Examining the Processes and Outcomes of a
School-Based Mental Health Pilot

Thesis

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Abstract

Despite research demonstrating the efficacy of school-based mental health (SBMH) as a strategy for improving mental health access and outcomes among youth, there exists a significant research to practice gap. In particular, more research is needed to understand which youth benefit from SBMH under what conditions. In this study, mixed methods were employed to examine the outcomes and processes experienced during SBMH adoption and implementation at four Title I elementary schools. Analysis of MH service records pointed to improved access and decreased symptomology among youth and Hispanic youth in particular. However, several symptoms remained above clinical benchmarks, and the use of family therapy proved challenging in a SBMH model. Interviews with 12 stakeholders, representing the schools, district, MH agency, and the state government, provided further insight into various processes involved in SBMH (e.g. such as establishing partnerships). Facilitators identified as important included administrative buy-in, role clarity, data, funding, and quality partnerships, though certain factors emerged as especially important during only certain aspects of the SBMH work. Overall, the findings of this study provided insight into the conditions which schools, districts, and states need to have or develop in order to facilitate the success of SBMH.
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Vita

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Chapter One: Introduction

Mental health (MH) has been broadly defined as:

“A state of well-being in which the individual realizes his or her own abilities, can cope with the common stresses of life, can have fulfilling relationships with other people, can work productively and fruitfully, and is able to make a contribution to his or her community (Miles et al., 2010, p.18).”

All people experience stressors which detract from this ideal state, but for 18-20% of the US population (Kataoka, Zhang, & Wells 2002; Merikangas et al., 2010; SAMHSA, 2013), diagnosable mental illnesses impede their MH. Unaddressed MH needs contribute to negative outcomes at multiple levels, qualifying this gap as a serious public health concern. Health disparities exist between adults with and without MH disorders, with the former group facing higher rates of diabetes and high blood pressure as well as lower life expectancy (Robson & Gray, 2007). Additionally, there are societal costs associated with untreated MH concerns. For instance, nationally, the economic burden of depression alone was estimated at $83.1 billion in 2000, with projections that this condition would be the leading cause of disease burden in high-income countries by 2030 (Greenberg et al., 2003).

Children’s Mental Health

While these statistics suggest that mental illness is an adult problem, 50% of MH disorders emerge prior to age fourteen (Kessler et al., 2005). The percentage of youth experiencing mental illness mirrors the trends in the overall population as an estimated 20% of youth have a “psychological, social, emotional, or behavioral problem[s],” and approximately 5-
10% of youth have a persistent, serious emotional disturbance (SED; Merikangas et al., 2010; Reinke et al., 2011, p.4). Common MH illnesses among youth include anxiety (13% of children and adolescents), behavior or conduct disorders (10.3%), and mood disorders (6.2%; AAP, 2004). Among youth with MH disorders, 20.9% have more than one diagnosis simultaneously, but 42% experience more than one diagnosis throughout childhood and adolescence (AAP, 2004; Merikangas et al., 2010).

Physiological causes of mental illness are exacerbated by environmental stressors & trauma such as experiences of abuse, family disruption, peer rejection, and witnessing or experiencing violence (Essex et al., 2006; Merikangas et al., 2010; Reinke et al., 2011; Schilling, Aseltine Jr., & Gore, 2007). Mental illnesses manifest as problems such as internalizing and externalizing symptoms or as the absence of positive attributes such as social competence or self-acceptance (Suldo, Gormley, DuPaul, & Anderson-Butcher, 2014). To understand how MH issues present in classrooms, Reinke and colleagues (2011) surveyed 292 teachers, among whom the five most frequently identified issues were behavior problems, hyperactivity/inattention, significant family stressors, social skills deficits, and depression.

While MH services can help to mitigate the effects of underlying mental illnesses and promote protective factors, an alarming 70-80% of youth who might benefit from services never receive them (Aratani & Cooper, 2012; Kataoka, Zhang, & Wells, 2002; Sarno-Owens & Murphy, 2004). When left “under-identified and under-served,” MH issues can contribute to negative outcomes in other domains of health and development (Kataoka, Zhang, & Wells, 2002; Kutash et al., 2007, p.161; Sarno-Owens & Murphy, 2004). Among youth, such negative outcomes include worse academic performance; higher rates of school drop-out; increased rates of substance use; and higher rates of juvenile incarceration (AAP, 2004; Cooper, 2008; Eber, Hyde,
& Suter, 2010; Hacker & Darcy, 2006). These experiences can, in turn, exacerbate MH concerns, ultimately causing a “spiraling [of] negative effects for youth (Suldo et al., 2014, p. 5).” Suicide, which results from interaction of contextual and psychological factors, was the second leading cause of death among 12-17 year olds in 2010 (Perou et al., 2013).

The reasons MH issues remain unaddressed are numerous and diverse. As such the negative outcomes experienced by those with mental illness are best thought of as the result of a confluence of problematic micro-, mezzo-, and macro-level system level factors rather than as direct results of an illness (Atkins et al., 2006; Miles et al., 2010). Systemic barriers that prevent youth from accessing services include the stigma, cost, complexity, and fragmentation that have historically characterized the MH system (AAP, 2004; Atkins et al., 2006; Cooper, 2008; Cowell, 2013; Miles et al., 2010; Hacker & Darcy, 2006).

Youth living in poverty and/or from marginalized ethnic groups are often acutely impacted by these barriers which compound upon each other within the context of disadvantaged circumstances (AAP, 2004; Atkins et al., 2006). These groups are less likely to access services (Coker et al., 2009; Cook, Barry, & Busch, 2012), and those individuals that do initiate services are more likely to prematurely terminate services (Aratani & Cooper, 2012; Yeh, McCabe, Hough, DuPuis, & Hazen, 2003). In part because of such trends, disparities in MH outcomes exist between youth from differing socioeconomic and cultural groups. Data from a nationally representative survey found that youth living below 200% of the poverty line were 1.6 times more likely to experience SEDs than the average youth, and both African American and Hispanic youth were overrepresented in the segment of young people dealing with SEDs (Mark & Buck, 2006).
In addition to adverse outcomes among individuals, there are high costs to society associated with mental disorders among children. When both direct (e.g., health care) and indirect (e.g., lost productivity) costs are accounted for, estimates suggest that the annual cost of children’s mental health disorders in the United States was $247 billion (Perou et al., 2013). The systemic nature of the problem, the disparities in outcomes among vulnerable groups, and the high price tag of mental illness have all contributed to the identification of children’s MH as an area of serious public health and social justice concern (Miles et al., 2010; New Freedom Commission, 2003; The White House, 2013; U.S. Department of Health and Human Services, 2000; Weist, 2005).

The Need for a Systemic Solution

In order to address systemic barriers and address the unmet needs of youth, a systemic solution is needed. The fields of public health and social work are well situated to lead the development of a “comprehensive and coordinated children’s MH system (Miles et al., 2010). Such an approach would emphasize promotion and prevention at the population level, making primary, secondary, and tertiary services available to individuals with varying levels of need (Kelly & Lueck, 2011; Merikangas et al., 2010; Miles et al., 2010; Weist, 2005). Such an approach also would work to address disparate outcomes and access unjustly experienced by disadvantaged youth and to promote multi-sector collaboration aimed at addressing social determinants of poor health (Miles et al., 2010).

As one possible solution to these multifaceted and important issues, interest in and political will behind a school-based approach to children’s MH has been increasing over the past decade given the growing body of research suggesting that such an approach can improve MH access and outcomes among youth (H.R.628, 2013; New Freedom Commission, 2003; S. 689,
The rapid expansion of school-based mental health, however, has outpaced implementation research (Atkins, Hoagwood, Kutash, & Seidman, 2010; Massey et al., 2005; Thaker et al., 2008; Weist, Lowie, Flaherty, & Pruitt, 2001) As such, more research is needed which incorporates an implementation science approach to translating a comprehensive, school-based approach to delivering MH services for youth (Forman et al., 2013 in Suldo, 2014).

This study builds upon the existing SBMH research by robustly examining, using mixed methods, the model at four Title I elementary schools in Utah. These schools serve an ethnically diverse student population, a large majority of which is living in poverty. Further, these schools had received focused attention and support from the Utah State Office of Education (USOE) within the context of a broader state wide effort to promote school-based mental health (SBMH). These characteristics made this context ideal for study as little research has been done in settings like these. By understanding the outcomes and processes experienced there, it will be possible to inform the work of other schools, districts, and states looking to understand what and how improvements to children’s MH can occur through SBMH.
Chapter Two: Review of Literature

Defining School Based Mental Health (SBMH)

The emerging SBMH approach to service delivery embodies all of the characteristics of a public health approach and is consistent with the values of the social work profession. Consistent with the call for a ‘population focus,’ schools reach more youth than any other public or private sector. Already, 70-80% of psychosocial services delivered are done in coordination with schools. Most of these services, however, are not school-based, and as stated, an extremely high percentage of youth remain unserved (Rones & Hoagwood, 2000; Kataoka, et al., 2003). An SBMH approach includes the full-continuum of services, promoting MH among all youth and intervening with secondary and tertiary prevention strategies when necessary (Iachini, Door, & Anderson-Butcher, 2008; Weist, 1999). Several of the other best practices / principles identified for SBMH are shown in table one, along with corresponding principles from the Public Health and Social Work Codes of Ethics (Lever et al., 2006; National Association of Social Workers, 2008; Thomas et al., 2002). As this table reinforces, SBMH is consistent with many of the ideals upheld by both professions even beyond some of the key tenets already discussed. For example, all three promote evidence-based practice, respect for cultural diversity, and collaboration across disciplines (Lever et al., 2006; National Association of Social Workers, 2008; Thomas et al., 2002.)
Table 1: Best Practices for SBMH, Public Health, and Social Work

<table>
<thead>
<tr>
<th>SBMH Principle</th>
<th>Public Health Practice Standard</th>
<th>Social Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Adapted from Lever et al., 2006)</td>
<td>(Thomas et al., 2002, p.1058)</td>
<td>(NASW, 2008)</td>
</tr>
<tr>
<td>Ensure all youth and families have access to care regardless of ability to pay</td>
<td>Ensure that “basic resources and conditions necessary for health are accessible to all people”</td>
<td>“Strive to ensure access to needed information, services, and resources”</td>
</tr>
<tr>
<td>Use evidence based practices to reduce barriers to development and learning</td>
<td>“Programs and policies should be implemented in a manner that most enhances the physical and social environment.”</td>
<td>“Fully use evaluation and research evidence in their professional practice.”</td>
</tr>
<tr>
<td>Actively involve students, families, teachers, and other key stakeholder groups</td>
<td>“Policies, programs, and priorities should be developed and evaluated through processes that ensure... input from community members”</td>
<td>“Strive to ensure meaningful participation in decision making for all people”</td>
</tr>
<tr>
<td>Respect cultural and developmental diversity among students, families, and school staff</td>
<td>“Anticipate and respect diverse values, beliefs, and cultures in the community.”</td>
<td>“Promote sensitivity to and knowledge about cultural and ethnic diversity.”</td>
</tr>
<tr>
<td>Promote interdisciplinary collaboration</td>
<td>“Engage in collaborations and affiliations in ways that build the public’s trust and...effectiveness”</td>
<td>“Participate in [interdisciplinary teams] and contribute to decisions that affect the well-being of clients”</td>
</tr>
</tbody>
</table>

**Components of SBMH**

At one end of the continuum of services are the universal strategies for MH prevention and promotion. Primary prevention strategies are those delivered to or on behalf of all students
which promote MH by teaching social and transition skills, creating a positive emotional climate, and providing information about MH resources (AAP, 2004; Adelman & Taylor, 1999). Examples of primary prevention strategies include the use of manualized skill-based programs (e.g. Botvin Life Skills [lifeskillstraining.com]; Boys Town Teaching Social Skills to Youth [www.boystownpress.org]), classroom-based management and school-wide climate strategies aimed to support all youth at school, as well as universal screenings to facilitate early identification (Weist, Rubin, Moore, Adelsheim, & Wrobel, 2007).

Secondary prevention efforts intervene with youth who have an identified MH need that does not yet interfere with their participation in the general education setting (AAP, 2004). Put differently, these services minimize specific risk factors that if left unaddressed, have the potential to contribute to the eventual onset of more severe mental illness. These services are more personalized and provide additional supports to youth, though not at the level of wrap-around services. Examples of youth who may benefit from such services include those who are transitioning between educational settings (e.g. from immigrant families), those who are frequently absent or truant, and those who need support dealing with a specific learning problem that may contribute to low self-esteem/self-efficacy (Adelman & Taylor, 1999; Adelman & Taylor, 2000).

Tertiary services are the intensive MH therapy or special education services and associated wraparound services implemented to minimize the negative impacts of severe, diagnosable mental illness. Because of the level of need in these cases, services for a single youth receiving tertiary services often involve multiple professionals (AAP, 2004).
Models of SBMH

Although most services are organized across these three strategies, different models for delivering MH services through schools have been identified. At the highest level of classification, a model can be either school-owned or the product of a school-community collaboration involving public and private partners (AAP, 2004; Adelman & Taylor, 2000). In school-owned models, these services are provided on staff by school staff such as school social workers, guidance counselors, or school psychologists (AAP, 2004). School-community collaborations often arise when schools do not have sufficient resources to provide a comprehensive MH services alone.

Within collaborative models, there is further distinction between school-linked, school-based, and community school models (Adelman & Taylor, 1999). Community (or full-service) schools are unique in the level of integration across types and levels services as well as in the level of investment/involvement of community partners in the school (Anderson-Butcher, 2008; Anderson-Butcher et al., 2010). The key difference between the other two types of collaborative models is where tertiary MH services are provided to youth. When services are provided on site at schools, these services are considered “school-based,” as opposed to “school-linked,” in which case services are provided at partners’ own off-site facilities (Adelman & Taylor, 1999). While location is the key difference, it is important to note that school-based services should be more than simply co-locating a therapist at the schools but should involve true collaboration between school and community partners to determine how best to integrate mission and approach.

The potential benefits of school-based MH have been described as “unparalleled” (Flaspohler et al., 2006, p.30). Students referred to SBMH are more likely to access care, and co-
locating services can alleviate transportation barriers which contribute to the high rate of drop-outs from clinic-based services, particularly amongst low-income youth (AAP, 2004; Atkins et al., 2006; Cummings, Ponce, & Mays, 2010; Evans, 1999; Flaspholer et al., 2006; Sarno-Owens & Murphy, 2004; Weist, 1999). SBMH proponents argue that clinic-based services reach only youth with the most severe needs rather than reaching youth with a broader range of needs and intervening early in instances of mental illness (Bradshaw, Buckley, & Ialongo, 2008; Evans, 1999). Finally, behaviors and skills may be taught and reinforced directly within the context to which they must be generalized (Evans, 1999; Sarno-Owens & Murphy, 2004; Flaspholer et al., 2006).

