of placements (e.g., restrictive and general education) when compared to states adhering to the stricter federal guidelines for ED classification (Becker et al., 2011). According to the U.S Department of Education (2016) in 2012-2013 there were 362,000 youth being served under the ED eligibility classification.

Youth with ED will typically be placed in special education and be served either in the general, resource, or self-contained classroom setting (Mattison, 2015). Students can also be served in alternative settings, which can include public or private schools, hospitals, home, or residential facilities (U.S Department of Education, 2001). In 2012, 20.4% of students with ED were in the general education classroom less than 40% of the time, 13% were placed in an alternative school, 1.8% in a residential center, 1.1% in a hospital setting, and 1.7% in a correctional facility (U.S. Department of Education, 2016).

An alternative education setting is a common placement for youth with EB problems who do not appear to benefit academically or behaviorally in the general or special education setting within their school of origin. Raywind (1994) categorized three types of alternative education settings and/or programs, each serving either a specific population or offering programs in a private school setting. Type 1 schools are considered schools of choice (i.e., magnet school). Innovative programs/tracks are offered, which are particularly attractive to gifted students. Type 2 youth typically present with severe EB problems and frequently incur serious discipline infractions. These youth commonly are court-mandated to attend school in a building designed to serve such students on a short-term basis to improve student behavior. This effort is framed as a preventative or “last chance” attempt to alter severe behavior that will more than likely result in dropout, juvenile justice placement, or imprisonment (Raywind, 1994). Type 3 settings have been designed as a therapeutic setting in which to specifically target youth with severe EB problems and assist with rehabilitation. Therefore, academic and behavior remediation programs are implemented simultaneously. Enrollment is typically voluntary at a type 3 setting (Raywind, 1994).

A total of 563,449 students were enrolled in public school districts and attended an alternative school and/or program during the 2010-2011 school year (U.S Department of Education, 2012). According to recent statistics, 35 states report that their target population for their alternative programs are students with behavioral problems who accrued severe discipline referrals and who were removed from their school of origin (Porowski, O'Conner, Luo, 2014).

Outcomes for youth with serious EB problems

Without prevention or intervention, a myriad of possible negative outcomes such as academic failure, poor employment opportunities, substance use, and poverty in adulthood are just a few outcomes associated with children with mental health disorders (President's New Freedom Commission on Mental Health. 2003; Substance Abuse and Mental Health Services Administration, 2002). These negative outcomes, such as dropout rates for the US educational system, have continued to evoke significant societal concern. The National Center for Educational Statistics (2015) released data from 2013, which indicated that 7% of youth and young adults (16-24 years of age) were not enrolled in a school and did not earn a high school diploma or a General Educational Development certificate at the time of survey. Minority males (except Asian Americans) who belong to a family with household earnings in the lowest quartile have stable and high rates of dropout in the US (National Center for Educational Statistics, 2015).

Other outcomes include large proportions of youth entering the juvenile justice system. In general, a large percentage of youth in the juvenile justice system have mental health needs (Steiner & Cauffman, 1998), with recent estimates ranging from 65% to 75% of youth in residential juvenile justice facilities presenting with mental health

concerns (Wasserman et al., 2002; Teplin, Abran, McClelland, Dulcan, Mericle, 2002).

The percentage of youth with mental health disorders are only slightly lower (approximately 50%) in non-residential juvenile populations (i.e., determined at probation intake) (Wasserman et al., 2005). A recent prevalence study by the National Center for Mental Health and Juvenile Justice (NCMHJJ) documented 70.4% of youth in the juvenile justice system as having at least one mental disorder (NCMHJJ, 2006).

Additionally, youth with EB disorders have high rates of placement in out of home settings, including psychiatric hospitals, residential centers, foster care placements, and juvenile justice corrections centers (Cohen et al., 1990). Overlap between populations served (i.e., youth with severe EB problems) in the public mental health and juvenile correction centers has been documented, suggesting ED youth are being detained due to their high levels of mental health needs (Lyons et al., 2001). Behaviors and risk factors associated with ED (e.g., truancy, use or possession of a firearm, peer dysfunction, poor adjustment to trauma, prior outpatient treatment, and multisystem needs) were predictive of a placement at an institutional setting (Lyons et al., 2001). A study evaluating predictors of community, institutional, and correction placements found that youth presenting with higher levels of aggression, antisocial tendencies, and a lack of parental supervision and monitoring had a greater probability of placement in a correctional institution (Lyons et al., 2001). The same study found that two groups emerged (i.e., behaviorally disordered and emotionally disordered) and that institutional placement was closely related to their clinical presentations. Specifically, those categorized as “behaviorally disordered” had a higher likelihood of being incarcerated, while those

considered “emotionally disordered” were more likely to be admitted to a state mental health facility (Lyons et al., 2001).

History of Coordination Care Services

As mentioned, in the US, serious EB problems in youth signify one of the most substantial unmet healthcare needs, with 1 in 5 youth exhibiting challenging problems and services reaching less than half of these youth (Burns et al., 1999; President’s New Freedom Commission, 2003). A coordinated network of care can greatly assist in addressing unmet needs. Unfortunately, clinicians, researchers, and community-based service agencies have operated individually and missed possible collaborative opportunities to provide more coordinated and comprehensive intervention and research efforts (Eber & Nelson, 1997; Joint Commission on the Mental Health of Children, 1969). Effective systems navigation between community-based service agencies may aid in individualized support that is organized to meet the unique challenges of youth and their families with serious mental health needs (Eber & Nelson, 1997).

Coordinated care systems were established in response to a call for reform in youth mental health services in the 1960’s. Reports documented and advocated for improved access and quality of mental and behavioral services for youth and families. This call to action was largely due to the alarming number of youth either not receiving services, youth being served exclusively in restrictive settings, and/or the discovery that community child-serving organizations were rarely collaborating (Joint Commission on the Mental Health of Children, 1969; President’s Commission on Mental Health, 1978; U.S. Congress Office of Technology Assessment, 1986).

Since the 1980's much work has been done to develop, streamline, and improve coordinated care models, such as the SOC model. Three existing models within coordinated care include wraparound services, care management entities, and SOC (De Voursney & Huang, 2016). The wraparound approach emphasizes the creation of a family-focused team approach to selecting and coordinating services (Walker, Bruns, & The National Wraparound Initiative Advisory Group, 2008). Care management entities consist of administrative organizations that support broader coordinated care systems (Pires, 2013), while SOC's offer a comprehensive spectrum of community-based supports for children and youth with mental health challenges (Stroul, 2002).

Systems of Care Services

The original SOC conceptual framework was first published in 1986 by Stroul and Friedman (1986), who defined it as: "A comprehensive spectrum of mental health and other necessary services, which are organized into a coordinated network to meet the multiple and changing needs of children and their families" (p. 3). This care model must serve as a holistic approach that provides a comprehensive, individualized, and coordinated effort in the least restrictive environment, while including families as active partners, with an emphasis on early identification and intervention (Stroul & Friedman, 1986). Clinical interventions and "traditional" services are utilized such as residential treatment, multisystemic therapy (MST), therapeutic foster care, and others, with emphasis on programs that are evidence-based (Burns, Hoagwood, & Mrazek, 1999; Burns & Hoagwood, 2002). Together, the framework consists of eight overlapping dimensions of service, which include mental health, social, educational, health, substance abuse, vocational, and recreational services (Stroul & Friedman, 1996).

System of Care initiatives develop interagency communication and collaboration to achieve common goals (i.e., improved academic achievement) (Anderson, 2011). A wraparound team appears to be the most common SOC delivery model when serving youth with EB problems (Wright, Russell, Anderson, Kooreman, & Wright, 2006). This team commonly includes the youth, one or more family members, guardians, friends of the family, a care coordinator, and representatives from service agencies or organizations (Anderson & Matthew, 2001). The wraparound team serves as a problem-solving instrument by creating the space to share information, develop multisystem plans, create goals, assess progress, troubleshoot barriers, and integrate supports in schools from community plans (e.g., truancy contracts) (Anderson, 2011). The literature has provided some examples of how the wraparound approach within a SOC initiative can be practical and solution focused. For instance, the SOC team can assist youth with learning how to appropriately communicate with adults or peers by implementing and monitoring social communication interventions “simultaneously” across settings (e.g. home and school) (Anderson & Matthew, 2001). The team can also develop homework planning systems that would be monitored across settings in order to increase the likelihood of success in the academic domain (Walker & Schutte, 2004).

School based resources are often designed to meet a youth’s academic needs and behavior within the educational environment. However, as previously stated, youth with EB problems may need additional supports, higher dosages of intervention, or intervention in multiple life domains to be successful in the academic domain. Unfortunately, schools often do not have the resources to accommodate such complex needs (Borgmeier & Horner, 2006). Therefore, it can be argued that the utility of SOC

teams is high as they can reach unmet needs that school teams such as a SPED IEP team cannot address. Wraparound teams historically meet more frequently (e.g., monthly), are constructed to be malleable to changing needs, and can react to time sensitive problems quicker than unilateral teams that are designed for a specific domain, such as an IEP team whom are only convened for school related matters (Anderson, 2011). By adopting this approach within education, school effectiveness in serving students with EB problems increases and the flexibility to serve such youth in community-based programs is strengthened (Eber & Nelson, 1997). Examples of flexible supports include youth mentorship programs that are linked to community, sporting, or extracurricular hobbies (Eber & Nelson, 1997). Although the literature documents that the coordination of mental and behavioral services are related to positive outcomes in children, evaluations of such coordination of care efforts appears sparse (Puddy, Roberts, Vernberg, & Hambrick, 2012; Painter, 2012; Strompolis et al, 2012; Vishnevsky, Strompolis, Reeve, Kilmer, & Cook, 2012). Within its design, SOC's are designed to provide coordinated, comprehensive, and individualized care plans that meet the specific needs of the youth and families. However, the components and their implementation are variable from within a given site or even differ between communities. The SOC is a service delivery philosophy and does not require particular practices (Cook & Kilmer, 2004; Stephens, Holden, & Hernandez, 2004; Stroul & Friedman, 1986; Stroul & Friedman, 1986; Walker & Schutte, 2005). Taken together, the necessity of collaboration between school-based problem-solving teams and community youth serving agencies to promote optimal outcomes for youth with more serious EB problems emerges as a resounding theme from SOC research.

The Role of Education with Students with EB Problems

Youth with more serious EB problems often require a significant amount of educational support, which can strain educational resources, commonly resulting in a schools' failure to even provide minimally supportive environments for these youth (Borgmeier & Horner, 2006). Youth presenting with severe EB problems that receive support only in the educational setting are likely to receive inappropriate or inadequate support (Knitzer, Steinberg, & Fleisch, 1990) and often are not connected with broader mental health services (Knitzer, 1996). In 2005, a national survey revealed that the majority of school-based mental health programs serve mental health needs by screening and counseling through the traditional "pull-out" service model, which removes the referred student from direct instruction (Foster et al., 2005). In an attempt to better meet student needs, some schools have adapted the "clinic within schools" model, which enables more intensive services but creates barriers with interdisciplinary collaboration between outside youth-serving agencies (Baker, Kamphus, Horne, & Winsor, 2006). Due to the need for intensive services, not all students in need of mental health services can be accommodated (Baker et al., 2006). Complications with identifying students with mental or behavioral needs can also occur. Historically, if behavioral concerns (i.e., arrests) did not directly influence educational variables such as attendance rates, a youth's mental health needs may go unnoticed by educators (Epstein & Walker, 2002). Further, students considered as having such challenges typically engage in negative behaviors that are not remedied with traditional school discipline procedures (Special Education Support Service, 2016). The needs for alternative behavioral strategies/supports for students with emotional and behavioral concerns are of particular salience when externalizing

behaviors result in suspensions or expulsions. Even though schools often use these punitive disciplinary methods (i.e., suspension; expulsions), the literature suggests these measures may increase the frequency of challenging behaviors (Safran & Oswald, 2003). Research supports that when student's psychological needs are adequately considered, the likelihood of school engagement and success increases (Adelman & Taylor, 2006; Vander Stoep et al., 2000; Zins, Bloodworth, Weissberg, & Walberg, 2004), with student engagement being just one variable associated with positive psychological and educational outcomes (Finn & Owings, 2006). As previously stated, youth with EB problems exhibit behaviors that require significant educational support, however, services unilaterally delivered in the educational system are not meeting the complex needs of these students (Borgmeier & Horner, 2006; Knitzer, Steinberg, & Fleisch, 1990). In an attempt to target such needs, SOC teams were uniquely designed to respond to the psychological and educational needs of the student by addressing challenges and supporting existing systems to provide a holistic approach to supporting students (Anderson & Matthews, 2001).

