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Sustaining school-based mental health services: a case study of the implementation of the San Diego Unified School District's Mental Health Resource Center

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Dissertation

SUSTAINING SCHOOL-BASED MENTAL HEALTH SERVICES:
A CASE STUDY OF THE IMPLEMENTATION OF THE SAN DIEGO UNIFIED
SCHOOL DISTRICT'S MENTAL HEALTH RESOURCE CENTER

by

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To my partner, Jesus
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SUSTAINING SCHOOL-BASED MENTAL HEALTH SERVICES: A CASE STUDY OF THE IMPLEMENTATION OF THE SAN DIEGO UNIFIED SCHOOL DISTRICT’S MENTAL HEALTH RESOURCE CENTER

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ABSTRACT

Problem: A major gap in adolescent mental health services exists in the United States. Nearly 80% of children and adolescents who are defined as needing mental health services are not receiving mental health care. School-based services have demonstrated promise as a strategy to address this gap. The purpose of this dissertation is to determine how a large urban school system implemented and sustained an innovative service of care model in response to financial, human resource, and community constraints and opportunities.

Methods: A case study of the San Diego Unified School District’s (SDUSD) Mental Health Resource Center (MHRC) was completed using Pettigrew and Whipp's Content, Context, and Process Model of Strategic Change (PWM) as the theoretical framework that guided the research. Three primary sources of evidence were collected covering a fifteen-year period of implementation (1999–2014): 1) documents; 2) archival records; and, 3) interviews. The interviews were conducted with local and state stakeholders (n=20) and with students who received MHRC services and their parents (n= 15). A
chronological reconstruction was completed and all data underwent a content analysis to organize and identify emergent themes based on the PWM framework.

**Results:** Eight factors were identified as critical to the implementation and sustainability of the MHRC: establishing the legitimacy of school as environment for the delivery of mental health services; aligning education and mental health policies; implementing cross systems collaboration; utilizing data to improve performance and prioritize services; strengthening parent and student involvement; commitment to lead; institutionalization of mental health training; and, investment in staff. Further analysis assessed potential system improvements and opportunities for new collaborations and produced sustainability recommendations for SDUSD and MHRC administration, staff, and stakeholders.

**Conclusion:** The MHRC provides a unique systems model that can inform best practices and policy decisions regarding the implementation and sustainability of school-based mental health services. Lessons learned from the sustainability of the MHRC support schools as a legitimate environment for the delivery of mental health services and the integration of mental health services in schools as a feasible strategy to improve student academic and mental health outcomes.
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LIST OF ABBREVIATIONS

ALBA: Alternative Learning for Behavior and Attitude community schools

CASRC: Child and Adolescent Services Research Center

CHIS: California Health Interview Survey

CHKS: California Healthy Kids Survey

EPSDT: Early Periodic Screening, Diagnostic and Treatment

IDEA: Individuals with Disabilities Act

MDE: Major Depressive Episode

MHIT: Mental Health Intervention Team

MHRC: Mental Health Resource Center

MHSA: Mental Health Services Act

NCLB: No Child Left Behind Act

NCS-A, NCS-R: National Comorbidity Survey -Adolescent, -Replication

PBIS: Positive Behavioral Intervention and Supports

PWM: Pettigrew and Whipp’s model of strategic change

SBHC: School-Based Health Center

SBMHS: School-Based Mental Health Services

SDUSD: San Diego Unified School District

SOC: System of Care

SS/HS: Safe Schools/Healthy Students

YRBS: Youth Risk Behavior Survey
Chapter 1: INTRODUCTION

A. Overview

The failure in the prevention, identification, and treatment of mental health problems among school aged youth represents a major public health concern in the United States. (1) Research has shown that mental health disorders experienced during early adolescence may adversely affect growth and development, school performance, and peer/family relationships in later adolescence, as well as increase the risk of negative health outcomes in young adulthood. (2, 3) Most mental health problems diagnosed in adulthood begin in adolescence: half of lifetime diagnosable mental health disorders start by age 14 and this number increases to three fourths by age 24. (4-7)

Yet, major gaps exist in the delivery of adolescent mental health services. With nearly 80% of children and adolescents between the ages of 6 to 17 defined as needing mental health services not receiving mental health care in the United States, school-based mental health services demonstrate promise as a strategy to address this gap. (6-8) However, the effectiveness of the majority of school initiatives is largely unknown and overall, few school-based programs have been subject to rigorous evaluation. (9, 10) In addition, the mental health service literature suggests a need to further investigate context, sustainability and scale of existing evidence-based school-based service delivery models. This dissertation will investigate the contextual factors that support the successful implementation of school-based mental health services and address the question of sustainability and in a large urban school district, using San Diego Unified School District’s Mental Health Resource Center as a model.
B. Background of Problem

School-based mental health services (SBMHS) have been part of the US education system since the turn of the early 19th century. They have undergone a long evolution from behavior modification, institutionalization and social reformation to a commitment to implement evidence-based practices that integrate current research on adolescent brain development and genetics. (11) However, the relationship between a child’s mental health and school achievement has only recently become a national priority as schools struggle to achieve the mandates of No Child Left Behind (NCLB), the Individuals with Disabilities Education Act (IDEA), and the goals set by the President’s Freedom Commission on Mental Health. Policy statements from the American Academy of Pediatrics and the National Association of Nurses have both outlined the advantages of integrating mental health services within the school environment. (12, 13) School-based tragedies such as those in Columbine, Colorado and Newtown, Connecticut have also highlighted the critical need of evidence-based school-based interventions and policies that include assessment, prevention, and treatment strategies. (14-16)

The prevalence of severe emotional and behavior disorders in adolescence has been reported to be higher than the most frequent major physical conditions, including asthma or diabetes. (17) One of the most comprehensive sources of data on the emergence and prevalence of mental health disorders in youth is the National Comorbidity Survey Adolescent Supplement (NCS-A) an extension of the National Comorbidity Survey Replication (NCS-R). (17) The NCS-R is itself an update and expansion on the original study’s scope that incorporates updated disease assessment criteria based on the Fourth
Edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM-IV). Two minority specific psychiatric epidemiological studies were attached along with the adolescent instrument on mental health. The NCS-A was conducted in 2005. It assessed a broad range of DSM-IV disorders in a nationally representative sample of 10,123 adolescents aged 13–18 years. The findings provide a canvas on which to understand adolescent mental health in the United States.

Overall, nearly half of the sample reported having met diagnostic criteria for at least one disorder, and about 20 percent reported that they suffered from a mental disorder with symptoms severe enough to impair their daily lives. Specifically:

- 11% reported being severely impaired by a mood disorder (e.g., depression or bipolar disorder),
- 10% reported being severely impaired by a behavior disorder such as attention deficit hyperactivity disorder or conduct disorder,
- 8% reported being severely impaired by at least one type of anxiety disorder, and,
- 40% of those who reported having a disorder also met criteria for having at least one additional disorder. (17)

Underscoring the notion that mental disorders manifest early in life, the researchers found that symptoms of anxiety disorders tended to emerge by age 6, behavior disorders by age 11, mood disorders by age 13, and substance use disorders by age 15. The researchers also reported strong links between parental characteristics and their teen's disorders. For example, children of parents with less education (e.g., no college degree) were at an increased risk for having any kind of mental disorder. (17)
The results of the NCS-A bring to the forefront the large population of children, adolescents, and young adults who are in need of preventive interventions, support and treatment. However, these data do not address key questions related to service delivery such as: *How do we reach the greatest number of children and adolescents?* *What kind of services should be provided?* and *Where do we do this work?* Schools may provide the answer to all three. The majority of children and adolescents in the United States spend their developing years on a school campus. As a result, schools provide an ideal environment for creating important opportunities for teachers, families, schools, and community based organizations to interact with adolescents in a way that fosters positive growth and development. However, the reality for many K–12 schools in the United States is that between 5% and 9% (2.75–5.0 million) of the 55 million enrolled children are not learning and achieving in school because of emotional and behavioral barriers. (18, 19) Unfortunately, many schools are not responding to the diverse needs of the adolescents due to competing educational priorities and inadequate financial resources.

**C. Purpose of Research**

The purpose of this research is to advance the understanding of the contextual factors that support the successful implementation and sustainability of school-based mental health services by developing a case study of the San Diego Unified School District’s (SDUSD) Mental Health Resource Center (MHRC) as a model for the delivery of school-based mental health services. The MHRC was established in October 2001, with a five year federally funded grant by the Safe Schools/Healthy Students Initiative. Its goal was to provide mental health assessment, case management and treatment for students at all
age levels. In contrast to many other school-based mental health programs, the MHRC has been successful in sustaining itself and has provided mental health services to over 980 students annually over the past 13 years.

In 2006, the Child and Adolescent Services Research Center (CASRC) at Rady’s Children’s Hospital-San Diego completed an evaluation of the MHRC. It focused on defining the students who received Safe School/Healthy Students (SS/HS) funded services, identified types of services provided, and explored the effect of these services on student behavior, attitudes, and school achievement. The evaluation provided data on the early implementation of the MHRC and the target population. However, it was not constructed to address the long-term sustainability of the MHRC. This dissertation will expand upon the earlier MHRC/CASRC evaluation and focus on understanding how and why the MHRC has been able to expand and become an effective and sustainable system of care model for the provision of mental health services in schools. The two research questions answered by the case study are:

1) How has the MHRC evolved and sustained itself as a service of care model in response to financial, human resource, and community constraints and opportunities?

2) What factors have supported the successful implementation of the Mental Health Resource Center (MHRC) within San Diego Unified School District?

Documenting how the San Diego Unified School District succeeded institutionalizing and sustaining the MHRC will provide a learning case study for other school sites across the state and nation as they grapple with the possibility of implementing mental health
services in their respective school districts. The results of the case study will inform the growing school-based mental health movement. Two public health practice products will be produced as part of this dissertation: a case study of the MHRC, which will inform school based mental health stakeholders, and a White Paper, which will be directed at San Diego Unified School District and provide key recommendations regarding future program implementation and direction.

**D. Design and Methods**

A case study was identified as the best study design to answer the research questions and was developed according to the methodology established by Yin. (20) The unit of analysis for the study was a single case: the Mental Health Resource Center. Three primary sources of evidence were collected: 1) documents, such as memos and program reports; 2) archival records, such as student academic records; and 3) interviews with stakeholders, students, and parents. These multiple sources of evidence were collected to ensure construct validity of the design and help to more fully understand the characteristics of the Mental Health Resource Center that have led to its successful implementation and long-term sustainability. As a whole, these data helped the researcher better understand the impact of the MHRC at the individual, family level and organizational level and contextualize the policies and political and organizational decisions that impact school based mental health.

Pettigrew and Whipp's Content, Context, and Process model of strategic change was chosen as the theoretical framework to support the development of the case study. (21) This model has been used in analyzing and learning retrospectively from change
processes in organizations and is based on empirical case-based organizational research. The successful implementation of school-based mental health services requires a level of organization change, learning, and transformation rooted in context that Pettigrew and Whipp define in their conceptual framework.

**E. Significance of Research**

Adolescents are a particularly vulnerable group that requires targeted interventions and models of service delivery. Neither child-centered nor adult-centered mental health models adequately respond to the needs of the developing adolescent. The high prevalence of mental health disorders among youth reinforces the importance of developing prevention strategies and promoting school-based early intervention for at-risk adolescents. School-based interventions have the potential for large-scale impact as a typical school day of 6 hours, 5 days a week, 180 days per year provides significant opportunities to improve mental and physical health of the adolescent through curriculum, pedagogy, and school/community enhancements.

This dissertation will increase the knowledge base by focusing on factors that lead to the successful implementation of school-based mental health services and documenting how the San Diego Unified School District succeeded in the institutionalization and ongoing sustainability of the MHRC. It will provide a learning case study for other school districts across the state and nation as they work to implement mental health services in their respective school districts. This research has the goal of advancing policymakers’ and program managers’ ability to reduce the burden of mental health
problems and support and develop a healthier and well-functioning young adult population.
Chapter 2: LITERATURE REVIEW

A. Introduction

A comprehensive literature review was conducted to identify best practices, implementation strategies, policy initiatives, and historical antecedents in school-based mental health services. This comprehensive approach allowed the researcher to better understand the needs of the target population and obtain a complete picture of existing research. (22)

The following databases were used to accomplish the literature review: PubMed, CINAHL, Google Scholar, PsycARTICLES, PsycINFO, and Web of Science. A grey literature search was also conducted to collect and document public and private non-Governmental Organizations (NGO) reports, manuals, and articles on urban school-based mental health models in the United States. EndNoteX7 was used to organize and maintain the literature review. The literature review is divided into six sections; 1) Adolescence: Demographics and Development; 2) Adolescent Mental Health Epidemiology; 3) The Role of Schools: Context and School Based Mental Health Services (SBMHS); 4) San Diego Unified School District (SDUSD) Mental Health Resource Center (MHRC); 5) Theoretical Foundations; and, 6) Implications of Current SBMHS Research.

B. Adolescence

Adolescence, encompassing 10–19 years of age, is a period characterized by many changes and transitions. A myriad of new developmental challenges are faced by the adolescent, including the onset and changes associated with puberty; the struggles of establishing independence while maintaining familial ties; the mental and psychological
shifts that accompany the emergence of sexuality; and, the educational transition from the relative protective environment of elementary school to the less secure environment of middle and secondary school. (23) Adding to this already stressful and confusing period, the child’s parent(s), caretaker(s), and other adults may also not be adequately prepared to provide the needed support to engender a healthy transition to adolescence. (24)

B.1 Demographics

In the United States, the adolescent population has experienced significant changes over the last few decades, including changes in size, family structure, and racial/ethnic composition. In general, after a steady decline in the size of the adolescent population since the mid-1970s, the number of adolescents in the U.S. began to increase in the 1990s (see Figure 2.1). (25)

Figure 2.1: Number of 12–17 year olds in the United States as a Percentage of the Populations, Selected years, 1970–2010, and Projections, 2020–2050

The following key demographic trends help inform the case study and future mental health interventions and policy strategies among this population:

**Adolescents are increasing as a percent of the US population.**

- From 1990 to 2000, the adolescent population between the ages of 10–19 increased by 16.6%, from 34.9 million to 40.7 million, while the US population as a whole increased by 13.2%. The 2010 census documented 42.8 million adolescents and this figure is expected to continue increasing through 2050. (26)

**Adolescents are becoming increasingly racially and ethnically diverse.**

- As of 2010 Hispanics comprised 20.1% of the adolescent population (ages 10–19). By 2020, that figure is expected to rise to approximately 25% and, by 2040, nearly 33% of adolescents are projected to be Hispanic. (27)
- Children who identify with two or more race groups are projected to make up 5% of all U.S. children by 2050. (25)
- Based on the 2010 Census, 6.3% of U.S. adolescents were born outside of the United States. Twenty-four percent of all children (age 0–17) are first or second generation immigrants. Among children age 5–17 in 2011, 22% of children did not speak English at home; however, only 5% of these children had difficulty speaking English. (28)

**The family structure in which adolescents find themselves growing up has changed.**

- Between 1996 and 2012, the proportion of children living in mother-only families has fluctuated between 22% and 24%, and was at 24% in 2013. Between 1990 and 2013, the share of children living in father-only families has fluctuated
between 3 and 5%, and was at 4% in 2013. The proportion living without either parent (with either relatives or with non-relatives) has remained steady, at approximately 4%. In 2013, 6% of all children lived in the home of their grandparents. (26)

• A growing number of children in the United States have a foreign-born parent. The percentage of children ages 0–17 living with at least one foreign-born parent rose from 15% in 1994 to 23% in 2011. (26)

• In 2013, 34% of black children were living with two parents, compared with 83% of Asian children, 74% of white children, and 58% of Hispanic children. (26)

More adolescents live in poverty.

• The percentage of adolescents (age 12–17) living in families with low income (<200% of the federal poverty line) increased from 36% in 2006 to roughly 41% in 2012. Nineteen percent of this age group lives below the poverty line. (29)

• Sixty percent of black and Hispanic adolescents live in low-income families, as do 58% of American Indian, 34% of Asian, 28% of white, and 40% of adolescents of some other race. In this age group, over half (54%) of children of immigrant parents have low incomes. (30)

• Children who live with two married parents are much less likely to be poor or low-income compared to children who live with a single parent. Twenty-nine percent (29%) of adolescents residing with married parents live in low-income families. Sixty-four percent (64%) of adolescents residing with a single parent - 4.4 million - live in low-income families. (30)
• Estimates of homelessness among adolescents vary a great deal. In 2013, youth were included for the first time in the annual "point-in-time" tally of the homeless conducted by communities across the United States. In what is likely to be an under-count, 47,000 youth (unaccompanied children and young adults under age 25) -- nearly 8% of the homeless population -- were found to be homeless on the night of the count. (30)

These demographic data provide a socio-ecological framework for the development and implementation of mental health delivery for adolescents in the United States. In order to develop and implement successful interventions and systems of care, an understanding of adolescent development and behavior is also required.

B.2 Development and Transition

Adolescence is a period of dramatic challenges, requiring many internal and external adjustments to changes in the self, in the family, and peers. (6) It is also characterized as a time when young people begin to explore and examine psychological characteristics of the self in order to discover who they really are, and how they fit in the social world in which they live. (7) How young people approach these challenges are influenced by many factors - biological, cognitive, psychological, and socio-cultural - yet no single influence acts either alone or as the “prime mover” of change in their lives. (6) Another viewpoint is that adolescents evaluate themselves both globally and along several distinct dimensions - academics, athletics, appearance, social relations, and moral conduct - and the link between specific dimensions of the self-concept and global self-worth varies across domains. (7)
demonstrate the continual change and transition that adolescents undergo and manage.

Helping to summarize the many viewpoints on adolescent development, two approaches are supported by Schwartz, et al as theoretical frameworks to explain and think about how to intervene and redirect outcomes in adolescence:

- The **risk and protective factors** approach is drawn in part from developmental psychopathology that holds that adolescents engage in destructive or abnormal behaviors, such as drug abuse, as a result of compromised developmental trajectories. In turn, compromised developmental trajectories are assumed to be caused at least in part by maladaptive intrapersonal processes and conditions in the youth’s environment.

- The **applied developmental science** approach holds that youth have the potential for thriving, where thriving is defined as fulfilling one’s potential and contributing positively to one’s community. Within this approach developmental asset - positive intrapersonal processes and mechanisms in one’s social ecology - are proposed as the primary predictors of thriving. (31-33)

In order to better understand and disseminate the work of many of adolescent development researchers, the Carnegie Foundation funded a synthesis and series of national reports in 1995. Based on over a decades’ worth of research and community engagement, *Great Transitions: Preparing Adolescents for a New Century* represents the concluding report of the Carnegie Council and the culmination of its work it addressing the needs of adolescents. (34) The final recommendations of the Carnegie Council rest on six basic concepts about adolescence, with particular focus on early
adolescence:

1. The years from ten through fourteen are a crucial turning point in life's trajectory. This period, therefore, represents an optimal time for interventions to foster effective education, prevent destructive behavior, and promote enduring health practices.

2. Education and health are inextricably related. Good health facilitates learning, while poor health hinders it, each with lifelong effects. Commensurately, a positive educational experience promotes the formation of good health habits, while academic failure discourages it.

3. Destructive, or health-damaging, behaviors in adolescence tend to occur together, as do positive, health-promoting, behaviors.

4. Many problem behaviors in adolescence have common antecedents in childhood experience. One is academic difficulty; another is the absence of strong and sustained guidance from caring adults.

5. Preventive interventions are more likely to be successful if they address underlying factors that contribute to problem behaviors.

6. Given the complex influences on adolescents, the essential requirements for ensuring healthy development must be met through the joint efforts of a set of pivotal institutions that powerfully shape adolescents' experiences. These pivotal institutions must begin with the family and include schools, health care institutions, a wide array of neighborhood and community organizations, and the mass media. (34)
Each of these six recommendations remains relevant today and requires attention as schools and communities across the U.S. grapple with how to address the mental health needs of US adolescents and their healthy development. The MHRC responds to many of the Carnegie recommendations, especially the need to include schools as an equal partner in ensuring healthy outcomes.

 Yet as schools are identified as critical partners in the development of healthy adolescents, it is important to note that personal changes are made more complex as adolescents have to also negotiate institutional changes as they age. Among young adolescents there is a change in school setting, typically involving a transition from elementary school to either junior high or middle school. How well the child, family, and community support networks navigate this school transition may affect future outcomes. For some, as each child establishes his/her own identity and coping mechanisms, these outcomes may not be positive and may surface in middle to late adolescence in negative behaviors, such as depression and suicidal ideation, substance use, unsafe sexual experimentation, and violent behavior. (8) In addition, for some children, this period also marks the beginning of a downward trajectory leading to academic failure and school dropout. While the potential for many of these negative outcomes exists with each child based on their particular risk factors, the potential for positive impact exists as well.

Adolescence is also marked by an important transition toward the primacy of peer relationships with more time spent with peers without adult supervision. Research consistently support that a relationship with a caring adult - a parent, teacher, coach, or mentor - is a strong protective factor supporting positive youth development. The parent-
adolescent relationship continues to be critical, as the most optimal adjustment occurs among adolescents who are encouraged by their parents to engage in age-appropriate autonomy while maintaining strong ties to their family. (31)

C. Profile of Adolescent Mental Health

C.1 Introduction

The 1999 Surgeon General’s Report on Mental Health defined mental health as “successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to change and to cope with adversity.” Mental illness refers to “diagnosable mental disorders that are characterized by alterations in thinking, mood, or behavior (or a combination thereof) associated with distress and/or impaired functioning.” (1) A 2005 report by the World Health Organization defines Child and Adolescent Mental Health (CAMH) as “the capacity to achieve and maintain optimal psychological functioning and well-being. It is directly related to the level reached and competence achieved in psychological and social functioning.” (35) According to both these reports, youth mental health encompasses the positive aspects of well-being as well as negative aspects of mental disorders. The positive aspects of mental health include a healthy psychological function to perceive and adapt to the environment, as well as communication and successful social interactions. The negative aspects are associated with mental illness and the inability of child and adolescents to react to environmental changes resulting in mental disorders that impair psychological and social functioning. (32, 33)

Most mental health problems diagnosed in adulthood begin in adolescence: half of
lifetime diagnosable mental health disorders start by age 14 and this number increases to three fourths by age 24. (5) If early onset mental health disorders are left untreated, the longstanding consequences are not only medical, but also have social and economical impacts. Recent research has shown that depression, behavioral disorders, attention deficit hyperactivity disorder (ADHD), and anxiety experienced during childhood may be associated with school failure, delinquency, substance dependence, accident, self-harm, sexual risk taking behavior and severe dysfunction in adulthood. These long-term costs include the lost of social productivity, an increase in violence and crime, and an increase in state benefits expenditure. (9, 10)

C.2 Adolescent Mental Health Data Sources

National, state and local data sources on adolescent mental health and service utilization are described below. Data from these surveys provide evidence of the need for improved adolescent mental services and the potential of school-based services to address this need.

California Health Information Survey (CHIS)

- The CHIS is the nation’s largest state health survey. It is a random dial telephone survey begun in 2001 and as of 2012 conducted on an annual basis. The CHIS provides a detailed picture of the health and health care needs of California’s large and diverse population and covers a wide range of health topics, including mental health. CHIS 2011–2012 surveyed 44,559 households, including 42,935 adults, 2,799 adolescents and 7,334 children. (36)
California Healthy Kids Survey (CHKS)

- The CHKS is an anonymous, confidential survey of youth resiliency, protective factors and risk behaviors. It is administered to students at grades five, seven, nine and eleven. It enables schools and communities to collect and analyze data regarding local youth health risks and behaviors, school connectedness, protective factors, and school violence. (37)

National Comorbidity Study – Adolescent Supplement (NCS-A)

- The NCS-A is a nationally representative survey of prevalence and correlates of the Diagnostic and Statistical Manual (DSM) of Mental Disorders (DSM-IV) mental disorders among US adolescents ages 13–17. The survey was carried out between February 2001 and January 2004 and the sample included over 10,000 adolescents who participated either in a home or in a school based survey. (4, 38)

National Health Interview Survey (NHIS)

- The NHIS is the principal source of information on the health of the non-institutionalized civilian population of the United States. It is a yearly, cross-sectional household, nationally representative interview survey. The 2012 NHIS interview sample consisted of approximately 43,000 households, 108,000 persons in 43,000 families. Approximately 4,800 adolescents were captured in the sample. (39)

The National Survey on Drug Use and Health (NSDUH)

- The NSDUH primarily measures the prevalence and correlates of drug use in
the United States. The surveys are designed to provide quarterly, as well as annual, estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health among members of United States households aged 12 and older. The survey covers substance abuse treatment history and perceived need for treatment, and includes questions from the DSM-IV that allow diagnostic criteria to be applied. (40)

**Youth Risk Behavior Student Survey (YRBSS)**

- The YRBSS monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults. It includes a national school-based survey conducted by Centers for Disease Control (CDC) and state, territorial, tribal, and local surveys conducted by state, territorial, and local education and health agencies and tribal governments. The 2013 National YRBSS was administered to a national probability sample of 13,583 students in public and private schools. (41)

The following sections present data from the above-mentioned studies. The majority of these reports measure symptoms of well-being or emotional distress and do not measure positive indicators such as well being and resiliency. This is particularly true with the national data sources. As such, they are also likely conservative estimates of emotional distress, because they exclude higher-risk populations such as the homeless and those in correctional facilities and inpatient treatment facilities. Despite some of the shortcomings of each report - sampling, age groupings, disorder definitions, and analysis
- collectively these data provide useful information to inform school based mental health service delivery models.

C.3 National Perspective

Depression

- Rates of past year major depressive episode (MDE) among youths aged 12 to 17 generally increased with age, from 3.3% to 10.3%. Among youth aged 12 to 17 with a past year MDE with severe impairment in at least one of four role domains (i.e., home, school/work, family relationships, or social life), rates also increased with age, from 2.3% to 8.1%. (41)

- Nationwide, 17% of students had seriously considered attempting suicide during the previous 12 months, 13.6% made a plan on how they would attempt suicide, and 8% attempted suicide. The prevalence for all (considering, planning and attempting) was consistently higher among Hispanic students when compared to their non-Hispanic Black and White peers. (42)

- Almost 30% of US high school students reported feeling so sad or hopeless almost every day for 2 or more weeks that they stopped doing some usual activities. Female students were more likely to report depressive symptoms than male students (39.1 versus 20.8%). Hispanic students report higher rates of depressive symptoms compared to their non-Hispanic Black and White peers, with 47.8% of female students and 25.4% of male students reporting symptoms. (42)
Anxiety Disorders

- Nearly one in three (31.9%) of adolescents meet the criteria for an anxiety disorder. All anxiety disorder subtypes were more frequent in females, with greatest difference observed in those suffering from Post Traumatic Stress Disorder (PTSD). (17)

- Severe anxiety disorders were present 8.3% of the population, which represent individuals with panic disorders or agoraphobia. (17)

Substance use

- In the U.S., 9.5% of 12–17 year olds reported using illicit drugs within the month prior to being surveyed. Illicit drug use increased among Blacks (8.1% to 10.2%) but not among White and Hispanic adolescents. (41)

- Nationwide, 8.2% of males and 6.2% of females ages 12–17 had a substance abuse dependence disorder; and 22.1% of youth experiencing substance abuse dependence had a co-occurring past year Major Depressive Episode (MDE). (17)

In summary, researchers concluded that anxiety disorders where most common (31.9%), followed by behavior disorders (19.1%), mood disorders (14.3%) and substance use disorders (11.4%). The overall prevalence of disorders with severe impairment was 22.2%. The median onset for disorder classes was earliest for anxiety (6 years) followed by 11 years for behavior, 13 years for mood, and 15 years for substance use disorders. Figure 2.2 provides an overview of the cumulative lifetime prevalence of major classes of DSM-IV disorders. (17)
In 2010, the state of California had an approximate population of 36.8 million residents, of whom 3.5 million (9.5%) were adolescents aged 12–17. In California, mental illness is a major cause of life disability. Mental health data for California and San Diego adolescents mirrors or ranks lower than much of the national data. The following data reflect the need for a response to the ongoing mental health status of the California adolescent:

- Twenty one percent (21%) of California teens were at risk for depression. Among California 9th graders and 11th graders, 30.5% and 34.7% felt sad or hopeless, respectively. Eight percent (8%) of 12–17 year olds experienced a Major

![Figure 2.2: Percentages of Youths Aged 12 to 17 Who Experienced a Past Year Major Depressive Episode (MDE) by Severe Impairment, by Age, and Gender: 2010](image_url)


### C.4 California and San Diego Perspective

In 2010, the state of California had an approximate population of 36.8 million residents, of whom 3.5 million (9.5%) were adolescents aged 12–17. In California, mental illness is a major cause of life disability. Mental health data for California and San Diego adolescents mirrors or ranks lower than much of the national data. The following data reflect the need for a response to the ongoing mental health status of the California adolescent:

- Twenty one percent (21%) of California teens were at risk for depression. Among California 9th graders and 11th graders, 30.5% and 34.7% felt sad or hopeless, respectively. Eight percent (8%) of 12–17 year olds experienced a Major
Depressive Episode (MDE) in the past year. (43)

- Suicide was the 3rd leading cause of death for 15–24 year olds and the 4th cause of death for 10–14 year olds. (43)
- Female adolescents had a higher number of suicide attempts while male adolescents have a higher suicide completion rate; suicide rates per 100,000 are higher for Whites (101.3), followed by African Americans (81.6), Hispanics (55.5), Native Americans (51.2) and Asian (35). (44)
- California high school aged youth with severe mental health disorders, who received special services, dropped out of high school at a rate that exceeded the state rate (39% versus 14.4%). (45)

Similar mental health outcomes have been reported within San Diego County where the 2009–2011 California Healthy Kids Survey findings showed:

- Twenty-six percent (26%) of 7th graders, 29% of 9th graders, 31% of 11th graders and 38% in alternate schooling programs experienced sadness and felt hopeless with impairment in daily activities. Female adolescents in all of these categories showed higher rates than their male peers.
- Twenty percent (20%) of all 9th and 11th graders, and 22% are alternative school students seriously considered attempting suicide.
- Conduct, depression, adjustment, and attention deficit hyperactivity disorders were the most common mental health problems among San Diego adolescents who received treatment. Substance abuse issues were present in 15% of 12–17 year olds who received mental health treatment.
• Seven percent (7%) of 9th graders, 10% of 11th graders and 21% of alternative school students experienced mental health and emotional problems while using alcohol and other drugs. (46)

C.5 Treatment and Utilization

The majority of children and youth who are in need of mental health are not utilizing available services. Based on available data, 21% of children in the United States who needed a mental health evaluation received such services. (6) Among Latino children this rate dropped to 11% compared to 24% for white children. (47) For 12–17 year olds who had a past year MDE, only 37.0% received treatment. Gender differences also exist in service utilization. Male adolescents of all ages used clinical health care and mental health care services significantly less than females, and use of services decreased, as they got older. (48) When male adolescents did seek services, they were more likely to receive services in school settings (23.9%) compared to female adolescents (16.2%). Stigma, lack of culturally competent services, lack of access, shortages of providers and insurance coverage all are variables that influence whether a young person utilized mental health services. (49)

Schools were the most common place of treatment and counseling. Approximately 20.9% of adolescents seeking mental health services accessed them on a school campus and 35.0% received services from both a school and non-school provider, such as a community health center. (50) Approximately 15% of adolescents received services only at non-school settings, which includes overnight treatment care centers, Emergency Departments, and day treatment programs in a hospital or community center. (51)
The County of San Diego Health and Human Services Agency (HHSA) reported during 2010–2011 that a little over 18,000 San Diegan youth received mental health care through organizational providers, such as community based health centers, fee-for service providers, and juvenile forensic providers. The majority of children and adolescents served were male (62%) and Hispanic (over 50%). (46) These data align with the SDUSD enrollment (46% Hispanic) but differ from national trends in gender-based service utilization.