**MH and Non-MH Outcomes of SBMH**

Past studies have in fact demonstrated that SBMH is associated with individual improvements in symptoms, academic performance, and behavior and system-level advances such as reductions in special education referrals or improvements in teachers’ perception of the adequacy of support services available (Atkins et al., 2006; Bruns et al., 2004; Eber, Hyde, & Suter, 2010; Suldo et al., 2014; Vernberg et al., 2006). As an example, Ballard, Sander, and Klimes-Dougan (2014) used a matched case design to compare the impact of SBMH versus treatment as usual (TAU) on elementary schools and on high risk youth within the matched schools. During the period of time studied, suspension rates at the SBMH schools dropped significantly while those at the TAU schools increased. Individual youth in the SBMH schools experienced significant reduction in overall MH symptomology; however, effect sizes were small (Ballard Sander, & Klimes-Dougan, 2014). Other studies have examined the impact of SBMH on proximal and distal academic outcome (see Suldo et al., 2014). Recent systematic reviews have compiled evidence that both universal social-emotional programs and intensive youth
psychotherapy can contribute to academic gains among youth (Baskin, Slaten, Sorenson, Glover-Russell, & Merson, 2010; Durlak, Weissberge, Dymnicki, Tayiro, & Schellinger, 2011).

However, the body of literature demonstrating SBMH impact on school-level academic performance is still relatively underdeveloped as most attention has focused on MH outcomes (Daly, Sander, Nicholls, Medhanie, Vanden Berk, & Johnson, 2013; Hoagwood et al., 2007; Suldo et al., 2014). In a systematic review of SBMH studies, Hoagwood and colleagues (2007) found that only 24 of 64 rigorous studies employed school-related measures, and 15 of these 24 found both positive MH and non-MH outcomes. Individual studies published since this review have had similarly mixed results. Eber, Hyde, & Suter (2010), for example, explored perceived risk of school failure, office discipline referral rates, and academic outcomes of 70 elementary and middle school youth receiving tertiary MH services in the context of a school-wide PBIS model, and found positive gains on all three indicators. Contrastingly, Daly and colleagues (2014) found no impact of SBMH on attendance, number of suspensions, math scores, or academic scores.

Similarly, there are some studies on the impact of SBMH on MH outcomes that have had null or mixed results. For example, in a longitudinal cluster analysis done by Bradshaw, Buckley, & Ialongo (2008), low performing youth who exhibited externalizing behaviors received both MH and/or special education services earlier (by grade) than internalizing, average performers and students with no symptoms. The authors held this finding up as evidence in support of the “squeaky wheel hypothesis (Bradshaw, Buckley, & Ialongo, 2008, p.171).” Another study also found that youth with internalizing disorders responded less to treatment than youth with externalizing disorders and also found that youth who had been sexually abuse were non-responders more often than those without such trauma (Jacobs et al., 2008).
These findings suggest that one reason for conflicting results in SBMH research may be the different responses to SBMH services among different groups of youth. As such, there is a need for more research examining SBMH models that successfully bring about outcomes and impacts among subgroups of students, including students with internalizing disorders and who are from racial and/or ethnic minority groups (Suldo et al., 2014). In other words, research is unclear for whom SBMH services, especially tertiary, work and under what types of SBMH approach or model.

**SBMH Adoption and Implementation**

Other barriers to effectively implementing and researching SBMH stem from the challenges associated with translating evidence-based interventions in real world settings. Given the “heterogeneity of school environments,” there is an element of “fit” that must be accounted for when exploring why interventions (proven in rigorous efficacy trials) succeed or fail within certain organizational cultures (Kutcher & Wei, 2012, p.311; Hoagwood & Johnson, 2003, p. 8). As captured in the empowerment evaluation framework depicted in figure one, contextual conditions as well as the characteristics and capacity of SBMH partnerships must be accounted for when looking to understand why and how MH and non-MH outcomes and impacts occur in some school settings but not others. Further, as this diagram depicts, the system is dynamic in nature, with intermediate outcomes feedback back into and changing the contextual conditions.
In the absence of single SBMH model that can be dropped into the diversity of school environments, it is important to know what mechanisms within broader systems facilitate or inhibit the adoption and implementation of SBMH (Kutcher & Wei, 2012). As captured by the Diffusion of Innovation Theory (Rogers, 2010) posits that innovations like SBMH are modified and adapted to some degree within each new context. Knowing under what conditions and why the model works can help to sustain effective programs and inform future school efforts to adopt, adapt, and implement SBMH (Massey et al., 2005). However, less research has been focused on these important considerations (Massey et al., 2005; Weist et al., 2014).

What work has been done to understand the contextual influences on SBMH adoption and implementation has been primarily been focused on the dissemination of a manualized intervention, as opposed to a holistic model and/or has accounted for the experiences of only a limited number of stakeholders involved in SBMH. Still, these studies have together produced initial evidence of what some of the general factors are which influence the adoption and implementation of SBMH.

One of the most fundamental barriers to SBMH has been the philosophical difference that exists between MH and educational professionals (Weist, 2005). Schools are under “severe
pressures” to achieve academic outcomes, and when SBMH first emerged as an approach, it was labeled by some as an “intrusion into the education system (Citizens Commission on Human Rights, 1995 in Evans, 1999, p. 172’ Weist, 2005, p.736).” Even if amenable to the idea of SBMH, schools have limited capacity (e.g. space, time, etc.) to spread across the “multiple and sometimes competing demands” that are placed upon them (Reinke et al., 2011, p.2; Weist, 2005).

Whatever the reason for it, lack of administrator buy-in can be severely undermine the long term success of school-based interventions and the type of collaborative school-community partnerships needed to sustain SBMH services (Anderson-Butcher et al., 2010; Bronstein et al., 2011; Mendenhall et al., 2012; Sanders, 2014; Suldo et al., 2010). On the other hand, administrator buy-in, at least among school principals, can be increased by providing funding, technical support, and recognition well as the use of accountability standards (Sanders, 2014).

Still other barriers exist. School-based MH clinicians struggle to implement MH services when they find themselves operating without full support of school administration and / or similarly spread across multiple responsibilities (Langley, Nadeem, Kataoka, & Stein, 2010; Weist et al., 2014). School-based clinicians have reported other challenges including a lack of parent engagement, the high rates of student absenteeism, and a mismatch between time required for many MH clinical interventions and that allotted within the school schedule (Kelly & Lueck, 2011; Weist et al., 2014). On the other hand, when based in schools, clinicians have access to more ready information from multiples sources and can observe the child within the normal environment, both of which can enhance the quality of care compared to clinic-based services (Evans, 1999).
The challenge of parent engagement in SBMH, in particular, has received focused attention given the recognition that “effectively working with families underpins virtually all effective child and adolescent MH interventions (Weist et al., 2014, p.246).” Weist and colleagues (2014) provided specific training to school-based clinicians to prepare them to engage families but found that they still struggled. As consultants in the work, the authors intervened to ensure that clinicians did not ascribe negative stereotypes to the families out of frustration with the situation. Important to note is that the challenge of parent engagement is not unique to SBMH but rather is a challenge that schools face in even the most basic of school functions (Mendenhall et al., 2012).

Other factors which have been noted in relation to SBMH adoption include the negative impact of staff turnover (Weist, 2005); the struggles of developing “systems of quality assurance;” the issues with maintaining adequate staffing and funding levels; and the challenges of developing collaborative school-community partnerships (Thaker et al, 2008; Vernberg et al., 2006; Weist, 1999, p. 132; Weist, 2005). Barriers to successful collaborative relationships include the presence of “system silos” which are hard to break down when potential partners have different language, mission, and understanding of roles (Powers et al., 2013). Additionally, poor communication can be a source of conflict between partners, especially when it interferes with key decisions or when lack of communication is perceived as lack of interest in collaboration (Powers et al., 2013). Further, the skills and individual capacities required to effectively participate in and manage complex, collaborative interventions are not traditionally taught during the professional development of school administrators, teachers, or MH clinicians (Ball et al., 2010).
While these factors are understood as challenges that partners encounter, there is less understanding of exactly how mechanisms such as the quality of community partnerships or legislative context impact the adoption and implementation of SBMH (Mellin & Weist, 2011; Weist et al., 2014). For example, barriers and facilitators are experienced differently by individuals in different stakeholder roles (Mendenhall et al., 2012). However, different roles are represented to varying extents in the existing literature and some roles (e.g. state educational agencies involved in SBMH) have not been represented at all. Similarly, theory and practice would both suggest that adoption and implementation of innovative practices within schools involves multiple, distinguishable processes; however, contextual factors not been examined in relation to such processes (Anderson-Butcher et al., 2008; Bryan & Henry, 2012; Rogers, 2010). In other words, research has looked at the challenges and strengths of SBMH overall, but has not necessarily distilled the various factors and influences across stages of adoption and implementation. As such, there is still much to learn about the complexity of facilitators and barriers that influence the adoption and implementation of SBMH (Flaspohler et al., 2008; Mellin & Weist, 2011; Suldo et al., 2014).

Thus while the literature base around SBMH is growing, gaps remain. As expressed by Saxe and colleagues in 1998, work is still needed to more fully understand:

“’(a) What therapy [works], (b) under what conditions, (c) for which children, (d) at what developmental level, (e) with which disorders, (f) under what environmental conditions, and (g) with which concomitant parental, familial, environmental, or systems intervention (in Jacobs et al., 2008, p. 239).’”

While the present study could not account all of these considerations, it does attempt to address certain remaining gaps in SBMH literature within the context of a pilot in Utah. SBMH
services had been shown to be effective but needed to be further investigated within diverse subgroups, including low-income, Hispanic students. The conditions affecting the implementation of SBMH had been explored and certain facilitators and barriers identified, but the role and influence of state government had not been accounted for in past studies. Further, environmental conditions have been presented as stable rather than dynamic constructs.

By developing a rich understanding of the processes involved in and outcomes/impacts associated with SBMH in four Title I elementary schools serving a low-income, ethnically diverse student population, the present extended the scope of knowledge available about the adoption and implementation of SBMH. Specially, answers to these questions were sought:

1) What outcomes, at the individual and system levels, result from SBMH model at Title I elementary schools serving a low income, ethnically diverse population?

2) What facilitators and barriers do partners involved in SBMH experience during processes involved in SBMH adoption and implementation?
Chapter Three: Methods

The adoption and implementation of a SBMH pilot in four schools in Utah was an ideal setting in which to answer these questions. By integrating the perspective shared by stakeholders’ experience with patterns detected in a secondary data review, this study used mixed methodology to consider not only the outcomes and impacts of SBMH but also the influence of the broader context in which these outcomes and impacts occurred. Further, this study was informed by the empowerment evaluation model with the dual goals of producing transferable knowledge and strengthening the capacity of the very system examined.

Context

Within the Utah school district of interest, one of the largest districts in the state, four Title I elementary schools were involved in this study. The district itself was formed in 2010 by voter referendum, and adoption of SBMH began in January 2013. Since then, MH providers have been located at the schools and incorporated directly into the standard case management and referral processes, referred to as “Care Teams.” Relevant indicators of academic achievement and demographics for the four schools are displayed in Table Two. Prior to the 2013-14 academic year, all four schools served sixth graders.
As displayed in table two, there were high levels of need among the diverse student population served by the four schools. Absenteeism and student mobility were higher than
state average, a large majority of students lived in poverty, and especially at Schools A and C, a significant proportion of the student body was made up of English Language Learners. The state report card grades demonstrate that the students and schools were underperforming academically. Given such indicators, these schools provided an appropriate context in which to study the outcomes, processes, barriers, and facilitators of SBMH specifically within schools serving high risk youth.

Prior to adoption of SBMH, students attending the four schools had been referred to the local MH agency for services delivered off site. SBMH was initiated within the context of broader school improvement efforts and was, in part, possible because of the influx of state funding that guaranteed reimbursement for MH services delivered to students not covered by private insurance or Medicaid. Beginning in January of 2013, a local MH agency contracted with two therapists to provide tertiary services to students on site at the four schools (each therapist was part time at two schools). In August 2013, a third therapist was hired so that two schools (schools B & C) had full time therapists. Therapists were responsible for billing against private insurance, Medicaid, or the state grant to get reimbursed for the services delivered. Billing procedures, training, and oversight was provided by the MH agency.

In addition to bringing tertiary MH services on site, each school created a Care Team to serve as the primary group responsible for receiving and triaging referrals from parents, teachers, and other school staff. These Care Teams met weekly to review new referrals and discuss the past referrals for which Care Team members were assigned responsibility for follow up.
Design: Mixed Methods Empowerment Evaluation

To ensure that proper consideration was given to process- and context-related factors, a modified empowerment evaluation approach was used as a guide. This approach emphasizes the importance of “taking stock” of the full system before drawing conclusions, of incorporating the expertise of stakeholders into evaluation, and of using the information gleaned from the evaluation to drive improvements in the evaluated program or model (Fetterman, Kaftarian, & Wandersman, 1997, p.18). As methods were designed to take stock of the many elements depicted in the empowerment evaluation framework (see figure one), they also were designed to do so in a way which also accounted for the dynamic nature of adoption and implementation. Finally, while goal setting steps that would traditionally be the third pillar of an empowerment evaluation approach, this step was outside of the scope of the current study. It should be noted, however, that the study was conducted within the context of an ongoing school-community-university partnership that has the capacity to see through the full process.

A mixed methods approach was employed. Specifically, a retrospective, secondary data analysis of the MHA’s records was utilized to understand MH outcomes among youth (changes in symptoms) and at the system level (changes in access). Interviews were conducted to triangulate the results of the quantitative components as well as to explore what facilitators and barriers were experienced by stakeholders involved in SBMH adoption and implementation. The remainder of this section details the quantitative and qualitative portions separately and how the results of the two types of methods were integrated to create a true mixed methods design. Study procedures were approved by the OSU IRB as well as the research review boards at the participating mental health agency and school district.
**Secondary Data Analysis.**

To examine MH outcomes among individual youth and at the systems-level, a secondary data analysis was conducted, examining records from the MH agency involved in SBMH.

**Procedures.** The MH agency retrieved services records two different ways. First, records were pulled for all youth served by the therapists contracted specifically to work at the four schools between January 2013 and June 2014. Merged with these records were records for youth served by the MH agency between August 2011 and December 2012 who resided in the schools’ two main catchment zip codes (which were identified by the district Director of Student Advocacy and Access). Youth with incomplete data or who fell outside of the inclusion criteria described next were omitted from the sample.

**Sample.** From the two sampling strategies, records for 203 youth were pulled, including 42 who were served in both time periods. Removed initially were twenty-eight youth with no data in their services records. Two inclusion criteria were then applied to further narrow the sample. Specifically, youth had to receive at least one service beyond the initial intake to be considered as a recipient of SBMH services, and youth had to be thirteen years old or younger when services were initiated (because the highest possible grade level for school-based was 6th grade). Based on these criteria, ten youth were removed from the sample because they received no services following intake, and six because they over the age of 13 for all services. Of the youth omitted, 16 were part of the 08/2011 – 12/2012 sample, and 28 were from the SBMH timeframe. The final sample included 159 youth.

Of the 159 students served between August 2011 and June 2014, 59.1 percent were male and 40.9 percent were female. The average age of the students when they first received services (relative to the 08/2011 - 06/2014 time period) was 8.54 years (SD=2.10; Range = 5 – 13
A majority of youth identified as White, Non-Hispanic (46.5%) or Mexican / Mexican American (33.3%). Complete demographics are reflected in table three. If Mexican / Mexican American youth are combined with youth identified as “Hispanic, Other” to reflect the demographic categories used in the overall school data, then 42.60% of the youth served by the SBMH therapist would be considered Hispanic. This proportion was significantly higher than the proportion of Hispanic students (30.25%) in the general study population across the four schools ($z=3.45; p=0.001$).