The Role of Education in a System of Care

Over the past two decades there has been a call for increasing the DOE/school's role in SOC to supplement school mental health services (Stroul & Friedman, 1996). Although SOC initiatives may adhere to the core philosophy and guiding principles of the SOC framework, the presence or level of involvement of local agencies working with each family and/or community can vary. Subsequently, this may render it difficult to broadly discuss the role of education as a key stakeholder (Hernandez & Hodges, 2003).

A small number of studies have addressed education's role in SOC for students with emotional and behavioral difficulties. In one qualitative study, Stein, Connors, Chambers, Thomas, and Stephan (2016), caregivers of youth with EB problems attended a focus group after participating in the Healthy Transitions Initiative as part of the program evaluation. Themes identified included a need for more information on the IEP process and a need for subsequent school meetings to address family needs and/or concerns. Further, communication regarding additional educational resources and direction when navigating between community systems and agencies were scarcely discussed with caregivers. Focus group participants also advocated for improved collaboration across agencies (e.g., mental health, educational system, and social services, etc.) (Stein, et al., 2016). Green, Xuan, Kwong, Anderson, and Leaf (2016) investigated more than 170 ongoing federally supported SOC communities in order to examine educational outcomes associated with the SOC referral process and existing collaboration model between school and SOC programs. Findings indicated that students referred to the SOC by schools showed a decrease in internalizing and externalizing symptomology, fewer absences, and reduced school failure rate. Overall, students referred from schools versus community mental health providers exhibited significant improvements in rates of absences (Green et al., 2016). These results suggest that involvement of school-based teams in collaboration with SOC may be linked to positive educational outcomes, further suggesting the integral role education plays in a SOC.

Taken together, research has communicated that shared participation and collaboration between agencies is necessary for effective treatment for youth with EB problems (Stroul, 2002). However, although community involvement in the treatment of

these youth has been rising, the level and degree of collaboration between education and SOC initiatives appears limited (Atkins, Hoagwood, Kutash, & Seidman, 2010). The federal and state government has responded to this call and has begun to allocate funding to create and strengthen partnerships between youth-serving systems. Specifically, grant support has promoted national and statewide initiatives calling for education as key partners in improving mental health services for youth.

Funding support

In 2013, President Barack Obama combined executive orders and calls for legislative actions to develop the plan “Now is the Time” as a means of promoting, creating, and increasing accessibility to mental health services (Now is the Time, 2013; SAMSHA, 2015b). The Now is the Time plan was largely in response to gun violence and multiple mass shootings in 2011 and 2012, including the mass school shooting at Sandy Hook Elementary School in Newtown Connecticut, where 20 children and 6 staff members were fatally shot by a 20-year-old male assailant (Horwitz & Fahrenthold, 2012; Now is the Time, 2013; SAMSHA, 2015b). Subsequently, President Obama targeted improving the quality and access to mental health services as a form of prevention of gun violence in America (Now is the Time, 2013). This project was consequential in launching system wide partnerships across youth-services systems.

The Now is the Time plan was designed with particular focus on overall EB wellness and has established resilience education through Project AWARE (Advancing Wellness and Resilience in Education), a grant program that supports state and local mental health capacity building strategies, increasing mental health awareness, providing access to established funding systems, and collaborating with other youth-serving

systems, families, and the community, all under the umbrella of a multi-tiered behavioral framework (SAMHSA, 2015b). Another grant was released as part of the Now is the Time plan, identified as Project Prevent, which provides funding to school districts to address capacity limitations to more effectively meet the needs of students who have either indirectly or directly been impacted by violence (U.S Department of Education, 2014). In addition, Project Prevent offers local educational agencies (LEA) funding to increase projects directly related to providing access to school-based counseling or connecting students to community-based services (SAMHSA, 2015a). In 2014, Project AWARE awarded 100 two-year grants to LEA's to train school personnel and students in Metal Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) (SAMHSA, 2015b). Both initiatives, Project Prevent and Project AWARE, were created to link educational and community mental health services for youth at the local levels. The Department of Education (DOE) has prioritized funding for LEA's targeting school climate and other mental health initiatives, such as the School Climate Transformation Grant which offer opportunities to implement projects that provide training and technical assistance to schools in support of multi-tiered behavioral supports (SAMHSA, 2015b).

Safe School/Healthy Students Program in collaboration with the federal DOE, Department of Justice (DOJ), and Health and Human Services has resulted in more than 13 million youth receiving mental health services, which has spanned \$2 billion in funding reaching 49 states in the US (SAMSHA, 2015a). Results from a five-year study evaluating the Safe School/Healthy Students program revealed significant decreases in both violence and substance abuse and increases in the number of students receiving mental health support in both the school and community setting (Derzon et al., 2012).

Recent funding initiatives supporting Florida school districts have occurred within the 2017-2018 year. Following the aftermath of the Marjory Stoneman Douglas High School mass shooting in Parkland, FL, Governor Rick Scott signed a bill as part of the Securing Florida's Future budget to invest more than 400 million in funding to increase safety, security, and mental health in schools (Securing Florida's Future Budget, 2018). Taken together, despite funding initiatives being formulated in response to crisis, the importance of mental health and positive school climate continues to be highlighted throughout the literature and legislation.

The Interactive Systems Framework and Getting to Outcomes Approach

As previously noted, a well-established finding is that shared participation and collaboration between agencies is imperative for positive outcomes for youth with EB problems (Stroul & Friedman 1986; Stroul, 2002; Atkins et al., 2010). In order to orient this study, a framework is presented that accounts for the common research to practice gap, which frequently renders initiatives and collaborations unsuccessful. The Interactive Systems Framework (ISF; Wandersman et. al 2008) highlights the importance of collaboration and communication amongst stakeholders. This framework depicts integral elements involved in the process of linking evidence-based research into practice while taking the difficulties with dissemination and implementation of interventions and/or initiatives into consideration (Wandersman et al., 2008). The ISF acts as a working needs assessment that identifies the who, what, where, and when components to increase collaboration and overall success (Wandersman et. al 2008). Based within a community-centered model, the ISF presents a lens in which to interpret varying capacity and motivation variables. According to Wandersman (2003), community-centered models

“begin with the community and ask what it needs in terms of scientific information and capacity building to produce effective interventions” (p. 230). This framework will serve as a basis of interpretation throughout the qualitative study and orient interpretation of collaboration, barriers, and recommendations for forging stronger partnerships within a local system of care.

The Getting to Outcomes approach (GTO; Wandersman, 2000) will also be used to inform the current study. GTO serves as results-based method of successful implementation of programs by organizations and has been adapted for various settings, including behavioral health services (Levison, Johnson, Dewey, & Wandersman, 2009). This method is specifically designed to assist organizations in achieving their desired outcomes by incorporating a 10-step accountability approach. The following steps include: 1) Needs/Resources; 2) Goals; 3) Best Practices; 4) Fit; 5) Capacity; 6) Plan; 7) Implementation/Program Evaluation; 8) Outcome Evaluation; 9) Continuous Quality Improvement; 10) Sustainability (Wandersman et al., 2016). The GTO approach will serve as the “how to” method that will orient results and inform future studies and implications for on-going quality improvement for SOC’s at broad. Taken together, the ISF framework will serve as the basis of interpretation of the level of collaboration between agencies, while the GTO method will be used to inform specific areas of improvement and next steps required for improved implementation and collaboration.

Project Description

The CBHC initiative was established in Palm Beach County (PBC), FL. This geographic location includes a diverse population of 1,422,789; 19.4% are under 18 years of age, 19% of the population is African American, and 21% are Hispanic or Latino. A

large percent of individuals (23.4%) residing in PBC are foreign born. The median household income is \$53,363 (United States Census Bureau, 2015). The School District of Palm Beach County is the 11th largest school district in the US and 5th largest in FL. The district is comprised of 187 schools that serve over 188,000 students, where an estimated 152 languages and dialects are represented from 198 different countries and territories of birth. The PBC Department of Exceptional Student Education currently serves 39,404 students, with an estimated 9,964 in gifted programs (The School District of Palm Beach County, 2017). With many students to serve and youth-serving agencies operating independently, the county created a proposal requesting care coordination services for youth. Five core partners including Boys Town South Florida, Center for Child Counseling, Families First of Palm Beach County, National Alliance on Mental Illness of Palm Beach County, and the Florida Atlantic University- Community Health Center applied for funding to develop a local SOC. Beginning in October 2014, the agencies received funds to support the development of a new effort- the CBHC.

The goals of the CBHC are to: 1) provide a comprehensive system of care meeting the behavioral health needs of children, increasing the functionality and stability of PBC children and families; 2) assist children and families in accessing an array of services to meet their needs; and 3) effectively utilize resources by reducing duplication, maximizing resources, and collaboration. Through funds from the Quantum Foundation, an evaluation of the CBHC is occurring. The evaluation occurred over a two-year period, from May 1, 2015 – April 30, 2017, with findings informing the potential for and form of additional support for the initiative for a three-year period beginning October 1, 2017. These evaluation reports, in sum have helped to improve the quality of and strengthen the

CBHC, which is viewed as an exemplary initiative to improve children's services in Palm Beach County.

Research Questions

Considering the social importance of and paucity of research within this area, we aimed to advance the SOC literature by evaluating responses from focus group participants and key stakeholders participating directly in the CBHC through interview and survey format. This example of a local SOC has informed on-going quality improvement by capturing unique strengths, barriers, and suggested improvements for this initiative. Specific research questions for each phase of the current study are as follows:

Focus group

1. What are stakeholder and client's perceptions of the CBHC?; 2. What are the strengths and limitations of the CBHC?

Key stakeholder interviews

1. What is education's current role in the CBHC?; 2. What existing barriers hinder collaboration between CBHC agencies and the education/school system?; 3. How can stakeholder-generated recommendations forge collaboration between CBHC agencies and the education/school system?

Survey

1. Which stakeholder-generated recommendation is most helpful for each community agency?; 2. What is the feasibility of implementing the stakeholder provided recommendations?; 3. How motivated are the stakeholders to implement the recommendation?

CHAPTER II

METHOD

Design and Conceptual Framework

This study was designed to systematically evaluate stakeholder perspectives on a SOC collaboration in PBC Florida. A mixed methods sequential exploratory design, which consists of two distinct phases: qualitative followed by quantitative (Creswell, Plano Clark, Gutmann, & Hanson, 2003) was employed. Research suggests an exploratory design be utilized when studying a phenomenon (Creswell et al., 2003). Additionally, this design is commonly used when the qualitative strand has greater weight within the design (Creswell & Plano Clark, 2011) and when findings from the first qualitative study inform quantitative data collection to best capture and explain the data (i.e., follow up) from the qualitative study (Onwuegbuzie, Bustamante, and Nelson, 2010).

Rationale for Mixed Methods Design

Greene, Caracelli, and Graham (1989) and Bryman (2006) present two typologies for using mixed methods, both including various rationales for combining qualitative and quantitative methodology to answer research questions. Taking the current study's research aims, three rationale typologies emerged from the literature to best support the use of mixed methods. First, the initiation typology presented by Green et al., (1989) discusses the utility of mixing methods when one aims for the discovery of new perspectives and/or frameworks, or results from one method with questions or results

from the other method. This typology captures both the exploratory and sequential phases that are built within this study. The current study aimed to identify perspectives, which would then directly inform secondary research questions (Stakeholder interviews and survey).

Secondly, Bryman's (2006) context typology guides the current framework in that the combining of both methods serves to provide contextual understanding and identify broad relationships. This is particularly useful given the nature of exploring perceptions amongst participants in both focus group and interview formats. Thirdly, the enhancement or building upon quantitative and qualitative findings typology (Bryman, 2006) emphasizes the "building on or making more of" the data, where multiple levels (design; methodology; results) inform each phase. To better understand the scope of the themes captured in Phase I, a second quantitative phase is designed to reach a larger sample in order to gain a broad consensus. The sequential exploratory design is most appropriate since this study aimed to connect (explain/build) upon data from Phase I by conducting a sequential quantitative follow up to capture a broader consensus and generalize to greater CBHC community and constituents.

Braun and Clarke (2006) describe a theme within qualitative analyses as, "A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set". The thematic coding methodology consists of rigorous review of transcribed data, which include sorting and categorizing data within identified themes. As described by Coffee and Atkinson (1996) the thematic process of coding and categorizing is not designed to consolidate the data, but to "expand the conceptual frameworks and dimensions for

analysis” (p. 30). Specifically, noting themes by assigning data codes can inform subsequent phases of the project that require further interpretation. This is particularly useful for the current study’s design since the purpose of Phase II is to further explore identified themes from Phase I in greater depth.