D. School-based Mental Health Services

D.1 The Role of Schools

School-based mental health programs have the potential for large-scale impact. The typical school day of 6 hours, 5 days a week, 180 days per year provides significant opportunities to improve mental and physical health through curriculum, pedagogy, and school/ community enhancements. Because mental health is a well-established predictor for academic performance and success, addressing the health and developmental needs of youth is a critical component of a comprehensive strategy for improving academic performance. (52)

However, the relationship between a child’s mental health and school achievement has only recently become a national priority as schools struggle to achieve the mandates of national legislation. These include the Individuals with Disabilities Education Act (IDEA), which has undergone amendments since passing in 1975 and established that “Children with emotional and behavioral disorders must receive an education that prepares them for optimal intellectual, occupational, and social functioning as adults. 
Related services that further this goal are an essential component of the child's education… A child with a disability means a child evaluated as having … a serious emotional disturbance, autism, traumatic brain injury, another health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services.” (53) Also the goals set by the President’s Freedom Commission on Mental Health of 2003 recommended that “Quality screening and early intervention will occur in both readily accessible, low-stigma settings, such as primary health care facilities and schools, and in settings in which a high level of risk exists for mental health problems, such as criminal justice, juvenile justice, and child welfare systems.” (54) Finally, The No Child Left Behind Act (NCLB) of 2001, replaced in 2015 with the Every Student Succeeds Act (ESEA) stated that schools must provide “…student access to quality mental health care by developing innovative programs to link the local school system with the mental health system.” (55) Policy statements from the American Academy of Pediatrics and the National Association of Nurses have also outlined the advantages of integrating mental health services within the school environment. (12, 13)

The reality for many large urban schools in the United States face is that well over 50% of their students manifest significant learning, behavior, and emotional problems. Over one half of the adolescents in the US who fail to complete their secondary education have a diagnosable psychiatric disorder. (1) These findings become more relevant as the middle school aged population transitions to high school. The Annenberg Foundation Trust in their 2004 report on Adolescent Mental Health found that high school student
depression and use of alcohol and illegal drugs is a more serious problem than various forms of violence, including bullying, fighting and use of weapons. More than two thirds (68%) of the high school professionals surveyed identified depression as a significant problem in their schools. Similar overall levels of concern were raised about use of alcohol (71%) and illegal drugs (72%). In addition, although 66% of the high schools indicated having a process for referring students with mental health conditions to appropriate providers of care, only 34% reported having a clearly defined and coordinated process for identifying such students. (38)

Two principle structural problems exist with many of the current school-based programs: 1) lack of coordinated care and treatment, involving both the child and their family; and, 2) compartmentalization of mental health issues into separate pathologies. Interventions are developed and function in relative isolation of each other, and they rarely are envisioned in the context of a comprehensive approach to addressing behavior, emotional, and learning problems and promoting healthy development. (56)

D.2 Conceptual Models of Delivery

To address these structural barriers and improve the delivery of school based interventions, three major models have been identified in the mental health literature to assist in creating a framework to systematically analyze school based mental health programs: The Mental Health Spectrum, the Interconnected Systems, and Positive Behavior Support. Each of these models is supported by the 2009 report by the National Research Council and the Institute of Medicine - Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. This report
describes the broad range of relevant research in school-based mental health and concludes that it is critical to shift the focus from treatment to health promotion and prevention. (57) The report further emphasizes the value of promoting mental health and considering mental health within a developmental framework defining the three types of prevention:

- **Universal prevention**: targeted to the general population,
- **Selected prevention**: targeted to a subgroup that has a significantly higher than average probability of developing a Mental, Emotional or Behavioral (MEB) disorder; and,
- **Indicated prevention**: targeted to high-risk individuals who are already demonstrating symptoms/problematic behaviors. (57)

**D.2.a The Mental Health Spectrum**

In this model, developed by Mrazek and Haggerty and adapted by Weisz and colleagues, the mental health provider enters the school environment with a comprehensive range of prevention and diagnostic strategies that are based on psychological and behavioral research and practice. (58, 59) The recent adaptation by Weisz et al is presented in Figure 2.3. Mental health programs typically target diagnostic groups, or children at risk for specific mental health disorders, such as depression or conduct disorder. In this updated framework evidence-based prevention and treatment is linked to strategies that include health promotion and positive development. This is an assets/strengths based approach and promotes schools as a setting for many health interventions in the spectrum of services.
This model encompasses a wide range of prevention approaches along the spectrum. Children with these diagnoses represent the large majority of the children who are candidates for selective and indicated mental health intervention, and school based mental health services programs that serve them typically use individual or group therapy, skills based programs to promote social functioning, and psychopharmacology. (56) Examples of universal level programs that are empirically validated that aim to prevent aggressive oppositional behavior, one of the most frequent problems among

school-aged children, include: Promoting Alternative Thinking Strategies (PATHS) and Responding to Peaceful and Positive Ways (RIPP); and examples of selective and individual programs include the Incredible Years and FAST Track. (49, 60-62)

D.2.b The Interconnected Systems

The Interconnected Systems model is guided by a public health strategy and supports attempts to balance efforts at mental health promotion and prevention, early detection and treatment, and intensive intervention, maintenance and recovery (see figure 2.4). The Policy and Practice Centers on School Mental Health at the University of Maryland and at University of California, Los Angeles (UCLA) have strongly advocated for this approach. (63-65) In this model, resources from the school and the community are pooled to produce integrated programs at the three levels of service need. At the systems of prevention level, services are implemented through and alcohol education as part of the K–12 curriculum. The community works alongside the school to promote health mental health by supplying access to prenatal care, recreational activities, and afterschool and mentoring programs. At the systems of intervention level, individuals who are at risk and who have moderate needs for services are targeted. At the schools, Early and Periodic Screening, Diagnosis, and Treatments (EPSDT) programs are made available. When problems are severe and long standing or when multiple domains of functioning are impaired and problems have persisted for at least one year, a young person may need intensive treatment. At this level of need, the systems of care (SOC) model is envisioned as an integrated and collaborative continuum of services provided by the various child-serving agencies aimed at children with the most intensive need and their families. (52)
An effective SOC will coordinate crisis intervention, long-term therapy and hospitalization if necessary. A wraparound approach may also be used in which services “wraparound” the child and family, services are individually tailored to the strengths of the child and needs of the family and are wrapped around them rather than placing a child into a particular program because of his/her diagnosis or pattern of behavior. This is an important distinction as the SOC operates at the systems level, while the wraparound approach focus is with the individual/client: they are not interchangeable processes. The System of Care model is over 20 years old and has been funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in over 120 communities and tribal nations. However, the engagement of schools has been weak and the evidence for overall effectiveness has been mixed but promising. (66)

D.2.c Positive Behavior Support (PBS)

Positive Behavior Support (PBS) has emerged from concepts of applied behavior analysis to implement prevention and intervention strategies from the individual to the

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**Figure 2.4**

The Interconnected Systems

- **Systems of Prevention**
  - Primary prevention
  - (low-end need/low-cost per individual programs)

- **Systems of Early Intervention**
  - Early-after-onset
  - (moderate need, moderate cost per individual)

- **Systems of Care**
  - Treatment of severe and chronic problems (high-end need/high cost per individual programs)

universal levels. This model is a systems model that requires consensus building among the school staff during the implementation process (see figure 2.5).

**Figure 2.5: The Positive Behavior Support Model**


The purpose of school wide PBS is to create positive school environments for all students. It is a proactive approach that replaces the need to develop individual interventions to system level implementation involving school-wide issues. When schools agree to use PBS as a model for school-based mental health services they are making a commitment to major system change, one that also require time and effort. Of the three models, PBS is still considered in its infancy; however, there is a growing body of research examining PBS and its efficacy at the universal and selective levels.
D.3 Evidence of Effectiveness of School-Based Mental Health Services

The above conceptual models allow each school system to best match their particular resources, values, stage of development and demographics to the appropriate delivery system. Once the model has been chosen, the next stage in developing a system-wide SBMH delivery system is to choose from the cadre of evidence-based programs. Most schools have some grouping of interventions to address a range of mental health and psychosocial concerns, yet many have not undergone the conceptual exercise to frame their interventions and model. (52) A 2006 study by the University of South Florida on empirically based school mental health programs found that (Table 2.1):

- Of the 92 evidence-based school-based programs, one third are targeting substance abuse, trauma, or health problems, while the remaining two-thirds address emotional regulation or social functioning.
- The majority (58%) of these programs take place on school campuses; 26% take place in community based organizations; and the remaining 16% take place in both community and schools.
- 61% of these evidenced-based programs have a training component focused on a student’s family. A little less than half (47%) have a similar teacher training component. (52)
Table 2.1: Target of Problem behavior and Level of Prevention for the 92 Programs that are Identified as Evidence based Programs (EBP)

<table>
<thead>
<tr>
<th>Level of Prevention</th>
<th>All Programs</th>
<th>Programs directed at substance abuse, trauma or health problems</th>
<th>Programs directed at social functioning, emotional regulation, or reducing aggression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicated</td>
<td>17</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Indicated/Selective</td>
<td>11</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Selective</td>
<td>14</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Selective/Universal</td>
<td>9</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Universal</td>
<td>39</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Indicted/Selective/Universal</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>92</strong></td>
<td><strong>32 (35%)</strong></td>
<td><strong>60 (65%)</strong></td>
</tr>
</tbody>
</table>

Adapted from: Kutash, K. Duchnowski, A. et al. (2006).

Recent studies have demonstrated the effectiveness of school-based mental health services for all these groups:

- Students who receive school based social-emotional support and prevention services achieve better academically in school. (69-71)
- Expanded school mental health services in elementary schools have been found to reduce special education referrals, improve aspects of the school climate and produce declines in disciplinary referrals, suspension, grade retention, and special education referrals and placement among at-risk students. (72-74)
- School-based mental health programs for elementary school children experiencing severe emotional and behavioral difficulties have demonstrated reductions in conduct disordered behavior, attention deficit/hyperactivity, and depression. (75)
- High school students had a 50 percent decrease in absenteeism and 25 percent decrease in tardiness two months after receiving school-based mental health services.
services and counseling. (76)

Mental health treatment has been shown to be just as effective whether delivered in a school or clinic setting. (56) Studies have also suggested that both students and those who refer students find school-based mental health services effective for a variety of mental health conditions, including depression, anxiety and substance use. (77-80)

Yet, reviews conducted of school-based mental health programs find that less than 1% of the studies met the requirement of having a rigorous research design and, overall, the effectiveness of the majority of school initiatives remains largely unknown. (9, 69, 71) The Substance Abuse and Mental Health Service Administration (SAMHSA), Prevention Research Center for the Promotion of Human Development at Pennsylvania State, Center for the Study and Prevention of Violence (CSPV) at University of Colorado, Boulder, US Department of Education (US DOE), and the Collaborative for Academic, Social, and Emotional Learning (CASEL) are the major institutions that are referenced and that confer and/or evaluate interventions to be evidence-based.

In 2006, SAMHSA launched the National Registry of Evidence-Based Programs and Practices (NREPP), an objective, scientifically based mechanism for tracking prevention and intervention programs for mental health problems and substance abuse and assisting users in evaluating their application. At that time SAMSMAHSA identified 66 models and 37 effective programs. In 2007, SAMSHA expanded eligibility criteria to include population, policy, and system level outcome ratings for interventions. (81) Table 2.2 provides examples of these evidence-based programs, which have been defined as evidence based by at least one of these institutions. It is worth noting that neither the
Mental Health Spectrum, the Interconnected Systems, nor Positive Behavior Support is currently listed as being evidence based. These models target outcomes for systems, rather than individuals, as the majority of evidence based interventions and models do. Consequently neither model has resulted in a “package” or an easy “how to” manual that communities or schools can readily and easily implement.

A more recent review of conducted in 2013 by George et al., found that 67 (34%) programs on the 200 programs on the NREPP registry were school based and focused on mental health promotion or treatment. Almost half of these programs (47%) consisted of universal mental health promotion, and only 6% were classified as selective and 5% as indicated, and the remaining addressed a combination of tiers. (82)

The Collaborative for Academic, Social, and Emotional Learning (CASEL) evaluated social and emotional learning (SEL) programs and found that among children and adolescents ages 5 to 18, participating in an SEL intervention program was associated with:

- 11% improvement in achievement test scores,
- 10% decrease in emotional distress, such anxiety and depression,
- 23% improvement in social and emotional skills; and,
- 9% improvement in school and classroom behavior. (72, 83)

Students achieved significant gains across the six of the outcome areas studied only when programs were well implemented. These six areas included social and emotional skills; attitudes about themselves, others and school; social and classroom behavior; conduct problems; emotional distress; and, achievement test scores. They also found that
<table>
<thead>
<tr>
<th>Prevention Level</th>
<th>Social Emotional</th>
<th>Substance Abuse</th>
<th>Trauma</th>
<th>Violence/Aggression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicated/Selective</td>
<td>Incredible Years A,C, Families and Schools Together (FAST) B</td>
<td></td>
<td>Cognitive Behavioral Therapy (CBT) A</td>
<td>FAST Track B</td>
</tr>
<tr>
<td>Selective</td>
<td>PENN Prevention Program, Across Ages B</td>
<td></td>
<td>Children in the Middle C, Children of Divorce Intervention Program (CODIP) B</td>
<td>Coping with Stress B, Social Relations Program B</td>
</tr>
<tr>
<td>Selective/Universal</td>
<td>Dare to be You A, Strengthening Families A</td>
<td>Keepin’ it Real A, Project ALERT A, D</td>
<td></td>
<td>Olweus Bullying Prevention A,C</td>
</tr>
</tbody>
</table>

A: SAMHSA; B: PENN State; C: CSPV; D: DOE; E: CASEL
significant gains were achieved only when classroom teachers were the primary implementers (as opposed to outside researchers).

Taken together, these findings suggest that school staff can effectively implement evidence-based programs and schools should invest the time and resources necessary to implement programs in a high-quality way. Taken as a whole, well-planned and well-implemented social and emotional programming in schools has been found to support the connection between positive mental health and positive academic outcomes. (71, 83, 84)

D.4 Implementation of School-based Mental Health Services

A review of the implementation literature has led researchers to conclude that the evidence regarding the implementation of innovations is particularly complex and relatively sparse. The lack of knowledge about implementation and sustainability has been identified as “the most serious gap in the literature ... uncovered.” (85) The Public Health Model provides a framework guide for the implementation of effective SBMH services. Of the four framework components: 1) surveillance; 2) identification of risk and protective factors; 3) develop and evaluate interventions; and, 4) implementation, monitoring, and scaling-up, implementation and scale-up have been the most challenging. These findings support the need for more research on effective service delivery implementation models and their modes of sustainability.

To assist in understanding the complexity of implementation, six stages have been identified to help define the implementation continuum: Exploration and Adoption; Instillation; Initial Implementation; Full Operation; Innovation; and, Sustainability. (86) Most of what is currently known about implementation of evidence-based practices and
programs is known at the exploration and initial implementation stage. (86, 87) Noting the difficult endeavor to achieve full operation and sustainability, Hunter and Weist identified the following characteristics of effectively implemented school-based mental health programs:

1. Coordinated training, coaching and frequent assessment of practitioners;
2. An infrastructure for training, supervision and coaching, and capacity to monitor processes and outcomes;
3. Involvement of communities and consumers in the selection and evaluation of programs and practices;
4. State and federal funding avenues, policies and regulations that support implementation of programs; and,
5. Evaluation and assessment of school, district and community levels factors that directly impact the fidelity, quality and success of program delivery. (88, 89)

Adelman and Taylor, at the UCLA Center for Mental Health in Schools, suggest that five mechanisms are being used across school sites to deliver mental health programs and services (Table 2.3). These mechanisms take on varying operational formats, and differ in the terms of focus and comprehensiveness, but they are not mutually exclusive. (65)
### Table 2.3: School Based Mental Health Delivery Systems

| 1. School-Financed Student Support Services | • Delivery mechanism tends to be a combination of centrally-based and school-based services.  
• School psychologists, counselors, and social workers perform services to address mental health and psychosocial problems |
| 2. School-District Mental Health Unit | • Operate specific mental health units that encompass clinic facilities, as well as providing services and consultation to schools.  
• Some have started financing their own School-Based Health Centers with mental health services as a major element.  
• The format for this mechanism tends to be centralized clinics with the capability for outreach to schools. |
| 3. Formal Connections with Community Mental Health Services | • Co-location of community agency personnel and services at schools–sometimes in the context of School-Based Health Centers, partly financed by community health organizations.  
a. Formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center.  
b. Formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of MH services.  
c. Contracting with community providers to provide needed student services. |
| 4. Classroom-Based Curriculum and Special “Pull Out” Interventions | • Most schools include in some facet of their curriculum a focus on enhancing social and emotional functioning  
a. Integrated instruction as part of the regular classroom content and processes.  
b. Specific curriculum or special intervention implemented by personnel specially trained to carry out the processes.  
c. Curriculum approach is part of a multifaceted set of interventions designed to enhance positive. |
| 5. Comprehensive, Multifaceted, and Integrated Approaches | • Process is to reconceptualize piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school  
• Intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment regimens.  
a. Mechanisms to coordinate and integrate school and community services.  
b. Initiatives to restructure student support programs and services and integrate them into school reform agendas.  
c. Development of Community schools model. |

Many of the listed mechanisms include the use of school-based health centers (SBHC). SBHCs have been identified as an ideal point of access for the delivery of mental health services. Nationally the presence of a SBHC is associated with improvements in children’s physical and mental health, decreased discipline problems, school absences, and increased academic performance. (90) Students served by SBHCs identify mental health counseling as the leading reason for visit. Several studies have shown that the barriers experienced in traditional mental health settings - stigma, non-compliance, and inadequate access - are overcome in school-based settings. (91)

The most recent national census completed by the School Base Health Alliance reported that the majority of SBHCs provide access to mental health (70.8%). Common staffing models for SBHC follow three models. First, the Primary Care Model (29.2%) is typically staffed by a primary care provider or nurse. The second model, Primary Care + Mental Health (33.4%), staffing is provided by a primary care professional in partnership with mental health professional, such as a licensed clinical social worker or psychologist. The third and most comprehensive of the three models, Primary Care + Mental Health Plus (37.4%), primary and mental health staff is joined by other provider types to complement the health care team. (91)

However, while the number of SBHCs is increasing, they only reach a small percentage of students. There are approximately 1,900 SBHCs operating in the United States, reaching less than 3% of the 98,000 public schools. (91) In San Diego only 11 SBHCs are operating in a district with over 220 schools. Therefore, while SBHCs must
be included in the discussion of implementation, a wider view must be taken in order to reach a greater number of youth in need.

Research continues to evaluate early instillation and operation of programs. Yet, very few studies focus on innovation and even fewer primarily on sustainability and scaling up of programs. (92) The likelihood of sustainability is heightened when there is an alignment, compatibility, or convergence of: 1) problem recognition in the external organizational environment or community; 2) the program in question; and 3) internal organizational objectives and capacities. (93) Therefore, research on sustainability requires several layers of data collection to capture the multiple components of the systems involved. Research on sustainability also needs to examine the processes used to gain access to and secure the cooperation of individuals, organizations, departments, and political groups. Organizational and systems intervention strategies represent a critical focus area for research on sustainability. Organizational Systems of Change theory was identified as the best-fit model to analyze the implementation of the MHRC within the context of a large urban school district.

E. Theoretical Perspective

E.1 Systems of Change

In order to fully understand the implementation and sustainability of the MHRC, a systems framework was needed that viewed it not only as a collection of evidence based interventions, but also as a complex organization working within an complex institution. Implementation of small and large-scale practices and programs, such as those of the MHRC, almost always require organizational change: “To be effective, any design
process must intentionally be, from the beginning, a redesign process.” (86) There is growing knowledge about the importance of organizational settings in implementing practices that are evidence-based. (94)

One barrier that is continually identified towards implementation of successful systems is the organizational context. Acknowledgement of the need to incorporate the contextual setting is new within implementation research. However, there is little guidance regarding which strategic processes are most effective under specific circumstances for successful implementation. Given the current knowledge gap between implementation, sustainability, and scale-up, research focusing on contextual factors that facilitate or inhibit implementation of evidence-based practices is needed. This case study will begin to address this gap.

E.2 Pettigrew and Whipp's Model of Strategic Change

The theoretical framework chosen to support the case study is Pettigrew and Whipp's Content, Context, and Process model of strategic change (PWM). (21) Pettigrew and Whipp’s model of strategic management of change has been widely applied in comparative case study research across many sectors and organizational contexts. (95-98) While originally developed to understand competitive large private sector organizations, it has been applied to the study of innovations in health care. (21, 95) The PWM model uses case-study methodology in order to identify broad constructs that are critical to strategic management.

The concept of change and strategic change can be interpreted and understood from different perspectives. Pettigrew proposes that change should not be considered only in
terms of the processes, but should also be considered from the historical, cultural, and political features of the organization. The model reveals a continuous interaction between the context of change, process of change, and content of change. The three dimensions of strategic change which Pettigrew and Whipp introduced for organizational success are:

1. **Context**: The *Why* of strategic change. This can be viewed externally (economic, political, and social factors) and internally (organizational culture, leadership, human and financial resources). Context aims at the internal and external environment, where the process is to be placed.

2. **Content**: The *What* of strategic change. The content dimension mainly aims at the purpose, objectives and goals for success in the field.

3. **Process**: The *How* of strategic change. It provides the way for the implementation of the procedures and methods to achieve the goal. (21)

Further developing their model, Pettigrew and Whipp presented five interrelated factors for the successful management of change. They are:

1. **Environmental assessment**: Monitors the internal and external environment of an organization through various learning and research methods.

2. **Human resource as assets and liabilities**: Posits that staff should feel supported and well treated by organization.

3. **Overall coherence**: Utilizes organized strategy with the goal of successfully advancing forward.

4. **Leading the change**: Organizational leadership creates and environment for change based on agreed upon vision and values.
5. Liking strategic and operational change: Builds upon operational and structural activities and is open to the possibility of new strategic changes. (21)

The PWM emphasizes the continuous interplay between these strategic dimensions and their role in organizational success (see Figure 2.6). It also defines implementation as a change process which is an iterative, cumulative and reformulating that requires interaction between these three dimensions. (21, 96)

Figure 2.6: PWM: The Dimensions of Strategic Change

- **Process (how)**
  - Change manager
  - Models of change
  - Formulation/Implementation
  - Pattern through time

- **Content (what)**
  - Assessment of choice products/services
  - Objectives and assumptions

- **Context (why)**
  - **Internal**
    - Resources
    - Capabilities
    - Culture
    - Politics
  - **External**
    - Economic
    - Political
    - Social


The successful implementation of school-based mental health services requires a level of organization change, learning, and transformation rooted in context that Pettigrew and
Whipp attempt to define in their conceptual framework. This case study adds to the implementation and systems of change literature by focusing on the path taken by San Diego Unified School District from exploration and adoption to sustainability. A foundational understanding of the Mental Health Resource Center is required to provide context for the case.

F. The San Diego Unified School District Mental Health Resource Center

F.1 Background

The Mental Health Resource Center (MHRC) with its decentralized, community oriented, “clinic without walls,” approach, has developed over the last fifteen years as a hybrid of the SOC and PBS models, incorporating elements of each as it has become institutionalized within San Diego Unified School District (SDUSD). The MHRC was established in October 2001, with a five year federally funded grant by the Safe Schools/Healthy Students Initiative. It aimed to provide mental health assessment, case management and treatment for students at all age levels. The overall mission statement of the MHRC is: “to work collectively to provide a seamless array of intervention services to improve health and safety and improve student achievement for students at the targeted schools.” Eight goals were established for the MHRC:

1. Improve student attendance and academic achievement
2. Reduce violence in schools
3. Prevent entry into the juvenile justice system
4. Reduce district mandated placements at Alternative for Learning Behavior and Attitude School (ALBA)
5. Provide prevention, early identification, and intervention for mental health issues
6. Provide prevention, early identification, and intervention for substance abuse
7. Provide curricula for life-skills building
8. Develop community supports for sustainability of these interventions. (99)

Schools within the SDUSD that were deemed at high-risk for violence, poverty, and academic underachievement were targeted by the MHRC. These schools are located in largely poor, inner-city, minority neighborhoods with an enrollment of at least 80% minority students. Ninety-three percent of the students in the targeted elementary schools, 74% in the target middle schools, and 66% at the selected ALBA schools qualified for free or reduced lunch program at SDUSD. (99)

F.2 Mental Health Resource Center Service Delivery Model

The MHRC selected evidence-based treatment approaches as it developed its Service of Care model (see Table 2.3). This conceptual approach is integral to the programming and implementation of services for the MHRC, which has focused on school environmental contexts that historically have demonstrated high rates for violence, poverty, and academic underachievement. This contextual focus resulted in a three-tier approach in the selection of school sites and provision of services:

**Tier 1**: Services at this tier targeted students placed in the ALBA. The ALBA Community Day School serves students in grades K–12 who have violated the Zero Tolerance school policy. It requires the suspension and/or recommendation for expulsion of students who violate rules regarding weapons, controlled substances and physical violence. The ALBA program began in 1997 to provide continued schooling
<table>
<thead>
<tr>
<th>Program Description</th>
<th>Evidence Based Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALBA</strong> <strong>ALBA OP (out patient)</strong></td>
<td><strong>Multisystemic Therapy</strong></td>
</tr>
<tr>
<td><strong>ALBA OP (out patient)</strong></td>
<td><strong>Botvin Life Skills Training (LST)</strong></td>
</tr>
<tr>
<td><strong>AB2726</strong></td>
<td><strong>MHRC is contracted to provide individual &amp; family therapy to students who need service through the IEP process</strong></td>
</tr>
<tr>
<td><strong>CAT</strong> <strong>Community Assessment Team:</strong> Delivered family based services for students who were at risk for violence or delinquency but had not yet entered the probation system or had been placed in ALBA.</td>
<td><strong>Second Step</strong></td>
</tr>
<tr>
<td><strong>Day Treatment</strong></td>
<td><strong>Strengthening Families</strong></td>
</tr>
<tr>
<td><strong>Full Day Rehabilitation program providing comprehensive treatment services to special needs students</strong></td>
<td><strong>Second Step</strong></td>
</tr>
<tr>
<td><strong>Early Childhood</strong></td>
<td><strong>Second Step</strong></td>
</tr>
<tr>
<td><strong>MHRC provides to services though consultation, assessment, referral and parent training</strong></td>
<td><strong>Second Step</strong></td>
</tr>
<tr>
<td><strong>HS</strong> <strong>Home Start:</strong> Local NGO providing family support and counseling services</td>
<td><strong>Second Step</strong></td>
</tr>
<tr>
<td><strong>Intensive Outpatient Program</strong></td>
<td><strong>Strengthening Families</strong></td>
</tr>
<tr>
<td><strong>Team consists of MH therapist, rehab tech., case manager, psychiatrist, and school and family members. Intensive semester long intervention</strong></td>
<td><strong>Second Step</strong></td>
</tr>
<tr>
<td><strong>LST</strong> <strong>Life Skills:</strong> Teaches personal and social skills that build resilience and help youth navigate developmental tasks, including the skills necessary to understand and resist prodrug influences**</td>
<td><strong>Botvin Life Skills Training (LST)</strong></td>
</tr>
<tr>
<td><strong>MST</strong> <strong>Multisystemic Therapy</strong></td>
<td><strong>Multisystemic Therapy</strong></td>
</tr>
<tr>
<td><strong>MHRC clinicians provide MST to families of all students at ALBA schools.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MHIT</strong> <strong>Mental Health Intervention Team:</strong> Provide services to all Special Ed classrooms. Develop and implement intervention plans, conduct therapy groups, and provide individual and family therapy as needed.**</td>
<td><strong>The Incredible Years</strong></td>
</tr>
<tr>
<td><strong>Transitional Counseling:</strong> For student transitioning out of school system</td>
<td><strong>Strengthening Families</strong></td>
</tr>
<tr>
<td><strong>YM</strong> <strong>Youth Mentoring:</strong> Traditional mentoring services provided to students by local NGOs</td>
<td><strong>Pilot: The Parent Project</strong></td>
</tr>
</tbody>
</table>
to students on suspended expulsion who were considered high risk for dropping out of school. ALBA was composed of three school sites: an elementary school (grades K–6); a middle school (grades 7–8); and a high school (grades 9–12). ALBA was chosen for the MHRC as research suggests that integrating mental health intervention in special education and/or alternative school campuses increases involvement and can potentially decrease disciplinary referrals. (59) Treatment services offered to ALBA students exhibiting a mental health need included Multisystemic Therapy (MST), Outpatient Services, and Individual, Group and Family Therapy. Universal services offered to all ALBA students included: Life Skills (LS) curricula, and Transitional Living Counseling (TC).

**Tier 2:** Three middle schools which were the highest referrers of students to ALBA were selected in order to provide earlier, more preventative mental health interventions with the goal of reducing future ALBA placements. Each school was assigned a Healthy Start Coordinator to facilitate the referral process. Services included:

- **Social Advocates for Youth-Community Assessment Team (CAT):** Founded in 1971, Social Advocates for Youth (SAY) San Diego is a nonprofit organization dedicated to supporting the positive development of young people, their families and communities in San Diego County. The Community Assessment Team (CAT) delivered family based services for students who were at risk for violence or delinquency but had not yet entered the probation system or had been placed in ALBA.
• **Youth Mentoring (YM):** Mentoring services were provided at all three middle schools by contracted agencies to provide group, and in some cases, individual mentoring services to guide and support student development in areas of academics, interpersonal skills, and goal setting.

• **Home Start (HS):** The mission of Home Start is to promote the safety and nurturance of children by fostering healthy families and communities. Middle school students were referred to Home Start to strengthen family support systems, improve access to health care and promote parent-child relationships.

**Tier 3:** The elementary schools chosen by the MHRC at this tier are considered feeder schools to the three selected middle schools. The ten schools were targeted with a multipronged approach, focused on more universal and preventative approaches to violence and juvenile delinquency. These elementary schools were also selected because they have established preschool programs. A MHRC Elementary Assessment team conducted full mental health evaluations and made appropriate referrals on students identified with problem behaviors. At the preschool level the MHRC implemented the *SecondStep* program, an evidence-based curriculum endorsed by the US Department of Education. *SecondStep* is a universal prevention program, designed to promote social competence and reduce social-emotional problems by teaching children skills in the core areas of empathy, emotion management (impulse control, emotion regulation, anger management), and social problem solving.
F.3  Mental Health Resource Center Evaluation and Findings

An evaluation was conducted as part of the initial grant that funded the MHRC. During the first year of funding (2001–2002), The Child and Adolescent Services Research Center (CASRC) of Rady’s Children’s Hospital in San Diego was contracted by SDUSD to evaluate the implementation of the Safe School/Healthy Students (SSHS) grant. Three broad evaluation questions were applied to all programs at the MHRC: 1) *Who are the students receiving Safe School/Healthy Students (SSHS) funded services?* 2) *What types of services were provided?* and, 3) *What effect did SS/HS services have on student behavior, attitudes, and school achievement?* For the purpose of this review results of the evaluation were stratified and reported by Tier: Tier 1) ALBA/High School, Tier 2) Middle School and, Tier 3) Elementary. The evaluation used a cohort design with repeated measures over time. Select findings of the MHRC evaluation representing the program service implementation years of 2002–2005 years are presented below:

1. *Who are the students receiving Safe School/Healthy Student funded services?*

**Tier 1:** The demographics of the ALBA sample were overwhelmingly male (a 4 to 1 ratio of males to females) and minority (50% Hispanic and 25% African American). At program entry, 90% of MST students met criteria for a mental health diagnosis. MST students had the highest rates of Attention Deficit Hyperactivity Disorder, conduct disorder, and mood disorders. At program entry 69% of ALBA-Out Patient students met the screening criteria for a mental health diagnosis; 81% received at least on suspension and 65% were receiving failing grades. (99)
**Tier 2:** The demographics of the middle school students were overwhelmingly male (a 4 to 1 ratio of males to females) and minority (60% Hispanic and 25% African American). At program entry, 45% of CAT students received at least one suspension and 74% of CAT students were receiving failing grades. At program entry, 34% of mentoring students received at least one suspension and 68% were receiving failing grades. At program entry, 48% of Home Start students received at least one suspension and 74% were receiving failing grades. (99)

**Tier 3:** The elementary sample was predominantly male (63%) and Hispanic (69%). At program entry, 88% of referred students met screening criteria for a mental health diagnosis; 50% were suspended at least once during the school year; and, 6% were reported absent at least once per week. Sixty-three percent of the Preschool population was male, with 99% Hispanic origin. (99)

2. *What types of services were provided?*

**Tier 1:** Multisystemic Therapy; Outpatient Services, Individual, Group and Family Therapy. Universal services offered to all ALBA students included: Life Skills curricula, and Transitional Living Counseling.

