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Collaborative Community Prevention: An Ecological Approach to Mental Health Support for Children in Rural America

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LOYOLA UNIVERSITY CHICAGO

COLLABORATIVE COMMUNITY PREVENTION: AN ECOLOGICAL APPROACH
TO MENTAL HEALTH SUPPORT FOR CHILDREN IN RURAL AMERICA

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN SCHOOL PSYCHOLOGY

BY

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CHICAGO, ILLINOIS

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ABSTRACT

There exists a dearth of research literature devoted to informing mental health practice in rural areas. However, what little research that does exist surrounding children's mental wellness in rural places describes mental health programs as being smaller, under-served versions of their urban counterparts (National Association for Rural Mental Health, 2001). Mental health collaboration in rural areas is a clear need and an ongoing challenge. This study aims to address these concerns by reviewing relevant theories, analyzing one rural community's mental health needs, and identifying next steps in mental health service delivery for this community.

Additional research surrounding the mental health of children in schools indicates that children benefit most from mental health services when the context of both the individual child and the child's environment is taken into account (Bronfenbrenner, 1979). Further, when taking the individual and systemic levels into account, research indicates that ideal delivery systems incorporate a preventative, public health model approach that uses a Multi-Tiered System of Support (MTSS). (Friedman, 2003). One way to effect change such as this is to create a school-family-community partnership. Such partnership allows previously separate organizations to create a common mission, streamline services, reduce redundancies, and enhance communication between professionals.

This study utilized a qualitative case study design of a rural county in the Midwestern United States, addressing the following research questions: How does one identify and enhance collaborations in rural mental health? What are barriers to creating an integrated system of support for children, adolescents, and families? What do community members see as the biggest concern for youth and the system currently serving them? What supportive services and resources already exist and can be built upon? In reviewing the literature, what is available or recommended to support the community in addressing its concerns?

CHAPTER ONE

INTRODUCTION

Mental health collaboration in rural areas is a clear need and an ongoing challenge. However, there has been a dearth in the research literature devoted to informing mental health practice in rural areas. This study aims to address this gap by reviewing relevant theories, analyzing one rural community's mental health needs, and applying relevant literature.

Every child develops within four main subsystems that affect his or her schema, well-being, and learning (Bronfenbrenner, 1979). Further, there is a system of overlapping spheres that encompasses the interaction between people, their learning, and their environment, which indicates that these spheres directly affect student learning, mental health, and development (Epstein, 1987). Essentially there is an intimate interaction between the individual and his or her environment, and if communities do not sufficiently address social, emotional, and physical health stressors affecting children's development, they may become significantly negatively impacted (Anderson-Butcher & Ashton, 2004).

There are a number of risk factors facing children in rural areas, which is of particular concern. Rural areas have been defined by the White House Office of Management and Budget to be a county with a core of at least 10,000 people but less than 50,000 people (OMB; U.S. Department of Health and Human Services, n.d.). Those

living within rural areas may often be characterized as vulnerable due to a higher likelihood of living in poverty, lacking health insurance, reporting poor health, and having a chronic health condition (Jameson & Blank, 2007) as well as fewer help-seeking behaviors, limited availability of human resources, and limited availability of financial resources (Clopton & Knesting, 2006). However, interagency collaboration and coordination can mediate those barriers to mental health services for children, and has also long been stressed as essential for meeting the needs of children in rural areas (Clopton & Knesting, 2006).

Background

Extensive research surrounding the mental health of children in schools indicates that children benefit the most when the context of both the individual child and the child's environment is taken into account. Bronfenbrenner's ecological systems model (1979) demonstrates how everything in a child and in that child's environment affects how a child grows and develops.

In addition to the ecological system's model, Epstein (1987) provides a model of overlapping spheres that encompasses the interaction between children, their learning, and their environment, which directly affects student learning and development. These spheres include (1) schools; (2) families; and (3) communities. The three contexts in which students grow can be brought together or pushed apart, as there are moments when the spheres act separately and moments when the spheres act together to influence children's learning and development (Epstein, 1987, Epstein 1992, Epstein 1994). There has been a growing call for the incorporation of this model and that of multitiered system of supports (MTSS) by the National Association of School Psychologists (2015);

specifically, the organization advocates for the facilitation of collaboration between school providers, community agencies, and other outside mental and behavioral health providers.

When examining issues surrounding children's mental health, it is also important to incorporate a preventative, public health model. Public health models focus on the mental health of all children within a population and can be used to track the occurrence and rate of a problem, identify risk and protective factors that can then inform interventions, design and evaluate interventions, and disseminate all of the gathered information (Friedman, 2003). Furthermore, the public health model helps psychologists and other professionals to investigate the cause of a given problem and to evaluate what factors, environmental, family or individual, may contribute to the problem. In providing the continuum of care that tiered services supports, schools and communities can form interventions that accelerate positive development, address problems as early after onset as possible, and introduce special assistance for acute and long term problems (Adelman & Taylor, 2014). This approach allows communities to focus on making services widely available and addressing individual, cultural, and environmental factors that affect mental health in an effort to not just treat mental illnesses and provide triage, but also to prevent mental illnesses (NASP, 2015). Further, using a tiered approach to mental wellness reinforces academic, social, emotional, and physical improvement (Adelman & Taylor, 2014). Finally, when taking the public health model into account, it is also important to consider the research coming out of the field of implementation science. Specifically, this field evaluates how to create sustained change through the use of evidence-based interventions (Madon, Hofman, Kupfer, & Glass, 2007).

One approach broadly recognized as a way to take these models and theories into consideration in practice is to use a school-family-community partnership. A collaborative partnership used within the aforementioned models would provide a structure that incorporates common missions from previously separate organizations with the intent to change the way services are designed and delivered (Anderson-Butcher & Ashton, 2004; Bodilly, Chun, Ikemoto, & Stockly, 2004). Meyers, Tobin, Huber, Conway, & Shelvin (2015) have engaged in collaborative work such as this and have seen much success and great impact on the children and the rural community in which they live. Specifically, Meyers et al. (2015) created a universal Social Emotional Learning (SEL) program for use in the schools as part of a countywide multi-tiered system of support. This system extended across a variety of service delivery sectors, such as public health, juvenile justice, medical, mental health, and education. Overall the researchers found when creating these changes there is a need for great attention to relationship building. In addition, the researchers concluded that ongoing communication at multiple levels of the system is key.

These partnership approaches may be especially important for rural areas because they allow for key stakeholders to accommodate the unique issues of the community where privacy, self-determination, and reluctance to acknowledge problems can be the norm. Despite these individualistic traditions, many people in rural communities feel they can work together to solve problems and will engage in high levels of trust and civic engagement with other community members (Clopton & Knesting, 2006). This community cooperation is key, especially when rural mental health programs are criticized as being smaller, under-resourced versions of their urban counterparts (National

Association for Rural Mental Health, 2001). The National Association for Rural Mental Health noted that when community partners work together, they can serve the students in the communities where they live and are comfortable, resulting in increased access to services and more effective treatment, which is especially important as there are great disparities in mental health services within rural communities as compared with their urban counterparts (National Association for Rural Mental Health, 2001).

Currently, most of what is known about collaboration is based on findings from urban settings and there is a dearth of literature examining interagency collaboration in rural areas, although the little that is known suggests that schools in rural areas report significantly lower rates of support from community partners (Hobbs, 1994; Pawlaowski, 2007). Some previous work has attempted to connect the ecological theory with the practice of interagency collaboration in rural areas (Meyers, et al., 2015). However, there is still little known about interagency collaboration and its effectiveness in promoting and addressing children's mental health and well-being in rural areas.

Purpose of the Study

The literature reviewed provides an overview of the complexity and the importance of interagency collaboration for children's mental health in rural areas. This study will seek to address some of the gaps in the literature by conducting a qualitative analysis using a case study design within a rural county in the Midwestern United States. This study will address the following research questions: How does one identify and enhance collaborations in rural mental health? What are barriers to creating an integrated system of support for children, adolescents, and families? From the community standpoint, what do community members see as the biggest concern for youth and the

system currently serving them? What supportive services and resources already exist and can be built upon? In reviewing the literature, what is available or recommended to support the community in addressing its concerns?

This study addresses these questions via interviews and a qualitative record review of existing data. Interviews took place with key stakeholders within the community, which included members of the county's Mental Health Board (MHB), the Human Resource Center, the Drug Court, non-profit mental health agencies, private medical practices, community mental health centers, a Children's Advocacy Center, the YMCA, parents, school psychologists, school counselors, and law enforcement agents. Every participant was asked if there were any specific people who should be interviewed and included as a member of a county-wide collaboration initiative. Participants identified barriers to collaboration and the provision of mental health services within their specific community, areas of strength within their community, goals for the collaborative that is to be formed among community agencies, and methods for creating change within their county.

Research Design

The present case study used qualitative methodology, which allowed for natural settings, multiple sources of data, inductive data analysis, and a holistic account of the beginning stages of developing a collaborative for mental healthcare provisions to children between the ages of 0-18 years in a rural county (Cresswell, 2009). A total of twenty interviews were conducted in conjunction with a record review of existing data in order to investigate the process of developing a collaborative between professionals with a stake in children's mental health and well-being. Within the interviews, participants

were asked about planning, implementation goals, and the potential sustainment of the collaboration. Further, existing data was reviewed to gain an understanding of the school climate in the county (e.g., youth risk behaviors and feelings of safety in the schools) as well as the role of the major mental health service provider in the county. In doing so a greater understanding was gained of the areas of strengths and weaknesses in providing mental health services to children within rural settings.

Semi-structured interviews were conducted with key stakeholders. All interviews were then inductively analyzed using steps outlined in Hill, Thomson, and Nutt-Williams' (1997) guide to consensual qualitative research (CQR). The steps to this data analysis technique will be further explained in Chapter 3. In short, this process utilizes the development of domains and codes to categorize all raw material into themes, followed by extensive auditing and cross analysis to ensure a thorough understanding of all themes exposed by the interview process.

Delimitations

It has been assumed within this study that all participants answered interview questions truthfully and accurately and to the best of their individual abilities. Further, although the researcher is not personally connected to the county, this research is driven as much by the community as it is the researcher. In this case, it was imperative the researcher stay as objective as possible when analyzing the data so as not to compromise the results.

This study is solely a representation of one type of rural county within the United States. It cannot be generalized with any certainty to other rural areas due to the inherent diversity that exists throughout these regions and the individual context in which this

study takes place. Despite that fact, this study provides future researchers with an understanding of what one rural community needs to create an interagency collaboration designed to support student mental health service provision and adds to the limited literature surrounding this topic.

CHAPTER TWO

REVIEW OF THE LITERATURE

This chapter reviews the professional literature in order to provide a context for the purpose and rationale of the current study. Specifically this chapter reviews the ecological model and related theories of learning, the following section reviews the application of these theories to schools in the form of collaboration, and then more specifically collaboration as seen in rural areas affected by poverty.

Theoretical Framework: Ecological Model and Related Theories of Learning

As demonstrated by Piaget's seminal work, learning is an active and constructed process. The child creates schemas – mental structures that explain phenomena – throughout his/her development, and is considered to learn when situations occur that require the child to assimilate and accommodate new information into those schemas (Brainerd, 1978; Piaget, 1969). Furthermore, information that affects a child's schemas can come from many different aspects of the child's life.

Brofenbrenner's (1979) ecological model illustrates four main subsystems that affect the *individual/child* (e.g., personality style, age, experiences, self-esteem, interpersonal competence), the child's schema, and consequently the individual's well-being and learning. These four subsystems include the: (1) *microsystem*, individual's interaction with a particular place where they engage in specific activities and social roles (e.g., son, daughter, student); (2) *mesosystem*, the interrelations between major settings

and the individuals at a specific point in their lives (e.g., family-school interactions, family-community interactions, school-community interactions); (3) *exosystem*, formal and informal structures that indirectly influence the individual (e.g., poverty training for staff, increased research in the field of psychology, preventative public mental health models); and (4) *macrosystem*, existing prototypes in culture and subculture that set the pattern for effects on the individual level (e.g., norms, values, beliefs, traditions, and policy; Greenleaf & Williams, 2009). The interaction of these four subsystems affects not just an individual's academic learning but also the child's perception of his or her surrounding world and the development of his or her mental health and well-being.

Another factor that falls within the macrosystem and strongly influences an individual's learning and development is culture. Culture occurs at the intersection of norms, values, beliefs, and traditions. Social cognition theory provides a framework for how culture plays a large role in the child's overall construction of knowledge (Vygotsky, 1978). Social cognition theorists argue that cognitive development occurs when children acquire and process information received from interactions in specific activities and with specific people (e.g., teachers, parents, or friends) thereby increasing the child's understanding of the world (Ibid, 1962; Vygotsky, 1978). To further this concept, situated learning theorists posit that learning itself is situated in a specific activity, context, and culture. That is, learning occurs within a "community of practice" which has been organized around beliefs, behaviors and knowledge. Most importantly, and similarly to Bronfenbrenner's model, these theories predicate that learning and development occur in places where young people spend time and within the relationships

young people share with those around them (Brown, Collins, & Duguid, 1989; Lave, 1988).

In addition to the idea that there is a “community of practice” from which children learn their beliefs, behaviors, and knowledge, there also exists the theory of Positive Youth Development (PYD). PYD refers to ongoing processes in which meaningful content, practice, and opportunities for active participation help students build the skills needed to be equipped for life. Awareness of students’ strengths is at the center of this theory, and it is believed that positive growth is more likely to occur when the environment builds upon these strengths (Benson, Scales, Hamilton, & Sesma, 2007). According to this theory, negative mental health development, however, can occur when one thinks about youth as problems in need of fixing rather than emphasizing their skills and building their assets (Benson, Scales, Hamilton, & Sesma, 2007).