Analysis can occur at a single point or concurrently, which is again dependent on the phasic structure. In the exploratory design, the researcher has three time points of analyses: after the qualitative data collection, after the follow-up quantitative data collection, and during the interpretation time point (Creswell & Plano Clark, 2011). During the interpretation time point, the researcher will “connect” the follow-up quantitative findings to the first phase to expand the Phase I exploratory qualitative results. The current study used this mixed methods interpretation method by making thematic observations across both the qualitative and quantitative results (Creswell & Plano Clark, 2011). Since Phase II only measures and addresses research aims specific to motivation, feasibility, and rankings of stakeholder suggested recommendations, inferences were only applied to overlapping themes derived from questions presented in Phase I. For example, phase II was an extension of one theme/research aim of Phase I, therefore merging of data and integration were only implemented for part of Phase I (i.e., recommendations discussed in the focus group and interviews). Therefore, inferences or “meta-inferences” (Teddlie & Tashakkori, 2009) were presented as general interpretations drawn from the separate strands, where applicable, and across strands where appropriate (Creswell & Plano Clark, 2011). Data analysis decisions typically used with the sequential exploratory design again consists of building or expanding upon

qualitative findings. Quantitative results will be discussed in how the larger sample's ratings and perceptions build and expand upon the first qualitative study.

Integration at the study design level

The level of integration is “interactive”, such that mixing the qualitative and quantitative phases occurred at the design level before interpretation, where the content of Phase II was dependent on the results from Phase I. A mix of “independent” and “interactive” levels of interaction was implemented at the final interpretation, such that data sets were merged together but with Phase II being analyzed and interpreted within the framework of the first phase. Therefore, the sequential exploratory method by design incorporated mixed methods integration at the most basic level.

Integration at the methods level

The current study's methods were informed by two approaches; the connection and building approaches (Fetters, Curry, and Creswell, 2013). The connection approach of integration serves to link one database to the other through selective sampling. Second, the building approach informs the data collection method of Phase II. In the current study, Phase I consisted of exploring stakeholder perceptions of the CBHC, which connected to a pool of interview participants that were selectively sampled for both the interviews and the online survey in Phase II. The building approach informed the development of Phase II research questions, such that their design recursively informed the results and themes built in the first phase.

Participants and Procedures

The current study was submitted to the Health Sciences South Carolina Institutional Review Board (IRB) and was classified as “exempt” and approved on

November 28th, 2016. Participant consent was implied through participation for each phase. No formal consent form was distributed. In the first phase, qualitative data were collected in the form of a focus group and key stakeholder interviews. Results of the interviews included stakeholder-generated recommendations for improving education's role as an active stakeholder and driver in the local system of care. In the second phase, quantitative data were collected by an online survey.

Focus group

A maximum variation strategy (Lincoln & Guba, 1985) was used to acquire insights into unique experiences of different groups of stakeholders, but also to examine if common patterns or themes emerge across stakeholders. This strategy was used to recruit diverse viewpoints from a range of stakeholders, as opposed to only gathering perspectives from one subset of stakeholders. Specifically, when identifying participants to participate in the focus group, invitations were sent to multiple subsets of participating agencies/groups, such as youth (18 and older), parents, mental health advocates, and system partners of the CBHC. Inclusion criteria required potential participants to have interacted with the CBHC as either a direct provider, care coordinator, administrator, or a family who has received mental/behavioral health services for their child through the CBHC. The care coordination agency for the CBHC, Boys Town South Florida, identified and recruited ten participants from partnering agencies and families. Participants were identified by Boys Town South Florida and were recruited by email and phone describing the purpose, procedure, and anticipated outcome of the study. The focus group occurred over a lunch hour (total duration of 90 minutes including introductions, instructions and responding to focus group sessions). Participants were provided with

numbered nametags for identification purposes. Two evaluators and a research assistant recorded comments verbatim. The focus group protocol (see Table 2.1) included nine open-ended questions. Discussion lasted for less than 60 minutes and were audiotaped and coded in preparation of qualitative analysis.

Key stakeholder interviews

Participants for the key stakeholder interviews included agency leaders recruited from the following participating agencies: Southeast Florida Behavioral Health Network (SEFBHN), Service Network for Severely Emotionally Disturbed Children and Youth (SEDNET) in Palm Beach County (PBC) school district, PBC Youth Services Department/Juvenile Justice, National Alliance on Mental Illness of PBC, Boys Town of south Florida, PBC Community Services Department, Families First of PBC, Quantum Foundation, John Fitzgerald Kennedy (JFK) Medical Center North, Center for Children's Counseling, PBC Sheriff's Department, and families. Participants included 13 stakeholders recruited from multiple subgroups to contribute additional diversity of participants than represented in the focus group. Specifically, attempts were made to oversample education stakeholders to further explore the unique perceptions, barriers and supports that impact the educational system and their collaboration with the CBHC. These participants granted deeper insight into the notable themes of educational support, process, and participation in SOC initiatives in PBC, Florida. Participating staff within Boys Town South Florida assisted with the identification of participants and were recruited by email and phone describing the purpose, procedure, and anticipated outcome of the study.

Seven questions using the Question Behind the Question method by John G. Miller (2001) were presented. This method was used to elicit the participant's own role in the collaboration effort with the educational system by structuring questions to target one's personal roles (i.e., what can you do to implement this recommendation?). Questions inquired on past and present experiences with the DOE, The School District of Palm Beach County, and/or other school personnel. Additionally, questions pertaining to barriers and recommendations on how to effectively and efficiently involve education stakeholders were presented. Please see Table 2.2 for the interview protocol. Interviews were conducted via telephone conference; therefore, no travel reimbursement was provided. Confidentiality and consent was discussed before the start of the interview. Stakeholders provided basic demographic information including gender, race/ethnicity, discipline, agency and years of experience. The evaluator assigned each participant a number for confidentiality purposes. The interview's total duration did not exceed 30 minutes and sessions were audiotaped in preparation for formal qualitative analysis.

As part of the interview protocol, participants were asked to provide recommendations on how to improve collaboration between DOE personnel and community system partners in the CBHC. Following the interviews, participants were asked to disseminate a survey consisting of a consolidated list of the top ten recommendations to their constituents. Results from the survey were used to gain additional knowledge on the helpfulness, feasibility, and motivation of the recommendations that were provided by the key stakeholder interview participants.

Survey

As previously stated, following the key informant interviews, all recommendations for improving education's involvement and collaboration in the CBHC were identified and organized into a survey. The survey was disseminated to potential participants through the network of existing stakeholders already connected to the CBHC. Participants provided basic demographic information including gender, race/ethnicity, discipline, agency, and years of experience, and rated each of the recommendations on a six-point Likert scale with 1 reflecting "poor" and 6 reflecting an "excellent" recommendation. Two follow up questions were presented after each recommendation, asking the participant to rate the feasibility of implementing the recommendation and rate their level of motivation to take action to implementing the recommendation. A six-point Likert scale with 1 reflecting "poor" and 6 reflecting "excellent" was used to capture the feasibility and motivation component of the survey. Following the ranking of each recommendation, respondents were prompted to identify one recommendation that would be the most helpful for their particular agency. Google Survey, a free online survey engine was used for efficient digital dissemination and convenient participant response. The survey was designed to take no longer than ten minutes to complete.

Data Analysis

Both the focus group and key informant interviews were transcribed in Microsoft Word and then uploaded to the NVivo 10.0 software platform. Formal qualitative analyses were conducted to systematically identify themes in both the focus group and key informant interviews. A systematic evaluation consistent with content analysis (Patton, 2002) was employed to evaluate the focus group and informant interviews.

Comments were marked with independent codes using a thematic methodology approach (Braun & Clarke, 2006). Transcripts were assessed line by line and assigned codes that captured the content of each participant response. First, data were coded by creating nodes, which consolidate and store information that represent themes, topics, concepts, or ideas. Case nodes were then created to represent units of observations that classify attributes, such as, person, organization, or gender. Case coding was created to detect themes across organizational variables, which granted insight into agency level trends. As codes were added, a naturally forming hierarchy of subcategories formed under existing codes. These hierarchies are an important part of the analytical process of investigation since they assist in refining themes and forming connections between themes. The examiner then collapsed codes to create larger themes. After coding was applied, Nvivo 10.0 was used to scan the data for code patterns, which produced code matrices that enabled the examiner to identify hierarchical codes (categories that describe major themes). Thematic coding methodology was applied per focus group and interview question to organize the material to reference the context of the question. An analytical coding strategy was then implemented to evaluate broad themes across all questions. After applying the coding structure in Nvivo 10.0, the software scanned the data for patterns and produced word frequencies. Major thematic categories formed from the notable themes will be discussed. Subsequently, the coding structure and representative quotes by rater and by questions will be presented.

Quantitative data from the online survey were descriptively analyzed. Descriptive data, including gender, race/ethnicity, discipline, agency and years of experience were analyzed as means of providing the background and context to the current study.

Percentages and frequencies for the top-ranking recommendations and the recommendation with the highest percentage of “excellent” helpfulness ratings for each agency will be discussed. In addition, feasibility and motivation was explored both within and across agencies. These descriptive statistics served as an exploratory investigation that informed on-going quality improvement and evaluated perceptions of recommendations to enhance collaborations between system partners and education.

Table 2.1 Focus Group Protocol Questions

1. What words come to mind when you think about the Children's Behavioral Health Collaborative?
2. Have you or someone you know well interacted closely with the Collaborative?
What was the experience like?
3. How would you describe the quality of services provided by the Collaborative?
4. What are your perceptions of how the agencies are working together?
5. How could the agencies work better together?
6. What are other strengths of the Collaborative?
7. How could your experience with the Collaborative be improved?
8. What other recommendations do you have for improving the Collaborative?
9. Would you recommend services through the Collaborative to friends and family?
Why or why not?

Table 2.2 Stakeholder Interview Protocol Questions

1. What are your perceptions of SOC?
2. What is your role in the SOC initiative (i.e., the CBHC)?
3. How would you describe the current role of the educational system in the CBHC?
4. What unique resources can education stakeholders contribute to the CBHC?
5. From an outside perspective, what perceptions do you think education stakeholders have of collaborating with the CBHC?
- 6a. What are the existing barriers that limit education's involvement in the CBHC?
- 6b. What barriers within your agency may be contributing to a lack of collaboration with the education system?
- 7a. What recommendations do you have for improving education's involvement in the CBHC?
- 7b. How feasible/practical would it be to implement this recommendation?
- 7c. How motivated are you to take action in establishing this recommendation?

CHAPTER III

RESULTS

Focus Group

Participants included ($n=10$) stakeholders, most of whom were female (66%) and between 19-57 years of age with an average age of 35.5 years. The majority of participants were Latino or Hispanic (60%), with the remainder being African American/Black (10%), Asian/Pacific Islander (10%), Caucasian (non-Hispanic) (10%), and “other” (10%). Professions listed included: a licensed mental health counselor, two consultants for youth serving community agencies, a social worker, a client of the CBHC, an educator/teacher, a government funder agency representative, a certified peer specialist, and two parents. Focus group results are organized into three broad categories that include impact of services, collaboration, and recommendations for enhancement. A total of 32 codes were assigned and then organized into an overall thematic hierarchy. Codes were collapsed into 9 subcategories, which were then analyzed, rendering 3 major thematic categories: schools/education, strengths, and suggested improvements.

Impact of services

Eight participants provided responses when asked how to describe the CBHC. A total of 12 codes were assigned. Two themes emerged, with 25% of participants describing the CBHC as “connecting” and 25% as “organizing”. Participants also noted the CBHC helps “forge partnerships”, is “comprehensive”,

and utilizes “a team approach”. Notably, no participants mentioned a negative descriptor when asked to provide words to describe the CBHC. When asked about general perceptions of the collaborative, participants discussed the struggle of locating appropriate services prior to accessing the CBHC. Specifically, participants discussed that the CBHC “put everything together”, which resulted in a “life changing” service. Parents shared that dramatic improvements were observed and that they were pleased with the level of communication between the partnering agencies and their families. Families shared their gratitude for the level of support and expressed that their child “is a different person now”. These trends of appreciation and transformation were mentioned frequently throughout the focus group. Strength-based support was documented by families and by community providers as “coming along side” the family. This approach was noted as making interventions meaningful to each individual family. Community stakeholders described the impact of services as highly communicative and collaborative across partnering agencies and within their own organization. Themes of advocating on the behalf of families and fast responses to familial needs were also shared by community providers. One participant characterized the CBHC as providing “a foot in the door” service where families can receive an array of services without a diagnosis, which is not possible when linked to services through a system such as Medicaid or managed care. This strength assists families by connecting them to providers that have the capability of helping families secure longer term services through different funding providers for underinsured or uninsured families.