**Tier 2:** The Community Assessment Team, Youth Mentoring services, and Home Start provided services to this tier of students and their families.

**Tier 3:** SecondStep

3. *What effect did SSHS services have on student behavior, attitudes, and school achievement?*
**Tier 1:** For the year following program entry all ALBA students regardless of the intervention had statistically significant decreases in suspensions and did not increase their absence rates. The percent of students receiving failing grades also did not increase. For those receiving MST, self reported psychosocial functioning revealed decreased associations with deviant peers at ALBA. Those receiving ALBA-OP revealed improvement in relationships with parents, self-control, empathy and overall social skills. Students who received Group therapy only showed improvements on school attitude. Those who received Life Skills had substantial decreases in the percentage scoring below basic levels on California Standardized Tests’ English and Math subscales. They also reported improvements in attitude, aspirations, and empathy across time. (99)

**Tier 2:** Students participating in CAT had a decreasing trend in suspension rates and parents reported significant decreases in overall problem behavior. Mentoring found differential results by school site. For a subset of students, students indicated an improvement in self-esteem, cooperation, and self-control. Students receiving Home Start services showed decreases in number of suspensions and no significant self or parent reported improvements in psychosocial function. Overall for this Tier, the most notable improvements were increased student self-esteem and social skills at follow-up. (99)

**Tier 3:** The Elementary Assessment program did not report outcome measures but utilized process measures in its evaluation. Thirty-seven percent of students were referred for mental health needs, 39% for family issues, and 31% for
disruptive behavior. The Child Outcome Interview was administered to a subset of students identified as aggressive. The analysis revealed increases in students’ overall knowledge of social skills. Parents also reported increases in child cooperation, social skills, and lowered internalizing problems. As a whole, this young population exhibited high rates of externalizing disruptive disorders as well as internalizing mood and anxiety disorders, supporting the need for targeted interventions for this younger population. (99)

G. Implications of Current SBMHS Research

There is evidence that there is a tremendous opportunity to reach children and youth with mental health needs through school-based interventions and programming. Schools are already the major providers of mental health services and students are substantially more likely to seek help when school-based mental health services are available. (66, 94) Students who receive social-emotional support and prevention services achieve better academically in school and have demonstrated reductions in conduct disordered behavior, attention deficit/hyperactivity, and depression. (69, 71, 75) Expanded school mental health services have also been found to reduce special education referrals, improve aspects of the school climate, and produce declines in disciplinary referrals, suspension, grade retention, and special education referrals and placement among at-risk students. (72, 100) Early evaluation outcomes from the MHRC validate these reports and reinforce the need to understand not only the program specific implementation and outcomes but also the context within which these evidence-based programs are implemented.
The increased involvement of the education system in the delivery of mental health services has the potential to impact access and utilization of services. The U.S. Surgeon General considers schools to be a major setting for the recognition of mental disorders in children and adolescents. (1) Two-thirds of school districts have reported that the need for mental health services had increased since the previous year. (101) Nearly 60% of 2.2 million adolescents aged 12 to 17 reported a major depressive episode in the past year and did not receive any treatment. (100) The dropout rate for students with severe emotional and behavioral needs is approximately twice that of other students. (102)

While there is an increasing consensus for locating mental health programs and services in schools, major challenges, such as limited trained staff, limited options for referral to specialty care and decreased funding, impede successful implementation and sustainability of programs. (101) In addition to challenges related to service delivery, more research is also needed to assess mechanisms of program implementation, sustainability, and transportability. (9, 82)

The Carnegie Council Task Force concluded that, while school systems are not responsible for meeting every need of their students, schools must meet the challenge when the need directly affects learning. (34) Research reviewed here shows that there is a clear link between mental health and academic achievement; between schools and access to services; and between SBMHS and positive developmental outcomes. Taken as a whole, well-planned and well-implemented social and emotional programming in schools has been found to support the connection between positive mental health and positive
academic outcomes. (70, 83, 103, 104) However, we know little about how to sustain these efforts and scale them into a systems approach.

Faced with the need to serve more of its students, the SDUSD created the MHRC as a model to bring mental health services to students by weaving resources into a cohesive and integrated continuum of interventions that promote healthy student development and learning. The MHRC also allowed for early intervention to address problems as soon after onset as feasible and provide assistance to those with chronic and severe problems. All of these elements have been identified as core to the creation of an Interconnected System of Care and require further investigation. (104) The MHRC also provided a unique systems model for research to better understand these links and how to make them stronger.

This literature review has described the two main gaps in SBMHS research: 1) the active elements that lead to successful program implementation, dissemination, and sustainability are not well delineated; and, 2) the impact that both internal context, such as school climate and human and financial resources, and external context, such as political climate and new polices and laws, has on the sustainability of SBMH services has not been sufficiently examined. This dissertation will address these gaps through an explanatory single case study of the MHRC.
Chapter 3: METHODS

In this chapter I will describe the research design and methodology used to examine the implementation and sustainability of school-based mental health services. This chapter is presented in five main sections: 1) Study Design; 2) Conceptual Framework; 3) Data Collection Process; 4) Data Analysis; and, 5) Validity and Dissemination.

A. Study Design

A.1 Case Study

A case study was selected as the best-fit design and optimal methodology to address the dissertation’s major research questions:

1) **How has the MHRC evolved and sustained itself as a service of care model in response to financial, human resource, and community constraints and opportunities?**

2) **What factors have supported the successful implementation of the Mental Health Resource Center (MHRC) within San Diego Unified School District?**

The following three applications established by Yin support the selection of the case study design: (20)

1. To describe the real life context in which the intervention has occurred:

   - The emphasis on the study of a phenomenon within its real-world context and collection of data in natural settings fit with the approach used in this study. The researcher situated himself as much as possible in the work, school, and community environments of SDUSD and MHRC staff, faculty, students and families, and stakeholders in order to collect data for the case study and
understand the contextual elements that impact the MHRC.

2. To explain complex causal links in real-life interventions:
   
   • This researcher was not interested in studying school-based mental health interventions individually, but rather studying the MHRC as a complex system within which these interventions exist and are implemented. By choosing a constructivist paradigm and viewing the MHRC as the unit of analysis, the researcher was able to provide a holistic understanding of the MHRC. As Patton states, “The advantages of qualitative portrayals of holistic settings and impacts is that greater attention can be given to nuance, setting, interdependencies, complexities, idiosyncrasies, and context.” (105)

3. To describe the intervention itself:
   
   • A goal of this research is to provide a rich description of the context, the activities, the participants, and the processes of the MHRC. The case study describes both the core service and organizational components of the MHRC; identifies the key decisions made towards implementation and sustainability; and, explores the links to student health and academic outcomes.

   In summary, case study research is a comprehensive research strategy that includes the development of a research model design, theoretical model, data collection, and data analysis. Each of these elements will, in turn, be detailed in this chapter.
A.2 Unit of Analysis

The unit of analysis chosen for the research design was an explanatory single case. (20) The single case designation was supported by the rationale of being both a longitudinal case, spanning a thirteen-year implementation period; and, a single system case, focused on the Mental Health Resource Center (MHRC). Based on this single unit of analysis an explanatory framework was chosen to guide the case study. As such, it is attempting to connect prior descriptive and exploratory research on adolescent mental health, school based mental health, and implementation and organizational science in order to better understand causative factors that impede and/or support effective implementation and sustainability of the MHRC.

A goal in case study research is to understand the boundaries of the case and the complexity of the behavior patterns of the bounded system and minimizing the likelihood of the researcher becoming overwhelmed by the amount of evidence being collected and analyzed. (20, 106) Setting boundaries for the case ensured that the study remained reasonable in scope and assisted the researcher to better distinguish between the phenomenon studied (the case/MHRC) and its context. This study addressed bounding the case in the following ways: (22, 106)

1. **Contextual**: The case study is specifically interested in examining, analyzing, and describing the internal and external contextual elements of the MHRC to determine how it has been able to adapt and sustain itself as a model.

2. **Sample/Data**: The researcher defined the core sample of stakeholders and participants that would participate in the case study. It was limited regionally to
California and San Diego. Documents and archival records were identified and collected based on accessibility, availability and relevance to research questions.

3. **Temporal**: The case study covered the time period of 2001–2014. This time frame allowed the researcher to explore the entire implementation continuum and better understand drivers and barriers that have led to the sustainability of the MHRC.

**B. Conceptual Framework**

The Organizational Systems of Change literature informed the design of this dissertation. In order to fully understand the MHRC, a conceptual framework was needed that viewed the case not only as a collection of evidence-based interventions, implemented at specific times for specific durations, but as a complex organization of programs working within a complex institution. Given the current knowledge gap between effective evidence-based program implementation and sustainability and system wide scale-up of SBMHS delivery, studies have recommended additional research focusing on contextual factors that facilitate or inhibit implementation of evidence-based practices.

The theoretical framework chosen to support the case study is Pettigrew and Whipp's Content, Context, and Process model of strategic change (PWM). (21) The PWM has been used to analyze and learn retrospectively from change processes in organizations and is based on empirical case-based organizational research. (107) The three dimensions of strategic change which Pettigrew and Whipp introduced for organizational success are: Context (the *Why* of strategic change); Content (the *What* of strategic change); and, 3) Process (the *How* of strategic change). (21) The PWM
emphasizes the continuous interplay between these strategic dimensions and their role in organizational success. It also defines implementation as a change process, which is iterative, cumulative, and reformulating, and requires interaction between these three dimensions. (96, 108, 109)

**Figure 3.1: Mental Health Resource Center, Case Study Conceptual Framework**


The successful implementation of school-based mental health services requires a level of organization change, learning, and transformation rooted in context that Pettigrew and Whipp define in their conceptual framework. The researcher utilized this framework to address the gaps identified in the research of school-based mental health services and
organize data collection. A conceptual framework was developed to examine MHRC’s degree of change, adoption of innovations, improved inter-organizational interaction, sustainability of reforms, performance improvement, and other results expected from actions intended to facilitate change (see Figure 3.1). (94)

C. Data Collection

Three primary sources of evidence were collected for the case study: documents, archival records, and interviews. Table 3.1 lists each of the data sources, and categorizes them based on case study sub-questions and the related PWM conceptual model dimension.

C.1 Documents

Documentary information has been defined to be relevant to every case study topic and critical to help the researcher uncover meaning, develop understanding, and discover insights relevant to the research problem. Primary source material was collected to develop an accurate chronology, identify key organizations and individuals involved with SBMHS and the MHRC, and discover information related to the context of the MHRC.

Documents collected and analyzed included:

- Evaluation reports published in 2005 and 2006 by the Child and Adolescent Services Research Center (CASRC) which assessed how the MHRC was implemented and how its service components impacted academic and behavioral outcomes among participating youth.
- Annual progress reports, meeting minutes, budgets, funding proposals and reports, staffing charts and other written reports by and for San Diego Unified
School District were reviewed to provide organizational history and a timeline of service implementation, changes in MHRC services, and challenges to success.

- Annual MHRC utilization reports and organizational charts over the 15 year bounded period.

Table 3.1: Mental Health Resource Center, Case Study Data Collection

<table>
<thead>
<tr>
<th>PWM Dimension</th>
<th>Sub Questions</th>
<th>Data Sources</th>
</tr>
</thead>
</table>
| CONTEXT       | Do teachers/administrators/parents support school based mental health services? If yes, why? | Stakeholder Interviews  
Parent/Student Interviews  
Documents: SDUSD memos, e-mails, reports, Board meetings  
Stakeholder Interviews |
|               | Why did the larger institution (SDUSD, DOE) implement SBMHS/MHRC?             |                                                                                                  |
|               | Why have policy decisions been made which influence the implementation of the SBMHS/MHRC? | Documents: CA Mental Health Policy Group minutes, CA DPH memos, CA MH laws  
Stakeholder Interviews |
| PROCESS       | How has the MHRC evolved over the course of the last 12 years?              | Stakeholder Interviews - transcripts  
Stakeholder Interviews - transcripts |
|               | How has leadership supported the implementation of the MHRC?                |                                                                                                  |
| CONTENT       | What have been key changes in the MHRC?                                     | Documents  
Stakeholder Interviews  
CASRC Evaluation |
|               | What have been key outcomes?                                                 | San Diego Unified School District (SDUSD) Archival Data  
- Student Achievement data  
- Referral/Suspension/Drop-out Rates  
- Parent/Family surveys  
- Utilization reports  
- Budget/funding reports  
Parent, Student, Stakeholder Interviews |
C.2 Interviews

Retrospective interviews were conducted with students, and their parents, who received MHRC services. In addition, a series of qualitative interviews were held with state and local stakeholders. The interviews were conducted to “see the research topic from the perspective of the interviewee and to understand how and why they have come to this particular perspective.” (110) Utilizing a constructivist paradigm, the researcher collected four perspectives - stakeholder/policy maker, school staff/administration, parent, and students. Four interview guides were designed and were used to collect data for the purpose of estimating the characteristics of a large school population of interest based on a smaller sample from that population. (22) The three PWM domains guided the development of the interview questions with the goal of collecting the following data:

Stakeholders/Policy Makers and School Staff/Administrators

- **Context**: Historical and contextual information on school-based mental health services and MHRC.
- **Process**: Key players/drivers/factors in the implementation of school-based mental health services and MHRC.
- **Content**: Future perspective/goals/recommendations for school-based mental health services and MHRC.

Student and Parent

- **Context**: Chronological description of how, where and what school-based mental health services were accessed and used by the student participant.
- **Process**: Satisfaction with school-based mental health services and the MHRC.
• **Content:** Recommendations for improvement of school-based mental health services and MHRC.

Each interview guide included a field note page to incorporate Eisenhardt’s technique to write field notes to capture whatever impressions occur and for the researcher to continually ask what is being learned and how each interview differs from the last. (111) These notes were written at the end of each interview to capture the researcher’s observations and impressions. All interviews were semi-structured utilizing open-ended questions, to allow themes to emerge based on each participant’s perspective. The interview guide allowed the researcher to be flexible and responsive during the interview. It supported the researcher to build a “conversation within a particular subject area, to word questions spontaneously, and to establish a conversational style - but with the focus on a particular subject that has been predetermined.” (105) All interviews were designed to take an average of 30–45 minutes to complete, audio recorded and transcribed verbatim. The guides are included in the Appendix B. Two Institutional Review Board (IRB) applications were submitted and approved by the Boston University Medical Center (BUMC) IRB: one for the stakeholders; and, one for the student/parent dyads.

**C.3 Archival Data**

Archival data was also collected and analyzed on the consented students. Data elements obtained from student paper and electronic records included: **Academic:** School attending, course grades, grade point averages, days absent from school, suspension records, teacher comments on grade reports. **Service:** diagnosis; type of services received by MHRC; intensity of services (number of encounters); and length of completed service
(enrollment to discharge). These data allowed for a more robust understanding of the participating youth and assisted in validating the parent and student qualitative interview data. Table 3.2 provides a summary of the data collected and its purpose in the research.

<table>
<thead>
<tr>
<th>Table 3.2: Type and Purpose of Document and Archival Data Elements</th>
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</thead>
<tbody>
<tr>
<td><strong>Type of Data</strong></td>
</tr>
<tr>
<td>Documents</td>
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<tr>
<td></td>
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<tr>
<td>Archival</td>
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<tr>
<td></td>
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<tr>
<td>Interviews</td>
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<td></td>
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</tbody>
</table>
C.4 Sample

This case study utilized non-probability sampling. Non-probability sampling requires the researcher to purposely select a section of the wider population to include or exclude from the sample because they illustrate some feature or process in which the researcher is interested. The aim is for the sample to represent itself rather than to seek generalisability. (22) The following non-probability sampling designs were utilized to recruit stakeholders and student/parent dyads to participate in the qualitative interviews for the case study:

Stakeholders (Policymakers & Administrators/Staff)

Ten (10) participants were recruited at the local (San Diego) and state (California) levels in a manner to adequately reflect multiple viewpoints of experience in the field. An oversample of San Diego and SDUSD based stakeholders was recruited in order to better capture the MHRC specific implementation experience. Each of these individuals was identified via public sources based on their work and leadership in the school-based mental health field. The researcher’s knowledge of and experience in local and state mental health service delivery and implementation also informed the selection of stakeholders. An introductory e-mail was sent to each prospective participant, requesting permission for the researcher to contact him or her, further describe the research, and schedule an interview. All of the approached stakeholders accepted the request for interview.

Eight (8) additional subjects were recruited through the snowball method: At the completion of the stakeholder interviews, each subject was asked to identify other
stakeholders who would contribute to the research. The initial participant contacted the potential subject and requested permission to provide contact information before the contact was made by the researcher. All interviews were conducted on the phone or in person and were audio taped, recorded, and transcribed.

**Students and Parent(s)**

All interviews of student/parent dyads were carried out in partnership with San Diego Unified School District. This study enrolled 15 SDUSD high school student/parent dyads. Students met the following inclusion criteria: currently enrolled in a SDUSD high school; 15 years of age or older; signed consent with SDUSD to participate in MHRC activities, services, and evaluation; and, received a minimum of one MHRC service intervention during middle or high school.

From the MHRC database of 500 eligible high school students, the parent/guardian of every 10th student received a letter of recruitment from the Director of the MHRC to “opt in” to participate in this research. The recruitment letter stipulated that both the parent and child needed to agree to participate in this research study. Following this protocol, fifty letters were mailed out in English and Spanish. Once a parent returned their intent to participate form and opted to participate, the researcher set up a time and place for consent and interview. Both consent and interview occurred on the same day with parent and student.

Three mailings were conducted, totaling 150 letters, in order to successfully recruit, consent and interview the 15 student-parent dyads. A $20.00 incentive in the form of local store gift cards was offered to each student and each parent after consent was
obtained and interview completed. Archival records from consented students were provided by the MHRC. The researcher followed all Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) requirements and all procedures were reviewed and approved by BUMC IRB.

C.4.a Appropriate Number of Participants

The sample size for this research was 20 individual stakeholder interviews and 15 student/parent dyads (30 individual interviews). The size of the sample was informed by the research objectives, research question(s), and design. As summarized in the literature, sample sizes in qualitative research should not be so small as to make it difficult to achieve data saturation, theoretical saturation, or informational redundancy. At the same time, the sample should not be so large that it is difficult to undertake a deep, case-oriented analysis. Additionally, the selected samples should generate sufficient data pertaining to the phenomenon of interest to allow thick, rich description; thereby, increasing descriptive validity and interpretive validity. (112, 113) According to the literature the following are sample guidelines for ideal sample sizes based on the study design: Grounded Theory (20–30 cases); Ethnographic (30–50 cases); and Phenomenological (5–25). (110) A total of 50 interviews were conducted: 20 stakeholders, 15 students, and 15 parents. For two of the parent interviews both parents decided to participate and were interviewed together and their responses were combined as one interview by the researcher. These numbers fall within the parameters stated in the literature and provided enough data for a rich case-oriented analysis.
D. Analysis

Data collection resulted in the accumulation of a large amount of data, primarily qualitative. Analysis of collected archival, document and interview data was guided by Miles & Huberma’s definition of three concurrent flows of activity in qualitative analysis: data reduction, data display and conclusion drawing/verification. (114) A general sequence of analysis included:

1. Affixing codes to a set of field notes drawn from observations or interviews;
2. Sorting and sifting through these materials to identify similar phrases, relationships between variables, patterns, themes, distinct differences between subgroups, and common sequences;
3. Isolating these patterns and processes, commonalities and differences, and taking them out to the field in the next wave of data collection;
4. Gradually elaborating a small set of generalizations that cover the consistencies discerned in the database; and,
5. Confronting those generalizations with a formalized body of knowledge in the form of constructs or theories. (114)

The content of documents, interview transcripts, and archival records were analyzed manually and the qualitative data analysis software package NVivo8 was used to classify, organize and store the coded results. Pre-specified codes and domains were identified from the literature review and guided by the PWM. New codes were created using open coding method, allowing the researcher to consider newly emerging themes in the data. Codes and definitions were refined systematically during analysis and all codes and
definitions were listed in a codebook. The coded data were used to identify factors that influenced the initiation, utilization, and success of MHRC implementation and sustaining activities. Emergent themes, drivers and inhibitors were documented within the Content, Context and Process framework established by Pettigrew and Whipp’s strategic change theory. The findings of the analysis were then organized according to the two research questions posed by the case study.

**Research Question 1:** In the first phase of analysis, the researcher concentrated on documenting the development of the MHRC to answer the first research question:

> How has the MHRC evolved and sustained itself as a service of care model in response to financial, human resource, and community constraints and opportunities?

The implementation continuum (see figure 3.2) was utilized to assist in the development of the chronological event listing in order to organize the development of the MHRC. (86) A chronological reconstruction was then completed utilizing Miles and Huberman’s Event-Listing Time Ordered Listing. (114) This resulting narrative matrix arranged and sorted MHRC events into a valid chronology. Upon completion of the Time Analysis, all document, archival and interview data underwent a content analysis to organize and identify emergent themes based on the PWM framework.
Figure 3.2: Implementation Continuum

Research Question 2: Primary source material, documentary evidence, and interviews, all focused on addressing the second research question:

*What factors have supported the successful implementation of the Mental Health Resource Center (MHRC) within San Diego Unified School District?*

NVivo8 was utilized to organize, code, and analyze all interview data collected. Coding categories were created both based on the conceptual frameworks and emergent themes. As a form of content analysis, coding is a “process of identifying and categorizing the primary patterns in the data” and codes are “tags or labels for assigning units of meaning to the descriptive or inferential information compiled during the study.” (105) The indexing of the data through the use of codes was a way of reducing and organizing the data for subsequent analysis. A pattern matching logic was applied to the analysis. (114) The results of the analysis informed new themes and validated major predetermined domains of the PWM framework (context, process, content) and major content themes identified in the literature (i.e., implementation, sustainability, school based health services, mental health, leadership, collaboration).

E. Validity and Dissemination

E.1 Validity of Study

Three approaches to qualitative data analysis have been described in the literature: interpretivism, social anthropology and collaborative social research. (115) This study took on an interpretivist viewpoint that is characterized by a focus on the individual (stakeholder, parent, and student) and the creation of meaning through the interplay of the participants and the researcher. (115) Qualitative researchers, who frame their studies in an interpretive paradigm, think in terms of trustworthiness and four factors to be considered in establishing the trustworthiness of findings from qualitative research:

- **Credibility**: Assuring the truth-value of the findings and accommodating the need to understand, in a holistic manner, a complex phenomenon;
- **Transferability**: Addressing the applicability of the findings but acknowledging that the research focus is particular to the case and not generalizable;
- **Dependability**: Assuring the methods and methodological choices of the emergent research design are documented for external inspection; and,
- **Confirmability**: Assuring the neutrality of the researcher to establish the degree to which the findings of an inquiry are a function solely of the respondents and conditions of the inquiry and not of the biases, motivations, interests, and perspectives, of the inquirer. (116)

As described, this dissertation collected a wide variety of data to support answering the research questions and achieving the stated objectives of the study. Several procedures assisted in analyzing the data to ensure credibility and dependability of the
data and findings. The researcher placed an emphasis on triangulation as a means of corroboration, which allowed the researcher to be more confident of the study conclusions. Triangulation was an essential element of the analysis due to the design of the study and is a primary strategy that supported the principle in case study research that the phenomena be viewed and explored from multiple perspectives. Collecting stakeholder interviews along with documentary evidence, allowed the researcher to better understand SBMHS. The collection and comparison of the data enhanced data quality based on the principles of idea convergence and the confirmation of findings. (117, 118)

Triangulating data sources and collection techniques supported a holistic perspective as the MHRC case study was created. Triangulation also directed the researcher to find corroborating evidence in the different sources of data to assure the accuracy of facts and interpretations. For example, student interviews were triangulated with parent interviews and archival data to help confirm findings and statements made by students. Triangulation helped reduce researcher bias since substantiation for claims were linked to data from multiple sources (see figure 3.3).

In addition, to increase confirmability in the case, the researcher utilized reflexive methods. Reflexivity is an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process. (119) As stated by Malterud: "A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions." (120) The researcher in this case made many
decisions regarding the study’s sample, design and methods based on his expertise in school based health and program implementation and evaluation. Decisions where also influenced by the bounds of time, access, and availability of data. In order to decrease bias, the researcher utilized Lincoln and Guba’s suggestion of a reflexive journal. (116) The researcher made regular entries during the research process, recording methodological decisions and the reasons for them, allowing the researcher to reflect upon study activities and how his own values and experiences influenced the ongoing research.

E.2 Dissemination of Study

The final explanatory case study provides a robust and holistic account of the implementation of the MHRC that has the goal of advancing the field of school-based mental health. Chapter 4 provides the Findings and Chapter 5 provides the Discussion, Recommendations and Conclusion of the case. At the completion of the case, the researcher utilized Stake’s assessment criteria to assess the readiness of the case for dissemination and publication (see Table 3.3). (106) One product, a White Paper, targeted
to the San Diego Unified School District and California school-based mental health stakeholders, is included in the Appendix A.

<table>
<thead>
<tr>
<th>Table 3.3: Stake’s checklist for assessing the quality of a case study report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is this report easy to read?</td>
</tr>
<tr>
<td>2. Does it fit together, each sentence contributing to the whole?</td>
</tr>
<tr>
<td>3. Does this report have a conceptual structure (i.e. themes or issues)?</td>
</tr>
<tr>
<td>4. Are its issues developed in a series and scholarly way?</td>
</tr>
<tr>
<td>5. Is the case adequately defined?</td>
</tr>
<tr>
<td>6. Is there a sense of story to the presentation?</td>
</tr>
<tr>
<td>7. Is the reader provided some vicarious experience?</td>
</tr>
<tr>
<td>8. Have quotations been used effectively?</td>
</tr>
<tr>
<td>9. Are headings, figures, artifacts, appendices, indexes effectively used?</td>
</tr>
<tr>
<td>10. Was it edited well, then again with a last minute polish?</td>
</tr>
<tr>
<td>11. Has the writer made sound assertions, neither over- nor under-interpreting?</td>
</tr>
<tr>
<td>12. Has adequate attention been paid to various contexts?</td>
</tr>
<tr>
<td>13. Were sufficient raw data presented?</td>
</tr>
<tr>
<td>14. Were data sources well chosen and in sufficient number?</td>
</tr>
<tr>
<td>15. Do observations and interpretations appear to have been triangulated?</td>
</tr>
<tr>
<td>16. Is the role and point of view of the researcher nicely apparent?</td>
</tr>
<tr>
<td>17. Is the nature of the intended audience apparent?</td>
</tr>
<tr>
<td>18. Is empathy shown for all sides?</td>
</tr>
<tr>
<td>19. Are personal intentions examined?</td>
</tr>
<tr>
<td>20. Does it appear individuals were put at risk?</td>
</tr>
</tbody>
</table>
Chapter 4: FINDINGS

A. Introduction

San Diego Unified School District (SDUSD) is the second largest district in California. The district has more than 226 educational facilities with 13,559 employees. Nearly 6,000 teachers are in classrooms at the district's various educational facilities, which include 117 traditional elementary schools, 9 K–8 schools, 25 traditional middle schools, 24 high schools, 49 charter schools, and 14 atypical/alternative schools. (121)

SDUSD’s $1 billion annual operating budget serves more than 132,000 students in pre-school through grade 12. The student population is extremely diverse, representing more than 15 ethnic groups and more than 60 languages and dialects (see table 4.1). The student population is also comprised of: 26.5% English language learners; 59.4% eligible for free or reduced meals; 11.3% receive Special Education services, 1.5% foster youth; and, 7% are from military families. (121)

The Mental Health Resource Center (MHRC) was established in October 2001, with a three year federally funded grant by the Safe Schools/Healthy Students (SS/HS) Initiative. Its goal was to provide mental health assessment, case management and treatment for students at all age levels. Since its inception, the MHRC has gone through periods of expansion and contraction in response to a dynamic mix of need, resources, and leadership that will be described in this chapter.
Table 4.1: San Diego, City and District Demographics

<table>
<thead>
<tr>
<th></th>
<th>San Diego¹</th>
<th>SDUSD²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>1,301,617</td>
<td>132,000</td>
</tr>
<tr>
<td>Male</td>
<td>50.5%</td>
<td>51%</td>
</tr>
<tr>
<td>Female</td>
<td>49.5%</td>
<td>49%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>29%</td>
<td>46.6%</td>
</tr>
<tr>
<td>White</td>
<td>45%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>6.7%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Filipino</td>
<td>5.9%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>10%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Multi-Racial</td>
<td>5.1%</td>
<td>6.5%</td>
</tr>
</tbody>
</table>


A series of qualitative interviews were held with state and local stakeholders. Retrospective interviews were also conducted with students, and their parents, who received MHRC services (see Table 4.2).

Table 4.2: Total Interviews Conducted by Sample Characteristic

<table>
<thead>
<tr>
<th></th>
<th>Local Stakeholders</th>
<th>State Stakeholders</th>
<th>Parent(s)</th>
<th>Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (50)</td>
<td>12</td>
<td>8</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

The stakeholders represented key participants from a variety of backgrounds (see Appendix C). Seven of the state and local stakeholders interviewed had direct involvement in the implementation of the MHRC. Nine were involved in local and state policy development. A third group (15) represented students receiving direct services; and, the fourth group (17) represented parents of these students. The demographics of these latter two groups are provided in Table 4.3.
Table 4.3: Student and Parent Interviewee Demographics

<table>
<thead>
<tr>
<th></th>
<th>Students</th>
<th>Parents*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>9 (60%)</td>
<td>3 (18%)</td>
</tr>
<tr>
<td>Female</td>
<td>6 (40%)</td>
<td>14 (82%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7 (47%)</td>
<td>7 (41%)</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>5 (33%)</td>
<td>7 (41%)</td>
</tr>
<tr>
<td>Non-Hispanic Black/African American</td>
<td>3 (20%)</td>
<td>3 (18%)</td>
</tr>
</tbody>
</table>

* For two interviews, both parents attended, and interviews were then collapsed into one

Emergent themes, facilitators and barriers were documented within the Content, Context and Process framework established by the Pettigrew and Whipp strategic change theory. The findings of the analysis were then organized according to the two research questions posed by the case study.

B. How has the MHRC evolved and sustained itself as a service of care model in response to financial, human resource, and community constraints and opportunities?