Finally, Epstein (1987) provides a model of overlapping spheres that encompasses the interaction between people, their learning, and their environment, indicating that these spheres directly affect student learning, mental health, and development. This concept is similar to Bronfenbrenner’s ecological theory as the spheres include: (1) schools, (2) families, and (3) communities. The external model of overlapping spheres recognizes that these three contexts in which students grow can be brought together or pushed apart. As such, there are moments when the spheres act separately and moments when the spheres act together to influence children’s learning and development (Epstein, 1987, Epstein 1992, Epstein 1994). Epstein’s model can be considered a more in-depth explanation of *mesosystem*, as the *mesosystem* is the interaction between agencies in a child’s life (e.g., the interaction between schools and families). Schools, in particular, have the opportunity

to choose to keep these spheres of influence relatively separate, but they also have the option to conduct high-quality interactions among the three spheres to give students common messages from varying people about the importance of school, working hard, thinking creatively, helping one another, and staying in school (Epstein, 2010). These messages are especially important as the child is considered the main force in his/her education, development, and success in school. The child is a crucial member in his/her development and success; therefore, any partnerships between agencies are best designed, and have a greater effect, when they actively engage, guide, energize, and motivate students (Epstein, 1995).

An example of bringing the three spheres of school, family, and community together would be a school that invites a community based health clinic to work out of an office adjacent to the school. This clinic may serve any number of mental and physical health issues that could arise within the student population (e.g., trauma, behavioral disorders, or transition concerns). If this school-based, community-run clinic were conducting a trauma group designed specifically for the schools, then it could accommodate families of the children who experienced the trauma as well as the teachers of those children. In this scenario not only would students be receiving greatly needed mental health services, but so too would families. At the same time, school staff could be given a greater understanding of what to expect within the classroom and how they can best support the individual student. Examples of such school-based mental health supports can be found in Lean and Colucci (2013) and in Doll and Cummings (2007).

Another example of the overlapping of spheres in action is that of an established tutoring organization with a working base in one of the schools it serves (Karahalios,

Sprague, & Shriberg, 2014). The tutoring organization in this scenario brings tutors from the community to the school after the school day has ended. They are then given greater access to student academic needs and support from the teachers via a communication system created specifically for the program through which the tutors and the teachers can update one another about student progress. This is a clear example of an interaction between two spheres in a child's life (school and community) overlapping to help actively engage and motivate a child to succeed in school and to provide the child with a positive relationship with an adult they can rely upon.

The public health model should also be taken into account when considering the mental health of children. The U.S. Surgeon General (U.S. Department of Health and Human Services [USDHHS], 1999) has argued that it is necessary to move from a medical, diagnostic model focusing on diagnosis and treatment of mental health illnesses to a more preventative public health model. Public health models are beneficial because they can be used to track the occurrence and rate of a problem, identify risk and protective factors that can then inform interventions, design and evaluate interventions, and disseminate all of the gathered information (Friedman, 2003). Furthermore, the public health model helps psychologists and other professionals to investigate the cause of a given problem and to evaluate which environmental, family or individual factors may contribute to the problem while working within multi-disciplinary teams. This would allow communities to focus on making services widely available and address individual, cultural, and environmental factors that affect mental health in an effort to not just treat mental illnesses and provide triage, but also to prevent mental illnesses (Strein, Hoagwood, & Cohn, 2003).

Much research within the field of implementation science examines the best way to make the changes that the public health model suggests. Specifically, the field of implementation science studies methods to promote the integration of research findings into healthcare policy and practice while simultaneously addressing the need to implement effective, evidence-based approaches as well as strategies for doing so (Forman et al., 2013; Madon, Hofman, Kupfer, & Glass, 2007). Using the framework provided by implementation science allows educators and mental health professionals to evaluate the programs such that they may understand why established programs lose their effectiveness or show unintended effects. A review of the implementation science literature demonstrated that public health and community-based practitioners often underutilize evidence-based interventions due to a lack of ability and motivation (Dodson, Baker, & Brownson, 2010; Steele, et al., 2014).

However, Leeman and colleagues (2015) examined a strategy for building practitioners' capacity to adopt and implement evidence-based interventions, as recommended by the public health model. Specifically, the authors reviewed the framework suggested by Wandersman et al. (2008), called Evidence-Based System for Innovation Support (EBSIS). This framework provides practitioners with strategies, anticipated outcomes, mechanisms for change, and mediating variables (e.g., practitioner capacity and planning behaviors) in the hopes that evidence-based interventions will be adopted and implemented with integrity. In their review of studies using this framework, Leeman et al. (2015) found continued support for the use of this framework, especially in schools and communities, which were the most common settings for capacity building interventions. The review found that the use of the EBSIS framework increased

communities' capacity to implement and adopt evidence-based interventions because it increased planning behavior through combining training, technical assistance, and the use of specific tools. In other words, communities that use the EBSIS framework are able to increase awareness, knowledge, skills, self-efficacy, and motivation in order to assess the context of the community and engage the change team in selecting, adapting, integrating, evaluating, and sustaining evidence-based interventions. Overall the authors found that building capacity within the community context is the best way to increase the adoption and implementation of evidence-based interventions (Leeman et al., 2015).

Other researchers have also sought to understand the best framework for providing and improving mental health care for children. Nastasi (2004) examined previous literature and determined that there are five components that create successful mental health support for children in communities, these include: (1) interagency and interdisciplinary collaboration for health, mental health, educational, and social service needs; (2) services on a continuum from prevention to treatment; (3) an ecological focus; (4) evidence based interventions; and (5) systematic program evaluation. Furthermore, Nastasi (1998) calls for communities and researchers to use a theory-research-action paradigm that utilizes existing theories and research to generate problem definitions and inform data collection. This strategy modifies existing theories to account for culture-specific and population-specific factors. In essence, a theory would be created that would be entirely specific to the culture where the research is occurring, which would naturally guide the development of interventions, evaluations, and subsequently further theory and research specific to the culture of the community.

Nastasi's viewpoint (1998) also states that in order to develop ecologically valid models of intervention, the elements of the intervention must be relevant to the targeted culture. In order to understand the individual, one must first understand the culture. Therefore, the intervention must use the language of the population and reflect members' values and beliefs because one cannot separate person from culture. As such, any future change efforts must address the role of culture in promoting and sustaining behavior patterns. Nastasi (1998) argues that both the researcher and stakeholders from the target culture and relevant ecological systems (e.g., educators and community members) should work as partners to identify the key individual, cultural, and ecological variables, develop interventions, and evaluate program acceptability and sustainability.

A common theme from these varying theories has begun to appear, and it is clearly seen that there is an intimate interaction between the individual and his or her environment. This interaction has the potential to affect a student's learning, mental health, and development in either a positive or a negative manner. As such, the need for agencies (e.g., schools, mental health centers, doctors' offices, youth centers, and surrounding businesses) to collaborate with each other in order to serve the students becomes apparent. Several researchers have attempted to address the interaction between the individual and his/her culture in their work (e.g., Hunt, et al., 2002; Jimerson, Ferguson, Whipple, Anderson, & Dalton, 2002; Killea, 2013; Nastasi, Varjas, Sarkar, & Jayasena, 1998; Schensul, 1998; Varjas, et al., 2006). Notably Nastasi, et al. (1998) found that in order to develop culture-specific interventions, formative research is critical and, in their case, allowed them to identify the domains (e.g., academic achievement) that were critical for understanding and influencing mental health of Sri Lankan youth.

Additionally, Nastasi et al., (1998) found that key stakeholders must be involved because they are able to not only provide culture-specific definitions, but they can also participate in intervention design, implementation, and evaluation.

Another strong call for community-agency collaboration is that, unfortunately, children are being increasingly exposed to a greater number of physical and emotional stressors within the various systems in which they exist. These stressors can become risk factors because of the way the environment interacts with the individual and affects the child's ability to learn (Bronfenbrenner, 1979). Communities must address the growing number of social, emotional, and physical health stressors if schools are going to be able to educate students (Anderson-Butcher & Ashton, 2004). Both the public health model and the ecological model articulate that interventions will be most effective when the interaction between the person and the setting and culture is taken into account (Bronfenbrenner, 1979; Meyers, Meyers, & Grogg, 2004; Meyers & Nastasi, 1999). It is necessary to integrate goals and systems via collaboration between professional organizations and across disciplines. One way to achieve this integration is through interagency collaboration.

Interagency Collaboration

Anderson-Butcher & Ashton (2004) stated it well when they noted, "No agency or professional can succeed alone in addressing the multifaceted needs of students and their families" (p. 40). Also underlying the push for collaboration between schools and communities is the framework of how organizations connect and how different community levels (e.g., school, family, community) impact students' learning (Bronfenbrenner, 1979; Epstein, 1995). Research regarding school and community

agency collaboration surrounding mental health began appearing consistently in the literature only within the past 25-30 years, in the late 1980s and early 1990s. Usually, this literature has examined how to facilitate collaboration, identify barriers to collaboration, and preliminary outcomes of collaboration (Faddoul 1989; Firestone & Drews, 1987; Levy & Copple, 1989; Melaville & Blank, 1991; Melaville, Blank, & Asayesh, 1993; Robinson & Mastny, 1989; Rodriguez, McQuaid, & Rosauer, 1988). Based on this research, collaboration has been defined as a formal working partnership between schools, families, and various local organizations and community representatives (Adelman & Taylor, 2007).

Collaboration stems from previously separate organizations becoming a single structure with a commitment to a common mission and unified goals, all in an attempt to change the way services are designed and delivered (Anderson-Butcher & Ashton, 2004; Bodilly, Chun, Ikemoto, & Stockly, 2004). Interagency collaboration occurs when two or more independent organizations, with different missions (e.g., a school and a mental health clinic), work together to reach a common goal. This type of collaboration is critical because, as stated previously, schools cannot be the sole entity to help children, and their abilities to teach children are challenged by stressors such as poverty, mental health concerns, and family conflict (Anderson-Butcher & Ashton, 2004), which outside agencies are also able to address – sometimes with greater efficacy than schools.

For example, community agencies often have the ability to provide mental health services that schools cannot, including: various types of counseling, outreach, and support to children that are unfeasible for school personnel to conduct due to issues surrounding liability, limited time available during the school day to reach students,

limited access to families, and qualifications of the mental health staff. Examples of agencies which can provide such supports include: nonprofit social services agencies that provide eight-week therapeutic social skills groups; mentoring programs such as Big Brothers and Big Sisters; internships and training provided by local businesses; and school resource officers funded through community-oriented policing services (Anderson-Butcher & Ashton, 2004). These types of collaborations work best when the operations of multiple agencies are coordinated and synchronized with each other and community stakeholders (e.g., parents, students, community leaders, schools, city government, mental health providers, and others). In synchronizing their efforts and goals, collaborators can begin to focus on the inclusivity and diversity of all members of the community rather than just students (Anderson-Butcher & Ashton, 2004).

Ideally, collaborations consist of a blend of resources that include at least one school, with community individuals, community-based organizations, businesses, programs at parks and libraries, and any facility used for recreation, learning, enrichment, and support (Adelman & Taylor, 2007). Specifically, schools and communities can provide a continuum of interventions that promote overall child wellness and therefore accelerate positive development by addressing problems as early after onset as possible (Adelman & Taylor, 2014). According to Adelman & Taylor, (2014), when the community and the schools collaborate to employ interventions that speak to those aspects, they can reinforce social, emotional, and physical improvement in addition to academic improvement. Additionally, communities that offer school-like opportunities and family-like settings and services reinforce good progress, creativity and excellence,

while also creating a learning community and a caring community (Epstein, 2010; Henderson, Johnson, Mapp, & Davies, 2007; Lewis, Schaps, & Watson, 1995).

Importance of collaboration to school psychology. School psychologists are mental health service providers in the school who have the training and expertise to coordinate mental health services among multiple stakeholders. In recent years, there has been a call for school psychologists and other school mental health professionals to collaborate with key stakeholders in the surrounding community in order to meet the needs of students, because no one individual or organization can succeed alone (National Association of School Psychologists, 2010). Traditionally, school psychologists have had a primary role in testing for special education, while social workers have served the social emotional needs of the family. In the health arena, nurses and doctors have protected the physical health of students while businesses and youth centers have provided students with the opportunity to explore goals for the future. However, all of these professionals have been working individually rather than collaboratively; and in order to meet the needs of their students' schools, Griffin and Farris (2010) argue that school psychologists should "step outside of the traditional role... and take on a strengths-based perspective" (p. 253). In other words, school psychologists should be open to allowing the strengths of others in the students' community to help provide support.

Other researchers have also advocated for more community support for the schools, especially surrounding social-emotional concerns. For example, Cowan and Vaillancourt (2013) note there is still an increased need to expand mental health services for all children and adolescents in America, as there are still many children with unmet

mental health needs (Nastasi, 2004). In response to this, Dowdy and colleagues (2015) argue for a school-based consultation program for mental health via a multi-disciplinary school-based care team. In implementing such a comprehensive strategy, they argue, children who are “just getting by” can be helped at the same time as those children in need of urgent care. This approach would then align better with the prevention and multi-tiered models of service delivery in use today (Radcliff & Cooper, 2013), as it would screen all students to offer them equal opportunity for early identification (Dowdy, Kamphaus, Twyford, & Dever, 2014). In this, a multi-disciplinary approach can be used such that team members can screen for signs of distress while having a planned response, protocols for interventions, and school psychologist awareness of how to best work with various team members (Dowdy et al., 2015). With these calls for schools to focus on more prevention based supports for academics as well as social emotional health, it becomes even more important for schools to engage with all providers, whether they work within the school system or outside of it.