<table>
<thead>
<tr>
<th>Demographic</th>
<th>$N$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>65</td>
<td>40.9</td>
</tr>
<tr>
<td>Male</td>
<td>94</td>
<td>59.1</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, Non-Hispanic</td>
<td>74</td>
<td>46.5</td>
</tr>
<tr>
<td>Mexican / Mexican American</td>
<td>53</td>
<td>33.3</td>
</tr>
<tr>
<td>Hispanic, Other</td>
<td>15</td>
<td>9.3</td>
</tr>
<tr>
<td>Other, Non-Hispanic</td>
<td>17</td>
<td>10.7</td>
</tr>
<tr>
<td><strong>Age at first service</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>8.2</td>
</tr>
<tr>
<td>6</td>
<td>19</td>
<td>11.9</td>
</tr>
<tr>
<td>7</td>
<td>23</td>
<td>14.5</td>
</tr>
<tr>
<td>8</td>
<td>22</td>
<td>13.8</td>
</tr>
<tr>
<td>9</td>
<td>24</td>
<td>15.1</td>
</tr>
<tr>
<td>10</td>
<td>28</td>
<td>17.6</td>
</tr>
<tr>
<td>11</td>
<td>19</td>
<td>11.9</td>
</tr>
<tr>
<td>12</td>
<td>6</td>
<td>3.8</td>
</tr>
<tr>
<td>13</td>
<td>5</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Table 3: Sample Demographics (n=159)

*First service during Aug 2011 – June 2014 time frame, regardless of history before 8/2011
The DSM IV-tr classification system was used by VMH therapists when determining the most appropriate diagnoses for these students. Diagnoses were collapsed into main categories in the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV-tr (American Psychiatric Association, 2000). The frequency of primary diagnostic categories (Axis 1: Diagnosis 1) is shown in table four. Actual diagnoses are shown within categories for which the most frequent diagnoses were not identified as “not-otherwise specified.” The percentages shown for the categories sum to more than 100% because of the 32 (20.1%) instances in which youth had more than one diagnosis. The frequency of dual diagnoses in this population matches the frequency (20.9%) found in the Methodology for Epidemiology of Mental in Children and Adolescents study (in AAP, 2004). There does, however, appear to be a possible overrepresentation of youth with disruptive disorders given that in national prevalence data, anxiety is more common than disruptive disorders (AAP, 2004; Merikangas et al., 2010).

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of Youth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Usually 1st Diagnosed in Infancy Childhood or Childhood or Adolescence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>71 (44.7%)</td>
</tr>
<tr>
<td><strong>Attention-Deficit/Hyperactivity Disorder</strong></td>
<td>34 (21.4%)</td>
</tr>
<tr>
<td><strong>Disruptive Behavior Disorder, NOS</strong></td>
<td>20 (12.6%)</td>
</tr>
<tr>
<td><strong>Adjustment Disorder</strong></td>
<td>51 (32.1%)</td>
</tr>
<tr>
<td><strong>Other Condition that may be a focus of clinical attention</strong></td>
<td>25 (15.5%)</td>
</tr>
<tr>
<td><strong>Child Maltreatment</strong></td>
<td>12 (7.5%)</td>
</tr>
<tr>
<td><strong>Anxiety Disorder</strong></td>
<td>28 (17.6%)</td>
</tr>
</tbody>
</table>

Table 4: DSM IV-tr Diagnoses (n=159) (Continued)
Table 4: Continued

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Count (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td>17 (10.7%)</td>
</tr>
<tr>
<td>Factitious Disorder</td>
<td>1 (0.6%)</td>
</tr>
<tr>
<td>Somatoform Disorder</td>
<td>1 (0.6%)</td>
</tr>
</tbody>
</table>

Measures.

*Youth Outcomes Questionnaire.* The Youth Outcomes Questionnaire (Y-OQ; Wells et al., 1996; Burlingame et al., 2001) was used by the MH agency to measure the progress and outcomes of MH services and was used in this study as an indicator of reduced MH symptomology (a MH outcome). This 64-item tool contains six subscales: Intrapersonal distress, somatic symptoms, interpersonal relations, social problems, behavioral dysfunction, and critical items. The process of tool construction and resulting psychometric characteristics have been described in detail elsewhere and are summarized in table five (Wells et al., 1996; Burlingame et al., 2001). Parents/caregivers completed the survey at intake and every thirty days thereafter until termination of services. YOQ data for all youth in this study were contained within the service records provided by the MH agency.

Pre and post YOQs were identified from among all of the YOQs completed for each individual youth. The Pre-YOQ was the first Y-OQ completed by a parent/caregiver after January 1, 2013. The post was identified the last Y-OQ completed following the pre-YOQ but prior to June 30, 2014 (the end of the sampling frame). Of the 159 youth in the total sample, four had no parent/caregiver Y-OQ results, and only 91 (57.2%) had multiple Y-OQs completed. Of the 91 youth, only 72 (45.3%) had two Y-OQs falling within the SBMH time frame and were included in subsequent analysis of Y-OQ data. Note that these inclusion criteria omit true-pre Y-
OQs for those youth received services in fall 2012, and post-Y-OQs were not necessarily completed at the termination of services as the MH agency required therapists to collect Y-OQs at the end of each school year. The results of this study reflect only the impact of SBMH and not the overall impact of receiving MH services.

Calculated YOQ total and subscale scores were included as part of the secondary data set. Because these scores are generated by a proprietary formula within the Y-OQ software, it was not possible to test the reliability of the tool within the population of the present study, and there were no missing data to account for beyond those cases that were deleted list-wise based on inclusion criteria (i.e. pre- and post- Y-OQ during SBMH time-frame). Frequency distributions of sub-scale and total scores were examined and found to be normally distributed (i.e. skewness and kurtosis values between +/- 2) and free of outliers.

Services Records. Records of each billable services provided to youth were contained in the service records provided by the MH agency and used to generate indicators of access at a system level. A variety of service types were represented in the 5885 unique service records, as shown in table six. Only those service types which were delivered to at least 50 percent of youth and which accounted for at least five percent of all services were retained in the data set used for analysis. Based on these inclusion criteria, individual psychotherapy, targeted case management, and family psychotherapy with the client present were further examined. Individual and family psychotherapy encompass the direct treatment of a MH disorder involving, respectively, only the youth or the youth along with the entire family. Targeted case management services involve coordinating referrals and linkages to additional services and resources.
<table>
<thead>
<tr>
<th>YOQ Sub Scale</th>
<th>Reliability</th>
<th>Definition</th>
<th>Sample Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrapersonal distress</td>
<td>0.93</td>
<td>Examines emotions including anxiety and depression.</td>
<td>My child seems anxious or nervous.</td>
</tr>
<tr>
<td>Somatic symptoms</td>
<td>0.74</td>
<td>Examines physical manifestations of psychiatric illness such as head or stomachaches.</td>
<td>My child complains of dizziness or headaches.</td>
</tr>
<tr>
<td>Interpersonal relations</td>
<td>0.89</td>
<td>Examines the relationships a child has with his or her peers, family, etc.</td>
<td>My child gets into physical fights with peers or family members.</td>
</tr>
<tr>
<td>Social problems</td>
<td>0.85</td>
<td>Examines engagement in negative behaviors within the social context such as truancy and substance use</td>
<td>My child cuts school or is truant.</td>
</tr>
<tr>
<td>Behavioral dysfunction</td>
<td>0.92</td>
<td>Examines the level of difficulty associated with life skills such as organizing tasks, concentrating, handling frustration, etc.</td>
<td>My child seems unable to get organized.</td>
</tr>
<tr>
<td>Critical items</td>
<td>0.74</td>
<td>Identifies distressing symptoms that require immediate attention including suicidality and hallucination</td>
<td>My child believes that others can hear her/his thoughts or that s/he can hear the thoughts of others.</td>
</tr>
</tbody>
</table>

Table 5: Y-OQ subscales (Wells et al., 1996)
<table>
<thead>
<tr>
<th>Service Activity</th>
<th>Percent of all services</th>
<th>Percent of youth (n=159) receiving service at least once</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment / Evaluation</td>
<td>2.97%</td>
<td>99.37%</td>
</tr>
<tr>
<td>Individual Psychotherapy</td>
<td>43.53%</td>
<td>96.23%</td>
</tr>
<tr>
<td>Targeted Case Management</td>
<td>19.88%</td>
<td>79.87%</td>
</tr>
<tr>
<td>Family Psychotherapy w Client Present</td>
<td>7.37%</td>
<td>58.49%</td>
</tr>
<tr>
<td>Family Psychotherapy without client present</td>
<td>0.88%</td>
<td>13.21%</td>
</tr>
<tr>
<td>Medication Management</td>
<td>2.01%</td>
<td>12.58%</td>
</tr>
<tr>
<td>Psychosocial Rehabilitative Services</td>
<td>7.87%</td>
<td>8.18%</td>
</tr>
<tr>
<td>Group Therapeutic Behavioral Services</td>
<td>8.62%</td>
<td>7.55%</td>
</tr>
<tr>
<td>Group Psychotherapy</td>
<td>2.74%</td>
<td>7.55%</td>
</tr>
<tr>
<td>Individual Skills Training &amp; Development</td>
<td>0.37%</td>
<td>4.40%</td>
</tr>
<tr>
<td>Transportation</td>
<td>1.89%</td>
<td>3.14%</td>
</tr>
<tr>
<td>Family Therapeutic Behavioral Services</td>
<td>0.22%</td>
<td>2.52%</td>
</tr>
<tr>
<td>Respite</td>
<td>0.83%</td>
<td>1.26%</td>
</tr>
<tr>
<td>Multiple Family Psychotherapy</td>
<td>0.08%</td>
<td>1.26%</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>0.05%</td>
<td>0.63%</td>
</tr>
<tr>
<td>Behavior Management</td>
<td>0.02%</td>
<td>0.63%</td>
</tr>
<tr>
<td>Treatment Plan Review</td>
<td>0.02%</td>
<td>0.63%</td>
</tr>
</tbody>
</table>

Table 6: Frequency of Service Types

For each billable unit, the date and type of service was provided. Where the same type of service was billed twice on one day for a youth, records were collapsed into one service instance. In total, there were a total of 2548 instances of individual therapy, 790 instances of
case management, and 431 instances of family therapy delivered between August 2011 and June 2014. Further descriptive statistics for these three service types are found in table seven.

<table>
<thead>
<tr>
<th>Service Patterns across Individual Youth*</th>
<th>Number of Services*</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Psychotherapy</td>
<td>2548</td>
<td>153</td>
<td>16.65</td>
<td>11.80</td>
<td>1</td>
<td>61</td>
</tr>
<tr>
<td>Targeted Case Management</td>
<td>790</td>
<td>110</td>
<td>7.18</td>
<td>7.54</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>Family Psychotherapy</td>
<td>431</td>
<td>93</td>
<td>15.90</td>
<td>6.67</td>
<td>1</td>
<td>23</td>
</tr>
</tbody>
</table>

Table 7: Frequency of three service types for further analysis

*Across entire data range (August 2011 – June 2014), not yet split by pre / post SBMH

Monthly counts for each month between August 2011 and June 2014 were created for the (1) number of each service type billed in that month and (2) the number of youth receiving at least one of each given service. Using these counts, a third variable was calculated for each month/type combination: the average number of services per youth served.

**Analysis.**

**Individual MH Outcomes.** Paired t-tests were used to determine independently whether youth experienced significant improvement in mental health functioning on the total Y-OQ and six subscales between the first and last Y-OQ completed during the SBMH time frame. One-sample t-tests were used to compare the post-test scores to the clinical benchmarks set by Burlingame, Wells, Lambert, & Cox (2004). Analyses were conducted for the overall group and for the subset of youth in the population who were Hispanic. Independent t-tests were used to
compare pre- and post- scores of Hispanic compared to those of non-Hispanic youth following additional tests to confirm that the two groups were similar in distribution of age (i.e. independent t-test) and gender (i.e. Chi-square analysis).

System-Level MH Outcomes. The monthly counts of services and youth served, along with the monthly averages of services delivered per youth, were plotted for visual inspection. Mann-Whitney U Tests were run to determine whether months following January 2013 had higher ranking counts of total services, number of youth served, and/or average services received by youth compared to months preceding SBMH adoption. All data were analyzed using SPSS v22 (IBM Corp., 2013) and Excel.

Qualitative Interviews.

Procedures. Purposive and snowball sampling methods were used to recruit interview participants, and efforts were made to recruit participants until saturation has been reached. The researcher in the current study was part of a larger university-based team acting as consultants and evaluators for the ongoing efforts in Utah, and the primary investigator of this broader team recommended administrative level individuals for inclusion in interviews based on her familiarity with the work. These stakeholders were then recruited via email. In instances where a role had been identified for inclusion (e.g. SBMH therapist) but no stakeholders in that role were known to the researcher or primary investigator, the administrator being recruited from that agency (e.g. SBMH program manager) was asked to provide a name and contact information. In this way, the SBMH program manager helped recruit two therapists; the principal helped recruit a school psychologist and vice principal; the Title I Director helped recruit a school psychologist; and the USOE education specialist helped recruit her counterpart at the Utah Department of Mental Health and Substance Abuse (UDMHSA). Meeting times
were set up via email, and consent forms were presented and signed at the beginning of these meetings.

A semi-structured interview schedule (see Appendix A) was used to guide interviews that lasted, on average 53 minutes (Range = 17 - 144 minutes). The development of this schedule was guided by the Empowerment Evaluation framework. Example questions included, “What factors influence the day to day implementation of SBMH?,” “In what ways, if any, is SBMH being implemented differently across the four schools now?,” and “If you were going to give another agency like yours a recipe for a successful SBMH program what ingredients would you include?” Probing occurred to clarify and elicit further detail. Interviews primarily took place in individuals’ office with the exception of one person who was interviewed in his own home. Interviews were recorded and transcribed verbatim. How long did interviews last.

**Sample.** Representatives from each agency involved in the adoption of SBMH at the four elementary schools were interviewed as shown in table eight. One of the originally recruited individuals (the current district Community Resource Coordinator) dropped out of the study so the former Community Resource Coordinator was recruited in her place so that the role was still represented. In total, thirteen participants were recruited, twelve of whom were available for interview.