Miles and Huberman’s Time Analysis and Fixen’s Implementation Continuum Framework were combined to create a full narrative of MHRC’s evolution and response to the financial, human resource, and community constraints and opportunities over the case bounded period of 2001–2014. (86, 114) Table 4.4 provides a summary of the chronological time analysis.

B.1 Phase 0: Exploration and Adoption (1999–2001)

During the Exploration and Adoption phase, organizations map and respond to community needs in order to understand the enabling and limiting aspects of the contexts in which the proposed intervention or system change is to occur.

Goal: San Diego Unified School District (SDUSD) responded to community needs for
improved access to mental health treatment, specifically, fragmented and uncoordinated mental health services, and, lack of attention to education outcomes, by establishing the Mental Health Resource Center (MHRC).

**Activities:** SDUSD administrators, led by the Center for Student Support and Special Education, established a broad based collaborative planning process that included SDUSD staff, County of San Diego Health and Human Services Agency, Healthy Start Collaboratives, school and city police; and other community based student focused organizations and partners (see Figure 1). During this phase stakeholders and community members met and responded to the funding opportunity offered by the Safe Schools/Healthy Students (SS/HS) Initiative.

The SS/HS Initiative, a collaborative effort of the U.S. Departments of Education, Health and Human Services, and Justice, was a discretionary grant program that provided communities with federal funding to implement a coordinated comprehensive plan of activities, curricula, programs, and services that supports the vision of the SS/HS program:

“To promote the mental health of students, to enhance academic achievement, to prevent violence and substance use, and to create safe and respectful climates through sustainable school-family-community partnerships and the use of research-based prevention and early intervention programs, policies, and procedures.”

SDUSD applied and was unsuccessful during the first round of grants in 2000. The school district resubmitted during the 2001 round, and was successful in its application.
Table 4.4: Mental Health Resource Center Chronological Time Listing

<table>
<thead>
<tr>
<th>Implementation Phase</th>
<th>Time Frame</th>
<th>PWM</th>
<th>Facilitators</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0</strong> Exploration &amp; Adoption</td>
<td>1999–2001</td>
<td>Context</td>
<td>SDUSD need for MH services</td>
<td>MH awareness &amp; knowledge</td>
</tr>
<tr>
<td><strong>Map and respond to community needs</strong></td>
<td></td>
<td>Content</td>
<td>Clear MH vision and mission</td>
<td>Lack of district MH policies</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td></td>
<td></td>
<td>Strong collaborators</td>
<td></td>
</tr>
<tr>
<td><strong>Cross-agency partnerships</strong></td>
<td></td>
<td></td>
<td>Cross-agency partnerships</td>
<td>IT/Data collection systems</td>
</tr>
<tr>
<td><strong>1</strong> Installation</td>
<td>2001–2002</td>
<td>Context</td>
<td>SS/HS funding</td>
<td>Staff resources</td>
</tr>
<tr>
<td><strong>Identify and install structural supports necessary to initiate programs</strong></td>
<td></td>
<td>Content</td>
<td>Strong EBP focus</td>
<td>Staff MH Awareness &amp; Knowledge</td>
</tr>
<tr>
<td><strong>Selection of evaluation team</strong></td>
<td></td>
<td></td>
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**Barriers:** The lack of a pre-existing school based mental health policies were barriers to the creation of the MHRC. A zero tolerance, expulsion and suspension culture to deal with most difficult students, and a general lack of knowledge and awareness of mental health among teachers, staff and community members were intrinsic barriers to the early success of the MHRC. The need to create new data collection and reporting systems were additional barriers that SDUSD had to surmount to implement the MHRC. The unsuccessful funding of the first SS/HS grant submission required that the SDUSD refocus efforts and staffing in order to keep the momentum of the collaborative process moving forward.

**Facilitators:** Three key drivers were identified in this phase: 1) commitment to providing better access to school based mental health services; 2) targeting at-risk and disruptive youth; and, 3) aligning and integrating mental health services and educational outcomes. The combined commitment of SDUSD and of the community to improve student mental health and implement the goals of the SS/HS initiative strengthened the collaborative process. SDUSD’s Director of the Student Support Services participated and led community-planning processes regarding the MHRC. Stakeholders from the Community Health Improvement Partners (CHIP) Mental Health Committee, the County of San Diego Mental Health Advisory Board, and the Juvenile Justice Coordinating Council participated in the planning groups. In addition, the SDUSD run school-based Healthy Start Collaboratives conducted community and staff focus groups and information forums in preparation for submitting the SS/HS proposal. The Healthy Start Collaboratives were an integral part of SDUSD infrastructure. They existed at 20 school campuses and
provided integrated family focused case management and other social support services for traditionally undeserved families. Located at each of the three targeted middle schools, Healthy Start Coordinators supported the implementation of the SS/HS grant in the community. Letters of commitment reflected the strong collaborative structure and was a strength of its SS/HS application.

One of the principal drivers for the early inception of the MHRC was the need to find alternative strategies to address the needs of at-risk and disruptive youth. Focusing on mental health indicators among adolescents such as violence, suicidality, and suspension and expulsion rates, this concern was articulated strongly by SDUSD’s Center for Student Support and Special Education in the final submission of the SS/HS grant. With a 1999 student population of 142,300, juvenile arrests for felony weapons within SDUSD rose 39% from 1995–1999, and juveniles accounted for 39% of all arrests for weapon violations, up from 26% in 1995. The 1999 Youth Risk Behavior Survey (YRBS) indicated that 22.3% of students had seriously considered attempting suicide compared to the 20.5% U.S average, 17.7% had a specific plan compared to 15.5% nationwide, and 9.2% made suicide attempts compared to the 7.7 nationwide. (122) SDUSD’s Accountability and Research Office summary reported district-wide suspension rate of 8.4/100 students, which was the third highest in the previous16 years and more concerning was the increasing suspensions rates reported in grades K–5. Over 900 students were on probation and 637 expulsions were recommended. At the County level 13,950 students were enrolled in County Office of Education Juvenile court and community schools with an average daily attendance of 3,150 students. (122)
At the end of Exploration Phase, a decision was made to proceed with the re-submission of the SS/HS grant and re-organize mental health funding streams under the MHRC. Healthy Start Collaborative coordinators played a pivotal role in keeping stakeholders engaged in the planning process as the SDUSD aligned internal resources and policies toward fulfilling the mission of the proposed MHRC. Programmatically, SDUSD created a SS/HS Advisory Board to select appropriate empirically based mental health interventions to meet the goals of the funder and the needs of the community. The Advisory Board also advised staff and the evaluation team. Their support, investment, and leadership were critical to move the MHRC into the Installation Phase. This cross-collaborative effort led to the Juvenile Court, SDUSD, and the San Diego Probation
Department to create a new secure data system that allowed for sharing of probation, attendance and other student information with the goal of targeting and providing services early to students in need.

**Funding:** SS/HS planning was a catalyst for SDUSD to align State and County Department of Education, County Mental Health, and local and state private partnerships and funding to anchor mental health services within the school district.

**Summary:** SDUSD submitted and successfully was funded the SS/HS grant that established the MHRC in October 2001. Community partnerships and key organizations were identified. A SS/HS advisory group began the work of aligning mental health and education missions, activities and outcomes.


During Program Installation structural supports necessary to initiate programs are put in place. These include ensuring the availability of funding streams, human resource strategies, and policy development as well as creating referral mechanisms, reporting frameworks, and outcome expectations.

**Goal:** Strengthen structural supports necessary to initiate the MHRC, including:

- developing human resources protocols and program policies;
- establishing evaluation plan;
- creating referral and data collection systems;
- and, receiving certification as an Early Periodic Screening Diagnostic and Treatment (EPSDT) provider.

**Activities:** In October 2001, the SDUSD was awarded the Safe Schools/Healthy Students Initiative grant. The overall mission statement created by the SSHS/MHRC Advisory Board was “to work collectively to provide a seamless array of intervention services to
improve the health and safety and improve student achievement for students at the targeted schools.” The Board of Education approved the MHRC in December of 2001. A parallel application to the San Diego County Health Human Services Agency for certification as an EPSDT provider was also approved. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit ensured that children and adolescents under the age of 21 who are enrolled in Medicaid, receive appropriate preventive, dental, mental health, and developmental, and specialty services. This designation allowed the school district to bill the state of California for MediCal reimbursement of covered services and was critical to the financial viability of the MHRC.

Activities focused on staff recruitment and training, with the goal of initial implementation during the 2002–2003 school year. The program manager, Shirley Culver was hired in 2002 along with other lead health clinicians and school program coordinators. MHRC staff was then recruited, including the Second Step coordinator who was hired in June 2002. Second Step was the evidenced-based violence prevention program targeted to the MHRC pre-school and elementary school sites. In addition, SDUSD awarded the evaluation contract to Rady’s Children’s Hospital Child and Adolescent Services Research Center (CASRC). The CASRC evaluation team was recruited during this year and efforts were targeted towards research evaluation design and creation of the MHRC database. Discussions with the Advisory Board led to the decision to create two master databases: one for referral sites (MHRC and the Healthy Start Coordinators at each targeted middle school) and one for the intake sites.
Barriers: The lack of a district-wide coordinated and integrated mental health approach created early obstacles to the seamless implementation of the MHRC. This was particularly true with hiring of staff. During the first year of implementation, 28 new positions were created requiring new job cards, approval, recruitment and hiring of staff. These positions were a mix of licensed (i.e. LCSW) and unlicensed clinicians (i.e. caseworkers). This mix was chosen to add layers of expertise among the MH team and to allow for a greater representation of San Diego’s Hispanic population in order to respond to the specific cultural and linguistic needs of the population. The recruitment and hiring process proved to be highly time intensive. As many of the new positions were mental health skills specific and not necessarily aligned with pre-existing education based positions, extra time was needed to agree on responsibilities and approve positions. Once funding was acquired, staff and community members not only had to coordinate program implementation but also provide support and education to staff, partners, and community members who had little awareness, knowledge or training in mental health.

Facilitators: The MHRC gained forward momentum with hiring of initial key personnel to lead the coordination and implementation efforts of SS/HS programs. An instrumental hire was the MHRC Director who as a former employee of the San Diego County Mental Health. She was able to maintain and strengthen partnerships between SDUSD and the County and strategically utilize existing reimbursement mechanisms, and create new policies for mental health reform in the school district. These strengths would prove to be critical in the long-term sustainability of the MHRC. The strong collaborative structure and relationship and trust among partners in SS/HS also facilitated the implementation of
the MHRC.

**Funding:** The implementation of the MHRC did not require any new general fund support from SDSUD. Instead the funding design emphasized a cooperative relationship, in order to tap into mental health services provided through San Diego County Mental Health Services, which were funded under California Assembly Bill (AB) 2726. Funds from the SS/HS grant, California AB 1113 Safe School and Violence Prevention funds, and other County funds through the Community Health Improvement Project, were the basis for the initial operating budget. Together the proposed first year of implementation funding of MHRC was $1.7 million.

**Summary:** Hiring of staff, creating MHRC protocols, and developing new and synergistic funding streams, such as EPSDT, were major activities and outcomes of this phase.


This phase is defined by changes needed in the administrative, policy and practice environment in response to adopting the program.

**Goal:** MHRC implementation of programs, evaluation and policies in response to student, staff, and community needs while also concurrently planning for the future sustainability of the MHRC.

**Activities:** For all MHRC programs, the 2002–2003 academic year was the first year of implementation. During this initial rollout of programs the MHRC’s lead clinician directed all ALBA programs and the Elementary Assessment. Ten elementary schools were targeted as feeding substantial numbers of students into the SS/HS targeted middle schools and also having a pre-school grant for children 0–5 years of age. Second Step
was implemented at the 10 pre-school and three child development centers. Six week parenting classes were also offered at each school site. The Elementary Assessment team conducted full mental health evaluations and made appropriate agency referrals on students identified with problem behaviors.

During this period a second lead clinician was hired to direct the ALBA program, which allowed the MHRC to expand and include a group therapy program. As part of its offerings to the most at-risk youth, the MHRC during this initial implementation year, offered three services to its ALBA students – Multi-Systemic Therapy (MST), ALBA-Out Patient (OP), and/or group therapy. Intake assessments were implemented as part of the ALBA intake to screen and refer students who were high risk, across numerous diagnostic categories. Multi-Systemic Therapy was implemented at the ALBA middle and high schools to target students exhibiting oppositional and conduct problems. ALBA Out Patient, providing less intensive interventions than MST, was implemented at ALBA middle and high schools, enabling the MHRC to provide services to a larger number of students.

Additional clinical staff was also hired which included a LCSW to provide on-site individual and group therapy to middle school sites. An additional mental health clinician was hired to provide services to high school sites. The strong focus of SS/HS funding on violence and substance abuse prevention required that the MHRC focus on intensive provision of these services at the ALBA campuses.

**Barriers:** Due to the scope of the MHRC and the quick roll-out of services, Information Technology (IT) quickly became a programmatic barrier. After a full half-year of use, it
became apparent that the databases needed major modifications. Both were shutdown until upgrades and changes could be made. The referral and intake systems were reconfigured and processes were streamlined. A third database was created to decrease the double entering of similar information and overall input errors. During this time, programmatic staff turnover required recruitment and training of new hires. Ongoing lack of trust between teaching staff and MHRC staff continued to be a district wide barrier that had to be addressed through ongoing education, meetings, and trainings.

Facilitators: As the MHRC built up programmatically and began to examine its future, the inclusion of a strong evaluation and outcomes focus assisted in prioritizing programs and activities. During this phase additional staff was hired by CASRC and efforts were targeted towards implementation of the evaluation design and dissemination of the SS/HS databases. CASRC, the MHRC Program Manager and lead staff met regularly to develop program forms and chart design, identify variables necessary to capture program outcomes and develop and monitor an electronic tracking system to collect service delivery data. All of these efforts allowed for the collection of data, reporting, and prioritizing of program efficacy in order to plan for sustainability.

As MHRC programs began to be implemented, teaching and school staff began to better understand the role of MH services in an academic setting and began to request more services and training. For example, the success of the Second Step curriculum implementation led to a request for district wide implementation and conducting school-wide teacher trainings. The MHRC was also awarded a two-year no-cost extension from SS/HS and was able to offer services for the 2004–2005 school year with a final
evaluation during the 2005–2006 academic year.

**Funding:** The budget for the 2002–2003 school year increased to $3.5 million to cover the cost of 32 staff working on the MHRC. A similar budget was implemented during the 2003–2004 school year. The increase in funding was attributable to the EPSDT designation and the larger budget request for years 2 and 3 of the SS/HS grant. During this phase the MHRC continued to expand its EPSDT billing with County Mental Health. The MHRC also began to identify and expand funding streams to develop MH services for special education population. The SS/HS did not focus on developing services for special education students, but they were of great interest to the SDUSD, and aligned well with the mission of the MHRC.

**Summary:** During Initial Implementation the MHRC focused on implementing all SS/HS programs; strengthening the evaluation and IT infrastructure; improving training and buy-in of staff and teachers across the district; expanding funding streams; and, expanding populations being served.


Full operation occurs once the innovation and new learning becomes integrated into practitioner, organizational, and community practices, policies, and procedures. During this phase the implemented program becomes fully operational with full staffing complements and full client loads.

**Goal:** The major goal was to achieve full integration of MHRC mission and services into SDUSD culture and community with a focus on maintenance, expansion and sustainability of MHRC.
**Activities:** During the 2004–2005 school year the MHRC achieved staff stability, strong integration of services at all school sites, a more efficient and streamlined intake and referral process, and more engaged school staff and administrators. At the elementary and pre-school levels, staff reported greater parent involvement and engagement with services. Evaluation activities at this time were targeted towards the completion of data collection and drafting final research evaluation reports. All databases were shut down in June 2005 and final downloads were sent to CASRC by each school site. During the 2005–2006 school year over 690 students received services from the MHRC. These included: 169 ALBA students returning to comprehensive sites received transitional counseling; 90 students received day treatment; 61 students received Multisystemic Therapy (MST); 274 ALBA students received MH treatment; and, MHIT served 52 classrooms. Figure 4.2 represents the major programs and staffing patterns at the end of the Full Operation Phase, which also paralleled with the end of the SS/HS funding.

**Barriers:** MHRC did not have financial and personnel resources required to scale services to adequately respond to district-wide need. End of SS/HS funding created programmatic delivery barriers and required the MHRC to reorganize efforts, prioritize programs and seek new funding streams for non-supported programs. The end of SS/HS funding also marked the end of the formal MHRC evaluation plan and access to a funded evaluation services and team. This required the MHRC to re-strategize how to maintain and scale evaluation and outcomes efforts.
Facilitators: At the state level, voters enacted the Mental Health Services Act (MHSA), also known as Proposition 63, in November 2004. The intent of this Act was to transform the public mental health system in California into a system that provides a broad spectrum of prevention and early intervention, treatment, and infrastructure support. The five key elements to the MHSA are: (1) a client/family-driven mental health system, (2) cultural competence, (3) community support and collaboration, (4) service integration, and (5) a focus on recovery, wellness, and resiliency.

The MHSA was written under the guiding principle that providing school-based mental health services helps address barriers to learning and provides appropriate student and family support in a safe and supportive environment. However, the early implementation of the MHSA proved to be daunting for counties. The level of
transparency, transformation, and training required exceeded the available county resources. Many school districts were not structurally ready to be early adaptors of the law and found the implementation and the infrastructure changes in areas such as human resources, contracting, information systems, and space, to be more challenging than anticipated. Yet, passage did allow for a state level conversation on mental health that facilitated the County of San Diego to address the existing gaps in county level services as they related to the five key elements of the law. Non-targeted SDUSD school sites began to inquire about service expansion. Increased mental health awareness attributable to the passage of MHSA created a rise in service requests across SDUSD. The strength of the MHRC partnerships, the early program outcomes, and the ongoing staff education and training built a strong foundation for sustainability.

**Funding:** The MHSA imposed a 1% income tax on personal income in excess of $1 million. Statewide, the Act generated approximately $254 million in fiscal year 2004–05, $683 million in 2005–06 and increasing amounts thereafter. The SDUSD and MHRC were able to utilize MHSA funds to expand the partnership with the County Probation Department in order to continue MST services with court involved youth. The evidence base and outcomes of the MST program during SS/HS years were critical to demonstrating the impact of the program and successfully compete for MHSA funding. EPSDT and Local Education Agency (LEA) Special Education contracts continued to be a source of funding for mental health services being provided at over 40 school sites across SDUSD.

**Summary:** By the end of the Full Operation phase, the MHRC had established its core
staffing; implemented programs at all of its school sites; finalized data collection under SS/HS funding; and, expanded it funding streams to align with new state sources.


During this phase, the innovation becomes accepted practice and operationalized. As a side effect of successful implementation of initial innovation, the need for growth and scaling of programs becomes a core activity.

**Goal:** Reach greatest number of SDUSD students in need of mental health services while maintaining quality of programs and staff.

**Activities:** By drawing on established sources of funding, strengthening partnerships, and supporting staff development, SDUSD began to expand services, sustain the MHRC, and grow to a team of over 100 SBMH staff members. The MHRC also strategically trained SDUSD staff who interacted with students every day - from bus drivers to teachers and school administrators - on important mental health issues, such as suicide prevention and bullying. The trainings significantly increased the staff’s understanding of mental health, especially the fact that mental health exists along a continuum.

The MHRC during this phase also responded to the challenges of multiple and new funding streams, reporting requirements, program scaling and fidelity, quality and satisfaction of services, and staff training and community education. After expanding school-based mental health services under the SS/HS grant, SDUSD approached its juvenile justice, mental health, and education partners to identify strategies to sustain services. The interagency collaborations focused on addressing the needs of vulnerable students who were either seriously emotionally disturbed or in the “school-to-prison
pipeline”, with the goal of supporting them to stay in school and achieve other positive outcomes while receiving MHRC services. Continued EPSDT funding and contracts with the County allowed for expansion of services to more school sites to work with special education students as part of their Individual Education Plans (IEPs).

During this period of Innovation, the Mental Health Intervention Team (MHIT) program was created and provided services to all elementary and middle schools on regular school campuses that have self-contained special education classrooms onsite. The MHIT was a collaborative service delivery model using school-based mental health teams to implement evidence-based interventions to promote positive social adjustment for youth with emotional and behavioral disorders (EBD) and their families as well as support classroom teachers. Program components included classroom behavioral interventions, consultation services, case management, traditional individual and group psychotherapy, and family outreach and parenting groups. MHIT consisted of 6 teams (1 mental health clinician and 1 rehabilitation specialist) to serve the ED classrooms. The MHIT staff were trained in one or more of the following interventions: a) The Incredible Years, b) Strengthening Families, and c) Parent Project. By joining educational staff and clinical providers in the classroom to treat students with EBD, the MHIT addressed a long-standing barrier in the provision of mental health services – lack of infrastructure to support mental health programs.

**Barriers:** Scaling of efforts required new innovations to address how to operationalize ongoing data collection evaluation, and service delivery. The end of the SS/HS funding coupled with the increasing need and requests for SBMH services required a focused
response to sustaining existing programs while expanding services to new sites and student populations. Staff now numbered over 100 staff, representing a combination of licensed, students, and certified professionals. The need for consistent training, coaching, and supervision in order to maintain effective and quality services became a human resource issue that required refocused attention. With the end of SS/HS funding, there was also an end to a formal evaluation team working with the MHRC. This lack of ongoing funding coupled with multiple reporting mechanisms created barriers to developing a uniform data collection system and subsequent analysis of data.

Facilitators: Although SDUSD initially focused its efforts on meeting the mental health needs of high-risk students, the MHRC led the efforts to reach out to the entire student body and offer prevention services on most campuses. Building the staff’s capacity to engage with students in ways that fostered mental well-being had an impact on the general campus community and climate and benefiting many other students who were not directly served by MHRC services. The strategy of training key adults and community members who touch large numbers of students in their daily interactions became a hallmark of the MHRC. This approach, coupled with the ongoing development and strengthening of collaborative partners, allowed the MHRC to both expand services and save costs.

Funding: As a cultural shift from off-site residential treatment to on-site day treatment services for high need students, the MHRC was able to save costs per student while providing services to more students in need. The cost of residential treatment can be as high as $140,000/student; in contrast, day treatment costs average $27,000/student, much
of which is offset by Medi-Cal reimbursement. MHRC was able to work with 105 high school and 42 middle school students during this period in Day Treatment. Funding was also used creatively to support the expansion of outpatient services being provided by the MHIT, Individual therapy or Enhanced classroom Teams. Local Education Agency funding (through CA Department of Education) was utilized to fund MHIT services, while Medi-Cal was used to reimburse for services provided in individual therapy or classroom settings. MHSA funding was secured to work with probation and ALBA students.

During the 2009–2010 school year the MHRC total budget would amount to $7.7 million. Approximately 38% of the budget would be covered by SDUSD services (25% special education reimbursable services) and 62% would be covered by County contracts (29% EPSDT reimbursable services), that included MHSA (5%) and outpatient services (7%).

**Summary:** During this phase the MHRC was institutionalized into the fabric of the SDUSD. The MHRC began to increase and further develop a prevention focus; it creatively used funds for secondary and tertiary services, and used data to guide program and policy actions and decisions.


A priority in this phase is achieving financial and programmatic sustainability by ensuring stable funding streams for the delivery of existing and new practice. Implementation infrastructure is also reinforced, reliable, effective, and sustainable.

**Goal:** SDUSD’s goal was to achieve MHRC financial and programmatic sustainability by
ensuring funding streams for delivery of existing and new services.

**Activities:** By the end of the 2013–2014 school year, the MHRC was operating under a $16 million budget and was providing services to over 800 students. Figure 4.3 provides an abbreviated organizational chart of the MHRC at the end of the case, 2014. The infrastructure and activities needed to ensure sustained quality implementation undertaken by the MHRC included:

- Expanding MH training and support for staff, teachers and administrators;
- Training and coaching of staff in grant writing and funding solicitation;
- Utilizing local university resources for evaluation and data analysis;
- Improving data collection and outcomes for continuous improvement and problem-solving;
- Expanding reach with the general education population;
- Increasing family/parent engagement in MHRC development and services; and,
- Diversifying and sustaining funding streams.

**Barriers:** As the MHRC scaled up, the organizational chart grew vertically with little mid-management growth. This created an organizational barrier. There were insufficient staff, for evaluations, coaching, and other administrative requirements. There was an increasing SDUSD wide need to address not only special education population, but also general education; however, funding was still predominantly focused on the former. Without funding to support an integrated evaluation plan, the MHRC was faced with how to incorporate and improve data collection and analysis methods. Parental input and education, coupled with the stigma and lack of basic understanding of mental health
illness, continued to be a barrier in providing services holistically to students in a school setting.

Facilitators: In 1984, Assembly Bill 3632 statutorily required a partnership between school districts and county mental health agencies to deliver mental health services to students with IEPs. In 2011, the California Legislature passed Assembly Bill 114, which eliminated all statute and regulations related to AB 3632 which had been the authority for providing mental health services to students in special education whose handicapping condition is emotional disturbance and who required mental health services in order to benefit from the free and appropriate public education (FAPE) to which they are entitled. The bill transferred responsibility and funding for educationally related mental health services, including residential services, from county mental health and child welfare departments to local education agencies (LEAs).

As a result of this new legislation, school districts became solely responsible for ensuring that students with disabilities received special education and related services to meet their needs according to the Individuals with Disabilities Education Act (IDEA) of 2004. As the MHRC had already been in existence for 9 years, SDSUD utilized the MHRC as the umbrella for responding to this law change. At this time the Mental Health Related Services (MHRS) Program was established under the auspices of the MHRC and tasked with developing and coordinating implementation of school wide procedures related to mental health assessment and service delivery. The MHRS program coordinated assessment and implementation of educationally related mental health services to eligible special education students attending SDUSD Special Education Local
Plan Area (SELPA) specific schools. Services were provided based on the Individualized Education Plans (IEPs). The law change allowed for the MHRC to expand their services to a population of students were not be accessing County Mental Health services and who had the greatest need to mental health treatment.

The MHRC continued to gather and use data to support, expand and reconfigure services. For example, data collected through SS/HS mental health screening showed that two-thirds of students entering ALBA met the criteria for a non-conduct mental health disorder, such as depression or anxiety. At that point, most community members and educators believed that students in alternative schools were willful troublemakers on the path to incarceration. These data were used to convince decision-makers to use school funds to hire experienced mental health professionals to address the mental health needs of students at ALBA and rethink in a systemic way why students were expelled. Such focused and adaptive use of mental health data and outcomes had significant impact on at-risk students in SDUSD. Alternative approaches to meet the mental health needs of students led to the closing of the elementary ALBA site and a decrease of students placed in alternative learning settings. These chances resulted in a significant decrease in ALBA students, from over 600 students when SS/HS began to fewer than 60 ALBA students during the 2013–2014 school year.

During this time, the MHRC became more integrated into the daily fabric of the SDUSD. The sustained effort, the outcomes focus, the improved changes in mental health delivery, and the overall satisfaction with the MHRC led to greater community buy in for school based mental health services.
Figure 4.3: Abbreviated MHRC Organizational Chart at Sustainability, 2014.

Funding: By the end of the 2013–2014 school year, MHRC was operating under a $16 million budget and was providing services to over 1,000 students. The budget was
reflective of the shift toward greater dependence on SDUSD contracts (70%) and a decreased dependence on County contracts (30%). Services being provided fell into the following categories: 69% outpatient; 17% day treatment; 11% behavioral interventions; and 3% residential treatment.

**Summary:** Scaling of MHRC required new efforts targeted developing new and creative partnerships for increased services and diversified funding, creating new management positions to handle human resource responsibilities, and, expanding training and education efforts for staff and community.

**C. What factors have supported the successful implementation of the Mental Health Resource Center (MHRC) within San Diego Unified School District?**

Four major groups of stakeholders were interviewed, local (LS), state (SS), student (ST) and parent (PT). These stakeholders identified and defined factors needed to implement and sustain school based mental health services and specific contextual elements that led to the sustainability of the MHRC. Responses were coded and themes were organized according to the content, context, and process of the PWM. Appendix D provides a listing of domains, sub-domains, codes and descriptions of codes. When approaching the MHRC as a system, eight factors were identified by this research as critical to the ongoing implementation and sustainability of the MHRC.

1. Establish legitimacy of school as environment for mental health delivery
2. Align education and mental health missions and policies
3. Implement cross systems collaborative approach
4. Utilize data to improve performance and prioritize services
5. Strengthen parent and student involvement

6. Commitment to lead

7. Institutionalize mental health training and education and address stigma

8. Invest in staff

As a system of care model that was implemented over a fifteen-year period, these factors helped build an understanding of key elements of the system and how they contributed to its development. In addition, they were not static but dynamic and changing, which reflects a core attribute of the PWM Systems of Change framework. Findings related to these factors are presented in the sections that follow.

C.1 Establish Legitimacy of School as Environment for Mental Health Delivery

*A school is somewhere you can build the capacity of not only the individual, but collectively you can build the capacity of all students.* SS

Interviews with all four stakeholder groups brought up the necessity of utilizing schools as an environment for the provision of mental health services. Yet, this overall acceptance of schools as a de facto delivery site did not necessarily translate into easy implementation by teachers and administrators. Competing outcomes, lack of resources, training and support, large class sizes, and inconsistent policy were identified as some of the challenges facing district staff with implementing school based mental health.

Regardless of these obstacles, schools were considered as both a viable and feasible site for mental health delivery.

*I don’t think it’s the whole answer, but I also have seen the data. For many kids that is the place where they get their services, and it makes perfect sense. When they go to school they have this person who is their teacher seeing their behavior in a totally different context and able to kind of compare them to other kids.*
think its great place to identify the issues and if it’s done appropriately think it’s a perfect place to have services. SS

The competing paradigms of education and mental health were consistent themes with state and local stakeholders. How to align the two missions and ease the existing tensions was a question that was brought up often, yet with few answers or easy solutions.

_Education is really one of the most difficult systems to break into. It’s not an open system; they don’t like outsiders. The barrier is that schools tend to be a closed environment, unless you have relationships and those take along time. Many times the relationships are based on funding and when the funding is gone they don’t see any need to support you beyond that._ LS

Parents were particularly vocal about the schools being an ideal site for mental health services. Schools were seen as places that elicit trust, provide a convenient point of access and are perceived as being less stigmatizing than going to a clinic to receive mental health services. Both parents and stakeholders brought up this last point repeatedly as one of the principal reasons to consider schools as an ideal site for MH.

_Schools are absolutely an appropriate place for mental health services. It’s the only place kids spend so much time other than spending time with family. I agree with it 100%. There are things that teachers and staff see that I don’t see._ PT

Parents went further and discussed the unique footing that schools hold in a community, as a place of trust and safety. Dealing with an issue as complex and misunderstood as mental health, schools are, in their estimation, the ideal site for access, service delivery, and MH education.

_Why they work is because we've experienced the different atmosphere at the agencies or the government agencies. When you come to schools it’s safe. I think that is the initial feeling that it’s safer there. You don’t have to deal with the same bureaucracy or same people that you experience on the outside._ PT
Notes of caution were also shared as schools look to expanding mental health services. The need to understand the disparate cultural viewpoints regarding MH, the institutional culture and challenges, the particular development phase of the children being served, and the home lives of the students all need to be considered in the development of SBMH. Facing the above challenges, stakeholders were keenly aware of the responsibility to implement mental health services and do it well.

*I think it’s a great place to identify the issues, and if its done appropriately I think it’s a perfect place to have services. Obviously it could be done in a way that could be negative and stigmatizing.* LS

C.2 Align Education and Mental Health Missions and Policies

*Challenging things happen. There is a first line of defense and teachers need to be that.* LS

A tension that was discussed at all among all stakeholders was that of delivering mental health services on school campuses while also while respecting the role of teachers and the mission of education. How this integration of education and mental health missions can be done while changing the current training paradigm of student support services or counseling services, which many times are not MH professionals, was a thread throughout the development of the MHRC.