There are many reasons for developing school, family, and community partnerships but most important is to help all students succeed in school and in later life (Epstein, 1995). Griffin and Farris’ (2010) call for action should truly be taken one step further. It is important for all providers in children’s lives to step outside their current, individualistic role. Instead, they must work together to achieve a preventative approach to mental health as Nastasi (1998) suggests. In strengthening the relationship and building solidarity between the school and community, professionals can increase communication, education, discussion, and feelings of support from other professionals. This, in turn, benefits all stakeholders and builds strong relationships. At the same time,

understanding the context in which students live can increase: (1) understanding of the issues students face; (2) student academic performance; and (3) rates of student attendance, all while concurrently reducing the rate of school suspensions (Anderson-Butcher & Ashton, 2004).

Forming strong collaborative relationships improves the present status and future well-being of children (Knox, 1999) because when, “the multiple needs of children, youths, and their families are met, students will come to school prepared to learn” (Anderson-Butcher & Ashton, 2004, p. 43). And, when implemented properly, collaborations can improve schools, strengthen families and neighborhoods, and markedly reduce students’ problems (Adelman & Taylor, 2007).

It is important to note that although collaboration between community agencies helps to prevent dropout rates, improve academic performance, and mental health, it does not necessarily guarantee success. The relationship between the school and the community agencies becomes a foundation but without dedication and hard work from stakeholders success is minimal (Porowski & Passa, 2011). When the community and activities within the community become an integral part of a student’s life and learning experiences, it serves as a protective factor for students who may be vulnerable (e.g., exposure to violence, mental illness, or living in poverty; Mathis, 2003).

Contextual Factors in Rural America

The United States government commonly uses two different definitions in order to define rural. The first is provided by the U.S. Census Bureau (2011) and is based primarily on population counts and residential population density. This definition states that an urban area is comprised of a densely settled core of census tracts and/or census

blocks that meet minimum population density requirements, along with adjacent territory containing non-residential urban land uses and territory with low population density included in order to link the outlying densely settled territory with the densely settled core. Essentially, in order to be defined as an urban area by the U.S. Census Bureau, the geographic region must encompass at least 2,500 people (this encompasses suburban areas), and at least 1,500 of those people must reside outside institutional group quarters. Any geographic region not meeting such dimensions is considered rural.

The second commonly used method to define a rural county is provided by the White House Office of Management and Budget (OMB; U.S. Department of Health and Human Services, n.d.). This definition states that counties with a core of at least 10,000 people but less than 50,000 people is considered a Micropolitan county, whereas those counties with a core urban area of 50,000 or more population is a Metropolitan county. Further, the OMB adds that all Micropolitan counties are considered rural (U.S. Department of Health and Human Services, n.d.). The definition provided by the OMB will be the definition used to define rural for this proposed study.

Individuals who currently live in rural areas are often characterized as a vulnerable population due to a higher likelihood of living in poverty, lacking health insurance, reporting poor health, and having a chronic health condition (Jameson & Blank, 2007). Additionally, a 2014 National Healthcare Quality and Disparities Report compiled by the U.S. Department of Health and Human Services found that some disparities between rural and urban areas have been worsening over time at a change rate of -1% per year or more. Specifically, the report found that there is increasing disparity among the number of suicide deaths per 100,000 population and more people in rural

areas who are unable to get, or are delayed in getting, needed medical care, dental care, or prescription medicines due to financial or insurance reasons. Despite these inequities, interagency collaboration has clearly proven to have a strong positive effect on both the individual child's academic and mental health as well as the surrounding community in situations when these vulnerabilities exist (Meyers et al., 2015). However, because one must understand the role of contextual influences on a developing child, it is therefore imperative that researchers and practitioners design and implement services emphasizing and addressing those ecological factors (Meyers, Meyers, Graybill, Proctor, & Huddleston, 2012). Indeed, services should be provided not only to individual students but also to entire educational and community systems as a whole (Meyers, et al., 2012). In other words, just as one might look beyond the individual learner in schools to address factors such as the curriculum, school climate, or school policies, so too should one look at the systemic factors within the surrounding community culture to recognize the influence of systemic factors at multiple levels. Meyers et al. (2012) state that by recognizing these systemic influences, researchers and practitioners alike can find a way to improve the system functioning by creating action plans designed to enhance moving forces and reduce restraining forces. It is also necessary to recognize systemic influences that are acting upon the community because social and cultural settings can influence a person's perceptions of his or her health, as well as the way that person experiences an illness, as well as preventative and remedial steps taken by the individual (Goins, Spencer, & Williams, 2011). This is especially important to acknowledge in certain geographic regions, such as rural communities, where there has been limited research

literature that is available to inform practice. The research that has been conducted indicates several significant differences between rural and urban communities.

Rural Community Factors

Although rural areas may sometimes differ from one another because no community looks exactly the same, there are still a greater number of consistent differences when comparing rural and non-rural communities than when differences across individual rural communities are examined (Clopton & Knesting, 2006). When one considers the differences between rural and urban communities, it is important to note that these differences are not obstacles or barriers to successful children's mental health support or interagency collaboration, despite potentially being referred to as such. In contrast they are differences that require a unique response from the researcher and the practitioner (Fagan & Hughes, 1985).

Areas of growth in receiving mental health services in rural areas. Following the 1980's there has been limited literature focusing on rural school psychology (Clopton & Knesting, 2006). However there are some consistent findings about rural areas. As stated previously those who live in rural areas may often be characterized as vulnerable. Some of these vulnerabilities create barriers to receiving mental health services. Recognized barriers to receiving mental health services in rural areas include (1) availability of financial resources – on a community-wide and individual level, (2) availability of human resources, and (3) help seeking behaviors (Clopton & Knesting, 2006).

Availability of financial resources. Rural environments are not only geographically diverse, they are also occupationally, socioeconomically, and culturally

diverse (Fox et al., 1995). Common factors faced by many people living in rural areas include poor housing, inconsistent road and telephone infrastructures, limited availability of work, and little to no public transportation (Fox et al., 1995). To stretch the capacity of rural environments even further, there is limited investment attraction in these areas, which often leads to higher resource deprivation levels. Although the advent of modern communication and highway systems may have erased some barriers that isolate individuals in rural areas, rural poor still consistently face challenges such as persistent poverty, lower education levels, and a significantly higher degree of social isolation (Fox, et al., 1995). Funding is a major concern for schools and service providers in many rural areas, and funding for schools is intrinsically tied with local economies. Unfortunately, poverty rates among rural populations tend to be consistently higher than those of urban populations (Clopton & Knesting, 2006). Issues of poverty can cause great difficulty when attempting mental health service provision to children. Indeed, a lack of financial resources in rural areas can lead to increased costs of education per student (Clopton & Knesting, 2006).

Poverty in rural areas. When people think about poverty, they tend to think city, not town and country (Dudenhefer, 1993). However almost 22% of all children in the United States under the age of 18 are living in rural areas, and about 26% of those are under the age of 5 and living in poverty (Housing Assistance Council, 2012). Most research studies use the official census definition of poverty when categorizing families (Weber, Jensen, Miller, Mosley, & Fisher, 2005). According to this definition, families are classified as poor when their incomes, before taxes, are lower than their poverty threshold (U.S. Census Bureau, 2011). The formula to calculate poverty thresholds was

developed in the 1960s and its essence has not changed much over time. Poverty thresholds can vary by family for reasons including the number of children and the age of the head of the household. Finally, while the poverty thresholds have been annually adjusted for inflation, they have remained largely unchanged (Weber, et al., 2005). However, while the poverty thresholds have remained unchanged, the number of people living in poverty has risen over the past four consecutive years (U.S. Census Bureau, 2011).

In a report for the Economic Policy Institute (EPI) Cooper and Hall (2013) note that although minimum wage has nominally increased it has not kept on par with inflation. Adjusted for inflation, minimum wage in 1968 was equal to about \$19,245 in today's currency. Today however, working a minimum wage job full time (40 hours/week, 52 weeks per year) with no vacation garners only \$15,080 (Cooper & Hall, 2013). Indeed, most parents who are minimum wage workers year round and full time still do not earn enough to live above the poverty line. The 2012 poverty threshold for a family of three (two parents, one child) was \$18,480, and the poverty threshold for a family of two (1 parent, 1 child) was \$15,825. A minimum wage salary would not allow either of those families to rise above those threshold levels, if only one parent is working full-time in the family of three (Cooper & Hall, 2013).

In 2011, the official poverty rate was listed at 15%, with approximately 46.2 million people living in poverty (U.S. Census Bureau, 2011). Further, out of all the age groups in both urban and rural America, children experience the highest poverty rate (The Carsey Institute, 2009; U.S. Census Bureau, 2011). In fact, it is estimated that 19-22% of children under the age of 18 live in poverty (Housing Assistance Council, 2012; U.S.

Census Bureau, 2011). Further, one does not need to live below the poverty threshold to experience the effects of poverty. Often, children who receive free- or reduced-lunch live above the poverty line, but experience very similar risk factors when compared with children living below the poverty line. Indeed, the federal government coordinates a National School Lunch Program (NSLP) that reimburses schools for providing students with free- or reduced-lunch. To qualify for this program, families must be considered low-income. Therefore, a family of three must earn less than \$25,389 annually to qualify for free lunch or less than \$36,131 annually to qualify for reduced lunch. A family of two, however, would need to annually earn less than \$20,163 to qualify for free-lunch or less than \$28,694 to receive reduced-lunch rates.

There are many ways to think about poverty, one of which is to characterize the distribution of poverty across America. In total, there are three main factors that characterize the distribution of poverty across America: (1) high poverty counties are geographically concentrated, (2) county level poverty rates vary across the rural-urban continuum, and (3) high poverty and persistent poverty are disproportionately found in rural areas – almost 20% of completely rural counties not adjacent to metropolitan areas are persistent-poverty counties (Weber, et al., 2005). Of those living in poverty, the 2011 U.S. Census found that for families with children under that age of 18, about 17% of the families lived in urban areas whereas over 21% of families lived in rural areas (U.S. Census Bureau, 2011).

People living in impoverished rural areas are often forgotten or hidden from mainstream America, but they have historically had some of the highest poverty rates for decades. Many counties where these families reside would also be considered persistently

poor, defined as having 20% or more of the population classified as poor for the last 30 years (U.S. Census Bureau, 2011). Further, the number of persistent poverty counties is actually increasing, and has grown by 8% from the level in 2000 (Housing Assistance Council, 2012).

In examining the differences between poverty in urban areas compared to poverty in rural areas, poverty in rural areas has been found to be both widespread and diverse, especially once one considers the four different types of rural areas. As such, there is no single image of rural poverty, which makes it harder to describe and discuss (The Carsey Institute, 2009). Despite some differences between rural areas, children living in rural communities are still more likely to be poor and living in entrenched, deep poverty, with deep poverty considered a family having an income at less than 50% of the poverty threshold. (The Carsey Institute, 2009). According to Mathis (2003), 244 of the 250 poorest counties in America are rural. In 2009, the US Census Bureau identified 386 counties as being persistently poor, with 340 of them being in rural areas. Overall there have been 730 different counties experiencing persistent poverty since 1970 and of those counties 601, or 82%, are considered rural (The Carsey Institute, 2009). Many of the families living in those counties lack opportunities such as transportation and social programs, and their families benefited from neither the economic boom nor the reform of the welfare system, both in the late 1990s (Mathis, 2003).

When comparing rural and urban children, 8% of urban children are considered to be living in deep poverty as opposed to the 10% of rural children (The Carsey Institute, 2009). Further, rural poor tend to be poor about 15% longer than urban poor, and those who live in persistent poverty experience a more severe impact on their functioning. This

severe impact exists not only because the individual family is poor, but also because the community they live in is often persistently poor. Between 1980 and 2009, more than twice as many counties experienced persistent child poverty than across all other years (The Carsey Institute, 2011). Indeed, returning to the comparisons between rural and urban children, 12% of urban children are considered to be living in a persistently poor county, as compared with 26% of rural children who live in counties whose poverty rates have been persistently high. Despite having nearly equal employment rates as compared with urban areas, the child poverty rate is consistently higher in rural families (The Carsey Institute, 2009). Finally, although just 65% of the United States of America is considered rural, about 82% of all counties experiencing persistent child poverty are considered rural (The Carsey Institute, 2011).

In addition to so many rural counties being among the persistently poor, rural schools in general spend about \$200 less per pupil on average than schools in urban areas. However, these are the schools that need more money rather than less due to the over-reliance on the property tax base (Mathis, 2003). Unfortunately it is difficult for rural schools to raise adequate funds through local property taxes when the community is suffering from a declining population and the agriculture recession (Mathis, 2003). Despite some progress, those living in chronically poor rural areas are still much further behind others in terms of educational attainment (The Carsey Institute, 2011).

Availability of human resources. Fagan and Hughes (1985) report that there have been a number of concerns raised in rural areas that are related to the families' abilities to access appropriate services for children, particularly a lack of available related services, long travel distances to access services, and high caseloads for school psychologists.

When services do exist within rural areas, particularly mental health services, they are often described as fragmented and inconsistent (Jameson & Blank, 2007). Jameson and Blank (2007) posit that this is due to the difficulty in successfully recruiting and retaining qualified personnel to provide services.

Intrinsic in understanding the context of rural areas are the results of a survey administered by Clopton & Knesting (2006), which indicated that the most frequent challenge for school psychologists in rural schools is the limited availability of mental health services outside the school system and additional stress caused by a lack of referral sources. Further, many rural counties do not have easy access to in-patient services, master's level or doctoral-level psychologists or social workers, and rarely have access to a psychiatrist (Jameson & Blank, 2007). When these services do exist, there is often minimal integration between primary-care professionals and specialty mental healthcare providers. However, despite this limited collaboration, many primary care physicians are reluctant to diagnose mental disorders due to uncertainty about diagnosis or problems with reimbursement for services given (Jameson & Blank, 2007). Fox et al. (1995) indicate that persons in rural areas are also less likely know about services that are available and often receive fewer referrals and experience services that fall below their needs or expectations.