Eleven of the twelve participants were within the positions listed at the time of the interviews. The former Community Resource Coordinator had left that role a year and a half prior to the interviews to take a position at the local university. The vice principal had served in that role at two of the Title I schools since SBMH was adopted. One of the SBMH therapists (P12) was initially split between two schools and continued to maintain a small case load at one of the schools even though she had transitioned to full time at the other. All other people in
place-based positions had been at only one site. The principal and one school psychologist (P2) had been at their respective schools since the beginning of SBMH adoption whereas the other school psychologist and SBMH therapist had each started at some point during the school-year in which the interviews took place. Aside from the exception noted for the Community Resource Coordinator, all other school district and state personnel had been in their respective positions when and since the SBMH work began at the four schools. The vice principal, former Community Resource Coordinator, and one of the school psychologists (P2) were male, and all other participants were female.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Stakeholders Interviewed (Participant Number*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>• 2 School Psychologists (P2, P6)</td>
</tr>
<tr>
<td></td>
<td>• 1 Vice Principal (P5)</td>
</tr>
<tr>
<td></td>
<td>• 1 Principal (P7)</td>
</tr>
<tr>
<td>MH Agency</td>
<td>• 2 SBMH Therapists (P8, P12)</td>
</tr>
<tr>
<td></td>
<td>• Program Manager of SBMH (P4)</td>
</tr>
<tr>
<td>School District</td>
<td>• Director of Student Advocacy and Access (P1)</td>
</tr>
<tr>
<td></td>
<td>• Community Resource Coordinator (Former; P3)</td>
</tr>
<tr>
<td></td>
<td>• Evidence Based Learning Director (P11)</td>
</tr>
<tr>
<td>State</td>
<td>• Education Specialist at USOE (P9)</td>
</tr>
<tr>
<td></td>
<td>• Program Administrator of MH for Children, Youth, and Families at Division of Substance Abuse and Mental Health (DSAMH; P10)</td>
</tr>
</tbody>
</table>

Table 8: Interviewed stakeholders’ roles by agency represented

*Participant numbers listed here are used to identify the speaker of quotes throughout remaining text*
**Analysis.** A hybrid of inductive and deductive coding was used to identify codes and emergent themes (Fereday & Muir-Cochrane, 2006). In other words, some codes were allowed to emerge organically but other theory-driven codes were used to align the qualitative analysis with the overall empowerment evaluation design and quantitative aspects of the analysis. Specifically, a priori code families were created to represent processes associated with school improvement processes as well as the different fields within the empowerment evaluation framework. Within each of these code families, actual codes emerged inductively, and the parameters around the processes were treated as flexible rather than hard and fast categories so that they could be adjusted to fit what was emerging inductively. Analysis began with multiple readings of each transcript in order to immerse in the data and to begin recognizing commonalities and differences. Because SBMH research has not specifically looked at barriers and facilitators across stages of implementation, data were also organized according to various steps in the process (i.e., creating buy-in, designing the model, etc.). Constant comparative method was used to look for patterns within and across participants (as well as the four systems represented) and thus enhance the rigor of the analysis (Padgett, 2008). In order to ensure the credibility of the analysis, an audit trail was kept and reviewed by the primary investigator involved in the broader partnership in Utah, who provided feedback when alternative interpretations or decisions were recommendable (Padgett, 2008). Atlas.ti version 6 was utilized for data management purposes (Scientific Software Development, 2012).

**Synthesis.** Given that the goal of this study was to explore the dynamic nature of SBMH, a mixed methodological approach was deemed most appropriate. As such, the results from the qualitative and quantitative methodologies were synthesized to look overall at the factors that influenced and the outcomes that resulted from the adoption and implementation of SBMH
within low income, ethnically diverse schools. The goal of this synthesis was to provide opportunities to triangulate results, provide additional depth to findings, and develop plausible explanations for patterns revealed in the quantitative data. More specifically, the qualitative and quantitative results relative to the first research question were compared to determine where the patterns noted by stakeholders were reflected in the data collected by the local MH agency. Areas where results conflicted across methods were recorded in the audit trail for the study and discussed with the expert reviewer. Knowledge of the processes, facilitators, and barriers encountered by stakeholders involved in SBMH provided rich context in which to more deeply understand the outcomes documented through both methodologies.
Chapter Four: Results

The two research questions explored were Q1) What outcomes, at the individual and system levels, result from SBMH model at Title I elementary schools serving a low income, ethnically diverse population? and Q2) What facilitators and barriers do partners involved in SBMH experience during processes involved in SBMH adoption and implementation? Results are shared by research question, and within each research question, by methodology.

Research Question One

*Individual MH Outcome: Y-OQ.* The results of the paired t-tests comparing pre- and post- Y-OQ data are displayed in table nine. Among the 72 youth with both pre- and post- Y-OQ data, the services provided varied widely. Pre- Y-OQs were completed as early as January 2013 and as late as April 2014. Post Y-OQs were completed as early as April 2013 and as late as June 2014. On average across the youth, 5.92 months (SD =3.99; Range=0-16) passed between pre- and post- Y-OQ administration. The number and types of services received between Y-OQ administrations varied widely as depicted in table nine.
Among all youth with complete Y-OQ data, statistically significant (p<0.05) improvement occurred in the total score as well as the intrapersonal distress, behavioral dysfunction, and critical item sub-scores (see table nine). The changes in interpersonal relations and somatic subscales approached significance (p<0.10). Even with the positive change, however, scores on the post Y-OQ remained clinically significant overall and in three of the subscales (interpersonal relations, social problems, and behavioral dysfunction).

<table>
<thead>
<tr>
<th>Service Patterns across Individual Youth</th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of Service (Months)</td>
<td>5.92</td>
<td>3.99</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Frequency of Any Service (Days)</td>
<td>19.98</td>
<td>13.90</td>
<td>1</td>
<td>55</td>
</tr>
<tr>
<td>Frequency of Individual Psychotherapy (Days)</td>
<td>15.17</td>
<td>10.32</td>
<td>0</td>
<td>37</td>
</tr>
<tr>
<td>Frequency of Targeted Case Management (Days)</td>
<td>3.26</td>
<td>4.29</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Frequency of Family Psychotherapy (Days)</td>
<td>1.54</td>
<td>2.93</td>
<td>0</td>
<td>26</td>
</tr>
</tbody>
</table>

Table 9: Frequency of three service types among youth with complete Y-OQ data (n=72).

<table>
<thead>
<tr>
<th>Pre Y-OQ Mean</th>
<th>Post Y-OQ Mean</th>
<th>Clinically Significant Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score</td>
<td>68.07</td>
<td>47.24^</td>
</tr>
<tr>
<td>Interpersonal Relations</td>
<td>8.53</td>
<td>7.42^</td>
</tr>
<tr>
<td>Intrapersonal Distress</td>
<td>22.99</td>
<td>18.51^</td>
</tr>
<tr>
<td>Somatic</td>
<td>6.36</td>
<td>5.42^</td>
</tr>
</tbody>
</table>

Table 10: Youth Outcome Questionnaire Analysis Results (n=72) (Continued)
Table 10: Continued

<table>
<thead>
<tr>
<th></th>
<th>Pre Y-OQ Mean</th>
<th>Post Y-OQ Mean</th>
<th>Clinically Significant Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Problems</td>
<td>4.90</td>
<td>4.46</td>
<td>3*</td>
</tr>
<tr>
<td>Behavioral Dysfunction</td>
<td>18.57</td>
<td>16.04^</td>
<td>12*</td>
</tr>
<tr>
<td>Critical Items</td>
<td>6.72</td>
<td>5.39^</td>
<td>5</td>
</tr>
</tbody>
</table>

^ Indicates post-Y-OQ mean was significantly different from the pre-YOQ mean (p<0.05)
* Indicates difference between pre- and post-Y-OQ mean was approaching significance (p<0.1)
† Indicates post-Y-OQ mean was significantly above a clinically significant score (p<0.05).

The paired t-test was repeated with only those youth in the sample who identified as Hispanic (n=20). Note that a significantly smaller proportion (27.8%) of the 72 youth with complete Y-OQ data was Hispanic compared to the proportion of the 159 youth in the total sample (42.8%; z=2.32; p=.02). There were no differences in the age (p=0.59) or proportion of males and females in the two groups ($\chi^2$=0.038, p=0.846).

Among the 20 Hispanic youth with both pre- and post- Y-OQ data, the services varied widely. Pre- Y-OQs were completed as early as January 2013 and as late as March 2014. Post Y-OQs were completed as early as April 2013 and as late as June 2014. On average across the youth, 6.45 months (SD =4.43; Range=1-16) passed between pre- and post- Y-OQ administration. During these months, the amount and types of services delivered to youth varied as shown in table eleven.
Service Patterns across Individual Youth

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of Service (Months)</td>
<td>6.45</td>
<td>4.43</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Frequency of Any Service (Days)</td>
<td>19.85</td>
<td>15.57</td>
<td>0</td>
<td>53</td>
</tr>
<tr>
<td>Frequency of Individual Psychotherapy (Days)</td>
<td>14.20</td>
<td>10.26</td>
<td>0</td>
<td>33</td>
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<tr>
<td>Frequency of Targeted Case Management (Days)</td>
<td>3.20</td>
<td>4.11</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Frequency of Family Psychotherapy (Days)</td>
<td>2.45</td>
<td>5.00</td>
<td>0</td>
<td>21</td>
</tr>
</tbody>
</table>

Table 11: Frequency of three service types among Hispanic youth with complete Y-OQ data (n=20).

There were no significant differences in the Y-OQ scores between Hispanic (n=20) and non-Hispanic (n=52) youth on the pre-test. On the post test, scores among Hispanic youth were significantly below those for non-Hispanic youth overall ($M_{\text{Hispanic}}=42.33$, $M_{\text{Non-Hispanic}}=61.96$; $p=.03$) as well as in the areas of intrapersonal distress ($M_{\text{Hispanic}}=13.86$, $M_{\text{Non-Hispanic}}=20.00$; $p=0.04$), and behavioral dysfunction ($M_{\text{Hispanic}}=10.95$; $M_{\text{Non-Hispanic}}=17.50$; $p=.003$). Among Hispanic youth, statistically significant improvement occurred overall as well as in intrapersonal distress, somatic symptoms, behavioral dysfunction, and critical items ($p<0.05$; See table ten). Changes in interpersonal relations and social problems approached statistical significance ($p<0.10$). The scores at post were not significantly different than the established benchmarks for clinical significance.
Table 12: Youth Outcome Questionnaire Analysis Results, Hispanic youth only (n=20)

<table>
<thead>
<tr>
<th></th>
<th>Pre Y-OQ Mean</th>
<th>Post Y-OQ Mean</th>
<th>Clinically Significant Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score</td>
<td>66.30</td>
<td>43.55^</td>
<td>46</td>
</tr>
<tr>
<td>Interpersonal Relations</td>
<td>7.65</td>
<td>5.15*</td>
<td>4</td>
</tr>
<tr>
<td>Intrapersonal Distress</td>
<td>22.60</td>
<td>14.35^</td>
<td>16</td>
</tr>
<tr>
<td>Somatic</td>
<td>6.70</td>
<td>4.80^</td>
<td>5</td>
</tr>
<tr>
<td>Social Problems</td>
<td>4.65</td>
<td>3.35*</td>
<td>3</td>
</tr>
<tr>
<td>Behavioral Dysfunction</td>
<td>18.05</td>
<td>11.55^</td>
<td>12</td>
</tr>
<tr>
<td>Critical Items</td>
<td>6.65</td>
<td>4.35^</td>
<td>5</td>
</tr>
</tbody>
</table>

^ Indicates post-Y-OQ mean was significant different form the pre-YOQ mean (p<0.05)

* Indicates difference between pre- and post-Y-OQ mean was approaching significance (p<0.1)

* Indicates post-Y-OQ mean was significantly above a clinically significant score (p<0.05).

**System MH Outcome: Service Patterns.** Figures two through ten display the total number of services delivered in a given month, the number of youth receiving at least one service in a given month, and the average number of services received per youth served for the three service types of interest: Individual therapy, Family therapy, and Targeted case management. As figures 1, 2, 4, and 5 depict, the number of individual therapy and case management services delivered and the number of youth reached increased substantially following the adoption of SBMH. In both cases, however, the initial increase began at the start of the 2012-13 school year when the school and district partners first started exploring the possibility of adopting SBMH with the local MH agency. The change in number of individual therapy and case management services received per youth is of a smaller magnitude though still in a mostly positive direction. Results of the Mann Whitney U Test (see table 11) confirm this
pattern as the months following SBMH adoption (compared to pre-SBMH) had higher counts of services, counts of youth served, and average number of services provided per youth served.

Different patterns emerged in relation to family therapy. While the total number of services and youth served did mostly increase after SBMH adoption, the average number of services per youth held steady, if not dropped slightly following SBMH adoption. Results of the Mann Whitney U Test (see Table 11) suggest that while the number of services and the number of youth served were higher during post-SBMH months, the average number of services delivered per youth served was lower during post-SBMH months.

![Figure 2](image-url)  
*Figure 2:* Quarterly totals for individual therapy sessions provided across total sample (n=159). School based services began in the first quarter of 2013. *Data from 3rd quarter 2011 represents only two months; all other quarters include three months. Third quarters include summer months when school is not in session.*
Figure 3: Average number of individual therapy sessions per youth who received at least one individual therapy session in a given quarter (sample size varies by month as depicted in figure two). School-based services began in the first quarter of 2013. *Data from 3rd quarter 2011 represents only two months; all other quarters include three months. Third quarters include summer months when school is not in session.

Figure 4: Quarterly totals for case management services provided across total sample (n=159). School based services began in the first quarter of 2013. *Data from 3rd quarter 2011 represents only two months; all other quarters include three months. Third quarters include summer months when school is not in session.
Figure 5: Average number of case management services per youth who received at least one case management services in a given quarter (sample size varies by month as depicted in figure 3). School-based services began in the first quarter of 2013. *Data from 3rd quarter 2011 represents only two months; all other quarters include three months. Third quarters include summer months when school is not in session.

Figure 6: Quarterly totals for family therapy services provided across total sample (n=159). School based services began in the first quarter of 2013. *Data from 3rd quarter 2011 represents only two months; all other quarters include three months. Third quarters include summer months when school is not in session.
Figure 7: Average number of family therapy services per youth who received at least one family therapy service in a given quarter (sample size varies by month as depicted in figure 5). School based services began in the first quarter of 2013.

Table 13: Results of Mann Whitney U Test

*Sample Size for pre SBMH drops to 11 because 0 youth served in 6 of the pre-SBMH months

\(^\wedge\) Post SBMH mean rank is significantly higher than Pre SBMH rank at p<0.05

\(^\vee\) Post SBMH mean rank is significantly lower than Pre-SBMH Rank at p<0.05
**MH and Non-MH Outcome: Stakeholder Interviews.** The interviews also showcased MH and non-MH outcomes which the participants perceived were occurring. Several themes emerged including the MH of individual youth, improved access to MH services, the effect of SBMH on academic performance of individual youth, and the system-wide impact of SBMH on the school environment. Each of these themes is discussed more fully here.

**MH Outcomes for Individual Youth:** Interview participants perceived that the “symptoms associated with the MH issues are reducing (P10).” Specific changes that stakeholders observed among students making “huge progress (P8)” are captured by the following examples:

- “He talks about his feelings more. He can express himself more openly (P8).”
- “But he’s so much more like comfortable with himself, you can tell he’s more at peace, he doesn’t feel that anxiety all of the time, he’s not as angry (P8).”
- Students “learn to cope better with what’s going on in their lives outside of school (P12).”
- Students who were “just really having a lot of failure” now have “a lot more successes with their behavior here at school (P2).”
- “Overall, emotionally, they’re feeling better (P12).”