*So now maybe we can talk about the integration of the whole child into the school environment rather than have it set aside as it is always to student support services.* SS

While the effort to write the SS/HS proposal was led from SDUSD Student Support Services, the MHRC was envisioned as a fully integrated systems of care model that led the district to address the mental health needs of all its students. The role that teachers played in the delivery of mental health services was a question that many of the
stakeholders saw as unanswered and critical to the discussion and implementation of mental health on school campuses.

Some of the major challenges initially is getting the buy in from the teachers. Some of the challenges are getting that piece and the logistics of when students are seen and that mental health staff are there to be an asset to the campus. LS

Parents also discussed the sense of responsibility that they saw teachers having not just in education but also in the holistic development of their child(ren).

I think that teachers are an integral part of that because they are the ones that see the child most of the day and so they need to be part of the plans and also just the regular mental health piece to know when a child needs therapy. PT

Changing educational paradigms was difficult and required the full attention of mental health practitioners and researchers. How to make clear the connection between mental health outcomes and academic outcomes and define what the role mental health plays in the day to day functioning of students were functions that mental health practitioners took on as part of their roles beyond service delivery.

I think that it's helping educators see that our role is bigger today than it ever was, and if we are going to get to the academic outcomes we have got to deal with the basic needs of our kids, the social emotional needs of our kids. It’s just a paradigm shift that takes time and you have to have a platform. SS

While the overwhelming response was for teachers to be more involved, stakeholders were also very cognizant of the need to support teachers in their role as educators. Identifying and integrating creative, innovative, evidence-based methods into the day-to-day teaching environment while developing teachers’ mental health knowledge and awareness was seen as a primary role that mental health practitioners needed to address and lead. Some stakeholders spoke of being guests in their “house” and the need for
mental health practitioners to learn how to be good guests and better understand the unspoken rules.

*Spending time in the classroom and helping the teachers learn how to redirect kids behavior or intervene on a particular situation and just try to make the environment more conducive to kids positive development as opposed to the teachers getting mad or frustrated.* LS

Both parents and stakeholders identified the burdens that teachers face. The current shift to Common Core, the over-sized classrooms, lack of classroom resources, and daily needs of their students were just some of the challenges identified by stakeholders.

*I know a lot of times it's not because they don't want to do it, it's because they are so overloaded with everything. Honestly, I don't think that the school system has enough. I honestly think that there needs to be more.* PT

Teachers spoke of the difficulty they faced balancing academic outcomes with the needs their students clearly bring into the classroom. Instructors mentioned the lack of adequate resources repeatedly as an ongoing frustration.

*Our hands are tied. We have to deal with the academics and we're trying to support kids. In a perfect world we have the resources, enough clinicians, so that the assessments can be done. Mental health is one of those areas. Mental health is more than an immediacy ... in a perfect world we would have access.* LS

### C.3 Implement Cross-Systems Collaborative Approach

*We cannot possibly solve the problems alone. The violence, the abuse, the mental health issues, we can't constantly do it alone. So, how do we all work together?* SS

The MHRC from its inception was developed as a coordinated network of partners that included school based collaboratives, city and school police, County Office of Probation, community based health organizations, and universities. This model has developed over the course of 14 years to respond to the mental health needs of SDUSD’s most vulnerable...
students. The sustainability of the MHRC was due in large part to the strength of the collaboration that was created in response to the SS/HS funding, was nurtured and strengthened throughout the implementation of the MHRC, and continued to grow and find innovative ways of working together.

*I think the promise of school based mental health is how can this model be different than what is. There is this ability to think about it in a more collective way and to do different types of intervention.* SS

Stakeholders shared how the collaborative nature of the MHRC had addressed the friction between education and MH and had helped the two worlds work together in a manner that supports both of their respective missions.

*We all want children to succeed. Whether my emphasis is by teaching math or making sure they have their mental health needs met. You still want the same end result. It is just understanding that we are more alike in our wants of what we are trying to do for our students than we are different.* SS

Parents, while not specifically bringing up the details of the MHRC collaborative efforts, spoke to the need of connecting community resources better with school based resources. They repeatedly brought up their frustration with the lack of connection, awareness, and communication to these services.

*Nobody told me about community services, such as NAMI. I think that is a disservice for the community and families. It keeps people in isolation.* PT

The work of creating a strong collaborative was referenced as something that was not easy to create, nor something that comes naturally to many people. Yet, in a period of budget cutting, new competing education priorities, and fewer support staff on many school campuses, a strong collaborative infrastructure became key to attracting, developing, and sustaining needed services.
What I have seen here is how critical it is to develop partnerships to build capacity, because schools can't do it, they don't have the money they don't have the manpower. I think it's about having the right infrastructure to bring in the supports into a district and I think that is what I see as the most critical piece. SS

As another stakeholder stated it was this collaborative approach that was the seed of innovation that helped lead to sustainability.

Where folks are in schools side by side...MH people, school based, and clinical people - they are really - in a good way - contaminating each other. The education people are talking about IEP and now the MH are sitting in and conversely the education staff is learning about assessment being done in MH and outcome that are different not educational related. LS

The discussion of systems arose with many of the state stakeholders. The questions of building capacity, maintaining institutional priorities, increasing mental health knowledge, and providing community education were seen as factors to long-term change and sustainability.

It really helps to create systems rather than just react to things. We are a pretty well accepted and respected, but I feel like I have to fight all the time to keep us out in front. SS

In addition, an outcome of creating strong cross-systems collaborations was the identification of new and diversified funding streams. As the MHRC evolved, and new funding streams were needed to scale and sustain programs, it was the cross-systems collaborative and relationships that would prove most beneficial in sustaining the MHRC.

We were then faced with the decision, what do we do, do it great and then it's gone or our we going to take the messier route which takes us to whoever's asking for help and wanting to partner? Sustainability is one of our functions. If we don't build these relationships, we won't have the ongoing funding and we'll just be here a short time. So we said yes to everybody and took the messy route. LS
C.4 Utilize Data to Improve Performance and Prioritize Services

We need to look at practices that have been done elsewhere and integrate those to understand what are the best practices and bring them in. SS

The MHRC, from its inception espoused a research orientation and worked alongside CASRC to evaluate program elements and collect and analyze student data. The MHRC nurtured this data driven focus in order to help prioritize and influence future funding sources and program development. Stakeholders attributed the leadership of the MHRC as one of the principal reasons for this focus:

One of the most amazing things that come from her (MHRC Program Manager) experience and her leadership at the County is that she was very open to research being conducted in the schools and that's not always been my experience as a researcher going into schools. LS

The openness to research was a key attribute that other stakeholders referenced as a driver to help shift the paradigm of school mental health in San Diego. The theme of “better data, more data” was mentioned repeatedly - yet how to define and collect the data was not clear. How to capture the impact of mental health services on academic and development outcomes was still unclear and in need of further inquiry and guidance.

I think we need to continue to provide better data. I think this thinking is still somewhat new. I think data is really going inform our practice, especially around mental health. LS

An infrastructure challenge that continued to evolve with the development of the MHRC was creating databases that were able to capture both academic and mental health outcomes while being flexible enough to address the needs of multiple funding sources. A further challenge was related to staff capacity to strategically ask the right questions
and collect the right data to inform future program development, and improve on program efficacy.

*Teachers have these students who have a lot of needs and in the classrooms they get so immersed in service provision that they're not necessarily collecting the outcome data, with as much consistency and then reviewing it and using it to tailor services. LS*

Funding of these evaluation systems also remained a challenge. While the SS/HS provided initial funding for a broad and robust evaluation, this effort was difficult to maintain at the original scope. Regardless, the MHRC maintained the ideal of an outcome focused delivery system and led these efforts. Whether an evaluation infrastructure can be simultaneously sustained was a question that remained unanswered.

*You need a sponsor within the district to do research in the district... a conduit between the research community and SDUSD. That’s a strength of the MHRC. LS*

**C.5 Strengthen Parent and Student Involvement**

*I was in denial I just thought she was bad and acting up. There were signs back then that there was something wrong with my daughter. I wish I could have known how to deal with her better. PT*

A wide range of responses was collected from parents and students as to their involvement and satisfaction with school based mental health services and the MHRC. A common thread among all parents was their lack of understanding of mental health and the process to access services.

*Its been really challenging to get the kind of help and support because its not as evident in the school setting, but it affects the school setting with everything that happens at home. We have been working with teachers and just doing everything that we can. I have found that the support has been really outstanding, I wish that we had come to this conclusion earlier it would have made a lot of difference in the past several years, but we are here now. PT*
Parents and students shared a wide range of experiences. These run the full spectrum, from satisfaction with the MHRC:

So far they have been doing an excellent job for me. They’ve been very supportive. I’ve gotten nothing but cooperation and positive feedback from the school. We are making it because of the support that we’ve been getting. PT

They had me counseling and stuff, they provided the best services I could possibly get and mom was thrilled to have it. I was very happy to be there. I went from a very uncomfortable situation to like almost family. ST

To a sense of failure on the part of the MHRC:

I look back and have trouble not crying. We were just fought every step of the way. And for people who are very kind and caring. Whether they were not aware of what they were doing or they had some sort of outlook that they were supposed to bar the door because resources were so tight. PT

The way that they speak to me, I don’t like that at all. They talk down at you as you are less or not smart. I get why I’m here. I’m not here because of my academics. ST

Time was another element that was consistently brought up by parents: the time to get an IEP, the time to get services, the time to find out about a placement, the time it took to get a diagnosis.

As a parent, so desperately needing help I’m just waiting. If I’m not being told what the plan is, it leaves me in a place of anxiety. It was difficult. PT

Some parents strongly recommended a guide, a primer, or some sort of simple, easily accessible tutorial of what to expect and do. The parent was left to connect the dots and many felt alone in their quest to get services for their child. They added that there should also be a mechanism for parents to share early in the school registration process any mental health concerns that they saw at home as a way of helping alert teachers and staff.

It was really hard to find anything out about SDUSD, maybe a paragraph I was desperate for information. I didn’t know where it was. I think the more
transparent the information is and communication is the better the services would be and the better the families would be. PT

Other parents spoke of the need to become as informed as possible, and if necessary involve a professional advocate to attend IEPs. The advocate was seen as someone who could help the parent better understand the policy options and service options available for their child and advocate on their behalf. For some this was seen as the only way to access services for their child.

*Go and do the research. You have to be armed with knowledge. Hire an advocate so that you know what all the other resources are out there. You have to find it out on your own.* PT

Stakeholders echoed the need for greater awareness, education, and supports for families. Families with limited English skills and low education were identified as in need of targeted support as they were most likely to encounter barriers to access.

*But the parents who are uneducated don't know how to navigate the system, don't understand mental health, those are the kids are falling through the cracks. In my opinion, they are the kids that need it the most.* LS

Peer support was brought up as another need by every parent. Whether school-based parent groups, better connections with community based organizations, or networking with other mental health professionals – the need to know what was out there, who has gone through similar experiences, and what resources and knowledge were available was identified as an underdeveloped area by the MHRC.

*There is no process or support around putting parents together. In my experience, having a peer group or having peer relations with other parents that are struggling with the same issues is life saving, it really is.* PT

Stakeholders also shared the challenge of involving parents and family members with their child’s mental health needs, while also supporting their academic outcomes. One
stakeholder spoke of the backpack as a metaphor for what the child brings to school and the overwhelming obstacles many teachers face on a daily basis.

*What do they bring to school in their backpack? It ain’t their homework. It’s the fact that they didn’t have dinner last night, it’s the fact that there is violence in their community, and their parent never came home, or their dad was in jail and the list goes on and on.* SS

Stakeholders and parents shared the need to involve not just the parent but also the student more fully in their care. How to do this was a question that staff in particular raised and struggled with, yet also identified as critical in the discussion.

*You want the professionals, you want the people that want the expertise. However, the people that are always in my opinion that almost always get left out, are the students themselves. I feel that they know. Ask them, involve them.* SS

Students echoed many of these discussion points in their interviews and repeatedly asked that their voice be given more credence in how mental health services are delivered. They acknowledged their need for services, yet also discussed how they felt as something that needed to be treated rather than someone who needs to be engaged.

*The staff need to listen to me a little bit more. Sometimes they get angry a lot. When I try to tell them something they don’t listen to it. They don’t listen enough.* ST

C.6  **Commitment to Lead**

*That’s why I feel like the opportunity is now with mental health and the window may shut. But now is the time to take advantage of those relationships and those opportunities.* SS

A common theme that emerged from all state and local stakeholders was that leadership and a shared commitment of values and mission were critical to the sustaining of any MH effort. One stakeholder commented,

*When you let go of the egos and let go of the territorial stuff and you realize that you can’t fix it alone and there’s no way I should even try to. But I need to engage*
my partners, together we can, we can have the collective impact. We’re trying to implement those issues and implement the practice of collective impact. LS

Stakeholders involved at the local level referenced the leadership and knowledge of the Program Manager as key to the sustainability of the MHRC. As someone who was hired with experience at the county level on mental health program development in terms of contracts and budgets, the Project Manager came to the MHRC with an eye toward sustainability and developing new partnerships in tandem with current funding priorities. Stakeholders often characterized her leadership as strong, insightful, respectful and inclusive. These traits helped bring together a variety of community members and policy makers in order to lead the many district and county-wide discussions regarding mental health. Stakeholders at the state level validated that this prior knowledge and expertise was an important asset in sustaining MH programs.

I really believe that you need a district person who can navigate the waters internally as well as externally while building these different sites and these different resources in the district. SS

These pre-existing partnerships and relationships also opened up new collaborative efforts and the possibility of finding new funding streams to address needed mental health services. The MHRC Manager worked with Special Education, County Probation Office and County Mental Health in creating new programs and sustaining MHRC efforts. Stakeholders discussed the importance of sustaining partnerships in tandem with sustaining programs as an activity that strong leaders do well.

Because I’ve seen so many projects that they get the funding and what changes? What was your legacy? What will you leave? ...What am I going to do beyond the dollars? The relationships that have been maintained and sustained are going to last way beyond these dollars. I think we're making really positive change and sustain these programs. SS
Over the 15-year implementation period, The MHRC has invested and developed the capacity of current and future leaders through extensive mentoring and training. These future leaders also embraced the values and principles of a system of care and were extremely knowledgeable about the structures and processes of all partners involved in the MHRC. The MHRC recognized the importance of starting this process early before leadership change occurs and finding individuals with the passion to lead and continue the expansion and sustainability of the MHRC.

*If you have individuals that have a passion for MH, make that opening and keep creating a greater wedge to open it, that’s what you get. Otherwise kids are not getting served until they are at the high end. Who is going to tell you have to do that? No one. SS*

### C.7 Integrate MH Training, Education, and Address Stigma

*We still address mental illness, as that is what the person is. Rather than that is something they have. That would be fabulous if we could change that. PT*

There was a consensus that schools were an ideal site for mental health services; however, the role of teachers and other education staff was still very much up for debate. The role of a teacher and his/her role in identifying mental health needs among their students was an ongoing discussion among stakeholders.

*Supporting teachers is really about helping them understand that the behaviors they may see are not against the teacher. Lots of time they personalize it and its seen as “we just want them out of the class” “it’s a behavior issue, we need to get rid of them” rather than saying “there is something going on in between and we need to get to the core of that” … I think that teachers need to know that there are supports out there. LS*

Stakeholders, in particular teachers, brought up the need for more education across the school site on mental health topics. While there was an awareness of key issues such as
bullying, teen suicide, and school shootings, they also shared that there was also a lack of a deeper understanding of mental health conditions and how to identify and support students in need.

*With recent tragedies, people all of a sudden want to talk about it, even in education. There was always fighting in education for how do you link it to academic achievement. I think now there's a recognition socially emotional well-being of students… it's more on the forefront and mental health is being part of that.* SS

They also shared that there still was a general perception that these larger mental health issues, such as violence and suicide, would not happen and/or that it was really not that bad at their school site. These statements emphasized the need for more training in areas that may help teachers and school site staff better identify and be more aware of warning signs. Current training efforts were seen as directed to or perceived to be only available to special education instructors, and that teaching staff were not consistently going through training every year. Overall, stakeholders emphasized the need for more training and teacher supports to help address mental health and socio-emotional needs on school campuses.

*Training is a huge component. Understanding that there are behavior issues and then there are other factors that may impact behavior and being taught to understand that. I see teachers being respectful of the social emotional well-being of the child as being part of the whole picture and not being so punitive in terms of behaviors and having alternative behavior responses.* LS

Another major point that stakeholders discussed was the stigma of mental health, and how it impacted teacher, parent, and community responses to mental health. The specifics of cultural competency not just in term of race and ethnicity but also language, nationality, sexual identity, economics were brought up. As a large urban school district,
students represent a continuum of socio-economic backgrounds. Regardless of these differences, both students, whether from a well-educated middle class family or from a recently immigrated poor family, were each facing mental health challenges that were specific to their contexts. How well school and MHRC staff were trained in the cultural factors that may impede or help service delivery is an area that required ongoing focus.

There is always the stigma that you find throughout the public especially with special needs. Educators, I would think that there might be more knowledge, but there really isn’t. The same biases and of course having to work in a society that again has stigma towards mental health, it is very difficult. LS

C.8 Invest in Staff

Teamwork is always emphasized. If you feel overwhelmed, ask for help, there's always someone who can help you. We’re all a team. That's always the message. LS

A consistent message from all stakeholders was the organizational commitment to recruit, hire and train the best staff for the jobs available at the MHRC. The early implementation success was due in large part to the MHRC leadership identifying and recruiting the staff that aligned with the mental health needs of students targeted by the MHRC. Many of the early activities during the adoption and installation phases were focused on creating new job cards, recruiting staff that responded to the cultural, linguistic, and socio-emotional needs of the students and families, and developing training and support systems for the new staff.

I think that selection makes a huge difference with the quality we had to begin with. We also offer consistent trainings ... While this ongoing training and support has helped, I think the initial recruitment was one of our biggest strengths. LS

The MHRC made a large investment in the recruitment, training, mentoring, and coaching of staff along the entire continuum of staffing positions. Staff worked alongside
each other to learn and understand each other’s scope of work and benefited from each other’s training and expertise. In order to support sustainability efforts, a component of staff training was to have the lead clinicians trained on grant writing and help in the proposal writing and submission process. This created an atmosphere among MHRC senior management of ownership with programs and a deeper understanding of the program elements, especially reporting, evaluation and outcomes.

"I think that regarding funding one of the really innovative things that the MHRC did, was to have all of the lead clinicians write grants. I think that that did a tremendous amount for bringing them together and bringing awareness to what they do. We just can’t do service provision or what do we do when funding runs out? What you do is you have service provision plus continuing to write for new monies to keep things going. LS"

The MHRC was able to retain staff and create a motivated and committed workforce.

Many of the key staff that were hired during the first two phases of the implementation of the MHRC were still working during it sustainability phase. Ongoing training and development of competencies in the growing mental health field and working with educators and administrators on how to support each other have led to stronger ties and relationships between the two fields and growing requests from school sites for more services. This need has allowed the MHRC to leverage partnerships to write new grants and sustain funding streams.

"The schools that we've been in for more years, you can see the difference in how many kids who serve there. They've used us for so long, they know what they bring and they utilize it a lot. LS"

This growing acceptance and availability of MHRC services also created an aware and knowledgeable education community that wanted to see more general and universal efforts across the SDUSD. The original SS/HS grant provided funding to implement
prevention-focused programs such as *Second Step*; however, when funding ended these programs also ended. MHRC shifted toward reimbursable services to expand and sustain services. This also caused a shift toward mostly working with students high need, vulnerable student populations who received reimbursable services.

*So what about these other kids, that kid who just need someone to talk to because they have a really rough day at home, and they have no one to talk to at school and their counselor can’t do it because they have 20 other kids waiting to see him in the lobby for something.* LS

As the MHRC begins its next cycle of organization change and growth, it is now back full circle incorporating and expanding on early prevention elements efforts through existing partnerships while sustaining reimbursable services. This adaptability and fluidity of response to student and district needs has been hallmark of the MHRC’s

**D. Strengths and Limitations of Case**

This case study was one of few that provides an in-depth examination of how a large education system, SDUSD, implemented and sustained school based mental health services while facing extremely fluid human, financial, and physical resource constraints and opportunities. The PWM Systems of Change framework, undergirded by a strong implementation framework, allowed the researcher to analyze implementation drivers and factors most important in facilitating or hindering implementation and sustainability of the MHRC. Findings provided useful insight into a model of service of care and conditions that may increase the likelihood of surmounting common implementation and organizational challenges.

The limits of this case are its focus on a single case. The unique conditions that existed in San Diego limit the ability to apply some of the findings to other sites.
However, because the themes found in this research are similar to those found in the broader implementation and organizational literature, the insights gleaned from this study may generalize to the implementation of other school-based efforts. The sample also was a limitation of the case. While the researcher attempted to reach out to as many stakeholders and family members as possible, he was also restrained by time and resource limitations. More student, parent, and stakeholder interviews could have provided alternative perspectives to those captured by the current research sample.

E. Summary

Although common challenges exist among all school sites attempting to establish school-based mental health services, much of the research has focused on the implementation of individual evidence-based programs rather than a systems approach. Compounding this need is the lack of focus on the stages of innovation and sustainability during implementation. The MHRC provided a unique case to study the facilitators and challenges covering a 15-year period of implementation.

Key factors that facilitated the sustainability of the MHRC were leadership, parent and student involvement, a strong collaborative approach, an investment in staff development, and community training and education. Lack of mental health knowledge, funding, managing growth, scaling programs, database challenges, and inconsistent evaluation efforts were barriers that the MHRC faced throughout its implementation. The ability of the MHRC to adapt, respond, and lead while facing these barriers and drivers was a core organizational trait that allowed the MHRC to sustain itself for over 15 years as a school-based system of care model. To further contextualize the findings of this case
study, two student case studies are included. Both student case studies illustrate the difficult years of adolescence, the importance of transition points along their development, and the role of school and community in improving their education and mental health outcomes.

Implications of these findings will be discussed in more detail in Chapter 5. Recommendations and lessons learned from the MHRC will also be provided to the education and mental health communities on how to implement and sustain school based mental health services. A White Paper is included in the Appendix that provides recommendations based on findings from the case for SDUSD as it embarks on the next phase of its organizational growth with mental health services.

Student Case 1

**Jessica** is a 16-year old female attending a SDUSD Charter High School. She receives special education support as a student with an Individualized Education Plan (IEP) and receives mental health services under the category of Autism due to a history of social, behavioral, and communication concerns. She was first assessed and qualified for an IEP in 6th grade after receiving a formal diagnosis of Asperger’s Syndrome.

Teachers describe Jessica as shy, withdrawn and introverted and generally unhappy at school. Academically she excels in her classes and is described as careful, meticulous, highly organized and persistent. Transitions have been difficult for Jessica: elementary to middle and then middle to high school. The transition to a traditional high school proved to be particularly difficult as a schedule with six different teachers and periods challenged her ability to self-regulate. As part of her IEP she was recommended to continue receiving Mental Health Related Services (MHRS) to address her social emotional goals in order to improve her education plan outcomes. During her sophomore year she was revaluated and multiple IEP meetings were held. She continued to qualify for an IEP under Autism category.

Jessica’s parents initiated the IEP in 6th grade. Parents shared that while they knew their daughter was having mental health difficulties, especially social and emotional management, they didn’t know what to do. In seeking help they initially did what they
were told. They were unaware of neighborhood resources and what services Jessica qualified for with her diagnosis. They visited special education classrooms and commented that what they saw were students with physical disabilities. As she tested well and overall was doing well academically, she was recommended to go to a STARS program. They didn’t know what that meant and their STARS school site visits did not go well. As a traditional diploma bound student, lack of flexibility and access to supports continued to be an issue. Parents felt throughout the process that were not being informed in timely and proper manner and hopelessly watched their daughter progressively worsen. They hired an advocate who helped as they were beginning to feel that “30 days turns into six months.” Parents declined the referral to STARS and sought out a school that would allow Jessica to pursue her diploma in a more specialized setting.

Jessica is now attending a SDUSD charter school with small classrooms and high teacher student ratio. She continues to receive services under her IEP, including a Positive Behavior Support Plan. She shares that “the staff listen to me a little bit more.” She is doing better academically, identifies that she can do better, and is on track as a traditional bound diploma student.

Jessica’s case illustrates a number of factors critical to the sustainability of the MHRC. First, the need to align education and mental health outcomes and policies. Second, the importance of strengthening parent involvement. According to Jessica’s parents, she was externalizing some of her emotional behavioral issues as early as the third grade. Yet, her parents felt lost and didn’t know what to do. Academically Jessica was doing well. Only until the EBD impairments became more significant did they request an IEP. The need to hire a professional advocate, further exemplifies the lack of power that the parents felt in trying to access the correct services for their child. The perceived lack of teacher involvement or awareness brings up the third factor, the need to institutionalize ongoing mental health training and address mental health stigma. Jessica’s parents shared their frustration of not being heard or understood when describing Jessica’s mental health needs. Finally, Jessica’s case encapsulates the primary role that school’s play in the access of MH services. SDUSD and MHRC were the primary venues for mental health services for Jessica. The MHRC’s ability to scale services and expand across the SDUSD allowed for appropriate placement of Jessica in a nurturing and appropriate academic setting while also receiving ongoing therapeutic service with the MHRS Team.

Student Case 2

Devon is a 17-year-old male attending a Day Treatment Outpatient Program at SDUSD. Family issues that have involved Child Welfare Services have placed Devon in the
uneasy situation of needing to be split between living with his mother and father. He has a long history of behavior and mental health issues at school and at home.

Devon was first referred to student support services (SST) in Kindergarten due to disruptive behavior and frequent complaints from staff and students. He was then referred for SST services again in 4th grade due to mental health concerns. Parents describe Devon’s relationship as highly stressful and very conflictive. Parents at this time were unsure of what was happening with Devon and described him as emotionally disturbed. He received his initial IEP in 5th grade. Teachers described Devon as very intelligent, smart and imaginative. But also demonstrating frequent loss of self-control, disruption and poor peer relations. He met eligibility criteria under IDEA as a student with Emotional Disturbance due to his anxiety, pervasive unhappy mood, and depression.

He moved out of state for 8th and 9th grades, which cause a disruption in his services and supports. He retuned for high school and began attending a traditional diploma track high school in San Diego. These were very difficult transitions for Devon. He was assessed for a new IEP during the 9th grade, as he was failing all his classes and had frequent emergency psychiatric hospitalizations. He was recommended for Mental Health Related Services (MHRS), including group counseling, and placement at the outpatient level of care. He was enrolled in New Dawn.

Parents speak of Devon as “really smart. He just has emotional issues.” Outpatient placement at New Dawn has been seen as a lifesafer for Devon and his parents. “He’s been improving now because he’s at New Dawn and it’s a proper placement for him because it’s a school with therapeutic services. New Dawn School is tailored to him and his needs. I’ve gotten nothing but cooperation and positive feedback to the school. I think that it’s a very good decision.” At New Dawn Devon has been seen as making excellent progress in both academics and behavior. Devon shared that he is “developing a more mature mindset because I am starting to look at stuff really differently from how I would have looked at it say a year, or two years ago.” He continues to receive therapeutic and psychiatric services and is on track to graduate. He plans to attend community college and pursue a computer sciences certificate.

Devon’s case illustrates the need of implementing a cross systems collaborative approach. SDUSD was the unifying element with Devon as he was involved in multiple services and public agencies. The critical importance of each of these agencies communicating with other and their involvement in his IEP assisted in Devon receiving more appropriate services. The early SS/HS focus on finding alternative services for at risk students like Devon, and the leadership position that the MHRC built through it implementation and sustainability phases led to the opening of New Dawn and Outpatient services. These education and mental health services became sustainable alternatives to expulsion or expensive residential treatment. Devon’s case also emphasizes the need for parent and student education and engagement. While Devon’s parents were as involved as possible, they were not knowledgeable enough to understand Devon’s mental health
needs or how to advocate on his behalf. Stronger community ties to other mental health advocacy agencies and basic MH education could have helped greatly in this case.

**Note:** Names and elements of each case have been changed to protect the privacy and confidentiality of each student and family.
Chapter 5: DISCUSSION, RECOMMENDATIONS, AND CONCLUSION

The purpose of this case study was to examine the contextual and organizational factors that impact implementation and sustainability of school based mental health services. Using a qualitative research framework, interviews were conducted with 15 local and state stakeholders and 15 student and parent dyads of students receiving mental health services through San Diego Unified School Districts’ Mental Health Resource Center (MHRC). Relevant documents and archival records were also collected. The data was analyzed and major findings were presented in Chapter 4. This chapter discusses the findings of this study and their implications for implementing and sustaining school-based mental health services in other settings. The chapter concludes with program and policy recommendations and suggestions for further research.

A. Discussion

Given the importance of schools as a critical environment for improving access to mental health services for children, this case study provided a retrospective narrative of the implementation of the MHRC and also identified key factors that facilitated or hindered implementation of school based mental health services. To answer the two research questions: 1) How has the MHRC evolved and sustained itself as a service of care model in response to financial, human resource, and community constraints and opportunities? and, 2) What factors have supported the successful implementation of the Mental Health Resource Center (MHRC) within San Diego Unified School District? The researcher utilized the Pettigrew and Whipp Model of Strategic Change as the theoretical foundation and emphasized the importance of considering factors across the outer and
inner contexts, process and content domains. (21) Fixen’s Implementation Continuum Framework, which describes six implementation phases: exploration and adoption, installation, initial implementation, full operation and sustainment, was used to organize data and identify facilitators and barriers to the development of a strategic climate for MHRC implementation. (86) Miles and Huberman’s Time Analysis provided a chronological organization to the data and findings. (114)

A number of important facilitating factors, as well as barriers were identified and categorized according to the theoretical PWM framework. Table 5.1 provides an overview of these main factors. While certain facilitators and barriers were more prominent in certain phases, many were fluid across phases and reflected the dynamism of the PWM Model of Change.

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<th>PWM</th>
<th>Barriers</th>
<th>Facilitators</th>
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<td><strong>Context</strong></td>
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<td>Internal</td>
<td>MH Awareness and Knowledge</td>
<td>Leadership</td>
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<td>Structural resources</td>
<td>Research and Outcomes focus</td>
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<td>Trust among staff</td>
<td>MH Champions</td>
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<td>External</td>
<td>MH Awareness and Knowledge</td>
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<td>Family Engagement and Education</td>
<td>MH Policies (AB 2726, Prop 63, AB 114)</td>
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<td><strong>Content</strong></td>
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<td>Lack of Policies aligned with MH needs</td>
<td>MH Mission and Vision</td>
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<td>Referral and Intake systems</td>
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<td>Funding</td>
<td>Expansion of MH treatment and prevention teams</td>
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<td>IT &amp; Data Collection Systems</td>
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<td>Management capacity and supervision</td>
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B. Three Major Periods of Organizational Development

Three periods of implementation were identified: 1) planning and early implementation; 2) growth and innovation; and, 3) sustainability and institutionalization. Utilizing the PWM framework, how the MHRC changed, adopted new innovations, and improved inter-organizational interaction and sustainability were examined. (123, 124)

B.1 Planning and Early Implementation (1999–2004)

This period includes the implementation phases of *exploration and adoption*, *installation* and *early implementation*. Three broad areas appear to be especially important in the early stage of an organization’s implementation: 1) absorptive capacity, 2) readiness for change; and, 3) receptive context. (94, 125)

1. **Absorptive capacity** refers to an organization’s preexisting knowledge/skills, ability to use new knowledge, specialization, and mechanisms to support knowledge sharing. Organizations that start with good knowledge/skills are highly specialized. Such organizations can incorporate new knowledge, have mechanisms in place to spread knowledge throughout the organization, are much more likely to explore evidence-based programs (EBPs), and eventually initiate them. (125-127) While lacking a cohesive district-wide mental health strategy, SDUSD, due in large part to it’s preexisting mental health efforts along with its mission and standing in the community, was primed to undertake the implementation of the MHRC.