Help seeking behaviors. Perhaps first and foremost when considering the differences between rural and urban areas, it is important to acknowledge that residents of rural areas tend to be self-deterministic and fiercely independent while also maintaining a well-developed sense of community from family, friends, and other community members that leads to a feeling of self-sufficiency and a hesitance to seek outsider assistance

(Fagan & Hughes, 1985). These findings have been substantiated more recently by Girio-Herrera, Owens, & Langberg (2013) who found that parents with at-risk kindergarteners in rural communities often sought informal help. When parents in rural did seek out formal help it was typically from medical doctors rather than school or clinical psychologists (Girio-Herrera, Owens & Langberg, 2013).

These behaviors were found to be the case not only for parents of low-risk children but also for parents of high-risk children (Girio-Herrera, et al., 2013). This may be due partially because to a perceived stigma surrounding mental illness in rural areas (Fox, Merwin, & Blank, 1995; Girio-Herrera et al., 2013; Mukolo, Heflinger, & Wallston, 2010; Pescosolido, Perry, Martin, McLeod, & Jensen, 2007; Philo, Parr, & Burns, 2003). Indeed, it has been posited that stigma against seeking help for children's mental health services can be just as strong as stigma for seeking services for adult mental illness (Pescosolido et al., 2007). In addition, the independent nature that may characterize people living within a rural community could account, in part, for their reticence to admit to any problems. Further, characteristics of self-reliance and stoicism have also been linked to fewer formal help seeking behaviors when it comes to mental illness and may be more evident among those living in rural communities (Williams & Polaha, 2014).

An additional factor that can reduce help seeking behaviors in rural areas is the perceived lack of confidentiality due to living in a community so small that everyone knows everyone's life history, with a fast travelling information system, and a desire to not have a label in order to avoid becoming the center of gossip (Goins, et al., 2011; Jameson & Blank, 2007; Link & Phelan, 2001; Philo, et al., 2003; Williams & Polaha,

2014). However living in a small community can also lead to a resistance to change and new innovations, especially if the change agents do not originate from the community itself (McLeskey, Huebner & Cummings, 1988).

Supports for receiving mental health service in rural areas. Despite the identified weaknesses in receiving mental health support in rural areas, there are also benefits existing within these systems. One such support could be perceived as a weakness, that is, strong traditions of self-reliance and individualism exist in rural places. Coupled with the individualism and self-reliance is a sense of high levels of trust and civic engagement (The Carsey Institute, 2008). The presence of a tight-knit community often leads to high levels of satisfaction among those who follow the community standard, although in another sense it can lead to distrust of outsiders (Cohn & Hastings, 2013). A survey conducted by the Carsey Institute (2008) throughout 19 rural counties demonstrated that most people residing in the area felt they could work together effectively to solve problems, even if they did not believe the local governments were able to deal with the more important community problems.

Perhaps one of the key benefits of the rural context is that local involvement is high in rural areas, especially in the Midwest, with many respondents joining business groups such as: the Chambers of Commerce; engaging in civic service such as the Elks, Kiwanis, or 4H; and local government, including zoning, school or conservation boards (The Carsey Institute, 2008). Furthermore, there are many opportunities for meaningful collaboration between professionals within the community (Cohn & Hastings, 2013). Indeed, coordination and collaboration has long been stressed as essential for meeting the needs of children in rural areas because it can meet not only the needs of the children but

also the needs of adults by reducing feelings of isolation in both service providers and parents (Clopton & Knesting, 2006; McLeskey, et al.,1988).

Interagency Collaboration within Rural Areas

School-family-community partnerships can improve school programs and climates, while also increasing parent skills and leaderships, thereby improving children's chances of success in school and life (Bryan, 2005). When family and community members are involved in students' education and mental health support, children are more likely to earn better grades, enroll in rigorous classes, attend college, and have improved social skills and attendance at school (Bryan, 2005). The Center for American Progress (2010) states, "Community is also a place where people and institutions, including schools, collaborate to build social capital that in turn strengthens schools, families, and communities." Community then becomes more about ownership than it does membership (Center for American Progress, 2010).

One key factor evident in high-poverty schools that are high-performing is a strong partnership with families and community members. These partnerships help the schools to build social capital and networks of trust (Bryan, 2005). This is reflected in rural communities as well, despite the traditions of self-reliance and individualism there are perceived high levels of trust and civic engagement within the communities (The Carsey Institute, 2008). Specifically, most people in rural communities feel they can work together to solve problems even if they believe the local governments are unable to deal with important community problems.

A collaborative focus on community building can help to remove the feeling of isolation, and can encourage service providers to become community members also,

(Center for American Progress, 2010). Connections between schools and communities can be critical in poor areas where schools tend to be the biggest piece of public real estate and potentially the largest employer (Taylor & Adelman, 2000). The links between families, schools, and communities have potential to give support to schools, students, and families. These links also benefit community agencies as it creates outreach opportunities and an impact on difficult to reach clients (Taylor & Adelman, 2000).

Henderson and Mapp (2002) examined the effect of parent and community involvement and the role this involvement has on impacting student achievement. In their research, they synthesized the research of over twenty different studies examining high performance schools and found that in schools that engaged parents and communities, children showed higher grade point averages and standardized test scores, greater enrollment in more challenging academic programs, improved behavior, and better social skills. Other research has shown that interagency collaboration creates a sense of shared responsibility for clients (Kapp, Petr, Robbins, & Choi, 2013). In other words, a client does not belong to one system or another but rather to both, and successful collaboration occurred when agencies shared similar goals for the client and were able to help each other provide support in creating formal policies, procedures, and structural mechanisms (Kapp et al., 2013).

Other notable factors in school-community collaborations include a focus on relationship building among parents and between parents and educators, leadership development among parents, and an effort to “bridge the gap in culture and power between parents and educators” (Center for American Progress, 2010). Community based organizations have the opportunity to become agents of change and serve as

intermediaries between educators and parents. When a community organization maintains deep roots and good credibility with their partners, they can reach and engage a multitude of parents and community members in a way that helps to ensure the success of all children (Center for American Progress, 2010).

Most of what is known about collaboration is based on urban settings (Hobbs, 1994). However, according to Hobbs (1994), the impact of the research surrounding collaboration was seen in improved communication between schools and agencies and greater access to services for students and families. Overall collaboration appears to be a successful way to serve at-risk youth (Hobbs, 1994). There is a dearth of literature examining interagency collaboration in rural areas, although the limited research that is available documents that schools in rural areas report significantly lower rates of support from community partners, with the exception of booster clubs, than both suburban and urban communities (Pawlaowski, 2007). Additionally, even though schools and districts would be willing to take the time to collaborate with community partners, most have yet to establish a systematic way to recruit and monitor partnerships that develop (Pawlaowski, 2007). Finally, previous studies have shown that unless schools and teachers in economically distressed communities work to build positive partnerships, affluent communities will continue have more positive family involvement. This pattern is especially true because schools in economically depressed communities tend to make more contacts about negative problems rather than positive accomplishments (Epstein, Coates, Salinas, & Sanders, 2002).

Some previous work has attempted to connect the ecological theory with the practice of interagency collaboration in rural areas (Meyers, Tobin, Huber, Conway, &

Shelvin, 2015). Meyers et al. (2015) argued that due to contextual factors specific to rural communities it is necessary to create and embed socially valid supports within systems that are already existing proximal to the children who live in those areas. Contextual factors named by Meyers et al. (2015) were: (1) residents often living a significant distance from services; (2) no easy access to public transportation or childcare; (3) low retention and high turnover of highly qualified mental health service providers; (4) perceived stigma about mental health problems and help seeking; and (5) preference for a self-sufficient approach to solving problems. Due to these culture-specific contextual factors, the researchers utilized a model of organizational consultation to create systems change within a school, establishing interagency collaboration between a university and several schools within the county. This model, employed by Meyers and colleagues (2015), encouraged active engagement from the consultation participants. It was then applied to create a primary prevention and universal service delivery of a Social Emotional Learning (SEL) program. The universal SEL program, however, was only a small portion of a countywide multi-tiered system of support that extended across a variety of service delivery sectors, such as public health, juvenile justice, medical, mental health, and education. These researchers used a five stage consultation process, (1) Entry, (2) Problem Definition, (3) Needs Assessment, (4) Intervention, and (5) Evaluation outlined in the ecological model of organizational consultation (Meyers et al., 2009; Meyers et al., 2012). The evaluation of the system change effort resulted in several lessons learned, including the need for great attention to relationship building. In addition, the researchers concluded that ongoing communication at multiple levels of the system is key and careful attention to the setting must take place.

Assessing readiness for change. It is important to note that despite the knowledge that collaboration between agencies is vital, collaboration appears to be happening on a small scale or not at all. It has been posited that, in addition to the contextual factors previously mentioned, this lack of collaboration may be due to failed attempts to implement new practices or policies within or between organizations. Specifically, these attempts fail primarily because of insufficient readiness for change (Kotter, 1996). Kotter (1996) suggests that one-half of all unsuccessful, large-scale, organizational change efforts were due to inability to establish sufficient readiness for change.

Readiness for change has been defined as the degree to which organizational members are in a state of being “both psychologically and behaviorally prepared to take action” (p. 67; Weiner, 2009), and shall be subsequently known as “readiness.” When readiness exists, members are more likely to take the initiative, exhibit greater effort and persistence, and show more cooperative behavior. However if readiness is low the change can be viewed as undesirable and subsequently avoided or resisted (Weiner, Lewis, & Linnan, 2009). There must be a shared resolve between members of the collaboration or organization because these complex changes involve a collective action by many people and problems arise when some people are more committed than others. It is only with a shared resolve, effective implementation methods, and organization/region infrastructure for implementation that there can be consistent uses of programs and reliable benefits to children and families (Fixsen, Blasé, Metz, & Van Dyke, 2013).

When organizational members hold similar beliefs in their collective ability to organize and execute the actions needed for change, they have what is titled change

efficacy (Weiner, 2009). Change efficacy is referring to capability for action rather than outcome expectations or assessments of knowledge, and it is higher when there is a shared sense of confidence that people can work together to implement some complex change. When assessing readiness, organizational members should be taking into account the structural assets and deficits, and assessors of readiness should recognize that it is situational. In other words, some features create more receptive contexts than others (Weiner, 2009). Weiner (2009) also notes it is important to take into account the change valence (i.e., do organizational members value the change?), in addition to change efficacy (i.e., a judgment of perceived ability to perform a task), and contextual factors (i.e., organization policies and organization support for change). Weiner (2009) further states that although organizational readiness for change is not a guarantee that the change will work, it is still necessary to anticipate participants' viewpoints. Judgments, he states, should be based on direct experience, as they will be more predictive and less susceptible to over- or under-estimation of the collective capabilities to implement change.

Finally, Weiner (2009) proposed it is important to assess readiness for change based on his interpretation of social cognitive theory, motivation theory, and implementation theory. He posits that social cognitive and motivation theory suggest that when readiness for change is high, members are more likely to begin the change, show greater support efforts, and demonstrate more persistence in the face of obstacles – to the point that members are making change efforts that exceed requirements and expectations (e.g., championing change). Further, he believes that readiness for change levels are high, staff will not resist the change but will rather “more skillfully and persistently take action” (p. 5) to create high quality change (e.g., implementation effectiveness).

In sum, it is necessary to use ecological theory, Epstein's model of overlapping spheres, and the public health model to understand the provision and protection of children and adolescents' mental wellness. This is especially critical in rural areas as they are frequently under resourced, underserved versions of their urban counterparts. Further, rural areas often show significant disparities in socioeconomic levels, as well as in mental and physical health outcomes. One way to alleviate the negative effects of such factors is to use methods such as interagency collaboration. However, there has been limited research conducted in specifically rural settings that addresses this particular concern.

Focusing on a rural county in Illinois, this study seeks to fill in some of the gaps of knowledge regarding what interagency collaboration can look like within rural areas, as community members prepare for organizational change, by utilizing key stakeholders. and explores: What supportive services and resources already exist within the county and can be built upon? From the community standpoint, what do community members see as the biggest concern for youth and the system currently serving them? What are barriers to creating an integrated system of support for children, adolescents, and families? How does one enhance collaborations in rural mental health? In looking at the literature, what is available or recommended to support the community in addressing its concerns?

CHAPTER THREE

METHODOLOGY

Chapter Two presented the rationale and purpose of the current study. A review of the ecological model and related theories of learning along with the application of these theories to schools in the form of collaboration pertaining to mental health, and then more specifically collaboration within rural areas affected by poverty. Chapter Three follows this by presenting the rationale for the qualitative methodology in answering the research questions identified at the end of Chapter Two. This chapter also discusses the procedures used to collect participant responses and to analyze the results generated.

Setting

Selection. This research sought a setting that met specific criteria. These criteria included: the community representatives indicate they would find value and use in the research, the community values a holistic approach to mental healthcare, the community met the White House Office of Management and Budget (OMB) definition of rural (i.e., a total county population below 50,000). The researcher adopted principles from participatory action research, which values strengths based approaches, community capacity building, and using action as a key part of the research process while also valuing community partners as equal contributors as they also value and have a vested interest in the research conducted (Minkler, 2004). Second, previous research indicates that a holistic and ecological approach to mental healthcare helps to support child

development and learning (Bronfenbrenner, 1979; Epstein, 1987; Nastasi, 2004). As such, the researcher felt it critical the community sought to engage in a preventative, holistic, and ecological approach to mental healthcare. In order to identify such a community, the researcher contacted a professor at a university located in a rural area in Illinois who had a working relationship with her dissertation chair. The professor at the school in the rural area requested the submission of a short proposal prior to contacting a member from a nearby community. Upon receipt of the proposal and discussion of the research goals, the professor coordinated a meeting between the researcher, the professor, the dissertation chair, and a member of a neighboring county's mental health board. In the initial meeting, identified research goals were agreed upon and deemed to be feasible. The mental health board member felt collaboration between mental healthcare professionals would be of value and use to the county and the children residing within the county. The mental health board member also expressed a desire to take a preventative, ecological approach to children's mental healthcare.