Despite noted improvements, however, stakeholders seemed to believe that the level of need remained high. One stakeholder provided a specific example of this, saying about one of her students, “Over the time we’ve been meeting, I mean I’ve just seen him blossom...Yes he’s still angry. He has every right to be - he has a lot of stressors and past trauma that he’s been through (P8).” More broadly, many stakeholders described the high levels of disruptive behaviors that still interrupt Care Team meetings and the day to day work of school administrators and staff.
MH Outcomes - Access: Stakeholders also observed that SBMH “makes it more likely that [students] are going to have access to services (P8);” “makes it so much more accessible to a lot of different people who would normally never get services (P12);” and overall, makes it so that “more kids are served (P6).” The second quote in this list captures a slightly more nuanced observation that SBMH may not just improve access overall but especially for certain groups of youth. An additional component to this change may be that the state provided additional funding so that SBMH therapists could serve “for every 10 kids referred,…about 8” which was “a huge, huge jump” from before (P4). However, stakeholders felt that having the services at the school was the key element because, as one stakeholder stated, “It just makes the most sense…Because really, when you’re working with kids, you have to work with the schools too. They spend so much of their time here. And it just makes more sense (P12).”

While not a primary point of discussion, two of the stakeholders described how universal strategies (e.g. use of the BoysTown curriculum within a “skills-based classroom model (P1);” instructing teachers on how to use “positive moments (P1)” in the classroom; teaching problem solving through PlayWorks!; creating a “safety room (P1);” etc.) promoted MH among students not in need of tertiary interventions. Some of the MH-related skills promoted in these strategies included, “how to get your needs met appropriately (P3),” and how to “calm themselves down (P1).”

Non-MH Outcomes among Individual youth. All of the stakeholders who were interviewed recognized that MH issues “impact how [students are] behaving at school…how they’re concentrating…their work completion…with attendance, and…overall academic performance (P12).” They felt that if comprehensive SBMH services are provided to meet youths’ MH needs, then youth would be more “ready to be taught (P9),” be “more successful at
school, and feel a stronger attachment to school (P4).” Those providing direct service shared many individual examples of improved school engagement and performance. One story, in particular, captured a variety of non-MH outcomes:

One kid in particular - he is a fourth grader - so quiet. His teacher said she would barely ever hear him talk. He never, ever, ever raised his hand for anything. Even if he had to go to the bathroom really bad, he would not raise his hand and ask for a chance to go to the bathroom. Or if he needed help, he would not ask for help. So he wasn’t doing any work, and he didn’t want to come to school. And he was actually running away from school at times. The police had to go and pick him up one time...So that’s what happened prior to me meeting him. And in just a short period of time, I mean, he started liking school. We talked about raising his hand and ask[ing] for help. Now he asks for help, and he provides answers in the classroom....He’s doing more work, he doesn’t have problems coming to school, he’s not having tantrums in the morning...And he likes school! How awesome is that! (P8)

While improvements in observable classroom behaviors were consistently noted, there were fewer mentions of changes (either positive or negative) on objective academic measures. One stakeholder captured one possible reason for this gap, saying that “as far as test scores and stuff like that, I feel like some of that is hard for us to gauge at this point. We’ve collected data, but we never have time to look at outcome stuff as well as we would like. (P2)"

**Non-MH Outcomes for School Environment:** Non-MH outcomes at the systems level were discussed in two ways. First, stakeholders felt that when “a student that is habitually disruptive (P5)” receives tertiary supports and behaves more appropriately, “there are direct benefits for the whole class (P5).” Intervening with a student who is bullying other students can
help him “understand the impact he may be having on others helps others” too (P8). Teachers can “focus on their best skills to teach (P1)” because no longer does a “disruptive moment disrupt the entire class (P1),” and students are encouraged to “be model and leaders for their peers” by demonstrating what it means to a “‘Marvelous Mustang’(P8).”

Stakeholders also reported improvements in the overall school climate. Teachers “feel supported (P2, P6)” and they as well as administrators feel less stressed. The positive changes in the school climate was described by one stakeholder as “palpable (P1),” with other words used to describe the improved school environments including “positive (P11),” “safe, warm, inviting (P1),” “consistent (P1),” and “inclus[ive] (P5).” Just as with individual youth, however, overall “data academically has not increased (P11)” significantly, particularly at the two most impacted schools. The other two schools, which have “done the best job coordinating all of their programs [including SBMH] together,” have “more positive environment[s], and they have fewer office disciplinary referrals (P11).”

Other factors, however, play into the differential successes across the four schools, reflecting the importance of “taking stock” of the full system before interpreting or generalizing the outcomes resulting in one context. The next results section focuses on answering second research questions and aims to describe more fully the dynamic context in which these outcomes occurred.

**Research Question Two**

Results in this section are framed around five processes that were part of the adoption and implementation of SBMH at the four schools, with particular focus on emergent themes within each process regarding 1) how each process was influenced by the state context (i.e. the focus and work of USOE and the Division of Mental Health and Substance Abuse [DMHSA]); 2)
the activities involved in each process; 3) the process outcome(s) that resulted from each process (i.e. the capacity-related innovations which moved the system towards MH and non-MH outcomes and impacts); and 4) the barriers and facilitators influencing each process. The five processes included creating a shared understanding for the need for SMBH, developing a viable model, developing partnerships, implementing the model, and institutionalizing the model.

It should be noted that the five processes were not viewed as discrete, consecutive stages. Activities within some processes occurred simultaneously, and changes in the context of the work would force stakeholders to revisit an early process that had been completed. Further, process outcomes of what might loosely be considered ‘earlier’ stages (e.g. defining the need) did facilitate success in what were usually later stages (e.g. implementing the model). Table 12 overviews the contextual factor and process and activity outcomes associated with each of the identified processes.

**Creating a shared understanding of the need for SBMH.**

**State Context.** As shared by the stakeholders representing the State, even before SBMH was explored by the four schools / district of interest in this study, there had been significant efforts at the state-level to create a shared understanding of the need for SBMH across USOE and DMHSA administration, the governor, and state legislature. Specifically, a strategic planning group had been brought together to define goals for the state in the area of children’s MH. The Program Administrator for MH at DSAMH reflected that at the end of significant advocacy efforts by USOE and UDMHSA staff as well as grassroots family advocacy groups, the “Everybody got it. They understood the importance of [SBMH] (P10).” Subsequently, the governor’s block grant and later legislative budget line-item helped to make the possibility of SBMH at local schools a tangible possibility and create the context in which the four schools could consider...
whether and how SBMH would fit within their systems. For example, while stakeholders working in frontline positions at the school did not mention or seem concerned with this aspect of the state context, those who were associated with the MH agency reflected that the work done to secure funding for children without MH coverage was a key predecessor to their own work.

**Activities.** In discussing their efforts to create a shared understanding of the need for SBMH, stakeholders referenced three key activities: data collection, consensus building, and advocacy. Data collection at the four schools primarily involved use of the Community and Youth Collaborative Institute’s School Experience Surveys. Stakeholders reflected that surveys revealed to them and others, for example, “how many of our kids [felt] sad on a weekly basis and how many weren’t sleeping (P1).” Whereas stakeholders reflected on data collection as a way objectively define the need, the other two activities involved stakeholders “selling SBMH (P9)” to garner support from others. To stakeholders, advocacy involved “selling SBMH” to external partners / funders while consensus building involved “selling SBMH” internally to generate administrative support (one of facilitators most frequently mentioned by stakeholders in later processes).

**Process Outcome.** The outcome of the completion of these activities, which stakeholders felt was helpful in their later work, was a shared, data-driven understanding of student need for comprehensive MH services. As expressed by one of the interview participants, when this outcome was achieved, “it was like the light bulb went on in everybody’s head (P3).” Several stakeholder reflected that having consensus about the need for SBMH helped to reduce some philosophical differences; to facilitate buy-in when establishing partnerships; and to generate funding to support the model.
<table>
<thead>
<tr>
<th>Process</th>
<th>Creating a Shared Understanding of the Need</th>
<th>Developing a Viable Model</th>
<th>Establishing Partnerships</th>
<th>Implementing the Model</th>
<th>Institutionalizing the Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td>- Data Collection</td>
<td>- Consulting external resources</td>
<td>- Defining Roles</td>
<td>- Delivering Services</td>
<td>- Evaluating</td>
</tr>
<tr>
<td></td>
<td>- Consensus Building</td>
<td>- Accounting for the context</td>
<td>- Developing Relationships</td>
<td>- Training</td>
<td>- Proceduralizing</td>
</tr>
<tr>
<td></td>
<td>- Advocacy</td>
<td>- Internal Realignment</td>
<td>- Formalizing Agreements</td>
<td>- Communicating</td>
<td>- Growing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Monitoring</td>
<td>- Diversifying Funding</td>
</tr>
<tr>
<td><strong>Process Outcome</strong></td>
<td>- Shared, data-driven understanding of student need for MH services</td>
<td>- Care Team Manual</td>
<td>- Formal, signed agreements</td>
<td>- Improved MH services for youth</td>
<td>- Model becomes “the way we do business”</td>
</tr>
<tr>
<td></td>
<td>- Administrator Buy-In</td>
<td>- An understanding of which components are required to implement SBMH with fidelity.</td>
<td>- A cohesive team with clear division of roles</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td>- Philosophical differences about the place for MH within academic institution</td>
<td>- Impatience to get started</td>
<td>- Capacity - Time</td>
<td>- Capacity – Concrete Needs &amp; Time</td>
<td>- Limited funds</td>
</tr>
<tr>
<td></td>
<td>- Tendency to do “business as usual”</td>
<td></td>
<td>- Lack of shared language</td>
<td>- Level of Need</td>
<td>- Turnover</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- “Artificial wall” between “separate entities”</td>
<td>- Role Confusion</td>
<td>- Fatigue</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Lack of Parent Involvement</td>
<td>- Student mobility</td>
</tr>
<tr>
<td><strong>Facilitators</strong></td>
<td>- Visible Need / Key Event</td>
<td>- Individual creating links to resources</td>
<td>- Individuals in key roles (e.g. liaison, peacemaker)</td>
<td>- Role Clarity</td>
<td>- Data</td>
</tr>
<tr>
<td></td>
<td>- Data from Multiple Stakeholders</td>
<td>- Existing standards/research/expertise</td>
<td>- Individual characteristics of team members</td>
<td>- Buy-in (especially among leadership)</td>
<td>- Individual characteristics of key staff</td>
</tr>
<tr>
<td></td>
<td>- Research Consultant</td>
<td>- Framework linking MH and academics</td>
<td>- Administrative support</td>
<td>- Data system</td>
<td>- “Critical friend”</td>
</tr>
<tr>
<td></td>
<td>- Charismatic Leader</td>
<td>- Financial leverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exemplar Quote</strong></td>
<td>- Everybody rolled their eyes until I showed them the data….They were shocked that [kids] were having these kinds of problems. It was like the light bulb went on in everybody’s head…they then said, “We’re open to your influence, what’s next?” (P3)</td>
<td>- I was very impatient initially and wanted to just get started, but he kept talking about, “This model...this model...this model”...We have to be true to the model. (P4)</td>
<td>- If you feel like you’re doing good things on that team, people will want to be there. People have said, “I honestly knew I couldn't scratch the surface with the amount of resources and time that I had...We were able to put more supports in place that gives the kids a chance.” (P6)</td>
<td>- There’s kids that I knew before this started that - they were so intense that I honestly knew I couldn’t have, you know, “This is one of my favorite meetings”...because people feel like...they’re part of something that’s successful and helping students. (P2)</td>
<td>- We saw the need. We’re building the infrastructure, and that’s kind of where we are. But I think down the road, we will be able to establish something that can be permanent, and that can be the way we work (P1)</td>
</tr>
</tbody>
</table>

Table 14: Overview of processes discussed by stakeholders
**Barriers.** Most stakeholders perceived that philosophical differences were a key barrier to generating buy-in for the need for SBMH. To explain what was meant by this, two stakeholders reflected that “Some people don’t find value in MH treatment (P10)” or simply do not view “MH on a par with our academic achievement (P1).” In other instances when stakeholders discussed barriers, the resistance they described seemed to originate not from others’ deep ceded philosophical differences but from a tendency of individuals and organizations to conduct “business as usual (P1, P3)” until met with a strong reason to change. To illustrate this idea, one participant equated the process of getting SBMH started to the “exact definition of inertia,” saying that “it really takes a very strong need” to overcome the “inherent immobility” of the existing “organizational structure (P1).”

**Facilitators.** The five stakeholders most directly involved in this process did, in fact, report that a strong, visible need in the community did facilitate the creation of a common understanding of the need for SBMH. Most pointed to how having the need was made visible through the collection and presentation of data. They also felt that the type of data collected was particularly useful because it accounted for the perspectives of multiple stakeholders (i.e., students, teachers / staff, and parents), allowing for an in depth understanding of the problem as well as the revelation that “really, we were all on the same page with our wants and desires (P3).” Aside from data, the Director of Student Advocacy and Access also remembered that extent was made acutely visible by a drug-related murder which occurred across the street from one school around the same time that the idea for SBMH was being discussed. She reflected that because this event highlighted the severe need of that particular school, the district was willing to fund a full-time social worker for that site in addition to bringing on the SBMH therapist (the other schools each had a part time social work intern from the local university).
A few other factors which were recalled by stakeholders as important facilitators to this process. One such facilitator, mentioned by five stakeholders, was the presence of a “confident, charismatic (P4),” and persistent “champion (P3)” at the district who was “relentless in driving this forward (P3)” and had the “good skills of social networking (P1).” This key individual by himself was not enough, however, as he reflected that before he had data, he was met with resistance from people who did not want to “reorganize [the] entire school structure around” an opinion (P3). As such, while other stakeholders mentioned the usefulness of having a consultant during this process, he was especially emphatic during his interview regarding the importance of having a consultant with skills in data collection and analysis. Not only did the consultant improve the capacity of the system to collect and use data, but stakeholders felt that her presence (as well as support from USOE staff) gave them, “tremendous leverage politically...to get buy-in at our district level and our community level (P3).”

**Developing a Viable Model.**

**State Context.** Having convinced the governor then legislature to set aside money for children’s MH, partners at USOE and DSAMH next had to figure out how to allocate the money. The UDSAMH stakeholder involved in this effort reflected that while the competitive Request for Proposal (RFP) that was used to allocate funds “turned out to [not be] statutorily supported,” she was “glad [she] didn’t know and did it wrong (P10).” She felt this way because the money was not granted formulaically but instead county representatives had to come together to develop quality plans that were “tied to their capacity (P10).”

In preparation to apply for this competitive “Early Intervention Grant,” as the RFP was called, the county MH authority in which the four schools were located approached the stakeholder (P4) who became the SBMH program manager at the MH agency. She reflected
that this partnership “just so happened” as the MH agency was recovering losing their status as the sole Medicaid provider in the county and was looking to diversify their services. The MH agency decided to move forward with the county as by receiving the Early Intervention Grant, was guaranteed reimbursement for services provided to children without MH coverage. The SBMH program manager reflected that having this source of revenue was what she “really attribute[d] the explosion” of SBMH because schools had not been interested in partnering with a MH provider who served only the Medicaid population. One of the first two districts to approach the now SBMH program manager about piloting SBMH with the Early Intervention Dollars was the district of interest in this study.

Throughout the entirety of this process, USOE and UDSAMH were hosting Learning Collaborative meetings to help county representatives learn about and develop viable models of SBMH. These meetings were organized by one of the interviewed stakeholders (P9) who reflected that that she always began them with a presentation from an exemplar “from the field doing really good work (P9).” The district Community Resource Coordinator (CRC; P3) representing the four Title I schools attended one of these meetings and heard the first school in Utah with SBMH present on the “integration of PBIS and SBMH.”