By 2001, SDUSD had already undertaken substantial efforts to address mental health needs, specifically targeting school based violence and high expulsion and suspension rates. Considerable information and data was available that allowed SDUSD to promote
the exploration and eventual adoption of the MHRC. The planning, writing, and submission of the Safe Schools/Healthy Students grant and its subsequent implementation were the principal activities during this period. A broad based collaborative planning process was initiated that included SDUSD staff, County of San Diego Health and Human Services Agency, Healthy Start Collaboratives, School and City Police; and other community-based student focused organizations and partners.

The identification and implementation of evidence-based programs (EBPs) was another defining activity during this period. A group of EBPs, that included, Second Step, The Incredible Years, and Multisystemic Therapy (MST), was selected and implemented across the targeted SS/HS schools sites. Recruitment and hiring of well-trained and culturally competent mental health staff was another focus of the MHRC to increase its specialization in mental health service delivery. Finally, the critical role of data collection and analysis became more central to the activities of the MHRC. Reporting requirements for the funder, along with the need to begin prioritizing sustainable programs and efforts post-SS/HS funding were begun.

2. Readiness for Change relates to the steps that an organization takes to assess and anticipate the impact of the innovation. Readiness is a marker to determine the ability of organizations to undergo needed change in order to sustain the effort. (124) Readiness would be an ongoing theme across each implementation phase. The SDUSD was already situated with a strong collaborative structure and a clear vision of how to move forward with the MHRC and the implementation of mental health services in the school district.

Studies of organizational readiness to change identify both process and structural
variables. (128) Process factors, such as organizational culture, climate and individual attitudes toward innovation, are key factors in the ability of a system to undertake change. SDUSD leadership in the planning and submission of the SS/HS grant and mental health service reorganization demonstrated its readiness for change. Implementation science research has identified the development of an implementation team that is charged with providing guidance through full implementation of the program as critical to successful installation. (86, 129) The SDUSD with the SS/HS Advisory Board helped with the identification and establishment of a core group that included the new MHRC Director, the lead clinicians, the evaluation leads, and the middle school Healthy Start Coordinators. This group of organizational and community leaders was instrumental in early implementation efforts increasing awareness and improving school climate and culture toward mental health.

Structural challenges became more evident in the initial implementation phase. The need to create new databases, education intake forms, training infrastructure were necessary to capture mental health outcomes on school campuses. The Center for Adolescent Services and Research Center (CASRC) was contracted to evaluate the program. The Center provided guidance related to the development of reporting systems and outcomes measures. The climate for implementing mental health and effective data capture systems were areas of growth for SDUSD. This was due in large part due to the lack of knowledge and understanding of mental health issues and their connection to educational outcomes.

In this initial period, four structural supports were identified as key to the
implementation and sustainability: 1) developing human resources protocols and program policies; 2) establishing an evaluation plan and creating necessary data collection systems: 3) creating appropriate and seamless referral system across school sites and programs; and, 4) receiving certification as an Early Periodic Screening Diagnostic and Treatment (EPSDT) provider. EPSDT designation allowed the school district to bill the state of California for MediCal reimbursement of covered services and was critical to the financial viability of the MHRC.

3. Receptive capacity incorporates factors that reflect the ability of an organization to embrace new ideas and face the prospect of change. While SDUSD and the MHRC had strong leadership, strategic vision, and good management and staff at the outset of the project, these strengths were developed further during this period. In addition, many of the key stakeholders were already aligned with the mission of the SS/HS grant along with the focused mental health vision of the SDUSD. Continuous training, open communication, and consistent on site school presence allowed for the building of trust among MHRC and SDUSD staff, in particular teachers, to implement EBPs and other MHRC efforts.

Leadership at all pertinent levels, from the MHRC director to the lead clinician to the SDUSD Student Services Director, combined with organizational support, promoted positive climate, attitudes, and the receptive capacity for change and implementation that led the implementation of the MHRC. Leadership, which was a facilitator across all phases, was a crucial variable in both creating the organizational culture and climate conducive to adoption of service innovations and in taking ownership of the process of
advancing a specific innovative practice. (123, 130, 131) Without an internal organizational champion, the probability that a practice can move past the exploration and adoption phases and into other implementation phases is likely to be lower. The strong leadership role from the director of SDUSD’s Student Support Services Department coupled with a clear vision and a strong collaborative spirit were key to early adoption and creating forward momentum. The Healthy Start Coordinators were also strong advocates and community champions behind the effort to implement the MHRC. The hiring of a respected and experienced manager for the MHRC also increased the receptive capacity of the MHRC and SDUSD’s efforts across the district and into the community.

As the MHRC began to grow beyond the early SS/HS goals, a key barrier that continued into the full operation phase was the lack of alignment between MH and education outcomes. This lack of alignment hampered the early implementation of data collection systems for the SS/HS grant.


This period covered the implementation phases of full operation and innovation, faced increased demand for services and expansion of efforts beyond treatment and referrals. In response, the MHRC was involved in three main activities: 1) increasing MHRC and school site staff training and education; 2) strengthening partnerships and increased funding streams; and, 3) improving efficiency of intake and referral processes across the district.

As a three-year funded project through SS/HS, the MHRC aimed to be both fully
operational and ready to sustain by end of year three. This quick timeline in many ways influenced the capacity of SDUSD to move through the three early phases of implementation in quick succession while moving toward full operation. A two-year funding extension was granted at the end of year three, which allowed the MHRC to continue with key programming, evaluation and sustainability planning. During this period the MHRC was busy streamlining intake and referral processes, increasing education and training efforts and improving engagement with parent and community members.

Barriers that the MHRC faced during this phase were the ongoing need for outcome data and IT support. These activities were provided by CASRC, whose role ended with the end of the funding cycle. The close work with CASRC from the early planning to full implementation underscored the importance of academic collaboration that successfully helped translate and implement findings. CASRC, as a consortium of over 100 investigators, representing Rady’s Children’s Hospital, University of California San Diego, and San Diego State University among others, focused on improving publicly funded mental health service delivery and quality of health. Partnerships between SDUSD and CASRC researchers continued post-funding; however, their involvement was limited and affected efforts to prioritize programs for sustainability and address deficits in programming.

Externally, a major policy change at the state and local level had long lasting implications on MH service delivery in California. In 2004 The California Mental Health Services Act (Proposition 63) was passed. The Mental Health Services Act (MHSA)
money was to be used by county mental health departments to provide new and innovative mental health services with a more recovery and consumer-driven focus.

MHSA divided this tax revenue into five main funding categories: Community Services and Supports, Workforce, Education and Training, Capital Facilities and Information Technology, Prevention and Early Intervention, and Innovation. (132) During the early implementation of the MHSA, the MHRC did not see major funding increases. However, the MHSA began a statewide dialogue on mental health that influenced innovative strategies and new thinking which directly impacted the future sustainability of the MHRC.

As the MHRC ended its SS/HS funding, a number of factors pushed the MHRC to assess its future activities – a core attribute of innovation. The passage of the MHSA, the designation of the MHRC as an EPSDT site, the increased demand for treatment and preventive services, and growing mental health infrastructure and staffing at SDUSD required a reassessment of MHRC’s trajectory. One outgrowth of this period was the establishment of the Mental Health Intervention Team (MHIT). The MHIT is a collaborative service delivery model using school-based mental health teams to implement evidence-based interventions to promote positive social adjustment for youth with emotional and behavioral disorders (EBD) and their families as well as support classroom teachers. MHIT personnel were assigned at all traditional elementary and middle school sites to work collaboratively with administrators, teachers, school psychologists, families and students.
B.3 Sustainability and Institutionalization (2010–2014)

Sustainability is a desired outcome of effective implementation; yet there has been little empirical work completed in this area. A comprehensive guiding conceptual model of sustainability does not exist. (133) The likelihood of sustainability is heightened when there is an alignment, compatibility, or convergence of: 1) problem recognition in the external organizational environment or community; 2) the program in question; and, 3) internal organizational objectives and capacities. (134, 135)

Sustainability was identified as a key leadership outcome of the MHRC from the early exploration and adoption phases. The MHRC leadership focused internally and externally on the future of the MHRC. The leadership leveraged partnerships, policy, and funding in order to continue, improve, and expand on services as needed. Principal activities during this period included: 1) expanding MH training and support for staff, teachers and administrators; 2) increasing family/parent engagement in MHRC development and services; 3) training and coaching of staff in grant writing and funding solicitation; 4) improving data collection and outcomes for continuous improvement and problem-solving; and, 5) diversifying and sustaining funding streams. During this time, the MHRC became more integrated into the daily fabric of the SDUSD. The sustained effort, the outcomes focus, the improved changes in mental health delivery, and the overall satisfaction with the MHRC led to greater community buy-in for school based mental health services.

Two barriers became critical to respond to during sustainability: staff retention and funding. Staff retention and replacement must be considered and planned for in all phases
of implementation; however, this concern becomes critical when considering sustainability. The schools had standard hiring procedures for education-based jobs; they were not geared to the needs of implementing mental health services. To address this the MHRC Manager worked closely to develop appropriate job descriptions and create recruitment and hiring process that would select for the best candidates. Recruitment and selection were geared toward sustainability and developing a culturally competent workforce for SDUSD students.

Another key factor in the sustainability is ongoing financial support. Sustainability planning models suggest that implementing agencies and schools should discuss the financial future of interventions early in the implementation process, and that this type of planning is highly related to community/agency/school support of the intervention and perceived need for the intervention. (63, 136, 137) Two key outcomes of the MHRC implementation supported its programmatic and financial sustainability: sharing leadership and ownership and improving school climate. SDUSD worked intensively with partners over the case period to bridge organizational divides and access funding streams in order to bring services to students at most risk. School climate improvements, through ongoing education, awareness, and training, continued to be a foundation for enriching structure, communication, and standards necessary for implementing mental health programming.

A second state-wide policy change had a major impact on the growth, innovation and sustainability of the MHRC. The California Legislature passed Assembly Bill 114 (AB 2726) on January 1, 2012, which shifted educationally related mental health service
obligations from counties to lead education agencies (LEAs) which were obligated to provide educationally related mental health services to eligible special education students who require such services to benefit from their educational program. SDUSD utilized the MHRC as the umbrella for responding to this law change. At this time the Mental Health Related Services (MHRS) Program was established under the auspices of the MHRC and tasked with developing and coordinating implementation of school wide procedures related to mental health assessment and service delivery. The MHRS was itself a direct response to the increasing need for expanded services and echoed themes that have been highlighted in past studies, such as support from administrators and other staff, implementation support and consultation, availability of resources and perceptions about the intervention itself. (86, 94, 138)

This case study examined implementation as a series of phases that were impacted by contextual and process facilitators and barriers as described in the PWM across the implementation continuum. Based on the outcomes of the case analysis the researcher was then able to move from how the MHRC was implemented to answer the second research question to determine what are the key factors that helped sustain the MHRC.

C. Factors Critical to Implementation and Sustainability

The findings of this case established eight factors critical to the implementation and sustainability of the MHRC: 1) establish legitimacy of school as environment for mental health delivery; 2) align education and mental health missions and policies; 3) implement cross systems collaborative approach; 4) utilize data to improve performance and prioritize services; 5) strengthen parent and student involvement; 6) commitment to lead;
7) institutionalize mental health training and education; and 8) invest in staff.

C.1 Establish Legitimacy of School as Environment for Mental Health Delivery

Schools are increasingly identified as appropriate environments for the development of mental wellness and addressing the mental health needs of young people. There is growing recognition that enhancing children’s social and emotional competencies also facilitates their ability to learn and achieve academically. (69, 104) A strong theoretical foundation in program and policy exists and is highly informed by the work over the last two decades by Adelman et al at UCLA’s School Mental Health Project (SMHP) and Flaherty and Weist et al. at the University of Maryland’s Center for School Mental Health (CSMH). (139-141) In addition, the US Department of Education, the Institute of Medicine, the National Research Council, along with professional organizations representing pediatrics, psychology and nursing have all issued policy reports supporting school based mental health services. (12, 13, 54)

At a program level, assessments of school based mental health services and programs show a variety of positive effects, including improved access to care, enhanced preventive services, increased early problem identification, and decreased stigma and provision of services in a more natural setting. (9, 142) However, despite their growth in recent years school mental health programs and interventions in K–12 schools remain mostly unavailable to many students who could benefit from them. The MHRC responded to this gap and need, and utilized the SS/HS grant to develop its vision and implement a mental health wellness model.

Key characteristics identified by SS/HS of effective school mental health included: a
continuum of coordinated and comprehensive services. The approach focused on developing a mental health wellness model to improve functioning rather than symptom reduction. It encompassed the universal, selective, and indicated interventions (public health approach); engaged families; and focused on social and coping skills, maximizing resources, and promoting schools as positive learning environments. (143) This paradigm shift – from illness to wellness - was a critical pivot point within the school based mental health service delivery research and was substantiated by many of those involved in this case study.

C.2 Align Education and Mental Health Missions and Policies

Once the legitimacy of schools as an appropriate environment has been established, the work of aligning education and mental health missions, outcome and policies became necessary. The tension between education and mental health exists and the legitimacy of practice and implementation has to be accepted and embraced by all parties in order to achieve long-term success and impact. The MHRC struggled in early implementation phases as it had to create new polices and human resource protocols that reflected the needs of a competent and well trained mental health workforce. These policies and procedures did not exist within the existing education system. As one stakeholder shared “we are guests in their home.” This shift in understanding the environmental context into which MH services and programs are placed and delivered was mentioned repeatedly by stakeholders.

An important component of integrating mental health efforts into the ongoing routines of schools is the identification and support of what researchers call indigenous
persons and resources within schools as agents of change. (144) The identification of indigenous resources involves both the selection of primary change agents and recognition of those factors involved in the successful performance of their roles. Teachers play this role as change agents, as they control the setting of primary importance to children's learning, classrooms. Thus, it follows that using mental health staff as “educational enhancers” to assist teachers in providing effective instruction and classroom management may be wise and is a different paradigm from traditional mental health practices in schools. In addition, imbedding mental health staff within natural settings such as classrooms can improve consultation efforts through the relationships that are formed and improve the implementation of the programs that are developed through enhanced input from school staff. The creation of the Mental Health Intervention Team (MHIT) and the Mental Health Related Services (MHRS) Program were direct outcomes of this “enhancer” approach that the MHRC embraced during its implementation.

C.3 Implement Cross-Systems Collaborative Approach

Service systems that are able to manage the diverse needs of youth and families require various partnerships across multiple service systems. Cross-system collaboration enhances the strengths of partnering agencies/programs to promote a continuous system of services for youth and families. Historically cross-system collaboration has presented a challenge because of the siloed nature in which systems have operated. This reality was heightened with the MHRC implementation as it attempted to bring together multiple systems: education, mental health, social services, health and justice. Collaborative
efforts were further challenges as the MHRC responded to statutory mandates, restrictive funding appropriations, and conflicting education and mental health missions. (145)

Recommendations for systems to address these sustainability challenges include: 1) acknowledging the inherent connection to other existing systems; 2) cultivating relationships that focus on serving the best interests of the youth they have in common; and, 3) committing through formalized agreements to partner/collaborate. SDUSD heeded these recommendations early in the implementation of the MHRC. First, prior to SS/HS funding, SDUSD as a large urban school district was already involved in developing cross systems collaborations. The development of the Healthy Start Collaborative, the ongoing work with the County and City and School Policing and Juvenile Probation systems, all would be leveraged in the development, submission and implementation of the SS/HS grant. The goal of such cross-system collaboration is to create an infrastructure that is sustainable over time. The MHRC consolidated this infrastructure after 15 years of implementing services. Secondly, the MHRC was able to leverage its partner organizations, with some core funding and flexibility in staffing, to institutionalize and/or obtain external funds to continue, expand or develop new programs. The MHRC created a collaborative and open system of sharing, learning, and leadership development that supported its sustainability. Finally, SDUSD and MHRC created long-term partnerships and formalized partnerships with many of the organizations that originally collaborated on the SS/HS and with those who continue to provide mental health services at school sites to continuously plan, reassess, prioritize, and reorganize to reflect funding, needs, and outcomes.
C.4 Utilize Data to Improve Performance and Prioritize Services

National initiatives in education and mental health service access, such as NCLB and IDEA, have created the need to develop outcomes focused education systems. Supporters of data-driven decision-making practices argue that effective data use enables school systems to learn more about their school, pinpoint successes and challenges, identify areas of improvement, and help evaluate the effectiveness of programs and practices.

There is a need to better align the interests of researchers to the interest of schools. In light of this, a recent study by the New Schools Venture Fund identified five key strategies of performance-driven school systems: 1) building a foundation for data-driven decision making; 2) establishing a culture of data use and continuous improvement expectations; 3) investing in an information management system; 4) selecting the right data; 5) building school capacity for data-driven decision making; and, 6) analyzing and acting on data to improve performance. (146)

As a leader in these areas, the MHRC worked with CASRC, staff, and community partners to establish an evaluation design and collect data to help inform the development and sustainability of the MRHC. Stakeholders spoke of the role the MHRC plays as a conduit between research and education in order to inform practice and improve services. The relationship between practice and research is defined as bi-directional whereby research informs practice and practice informs research. Bridging this gap between the researcher and the program, between outcomes and planned programs and strategies, was a role that the MHRC embraced. Opportunities exist to further the sharing and use of data and build on the outcomes and indicators that schools use all the time, such as school
readiness, dropouts, tardiness, and attitudes about drugs and with mental health data such as behavior, readiness, and climate. The lack of funding and the ability to initiate these funds impacted the scope and sustainability of evaluation efforts.

C.5 Strengthen Parent and Student Involvement

Although active involvement of parents in their child's learning and participation in school has been given considerable attention within the school psychology literature, many schools limit family involvement to a narrow set of activities. Yet, MHRC parents were very vocal about the need to be more involved, more educated about mental health, and more informed about school and community services. Parents shared how “desperate” “lost” and “alone” they felt through the process of seeking services for their child. They shared how they often felt powerless as they witnessed their child’s struggles with mental health. Many parents requested a more transparent and accessible system of access. They also asked to have more information regarding community mental health services, support groups, and parent resources and how to connect with them.

While the question of how to engage parents has begun to be addressed in the research, how to engage students to inform the development of services is still lacking. Students interviewed for this study shared their frustrations with “being talked down to” or “not listened to” while also requesting for the opportunity to be more involved in their therapeutic services. While education and mental health outcomes are being measured, a different set of questions targeted and created for youth is needed. Further, the responses obtained from these qualitative inquiries can be used as a method to inform and improve the quality of quantitative measures of patient satisfaction used in mental
health settings. Feedback mechanisms to MHRC staff need to be created to provide timely response and evaluation. This could provide a clearer view about how youth, parents, and caregivers perspectives differ.

While the requests for greater parent and family involvement was heard by SDUSD and the MHRC, teachers and school staff questioned their role in the development of mental health services. They struggled with how to balance being an involved teacher and adult while not over-stepping parental responsibilities and roles. This is a key question that needs to continue being discussed with parents, teachers, and mental health providers. It is important for future studies to continue this line of research in order to better guide mental health services providers as to the best ways to obtain and utilize parent and student input.

C.6 Commitment to Lead

Along the entire implementation continuum, the role of leadership was emphasized as a key factor in the implementation and sustainability of the MHRC. Leadership has been shown to be an important implementation driver. Research on the associations among leadership and organizational variables has found that high-quality leadership is important in times of system change and may reduce poor organizational climate and subsequent staff turnover. (137) This transformational leadership, is also associated with better staff attitudes towards adopting EBPs. A transformational leader is one who leads changes in mission, strategy, structure and culture, in part through a focus on intangible qualities like vision, shared values and ideas, and relationship building. From a systems perspective, research has looked at the idea of transformational leadership as a guiding
example and has identified four stages of organizational change under transformational leadership. (94, 147, 148)

1. **Make a compelling case for change**: Both the leadership of SDUSD and the MHRC brought about the systems change needed by making a convincing case for integrating mental health services into the school environment. The successful submission of the SS/HS grant and the subsequent implementation of mental health services through the MHRC required a system level change in how to plan, deliver, and assess mental health services across the district.

2. **Inspire a shared vision**: The collaborative approach and cross-systems strategies allowed the SDUSD and the MHRC leaders to discuss, share, coach, and inspire a shared vision of broad mental health services as a key service to student academic improvement and well-being.

3. **Change needs to be led**: The implementation of mental health services was led by the MHRC Manager who was able to understand and navigate the cultures of multiple systems, while focused on the long-term sustainability and collective impact of the MHRC. Collaboration was encouraged, and an environment that was conducive to the creation and sharing of knowledge was nurtured with partners.

4. **Change needs to be embedded**: Sustaining and institutionalizing the MHRC was a long-term goal of SDUSD. This stage speaks to the structural and process preparedness, which was achieved through monitoring, evaluation, progress, changing appraisal systems, and hiring, staff with a commitment to the vision of the MHRC.
C.7 Institutionalize Mental Health Training, Education and Address Stigma

Studies have found a positive relationship between supporting school staff and implementing high quality school-based programs. (149) Perceptions of training effectiveness, usefulness of materials and training sessions, program acceptability, and intrusiveness are factors that have been identified as impacting successful implementation of school based services. (150, 151) The MHRC was very conscious of the key role that teachers and all school staff play in the integration of mental health services and improving school climate and culture toward mental health. Support mechanisms in the classroom for teachers, trainings for other school staff such as bus drivers, and consistent training opportunities for MHRC staff were key functions that the MHRC has undertaken. Follow-up with parents and students spoke to an increased need and focus on awareness, education, and engagement efforts. In addition to focused efforts for parents and students, building capacity with staff helped address the need that many stakeholders discussed as critical for successful scale up of MHRC programs.

The stigma of psychiatric labels was also a point of discussion among parents and students. Adolescents in particular are acutely attuned to the judgments of their peers; misunderstandings and negative attitudes about mental illnesses among those peers may be particularly painful. The early SS/HS application was built on changing a paradigm of punitive measures and reversing the trend to place at risk students in more restrictive environments. Ostracism, rejection, bullying, and damage to self-esteem, as well as reluctance to seek or accept mental health treatment, are among the possible consequences of stigma and punitive actions. The SDUSD, as many school districts
around the country, created and implemented stand-alone interventions for many of the listed mental health issues. What the institutionalization of the MHRC provided is a unique model that organizes and supports all of these efforts under one collective district-wide vision.

C.8 Invest in Staff

One consequence of the movement toward the dissemination or scaling up of evidence-based programs is that more attention is being directed to understanding the complexities of program implementation under “real world” conditions. The literature on scaling up of innovative practices in schools has tended to focus on “big picture” contextual factors, such as the development of the organizational infrastructure necessary to support and sustain change over time (e.g., capacity building, redeployment of resources, integration of services). (124, 141, 152) Even when motivated to implement, however, agencies/schools that lack sufficient organizational capacity may be unable to sustain interventions. (134) Common components of organizational capacity include the ability of an agency/school to maintain trained and appropriate staffing levels (e.g., implementers and support staff), effectively manage funding, and work toward shared goals.

The MHRC, as an integrated school based model, was acutely aware of the internal system challenges, such as competing expectations in the areas of academic outcomes, accountability, and safety, and led efforts to provide teacher training, classroom supports, and consistent mental health services to the original SS/HS school sites while scaling to other sites post-SS/HS funding. The development and implementation of the MHIT and
MHRS programs, and the implementation of the Positive Behavior Intervention and Supports (PBIS) model across 45 school sites, are example of these efforts. Additionally it invested in its own staff, providing training, coaching, and supervision, which led to low turn-over rates among the MHRC staff.

**D. Summary**

The goal of this case study was to answer how the MHRC evolved and sustained itself and identify what factors supported the implementation and sustainability of the MHRC. What this case demonstrated in its analysis of the implementation and sustainability of a large urban school based mental heath service system, is the critical need of staffing, leadership, training and fluid funding streams that respond to policy and funding changes. The case also highlighted the inherent struggle of delivering services and including recipients (students and parents) and facilitators (teachers) in the development and planning of the services.

Recent national reviews of school-based mental health service implementation and sustainability validate many of the findings of this case. A review by the National Research Council and Institute of Medicine recommended multiple strategies for enhancing the psychological and emotional well-being of young people, which include: promoting mental health in schools; preventing specific disorders; strengthening individuals and families; and, promoting mental health through health care and community programs. (57) Each of these five points is expanded upon in the findings of this case and speak to the work that MHRC accomplished in establishing the legitimacy of the school as an environment for mental health services delivery in San Diego and
providing a continuum of interventions, while increasing the engagement of parents and students in mental health services.

Further, the eight key implementation and sustainability factors are aligned with the research of Mancini and Marek’s and the National Association of School Based Mental Health (NASBHC). Both of these efforts speak to the importance of competent leadership; a cohesive and compelling vision; intentional planning and a shared agenda; committed and qualified staff in the development and execution of the program; effective process and outcomes evaluation; strong collaborations; and, models that maximize use of revenue and categorical grants for including prevention and early intervention. (153, 154)

The SDUSD in establishing the MHRC set out to achieve the goals of the SS/HS by targeting school violence, aggressive behavior, and substance use; modifying the school environment to promote pro-social behavior; and, developing students’ skills at decision making, self-awareness, and conducting relationships. The MHRC accomplished each of these. One major goal that the MHRC set was reducing school expulsions by meeting the needs of at risk and underserved youth with an array of services. During the implementation of the MHRC, expulsions have decreased dramatically and referrals to the Alternative Learning, Behavior and Attitude (ALBA) schools have been reduced by over 50%. The MHRC has also undertaken Positive Behavioral Intervention and Supports (PBIS) in its efforts to expand services and is helping by build resilience and skills and improving cognitive processes and behaviors among SDUSD students. The MHRC staff worked very closely with school staff to provide universal prevention
services and is in the process of expanding services to reach greater number of students. This, along with greater parent engagement, is inherently the next big challenge for the MHRC. Figure 5.1 provides an overview of the ecological public health model approach that the MHRC undertook to address mental health needs, scale-up services, and sustain efforts.

**Figure 5.1: MHRC Ecological Model**

The recommendations below form a basis for an agenda for school-based mental health services that considers the school context as a means of promoting children's mental health, and makes children's adaptation to school a primary goal for services. This agenda involves acknowledging a new set of priorities, which include: the use of resources within schools to implement and sustain effective supports for students'
learning and emotional/behavioral health; inclusion of integrated EBPs to enhance learning and promote health; attention to improving outcomes for all students, including those with serious emotional/behavioral needs; and strengthening the active involvement of parents.

E. Recommendations

The findings of this case point to six recommendations for addressing and improving the types of systems and behavioral support that are critical for success of school-based mental health services: (1) develop and make available a continuum of social and emotional services and interventions for students; (2) integrate and improve teacher training and education on mental health and mental health EBPs and services; (3) collect and use mental health and education data to improve and sustain services, (4) increase parent and student in the creation of family-driven, youth-guided services, (5) invest in staff, staff development and community collaborations to improve and expand school-based health services; and (6) expand, improve, and increase funding streams.

E.1 Develop and make available a continuum of social and emotional services and interventions for students

This case demonstrated how a larger urban school district (SDUSD) led the change to integrate and build a sustainable infrastructure of mental health services and supports. The MHRC’s early success addressed the mental health needs of students most at-risk and in need of intensive interventions. As the MHRC grew and sustained itself, stakeholders discussed the need to provide a full continuum of mental health services to diminish the likelihood of students falling through the cracks. In order to provide more
universal and secondary interventions across the district, the MHRC built on its existing partnerships and strengthened its cross-systems collaborations. With mental health needs exceeding the resource capacity of the district or the MHRC, these collaborative efforts established innovative programs and service delivery mechanism to reach students and family members.

Internally, the Positive Behavioral Intervention and Supports (PBIS) process utilized by the SDUSD, emphasizes the creation of systems that support the adoption and durable implementation of evidence-based practices and procedures, and fit within on-going school reform efforts. This interactive approach targets opportunities to correct and improve four key elements focusing on: 1) outcomes, 2) data, 3) practices, and 4) systems. As the MHRC continues to expand, PBIS provides an EBP model to strengthen and expand its reach. As staff capacity will continue to be a challenge as mental health needs increase across SDUSD, the MHRC can expand its efforts to “value add” mental health and integrating into services and interventions that are led by SDUSD or community partners. These include the Healthy Start Collaboratives; nutrition, activity and physical fitness interventions led by community organizations; and school-based health centers. All of these activities provide an opportunity for the MHRC to expand its scope, reach and funding.

E.2 Integrate and improve teacher training and education on mental health and mental health evidence based programs and services

Any effort at implementing school-based mental health needs to consider improving the capacity of teachers and administrators. Teachers often feel unprepared to deal with
student behavioral issues. One way to improve staff capacity is to provide professional development specifically aligned and focused on improvement of student behavior. Training that focuses on best approaches to address behavioral supports (which are critical for student success) should be provided for administrative leaders and classroom teachers alike. Professional development should also focus on training staff to establish preventive behavioral health practices, as well as on the active use of data collection and analysis for accurate decision-making, which should be prioritized as a topic of conversation whenever teachers and administrators discuss school improvement issues. Another area of training is developing and maintaining personal mental health and wellness. Opportunities for teachers, staff and parents to develop coping, stress reduction and wellness skills should be integral to any district-wide mental health effort.

At the state level, the Student Mental Health Policy Workgroup recommended that the State Superintendent of Public Instruction request that teacher credentialing programs (starting with multiple/single-subject and administrative services credentials) include mental health and wellness curricula with information about mental health conditions and how they manifest at school. This recommendation addresses one of the most frequently neglected issues in educator training: the social and emotional health of vulnerable children. As this credentialing is implemented, it can provide a learning model for other states on how institutionalize teacher mental health training.
E.3 Collect and use mental health and education data to improve and sustain services

There is a need to develop and integrate systemic procedures to analyze education and behavioral data in order to increase the effectiveness of any mental health program. Consistent, formalized processes of data collection enable administrators to understand better the complexities of data, and the types of concerns for which data can and cannot account. Furthermore, understanding the strengths and weaknesses of data enables administrators to make sound data driven decisions. Key recommendations, such as reviewing data on a regular basis, could be accomplished through the development of a building-level matrix or profile. This activity can help leadership teams, guidance department teams, and administrators fully organize and understand the data collected about such things as office referrals, the types and patterns of referrals, attendance, and suspensions.

Additionally, a district-level overview should be established, so that trends may be noted from year to year, or even disaggregated further, such as from month to month. Building internal leaders and university partnerships around education and mental health data collection and systems would support the current reporting capabilities and increase the capacity of the district to report out and build new programs. School districts have become rich with data about varying levels of achievement in core content areas, such as math and literacy. Leadership in school systems must view data sets about student mental health and behavior in the same light. New and additional training is needed to ensure administrators have the necessary tools to improve practices in the arenas of collecting
and analyzing data. Additionally, evaluation efforts should value the collection of qualitative data to inform quantitative data.

E.4 Increase parent and student engagement in creation of family-driven, youth-guided services

Students thrive most when parents and caregivers are involved in their children’s school lives and are engaged as key collaborators in providing emotional support and reducing external stressors that affect mental health. Mental health promotion efforts must comprehensively involve schools, families, and communities. Despite research, legislation, and professional guidelines suggesting the positive impact that parent involvement can have on student performance, parent-based interventions continue to be implemented primarily in clinical settings.