Description. The county selected is a rural county in the Midwest. Because this is the only county involved with this study it will be referred to simply as "the county" or "the community." As of the 2010 U.S. Census, the county has a population of 16,420 people. Of that number, 22.1% of the population is 18 years old or younger, and 5.6% of the population is 5 years old or younger. The median age of the county is 43. Please see Tables 1 and 2 for demographic data reported by the U.S. Census Bureau. Located within this county are two school districts. Please see Table 3 for demographic data reported by the National Center for Education Statistics (NCES) and by the Illinois Report Card. The

data presented is from the 2012-2013 school year and is the most recent data available through NCES. This research will focus on providing mental health services for children between the ages of 0-18, who currently attend or will attend one of the schools within those two school districts.

Table 1. County Population Percentages

Category	Percent per Group					
	White	Black/African American	American Indian/Alaska Native	Asian	Two or More Races	Hispanic or Latino
	95.2%	0.8%	0.2%	0.5%	1.2%	2.3%
Age Group	Under 5	Aged 5-9	Aged 10-14	Aged 15-19	18 & Under	
	5.6%	6.7%	6.3%	6.5%	22.1%	
Gender	Female	Male				
	50.1%	49.9%				
Educational Attainment	High School or Higher	Bachelor's or Higher				
	91.4%	17.1%				
Disability	% With Disability					
	2.8%					

Table 2. Population Statistics

Category	
Land Area	397.51 Miles ²
Persons/Mile ²	41.7 People
Per Capita Income (2012)	\$27,222
Median Household Income	\$49,626
Persons Below Poverty Level	10.4%

Table 3. School District Demographics

Category	District 1	District 2
Number of Schools	6	4
Number of Students	1,970	809
Student/Teacher Ratio	14.49	13.68
Number of Guidance Counselors	3.7	1.0
Total Revenue/Student	\$11,375.0	\$13,585.0
Total Expenditures/Student	\$10,460.0	\$11,155.0
Population Under 18	3038.0	1291.0
Percent Low Income	44.4%	42.7%
Students with Disabilities	16.2%	11.9%

In addition to the school districts, several agencies provide mental healthcare services to members of the community. These agencies include but are not limited the county's Mental Health Board (MHB), a Human Resource Center, a Drug Court, non-profits, private practices, medical centers, community mental health centers, a Children's Advocacy Center, and YMCA's. Although there are a variety of services available, they are not currently available for every child. For example, some programs may be available in one school district but not another depending upon the agency offering services.

Participants. Twenty members of the county were recruited for participation. These participants included members from the Mental Health Board, individuals from local mental health agencies, school counselors, school psychologists, social workers, parents, representatives from the juvenile justice system, representatives from the medical system, members of the faith community, representatives of the county's special education cooperative, and providers from private and non-profit mental health agencies. Participants were identified via the snowballing method, "identifies cases of interest from people who know people who know what cases are information-rich" (Creswell, 2013,

p.158). This recruitment method ensured that all key stakeholders within the county who wish to be included in the collaboration were included.

Design

The present case study used a qualitative methodology to allow for natural settings, multiple sources of data, inductive data analysis, emergent design, and a holistic account of how to develop collaboration of mental healthcare for children ages 0-18 in a rural county (Creswell, 2009). Specifically, in order to understand how the ideal conditions for collaboration between mental health service providers in rural settings are created and how this, in turn, permits the development of an action plan to create system wide levels of mental health care, a case study design was used. Case study design allows for an in-depth examination and analysis of the community by which the study is bounded (Merriam, 2009). Qualitative data was used to describe the process of developing collaboration between service providers as well as how those involved in the collaborative identified, defined, and acted upon their main goals for providing systemic mental health support for children ages 0-18.

Instrumentation

Interviews, existing data, and quantitative measures of readiness for change and levels of collaboration were used to investigate the process of developing a collaborative between service providers in mental health for children in the community. Participants were asked about planning, implementation, and potential sustainment of the collaboration. Additionally, participants were asked what they define as their personal goals for the collaborative. Finally, participants were asked about their perception of

child well-being currently and how it might be affected by collaboration between community partners. Existing data included information regarding what services are currently available; previous survey data examining children's alcohol, tobacco, and other drug use, feelings about school, and health and nutritional behaviors; the number of children served by mental health service providers; community statistics; and youth risk behaviors (e.g., teen pregnancy or drug use).

Two quantitative measures were administered to participants to establish a baseline measure of the community's readiness for change and the extent of their existing collaborative methods. A measure of readiness for change was given to interview participants and asked about participants' confidence level in the organizations' abilities to invest in and implement change. The readiness for change measure also ascertained participants' desire to implement change, their confidence in handling challenges that might arise, and their perceptions of other staffs' feelings towards change. A measure of collaboration was also given to participants and examined the extent to which community organizations collaborate with each other as determined by levels of sharing items such as funding, facility space, developing programs, and staff training. These measures are discussed in further detail below.

Previous literature surrounding mental health in rural areas (Meyers et al., 2012) indicates it is necessary to utilize active engagement from participants to assist in creating a collaborative between agencies. Meyers et al. (2012) suggest using a consultative approach to understand the context in which the community exists (entry), define what exactly the community considers a problem (problem definition), conduct a needs

assessment (needs assessment), intervene, and evaluate the process. Interview questions were developed in response to this need, as well as to answer increasing calls for collaboration between mental health professionals in order to support the well-being of children (Anderson-Butcher & Ashton, 2004; Knox, 1999; Nastasi, 1998). Questions were also created with a goal to understand the context of the community in which the needs assessment takes place. Further, questions were developed so as to get an in-depth picture of barriers to creating an integrated system of support and to identify the community's biggest concerns for the youth, areas of support that already exist, and how the community can build upon existing areas of support. Finally, interview questions were based upon a similar project with similar goals led by one of the committee members (Brenda Huber, personal communication, February 13, 2014). Please see Appendix A for the interview protocol.

Interviews. Semi-structured interviews were conducted with twenty participants who were identified as key stakeholders within the community. Each person interviewed was considered to be a member of the mental health collaborative that is still being developed. Each person has been identified as being involved in the initial development and implementation of the collaboration, and provided unique perspectives regarding the community needs and the progress of the collaboration. The researcher, so as to avoid any conflicts of authority influencing the responses of participants, individually interviewed each person.

Organizational Readiness for Implementing Change (ORIC) scale. See Appendix B to view the measure. This measure is a new, theory-based measure called

Organizational Readiness for Implementing Change (ORIC), which was developed by Shea, Jacobs, Esserman, Bruce, & Weiner (2014). This measure was created in an attempt to create a brief, reliable, and valid measure that could help to “advance scientific knowledge of the determinants or outcomes of readiness to provide evidence-based guidance” (p. 2; Shea et al., 2015). Readiness, on this measure, was conceptualized using Weiner’s theory of organizational readiness for change (Shea et al., 2014, Weiner, 2009). In his conceptualization, Weiner characterized readiness as a multilevel construct that can be assessed at the individual and supra-individual level, however Shea and colleagues (2014) choose to focus on the supra-individual level due to many innovations requiring a collective and coordinated approach from many organizational members. In doing so, they created a measure that had the following characteristics: (1) was group-referenced; (2) involved multiple respondents from the same unit; and (3) allowed for checking of inter-rater agreement prior to aggregating individual perceptions (Shea et al., 2014). The creators of the ORIC chose to focus on group-referenced (e.g., “We are ready to...”) items so that respondents’ attention was focused on the collective regardless of personal readiness. Finally, they focused on assessment of multiple respondents because it was unlikely that assessing individual’s readiness was unlikely to generate valid data when it comes to an organization’s readiness for change.

The ORIC questionnaire is a 12-item self-report measure designed for use within an organization. Responses are based on a five point rating scale of agreeableness and none of the items are reverse coded. Based on the theory of organizational readiness for change, the ORIC has two domains that make up the construct of readiness. The domains

are change commitment and change efficacy. Change commitment measures the perceived need, benefits, timeliness, and compatibility of change, whereas change efficacy measures task knowledge and knowledge of resource availability. Regarding reliability, the ORIC domain scores have shown strong content adequacy and high inter-item consistency for individual-level scales for change commitment and change efficacy. Finally, inter-rater reliability and inter-rater agreement support aggregating individual responses to the organizational level (Shea et al., 2014).

The Interagency Collaboration Activities Scale (IACAS). See Appendix C to view the measure. Also retrieved from the implementation science literature, the IACAS was developed based upon literature review, existing instruments, and agency personnel interviews (Dedrick & Greenbaum, 2011; Greenbaum & Dedrick, 2007). It was developed based on the notion that there has been an increase in the call for collaboration among child-serving organizations, with many reforms in children's mental health service delivery emphasizing interagency collaboration as an important element in providing comprehensive services to children (Dedrick & Greenbaum, 2011). This measure was designed to address the complexity of creating such collaboration efforts given the fact that measures of interagency collaboration can vary both within and between organizations. The creators of this questionnaire designed it for use with multiple informants within and across organizations in order to produce a multilevel, nested structure. Appropriateness, clarity, and completeness of the questionnaire was determined by an expert panel of mental health professionals, in addition to reliability analyses establishing adequate levels of internal consistency (.83-.86 in an initial study

and .76-.86 in a second study) and test-retest reliability (.76-.82) for each of the four scales. In assessing test-retest reliability, paired t-tests compared the four scale means from the first to the second administration and indicated no statistically significant differences ($p>.05$; Greenbaum & Dedrick, 2011).

The IACAS is a 17-item self-report questionnaire, which is used to measure four scales within the construct of interagency collaborative activities. The four scales are: (1) Financial and Physical Resources; (2) Program Development and Evaluation; (3) Client Services; and (4) Collaborative Policies. All items were measured on a five-point scale from *Not at all* (1) to *Very much* (5). Additionally, participants are given the option to select *I don't know*. The Financial and Physical Resources scale (4 items) measures interagency sharing of funding, purchasing of services, facility space, and record keeping. The Program Development and Evaluation scale (4 items) measures program/service development, program evaluation, staff training, and informing the public of available services. The Client Services scale (5 items) covers activities related to diagnoses and evaluation/assessment, common intake forms, child and family service plan development, participation in standing interagency committees, and information about services. The final scale, Collaborative Policies (4 items), measures interagency case conferences or case reviews, informal agreements, formal written agreements, and voluntary contractual relationships.

Existing data. The Illinois Youth Survey (IYS; Center for Prevention Research and Development, 2015), the 2014 annual Monitoring the Future Survey via the National Institutes on Health, the US Census, and mental health board public documents were

collected to inform the qualitative data collected from the interviews. The IYS is a self-report survey funded by the Illinois Department of Human Services for biennial administration (Center for Prevention Research and Development, 2015). According to the Center for Prevention Research and Development (2015), this survey is designed specifically to be administered in school settings so as to gather information about a variety of health and social indicators including substance use patterns and attitudes of Illinois youth. The IYS has been demonstrated to have substantial validity when compared to surveys similar to the IYS that check substance use responses against actual drug tests. Further, The IYS demonstrates a pattern of use that is consistent with measures such as differential treatment rates. However, the IYS has some limitations in that it relies upon voluntary administration by schools and responses from students. Further it does not include youth who are chronically absent, in alternative school settings, or who have dropped out of school. The IYS included herein was administered to one middle school within the county and examined children's alcohol, tobacco, and other drug use, feelings about school, and health and nutritional behaviors.

The 2014 annual Monitoring The Future survey is funded by the National Institute on Drug Abuse and is conducted by the University of Michigan. In 2014, 41,551 students from 377 public and private schools in the 8th, 10th, and 12th grades participated in the 2014 survey. Other existing data included demographic information pulled from the census and statistical information received from the public health board that serves the county.

Procedure

Interviews. Participants were recruited via email (please see Appendix D for the recruitment email). Interviews were conducted by the researcher in a private office, audio-recorded, and transcribed by the researcher. All participants were given the option to consent to participation but not audio-recording, and were allowed to withdraw from the research at any time. Two participants chose not to participate in audio recording, however they both permitted notes to be taken during the interview. Interviewees were informed that any mention of any names, organizations, counties, or schools would be recoded during transcription so as to protect their and others' confidentiality while maintaining valuable information regarding services available (please see Appendix E for the consent form). The interviewer reviewed the consent form with the interviewee prior to conducting the interview. Interviews lasted an average of 45 minutes total, with a range from as short as 15 minutes to as long as 1 hour and 15 minutes. Following the interviews, several participants were contacted for member checking. These participants completed a follow-up consent form (to see this form please view Appendix F).

Questionnaires. The ORIC and the IACAS were administered following the completion of their interview. All participants were given the option to refuse to fill out the questionnaires at any time or to skip an item that they perceive as uncomfortable or unanswerable. Participants were informed that the questionnaires would solely be used for triangulating data from the interviews, and that no names would be attached to their responses. Of the twenty participants, seventeen completed the questionnaires. Two of the participants were parents in the community and felt their responses would not speak

to the community's readiness for change or engagement in collaborative activities. The third participant declined taking the questionnaires without giving a reason.