**Activities.** For the CRC, his work developing a model began to crystalize following this meeting. He and the stakeholders involved in the process of model development discussed three activities that were involved: learning from experts, early adopters and best practices; accounting for aspects the broader context; and undergoing internal realignment. With respect to the first activity, the CRC approached the facilitator of the meeting who linked him to a university consultant. In describing their working to develop the model, stakeholders reflected on two contexts (other than the state) that had to be considered: that of the MH agency and
that of the schools. With respect to the schools, stakeholders from the schools knew that the model would have to fit with the schools’ core academic mission and overall school improvement processes. (The SBMH program manager reflected that she did not come to realize this until her model in an unrelated school fell apart). As far as internal realignment, several stakeholders discussed a few ways in which roles and responsibilities were redefined for the purpose of SBMH adoption. The most commonly mentioned example of this the way in which the role of the school psychologist was changed, as one of the school psychologists reflected, to being “more of a leader …as opposed to just being a service provider (P2).”

**Process Outcome.** The tangible result of this process was the CARE Team manual mentioned only by the CRC (P3), but more stakeholders discussed in some form or another, a more abstract outcome, which was having an understanding of which components, or “model values (P4),” were required to implement SBMH with fidelity given the broader context. Initially, the Care Team structure was the key non-negotiable that all stakeholders involved in the SBMH model adoption recognized as the model; however, when reflecting on the overall process, stakeholders we able to identify other, more abstract components that they came to realize were also non-negotiable aspects of hits model (e.g. “communication in real time [P4]”). By identifying then “staying true to the model (P4),” stakeholders reported that they were “focusing [their efforts] on those interventions that are [evidence]-based, that are likely to provide the biggest bang for your buck (P2).”

**Barriers.** A barrier to the model development process was mentioned by the program manager for SBMH at the MH agency when she spoke about her own impatience to “just get started (P4).” In the following quote, she shared how her experience at the four schools transformed how she approaches model development with other schools and districts:
When [the CRC] approached me...he was excited about this model...I was very impatient initially and wanted to just get started, but he kept talking about, “This model ...this model....this model.” And interestingly enough, that’s the verbiage I use all the time now. That we have to be true to the model. (P4)

No other barriers to model development emerged from the data.

**Facilitators.** From the stories shared by stakeholders, it became evident that the availability of the external research and expertise (e.g. a model from the University of Maryland; new standards for school psychologists; an external consultant) was a key facilitator. As was the case when external sources were involved in defining the need, two stakeholders reflected that this was the case not only because these sources provided helpful information but also because they afforded “credibility (P1)” to the model development process. By creating linkages to the external resources, the USOE education specialist featured in several stakeholders’ stories as an individual in a key role who facilitated the work of others.

Many stakeholders working within the schools reflected that the use of an external framework also was helpful in creating alignment with the school context. In particular, stakeholders felt that the Community Collaboration Model for School Improvement (CCMSI), which was the basis for the schools’ broader school improvement work, helped to demonstrate how SBMH fit with schools’ core academic mission. One stakeholder explained the usefulness of the framework as follows:

The biggest thing that [CCMSI] did for us was give us a framework to organize all of our efforts around. So our primary mission, of course, is academics, and that’s what we really liked the model...it helped us put all those other things [such as SBMH] in perspective for the ultimate outcome and goal (P1).
Another strategy that many stakeholders discussed as something they intentionally did to facilitate linking SBMH to the broader context, as well as internal realignment, was involving internal partners in the development of the model. For example, when asked why she thought others at her school was so supportive of SBMH, one therapist observed that, “they were involved in that creation of the program enough keep moving it forward (P12).” As another example, district stakeholders were aware that the Care Team model would change the role of the school psychologists, who were supervised by a different department within the district. Knowing this, Director of Student Advocacy and Access recalled that they were intentional about “work[ing] internally with [the] district folks” from the beginning in order to “craft the language” in a way that was acceptable to all.

In this situation, money was also reported as a facilitator. Specifically, the Director of Student Advocacy and Access also recalled how, because Title I funding paid for half of the school psychologist positions, she had “access to say, ‘yes, these are some of the things we want to be doing (P1).’” Similarly, one stakeholder perceived that the MH agency was open to the idea of the SBMH model because they “could see the cost benefit” of “not having the same level of overhead (P9)” costs associated with a clinic and having the youth as a “captive audience in schools (P9).” It should be noted that while these examples demonstrate how some stakeholders felt like having a model that was fiscally viable was important, more of them expressed that the “overall buy-in [was] from people knowing that it was a good thing to do (P9).”

**Developing the Partnership.**

Developing partnerships (or restructuring, if an existing partnership) happened concurrently with the processes discussed thus far and continued into implementation. While
some of the themes that emerged in relation to this are thus mentioned of these other processes, those most directly related to developing partnership tasks (rather than how the partnership influenced other process) are shared here.

**State Context.** Because of the Education Specialist’s role as a facilitator and supporter, many of the stakeholders, including the education specialist, perceived USOE as one partner in the SBMH with which the other partners had to facilitate a relationship. As such, there were not many unique aspects of the state context discussed by stakeholders in relation to this process, but rather the activities, process outcome, and barriers / facilitators described in the remainder of this section were also discussed by stakeholders as they related to working with USOE, and the education specialist in particular, as one partner in the work.

**Activities.** Several themes emerged related to three activities involved in developing the partnership, namely defining roles, developing relationships, and formalizing agreements. The importance of clearly defining roles emerged as key because without it, “role definition really [was] the number one barrier (P11).” The task of developing relationships involved partners “get[ting] that rhythm of communication down,” and learning “how we work together (P10).” Formalizing agreements involved negotiation of official details. While several stakeholders mentioned that these governance documents existed, fewer spoke to the processes of negotiating them. The individual most involved in this activity was the Director of Student Advocacy and Access, shared that the agreements that the district formed on behalf of the four schools included the memorandum of understanding with the local MH agency as well as agreements with other school partners (e.g. Boys & Girls Club afterschool program) who agreed to adopt the same universal behavioral support strategies as the schools.
**Process Outcome.** Stakeholders seemed to define successful partnership development as having a “cohesive (P2)” team with clear division of roles. While Care Teams were not the only form that partnerships took on, many stakeholders, especially those in frontline roles, felt that the Care Team was where a lot of the partnership and “community stuff comes together and starts to mesh and work together (P5).” As a result, the development of the Care Team received a significant amount of attention during the interviews. Adjectives used by stakeholders to describe either their actual (or ideal) Care Team included: “congruent (P5),” efficient (P2, P5),” “inclusive (P1),” respectful, and focused.

While no school consistently embodied each of these characteristics, many of the reasons why stakeholders felt the four schools had differing levels of success were related to their relative success during the partnership development process. Beyond having a team capable of implementing the SBMH model with fidelity, stakeholders reflected that “knowing the power of collaborative and having a team [already] at the table (P9)” allowed partners to leverage relationships for reasons beyond their initial purpose. Thus a “very functional (P4)” partnership became a facilitator for stakeholders in the scheme of the overall work.

**Barriers.** A few barriers to developing the partnership emerged from the data. Challenges that stakeholders encountered with role definition originated from “territorial (P10)” issues when people had “rigid (P1)” understandings of their roles and / or felt threatened that by adding SBMH therapists, the district was “try[ing] to get rid of a job (P12).” Another perceived source of confusion was the lack of alignment at the district level. Care Team members who were school employees (e.g. school psychologist, achievement coach, etc.) had different district supervisors. Principals at the schools also reported to three supervisors. District stakeholders perceived that problems arose not necessarily originate from “them being
housed under different areas” but rather from when those different areas were “not on the same page” about how they “define...role[s] (P11).” Interestingly, though, no school stakeholders interviewed referenced the poor district alignment as a barrier.

The legal formalities, while understood to be necessary, were perceived as another source of “an artificial wall” between partners trying to form a “cohesive,” congruent” team. As an extreme example of this, two stakeholders told the story of how administrators at one school had a restrictive understanding about “what should and shouldn’t be disclosed (P4)” in front of the SBMH therapist, which “led to a real breakdown of the team (P4).” Note that none of the stakeholders directly associated with this school were participants in this study.

Compounding the legal division between the schools and SBMH therapists was the fact that “there were certain restrictions on the role and capacity (P7)” of SBMH therapists by nature of “the insurance piece (P11).” School personnel spoke about these restrictions as sources of frustration when the SBMH therapist could not serve all students like a school employee would be able to. For one SBMH therapist, these restrictions meant that she could not bill for some of the work she did which put “a lot of stress on a person who’s trying to make a living (P8).” Thus while the implications of the division were perceived differently by different stakeholders, the role of the SBMH therapists (versus “school psych versus social worker [P9]”) was broadly reflected on as one of the most difficult to define. At the two schools where stakeholders felt they had worked through these barriers, however, the nature of the SBMH therapist as a “separate entity” was not as significant as barrier to SBMH / the function of the Care Team and in fact, in some cases, became a facilitator.

Another barrier to developing relationships reported by many stakeholders was the challenge of not “speaking the same language (P10)” across SBMH and educational practitioners.
and agencies. One stakeholder recommended that “each party [be] more reflective of what their model, or...practice is about, (P4)” rather than assuming that the other partner would automatically understand their acronyms (e.g. PBIS) and align with their approach. Another recommended that training be provided to clinicians to “better educate them about the school system. (P1)”

Finally, establishing partnerships simply required time. Stakeholders from the schools, district, MH agency, and state all mentioned this, suggesting that factors which limited the capacity of individuals or systems with respect to time (e.g. turnover, competing responsibilities, part-time versus full-time staff, etc.) were key barriers to the development of successful partnerships.

**Facilitators.** Several themes emerged from the data about factors which were helpful in facilitating partnerships and collaboration. To continue the example about the school struggling with confidentiality and disclosure, administrators from the district and MH agency reported stepping in to facilitate “healthy conversation (P4)” about the issue. One stakeholder that was involved in this situation indicated that administrator support was needed to intervene when relationships broke down. She felt that having administrators from the two partnering agencies that were “exactly together” in their understanding of “philosophy” and “procedure (P1)” facilitated a positive resolution, demonstrating the need for relationship building at all levels.

In the limited instances of conflict discussed in interviews, administrators most often fulfilled key functional role of a “peacemaker” who could mediate conflict (though one of the state-level stakeholders (P10) reported that this was often her role for other school districts and counties). Stakeholder s mentioned several key roles that were important, including those of a connector who linked potential partners; a “liaison (P12)” who facilitated communication
between partners; and a gatekeeper who could “delineat[e]...where that line would be for an outside agency coming in[to the school].” Stakeholders also described individual characteristics that they felt had allowed themselves or others to successfully participate in partnerships, including the ability to be “team-player” as well as being “communicative,” “detail-oriented,” open to change, and “skilled” in their own role (P4). Four stakeholders also mentioned examples of when it was helpful that they or others could “see [SBMH] from all points of view (P1)” based on past experience in a different role (e.g. one of the therapists had formerly been a school social worker).

**Implementing SBMH.**

**State Context.** During the implementation stage, a university consultant, funded by USOE, was supporting the schools in their SBMH and overall school improvement work. As the USOE Education Specialist shared, USOE invested in and supported the work because they were “wanting to use District as a demonstration site so [we] could grow the work state wide (P9).” Contrastingly, the stakeholder from DSAMH who was working to support the statewide dissemination of SBMH was familiar with though not involved in the work at the four schools because their work was a “different beast,” albeit one which she found “inspirational (P10).” What both of these stakeholders shared was different about the four schools as compared to other SBMH work across the state was the use of a framework to integrate SBMH into the overall school improvement process. The USOE Education Specialist reflected in depth on this distinction and what it meant for her investment in the four schools, saying:

There’s a lot of local autonomy in our state, meaning a lot of local control, so it’s hard from a state level....to go in and say, “We want you to do [SBMH] exactly this way.” [The state] can require outcomes... [But USOE wants to] be able to help some of those
practices [from District] steer the other local mental health authorities [by coaching],

“Are you following some sort of framework? Are you struggling with collaboration with
the district? Here’s a success story (P9).”

**Activities.** A number of activities were mentioned by stakeholders that helped with
SBMH implementation, including providing of services, training, communicating, and
monitoring.

Stakeholders further described a number of activities involved in the provision of direct
service. They described how teachers filled out a referral form for students needing additional
supports, and then the Care Teams (consisting of the school psychologist, SBMH therapist,
achievement coach, social work intern, vice principal, and principal) reviewed referrals and
“connect[ed] the appropriate people to the appropriate problems (P2).” Stakeholders identified
several differences in the direct services activities at the four schools which contributed to
differences in experiences with SBMH at the four schools.

With respect to the training involved in model implementation, stakeholders identified
two types, that provided from the district to the schools and that provided by schools to their
staff. For example, training for Care Team members was provided by the district CRC, and
schools trained teachers so that “they’re comfortable to refer (P7).” One stakeholder reflected
that teachers also were trained in how “to manage behavioral” in order to create universal
interventions for the “90% of the kids who - that’s all they needed(P1)” to be successful in the
classroom.

Several stakeholders also stressed the importance of communicating. In fact, the SBMH
program manager identified communicating “in real time (P4)” as the most important activities
because “that was the predecessor to [defining] role or referrals or identifying kids.”
Stakeholders described using communication in several ways when implementing SBMH. Not only did the partners and Care Teams communicate with each other as they had throughout the process of getting ready to implement, but they also now had to with others in the different systems they worked in. Most often referenced was the importance of keeping teachers aware of the work of the Care Team because when the heard nothing, they “made an assumption that kids that were referred were not being seen (P4).” The SBMH program manager also talked about how she had worked to improve communication between SBMH therapists and therapists in other settings to facilitate referrals when youth and families were in need of more intensive services (e.g. home visits; respite; etc.).

Finally, examples of “monitoring (P10)” and “ongoing evaluation of the program (P9)” were shared by stakeholders in reference to both the direct service and administrative level. Examples from frontline workers included that Care Teams tracked referrals, and SBMH therapists collected the Y-OQ from parent /caregivers. Similarly, administrators spoke to the importance of “collect[ing] data along the way so that you can monitor and see how things are going (P1)” and when necessary, hold people accountable when implementation is not occurring as expected.

**Process Outcome.** Stakeholders mentioned that when executed well, implementation activities contributed to the delivery of improved MH services for youth and a more efficient use of schools’ capacity. These two types of improvements emerged as separate themes and are discussed as such below. Common to both improvements were the findings that 1) stakeholders reported that documenting improvements in services and outcomes helped to leverage buy-in and funding for institutionalizing and sustaining SBMH and 2) stakeholders’ observations that
improvements occurred to varying degrees at the four schools were attributed to a number of different facilitators and barriers which were differentially present at the four sites.

Improved MH services. Stakeholders described a number of reasons they felt having SBMH improved MH services. For schools, being able to “refer to someone who’s right here in the building (P7)” helped connect kids with the most severe needs to services whereas before, “the referrals...more often than not...wouldn’t happen (P6).” One school psychologist reflected that:

There’s kids that I knew before this started that - they were so intense that I honestly knew I couldn’t scratch the surface with the amount of resources and time that I had. So they ended up getting nothing, honestly. It was kind of just like, Band-Aid it through the day or the year. We were able to put more supports in place that gives the kids a chance. (P6)

Stakeholders also felt that SBMH facilitated better communication and coordination between partners which helped to create “consistency of the environments (P3)” on which youth could depend, especially when parents were involved. SBMH therapists also felt that they had more comprehensive, immediate information about “what my kids are up to at school (P8);” had “access to so many more resources (P12)” through the other school professionals (e.g. the social work interns); and had a “better understanding of what the families are facing in their own neighborhoods” because school-based services are provided “right in the middle of it (P12).”