The original system of care concept used the terms “child centered and family focused” as a core system of care value. The growth of family and youth voices has led to the use of the terms “family driven and youth guided” to reflect the primary decision-making roles of families and youth in their own care and in the systems, policies, and procedures that govern care at every level. This conceptual shift is a pivot point from which to address some of the concerns and recommendations that parents, students and teachers in this study shared. More specifically, recommendations include: working together to plan mental health prevention and intervention strategies; identifying and partnering with community agencies that provide mental health services; supporting and sustaining Family Resource Centers, such as the Healthy Start Collaboratives; facilitating connections between families, community resources and mental health supports; and,
engaging parents and students in planning, implementing and evaluating school based mental health services.

E.5 Invest in staff, staff development and community collaborations to improve and expand school based health services

Researchers and practitioners have called for policy changes that encourage cross-system collaboration as a strategy to address critical infrastructure and practice issues in children’s school-based mental health services. Building capacity begins with being aware of and providing the professional development and training needed to help staff members respond to student needs. As demonstrated in this case, it is important that all staff members (including teachers, bus drivers, and paraprofessionals) are able to interact positively with all students, including those with severe emotional and behavioral needs. This is a critical system underpinning to supporting the mental health of all students. Although schools often have access to the expertise of both school-based and community-based mental health providers, it is important that school employed professionals be empowered to have a leadership role in supporting mental health services in the school setting.

Effective professional development and training, information sessions, and skill-building workshops can create awareness and impart the knowledge, skills, and attitudes needed to address student mental health needs, and provide strategies for managing crisis situations. Establishing all of these informal and formal partnerships develops a successful school-based mental health service program. These nurtured partnerships become teams that are invested in the long-term sustainability of student health and
mental health and typically make a wider array of services available to students and mobilize community members to support school and student success.

E.6 Expand, improve, and increase funding streams

Developing and sustaining funding streams to support the delivery of school-based mental health services and prevention programs continues to be an obstacle at local, state, and national levels. Efforts such as SS/HS, which pooled funds from multiple federal agencies to achieve it stated goal, are recent examples of funding opportunities for SBMHSs. The passage of the Affordable Care Act provided funding to improve delivery and support expansion of services at School Based Health Centers (SBHCs). The funds were awarded to create new school-based health center sites and expand preventive and primary health care services at existing school-based health center sites. Neither of these adequately responds to the mental health needs that school districts are facing, and SBHCs still struggle with integrating mental health services into their service delivery plans. Recent federal initiatives included in the President and Vice President’s Now Is the Time plan provided funds for the training of new mental health providers and teachers to recognize mental health issues in youth and connect them to help. This case demonstrated that in order to grow, expand, and sustain mental health services efforts, leadership must address the challenge of securing long-term, sustainable funding from early exploration and adoption phases and continue planning throughout its implementation lifecycle. A clear plan must be created that maximizes all possible sources of funding, develops the infrastructure to support billing capacity, uses data to drive decisions, and nurtures mutually beneficial partnerships to provide services to students at most risk.
F. Limitations of Research

One limit of this case is its focus on a single case. Single case study analysis has been subject to a number of criticisms, the most common of which concern the inter-related issues of methodological rigor, researcher subjectivity, and external validity. The researcher has in the methods chapter outlined the efforts that were taken to increase rigor of the case study. The study protocol was developed and implemented to address issues of credibility, transferability, dependability and confirmability. The researcher placed an emphasis on triangulation as a means of corroboration, which allowed the researcher to be more confident of the study conclusions. A reflexive approach also helped verify results, and helped to support the accuracy of the themes mined out of the interview transcripts.

An additional limitation was a small study sample. More student, parent and stakeholder interviews could have provided alternative perspectives to those captured by the current research sample. A final limitation relates to the issue of generalisability and transferability. Information obtained during the interviews was largely dependent on the interviewee and what he or she was willing to share and the nature of their information was limited to his or her own perspective and lived experiences. Regarding transferability, the unique conditions that existed in San Diego, while they limit the ability to apply some of the findings to other sites, contain a rich amount of learned experiences and outcomes that many similar large urban school districts can utilize and implement in their SBMH efforts.

Despite the above-mentioned limitations, this study makes several unique
contributions to the study of the implementation and sustainability of SBMHS. First, this study suggests that sustainability is possible and funding is often obtainable. Additionally, this study suggests that obtaining and maintaining school support at all levels should be a priority, as school support and positive school climate is associated with long-term sustainability. Finally, this study suggests that sustainability planning and strong leadership are key factors in actual sustainability. Future research is needed further build on the outcomes of this case to support the development of SBMHS.

G. Implications for Further Research

The purpose of this case was to identify and understand the factors involved with implementing and sustaining school based mental health services, using the MHRC as a model. The qualitative case study methodology utilized in this study offered a detailed examination of the experiences of local and national stakeholders, teachers, parents and students with school based mental health services. In addition, the case methodology allowed for a longitudinal lens from which to analyze how, when and why administrators and other stakeholders make key decisions. While this case study represents a large body of research on the contextual factors that impact implementation and sustainability, further research is necessary.

Given the limited progress in establishing consensus about effective and efficient school mental health programs that can be sustained within the varied ecologies of schools, Adelman and Taylor and Evans and Weist suggest a research agenda that prioritizes mental health programs and practices that are integrated into the school ecology. (64, 65) This case supports this ecological perspective and moves away from
siloed, intervention and pathology specific research modalities. While these are still needed to support and to establish EBPs and best practices for care and treatment, the role of context may provide more long-term learning for sustainability efforts.

First, this case demonstrated the importance of recruitment, hiring, training, and supporting staff in the long-term sustainability of the MHRC. Unfortunately, schools many times hire reactively in response to new funding or immediate needs, while possessing neither the systems nor the knowledge base to create a deliberate process. What are the best job qualifications, hiring mechanisms, and supervisory systems for mental health workers in a school system is a poorly understood area that this case demonstrated is central to the long-term sustainability of the MHRC.

Second, little research has been done that examines all school personnel and their impact on emotional/behavioral health and academic outcomes. The training of bus drivers, custodians, school aides and other support staff is an area of research that has yet to be tapped and can provide needed insight on the influence these individuals have on behavioral/emotional outcomes. Another similar area of research is to better understand the role of gatekeepers, such as principals, vice principals, and counseling staff, and how their awareness, knowledge and attitudes influence mental health service delivery on school campuses. This line of inquiry would also provide mental health program administrators the ability to adapt interventions based on the specific needs of the school sites.

Third, how and what data to collect are questions that still need much more research in order to support schools as they focus on continual school improvement. Researchers
have provided school leaders with data and evidence that suggests that students who struggle with maintaining appropriate school behaviors typically struggle with academics, as well. For this reason, school districts and school administrators must engage in data collection practices that can be used to inform practice and improve outcomes for students. The importance of university/school collaborations and how to develop and sustain these relationships is another parallel line of inquiry to help inform future school based mental health efforts.

Finally, future studies need to continue the line of research this case began as to the best ways to obtain and utilize student and parent input in order to better guide mental health services. The MHRC case has suggested that there may be a need to develop a different set of questions for youth versus caregivers for the purpose to inform and improve the quality of quantitative measures of more traditional patient satisfaction surveys used in health care settings. Future studies may also benefit from examining the specific youth-caregiver and youth-parent dyads to see if there are links between response types. Identifying salient categories of concerns has the potential to inform the development of targeted strategies for fitting mental health services with the needs, preferences, and priorities of youths, parents and their mental health providers. It also will be useful to assess and compare perspectives with actual outcomes along with the retention rates of youth in services. These data can then be used to better understand perceptions of services in relations to factors such as age, race, diagnosis, and family history.

Each of these implications for further research specifically target contextual factors to
better understand and hypothesize relationships between program sustainability and program factors. Research on predictive relationships proposed in these models awaits scientific evaluation. Prospective research is needed to determine longitudinal associations between sustainability strategies proposed in theoretical models and program survival. (92, 125) The MHRC as it moves toward its second decade of service provision is primed to engage in prospective research as it enters a new cycle of implementation and growth.

Current models of school-based mental health remain overly focused on conventional definitions of mental health practice and provide inadequate attention to contextual issues that may influence both schooling and mental health. This case proposes an agenda for school mental health services that considers the school context as a means of promoting children's mental health, and makes children's adaptation to school a primary goal for services. Toward this goal, research can contribute to effective SBMHS by proposing targets for change and collaborating with educators, researchers and program administrators to understand how to best effect these changes.

**H. Conclusion**

*We still address mental illness, as that is what the person is. Rather than that is something they have. That would be fabulous if we could change that. Parent*

Adolescents are a particularly vulnerable group that requires targeted interventions and models of service delivery. Neither child-centered nor adult-centered mental health models adequately respond to the needs of the developing adolescent. The high prevalence of mental health disorders among youth reinforces the importance of developing prevention strategies and promoting school-based early interventions for at-
risk adolescents. School-based interventions have the potential for large-scale impact as a typical school day of 6 hours, 5 days a week, 180 days per year provides significant opportunities to improve mental and physical health of the adolescent through curriculum, pedagogy, and school/ community enhancements.

There exists a tremendous opportunity to reach youth with mental health needs through school based interventions and programming. Schools are already the major providers of mental health services and students are substantially more likely to seek help when school-based mental health services are available. (9, 140) Expanded school mental health services have also been found to reduce special education referrals, improve aspects of the school climate, and produce declines in disciplinary referrals, suspension, grade retention, and special education referrals and placement among at-risk students. (69, 83, 139) The MHRC case study validates these reports and reinforces the need to understand not only the program specific outcomes but also the context within which these evidence-based programs are implemented.

While it is clear that challenges remain, the potential of this systems approach to begin addressing mental health as a major public health concern is significant. While there is an increasing consensus for locating mental health programs and services in schools, major challenges, such as trained staff, limited options for referral to specialty care, and decreased funding, impede successful implementation and sustainability of programs.

The MHRC provides a unique systems model to better understand how to address these challenges and improve the long-term sustainability of implementation efforts.
Despite the development of evidence-based intervention for various psychological disorders in youth and young adults, prevalence remains high and service utilization remains low. A system-wide approach that involves school- and curriculum-based interventions may offer an alternative or supplement to traditional modes of individual psychosocial treatment, due to its unique potential to reduce many of the barriers associated with seeking help and increasing access to services for youth in need.

This research had the goal of advancing policymakers’ and program managers’ ability to reduce the burden of mental health problems and support and develop a healthier and well-functioning young adult population. The case highlighted the efforts of one school district toward the successful implementation and sustainability of school based mental health services. SDUSD’s success was influenced by a variety of internal and external factors, that while specific to the MHRC implementation are not unique to San Diego, These include: the district’s flexibility to adapt and lead; community readiness to address mental health; staff recruitment, training and retention; and parent, family and student engagement. The MHRC working at this local level - responding to community needs and opportunities - it is here that the potential for long-term impact is greatest. The implementation of SBMH services is one major step toward the realization of a healthy, functioning, and just society and San Diego can provide a model for the nation.
Appendix A, San Diego Unified School District White Paper
**Introduction**

Devon is a current 12th grader at San Diego Unified School District (SDUSD) and has a long history of social, emotional and behavioral problems. Family and home issues have also complicated his ability to focus on academics and succeed at school. Devon had his first referral in Kindergarten and by 5th grade met IDEA criteria as a student with Emotional Disturbance. He was diagnosed with anxiety, mood disorder and depression. Prior to starting junior high, his family decided to send him out of state to live with another family member, as they did not feel they could control or help Devon. He did not receive any services during this time and his grades spiraled downward as did his behavior. He was sent back to San Diego and was enrolled in 9th grade where he was re-assessed with a new IEP. Issues with his medical coverage surfaced during his first year of high school, creating lapses in service. He also had multiple psychiatric hospitalizations, began receiving community-based services and was involved with Child Welfare Services and San Diego Probation. As he continued to struggle in a traditional school setting a new IEP was created. He was recommended to Day Treatment services and to attend New Dawn School. A new service plan was created and a Behavioral Support Plan was put in place. Devon’s grades have improved, his behavior and emotional self-control are better managed, he has a more positive outlook and he is back on track to graduate.

Devon’s case illustrates the critical academic and developmental transition points in a young person’s life and the clear impact of mental health on academic outcomes and positive functioning. While gaps in service existed, SDUSD was the unifying element in Devon’s care. A case study of SDUSD’s Mental Health Resource Center was completed to better understand the contextual factors that support the successful implementation and sustainability of school-based mental health services. This white paper highlights the outcomes of the two research questions answered by the case:

1) *How has the MHRC evolved and sustained itself as a service of care model in response to financial, human resource, and community constraints and opportunities?*
2) What factors have supported the successful implementation of the Mental Health Resource Center (MHRC) within San Diego Unified School District?

Background

The failure in the prevention, identification, and treatment of mental health problems among school aged youth represents a major public health concern in the United States.\(^1\) Most mental health problems diagnosed in adulthood begin in adolescence: half of lifetime diagnosable mental health disorders start by age 14.\(^2\) The prevalence of severe emotional and behavior disorders in adolescence has been reported to be higher than the most frequent major physical conditions, including asthma or diabetes.\(^3\) Nearly half of the sample reported by the National Comorbidity Survey Adolescent Supplement (NCS-A) met the diagnostic criteria for at least one mental health disorder, and about 20 percent reported that they suffered from a mental health disorder with symptoms severe enough to impair their daily lives.\(^4\) Specifically,

- 11% reported being severely impaired by a mood disorder;
- 10% reported being severely impaired by a behavior disorder such as attention deficit hyperactivity disorder or conduct disorder;
- 8% reported being severely impaired by at least one type of anxiety disorder; and,
- 40% of those who reported having a disorder also met criteria for having at least one additional disorder.\(^4\)

Mental health data for California adolescents mirrors much of the national data:

- Twenty one percent (21%) of California teens were at risk for depression. Among California 9\(^{th}\) graders and 11\(^{th}\) graders, 30.5% and 34.7% felt sad or hopeless, respectively.
- Eight percent (8%) of 12–17 year olds experienced a Major Depressive Episode (MDE) in the past year.
- Suicide was the 3\(^{rd}\) leading cause of death for 15–24 year olds and the 4\(^{th}\) cause of death for 10–14 year olds.\(^5,6\)
California high school aged youth with severe mental health disorders, who received special services, dropped out of high school at a rate that exceeded the state rate (39% versus 14.4%).

Similar mental health outcomes have been reported within San Diego County where the 2009–2011 California Healthy Kids Survey findings showed:

- Twenty-six percent (26%) of 7th graders, 29% of 9th graders, 31% of 11th graders and 38% in alternate schooling programs experienced sadness and felt hopeless with impairment in daily activities. Female adolescents in all of these categories showed higher rates than their male peers.
- Twenty percent (20%) of all 9th and 11th graders, and 22% of alternative school students seriously considered attempting suicide.
- Conduct, depression, adjustment, and attention deficit hyperactivity disorders were the most common mental health problems among San Diego adolescents who received treatment. Substance abuse issues were present in 15% of 12–17 year olds who received mental health treatment.

If early onset mental health disorders are left untreated, the longstanding consequences are not only medical, but also have social and economical impacts. Recent research has shown that depression, behavioral disorders, attention deficit hyperactivity disorder (ADHD), and anxiety experienced during childhood may be associated with school failure, delinquency, substance dependence, accident, self-harm, sexual risk taking behavior and severe dysfunction in adulthood.

Major gaps exist in the delivery and utilization of adolescent mental health services. Only 21% of children in the United States who needed a mental health evaluation received such services. Among Latino children this rate dropped to 11% compared to 24% for white children. For 12–17 year olds who had a past year MDE, only 37.0% received treatment. Gender differences also exist in service utilization. Male adolescents of all ages used clinical health care and mental health care services significantly less than females, and use of services decreased, as they got older. When male adolescents did seek services, they were more likely to receive services in school
settings (23.9%) compared to female adolescents (16.2%). Stigma, lack of culturally competent services, lack of access, shortages of providers and insurance coverage all are variables that influence whether a young person utilized mental health services. School based mental health services demonstrate promise as a strategy to address this gap.

**SDUSD Solution: The Mental Health Resource Center (MHRC)**

Schools provide a universal entry point to the identification, delivery and maintenance of mental health services to school aged children and adolescents. When utilizing mental health services, schools were the most common place of treatment and counseling. Approximately 20.9% of adolescents seeking mental health services accessed them on a school campus and 35.0% received services from both a school and non-school provider, such as a community health center.

In response to the growing need for mental health services, the San Diego Unified School District established the Mental Health Resource Center (MHRC) in 2001, as a systems-wide approach to address the mental health needs of San Diego school aged children and youth. This white paper discusses the contextual factors that support the successful implementation and sustainability of the MHRC’s school based mental health services. Recommendations are given to support long-term sustainability and the implementation of a quality system of care for all SDUSD students.

**The MHRC Case Study**

A case study, covering the period 1999–2014, was completed utilizing three primary sources of evidence: 1) documents; 2) archival records; and, 3) interviews with local and state stakeholders, students, and families. These multiple sources of evidence helped to more fully understand the factors that have led to the MHRC’s successful implementation and long-term sustainability. The MHRC’s implementation was examined and data was organized chronologically. Three periods of implementation were defined:

1) **Planning and Early Implementation (1999–2004)**

This period included the implementation phases of exploration and adoption, installation and early implementation. The planning, writing, and submission of the Safe School/Healthy Student grant and its subsequent implementation were the principal
activities during period. A broad based collaborative planning process was also initiated and that included SDUSD staff, County of San Diego Health and Human Services Agency, Healthy Start Collaboratives, School and City Police; and other community based student focused organizations and partners (see Figure 1). Three structural supports key to the implementation and sustainability of the MHRC initiated during this period were: 1) developing human resources protocols and program policies; 2) establishing an evaluation plan, creating referral systems, creating necessary data collection systems; and, 3) receiving certification as an Early Periodic Screening Diagnostic and Treatment (EPSDT) provider. EPSDT designation allowed the school district to bill the state of California for MediCal reimbursement of covered services and was critical to the financial viability of the MHRC.

Figure 1: Safe School/Healthy Students Collaborative Structure
In October 2001 the SDUSD was awarded the Safe Schools/Healthy Students Initiative grant. The overall mission statement created by the SSHS/MHRC Advisory Board was “to work collectively to provide a seamless array of intervention services to improve the health and safety and improve student achievement for students at the targeted schools.” An instrumental hire would be the MHRC Director who as a former employee of the San Diego County Mental Health, was able to maintain and strengthen partnerships between SDUSD and the County, strategically utilize existing reimbursement mechanisms, and create new policies for MH reform in the school district.

Prior to the funding of the SS/HS grant EPSDT designation, SDUSD was allocating approximately $500,000 toward mental health interventions and services, while contracts with San Diego County Mental Health Services covered reimbursable services. The budget for the 2003–2004 school year would increase to $3.6 million: 30% would be covered by SS/HS and 45% by EPSDT. During this period staffing would increase to 32 licensed and unlicensed staff working on the MHRC.

**2) Growth and Innovation (2004–2010)**

During this period, covering the implementation phases of **full operation** and **innovation**, the MHRC faced increased demand for services and expansion of efforts beyond treatment and referrals. In response the MHRC: 1) increased MHRC and school site staff training and education; 2) strengthened partnerships and increased funding streams; and, 3) improved efficiency of intake and referral processes across the district. In November 2004, voters enacted the Mental Health Services Act (MHSA), also known as Proposition 63. The intent of the MHSA was to transform the public mental health system in California into a system that provides a broad spectrum of prevention and early intervention, treatment, and infrastructure support. During the early implementation of the MHSA, the MHRC did not see major funding increases, yet the MHSA did begin a statewide dialogue on mental health that influenced innovative strategies and new thinking which directly impacted the future of the MHRC. During this period of **innovation**, the Mental Health Intervention Team (MHIT) was created and provided services to all elementary and middle schools on traditional school campuses. The MHIT
is a collaborative service delivery model using school-based mental health teams to implement evidence-based interventions to promote positive social adjustment for youth with emotional and behavioral disorders (EBD) and their families as well as support classroom teachers.

The MHRC’s growth and innovation were guided by The Child and Adolescent Services Research Center’s (CASRC) outcome and process evaluation that was completed during the SS/HS funding period. The overall positive impact of MHRC services on targeted students: improvements in self-control, empathy, attitudes toward school and future aspirations, and overall social skills; and, significantly decreased school suspensions; were documented in reports, publications and communication among partners. These results are noteworthy as the majority of targeted students demonstrated poor academic performance; low psychosocial functioning and high mental health need at program entry. Table 2.1 provides a summary of the services provided by the MHRC over the case bound period. Parents and teachers also reported improved relationships, fewer discipline referrals, and significant improvements in youth’s pro-social behaviors such as cooperation, responsibility and self-control. These outcomes would establish the foundation that would continue to inform the development of the MHRC over the following 10 years.

By the end of the SS/HS funding in 2006 over 700 students received services from the MHRC. As the MHRC expanded services and reach across the district, the total budget during the 2009–2010 school year would amount to $7.7 million and account for over 100 staff members. Approximately 38% of the budget would be covered by SDUSD services (25% special education reimbursable services) and 62% would be covered by County contracts (29% EPSDT reimbursable services), that included MHSA (5%) and outpatient services (7%).

3) Sustainability and Institutionalization (2010–2014)

Sustainability was identified as a key leadership function of the MHRC from the early exploration and adoption phase and defined as a priority across all three periods of implementation. During the time frame of this case study, the MHRC leadership
leveraged partnerships, policy, and funding, in order to continue, improve, and expand on mental health services and programs. Principal activities during this period included: 1) expanding mental health training and support for staff, teachers and administrators; 2) increasing family/parent engagement in MHRC development and services; 3) training and coaching of staff in grant writing and funding solicitation; 4) improving data collection and outcomes for continuous improvement and problem-solving; and, 5) diversifying and sustaining funding streams. During this time, the MHRC became more integrated into the daily fabric of the SDUSD. The sustained effort, the outcomes focus, the improved changes in mental health delivery, and the overall satisfaction with the MHRC led to greater community buy-in for school based mental health services.

Externally another policy change had a major impact on the growth, innovation and sustainability of the MHRC. The California Legislature passed Assembly Bill 114, which transferred responsibility and funding for educationally related mental health services, including residential services, from county mental health and child welfare departments to education. SDUSD utilized the MHRC as the umbrella for responding to this legal requirement. At this time the Mental Health Related Services (MHRS) Program was established under the auspices of the MHRC and tasked with developing and coordinating implementation of school wide procedures related to mental health assessment and service delivery.

By the end of the 2013–2014 school year the MHRC was operating under a $16 million budget and was providing services to over 1,000 students. The budget reflected the shift toward greater dependence on SDUSD funding (70%) and a decreased dependence on County contracts (30%). Services provided included: outpatient (69%); day treatment (17%); behavioral interventions (11%); and, residential treatment (3%).

MHRC Implementation Facilitators and Barriers

We all want children to succeed. Whether my emphasis is by teaching math or making sure they have their mental health needs met. You still want the same end result. It is just understanding that we are more alike in our wants of what we are trying to do for our students than we are different. Stakeholder
Eight factors were identified as critical to MHRC’s implementation and sustainability:

1. establish legitimacy of school as environment for mental health delivery
2. align education and mental health missions and policies
3. implement cross systems collaborative approach
4. utilize data to improve performance and prioritize services
5. strengthen parent and student involvement
6. commitment to lead
7. institutionalize mental health training and education
8. invest in staff

As a system of care model, these factors helped build an understanding of key elements of the system and how they contributed to its development. The factors are aligned with other national reports, such as the National Association of School Based Mental Health (NASBHC) critical factors. Each of these highlights the importance of establishing a cohesive and compelling vision and shared agenda for school mental health with a centralized organizational infrastructure and accountability mechanisms to assure the vision’s implementation and sustainability. 22,23

1) Establish legitimacy of school as environment for mental health delivery

The SDUSD and the MHRC were successful in demonstrating the link between academic achievement and mental health and responding to the education and support needs of the school based community. The leadership provided by the Director of Student Support Services and the eventual hire of the Project Manager added strong legitimacy to the efforts of the MHRC. The outcomes of the CASRC evaluation, increased referrals and by school based staff, and increased engagement by parents and family members further validated the legitimacy of the work and need for mental health services. Statewide, efforts by the CA Department of Education’s Student Mental Health Policy group, the CA School Based Health Alliance and the MHSA Oversight and Accountability Commission assessed the current mental health needs of California
students and families and gathered evidence to support statewide policy recommendations. Similar work has occurred at the County level with leaders and community members involved with the County Health and Human Services’ Behavioral Health Advisory Board and also the County Office of Education’s Student Mental Health Initiative. All of these collaborative efforts and activities have helped create an environment across San Diego for the establishment of school sites as a place for mental health delivery, access, support and education. While challenges still exist and mental health may not be fully embraced as a function of the education system, delivery of mental health services has become institutionalized as part of the district’s mission. Consistent improvement in climate, attitudes, and acceptance has been observed and documented across SDUSD with institutionalization of mental health services.

2) Align education and mental missions and policies

SDUSD and the MHRC led the work of aligning education and mental health missions, outcome and policies in order to better service the students of SDUSD. A major early function was creating the necessary human resource protocols and recruitment efforts to create a competent and well-trained mental health workforce that reflected the needs of SDUSD community. Understanding the language and culture of education was a key in implementing and sustaining school-based services. As one stakeholder shared “we are guests in their home.” This shift in understanding the environmental context into which mental health services and programs were placed and delivered was mentioned repeatedly by stakeholders. Rather than superimposing a new set of programs or professionals on overwhelmed schools, using mental health staff as “educational enhancers” to assist teachers in providing effective instruction and classroom management may be wise and is a different paradigm from traditional mental health practices in schools. The MHRC was acutely aware of this structural need and imbedded mental health staff within classrooms to improve collaborative efforts with teachers and school based staff. Consistent and long-term relationships were formed and improved the implementation of MHRC programs that was possible only through enhanced input and buy-in from school staff.
3) **Implement cross-systems collaborative approach**

The MHRC was successful in creating cross-system collaboration and confronting the siloed nature of existence between education and mental health. Prior to SS/HS funding, SDUSD had already laid the foundation of creating cross-systems collaborations: through its work developing the Healthy Start Collaboratives, its work with the County Mental Health, City and School policing, and Juvenile Probation systems, and its strong partnership with its university partners. Each would be leveraged in the development, submission and implementation of the SS/HS grant in order to improve quality and efficacy by sharing resources, strengthening referral networks, reducing duplicative services, and increasing service efficiency and capacity. Dual goals of a cross-system collaborative approach are to complement and enhance student mental health efforts and also create an infrastructure that is sustainable over time. The MHRC had a keen understanding of both of these factors early in its implementation. Sustainability was seen as “one of its functions” and in response it created a system of sharing, learning, and leadership that supported its sustainability.

4) **Utilize data to improve performance and prioritize services**

The MHRC was a leader in bridging the education and research communities to establish an evaluation design and collect data to help inform the development and sustainability of the MRHC. While lack of funding impacts the scope of evaluation efforts, there is an opportunity to build on school based outcomes and indicators, such as school readiness, achievement, dropouts, and tardiness, with mental health data collected from public health surveys, such as the YRBSS and the California Information Survey. In order to accomplish this, there is a need to align the interests of researchers to the interest of schools. Stakeholders spoke of the role the MHRC can play as a “conduit” between research and education in order to inform practice and improve services. A recent study by the NewSchools Venture Fund identified five key strategies of performance-driven school systems: 1) building a foundation for data-driven decision making; 2) establishing a culture of data use and continuous improvement expectations; 3) investing in an information management system; 4) selecting the right data; 5) building
school capacity for data-driven decision making; and, 6) analyzing and acting on data to improve performance. The MHRC, working with CASRC, has led in these areas and the opportunity exists for educators to know how to better use data to inform all areas of education decision making.

5) Strengthen parent and student involvement

The MHRC continued to improve and address the challenges of parent and student involvement and engagement throughout its implementation. Parents were very vocal about the need to be more educated about mental health and also be more informed about school and community mental health services. Parents often felt powerless as they witnessed their child’s struggles with mental health, and asked for more education, support and opportunities to learn. Parents shared how “desperate” “lost” and “alone” they were through the process of seeking services for their child. Many parents identified the need for creating more transparent and accessible procedures and also accessing support structures with other organizations and parents. While new models of parent engagement are being tested in practice and research, engagement of students to inform the development of mental health services is rare. Students shared their frustrations with “being talked down to” or “not listened to” while also requesting for the opportunity to be more involved in their therapeutic services. Stakeholders identified parent and student engagement as an area of continued growth and opportunity for the MHRC.

6) Commitment to lead

The role of leadership was emphasized as a key factor in the implementation and sustainability of the MHRC. Starting with the Director of Student Support Services and continuing with the MHRC Manager, each stage of organizational change was led by a transformational leader who has, as stakeholders stated, “navigated the water internally and externally” in order to achieve “collective impact.” The collective leadership of SDUSD and the MHRC brought about the systems change needed by making a convincing case for integrating mental health services into the school environment. Additionally, the collaborative approach and cross-systems strategies allowed the SDUSD and the MHRC leaders to discuss, share, coach, and inspire a shared vision of
broad mental health services as a key service to student academic improvement and wellbeing. These efforts have allowed the MHRC to institutionalize its efforts and structural and process preparedness through ongoing monitoring, evaluation, and changing appraisal systems. As the MHRC scaled it services across SDUSD school sites, an area of organizational growth and opportunity will be the ability to sustain this leadership and train and support the next level of transformational leaders with a commitment to the vision of the MHRC.

7) Institutionalize mental health training, education and address stigma

Training of education school personnel is critical in order to gain their acceptance and feeling of efficacy in working at-risk and vulnerable youth. These youth often evoke punitive teacher responses and peer rejection, leaving teachers and administrators to place such students in more restrictive environments or settings. The early SS/HS application was built on changing this paradigm of punitive measure and reversing the trend to place at risk students in more restrictive environments. This work continued with the MHRC and its partners. Building capacity and training with MHRC and school based staff, parents and student education and engagement, and strengthening community partnerships were discussed by many stakeholders as critical for successful scale-up of MHRC programs. For example, the work that the MHRC undertook with support staff, such as bus drivers, increased mental health awareness across the district. Another major point that stakeholders discussed was how stigma impacts teacher, parent, and community responses to mental health. The specifics of cultural competency not just in term of race and ethnicity but also language, nationality, sexual identity, economics were also brought up. The stigma of psychiatric labels was also a point of discussion among parents and students. Adolescents in particular are acutely attuned to the judgments of their peers. Misunderstandings and negative attitudes about mental illnesses among peers may lead to ostracism, rejection, bullying, and damage to self-esteem, as well as reluctance to seek or accept mental health treatment. Education, prevention and training efforts were led by the MHRC on school campuses through the creation of the Mental Health Intervention Teams (MHIT) and the implementation of Positive
Behavioral and Intervention Supports (PBIS) in 45 schools across the SDUSD. These efforts were also reinforced by Mental Health Service Act (MHSA) funded state and county initiatives that have directly targeted stigma and mental health service seeking behaviors.

8) Invest in staff

The MHRC experience supported the importance of developing and sustaining organizational capacity. Activities that led to the increased capacity of the MHRC included: maintaining trained and appropriate staffing levels; managing funding effectively; and, working toward shared goals. The early implementation success of the MHRC was due in large part to the leadership identifying and recruiting staff that aligned with the mental health needs of students targeted by the MHRC. The MHRC made a large investment in the recruitment, training, mentoring, and coaching of staff along the entire continuum of staffing positions. Staff worked alongside each other to learn and understand each other’s scope of work and benefited from each other’s training and expertise. In order to support sustainability efforts, a component of staff training was to have the lead clinicians trained on grant writing and help in the proposal writing and submission process. This created an atmosphere among MHRC senior management of ownership with programs and a deeper understanding of the program elements, especially reporting, evaluation and outcomes. Many of the key staff that were hired during the first two phases of the implementation of the MHRC are still working during the sustainability phase. Ongoing mental health training and developing competencies with educators and administrators, led to stronger ties and relationships between the two fields and growing requests from school sites for more services.