Existing data. The researcher worked with the mental health board member to collect existing data. In order to collect these documents the mental health board member and the researcher reached out to the mental health professionals in the community as well as any providers within the county who worked with children. The mental health board member requested existing data via email, and the researcher asked if participants had any "hard documents" they felt would be useful in the research process. Information regarding existing documents was primarily found, however, through national and state databases that research youth risk behaviors.

Analysis

Interviews. All interviews were inductively analyzed using steps outlined in Hill, Thompson, and Nutt-Williams' (1997) guide to consensual qualitative research (CQR). According to Hill et al. (1997), CQR follows three general steps which involve: 1) dividing responses open ended questions into domains; 2) constructing core ideas for all material within each domain; and 3) cross analyzing responses in order to develop categories and describe consistency within the core ideas. Notes about impressions of the interviewee and comments regarding the flow of the session were kept in accordance with the CQR technique (Hill et al., 1997). Next, interviews were transcribed by the researcher verbatim and reviewed to ensure an accurate transcription. Following transcription, the researcher redacted any identifying information with codes replacing any proper names (Hill et al., 1997).

Developing domains. Following the transcription of all interviews the researcher and an advanced graduate student read through the transcripts to gain an understanding of the data. Then, the researcher and the advanced graduate student read through the transcripts again, taking notes on topics discussed. These notes became the start list, and from it the initial domains were developed (Hill et al., 1997). Domains were used to group data about similar topics and were created first based on a review of the literature and the interview protocol (e.g., an example domain was existing practices in the community; Hill et al., 1997). During this process the researcher and an advanced graduate assistant trained in the CQR process reviewed the transcripts again, at this point segmenting data, redefining domains to be more precise, deleting domains that no data fit into, and finally adding new domains for any unexpected data that emerged. The interviewer and trained graduate assistant each read through an individual transcript, selected at random, and assigned each block of data to a domain, or multiple domains, placing all material from the interview into at least one domain (Hill et al., 1997). Once each member of the pair independently coded the transcript the two met to discuss the codes for the transcript. This dialogue allowed for the team to arrive at a consensus decision about the appropriate domain for the data (Hill et al., 1997). At this point, a consensus version of the transcript with all of the domain titles and raw data was created, with any extraneous material deleted. Data was coded in this manner for the remaining seventeen transcripts prior to constructing core ideas.

Constructing core ideas. The next step in the process of CQR was to summarize the content within each domain for a given case. In this case, both the researcher and the

volunteer graduate student independently summarized the data in each domain into core ideas, also known as abstracting – in which explicit meaning of the data was summarized. In other words, each snippet of text within the domains was condensed into a three-line, or less, summary of the longer text. The researcher and advanced graduate student then met together to determine a consensus version of each abstract. This was completed for all eighteen transcripts. Following the creation of a consensus version of each transcript containing domains and abstracts, the researcher and the graduate student then created codes into which all abstracts could fit.

Auditing of domains and codes. Once the researcher and trained advanced graduate student (the coders) came to a consensus regarding the major domains within the first five interviews, a second advanced graduate student from an outside institution (hereby referred to as the auditor) audited the domains. In other words, the auditor received copies of all domained transcripts, read through all raw material within each domain, determined if it was in the proper domain, and returned the audited transcripts to the two coders. Following this auditing, the two coders made the suggested changes, completed domaining the remaining thirteen transcripts, and submitted the transcripts for the auditor's review. Once again the auditor returned the transcripts with suggestions, the coders came to a consensus regarding any changes made and began the abstracting and coding process.

Similarly to the auditing of domains, the two coders abstracted the first five transcripts, submitted them for the auditor's review, discussed and made appropriate changes given auditor feedback, and then abstracted and submitted the remaining thirteen

transcripts. The auditor then provided feedback to the researcher who met with the graduate volunteer coder to discuss each comment, accepting or rejecting the comments based on mutual discussion and agreement. Finally, the two coders coded all abstracts within each domain, following the process of coding five transcripts, receiving auditing, making changes, coding the remaining thirteen transcripts, and making final changes together based on mutual discussion and agreement of the auditor's review.

Cross analysis. In this phase the researcher and the coder examined data across cases to identify similarities among cases by examining all core ideas and determining how the core ideas cluster into categories. They did so by looking independently at all core ideas and thinking of all the various categories that would apply. Then they met, compared categories, and determined which made the most sense (Hill et al., 1997). Categories were continually modified as the data analyses continued, with any categories that did not apply to more than two or three cases being dropped, a category applying to half or more of the cases being considered typical, and categories applying from 3 cases to just less than half of the cases being considered variant (Hill et al., 1997).

Auditing of cross analysis. The auditor then examined the cross analysis, making note of every time she contested the categorization, whether or not the category label was accurate, and if a new category should have been created (Hill et al., 1997). The coding pair then considered the auditor's comments and reached a consensus about making changes, consulted with the auditor about her decision, and repeated the process until the auditor and the coding team felt comfortable that an understanding of the data had emerged (Hill et al., 1997).

Triangulation of existing data and questionnaires. Existing data and questionnaires were reviewed and a report of descriptive statistics was compiled. Content analysis as described by Berg and Lune (2011) was used to identify patterns within all texts, such as themes or major ideas. In this process, sampling occurred at the phrases, sentences, and paragraphs level to create themes. The sampling level was dependent upon the type of document analyzed at the time, as some documents were in paragraph form whereas others listed bullet points of survey results. Similarly to the interviews, domains were created along with codes within those domains, and a cross-analysis of codes was conducted. Coding and cross-analysis was conducted solely by the researcher. To begin the coding, the researcher immersed herself in all documents prior to initiating the coding procedures so as to gain a thorough understanding of this information. Upon the second read through, the researcher took notes to identify any apparent themes and domains. This process is known as coding frames (Berg & Lune, 2011), as it requires a successive sorting of all cases moving from general to specific. Following the second read through of the data, all subsequent readings coded the information into smaller and smaller pieces so as to encompass as much of the data as specifically as possible. At this point in time, the researcher also examined the data for each individual case, choosing any illustrative cases and ensuring that all data was thoroughly analyzed.

CHAPTER FOUR

RESULTS

Chapter Three presented the rationale for conducting a qualitative case study to understand the experiences and needs of community members living within a rural county in the midwest. The specific methods and processes used to collect and analyze data included: descriptions of the research site; participant recruitment; procedures for conducting the research; the instrument used in the semi-structured interviews; the quantitative instruments used; and the description of the consensual qualitative analysis technique used to analyze the results of the interviews and other public data.

This chapter presents the results of the data analyses and includes descriptions of the codes derived from the themes found in the interviews. Examples of participant voices pulled from the transcripts are presented below so as to demonstrate the themes that emerged from the data. Also discussed are the results of two quantitative questionnaires and other public data compiled for this research. The results are structured to align with and answer the four main research questions. Quantitative results and public data are embedded, when available, in the presentation of qualitative results.

Contextualizing the Data Analysis Process

As these interviews were semi-structured, no two transcripts shared exactly the same organization during the analysis phase. Often during the interview process,

participants answered interview questions without direct questioning as part of their own description of what the mental wellness system in the county looks like, and how it can or cannot be improved. In the end, data analysis involved the coders and the auditor first carefully reading the transcripts several times through in order to come to a full and complete understanding of what the participants were saying. Then the initial round of identifying themes and assigning domains occurred with much discussion between both coders, and between the coders and the auditor, until the three were able to code the transcripts such that there was consensus at all levels of analysis. The first round of coding sought to identify major themes, with subsequent rounds of abstracting precisely what the participant said. Common themes throughout the research question analyses included: (a) existing mental wellness services have the potential to be comprehensive, but are instead limited due to staff, time, or education, and (b) the community's desire to promote children's mental wellness but the need for a leader to step up and help to guide the process of improvement forward.

Participants' Experiences with Children and Adolescents

This portion of the results details participants' experiences with children as expressed by the participants themselves. Every community member involved with this research had some interaction with children, either through parenting, volunteerism, or professional experiences. There was a minimum of five years of experience in a role that has contact with children, with the maximum years of experience being thirty-three years. While parenting roles are self-explanatory, and could be attributed to many community members in this research, a more in-depth description of other participants' identities in the community is provided herein.

Several participants expressed that their main connection to children was through volunteerism. One woman explained that she has volunteered in this community since she was a child and continues to work for many grassroots organizations that address stigma and other mental health related initiatives. Another volunteer offered his time through Big Brothers, Big Sisters of America, serving as a mentor for children who live in this county. Still other participants expressed that they both volunteer *and* work with children. Included in this sample are: former teachers, school psychologists, and principals; guidance counselors; youth program directors; prevention specialists; researchers; pastors; mental health counselors; case managers; and medical and legal advocates. For more specific participant roles in the community, please see Table 4; in reviewing this table note that, due to the small size of the county, some information was withheld to protect the identities of the community members who participated in this study.

Table 4. Participant Roles in the Community

Education	Participant 1
	Participant 3
	Participant 17
Law Enforcement	Participant 2
	Participant 10
	Participant 13
Community Wellness	Participant 4
	Participant 9
	Participant 19
Medical	Participant 7
Faith Community	Participant 12
Parent	Participant 16
	Participant 18
Mental Health	Participant 5
	Participant 6
	Participant 8
	Participant 11
	Participant 14
	Participant 15
	Participant 20

Research Question One

Research question one was, “What supportive services and resources already exist and can be built upon?” Participants cited existing services, resources, practices, and collaborations that all have the potential to be enhanced. They also discussed several critical resources that are missing from the county. Participants indicated that there are supportive services and practices that exist within the county; however, they are not sufficient. One result of the interviews indicates that providers and community members alike may be inadequately equipped and resourced to serve the role they are being asked to perform.

Existing resources. Participants' responses indicated there are several types of resources that exist within the county. These resources have been categorized as follows: (a) comprehensive service providers; (b) scholarships; (c) basic needs; (d) mental wellness; (e) mental health; and (f) services addressing poverty. The Human Resource Center (HRC) in this county was mentioned in every single category. The Community Action Agency (CAA) was included in all categories excepting mental wellness, and the YMCA was included in all categories excepting comprehensive service providers and services addressing poverty. The remaining programs mentioned included: the church, the 4H, the Mental Health Board, the Drug Court, the domestic abuse agency, the sexual assault center, and the residential treatment facility. Each of those agencies were mentioned in only one or two categories. However, despite the overwhelming acknowledgement of the HRC as a service provider, there appeared to be limitations to their ability to provide enough or adequate services. As a mental health professional said,

And so they [the HRC] have a variety of services. Um, I am not real familiar with their particular programs. I know they offer a variety of counseling and things like that. But I also know that in order to get more specialized, intensive [services], you have to go outside of this area. Which, some of the families I work with there's no way.

Existing resources outside of the county. Due to an identified lack of sufficient mental health resources, the majority of participants indicated that people must leave the county in order to receive psychological or psychiatric care. In addition, several participants stated that individuals must also receive basic necessities such as food stamps from outside the county. Participant 2 noted that the county "does not have a medical institution or a hospital with a psychiatric care unit." One parent told the story of her daughter, who has multiple mental health diagnoses. In doing so, she recounted a major

source of frustration for her was the lack of a psychiatric intake facility in the county. At one point in the interview, this participant spoke about her daughter getting caught cutting at school, being identified as at risk due to suicidal ideation, and the response she received from the emergency rooms as she tried to get her daughter admitted into in-patient psychiatric care,

So we took her to In County Hospital who, it was a big confusion because they're like, why are we seeing her? Well, Out of County Hospital wouldn't take her with the cut on her arm, she had to be treated medically before she could do the psychiatric part of it. Um, In County Hospital's like, we can't do anything, it's been too long. That was a sense of frustration for me because it's like, you guys don't understand she needs the help now. So we eventually got her down to Out of County Hospital which was a whole 'nother mess of screaming, yelling fits

Continuing on about the In County Hospital she said, "But they're not seeing these cases a lot so they're not ready to deal with them, but it was just so frustrating on my part because they're just going to release her and I get to deal with it."

Other resources mentioned as existing outside of the county and therefore requiring a minimum of a 30-45 minute drive to reach were: offices for receiving food stamps; corporate offices for the Catholic medical provider, the CAA, and the sexual assault center; the office of a pediatric neuropsychologist; and a program that teaches high school students financial literacy skills. This distribution of resources within the county and outside of the county affects the county's practices regularly. In other words, due to the nature of the widely dispersed resources, this community has specific policies and protocols they tend to follow when managing prevention, intervention, and crisis scenarios – however they are policies that can impart frustration on community members.

Existing practices. Existing practices within the county encompasses the numerous ways the service providers and community members handle a myriad of situations that arise. These have been divided into the following six categories: preventative, intervention, educational, crisis, collaborative, and funding practices. For a complete list of the existing practices described in the interviews, please refer to Table 5.