Efficient use of capacity. Another interviewee mentioned process improvements related to changing and/or expanding the roles of professionals working in the school. As one stated, schools were “Using our staff more efficiently (P2).” Many stakeholders reflected that when the model was being implemented as intended, they felt that individuals were focusing on using
their “best skills (P1)” for teaching, administrating, providing therapy, case coordinating, etc. As an example of what happened prior to adoption of SBMH, the principal described a situation in which a mother experiencing domestic violence came to the school:

She had been battered and abused and was fearing for her life and that of her kids, and that year, we hadn’t necessarily had those services in place, so I was searching for resources for her...It was me. I did all of those things before. And now, to be able to have a team of people, it just makes me be able to do to the instructional part of my job so much easier. (P7)

Not only did most stakeholders feel that individuals’ time and abilities were being used efficiently, but many stakeholders also felt that the new model, and the Care Team structure in particular, helped to better “allocate our resources to support” students (P7). Instead of “pouring our resources into kids (P2),” the diverse professionals on the Care Team helped to understand the “function of the behavior (P3)” then link youth to appropriate services.

**Barriers.** Several themes emerged from the data in relation to barriers to implementation. Limited capacity was a barrier during implementation. Initially, there were issues with meeting the concrete needs of therapists (e.g. “appropriate” space, filing cabinet, etc.). As concrete needs were mostly taken care of, capacity issues stemmed from the competing demands placed on people’s time. Communication did not always happen “by virtue of [people] just being busy (P4).” Data collection took time and became an additional “burden (P8)” when stakeholders felt like “we end up collecting data just to collect data (P2).” In the case of the Y-OQ, for example, there were concerns about the language and length of the tool relative to some parents’ literacy skills, especially though not only among Spanish speaking parents (even though a Spanish translation was used).
The level of need at the schools also became a barrier during this process, in part because it contributed to the demands placed on individuals’ time. While was not directly mentioned by all stakeholders, those that did not explicitly identify it often shared a story illustrating this point. For example, two of the three stakeholders representing one school described how that the weekly Care Team meetings at one school were “interrupted quite a lot by behaviors.” Care Teams also tracked fifty to sixty students at a time, and this number of youth bogged down the process and created feelings of frustration and inefficiency among stakeholders. While stakeholders at one school felt that they had been able to refine the Care Team process to be able to manage this volume of need, the school psychologist involved in this refinement reflected that he now had to “juggle the efficiency of the meeting versus the depth of the services” and be careful that “we’re not losing kids after they’ve been referred and they’ve been connected initially (P2).” A different stakeholder suggested that part of the issue here was that “there’s a breakdown in [schools’] system with how they’re supporting their teachers with classroom management (P11).”

Role confusion was reported by stakeholders as another barrier to implementation when people did not understand the function of individuals (e.g. SBMH therapist) and / or the function of teams (e.g. Care Team versus the academic-focused “Student Study Team” at one school). When boundaries around roles were not clear, stakeholders felt that they and others were asked to deal with situations beyond their capacity and/or expertise. At one school, confusion around the two teams led to teachers not making any referrals or bypassing the system to speak directly with the SBMH therapist. Such issues contributed to inefficient use of time and resources and in the case of at least one stakeholder, an emerging sense of burn-out.
A final, “major” barrier to implementation was lack of “parental support (P7).” Almost all of stakeholders spoke to the notion that “if you're not working the whole family, it's really tough for the child to really benefit fully from the support (P11).” In fact, one of the perceived benefits of having SBMH therapists was their ability to provide comprehensive family services, and the therapists felt like the schools could help facilitate linkages with hard to reach parents. However, these benefits were not always realized. Reasons to which stakeholders’ attributed the lack of parental involvement included language barriers (about 50% of one therapist’s parents spoke Spanish); different cultural norms for addressing MH issues; and the observation that “a lot of [parents] are in survival mode (P8).” The inflexible translation services reported by one of the SBMH therapists exacerbated these barriers, though as a different stakeholder observed, services were still “just not as authentic (P7)” when provided through an interpreter. SBMH therapists still “[got] authorization from the families” and involved parents in the initial intake. After that though, if the therapist “never see[s the family] again, it’s not optimal, but [she]'ll still serve the kid (P4).” While this choice meant they were not always staying “truly accurate to the model,” the alternative would be that “kids that the schools...know need to be seen wouldn’t be seen (P4).”

**Facilitators.** Whereas role confusion was a key barrier, role clarity – when it existed – became a key facilitator that emerged from the data. As one interviewee stated, “Having clearer boundaries (P2)” around roles reduced turf issues and improved the “cohesion” of the Care Team. This same stakeholder recognized, though, that “you can’t have really strict roles in the school system because there’s so much...to do (P2).” In situations when stakeholders did thus experience “overlap in roles,” having role clarity was essential so that the overlap occurred in a way which promoted coordination rather than duplication. For the SBMH therapist who
was often called upon to help with projects and situations that she could not bill for, this role clarity helped her to identify her own boundaries and communicate them effectively in ways which helped her job become more manageable.

A second facilitator mentioned by a majority of stakeholders was buy-in, particularly among leadership. At the schools where the model was most successful, stakeholders felt that they had a “strong administrator with a very clear vision and...the organizational skills to make it happen (P1).” Buy-in among district administration was perceived as necessary as well because, without buy-in at all levels of leadership, “[SBMH] will be sabotaged, it will get broken down, it will get shoved aside (P3).” Although mentioned by fewer stakeholders, buy-in among other individuals was viewed helpful because then they were more flexible when roles were changed or barriers encountered. For example, at one of the schools struggling with implementation of the Care Team, the school psychologist still felt that their “persistence in that matter has been a success” because Care Team members “kept [the meeting] time sacred” and “haven’t lost sight of the end goal of being a really well functioning coordinated team (P6).”

A final facilitator that stakeholders reported was a system which simplified collecting data and using data “to reflect and to set goals (P1).” For example, one school moved the teacher referral system online, which streamlined tracking and monitoring activities.

**Institutionalizing SBMH.**

**State Context.** Stakeholders at the state level reported that the role of the state would be changing as the district and four schools looked to institutionalize SBMH. More specifically, after two years of funding the consultant for the district, the USOE education specialist was looking to shift “ownership” of these costs to the district so that USOE’s money could be
repurposed to “take this [model]…across state initiatives (P9).” She anticipated that the “successes from <District>, the data, [and] the reports (P9)” would all be useful in advocating for additional resources for her effort to “scale up” the model. While the funding for the infrastructure of SBMH was thus being eliminated, stakeholders felt that the funding for the SBMH services themselves were sustainable. In particular, the stakeholder interviewed from DSAMH interpreted the state legislature’s allocation of 1.5 million of TANF dollars as an “effort” displaying their ongoing commitment to children’s MH. Unfortunately, she also reported that the “eligibility requirements” and enrollment processes were “so intense” and burdensome that the decision was made to not pursue renewal of these funds.

**Activities.** Several activities were reported by participants as crucial for institutionalization, including growing, “proceduralizing (P1),” and evaluating the model as well as sustaining funding. At the four schools, growth occurred because the number of youth referred for services, and the result was the hiring of a third therapist. “Proceduralizing” the model, which involved establishing formal structures and expectations around roles and tasks, was mentioned as essential by one district-level stakeholder in particular. As an example of what this might look like, the school psychologist described how he created a set agenda to make Care Team meetings efficient (and initially used a timer to make sure the agenda was followed).

Stakeholders viewed evaluating the model as important not only for monitoring progress as described previously but also for “getting the outcomes reported correctly (P9)” to funders. Most of the funding for SBMH was drawn down from the Early Intervention Grant and other funding government sources (e.g. a one-time TANF grant) that became available during implementation. While none of these sources were permanent, the SBMH program manager
was confident in her agency’s ability to “get creative” to make sure that the therapists could bill against an insurance or funded grant. As such, she did view the model as “very sustainable.”

**Process Outcome.** Stakeholders described what might be considered the outcome of this step when they spoke to how they wanted the SBMH model to become “just how we do business (P1).” One school psychologist provided, unprompted, an example of how this was already happening, noting that for “kids that need more services...this is just the way we do it now. This is how we get them services (P6).” For the most part, though, stakeholders recognized that had work left to do before realizing this outcome. As captured by one stakeholder:

> We saw the need. We’re building the infrastructure, and that’s kind of where we are. But I think down the road, we will be able to establish something that can be permanent, and that can be the way we work (P1).

**Barriers.** Turnover emerged as a barrier in relation to institutionalizing, but in a broader sense than was the case during the process of establishing partnerships. One interviewee provided an example of when turnover impeded progress. She reported that at the district, the CRC left during the first year of implementation without "encoding" his knowledge in a “set of policies and procedures.” As another example, two stakeholders anticipated that a recent change in the district superintendent brought a “whole different lens, different view, different knowledge base” would have implications for SBMH oversight even though the superintendent did not play a direct role in SBMH. The high rate of mobility among students was mentioned a related barrier. Also related to both turnover and mobility was the fatigue that stakeholders either felt or perceived among others, as each change meant “always going back to square one (P1).”
Even with diversified funding to sustain the SBMH therapists, the general lack of student support services was reported by several interviewees as a barrier, though fewer directly attributed this to a funding issue. As one stakeholder did observe, “funding for personnel is always a barrier...[but] you can't let that get in the way because otherwise you'll be paralyzed in education (P11).” The addition of the SBMH therapists provided valuable services, but as described earlier, stakeholders recognized that there were limits to their roles that prevented them from filling significant gaps in services. For example, having a SBMH therapist was not viewed by stakeholders as a substitute for “having a school-based social worker (P8),” yet three of the four schools only had part-time social work interns. Similarly, even as the SBMH model was being institutionalized state-wide, the USOE education specialist recognized that “the money [was] still not enough” to reach all students and families needing services (P9).

Facilitators. A few factors helped facilitate institutionalization. Having data to demonstrate the outcomes of the work was reported as facilitator during this process, but also as a requirement. As reflected by one of the state-level stakeholders, one “thing the legislature was very clear on was, ‘Okay we’ll give you the money, but we want to see your outcomes.’” Additionally, where the initial CRC’s skill set was in partnership building, the Director of Student Advocacy and Access shared that the CRC hired to replace him had the skills to systematize procedures across the four schools, reflecting the importance of “getting the right person at the right time (P1)” for key staff roles. A few stakeholders also felt that it was helpful to have someone in the role of a “critical friend,” or a “non-biased person... who can stand back out of the day to day challenges of dealing with disruptions to look at it systemically (P1).”

While few stakeholders spoke to this explicitly, a final facilitator seemed to be a personal belief in the value of SBMH that helped individuals to persevere despite barriers and
resistance. One stakeholder expressed this saying, “I love, love, love serving the populations that we’re serving - that’s what I love doing (P4).” Another emphasized, “I just believe in it. I believe in it, I believe it makes a difference (P10).” And a final stakeholder expressed, “that sometimes society just kind of writes certain people off and certain groups of people off, and I am just glad that I don’t have to be part of that. I can see how much these kiddos can really grow and be...and be amazing. (P8)”
Chapter Five: Discussion

Findings

SBMH Outcomes and Impact.

The results of this study point to the positive influence of SBMH services on both individual and systems, supporting the classification of SBMH as a public health solution to children’s MH issues (Miles et al., 2010). Parent /guardians reports of their children’s MH related symptoms were significantly different at post than pre overall and in three specific domains. Stakeholders described many of the same improvements when talking generally about the benefits of SBMH as well as when providing examples of individual youth. Growth in Y-OQ scores was especially noted among Hispanic youth, which was encouraging given the particular challenges stakeholders reported in relation to cultural and linguistic barriers faced when serving these youth.

Stakeholders also reflected on the non-MH (i.e. academic) outcomes of SBMH services. Those familiar with individual youth receiving school-based clinical services spoke about enhanced classroom participation and improved attitudes towards school, some of the proximal indicators of academic improvements identified by Suldo and colleagues (2014). Resultant themes emerging from the interviews suggest that the school climate had improved at the four schools as a result of the implementation of the full continuum of SBMH services, including the tertiary interventions as well as the primary and secondary interventions. Stakeholders also indicated that teachers seemed to feel more supported, as has been found in other SBMH
related studies (Ball & Anderson-Butcher, 2014). Further, when SBMH services were implemented successfully, individuals in all roles reported being able to focus on using their best skills to the betterment of youth.

System-level MH outcomes also were documented through the quantitative analyses. The examination of the MH agency’s records demonstrated an increase in the number of services delivered, the number of youth served, and for individual therapy and case management services, the average number of services per youth. These patterns reaffirm the frequent claims that SBMH improves access, an important finding in light of the observation that traditionally, only 20-30% of student needing services have received them (AAP, 2004; Atkins et al., 2006; Evans, 1999; Flaspohler et al., 2006; Powers et al., 2013; Sarno-Owens & Murphy, 2004; Weist, 1999; Weist, Evans, & Lever, 2003). Interviewed stakeholders lent additional depth to this result, suggesting that beyond increasing the number of youth served, SBMH services created access for a demographic of youth that would not have accessed services outside of school. Further, Hispanic youth represented a higher proportion of students served by the MH agency than in the overall student body. Given the evidence demonstrating that youth living in poverty and /or from vulnerable ethnic groups are overburdened by barriers to traditional MH care (Coker et al., 2009; Cook, Barry, & Busch, 2012), it is encouraging that SBMH can eliminate barriers that otherwise play a key role in perpetuating disparities.

Despite these positive trends, however, both quantitative and qualitative results revealed that high levels of need remained unmet at the four schools. Post- Y-OQ scores and scores in three subscales were above established benchmarks for clinical concern for youth overall, though not for Hispanic youth. There was evidence from the interviews which reaffirmed the persisting level of need. In particular, the number of students referred to Care
Team, as well as high levels of disruptive behavior at two schools, threatened to overwhelm the model.

Patterns in the results revealed not only the high level of need but also possible reasons for which need remained despite SBMH. Foremost, the broader neighborhood context in which the four schools operated was burdened by high rates of student poverty and mobility. While the amount of risk factors in such neighborhoods often contributes to higher prevalence of MH needs (AAP, 2004; Atkins et al., 2006), it is worth noting that therapists interviewed for this study felt more equipped as clinicians because they were immersed in and had a better appreciation for the youths’ everyday context. This benefit of SBMH has been documented by others as well (Evans, 1999). SBMH is not singularly able to counter the complex interplay of social determinants of poor health, but as one intervention in the array of services and policies needed to change a community’s social determinants of health, MH services that are school-based have benefits that traditional approaches to children’s MH do not offer.