Collaboration

School involvement emerged as one of the most prevalent themes throughout the focus group responses. This occurred both when participants discussed their experiences with the CBHC and their perceptions of collaboration between agencies. Particularly, the discussion of school collaboration with community service providers were communicated by the majority of participants. According to participants, collaboration efforts varied largely on a “school by school” basis.

Results revealed disagreement between participants on the quality and level of involvement of the school system in the CBHC. One parent reported, “I still think the school system needs to do more. There has to be a connection there, which is non-existent right now”. Differing perspectives regarding the level of school and community collaboration occurred not only between parent and staff providers, but varying opinions emerged between community stakeholders. Individual schools as “gate keepers” of services were mentioned as a concern by both parent and community stakeholders. One community stakeholder stated:

I think really each school has its own policy. They’re the gatekeepers. Some are more open and even when you have a school like that it’s hard to see the child because they have a lot of issues and challenges they face, so some are pulled out of school by the parents.

However, positive feedback regarding school level collaboration was also discussed. A different community participant commented:

When I do my follow ups or after I speak to a case manager and give the feedback to the parents or follow up with the school, everybody seems to be

communicating and everybody seems to be pleased with the outcomes that are actually happening.

Community stakeholders noted difficulties entering schools to provide direct services. Due to this barrier, the CBHC provides a unique opportunity for providers to serve families in additional capacities, such as linking students to a peer mentors or care coordination staff that have more flexibility to maneuver the school environment. This team approach reinforces the collaborative nature of cross agency or cross setting care. Despite community providers partnering with school-based staff, parents continued to share frustrations with the disconnect and lack of communication when attempting to align community service goals with their child's IEP. In response, a stakeholder from the DOE discussed legal limitations. The participant shared:

We have to take into consideration the school district is there to educate, so there are certain rules and parameters they have to follow as well. . . making sure the agencies know who in the school district to contact to make those things happen while still following the law and the spirit of the law, which is that we must intervene and put certain things in place while still understanding the situation.

Suggestions were provided to improve the collaboration between agencies. Parent participants stated concerns regarding a lack of follow up plans and shared a desire to review service plans before the dismissal of services. A few staff participants agreed that continued efforts towards building partnerships between service providers would aid in establishing "good transitions". Wrap around services were described as beneficial by enabling teams to answer difficult questions referring to transitions, such as, "what do we do now"? Staff from partnering agencies shared similar statements in that the relationship

between agencies aided in establishing new relationships with new family serving organizations. Two out of four participants who contributed to this question noted that organizing team meetings to discuss client progress, dismissal, and transition plans would improve collaboration between families and community providers.

Recommendations for enhancement

Two participants, one out of the two parents and one staff stakeholder whom participated in the focus group, provided feedback on how to improve experiences with the CBHC. Suggestions included establishing additional support groups at varying geographical locations. One participant provided a recommendation that would impact both families and community service providers. Specifically, holding therapeutic appointments more regularly to discuss progress and communicate clear discharge plans with the family. Parents acknowledged the positive outcomes that led to their child being discharged of mental and behavioral health services, however, wished to be given more time to process the change with their child. One parent shared that for her child, the therapist was the first positive adult relationship her child had developed.

Understandably, she expressed concern that ending services abruptly could have long term negative effects and possibly reverse progress. A community service provider participant shared:

Give lots of notice about discharge. Whether that is for the family, the care coordinator, or the therapist. If we were able to meet more regularly, I think that would be one of the solutions for that because the families need that time. If we have more communication about spacing, then it might not be a surprise for some families or providers.

Themes of communication surfaced as a reoccurring topic when discussing recommendations for overall quality improvement. Communication channels appeared to dissolve between the staff/agency and family systems. However, perceptions of the quality and frequency of communication between service providers and families varied between participants.

Stakeholder Interviews

Participants included ($n=13$) stakeholders, most of whom were female (69.2%) and Caucasian (non-Hispanic) (91.6%). Participants represented varying professional disciplines including, social work, law, licensed mental health counseling, law enforcement, school counseling, public administration/government funding, business administration, special education educator, and parents. The majority of participants have served in their discipline between 23-33 years (average 28.3 years). All community stakeholders now serve in leadership positions within the following agencies: Families First of PBC, PBC Youth Services Department, Boystown of South Florida, PBC Sheriff's Office, the School District of Palm Beach County, Quantumm Foundation, SEFBHN, PBC Community Services Department, Center for Children's Counseling, and JFK Medical Center North Campus Psychiatric Hospital.

Qualitative findings for the stakeholder interviews presented in this section first discuss overarching themes. Results are then organized and presented by question, with notable themes and participant quotes reviewed. Participants identified their roles as the following: parents, provider of behavioral health services, government funder, community and PBC district behavioral and mental health coordinator, executive director of Boystown, chair of Family First of Palm Beach County, district administrator of

school counseling, private foundation funder, education coordinator and case liaison for youth in psychiatric hospitals, and various leadership positions that assist with community initiatives that serve youth and families.

Perceptions of a SOC

Themes of collaboration, accessibility, and being a provider of a continuum of services were identified when participants were asked to share their unique perceptions of a SOC. Topics included how the SOC model provides early identification of behavioral and mental health problems, assigns appropriate levels of interventions, and provides the necessary follow up with families that are not always prioritized in other care models. In terms of collaboration efforts, participants noted the necessity of community level supports to supplement school-based services. This “aligning of systems is used to fill gaps in services for children and families”. One participant mentioned, a SOC is, “creating a systemic progressive approach to coalescing around a single issue”. In particular, one participant described a SOC as utilizing “integrated partnerships” and another noted how a SOC is founded on “guiding principles” that provide “navigation for families while supporting a healthy community for all”. Additional perceptions within the theme of collaboration included a “connected network”, “open doors”, and “allowing everyone in the community to steer services within a given system”.

Accessibility also emerged as a notable theme. Participants stated how the SOC model “facilitates professional and/or natural supports to help families understand and communicate” by granting multiple access points to receiving appropriate services. Last, participants shared similar statements that fell under the theme of a continuum of services. The following quote is an illustration of that theme:

A system of care should have open doorways and what I mean by that is no one is turned away, so if someone tried to enter the SOC and maybe they are trying to enter it with the wrong agency or an agency that wouldn't be able to truly help them; that agency would be responsible for assisting that parent, child, staff member, or whoever that person is in the community to get to that right place.

Serving families by creating multiple “doors” to access services was discussed by 2 of the 13 participants. Additionally, a participant mentioned how a SOC should utilize a Multi-Tiered System of Supports (MTSS) framework, where the level of supports is designed to meet the level of need. This measurable framework enables community service providers to assess level of impact, which directly informs quality improvement.

Education and the CBHC

Collectively, themes of progression through evolving formal and informal systems emerged. Education’s involvement in the CBHC was frequently described as “evolving” at multiple levels within the school district. Formalizing training for teachers to identify students with emotional and behavioral problems was recommended to aid in the referral process to the CBHC. Involvement has improved over recent years, specifically the education/school’s level of organization and attitude towards community supports were noted by multiple participants. Additional formal relationships were described as “ongoing” such as utilizing MOU agreements with the school district to integrate services. To improve collaboration, informal relationships with both principals and school district personnel need to be formalized. In particular one participant stated:

I think what we are looking to do in the next iteration of our contract and the next step of the CBHC is to more formally involve the school system in the CBHC

process, so either by involvement in the steering committee, formalized meetings, or student services department. What I see and think our current state is that people in the school system that know us really like us and refer a lot, but there's a lot of people that don't know us and may have kids that could use our service.

Tension and resistance were words used to describe collaboration efforts of the education system with youth and family serving community agencies. Specifically, open conversations surrounding the education system's role has historically been a difficult topic to discuss, which has contributed a significant level of distress and frustration with community service providers. The school continues to remain the first line of contact with students exhibiting emotional and/or behavioral concerns according to many community stakeholder participants. Education stakeholders agreed that educating children is their primary objective, however, they did state that the school setting is the "first line of intervention" if mental health concerns arise. Supports including prevention initiatives, psychoeducation, and small counseling groups are all within the capacity of individual schools. Additionally, education stakeholders did express an understanding of when to connect with the community, for example such that when schools identify the needs of a student or family are beyond their capacity. Discussion of core operations, both positive and negative by multiple participants occurred. Specifically, one participant stated:

I have to be honest that sometimes the core operation is not as much as it needs to be. The referral part of it is great, the follow up, and evaluating the results still gives me pause.

Other participants noted similar opportunities for improvement by noting core operations are evolving and systems are currently identifying gaps. Participants that discussed the status of the CBHC's core operations stated a positive outlook and confidence for the successful progression of the CBHC and its collaboration efforts. The following quote is an illustration of this theme:

I think we've got a touch point- and that we are moving in that direction and I think it just probably requires a little more relationship building and kind of be a little more concrete in our shared values; our shared vision, because I think there is a lot of overlap and we are on the same page. I don't think we've been able to nail that down, so I think we are on the cusp of being able to engage effectively with our Palm Beach County school system, but I don't think we are here yet.

Additional perspectives from education stakeholders stressed the importance of transparency and its association with the quality of on-going improvement of collaboration efforts. In particular, one education stakeholder shared:

I believe if we are trying to improve things we have to be fair and be honest. I do believe that some of our schools in the district get more information than others at times. I also believe that some folks believe that some areas in the district should have more support than others but really everybody should be getting the same amount equally and that would be ideal.

It appears as though despite recent improvements with communication, levels of involvement, and relationships with district personnel being formalized, there are still gaps and opportunities for improvement. Taken together, participants expressed an overall positive outlook regarding the progression of collaboration efforts between the

education department/school systems and the CBHC. Recommendations provided generally highlighted the need for growth in the areas of evaluation, follow up services, formalizing relationships with principals, and the dissemination of CBHC services to all schools within The School District of Palm Beach County.

Resources

Overall, the most frequently mentioned resources were: funding, space to meet with students and families, access to students, and information on student functioning. Multiple participants stated that sharing financial resources, such as applying for grants that aid in community partnerships is one of the most influential resources the school district can offer. The most prevalent theme was the importance of community service providers receiving information on a student's level of academic, social, emotional, and behavioral functioning pre and post intervention from the student's teacher and/or school. Notably, one participant expressed, "Within the confines of the law, we need to be able to provide information on how children are doing after interventions have occurred". This information is integral to maintain successful programming for current and future students and for families to receive appropriate services. One funder participant specifically addressed the integral role the DOE/schools plays in cooperating with community partners. The participant stated, "That's essential on how to know and for any of the funders in the community to know if this is a worthwhile expenditure or not. We don't know and if we can't track what the results are afterward". This is pertinent information for funding agencies since this school level data directly informs the continuation and consistency of services. Other notable comments included school staff access and ability to identify mental and behavioral concerns early. Education

stakeholders expounded on the unique resources school systems can offer. As school district personnel, education stakeholders are the “eyes and ears for the community” that have multiple access points to monitor and advocate for students. This accessibility includes school district personnel and paraprofessionals such as, nurses, school counselors, school psychologists, bus drivers, cafeteria workers, custodians, and other staff. Students have access to many adults that are trained in child development and behavior and have the unique opportunity to “notice concerns and know how to act on those concerns appropriately”. The theme of accessibility also included remarks regarding how the school system offers accessibility to outside community service providers and families through their Student Based Teams (SBT) and Positive Behavioral Supports teams (PBIS). These meetings provide the opportunity for the school to invite community agency representatives to be active participants in the decision-making process. In particular one education stakeholder stated, “We can invite our community agency friends to the table to improve that service interaction, so when a family is needing that help, it’s not choppy and in a silo; its more seamless”. Interestingly, an education stakeholder described the experiences of collaboration, including the community’s utilization of the school districts’ resources from a different perspective. The participant noted:

Some of my responses have an aspirational tone. We have areas of our community that do it better and we have areas in our community that are still struggling with this, but we all are working towards this idea of a more seamless system of supports for our families.

Education stakeholders have the access and expertise to view student functioning through an educational lens, one that values assisting students' behavioral and mental health, so that all students can meet their educational goals. These school district personnel have a unique set of tools, such as the knowledge on how a student learns and develops. This perspective is going to directly inform the approach to serving a family and targeting goals, which according to one education stakeholder, is very different in a school setting versus a community or home setting.