Table 5. Existing Resources and Practices in the County

<p>Preventative <i>Working to improve mental wellness before a problem becomes a crisis</i></p>	Home-based visitation for low-income families with children younger than 3
	Head Start
	Y-Zone after school program
	Fellowship of Christian Athletes
	Big Brother, Big Sister
	4H programming
	YMCA Daycare
	YMCA Camps
	Telehealth program for cardiology
	HRC runs prevention programs in schools
	DARE is used as a drug prevention program in the schools
	The YMCA mission statement
PBIS is used in Tiers 1 and 2 the schools	
<p>Intervention <i>Programs or techniques used with people already experiencing problems</i></p>	Drug Court uses Moral Reconciliation Therapy
	Anti-bullying program through church
	Grass-roots coalitions to reduce crime
	School supply drives
	HRC Thrift Store
	Probation
	Art programming at the YMCA
	Social skills interventions provided by guidance counselors and school social workers
	Telehealth program for cardiology
	Children receiving services for disabilities are referred to out of county programming
	Sometimes individual counseling needs are given precedence over family counseling needs
	HRC maintains day programs for developmentally disabled

	Referrals to residential school are being replaced with home-based supports
	Domestic violence program exists within the county
Educational <i>Teaching about mental health and emotional intelligence</i>	Guidance counselors in schools
	Youth groups at church
	Mental Health First Aid
	MHB conducts education forums for community members
	Special Education Association provides community and parent education opportunities
	Law enforcement are trained to recognize people with a mental illness
Crisis <i>Responses to active crises</i>	HRC provides immediate counseling services
	In County Hospital does not accept psychiatric intake patients except in extreme emergency
	Typically police only respond to crises
	Police can submit a petition for an involuntary committal to a psychiatric care unit
Collaborative <i>Established relationships and protocols between agencies</i>	Summer lunch program with HRC and a nearby University
	Special Education Association staffs psychologists and social workers in schools
	Probation and schools collaborate when working with youth offenders
	Law enforcement are first responders to crisis situations
	Christian medical provider will work with out of county schools in providing programming and administering medication
	Principal opened up school to faith community and HRC following a suicide
	County Community Coalition connects social service providers on a monthly basis
	Law enforcement relies heavily upon HRC and an out of county youth advocacy center
Funding <i>How funds are received and shared</i>	Scholarships from Church to go to Christian universities
	Scholarships from YMCA for membership
	HRC grant for drinking prevention
	YMCA is funded in part by United Way
	MHB funds YMCA, HRC, Drug Court, Domestic Violence Agency, Children's Advocacy Center, Sexual Assault Center

Preventative practices. Preventative practices are described by participants as programs such as DARE, the YMCA and how the organization views and implements their mission statement (e.g., to promote wellness, both physical and mental), an office at the HRC dedicated to prevention, and PBIS being implemented in the schools at the Tier 1 and Tier 2 level. All of these programs are devoted to preventing a crisis or problem from occurring in the first place. For example, according to Participant 4,

One of the Y's mission statements is healthy living, youth development. And so youth development doesn't just mean athletic ability... It's about mental health and overall health as well. And so it's all about making it positive and trying to better their lives any way that we can.

The prevention practices take a more ecological viewpoint of child development and seek to improve mental wellness before a problem becomes a crisis.

Intervention practices. Intervention practices, unlike prevention practices, entail programs or techniques used to work with people who are already experiencing problems (e.g., mental illness, substance abuse, academic difficulties, or behavioral concerns). One example of such practices is Moral Reconciliation Therapy (i.e., a form of cognitive behavioral therapy) used by the Drug Court in order to, as Participant 13 states, "change how people think. Because," he continues, "a lot of their criminal behavior is a result of how they view things, how they think about things. And so we try to address their criminological thinking and change their attitudes." Other examples of intervention practices include interventions at the school (both academic and social skills based) as well as referrals to the residential day school, an art program at the YMCA, and probation.

Educational practices. Educational practices include both activities children complete during the school day, and the activity of teaching and engaging adults in mental health knowledge. In an example of the later, Participant 2 notes that law enforcement agents are trained in the identification of mental illness. This way, they are able to better mediate and calm down a person who may be experiencing a crisis related to their mental illness. However, Participant 2 also states this about the training he received,

I think it's very good, but again, it kind of stops at the identification of mental illness and also to some degree how to deal with that. You know as far as, we do get training and refreshers on kind of the do's and don'ts, as far as don't argue with them, you're not going to convince them that they're ridiculous, but that's kind of the very basic mental health survivor

Crisis practices. Crisis practices within the county typically involve people who are experiencing a crisis due to a mental illness and need to receive immediate care, typically from law enforcement or psychiatric hospitals. Both Participant 10 and Participant 2 stated that law enforcement "typically only sees the crises." As such, most of the information about these practices came from the law enforcement professionals in conjunction with a parent of a child diagnosed with Bipolar Disorder, Major Depressive Disorder and Attention Deficit Disorder. All three of these participants noted multiple times, at a minimum of three times each, that the psychiatric hospital is not in the county and therefore it can be difficult to receive the help they need right away. In that context, Participant 2 spoke about the process needed to involuntarily commit someone, stating, "What I know of the system that we use regarding involuntary committals is that when a petition and a certificate is completed for an involuntary committal, whether it be juvenile or adult, the person is then placed in a psychiatric care unit for a minimum of 72 hours."

Participant 18, on the other hand, provides a parent's perspective of the process at both the In County Hospital and the Out of County Hospital. About her experience with the In County Hospital when her daughter was younger she said,

I called the crisis counselors, I called the HRC, and they said they're in with an emergency right now. And I'm like, if I don't get her somewhere there's going to be another one. It's not like I could take her home. And that's the frustrating part because they told me you can bring her back in a couple of hours. There is no coming back. If I stop this car she's jumping out. That's how bad she was. We had the child safety locks on. She's kicking and screaming. Kicking my windows, hitting my windows. Just like, somebody in a fit. It's almost like she was high on something... Finally they said if you can't wait you need to take her to the hospital, so we took her to In County Hospital, got her into a room. She was a flight risk so they had the EMT standing by the door, and I mean, she was fairly, she was junior high age or maybe a little under, and so the doctor came in. They talked to her. A counselor eventually came in. And she told them everything they wanted to hear, was all nice and sweet and calmed down. And she turns around as they walk out of the room, and she's like I told you I could do this. Like, completely Jekyll and Hyde. I couldn't believe my own kid. And they're like, there's nothing we can really do, have her set up for counseling. And I'm like, "oh my god, I'm leaving here you know" so it's just kind of like, that's kind of scary as far as being so far away from a facility that can actually take her in those circumstances... They didn't see the game that was being played. The manipulation that they're under. They didn't even realize it.

Despite the negative experience that occurred at that time with the HRC, the participant generally spoke about the HRC before and after that statement glowingly. She shared that they are generally able to handle her daughter's crises and will find a way to get to her daughter so that they can help mitigate the situation, regardless of where she is located in

the county. Additionally, in speaking about her daughter's involuntary committal to the

Out of Patient Hospital, Participant 18 said the following:

That was kind of a mess. Not a mess as far as her treatment or anything. I mean they were very great about everything and keeping in contact with me and me not being allowed to see her. It became an emotional time because, number one you don't want to see your kid in the hospital and number two her dad didn't have anything to do with her during that time. And I kind of felt alone trying to do everything. And I've been divorced for a while. So it was kind of like alone. My mom couldn't go down there with me to see her. Her sister, her natural sister couldn't go down there with me. And it's a lot of expense driving back and forth, getting certain clothes because they [the patients] can't have certain clothes. So it's that added expense. There's a little bit of distress with that.

Overall, the interviews suggest that there is a limited amount of resources available to handle crises when they occur. The police are able to mitigate some of that now that they are trained to handle committing a person to a psychiatric hold rather than having to bring in the HRC as a middle man to complete the paperwork; however, there are still circumstances in which there are no staff available to help solve the crisis, leaving both parents and professionals feeling frustrated and scared.

Collaborative practices. Collaborative practices specifically mean that there are organizations in the community that have established relationships and general protocols that they follow when contacting each other. For example, according to Participant 7, the Catholic medical provider works closely with the HRC and the school nurses. Typically they will arrange for the school nurse to provide medication and will refer children to the HRC to see a psychologist or a psychiatrist. Another example includes a community coalition that connects social service providers on a monthly basis in order to keep members up to date on various mental health initiatives occurring throughout the county. One more example of a collaborative practice within the county comes from Participant

13 who discusses how the probation officer coordinates with the school to ensure that youth offenders are attending, making suitable progress, and behaving.

Existing connections between agencies. Throughout the interview, other existing connections between agencies were discovered. Of the forty-six different connections between agencies identified, the HRC and the schools were mentioned the most at seventeen and sixteen times, respectively. The third most mentioned organization in these collaborations was law enforcement as a whole, although it encompassed departments such as the Sheriff's Department, the Chief of Police, Probation, and the State's Attorney's Office. Other agencies listed included the YMCA, the CAA, the churches, the mental health County Coalition, medical organizations such as the ER and the Catholic medical providers, and the United Way. For a complete reference of the various connections, please see Figures 1-3.

Figure 1. Connections Between Community Agencies – Main Connections of Human Resource Center.