This is not to say, however, that the SBMH model adopted and implemented at the four schools was effective in all of the best practices of SBMH, as there was room for improvement. For example, one of the SBMH principles identified by Lever and colleagues (2006) was the active involvement of students, families, teachers, and other key stakeholder groups. The average number of family therapy sessions per youth was higher during the months preceding SBMH adoption, suggesting that the use of this best practices had stagnated even while other services types grew on pace with the number of youth served. This trend from the MH agency services records was mirrored in the frustration that stakeholders expressed about their (oftentimes unsuccessful) efforts to engage parents, and both findings were consistent other research done by Weist and colleagues (2014). Because family engagement is a best practice in
children’s MH services, strategies are needed to improve this aspect of the model. Given the finding in this study that schools often try to function as the link between SBMH therapists and parents, trainings such as that provided by Weist and colleagues (2014) might be enhanced by including and facilitating dialogue between schools and school-based clinicians rather than focusing solely on therapists.

Similarly, most stakeholders defaulted to talking about the Care Team and tertiary services even when questions referenced the full continuum of services. For example, teachers were most often discussed in reference in needing to keep them informed about MH services rather than as equal partners in SBMH. Thus, while comments by a few stakeholders did reveal that primary services were occurring, the universal strategies were not viewed a focal point of the model or perhaps were not seen as part of SBMH by all stakeholders. More training is needed to increase teachers’ competencies in dealing with MH issues and to ensure that professionals involved in SBMH understand the connections between and importance of providing primary, secondary, and tertiary services. As long as services are reaching only the individual, and not families and other collateral systems, the potential outcomes and impacts are limited and SBMH is not fulfilling its potential as a public health solution to children’s MH (Ball & Anderson-Butcher, 2014; Newsome et al., 2008; Weston, Anderson-Butcher, & Burke, 2008).

**SBMH Adoption and Implementation**

This case study also uncovered several perceived barriers and facilitators that influenced the adoption and implementation of SBMH and demonstrated that the facilitators and barriers were dynamic rather than stagnant. That is, certain factors were especially prominent during the five processes that stakeholders identified (i.e. creating a shared understanding of the need;
developing a model; establishing partnerships; implementation; institutionalization). Further, certain process outcomes, or process and product innovations as identified by Bodily, Chun, Ikemoto and Stockly (2004), helped to address barriers or create facilitators in ways which moved the context towards being more accepting of or conducive for SBMH.

**Facilitators.** Having data was one of the key facilitators throughout different aspects of SBMH work at the four schools but for different reasons at different times. Initial needs assessment data were helpful to communicate the need for SBMH, then data were helpful for monitoring the progress of individual youth and the system overall. Finally, evaluating the system helped to generate both reasons and recommendations which could inform institutionalization. Given the different needs for data, simply having data was not the facilitator; instead, it was important to have the right type and amount of data and to have a system that allowed for efficient collection and use of the data.

As a related facilitator and example of how data were used, the presence of a strong, visible need in the community was a facilitator for creating a shared understanding of the need for SBMH. Recognition of the need for SBMH helped to generate and sustain administrator buy-in, which was a facilitator in almost every process of adoption and implementation. The importance of administrative buy-in in this case study reinforces the findings of other school-related research (Anderson-Butcher et al., 2010; Mellin & Weist, 2011; Sanders, 2014; Mendenhall et al., 2012).

Having individuals skilled at particular roles was another important facilitator, and those key roles were different during different processes. Initially, a champion was needed to garner support. Then the schools benefited from having someone at the state that could link them to resources as model development occurred. A liaison helped negotiate terms of the relationship
when establishing partnerships, and during implementation, a mediator who could step in to
problem solve was needed. In this way, one stakeholder’s observation that it helped to have
the “right person at the right time” might be extended to the entire system in that it was
important to have the right people in the right roles at the right times.

Another key role was that of a “critical friend,” or an unbiased observer who could
provide objective feedback and advice. In past research and in this current study, this valuable
role was filled by a university consultant who was both building the capacity of and evaluating
the system (Powers et al., 2014; Weist et al., 2014). In this current study, stakeholders
perceived that consultative support also was available from the state official most heavily
invested in the work and success of the pilot. As little research has been done to understand
the role of the state in SBMH, this finding suggests that if SBMH is adopted and institutionalized
on a larger scale, the role of the state may be similar in some ways to the role that thus far
university researchers have held.

**Barriers.** Consistent with past research, philosophical differences among stakeholders
were a significant barrier (Powers et al., 2014; Weist, 2005). Philosophical differences in this
study stemmed both from a lack of awareness of the need for MH services as well as the
perspective that academic needs must be prioritized ahead of MH needs. While lack of
awareness was addressed (though not completely eliminated) through strategic advocacy and
consensus building, the more fundamental philosophical differences continued to be a source of
challenges. While peripheral to the day to day activities of SBMH, they became a central issue
again when stakeholders were looking to institutionalize SBMH because that was when tough
decisions had to be made about allocation of resources. That such decisions had to be made
reflected other macro-level factors, such as the extremely low per pupil funding rate in Utah compared to other parts of the country.

Limited capacity also was viewed as a barrier as has been found in other research on school improvement (Weist, 2005). Initially, issues needed to be solved when SBMH therapists lacked access to appropriate space and technology. Aside from concrete needs, stakeholders expressed that one of the biggest challenges was finding time to attend to the many competing demands placed on their time, echoing the findings of past research (e.g., Langley et al., 2010; Reinke et al., 2011). Time was needed in two ways: to keep up of the day-to-day implementation one’s job (both internally and as they relate to partnerships) and to form lasting relationships. Related to the lack of time was a lack of sufficient support staff to address the high level of need at the schools.

While the collaborative relationship with the local MH agency allowed schools to meet MH needs that were inadequately met beforehand, the restrictions around the role of the therapist meant that individuals in this role could not be leveraged to meet other needs that the school staff viewed as important. The actual and perceived boundaries surrounding the role of the therapist as a separate entity also were one source of role confusion and role conflict. Others have similarly found that learning how to partner across agencies is a challenge associated with the collaborative rather than school-owned approach to SBMH (Powers et al., 2014; Bronstein et al., 2011).

Role confusion, a key barrier during implementation, also originated from inherent newness of the model, from turf issues, and from the poor alignment between district level administrators’ expectation of school-level staff. Uncertainty about responsibilities and boundaries contributed to frustration whereas role clarity contributed to improved efficiency.
and cohesion across team members. As suggested by Weist and colleagues (2012) as well as Bronstein and colleagues (2011), interdisciplinary training may help individuals from different professional backgrounds to understand the different functional roles involved in SBMH and to develop a common language with which they can effectively communicate about services and issues.

Because there will be variability across individuals in the same roles just based on individual differences, turnover was an inhibiting factor when individuals were establishing partnership because relationships take time to build. Similarly, turnover was a challenge when institutionalizing the model when a) a key individual left and took with them valuable experience and expertise or 2) new administrators brought new priorities and new structures which may not be conducive to SBMH.

Finally, the high level of need in the community which facilitated gaining support for SBMH was a barrier during implementation services because the need threatened to overwhelm the system put into place. Additional support staff were desired to meet the high levels of need among students, but at the same time, improved universal strategies, both within the schools and broader community, were needed to better prevent and interrupt the cascade that resulted in the high levels of need among students.

Limitations

Several limitations must be noted that may limit the generalizability of the findings. That only one district used in this study limits the generalizability of findings given the heterogeneity of school environments, though comparisons across the four schools allowed for some understanding of the influence of different contexts. The schools involved in this study may have already had a certain level of readiness in place for adopting SBMH given that they
had already started to work to become community schools, thus the perspectives shared by stakeholders in this study may not generalize to all settings. The attention to the influence of the context, however, helps to minimize the impact of this limitation. Further this study was focused on schools with a high proportion of Hispanic youth and high rates of poverty and mobility. As the implementation of SBMH within such a context has not been fully investigated, this study adds a unique perspective to the growing body of literature. Further, the schools garnered particular interest from the state because of the community schools work so this context also provided a unique opportunity to look at the role of the state. Still, future research should expand on this work by identifying and studying schools and districts that have more varied levels of readiness, including schools in which resistance among administrators has prevented the adoption of SBMH entirely.

Within the quantitative data no comparison group was available for Y-OQ data, and data on access looked at trends rather than comparing similar populations receiving services prior to and after SBMH. Further, there were high rates of missing data, and reasons to believe that the missingness was not at random. Stakeholders responsible for collecting the Y-OQ expressed frustration that the Y-OQ was hard for many parents to understand, and Hispanic youth were underrepresented in the population of youth with complete Y-OQ data. The lack of a comparison group means that this study could not account for the influence of changes and trends that occurred simultaneous to the adoption and implementation of SBMH. Future research should explore leveraging natural opportunities for quasi-experimental designs, using schools that opt to not adopt SBMH as a (albeit nonequivalent) control group to schools that do. Still, that qualitative results triangulated patterns in the present study helps to address this limitation and improve the robustness of the results despite the missingness of data and lack of
comparison group. Further, while a limitation in this study, this pattern itself speaks to some of the challenges associated with data collection within the SBMH adoption and implementation.

As another important caveat, this study used only pre- and post Y-OQs completed during the SBMH time frame, which did not always align with the initiation and termination of services. The criteria were set conservatively to prevent overestimating the outcomes of SBMH, but it also is important to not underestimate the potential impact of MH and SBMH based on the results of this study. That said, the types and amount of services received during the SBMH time frame varied widely across youth, but the small sample size precluded tests to determine the mediating influence of service duration or frequency on service outcomes. Finally, because data collection relied on self-report of parent data, there is the possibility of response bias, for example if parents felt compelled to report reduced symptoms out of gratitude for the SBMH services. Additional studies are needed covering time spans long enough to generate a sufficient sample of complete cases for analysis, and more objective measures of students’ MH status would improve the reliability of findings.

The recruitment strategies used in the qualitative portion were a source of limitations in that portion of the design. A broad range of perspectives were gathered which provided breadth but limited the depth of conclusions that could be drawn. Several interview participants also were familiar with the researcher prior to the interview because of an ongoing consultative relationship between the university and state / school district. While this may have biased the information they shared, there are other benefits that do come from being both a researcher and consultant, particularly when working from an empowerment orientation (Barker & Pistrang, 2005; Meyers et al., 2012).
Implications

Implications for Research.

While the limitations of the study design must be considered, there are still implications that emerge from this study. Foremost, SBMH as an approach to children’s MH seems to have the ability to produce many positive outcomes among youth as well as at a systems level. This study produced initial evidence that the model had positive impacts among Hispanic youth in particular, though future research with a larger sample size is needed to confirm this finding. The real and perceived barriers and facilitators to adoption and implementation can inform other schools, districts, and states looking to develop SBMH. This study included the perspective of the state officials involved in SBMH, allowing for additional breadth of understanding of such barriers and facilitators. As more is learned about the best practices used to implement SBMH within schools and districts, it will be important to further build knowledge about how to create policy and environmental contexts that are conducive to dissemination of SBMH. Because of the dynamic nature of the systems involved in SBMH, future research should also further examine how barriers and facilitators change and can be intentionally changed over the course of SBMH work.

Implications for social work and public health practice.

Even as more research is needed, there are certain implications for social work practice that emerge from the current study. In particular, there is a need for strengthened universal strategies which promote MH and prevent mental illness because without these services, secondary and tertiary services will continue to be overwhelmed by persistently high levels of need. For example, schools adopting SBMH in coordination with a local MH agency might consider also training their teachers in strategies consistent with the principles of trauma-
informed care. There also is a need to more fully integrate the different types of SBMH services across the PBIS continuum so that tertiary MH services can come to be viewed as a natural part of the educational experience rather than as a competing priority. School social workers are well equipped to lead the implementation of these two recommendations given their expertise in linking services and systems and appreciation for the important influences that environments have on youth and families.

Similarly, public health professionals are well positioned to advocate not only for the continued dissemination of SBMH but also the promotion of MH across broader community systems. Oftentimes, the needs of the students at the four schools involved in this study stemmed from adverse experiences beyond the school walls. Some of the reasons stakeholders felt that parents were not involved in children’s MH services were parents were dealing with their own MH issues and /or struggling to fulfill other basic needs. Even as SBMH gains popularity as an innovative approach to children’s MH, it necessary to attend to and address broader social determinants of mental illness.

**Implications for policy.**

Professionals from both social work and public health should advocate for policies which are conducive to SBMH. At the four schools in this study, the allocation of state funds for SBMH preceded the development of the SBMH model. However, even as the SBMH therapist provided valuable services, their role as a contracted provider limited the extent to which they could support and meet the needs of all students within school. School, district, and state policies should be written in a way which accounts for the importance of student support services, including but not limited to SBMH services, because the needs of students and families are complex and require integrated, multi-faceted solutions.
It should be noted that the success of the four schools was not attributable only to the change in state policy and funding but also to the support provided by USOE and an external university consultant. This suggests that changing policy may not be enough to bring about change in practice unless there is an infrastructure in place to support those agencies (i.e. schools, districts, and MH agencies) which are called upon to adopt and implement SBMH.

Conclusion

Not only at the four schools in Utah, but at schools and districts across the country, SBMH is changing the way that children’s MH is approached. SBMH integrates a full continuum of services in order to prevent mental illness and promote MH and improves access to MH services for youth, important especially for youth from marginalized groups that historically remained under- and unserved. When MH needs are not met, a negative cascade of outcomes across the lifespan can result, with severe costs for individuals and society. In contrast to this bleak picture, the potential impact of SBMH was captured well in a story shared by one of the stakeholders in this study who reflected, “I remember one father particularly saying to me, ‘If I would’ve had this mental health treatment when I was a child, my son might not be needing it (P10).’” While there is much to learn about why, how, and for whom SBMH works best, there is a high level commitment among partners in this work who recognize and aim to realize the full potential of SBMH as a way to support student success in school and in life.
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Appendix A: Semi-Structured Interview Guide
1. What is your role in or connection to the Title I elementary schools in Canyons District?

2. How have you been involved in the school-based mental health services at these schools?

3. In what ways, if any, has your role changed during and since the adoption of SBMH?

4. In what ways, if any, are mental health services different when they are school-based instead of clinic-based?

5. In what ways, if any, does school-based mental health fit within the overall school improvement process occurring at the four elementary schools?

6. How have school-based mental health services impacted the youth served?
   a. Probe for both mental health and non-mental health impacts

7. How have school-based mental health services impacted the school?
   a. Probe for impacts on patterns in services, school climate, etc.

8. What, if any, other impacts have you seen resulting from school-based mental health?

9. What factors influenced the adoption of school based mental health as it first got started?
   a. Probe for people, partners, institutional, policies, systems factors
   b. Probe for facilitating and impeding factors

10. What factors influence the day to day implementation of school based mental health?
    a. Probe for people, partners, institutional, policies, systems factors
    b. Probe for facilitating and impeding factors

11. If you were going to give another <agency like yours> a recipe for a successful school-based mental health program, what ingredients would you include? What steps would you include?
12. In what ways, if any, was the adoption of school-based mental health different across the four schools? *If differences are noted,* why do you think these differences occurred?

13. In what ways, if any, is school-based mental health being implemented differently across the four schools now? *If differences are noted,* why do you think these differences exist?

14. What, if any, new or different challenges are you facing now compared to when you first got started with school-based mental health?

15. In what ways, if any, has the experience with school-based mental health informed other aspects of your job?

   a. *For participants at the admin level,* probe about SBMH at other schools

   b. *For participants at the policy level,* probe about policy implications

16. What do you see as the long term future of SBMH at and/or beyond the four schools?

17. Is there anything else that I should know about your experience with SBMH?