Perspectives from other youth-serving systems

Community stakeholders were asked to provide remarks on what they believed to be the education's perspective on collaborating with the community. The following responses were provided by participants working in various community roles. Responses varied among participants, with only 22% (2/9 responses) categorized as positive perspectives. Positive responses from these two participants lacked specificity, with participants reporting that education stakeholders believe collaboration with the community as "pretty positive" and "very helpful". Multiple comments surrounded the theme that education stakeholders possibly believe the community should be responsible for intervening with students with severe behavioral problems, even if school mental health personnel (e.g., guidance counselor or school psychologist) have a positive rapport with the student. Other statements included that education stakeholders possibly feel overwhelmed with the behavioral and mental health of students presenting with more significant difficulties. Resistance and a lack of trust with the community system were also discussed. Lastly, one participant noted that perspectives amongst education stakeholders possibly vary by role (i.e., leadership administration versus instructional

personnel). Notably, multiple participants expressed positive progress at the leadership/administration level through recent social-emotional initiatives through The School District of Palm Beach County's 5-year Strategic Plan.

Barriers

Barriers were discussed and identified within community agencies and within the education/school system. Community agencies self-identified "not getting referrals on time" and managing caseloads across a vast geographical district as two factors that limit time with students. The most recurrent theme provided by community stakeholders regarded that of parents. Specifically, parent's resistance to labeling their child in order to continue supportive services frequently posed as a barrier. Additionally, a lack of parental involvement and parental advocacy were discussed as detrimental barriers to collaboration. Notably, one participant stated,

We still have a capacity issue, so if all of the schools all of a sudden heard everything about us and started referring every kid that is eligible, we wouldn't be able to serve them with our system because we are not that big. We still have that kind of capacity issue.

Other themes emerged regarding cultural and stigma factors that negatively impact a family's likelihood of seeking services, such as their willingness to involve service providers to assist with educational planning at school. Confusion or misunderstanding of behavioral health services were also barriers. Also, it was communicated that there is a lack of awareness of available services and this was particularly detrimental. When evaluating intra-agency topics, areas for improvement were identified. One participant shared that their agency has historically struggled to

collect and examine student's academic data post treatment. This weakness continues to negatively impact and interrupt service delivery. Education stakeholders identified two major themes when discussing barriers within the school system that negatively interfere with collaboration with community partners. A reoccurring theme of identifying principals as the gate keepers to behavioral and mental health supports were frequently mentioned. This theme appeared to have classroom and teacher level implications. The following quote is an illustration of this theme:

I think what we struggle with is not unique to us it's when that hits the classroom level or the school principal level it lays in tension with academic expectations, so when it gets down to the nitty gritty and when it gets down to the school grade or when it gets down to impacting a teacher's paycheck or a principal's evaluation its seen as competing with academic demands and academic demands are going to take priority.

Despite the discussion of barriers, participants shared a positive outlook and provided recommendations for addressing these identified barriers. Importantly, participants stated that openly discussing such barriers should not be seen as a poor reflection of the quality of services rendered by all stakeholders, but as a positive first step in the direction of an evolving quality improvement strategy.

Recommendations

All stakeholder participants were asked to provide recommendations on how to improve and strengthen the collaboration between the education/school system and the CBHC. Overall, results revealed that stakeholders valued varying strategies, such as increasing accessibility and awareness of the services provided through the CBHC,

improving communication and sharing of information with respect to the law and consent, and psychoeducation in-service training for school staff. Additional recommendations included developing plans to improve communication between community working groups, district wide standardized programming, and securing additional funding. Education stakeholders identified communication within and across agencies as being the most helpful recommendation. Specifically, it would be helpful to create a small working group of district stakeholders and county agency representatives to meet quarterly and discuss initiative successes, barriers, and create action plans. Similarly, another recommendation was to improve communication within existing working groups to avoid initiatives being developed in isolation. Community stakeholders broadly presented recommendations in the areas of increasing awareness, accessibility, school-based psychoeducation and training, increased funding efforts, and mandated district wide socio-emotional policies. The two participants from the funding organizations provided two recommendations, which included improving communication between working groups, which was consistent with a recommendation from an education stakeholder. The second funder participant stated that improving psychoeducation regarding mental and behavioral health would be helpful in strengthening collaboration efforts. It appears that themes emerged when observing the utility of implementing specific recommendations across particular stakeholder agencies. For example, education stakeholders appear to value the improvement of communication broadly, while community stakeholders recommend strengthening partnerships with principals and school personnel. It was also suggested to apply for additional funding to support existing programs, and gain access to student functioning data to inform services.

These recommendations identified gaps that should be addressed to facilitate an increase in collaboration with the School District of Palm Beach County. Recommendations listed by specific agencies are provided in Table 3.1.

Feasibility and motivation

Each stakeholder stated high feasibility with respect to implementing their proposed recommendation. Motivation to implement the individually proposed interventions did, however, vary slightly. Only one participant expressed low interest in implementing the provided recommendation. All other participants were highly motivated and provided the following statements depicting their level of motivation: “absolutely”, “very motivated”, “extremely”, “I’m passionate”, “I am jumping to the head of the line”, and “I would be totally up for taking action”.

Summary of Qualitative Findings

Broadly speaking, results from Phase I suggested an overall theme of the impact of services provided by the CBHC. Specific comments within this theme highlighted general perceptions of the CBHC, collaboration efforts between education/schools, barriers, and recommendations. Connection and organization were two descriptors frequently used to describe the CBHC in both the focus group and key stakeholder interviews. The following themes were identified across focus group and key stakeholder participants.

Parent participants shared positive comments regarding the quality of communication but noted that the quantity of communication as it relates to transition procedures could be improved. Interview stakeholders reported communication with community partnering agencies and their case managers as a strength. Nonetheless,

parents did highlight communication barriers in corresponding with school-based personnel. Results from both qualitative investigations rendered mixed findings as to the status of collaboration between education/schools and community agencies. Both parents and community stakeholders provided split opinions on the current quality and outlook of future partnership. Notably, the topic of school involvement emerged organically when presented with general questions inquiring about barriers during the focus group. However, given these results, the interview protocol for stakeholder interviews were designed to explore this phenomenon and probe for specific rationale. Common barriers mentioned were largely school related. Parents drove the conversation on this topic during the focus group. Subsequently, their concerns surrounded barriers that impact familial factors (i.e., parental input at IEP meetings). A few community partners did note the difficulty aligning treatment goals in school settings (i.e., IEP's), communication restrictions, and weak follow up plans. Statements regarding restrictions of communication and collaboration also have historically been impacted by the law and an individual's interpretation of the law. Constraints given SPED legal timelines and consent for school psychoeducational evaluations and communication across systems were broadly discussed in both the focus group and interviews. Despite these constraints, participants overall stated that there is a need to improve. Most participants either formally or informally expressed high motivation to take action within their given role and capacity.

Following analysis of the focus group and stakeholder interviews, a survey was created to investigate the level of helpfulness, feasibility, and motivation to implement

the top ten recommendations to strengthen and improve the collaboration between the department of education/schools and the CBHC.

Survey

The survey was open for participation between March 1st 2018 to May 1st 2018. Participants included ($n=33$) stakeholders, most of whom were female (72.7%) with years of experience ranging from 1 to 40 years ($M= 17$). The majority of participants were Caucasian (non-Hispanic) (84.8%), with the remainder being African American/Black (12.1%), and Asian/Pacific Islander (3.0%). Participants represented various agencies, with the School District of Palm Beach County and Families First of Palm Beach County having the highest response rate, 6 and 7 participants respectively. Other agencies represented included: Center for Children’s Counseling, United Way of PBC, PBC Youth Services Department, NAMI of PBC, PBC Health Department, The Alliance of Eating Disorders Awareness, SEDNET, Boystown of South Florida, Catholic Charities Diocese of Palm Beach, SequelCare, Bridges of Children’s Service Council of PBC, The Children’s Healing Institute, ChildNet, Pediatrician’s office, and a parent. Disciplines listed included: social work, education, psychology, government, administration, school health, medicine, mental health, school counseling, nonprofit management, and customer service. The greatest number of participants were represented from the following community agencies, Families First of PBC ($n=7$), NAMI ($n=4$), and Boystown of South Florida ($n=3$).

The overall most helpful recommendation identified by the survey participants was to secure additional funding to support existing staff, initiatives, and programming. This recommendation was rated as “excellent” (rating of 6) by 81.8% of participants.

Feasibility of implementation was rated as “poor” (rating of 1) by 6.1% of participants, 36.4% as 4, 24.2% as 5, and 12.1% as being “excellent” (rating of 6). Motivation for implementing this recommendation was rated as “excellent” by 57.6% of participants. The second highest rated recommendation for level of helpfulness was to educate school staff and students on mental and behavioral health, with 75.8% of participants rating it as “excellent”. Feasibility for implementation was rated slightly higher compared to the previous recommendation, with 33.3% of participants rating it with “excellent” feasibility. “Excellent” motivation levels were rated by the majority of participants (66.7%).

The School District of Palm Beach County ($n=6$) rated the following recommendation with the highest frequency: educate school staff on trauma informed care (i.e., effects of adverse childhood experiences on learning). An average feasibility rating of 5.5 was calculated. Both participants who ranked this recommendation as the most helpful reported “excellent” levels of motivation. Families First of PBC indicated that prioritizing family voice in treatment planning by increasing opportunities to prioritize individual/family needs (feasibility $M=5$ and motivation $M=5.5$) and provide feedback on services rendered and implement policy to mandate a district wide standard to addressing mental health in each school as a part of the curriculum (feasibility $M=4.5$ and motivation $M=6$) were equally rated as being most helpful to their agency. NAMI reported that educating school staff and students on mental and behavioral health (feasibility $M=6$ and motivation $M=6$) and improving policy to mandate a district wide standard to addressing mental health in each school as a curriculum (feasibility $M=3.5$ and motivation $M=6$) as both being equally helpful. Lastly, Boystown South Florida

unanimously rated securing additional funding to support existing staff, initiatives, and programing (feasibility $M= 3.6$ and motivation $M=4.6$) as the most helpful recommendation.

Taken together, when comparing recommendations across community agencies, the following recommendations were rated at the highest frequency as most helpful: prioritize family voice in treatment planning by increasing opportunities to prioritize individual/family needs and provide feedback, educate school staff and students on mental and behavioral health, and implement policy to mandate a district wide standard to addressing mental health in each school as a part of the curriculum. Please see Table 3.2 for a complete list of the top ranked most helpful recommendations by agency and Figure 3.1 for a visual representation of the results reported in Table 3.2. A complete list overall averages for the helpfulness, feasibility, and motivation level are displayed in Table 3.3.

Table 3.1 Agency Provided Recommendations for Improving Collaboration Between the Department of Education/Schools and the CBHC.

Recommendation	Agency
1. Introduce system partners and present available services to schools with new principals and teachers. The goal of this meeting would be for community agencies to receive feedback on the specific needs of each school.	Families First of PBC
2. Schools providing follow up information to outside agency on students referred by the school to the partnering agency. This information is not limited to grades, attendance, discipline referrals, and behavior.	PBC Youth Services Department
3. Educate school staff on trauma informed care (i.e., effects of adverse childhood experiences on learning).	PBC Youth Services Department
4. Hire and/or place professionals in schools to serve as mentors to students.	PBC Sheriffs Department
5. Improve communication and collaboration between working groups to avoid specific strategies or objectives being developed in isolation.	School District of PBC Guidance Specialist for School Counselors Funding agency: Quantum Foundation
6. Prioritize the individual and family voice in treatment planning by increasing opportunities to prioritize individual/family needs and provide feedback on services rendered.	SEFBHN
7. Educate school staff and students on mental and behavioral health.	Funding agency: PBC Community Services Department
8. Implement policy to mandate a district wide standard to addressing mental health in each school as a part of the curriculum.	Center for Children’s Counseling

9. Secure additional funding to support existing staff, initiatives, and programming.	JFK Medical Center North Campus
10. Create a small cohort (i.e., 8-12) of district stakeholders and county agency representatives that meet quarterly to discuss initiative successes, barriers and create action plans.	School District of PBC/Previous SEDNET Coordinator

Table 3.2 Top Ranked Most Helpful Recommendations for Improving Collaboration Between the Department of Education/Schools and the CBHC.

Recommendation	Agency
8. Implement policy to mandate a district wide standard to addressing mental health in each school as a part of the curriculum	Families First of PBC
	Center for Children’s Counseling
	NAMI
9. Secure additional funding to support existing staff, initiatives, and programming	PBC Health Department
	Boystown of South Florida
	Catholic Charities Diocese of Palm Beach
7. Educate school staff and students on mental and behavioral health	United Way of PBC
	The Alliance for Eating Disorders Awareness
	NAMI
6. Prioritize the individual and family voice in treatment planning by increasing opportunities to prioritize individual/family needs and provide feedback on services rendered	Families First of PBC
	Pediatrician’s Office
3. Educate school staff on trauma informed care (i.e., effects of adverse childhood experiences on learning)	The School District of Palm Beach County
	SEDNET
2. Schools providing follow up information to outside agency on students referred by the school to the partnering agency. This information is not limited to grades, attendance, discipline referrals, and behavior.	PBC Youth Services Department

Table 3.3 Mean Helpfulness, Feasibility, and Motivation per Recommendation.