Recommendations

*We still address mental illness, as that is what the person is. Rather than that is something they have. That would be fabulous if we could change that.* Parent

Based on the experience of the SDUSD and the MHRC and the identified key implementation factors the following are recommendations to support future growth, implementation and sustainability:
1) **Expand Universal Services.** Over its 14-year implementation period, the MHRC has established the legitimacy of schools as a site for the delivery of mental health services in San Diego. While the MHRC has been able to scale and sustain its tertiary and secondary services, targeting its most vulnerable and at-risk students, universal prevention efforts are an increasing request among school sites and community members. A slow-roll out/pilot phase that allows for both formative and process evaluations would be ideal. As these are not reimbursable services, grant writing is a necessary function to obtain these funds. Strategies for incorporating mental health into a comprehensive K–12 health education curriculum effort could be substantial.

a. **Focus on key adolescent and child developmental and transition periods along the academic pathway.** Based on the research that middle school youth have fewer protective factors, it is important that the unique characteristics and needs of the early adolescent not be lost in the planning and implementation of services.

b. **Select evidence-based programs that are specific to the target need, age, developmental level and community.** Use of qualitative tools, such as surveys and interviews, with parents, students and counselors may assist with process and outcomes evaluation of programs and services.

c. **Review District wellness policies that address nutrition and physical activity.** They can have greater impact when they are integrated with and staff is trained in mental health. Access to nutritious meals and physical education has been shown to improve academic, behavioral, and emotional functioning.

2) **Establish SDUSD Mental Health/Education Policy Group.** At the statewide level and at the county level, organized groups have to come together to share resources and network to develop strategies for mental health implementation and sustainability. San Diego Unified, as one of largest urban school districts in the state, would benefit from establishing a local SDUSD specific group. The inclusion and representation of teachers, counseling staff, parents, students, other school based staff and local universities working together to align and implement mental health would strengthen and sustain efforts.
Functions could include:

a. **Identify areas for mental health integration.** Review existing evidence-based health education curriculum materials that address specific behavior areas (e.g., tobacco/drug/violence prevention, HIV/STI prevention, pregnancy prevention), identify areas for integration with mental health, and provide teachers with updated instructional materials to complement existing units.

b. **Advise SDUSD and MHRC on mental health issues.** Provide guidance on policies and priorities MHRC should be pursuing and help identify and plan for new funding opportunities.

c. **Plan and hold annual or bi-annual community mental health conference.** This meeting can provide both a community report back mechanism and provide an opportunity to plan future growth.

3) **Strengthen and Expand Community Collaborations.** As funding becomes more challenging and the need for mental health services increases the MHRC will need to continue to strengthen existing collaborations while also expanding and developing new ones in order to fund and sustain services. The MHRC has shown adeptness in identifying and developing new partners while strengthening existing partnerships. MHRC leadership will need to continue to expand and think of new opportunities for collaboration in order to respond to the many needs across the district. Increased partnerships could allow for more funding opportunities to target school sites, communities or sub-populations of students, such as Hispanic/Latino families, English learners, and recent immigrants and refugees. The MHRC will not be able to address all these issues by itself and there will be a need to bring on board partners who can provide services and collaborate on the school based efforts. These all provide an opportunity for collaboration and possible expansion of funding.

   a. **Strengthen strategic partnerships.** Align MHRC efforts with local mental health nonprofits such as NAMI. These partnerships would respond to the parent need of peer support and education.
b. **Improve culturally competent care and stigma reduction efforts.** Develop strategic partnerships with community-based groups, such as local refugee assistance leagues, ethnic organizations, and faith-based groups to increase culturally competent mental health services.

c. **Develop stronger partnerships with community based public health prevention efforts in chronic diseases.** Create synergistic partnerships to strengthen mental health role with local and county chronic diseases and health disparity efforts.

4) **Develop a Comprehensive Evaluation Plan:** SBMH services have been shown to improve health and behavior outcomes that directly impact academic outcomes. This model needs to be evaluated further, particularly as it relates to diminishing disparities among many San Diego communities. Sustainability hinges on the school’s ability to demonstrate the impact that services have on the school environment and student achievement. Quality data, collected using valid and reliable tools, can be used in planning, policy development, decision-making, prioritizing program activities, and advocating for more resources.

   a. **Develop MHRC systemic standards and benchmarks.** A SDUSD wide framework needs to be created to enhance a system of accountability and innovation with mental health interventions and services.

   b. **Integrate qualitative evaluation approaches.** Develop evaluation strategies that also include the input of parents, teachers and students to better understand service outcomes, utilization and satisfaction.

   c. **Leverage partnerships.** Identify and target funding that would allow for expansion and institutionalization of mental health evaluation efforts.

5) **Increase Parental and Student Support and Involvement.** Increased opportunities for parent involvement should be made available throughout the implementation process to engage and hear as many family voices as possible. Parents feel isolated and alone in a very daunting and overwhelming process. Students felt that they were not necessarily involved in the decision-making and felt like passive recipients of services. Both
acknowledged the hard work of delivering mental health within a school setting. How to strengthen the relationship between the MHRC and parents/students and engage them in a more pro-active manner in the planning and implementation of mental health services will be a major function over the next few years.

a. **Increase access to MH education and awareness activities and materials.** Mental health education and access to services is difficult to find, comprehend, and is not easily found on the SDUSD website. Families, especially English learners, are requesting a more streamlined intake process and more education, information and guidance on mental health, district and community services.

b. **Implement an Individualized Education Program (IEP) quality improvement process.** Parents were not satisfied with the current IEP process. How and what improvements can be made require a system wide effort and would greatly improve the relationship between parents who are seeking mental health services for their children and SDUSD.

c. **Increase parent engagement efforts.** Utilize existing SDUSD forums, such as PTSA, parent liaisons, and advisory boards, to engage family members in promoting positive mental health of students. A parent advisory group/working group could inform future expansion and sustainability efforts.

d. **Improve student engagement.** Consider developing a student speakers group, youth council, and leadership group to assist with planning, needs assessment, evaluation and addressing MH stigma.

6) **Leverage Leadership to Create Policy and Expand Services.** As one of the largest urban school districts in the state, SDUSD has the potential to be a leading voice in the development of school base mental health services. Utilizing a System of Care (SOC) approach, the MHRC, has developed a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other behavioral challenges. As it enters a second and third decade of service implementation, the MHRC is facing unprecedented growth in staffing and request for services at all levels of
delivery. In response to these increasing requests for services, community based organizations have also begun establishing a MH presence on school campuses across the district. Over the 15-year implementation period covered in this case, the MHRC has invested and developed the capacity of current and future leaders through extensive mentoring and training. These future leaders also embrace the values and principles of a system of care and are extremely knowledgeable about the structures and processes of all partners involved in the MHRC. How these leaders will leverage current and new partnerships and utilize their experience to lead the expansion and sustainability of the MHRC waits to be seen.

a. **Support new leadership roles.** Incorporate participation in City, County, and State mental health councils and advisory boards as a function of MHRC leadership roles to influence policy and funding.

b. **Develop Partner Agreements.** Memoranda of Understanding and/or linkage agreements with community agencies that stipulate how they partner with schools to provide MH services to students. Currently this is a very informal system and can cause confusion and duplication of services on certain high need school campuses.

c. **Leverage School Based Health Centers (SBHC).** While the number of SBHC’s in San Diego is small (11) there may exist an opportunity to organize mental health services, implement EBP programs, and pilot evaluation to increase collective impact. Encourage SBHCs to collaborate with the MHRC in areas of service delivery, EBP implementation and evaluation.

7) **Integrate and Expand Training and Awareness:** The MHRC has been able to move the dial forward toward a greater understanding of the need to address mental health in San Diego. Yet, an overabundance of feedback from stakeholders and family members was the lack of understanding of mental health and in particular its connections to academic outcomes. While the MHRC has been a leader in providing mental health education and increasing awareness, more is needed and the MHRC may not be able to do it all by itself.
a. **Increase training opportunities for all school-based staff.** Continue training efforts for support staff. Develop mental health champions among SDUSD principals and lead administrators. Encourage and train after-school and extracurricular activities and sports to promote mental health efforts such as, team-building skills, self-confidence and self-esteem.

b. **Create a training and speakers bureau.** Identify mental health leaders and partnerships in SDUSD, County and State levels that can support education and awareness efforts that schools and SDUSD departments can access for training and education services.

c. **Promote mental health of all staff.** Encourage staff, both MHRC and school based, to take care of their own health and well-being. Establish a standing committee to assess needs of all school employees, identifying resources, and evaluating the impact of school-site mental health promotion efforts. Health promotion for staff provides students with positive role models, increases staff morale, prevents absenteeism, and increases productivity, all of which can contribute to a healthier school climate.

8) **Develop Current and Future Leadership:** A consistent message from all stakeholders was the organizational commitment to recruit, hire and train the best staff for the jobs available at the MHRC. The early implementation success was due in large part to the MHRC leadership identifying and recruiting the staff that aligned with the mental health needs of students targeted by the MHRC. The MHRC has been able to retain staff and create a motivated and committed workforce. Ongoing training and development of competencies in the mental health field and working with educators and administrators on how to support each other have led to stronger ties and relationships between the two fields and growing requests from school sites for more services. As the MHRC begins its next cycle of organization change and growth, it is now back full circle incorporating and expanding on early prevention and universal efforts as it sustaining and expands its system of care model.
a. **Expand professional development and training.** While current MHRC leaders are well trained in mental health services and delivery, they would benefit from professional training. Professional development can help demonstrate how to work collaboratively across disciplines and enable school administrators to implement policies that promote student health and mental health. The MHRC needs to continue training and involving its lead staff in grant writing and program planning as one of their programmatic functions.

b. **Develop an organizational vision that distributes workload according to experience, training and need.** The current MHRC organization is siloed and vertical with only one Lead Manager position. Future growth will require a more horizontal approach in order to sustain services, quality and satisfaction among providers, community, and students/family.

**Conclusion**

*That’s why I feel like the opportunity is now with mental health and the window may shut. But now is the time to take advantage of those relationships and those opportunities.*

Stakeholder

Adolescents are a particularly vulnerable group that require targeted interventions and models of service delivery. Neither child-centered nor adult-centered mental health models adequately respond to the needs of the developing adolescent. The high prevalence of mental health disorders among youth reinforces the importance of developing prevention strategies and promoting school-based early interventions for at-risk adolescents. School-based interventions have the potential for large-scale impact as a typical school day of 6 hours, 5 days a week, 180 days per year provides significant opportunities to improve mental and physical health of the adolescent through curriculum, pedagogy, and school/ community enhancements.

There exists a tremendous opportunity to reach children and youth with mental health needs through school based interventions and programming. Schools are already the major providers of mental health services and students are substantially more likely to seek help when school-based mental health services are available.\(^{30-32}\) Expanded school mental health services have also been found to reduce special education referrals,
improve aspects of the school climate, and produce declines in disciplinary referrals, suspension, grade retention, and special education referrals and placement among at-risk students. 69–71 The MHRC experience validates these reports and reinforces the need to understand not only the program specific outcomes but also the context within which these evidence-based programs are implemented.

While there is an increasing consensus for locating mental health programs and services in schools, major challenges, such as trained staff, limited options for referral to specialty care, and decreased funding, impede successful implementation and sustainability of programs.33–35 The MHRC provides a unique systems model to better understand how to address these challenges and improve the long-term sustainability of school based mental health efforts. Over its 15-year implementation period, the MHRC has been able to grow services, increase staff, improve mental health and academic outcomes among at-risk and vulnerable youth, decrease stigma, and sustain and expand funding. SDUSD’s success was influenced by a variety of internal and external contexts including the district’s flexibility to adapt and change, community readiness to address mental health, local and state stakeholders and policy makers, and family involvement and satisfaction. The recommendations described in this White Paper provide a beginning point to plan and implement the next 15 years of MHRC growth and innovation. Training and retention of staff, expanding universal services, strengthening key partnerships, sustaining funding, and increasing parent and student engagement will all be at the center of the efforts in San Diego. At this local level - it is here that the potential for long-term impact is greatest. The implementation of school based mental health services is one major step toward the realization of a healthy, functioning, and just society and San Diego can provide a model for the nation.
White Paper References


Agenda for Improving the Mental Health of Our Youth. Annenberg Foundation Trust at Sunnylands, University of Pennsylvania, Philadelphia.


Appendix B, Case Study Stakeholder, Parent, Student Interview Guides
Interview Cover Sheet

☐ Student   ☐ Parent   ☐ Stakeholder

Interview #: __________________________

Date: __________________________

Interview Site: __________________________________________

Consent:  ☐ Yes  ☐ No

Time Start: ________________ ☐ AM  ☐ PM

Time End: ________________ ☐ AM  ☐ PM

NOTES:
State and Local Stakeholder Interview Guide

Introduction:

Thank you for taking the time to meet with me and participate in this interview. As described in the consent form, I am conducting these interviews as part of a stakeholder analysis regarding school-based mental health services. I am conducting this research study as part of my requirements for my doctoral degree in the Department of Maternal and Child Health, at Boston University School of Public Health, Boston, Massachusetts.

I plan to conduct about 20 interviews to produce a case study based on a qualitative analysis of the information obtained during all the interviews. I would now like to ask you a few specific questions about your opinions and viewpoints regarding school-based mental health services.

State Stakeholder/Key Informant Interview Protocol

1. Tell me about your current role and how it supports the implementation of school based mental health services.

2. How have you seen school based mental health services evolve over the years?

3. What are some the challenges /obstacles that you see in the delivery of school based mental health services?
4. What roles do teachers and other school staff play in supporting the implementation of school based mental health services?
5. What are some of the current opportunities that exist for school based mental health services?

6. What programs do you consider models (in your state/nationally)?
7. What are the program components that make these programs models in your estimation?

8. How do you see current state (i.e., MHSA) and/or national (i.e, ACA) funding influence the delivery of school based mental health services?
9. How can the current system of funding and implementation be strengthened to assure long term sustainability of efforts?
10. What do you see as the future of school based mental health services?

11. Is there anything you would like to add to this interview that has not been covered?
MHRC Staff Interview Protocol

1. Describe for me your role in the MHRC? How long have you worked with the MHRC?
2. How has this program impacted you as a mental health provider?
3. Describe the students you serve.
4. What changes/development have you observed in the children as a result of the MHRC?
5. What is the benefit of school based versus clinic based mental health services?
6. What do you consider to be the strengths of the program? Weaknesses?
7. What do you see as a need that the MHRC could respond to if it had adequate funding and resources?
8. If I asked a parent about this program, what do you think they would say?
9. If I asked a teacher about this program, how do you think they would describe the impact of the program?
10. Why do you think the program has been sustained for as long as it has been?
11. Is there anything you would like to add to this interview that has not been covered?

MHRC Project Director’s Interview Protocol

1. Describe for me your role as project director for MHRC.
2. How were mental health services delivered/organized prior to the MHRC at SDUSD?
3. How has the system of care evolved over the course of implementing the MHRC? Which program components have been sustained since the inception of the program?
4. What are the core components to the MHRC? What do you consider to be the strengths of the program? Weaknesses?
5. How has funding supported or been a challenge to the MHRC?
6. How is the MHRC currently funded?
7. How is the program evaluated and monitored?
8. How does the administration of SDUSD support the MHRC?
9. Who have been the champions of the MHRC locally and nationally?
10. If I asked a parent about this program, what do you think they would say?
11. If I asked a teacher about this program, how do you think they would describe the impact of the program?
12. What impact have you seen in students because of their participation in the MHRC?
13. Why do you think this program has been able to sustain itself?
14. What impact has it had on SDUSD and the SD community it serves?
15. What are plans/vision for the future of this program? What are the challenges and opportunities you see?
16. Is there anything you would like to add to this interview that has not been covered?
Interview Protocol-Parents

Introduction:

- Introduce yourself
- Discuss the purpose of the study
- Provide informed consent
- Provide structure of the interview (audio recording, taking notes, and use of pseudonym)
- Ask if they have any questions
- Test audio recording equipment
- SMILE-make the participants feel comfortable

1. What services did your child receive at the MHRC?
   a. What grade was s/he when he began receiving services?
   b. How long did s/he receive services?
   c. For each service how satisfied were you?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td></td>
<td>Very dissatisfied</td>
<td>dissatisfied</td>
<td>unsure</td>
<td>satisfied</td>
<td>very satisfied</td>
</tr>
</tbody>
</table>

2. Are there some things you feel were especially good or helpful about the treatment your son/daughter received?

3. How is your son/daughter doing at school?
   a. How is s/he doing academically?
   b. How is s/he getting along with his/her teachers?
   c. How is s/he getting along with his/her friends and other students?

4. How is your son/daughter doing at home?
   a. How is s/he getting along with you?
   b. How is s/he getting along with other family members?

5. Have the services s/he has received helped him/her deal more effectively with his/her problems?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Yes, they helped</td>
<td>Yes, they helped</td>
<td>not sure how they</td>
<td>no, they really</td>
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<tr>
<td></td>
<td>a great deal</td>
<td>a little</td>
<td>helped</td>
<td>didn’t help</td>
<td>made things worse</td>
</tr>
</tbody>
</table>

   a. If yes, how have they helped?
   b. If no, why do you feel they were not helpful?
6. Did you get the kind of services you wanted?

1 2 3 4 5
Yes, Yes no really sure no, not no definitely
definitely generally really not

7. What is some advice you may want to give to parents who have children who may need mental health services?

8. Is there anything you would like to add or share about what we have discussed that you feel is important for me to know?

Concluding Questions and Statements
- Concluding Statement
- Thank them for their participation
- Ask if they would like to see a copy of the results
- Record any observations, feelings, thoughts and/or reactions about the interview
Interview Protocol-Students

Introduction:

- Introduce yourself
- Discuss the purpose of the study
- Review informed consent
- Provide structure of the interview (audio recording, taking notes, and use of pseudonym)
- Ask if they have any questions
- Test audio recording equipment
- SMILE - make the participants feel comfortable

1. When did you first use services at the MHRC?
   a. What grade were you in when you started?
   b. Tell me a little about the services you received.
   c. How long did you receive services from the MHRC?
   d. For each service how satisfied were you?

   1 Very dissatisfied  2 dissatisfied  3 unsure  4 satisfied  5 very satisfied

2. Are there some things you feel were especially good or helpful about your treatment?

3. Tell me a little about how you’re doing at school.
   a. How are you doing academically?
   b. How are you getting along with your teachers?
   c. How are you getting along with your friends and other students?

4. Tell me a little about how you’re doing at home.
   a. How are you getting along with your parent(s)?
   b. How are you getting along with other family members?

5. Have the services you received helped you to deal more effectively with your problems?

   1 Yes, they helped a great deal  2 yes they helped a little  3 not sure how they helped  4 no, they really didn’t help  5 no, they made things worse

   a. If yes, how have they helped?
   b. If no, why do you feel they were not helpful?
6. **Are you satisfied with the amount of help you received?**

1. Very dissatisfied  
2. Dissatisfied  
3. Unsure  
4. Satisfied  
5. Very satisfied

7. **Did you get the kind of services you wanted?**

1. Yes, definitely  
2. Yes, generally  
3. No, not really sure  
4. No, not really  
5. No, definitely not

8. **Is there anything you would like to add or share about what we have discussed that you feel is important for me to know?**

**Concluding Questions and Statements**

- Concluding Statement
- Thank them for their participation
- Ask if they would like to see a copy of the results
- Record any observations, feelings, thoughts and/or reactions about the interview
Appendix C, State and Local Stakeholders Interview List
### State Stakeholders

<table>
<thead>
<tr>
<th>POSITION</th>
<th>ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinator, Family Services</td>
<td>NAMI, San Diego</td>
</tr>
<tr>
<td>Director, Integrated Support</td>
<td>Sacramento City Unified School District</td>
</tr>
<tr>
<td>Services</td>
<td></td>
</tr>
<tr>
<td>Executive Director</td>
<td>CA Office of Statewide Planning and Development</td>
</tr>
<tr>
<td>Program Director</td>
<td>CalMHSA</td>
</tr>
<tr>
<td>Executive Director</td>
<td>UC San Francisco, National Adolescent Health Information and Innovation Center</td>
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<tr>
<td>Director</td>
<td>CA Adolescent Health Collaborative</td>
</tr>
<tr>
<td>Executive Director</td>
<td>CA School Health Centers Association</td>
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<tr>
<td>Education Programs Consultant</td>
<td>CA Department of Education, School Mental Health Services Programs</td>
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### Local Stakeholders

<table>
<thead>
<tr>
<th>POSITION</th>
<th>ORGANIZATION</th>
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</thead>
<tbody>
<tr>
<td>Project Manager</td>
<td>SDUSD, Mental Health Resource Center</td>
</tr>
<tr>
<td>Director, Behavioral Health</td>
<td>San Ysidro Health Center</td>
</tr>
<tr>
<td>Medical Liaison to SDUSD</td>
<td>UCSD Department of Pediatrics</td>
</tr>
<tr>
<td>Director, Student Attendance, Safety and Well-Being</td>
<td>SD County Office of Education</td>
</tr>
<tr>
<td>Program Manager, Screening Unit</td>
<td>SD County, Health and Human Services Children’s Mental Health</td>
</tr>
<tr>
<td>Lead Licensed Mental Health Clinician</td>
<td>MHRC</td>
</tr>
<tr>
<td>Lead Licensed Mental Health Clinician</td>
<td>MHRC</td>
</tr>
<tr>
<td>Vice Principal</td>
<td>San Diego City Schools</td>
</tr>
<tr>
<td>Education Specialist</td>
<td>San Diego City Schools</td>
</tr>
<tr>
<td>Evaluation Consultant</td>
<td>San Diego State University, CASRC</td>
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<tr>
<td>Instructor</td>
<td>San Diego City Schools</td>
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<tr>
<td>Lead Instructor</td>
<td>STAR Program, SDUSD</td>
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Appendix D, Coding Hierarchy and Definition of Codes
## Appendix D: Coding Hierarchy and Definition of Codes

<table>
<thead>
<tr>
<th>PWM DOMAIN</th>
<th>SUB-DOMAIN</th>
<th>_CODES</th>
<th>Description</th>
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<tr>
<td></td>
<td>School Site</td>
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<td>Role of Teacher</td>
<td>References to the central role of teaching staff in delivery of MH services</td>
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<td>Culture Clashes</td>
<td>References to education vs. mental health</td>
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<td>References to need for administrative support in MH implementation</td>
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<td>References to teacher, administrative and staff training</td>
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<td>References to staff, family, administrative communication on MH services, issues</td>
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<td>Environment</td>
<td>References to the school as the primary site for implementation</td>
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<td>References to role of leaders in the successful implementation of MH services</td>
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<td>References to state and national laws which influence local MH service delivery</td>
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<td>Political Climate</td>
<td>References to local, state, and national politics internal and external to SDUSD and MH service delivery</td>
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<td>References to processes for communicating among state and county entities with local MH implementers</td>
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<td>Linkages &amp; Partnerships</td>
<td>References to collaborations and linkages between county, state and local agencies</td>
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# Appendix D: Coding Hierarchy and Definition of Codes

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<th>_CODES</th>
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<td>References to communication among MHRC staff</td>
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<td>Communication outside of Staff</td>
<td>References to communication among MHRC staff and school staff, community</td>
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<td>Understanding of MH and Field</td>
<td>References to mental health and knowledge base among peers, teachers, and families</td>
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<td>Team Approach</td>
<td>References to MHRC team and staff collaboration</td>
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<td>HR policy and hiring process</td>
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<td>Training and Development</td>
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<td>Consistency</td>
<td>References to unified vision and goal orientation of MHRC team</td>
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<th>SUB-DOMAIN</th>
<th>_CODES</th>
<th>Description</th>
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<td>Availability</td>
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<td>References to funding needs to provide mental health services</td>
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<td>Scope</td>
<td>References to how many students, school sites MHRC reaches and limits of reach</td>
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</table>
BIBLIOGRAPHY


CURRICULUM VITAE

Ramón Abel Hernández, MPH, DrPH
1228 Connecticut Street, Imperial Beach, California 91932

Professional Profile

- Motivated achiever with a Master of Public Health in Health Service Administration and candidate for Doctor of Public Health in Maternal, Child Health.
- Vision focused, dedicated leader with local and national experience in adolescent and young adult development, academic enrichment programming, minority and urban health, non-profit management, public health education and prevention strategies, and coalition building.
- Strategic short and long-term systems oriented thinker with a proven track record of bringing together diverse communities and sectors to work toward a common mission and outcome driven objectives.
- Diplomatic, creative communicator, negotiator, and presenter.
- Bilingual/bicultural, fluent in writing, reading, and speaking Spanish. Comfortable, adept and respectful of working with many diverse cultures, traditions and belief systems.

Areas of Expertise

- Program development, implementation and evaluation
- Youth development, health and wellness
- Minority, urban and immigrant health
- Strategic planning and data driven decision making
- Adult and youth supervision, coaching, and mentoring
- Qualitative and Social Science research model
- Academic enrichment and mentoring programs
- Cultural competency curricula development and implementation
- Collaborative and coalition models
- Public and private grant and report writing
- Budget development, monitoring, and analysis

Education

- DrPH, Boston University School of Public Health, Maternal & Child Health, Boston, MA. January 2016.
Professional Experience

Project Director, *University of California San Diego School of Medicine*, November 2009 to present

- Managed the day to day operations of NIH and HRSA funded Comprehensive Research Center in Health Disparities (CRCHD) Training Core, The Hispanic Center of Excellence (HCOE), and the Health Careers Opportunity Program (HCOP). Programs focused on underrepresented and disadvantaged high school, community college and undergraduate youth and represented a total of over $9 million of funding.
- Developed and implemented all program components, including: research and cultural competency curricula, summer residential and yearlong academic enrichment and mentoring programs; youth leadership training and employment; summer and academic year structured internships.
- Monitored progress of all student pipeline programs toward project objectives, tasks, and timelines based upon funding source deliverables.
- Developed and conducted research and evaluation on wide range of academic pipeline programs targeting underrepresented minority and disadvantaged groups in the health and biomedical sciences.
- Supervised and mentored a youth staff of 15 and mentored and coached an adult staff of 6.
- Established and maintained strategic partnerships with local, state and national academic, community and university partners.
- Led all dissemination efforts across a variety of platforms including print, electronic and social media.

Associate Director, Education, Outreach, and Public Programs, *San Diego Museum of Art*, San Diego, California, August 2003 to August 2007

*Recruited to lead community and school partnerships, strengthen curriculum, and stabilize funding and income streams*

- Led a dynamic education department that included management and direction of: library services, docents, outreach team, bi-national initiatives, art school, public programs, and school - based partnerships.
- Supervised 8 full-time staff, 12 part-time staff, and supported the management of over 30 volunteers.
- Developed and monitored annual budget, assisted in policy writing, updating of standards based curriculum, and evaluation.

Adjunct Professor, Graduate Program, *Springfield College*, San Diego, California, July 2001 to May 2004

- Developed and taught graduate level core class *Developing Multicultural Communities* at the School for Human Services.
- Responsible for class development, lectures, grading, and ongoing student support.
Director, Community Programs and Collaborations, YMCA of San Diego County, San Diego, California, July 2001 to August 2003

Promoted within YMCA leadership to direct and lead new department of community and school-based partnerships and programs

- Directed six community-based programs within the Youth and Family Services Department. Program services included: mentoring, tutoring, after school activities, counseling, health and mental health referrals, youth leadership, technology access and knowledge, and a large community based collaborative.
- Established and maintained community partnerships with schools, businesses, community organizations, community leaders and parents.
- Led the planning and early implementation efforts of the Meade Avenue Community Center.
- Responsibilities included: program development, grant writing support, evaluation, fundraising, report writing, staff supervision, budget development and management, and direct services.

Project Director, YMCA of San Diego County, San Diego, California, June 1999 to July 2001

- Implemented the $1.2 million 21st Century Community Learning Centers project funded by US Department of Education to San Diego City Schools. Lead liaison between San Diego City Schools, US Department of Education, and the YMCA of San Diego County.
- Developed all related programming at three elementary and one middle school site. Core services at each site included: group and one-to-one mentoring, family home visits, academic tutoring, after school enrichment activities, clinical counseling, peer mediation, youth leadership groups, and parent education and skill development.
- Responsibilities included program and budget development and oversight, local and federal reporting, evaluation, and supervision of all program staff.

Lead Instructor/Development Assistant, La Escuela Tlatelolco Centro de Estudios, Denver, Colorado, September 1997 to August 1998

- Instructor, advisor, and mentor for seventh through twelfth graders at 30+ year-old private independent community school for Mexican/Chicano youth.
- Responsibilities included course advisement, parent liaison, youth development work, and writing and implementation of Math, Science, and Health curriculum for all grades.
- Played a key role in the strategic plan and growth of La Escuela to include elementary school grades.
- Assisted CEO/President in fundraising, grant writing, and corporate solicitation for school funds.


- Organized citywide planning grant addressing children and youth’s safety and health. Chicago was one of eight cities selected by the Robert Wood Johnson Foundation for this national planning project.
Responsibilities included: community organizing, liaison to broad-based city-wide coalition, committee development and staffing, project planning and organization, oversight of data collection, focus groups, trainings, and evaluation and materials development.

**Director, ROCA, Inc., Chelsea, Massachusetts, February 1994 to December 1995**
- Led and managed $1.5 million youth service organization working with 12–21 year olds in Chelsea, Massachusetts. ROCA, Inc. is a holistic youth development organization that has gained state, regional and national recognition for its youth and community development and social justice work.
- Supervised 8 adult and 12 youth staff, led overall program direction, and co-led strategic planning process.
- Other responsibilities included: direct youth service, grant writing, budget oversight, personnel oversight, community networking, evaluation, and report writing.

**Project Coordinator, Boston City Department of Health and Hospitals, Boston, Massachusetts, November 1992 to February 1994**
- Formed and sustained the Jamaica Plain Healthy Boston Coalition, representing over 25 community groups and agencies.
- Responsibilities included: planning and start-up activities, completion of neighborhood needs and resource assessments, writing action and implementation plans, coalition support, report and grant writing, office oversight, newsletter publication, and neighborhood workshops.

**Program Coordinator, Community Research Initiative of New England, Boston, Massachusetts, October 1990 to November 1992**
- Develop and implemented education programs and outreach for community based HIV/AIDS research initiative.
- Advocated for underrepresented communities in HIV/AIDS research in New England at the local and national level.
- Responsible for all educational material development, representation on local and national boards, and advocacy with regional teaching hospitals.

**Program & Planning Coordinator, Massachusetts Department of Public Health, Lawrence, Massachusetts, June 1988 to September 1990**
- Created the Merrimack Valley AIDS Coalition, representing 17 cities and towns and over 25 community organizations and health systems.
- Implemented a regional HIV/AIDS need assessment, led community organizing efforts, advocated for HIV/AIDS communities, developed youth led HIV/AIDS education efforts, and published final assessment report with the state.
Youth Coordinator, Merrimack College/MA Board of Regents, North Andover, Massachusetts, September 1988 to September 1990

- Led efforts to identify, recruit and mentor high-risk, vulnerable youth at Lawrence High School.
- Responsibilities included family, parent, and teacher contact, home visiting, tutoring, after school activities, and summer college immersion camp.