Recommendations	Helpfulness	Feasibility	Motivation
1 Introduce system partners and present available services to schools with new principals and teachers. The goal of this meeting would be for community agencies to receive feedback on the specific needs of each school.	5.33	4.21	4.90
2 Schools providing follow up information to outside agency on students referred by the school to the partnering agency. This information is not limited to grades, attendance, discipline referrals, and behavior.	5.42	4.00	5.00
3 Educate school staff on trauma informed care (i.e., effects of adverse childhood experiences on learning).	5.63	4.69	5.39
4 Hire and/or place professionals in schools to serve as mentors to students.	5.30	4.30	5.03
5 Improve communication and collaboration between working groups to avoid specific strategies or objectives being developed in isolation.	5.54	4.72	5.27
6 Prioritize the individual and family voice in treatment planning by increasing opportunities to prioritize individual/family needs and provide feedback on services rendered.	5.48	4.78	5.33
7 Educate school staff and students on mental and behavioral health.	5.66	5.03	5.51
8 Implement policy to mandate a district wide standard to addressing mental health in each school as a part of the curriculum	5.51	4.00	5.18
9 Secure additional funding to support existing staff, initiatives, and programming.	5.75	4.00	5.36
10 Create a small cohort of district stakeholders and county agency representatives that meet quarterly to discuss initiative successes, barriers and create action plans.	5.45	4.81	5.18

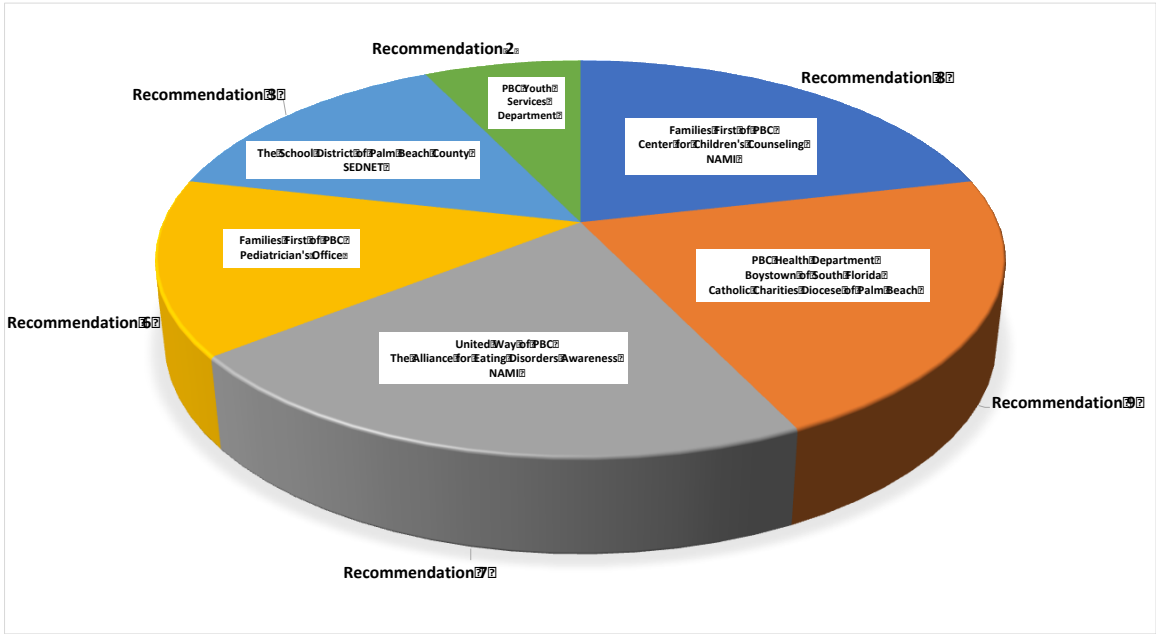


Figure 3.1 Top Ranked Most Helpful Recommendations for Improving Collaboration Between the Department of Education/Schools and the CBHC.

CHAPTER IV

DISCUSSION

Previous SOC evaluative research studies have reported variable findings (Bickaman, Sumerfelt, Firth, and Douglas, 1997; Bickman et al, 1999). The literature also has documented variability in the implementation of SOC principles. Contributing factors include inconsistent definitions of SOC values and varying assessment procedures to measure constructs in evaluative studies (Cook & Kilmer, 2004). Notably, previous research has investigated longitudinal outcomes for youth enrolled in a SOC, including intraindividual and interindividual differences across time (Vishnevsky et al, 2012). However, the existing literature has documented the Department of Education/schools' lack of involvement in SOC initiatives (Painter, 2012). Few studies have evaluated the level of partnership from the Department of Education/schools in a local SOC model and/or partnered with the education system as a core partner in the wraparound service delivery model (Painter, 2012; Stein et al, 2016; Green et al, 2016). Stakeholders, such as parents in previous qualitative studies communicated the necessity for schools to engage as an active partner in a SOC (Stein et al, 2016).

The majority of a student's day is spent within the educational environment and therefore, this environment provides intervention opportunities and may provide valuable daily functioning information to community service providers. Research supports that when psychological needs are considered,

the likelihood of school engagement increases (Adelman & Taylor, 2006; Vander Stoep et al., 2000; Zinns, Bloodworth, Weissberg, & Walberg, 2004), Student engagement has been linked to positive psychological and educational outcomes (Finn & Owings, 2006), which is a salient benefit to both families and educators alike. One study, Painter (2012) highlighted that the school district was a key factor to success when evaluating the outcomes from one SOC. Specifically, it was noted that funding and resources provided by the school district enabled families to receive mental and behavioral services by co-located staff from community partners at a less stigmatizing location. Overall, the Department of Education/schools can positively contribute as an active partner in a SOC. Such that, the educational system is designed to respond to educational needs of students by addressing daily challenges and supporting existing systems (Anderson & Matthews, 2001).

The current study explored stakeholder's perceptions and recommendations for ongoing quality improvement of a local system of care, the CBHC. Results are examined through the lens of the community-centered model, the ISF and in consideration of the GTO approach as a method to address results that will inform the SOC literature at broad. Such that, stakeholder perceptions of the level of shared participation, motivation, and feasibility of specific collaborations are considered. This paper was designed to fill the gap in the literature by investigating factors related to the success and short comings of a SOC and inform the SOC literature. In addition, this study aimed to inform research by providing recommendations for improvement by serving as a potential example of cross-system collaboration within a local SOC. This is particularly salient, given previously identified gaps in the SOC literature, suggesting

the lack of documented involvement of education/schools coordinating behavioral and mental health services for youth across community youth serving systems.

Qualitative results from both the focus group and stakeholder interviews highlighted strengths, such as the high quality of communication, identified financial and logistical barriers, and most importantly highlighted gaps in collaboration efforts of service. As the study expanded upon identified areas of improvement from the focus group, stakeholders provided a high level of detail within each area of concern. Specifically, each stakeholder proposed their unique perspectives on the status and quality of collaboration between education/school systems and community providers through the CBHC initiative. Notably, despite the diverse backgrounds of stakeholders, a consensus regarding the difficulties of communication and collaboration between the School District of Palm Beach County and community providers as inconsistent but evolving. A discussion of the current study's results and implications of findings are presented below.

Focus Group

Overall impressions of the CBHC at broad were extremely positive. Many participants used words that depicted a bridging of service or partnerships that forged connections. Stakeholder perceptions included broad stroke comments, such as the CBHC was life changing and some stakeholders provided specific comments of personal experiences that were later highlighted in the focus group forum as a strength of the CBHC. All three family stakeholders (parents and a student client) shared that the CBHC has made significant life changing impacts in their daily functioning and overall outcomes. Families appeared to be satisfied with the level of communication and quality

of services rendered. Notably, the notion of implementing a strength-based support approach appeared to be highly valued among families. This theme of approaching families holistically from a strength-based model was also noted by community partners. These results are substantive given the CBHC's SOC model is to deviate from the traditional medical model of services, where services are driven by a deficit or diagnosis. Community stakeholders focused more on how the CBHC has aligned goals across agencies and forged partnerships. Interestingly, both community and family stakeholders frequently mentioned the high-quality partnerships and subsequent relationships. Families who reported high satisfaction with the CBHC also appeared to have experienced positive relationships with care providers, which may partially explain positive outcomes with their family due to increased buy in and trust of the therapeutic relationship. This is consistent with previous research on the significant impact of a therapeutic alliance between care providers and their client's positive outcomes. Feedback from the focus group stakeholders aligned with the ISF framework, in that per their report, the CBHC has targeted shared participation of stakeholders. The ISF highlights the importance of collaboration and communication amongst stakeholders and helps one conceptualize influential variables, such as the who, what, where, and when components to increase collaboration efforts (Wandersman et al., 2008).

Limitations of the CBHC were determined to largely exist when participants discussed education/schools' role in the CBHC. These limitations identified school system barriers, in that clients of the CBHC recommended the Department of Education/schools begin to be play a more active role as a stakeholder in the CBHC. These limitations of the school and community communication breakdown is consistent

with other SOC qualitative evaluative studies (Stein, Conners, Chambers, Thomas, & Stephan, 2016). Improving communication was voiced as the primary recommendation. It appears as though to successfully establish clear communication channels, interventions must be targeted to improve communication at the school to family level, the school to community level, or both simultaneously to improve outcomes. This can be targeted by evaluating current procedures for parental involvement within the school, so that behavioral services are explicitly described and established in conjunction with the parents and their goals. Targeting the frequency and quality of communication is highly valued by participants from every stakeholder group (family, community, and education personnel).

Stakeholder Interviews

Stakeholders in upper leadership were selectively sampled from the participating agencies in the CBHC to gain additional insights as to the impact of services, barriers, and recommendations for on-going quality improvement. Interestingly, perceptions of the CBHC were consistent with focus group responses, in that stakeholders described the CBHC as collaborative, accessible, and a provider of a continuum of care services. This is informative given perceptions of community agency providers and families similarly mirror those in upper leadership positions of the participating agencies. These results may suggest that the strengths and limitations experienced by participants are observable across employment positions and rank.

The majority of stakeholders interviewed discussed the limited involvement and collaboration between the DOE/school system and community providers. However, the relationship was defined as “evolving” or “ongoing”. Notably, participants did not report

communication as non-existent nor did they attribute a lack of collaboration as purposeful. However, multiple participants did share that historically there has been “tension” and “resistance” with engaging in open dialogue about institutional barriers. The current role of DOE/schools in the CBHC appears to be functioning well in some areas of the district, which is highly dependent on principal relations. Principals were described as being the gate keepers to the school as a decision maker on the services provided to their students. MOU agreements have assisted progress towards building formal relationships, however, impressions seem to be that not all schools are aware or utilizing available services.

Barriers negatively impacting communication, sharing of information, and collaboration were largely due to system wide restrictions, such as MOU agreements, case load allocation, and a lack of standardized and mandated programming. Interpersonal barriers were also identified as a factor that significantly interferes with the CBHC’s ability to successfully make change within schools. These system wide barriers are consistent with the literature at broad and in alignment with GTO, which proposes the importance of communication of system level barriers and a needs assessment to target the gap in implementation. This resource mapping is captured through GTO’s thorough planning phase, which is designed to consider implementation and aligning efforts across multiple initiatives. These barriers may be addressed through the GTO approach and can be aligned with the stakeholder generated recommendations. Recommendations were provided by all stakeholder participants and varied greatly. Variability of recommendations appeared to be attributed to the specific needs and experiences that are unique to each partnering agency or family. For example, improving one aspect of the

CBHC may be salient to service providers but not necessarily be helpful to a funding agency or a family. Therefore, broad themes emerged within education stakeholders and community partners. These recommendations aimed to avoid duplication of services and reduce miscommunication to improve overall outcomes. To adequately execute these goals, the DOE/schools would need to assume a position as an active stakeholder in the CBHC. Unlike previous studies that did not specifically evaluate the status of collaboration between the DOE/schools, the current study expanded the literature by investigating collaboration efforts within a local SOC. Notably, this study fills a gap in the literature base by evaluating stakeholder voice, such as collecting stakeholder generated recommendations to inform quality improvement.

Survey

Notably, the survey results, which provided recommendations were distilled from three sources (Focus group, key stakeholder interviews, and survey participants), all which contributed to the direction and specificity as to how collaboration efforts can be improved. Therefore, many participants from Phase I directly informed Phase II, which subsequently impacted the recommendations that were provided to survey participants. Taken from this perspective, these final quantitative findings are the result of stakeholder feedback across three separate investigations.

Recommendations appeared appropriately individualized given the agency and/or DOE/school's role (i.e., a community agency rated recommendations that included direct service with families as most helpful). The School District of Palm Beach County's feasibility and motivation rating for their top recommendation were closely rated (5-6), while differences between feasibility and motivation levels emerged within community

agencies and were recommendation specific. For example, a few participants from different agencies voted low feasibility ratings (2-4) despite their ranking of a proposed recommendation as “excellent” regarding its helpfulness. Notably, those participants that noted low feasibility scores rated higher motivation levels (5-6). These results suggest that stakeholders are highly motivated to engage in the implementation of a recommendation one identifies as having the most utility and saliency for their given agency. However, approximately half of the participants from the top three highest responding agencies (The School District of Palm Beach County, NAMI, Boystown, and Families First of PBC) reported a disconnect between their perceived feasibility (i.e., low) and level of motivation (i.e., high), suggesting that despite high personal motivation, perceived barriers would interfere with successful implementation. These perceived barriers can impact implementation readiness for a SOC collaboration.

As previously stated, variability was present when comparing overall community agency recommendations with The School District of Palm Beach County’s top recommendation. This is consistent with previous SOC research, which indicated mixed findings are due to SOC being more of a philosophy than a specific practice model. Communities, therefore, have the flexibility in how they interpret a SOC value or principle and chose an implementation strategy (Cook & Kilmer, 2004; Kilmer, Cook, & Palamaro Munsell, 2010).

In order to align shared values, results from this study provide possible areas of overlap between DOE/schools and the CBHC. Education stakeholders reported that educating school staff on trauma informed care (i.e., effects of adverse childhood experiences on learning) would be highly useful and one highly ranked recommendation

from a community partner was to implement policy that could mandate a district wide standard to addressing mental health in each school as a part of the curriculum. These values are in alignment. Integrating these recommendations to best serve the needs of both agencies may raise the likelihood of increasing buy in and empower the DOE/schools to engage as an active stakeholder in the CBHC. Additionally, across all participants, the highest rated recommendation regarded securing additional funding for existing, initiatives, staff, and programming. This recommendation may also be integrated with The School District of Palm Beach County's recommendation, such that possible collaborative efforts may render additional funding to support the district's existing initiatives. Interestingly, the difference in recommendation value across agencies may be impacting the quality and quantity of communication and collaboration. Specifically, valued initiatives may be operating within silos, which can negatively influence communication efforts.

This survey served as part of an evaluative investigation as to the basic valued needs and current functioning of collaborative efforts between CBHC stakeholders and the education/schools. The results of the survey indicate varying needs that are agency specific, yet all align with shared values that aim to improve the lives of families in which they serve. It is recommended that the CBHC use the aforementioned topics for discussion in future collaborative meetings and share results with leadership as part of an informative on-going quality improvement update. These results should help provide the groundwork for areas of future studies. Consistent with GTO, next steps should include school-based needs assessments to gain a broader consensus of feasibility and motivation for implementation across the district. In addition, a more thorough needs assessment

should specifically investigate influential barriers that prevent the implementation of the provided recommendations. These results capture the unique strengths and barriers of collaboration efforts of a SOC and may serve as an example of possible areas of impact for other SOC's at broad. Notably, the resulting recommendations and investigation of feasibility and motivation constructs within this sample fill gaps in the evidence base by identifying areas of improvement at both the school and system levels. Specifically, the disjointed results amongst stakeholders when discussing personal evaluations of feasibility and their level of motivation were noted. This study has taken into consideration the aforementioned interpersonal factors that largely, in part interact with the successfulness of program implementation (i.e., SOC implementation) and advances the understanding of collaboration in a SOC when viewing these factors within the GTO model. Further, future studies should explore the perspective of the principal, given a theme throughout Phase I and Phase II identified the principal as the primary gatekeeper to improving collaboration. Given the results, additional research may be conducted to explore feasibility and motivation levels between leadership and staff within a given agency as an effort to further identify barriers and recommendations for on-going quality improvement.

Limitations

Participant responses may not generalize to the overall population due to selective sampling, number of participants, and rater bias. Each participant served as a representative of varying organizations that serve in a variety of capacities within the CBHC. Their unique experiences may not represent experiences or perceptions of stakeholders who were not interviewed as a part of the current study. Additionally, the

current study served as an evaluation of the CBHC at one time point during each phase of the study. Therefore, due to the cross-sectional design, results do not capture, or report change of perspectives or experiences over time. Lastly, due to sample size, results cannot be generalized to the greater CBHC population of providers and families. For example, only two parents participated in the key stakeholder interviews. In addition, ethnic minorities were underrepresented in the participant pool for the stakeholder interviews and survey, which again may impact generalizability of findings to underrepresented ethnic groups within the CBHC. Lastly, education stakeholders were underrepresented. This current study experienced challenges with recruiting education personnel. Recruitment efforts for education stakeholders were nonlinear and required communication through multiple channels and administrative approval before contact was granted. Less volunteerism was observed with these stakeholders than any other group during the recruitment phase. However, education stakeholders were one of the highest participating agencies observed in response to the survey. Recruitment efforts at the community level, specifically targeting staff personnel rendered challenges. Investigation of successful recruitment methods for community-based agencies is warranted.

Implications and Future Directions

In continuation of previous SOC evaluation research, this study has expanded the literature base by not solely focusing on barriers, but by asking stakeholders what recommendations would be most helpful in addressing the barriers that were mentioned throughout the focus group and stakeholder interviews. This is of particular usefulness given these recommendations were provided by stakeholders for stakeholders.

Recommendations for strengthening partnerships and encouraging a dialogue between the community and schools were presented. It is encouraged that future SOC studies evaluate current needs at the individual school level. It is suggested that this be conducted as part of a needs assessment, one consistent with GTO's methodology. Participants frequently referenced system wide restrictions as a barrier to collaboration across agencies. However, comments regarding recommendations typically included interpersonal relationship building through a network of school principals or school-based staff. Such findings have implications for policy makers at the local and state level and for system administration, given the necessity of additional funding to support existing programming and collaboration efforts in light of having limited resources. Future studies should target recruitment of education stakeholders in an attempt to examine their unique experiences and perceptions of collaboration efforts. It is integral for future research to examine perceptions of principals within their school district's SOC. Taken together, targeting both individual schools and district wide policies that restrict communication would be salient for families, schools, and community providers alike. Additionally, future studies may explore motivation and feasibility levels by job title and/or job responsibility to evaluate if the variability of motivation levels are influenced by job role or rank. This is of particular interest due to the variability of roles in organizations that may impact one's perception of their ability to be an active agent of change within their current role.

REFERENCES

- Adelman, H. S., & Taylor, L. (2006). The implementation guide to student learning supports in the classroom and schoolwide: New directions for addressing barriers to learning. Thousand Oaks, CA: Corwin Press.
- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Anderson, J. A. (2011). Patterns of school functioning over time among students served in a system of care. *Remedial and Special Education, 32*(6), 482-495.
doi:10.1177/0741932510364545
- Anderson, J. A., & Matthews, B. (2001). We care for students with emotional and behavioral disabilities and their families. *Teaching Exceptional Children, 33*(5), 34–39.
- Atkins, M. S., Hoagwood, K. E., Kutash, K., & Seidman, E. (2010). Toward the integration of education and mental health in schools. *Administration and Policy In Mental Health And Mental Health Services Research, 37*(1-2), 40-47.
doi:10.1007/s10488-010-0299-7
- Baker, J. A., Kamphaus, R. W., Horne, A., & Winsor, A. P. (2006). Evidence for population-based perspectives on children’s behavior adjustment and needs for service delivery in schools. *School Psychology Review, 35*, 31–46
- Becker, S. P., Paternite, C. E., Evans, S. W., Andrews, C., Christensen, O. A., Kraan, E. M., & Weist, M. D. (2011). Eligibility, assessment, and educational placement

- issues for students classified with emotional disturbance: Federal and state-level analyses. *School Mental Health*, 3(1), 24-34. doi:10.1007/s12310-010-9045-2.
- Bickman, L., Noser, K., & Summerfelt, W. T. (1999). Long-term effects of a system of care on children and adolescents. *The Journal of Behavioral Health Services & Research*, 26, 185–202. doi: 10.1007/ BF02287490
- Bickman, L., Summerfelt, W. T., Firth, J. M., & Douglas, S. M. (1997). The Stark County evaluation project: Baseline results of a randomized experiment. in C. T. Nixon & D. A. Northrup (Eds.), *Evaluating mental health services: How do programs for children “work” in the real world?* (pp. 231–258). Thousand Oaks, CA: Sage
- Bradley, R., Doolittle, J., & Bartolotta, R. (2008). Building on the data and adding to the discussion: The experiences and outcomes of students with emotional disturbance. *Journal of Behavioral Education*, 17(1), 4-23. doi:10.1007/s10864-007-9058-6
- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology* 3, 77-101.
- Bryman, A. (2006). Barriers to integrating quantitative and qualitative research. *Journal of Mixed Methods Research*, 1, 8-22.
- Borgmeier, C., & Horner, R. H. (2006). An evaluation of the predicted validity of confidence ratings in identifying functional behavioral assessment hypothesis statements. *Journal of Positive Behavioral Interventions*, 8(2), 100–105.
- Burns, B. & Hoagwood, K. (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press.

- Burns, B., Hoagwood, K., & Mrazek, P. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review*, 2, 199-254
- Center for Disease Control and Prevention. (2016) Adverse Childhood Experiences (ACEs). Retrieved from: <https://www.cdc.gov/violenceprevention/acestudy/>
- Cicchetti, D., & Toth, S. (1995). Developmental psychopathology and disorders of affect. In D. Cicchetti & D. Cohen (Eds.), *Developmental psychopathology: hl. 2. Risk, disorder, and adaptation* (pp. 369-420). New York: Wiley
- Coffee, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. Thousand Oaks, CA: Sage.
- Cohen, R., Parmelee, D., Irwin, L., Weisc, J., Howard, P., Purcell, P., & Best, A. (1990) Characteristics of children and adolescents in psychiatric hospital and a corrections facility. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 909-913.
- Cook, J. R., & Kilmer, R. P. (2004). Evaluating systems of care: Missing links in children's mental health research. *Journal of Community Psychology*, 32, 655–674. doi: 10.1002/jcop.20024
- Creswell, J. W., & Plano Clark, V. L., Gutmann, M., & Hanson, W. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 209-240). Thousand Oaks, CA: Sage.
- Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd Ed.). Thousand Oaks, CA: Sage

- De Voursney, D., & Huang, L. N. (2016). Meeting the mental health needs of children and youth through integrated care: A systems and policy perspective. *Psychological Services, 13*(1), 77-91. doi:10.1037/ser0000045
- Derzon, J. H., Yu, P., Ellis, B., Xiong, S., Arroyo, C., Mannix, D., & Rollison, J. (2012). A national evaluation of Safe Schools/Healthy Students Initiative: Outcomes and influences. *Evaluation and Program Planning, 35*(2), 293- 302. doi:10.1016/j.evalprogplan.2011.11.005
- Dube, S., Felitti, V., Dong, M., Giles, W., Anda, R. (2003). The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900. *Preventive Medicine, 37*(3), 268-277.
- Eber, L., & Nelson, C. M. (1997). School-based wraparound planning: Integrating services for students with emotional and behavioral needs. *American Journal of Orthopsychiatry, 67*(3), 385-395. doi:10.1037/h0080241
- Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: Results from the Adverse Childhood Experiences study. *The American Journal of Psychiatry, 160*(8), 1453-1460. doi:10.1176/appi.ajp.160.8.1453
- Epstein, M. H., & Walker, H. H. (2002). Special education: Best practices and first steps to success. In B. Burns & K. Hoagwood (Eds.), *Community and treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*.

- Fetters, M., Curry, L., Creswell, J. (2013). Achieving integration in mixed methods designs- principles and practices. *Health Services Research*. DOI: 10.1111/1475-6773.12117
- Finn, J.D., & Owings, J. (2006). The adult lives of at risk students: The role of attainment and engagement in high school statistical analysis report,
- Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). School mental health services in the United States, 2002–2003. DHHS Pub. No. (SMA) 05–4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Garland, A., Hough, R., McCabe, K., Yeh, M., Wood, P., Aarons, G. (2001). Prevalence of psychiatric disorders in youths across five sectors of care. *Journal of American Academy Child Adolescent Psychiatry*, 40(409).
- Green, J.C., Caracelli, V.J., & Graham, W.F. (1989). Toward a conceptual framework for mixed-methods evaluation designs. *Educational Evaluation and Policy Analysis*, 11(3), 255-274.
- Green, J. G., Xuan, Z., Kwong, L., Anderson, J. A., & Leaf, P. J. (2016). School referral of children with serious emotional disturbance to systems of care: Six-month clinical and educational outcomes. *Journal of Child and Family Studies*, 25(12), 3728-3738. doi:10.1007/s10826-016-0511-9
- Herron, M., Martin, J. (2015). Capacity and Opportunity: Predicting Engagement for Middle School Students with Behavioral Disorders. *Journal of Emotional and Behavioral Disorders*, 23, 4, 215-225.

Hernandez, M., & Hodges, S. (2003). Building upon the theory of change for systems of care. *Journal of Emotional and Behavioral Disorders, 11*(1), 17-24.

doi:10.1177/106342660301100104

Horwitz, S., Fahrenthold, D. (2012). The Washington Post. Retrieved from:

https://www.washingtonpost.com/politics/sandy-hook-elementary-school-shooting-leaves-students-staff-dead/2012/12/14/24334570-461e-11e2-8e70-e1993528222d_story.html?utm_term=.78fbb3024736

Joint Commission on the Mental Health of Children. (1969). Crisis in child mental health. New York: Harper & Row.

Kilmer, R. P., Cook, J. R., & Palamaro Munsell, E. (2010). Moving from principles to practice: Recommended policy changes to promote family-centered care.

American Journal of Community Psychology, 46, 332–341. doi: 10.1007/s10464-010-9350-9

Knitzer, J. (1996). The role of education in systems of care. In B.A. Stroul & R.M. Friedman (Eds.), *Systems of care for children's mental health*. Baltimore: Brookes.

Knitzer, J., Steinberg, Z., & Fleisch, B. (1990). *At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional problems*. New York: Bank Street College of Education.

Levison-Johnson, J., Dewey, J., & Wandersman, A. (2009). *Getting to Outcomes in systems of care: 10 steps for achieving results-based accountability*. Atlanta, GA: ICF Macro.

- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications, Inc.
- Lyons, J. S., Baerger, D. R., Quigley, P., Erlich, J., & Griffin, E. (2001). Mental health service needs of juvenile offenders: A comparison of detention, incarceration, and treatment settings. *Children's Services: Social Policy, Research, & Practice*, 4(2), 69-85. doi:10.1207/S15326918CS0402_2
- Mattison, R. (2015). Comparison of students with emotional and/or behavioral disorders as classified by their school districts. *Behavioral Disorders*, 40, 3, 196-209.
- Miller, J. G. (2001). QBQ! Question Behind the Question. What to Really Ask Yourself. Practicing Personal Accountability in Business and in Life. Denver Press.
- Morgan, P. p., & Farkas, G. (2016). Evidence and Implications of Racial and Ethnic Disparities in Emotional and Behavioral Disorders Identification and Treatment. *Behavioral Disorders*, 41(2), 122-131.
- Morgan, P. L., Farkas, G., Hillemeier, M. M., & Maczuga, S. (in press). *Extensive evidence of racial and ethnic disparities in disability identification in U.S. schools*. Manuscript submitted for publication.
- National Center for Education Statistics: U.S. Florida Department of Education. (2017). Exceptional Student Education. Retrieved from <http://www.fldoe.org/academics/exceptional-student-edu/>
- Nelson, J. R., Stage, S., Duppong-Hurley, K., Synhorst, L., & Epstein, M. H. (2007). Risk Factors Predictive of the Problem Behavior of Children At Risk for Emotional and Behavioral Disorders. *Exceptional Children*, 73(3), 367-379.

Now is the Time (2013). Washington D.C. Retrieved from:

https://obamawhitehouse.archives.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf

Onwuegbuzie, A.J., Bustamante, R. M., and Nelson, J. A. (2010). Mixed research as a tool for developing quantitative instruments. *Journal of Mixed Methods Research* 4 (1), 56-78

Painter, K. (2012). Outcomes for youth with severe emotional disturbance: A repeated measures longitudinal study of a wraparound approach of service delivery in systems of care. *Child & Youth Care Forum*, 41(4), 407–425.

<https://doi.org/10.1007/s10566-011-9167-1>

Patterson, G., Reid, J., & Dishion, T. (1992). *Antisocial boy*. Eugene, OR: Castalia.

Patton, M. Q. (2002). *Qualitative research and evaluative methods*. Thousand Oaks, CA: Sage

Pires, S. (2013). Customizing health homes for children with serious behavioral health challenges. Retrieved from:

http://www.chcs.org/publications3960/publications_show.htm?doc_id126488

Porowski, A., O’Conner, R., Luo, J. (2014). How do states define alternative education? Institute of Education Sciences. U.S. Department of Education.

President’s Commission on Mental Health. (1978). Report of the sub-task panel on infants, children, and adolescents. Washington, DC: Author

- President's New Freedom Commission. (2003). *Achieving the promise: Transforming mental health care in America*. Washington, DC: President of the United States.
<http://govinfo.library.unt.edu/mentalhealthcommission/reports/reports.htm>
- Puddy, R. W., Roberts, M. C., Vernberg, E. M., & Hambrick, E. P. (2012). Service coordination and children's functioning in a school-based Intensive Mental Health Program. *Journal of Child and Family Studies, 21*(6), 948-962.
doi:10.1007/s10826-011-9554-0
- Quinn, K. (2004). School-based strategies for meeting the needs of socially and emotionally challenged children and youth. Retrieved May 30, 2006, from <http://www.albany.edu/aire/urban/quinn.html>
- Raywid, M.A. (1994). Alternative schools: The state of the art. *Educational Leadership, 52*(1), 26-31
- Safran, S. P., & Oswald, K. (2003). Positive behavior supports: Can schools reshape disciplinary practices? *Exceptional Children, 69*, 361-373.
- Securing Florida's Future Budget. (2018). Gov. Rick Scott signs the Securing Florida's Future budget. Retrieved June 2018, from <https://www.flgov.com/2018/03/16/gov-rick-scott-signs-the-securing-floridas-future-budget/>
- Steiner, H., & Cauffman, E. (1998). Juvenile justice, delinquency, and psychiatry. *Child and Adolescent Psychiatric Clinics of North America, 7*, 653-672.
- Stein, K., Connors, E., Chambers, K., Thomas, C., Stephan, S. (2016). Youth, Caregiver, and staff perspectives on an initiative to promote success of emerging adults with

- emotional and behavioral disabilities. *The Journal of Behavioral Health Services & Research*, 43, 582-596.
- Stephens, R. L., Holden, E. W., & Hernandez, M. (2004). System of care practice review scores as predictors of behavioral symptomatology and functional impairment. *Journal of Child and Family Studies*, 13, 179–191. doi: 10.1023/B:JCFS.0000015706.77407.cb
- Strompolis, M., Vishnevsky, T., Reeve, C. L., Munsell, E. P., Cook, J. R., & Kilmer, R. P. (2012). Educational outcomes in a system of care for children with emotional disturbance. *American Journal of Orthopsychiatry*, 82(1), 129-136. doi:10.1111/j.1939-0025.2011.01126.x
- Stroul, B. (2002). Systems of care: A framework for system reform in children's mental health. Retrieved from <http://gucchd.georgetown.edu/products/SOCIssueBrief.pdf>
- Stroul, B., & Friedman, R. (1986). A system of care for children and youth with severe emotional disturbances (rev.ed.). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.
- Stroul, B., & Friedman, R. (1996). The system of care concept and philosophy. In B. A. Stroul & R. M. Friedman (Eds.), *Systems of Care for Children's Mental Health*. Baltimore: Brooks.
- Substance Abuse and Mental Health Services Administration (SAMHSA) (2002). Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders. Rockville, MD.

- Substance Abuse and Mental Health Services Administration (SAMHSA). (2015a). Safe Schools/Healthy Students. Retrieved from <https://www.samhsa.gov/safe-schools-healthy-students/about>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2015b). Project AWARE Grant Information. Retrieved from <https://www.samhsa.gov/nitt-ta/project-aware-grant-information>
- Teplin, L., Abran, K., McClelland, G., Dulcan, M., & Mericle A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 59, 1133-1143
- The School District of Palm Beach County. (2017). Office of communications. 2017 facts at a glance. Retrieved from: <https://www.palmbeachschools.org/communications/wp-content/uploads/sites/52/2016/04/District-Facts-Brochure.pdf>
- U.S. Congress, Office of Technology Assessment. (1986). Children's mental health: Problems and services—a background paper. Washington, DC.
- U.S Department of Education (2016). Building the Legacy: IDEA 2004 Retrieved June 3, 2016 from: <http://idea.ed.gov/explore/view/p/,root,regs,300,A,300%252E8,c,4,i>
- U.S. Department of Education, National Center for Education Statistics (2001). *Digest of education statistics, 2010* (NCES 2011-015), Chapter 2.
- U.S. Department of Education (2012). National Center for Education Statistics, Core of Data (CCD), "Public Elementary/Secondary School Universe Survey," 1990-91 through 2010-11. Retrieved August 13, 2016 from: https://nces.ed.gov/programs/digest/d12/tables/dt12_108.asp

- U.S Department of Education. (2014). School Climate Transformation Grant- Local Educational Agencies. Retrieved from:
<https://www2.ed.gov/programs/schoolclimatelea/index.html>
- United States Census Bureau. (2015). Quick facts, Palm Beach, Florida. Retrieved from:
<https://www.census.gov/quickfacts/table/PST045215/12099>
- Vander Stoep, A., Beresford, S., Weiss, N. S., McKnight, B., Cauce, A. M., & Cohen, P. (2000). Community-based study of the transition to adulthood for adolescents with psychiatric disorder. *American Journal of Epidemiology*, 152, 352–362.
- Vishnevsky, T., Strompolis, M., Reeve, C. L., Kilmer, R. P., & Cook, J. R. (2012). Using latent growth curve modeling to examine changes in mental health outcomes for children enrolled in a system of care. *American Journal of Orthopsychiatry*, 82(1), 121–128. <https://doi.org/10.1111/j.1939-0025.2011.01131.x>
- Walker, J. S., & Bruns, E. J., & The National Wraparound Initiative Advisory Group. (2008). Phases and activities of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children’s Mental Health. Retrieved from [http://nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-\(phases-and-activities\).pdf](http://nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf)
- Walker, J.S., & Shutte, M. K. (2004). Practice and process in wraparound teamwork. *Journal of Emotional and Behavioral Disorders*, 12, 182-192.
- Walker, J. S., & Schutte, K. M. (2005). Quality and individualization in wraparound planning. *Journal of Child and Family Studies*, 14, 251– 267. doi: 10.1007/s10826-005-5052-6

- Wandersman, A. (2003). Community science: Bridging the gap between science and practice with community-centered models. *American Journal of Community Psychology, 31*, 227-242.
- Wandersman, A., Alia, K., Cook, B. S., Hsu, L. L., & Ramaswamy, R. (2016). Evidence-based interventions are necessary but not sufficient for achieving outcomes in each setting in a complex world: Empowerment evaluation, getting to outcomes, and demonstrating accountability. *American Journal of Evaluation, 37*(4), 544-561. doi:10.1177/1098214016660613
- Wandersman, A., Imm, P., Chinman, M., & Kaftarian, S. (2000). Getting to outcomes: A results-based approach to accountability. *Evaluation and Program Planning, 23*, 389–395
- Wandersman, A., Dufy, J., Flaspohler, P., Noonan, R., Lubell, K., Stillman, L., Blachman, M., Dunville, R., Saul, J. (2008). Bridging the gap between prevention research and practice: The interactive Systems Framework for dissemination and implementation. *American Journal of Community Psychology, 41*, 171-181.
- Wasserman, G., McReynolds, L., Ko, S., Katz, L., & Carpenter, J. (2005). Gender differences in psychiatric disorders at juvenile probation intake. *American Journal of Public Health, 95*, 131-137
- Wasserman, G., McReynolds, L., Lucas, C., Fisher, P., & Santos, L. (2002). The Voice DISC-IV with incarcerated male youths: Prevalence of disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 314-321

Wright, E. R., Russell, L. A., Anderson, J. A., Kooreman, H. E., & Wright, D. E. (2006).

The impact of team structure and roles on achieving treatment goals in a system of care. *Journal of Emotional and Behavioral Disorders*, 14, 240–250.

Zinns, J. E., Bloodworth, M. R., Weissberg, R. P., & Walberg, H. J. (2004). The

scientific base linking social and emotional learning to school success. In J. E.

Zinns, R. P. Weissberg, M. C. Wang, & H. J. Walberg (Eds.), *Building academic*

success on social and emotional learning: What does the research say? New York:

Teachers College Press.