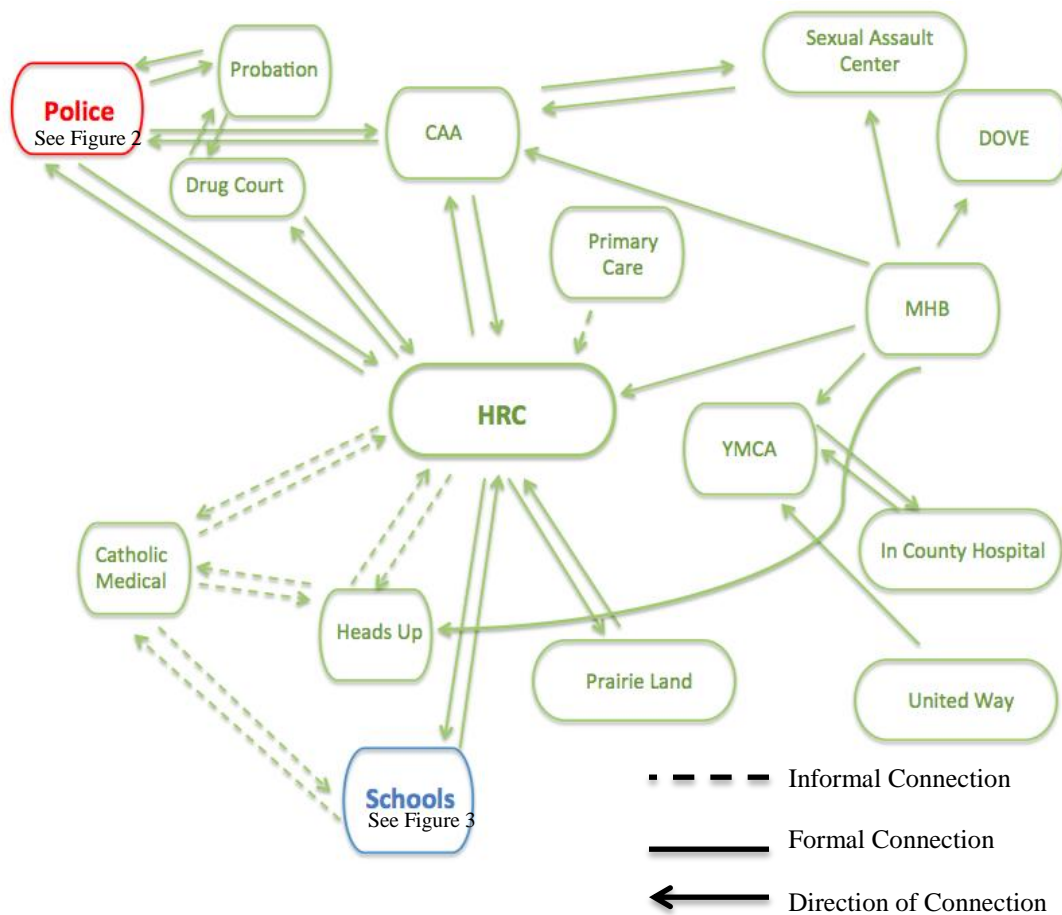


Figure 2. Connections Between Community Agencies – Main Connections of Police

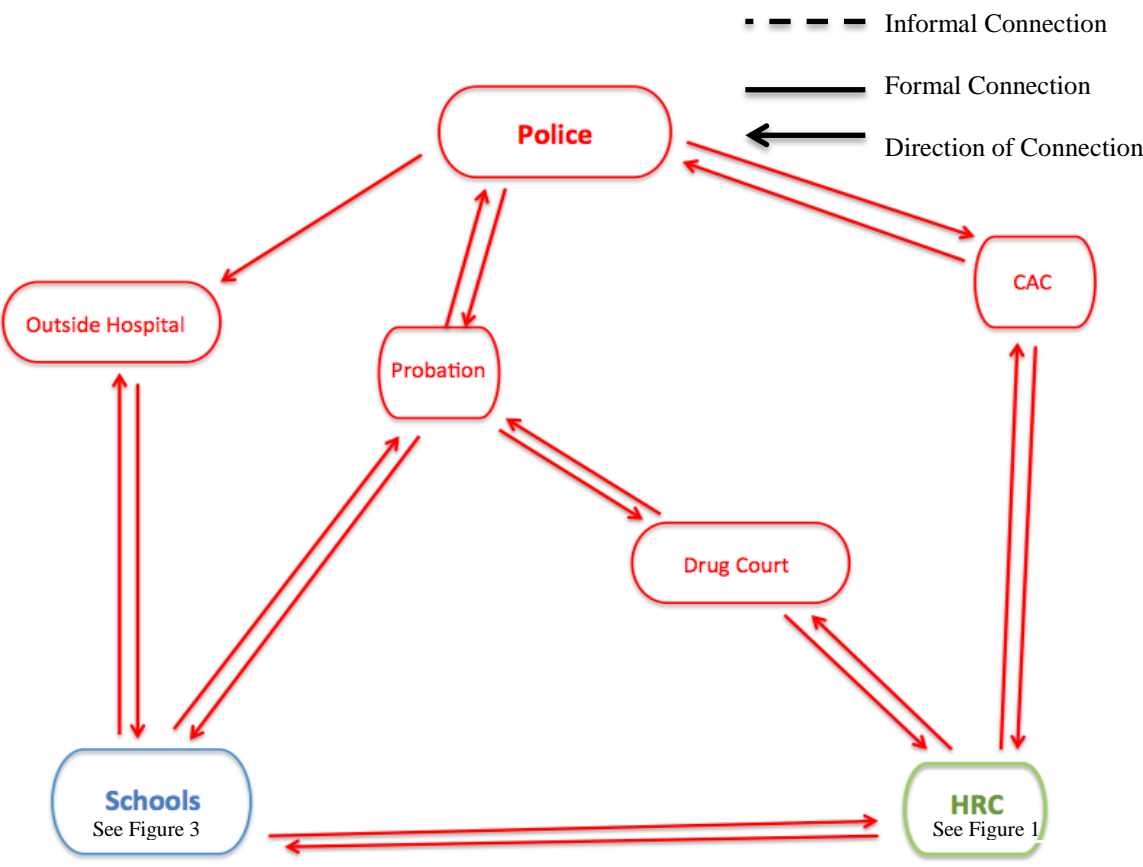
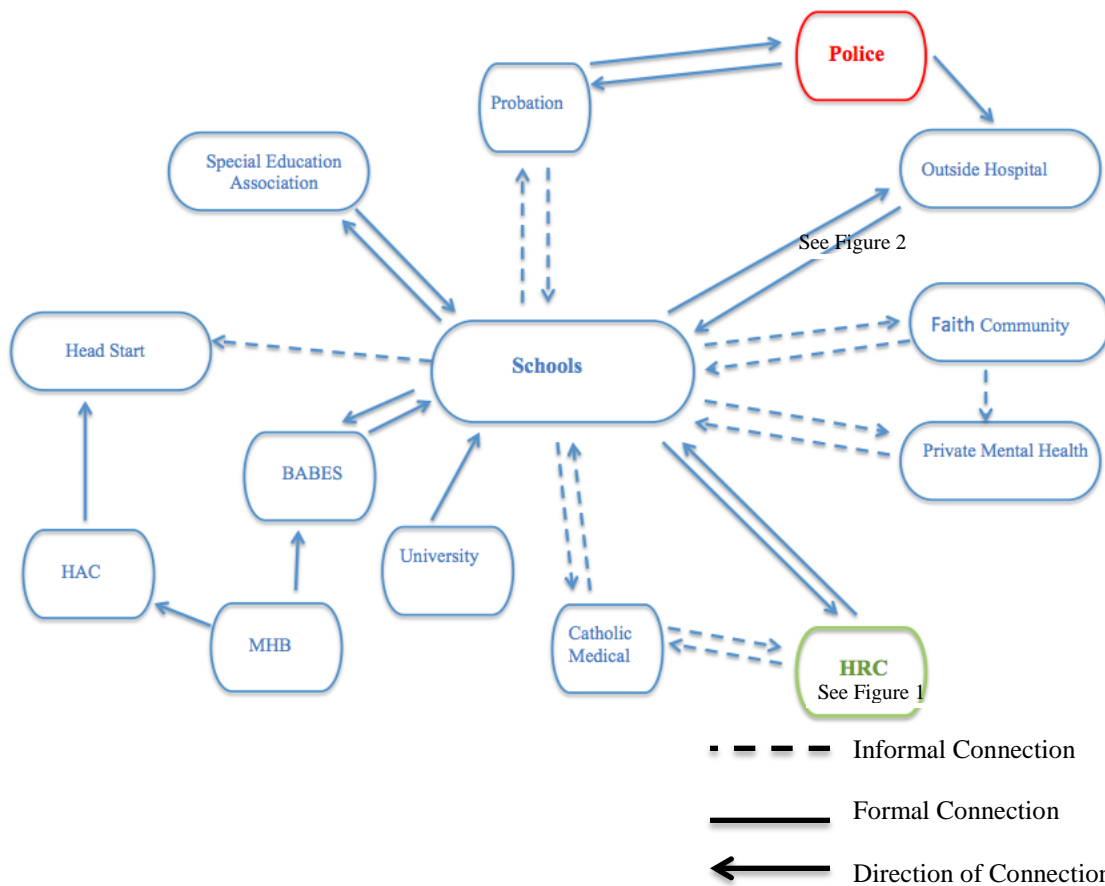


Figure 3. Connections Between Community Agencies – Main Connections of Schools.



Even with these mental health practices and connections between agencies in place, there were still some problems noted. To begin, Participant 13 indicated that probation does not have much say in the juvenile offender’s punishment from the school when he or she has behavior problems. He further stated probation officers frequently disagree with how the school will handle the situation, especially when the school starts looking to expel the student. Participant 7 added that although she works closely with other professionals, she would typically wait to be contacted by them. One example she gave was that of her collaborative practices with the school nurse, stating “It’s more of her contacting us, that I have this student, we know they’re a patient of yours, we have

concerns, um, how can we work together?” Finally, in some of the collaborations noted, when asked how organizations such as the HRC and the schools communicated and collaborated one person said,

I don't know that... They got permission, I've signed releases for them to do so, but I don't know... they would report something if there was a problem to me, but I don't think they [the school] would report to HRC if there was a problem.

Despite all of the identified concerns in collaboration, Participant 9 indicated that in this rural county people want to and do work well together, saying,

Well, and things differ from county to county... But you know I have found both This County and The Other County, which is the two counties I cover, you know I think more in the rural areas your chances of partnership, anyways my experience has been people... you're too small to all want to do your own thing so we really do work well together.

Funding practices. The most identified source of funding in this county was the Mental Health Board (MHB), which helps to fund six different organizations and programs that impact the mental health of children. Funding practices also include the exchange of funds between other agencies; specifically, the YMCA receives money from the United Way to give out scholarships to people who would like to join and can't afford it. Additionally, the HRC will help to provide funds for people who receive counseling services there to attend the YMCA. In effect, people receiving counseling services at the HRC can be given a “prescription to the Y” according to Participant 4, and the HRC will pay for their membership.

Existing data on existing resources. Data from a funding request to the county's mental health board was reviewed. This document provides information about a variety of services available and the people they support. Specifically, the Drug Court recognized

that it screened 35 people since the inception of the program in 2010, with 21 people being accepted to the program and 9 people completing the program. Further, the HRC section of the request indicated that the organization provides a wide range of mental health, crisis intervention, substance abuse, and developmental/intellectual disability services. In the fiscal year of 2014, for example, 398 people were served through these mental health programs, which equated to 4030 hours of service. This number reflects all people served within the county, not just children and adolescents. For a breakdown of the types of services provided, please see Table 6.

Table 6. HRC Programs and Services

	FY 2013		FY 2014 (excludes June data)	
	Clients Served	Service Hours	Clients Served	Service Hours
Clinical Services				
Out Patient Mental Health	403	3202	381	2257
Crisis Intervention	88	162	83	213
Case Management	209	1143	226	1473
Addictions Recovery	124	2113	115	1522
Drug Court Clients	9	1438	10	805
SASS	-	-	16	28
Psychiatry and Medications	158	84	191	168
Youth Violence Prevention				
School-Based Program	109	447	112	346
Community Transition Services				
Supported Residential	14	722	14	712
Developmental Training	31	38122	35	37493
Employment Services	40	15332	33	12359

Additionally, the domestic violence program that supports children within a five-county area explained their prevention initiative to help children make responsible decisions, increase their self-esteem and coping, while also helping them to understand

the effects of smoking, divorce, bullying, and abusive situations. This program served 393 children In County this past year, and expected to serve 573 children in the following year. The sexual assault center, which also receives funding from the mental health board and serves a five-county area, indicated they provide educational programs to schools and community organizations, along with professional training to various service agencies. Due to budget cuts they have had to reduce all full-time positions within the county to part-time positions.

Also funded through the Mental Health Board, the Children’s Advocacy Center, which provides counseling services to children who have experienced severe physical and sexual abuse, interviews children and coordinates a multidisciplinary team response for the investigation into the abuse. Please see Table 7 for a list of the services they have provided over the past four years. Currently, there is no other agency in this county providing these types of services.

Table 7. CAC Client and Service Hours

	2011	2012	2013	2014 (as of June 30)
Unduplicated child victims and non-offending caregivers served	68	92	83	56
Direct service hours to child victims and non-offending caregivers	350	498	430	165

Finally, the YMCA was listed as providing free memberships and services to persons with disabilities, and families and individuals in the HRC mental health counseling, while families who have HRC-related memberships receive a 50 percent

discount on programs. Over the past year the YMCA was been able to provide 27 memberships to HRC clients and served 68 additional members. Further, they had 10 clients attend the YMCA from the program for adults with disabilities, and were able to provide financial assistance such that 4 children could attend the after school program and 2 children could attend the summer camp. Also, the YMCA was able to provide access to the pool for alternative education and therapy for students in special education.

Summary. Certainly there are mental wellness practices that already exist within the county. These categories of practice are used to help delineate the various options for mental wellness that exist within the county. It also came to light however, that throughout all of these various practices the organizations within the community might not be adequately equipped to serve the role they are being asked to perform. As an example of this, Participant 8 states, “The prevention department, I guess you could say, used to be much bigger. We had several programs, but budget cuts and programs ending it’s slowly been shrunk down so it’s just myself.” And Participant 6 adds,

Well, I guess from a general perspective the thing that comes to mind is that the school setting is becoming a setting for the delivery of a wide range of services affecting children’s health, mental and otherwise. Um, and I don’t... I really can’t say to the extent to which that system is equipped with the resources to be able to serve that role. I don’t know that that necessarily was education’s role in the past so much as it’s becoming more so today.

Now that the existing practices are better understood it is possible to further consider the concerns community members have for youth, the barriers to creating an integrated system of support, and how a rural community can enhance the collaborations that support children’s mental health.

Research Question Two

Research question two is as follows: “What do community members see as the biggest concern for youth and the system currently serving them?” Participants’ concern for children arose both naturally during the interview and from direct questioning. At times these themes appeared to overlap with those of Research Question Three, which is discussed in greater detail later. Themes included herein are explicitly stated participant concerns for children in the community. In conjunction with the themes derived from the CQR analysis, results from the Illinois Youth Survey given to one school at the Junior High level will be presented. Designed and funded by the Illinois Department of Human Services, this biennial, self-report survey gathers data from students about a variety of health and social indicators such as mental wellness and substance use and abuse. Also reported herein is a summary from a review provided by the bicounty public health department. This review assessed results from a survey and public forum surrounding the topics of mental health and medical access for residents of the county.

Concern for children. Participants cited their major concerns for children in the county included: (a) substance use/abuse and mental wellness, (b) lack of education, (c) lack of parent support, (d) lack of safe places and resources, (e) overwhelmed schools, and (f) an increase in self-harm behaviors. There was also an overarching theme of negative system cycles causing the similar families to slip through the cracks and the same events to repeat over generations.

Substance use/abuse and mental wellness. Multiple participants cited a concern for children’s mental wellness. Some participants indicated that overall there appears to be a growing concern of mental health wellness among younger children, positing, “And

I don't know if that's more related to the economy and stress parents are under or exactly what that is, but that's kind of been something that I've seen over time..." (Participant 1).

Other participants indicated that children's mental wellness was affected because of their parents using and abusing drugs, "A lot of the kids that we deal with, their parents are involved with the criminal justice system, their parents have substance abuse issues, I would not be at all surprised if there's not a fetal alcohol syndrome problem here" (Participant 13). In other words, people in the community are concerned with children's mental wellness in part because of the negative effect parents' substance abuse has on children's success later in life.

Additional concerns about children's mental wellness as related to substance use and abuse were raised. Several participants indicated that drugs seem to be heavily used in the county. One participant stated, "I think drugs seem to be huge here. But I don't know if that's significantly different from other communities. But I do see that a lot here" (Participant 16). And another said "in our rural communities... underage drinking and the dangers of underage drinking and driving is an extremely, I don't want to say it's a big problem, but any bit of that problem is a high risk" following that statement with a story describing how he held a 17 year-old girl in his arms as she died from an accident caused because she drove while intoxicated.

Participant 8 indicated that the typical substances abused by children and adolescents are alcohol, tobacco, and marijuana,

Typically you'll find this in most, pretty much nationwide, it's always alcohol, tobacco, marijuana. It's always the top three. They're the top three in The County, alcohol being the number one. And that's according to 2014 data. Yea, alcohol, tobacco, then marijuana.

She added, “They have pretty easy access socially. So they’re not going to the store and buying it... but they’re getting it from someone they know.”

Several participants indicated that when children and adolescents have nothing to do they turn to substance abuse. Participant 13 noted the three main criminal offences he sees with children “are property offenses, thefts, and then substance abuse.” He also says that this is often made worse when they get kicked out of school and “lose the only safe place they have to go or eat.” One participant added that

As they [children] get older I think a huge part is just that there’s not a whole lot to do in a small town. *I* grew up in a small town. And so I know the trouble *I* got into when there was nothing to do. So that’s probably why I get that so much and that I’m more sensitive to that, and I you know, just working, I’ve worked with the kids in the Youth Group for... I don’t know... eight, ten years, something like that. I hear all their stories, and we have kids at our house all the time. And I hear what keeps them busy, and, and there’s just nothing to *do* outside of going to the bonfires, and drinking, and drugs. Unless they have a really great friend group that has intentionally decided they’re not going to get involved in that, it’s *so* hard for them because they want to have friends. They want to go out on the weekends, and so if the only thing to do is to go to a party where everyone else is going to be then 9 times out of 10 they’re going to go. (Participant 16)

Data regarding substance use and abuse from the county-wide IYS are presented in Tables 8 and 9 alongside state-wide data from the IYS, while national data collected in the 2014 Monitoring the Future survey is described qualitatively. Data comparisons between the county-wide and state-wide IYS data indicate that there is some consistency in the average number of youth partaking in risky drug and alcohol decisions. The county-wide IYS data indicate that 15% of 6th graders reported having used any substance (i.e., alcohol, marijuana, and prescription drugs) in the past year and 8% of 6th graders reported they had used alcohol within thirty days prior to taking the survey.

Additionally, on the county-wide IYS 33% of 8th graders reported having used any substance in the past year, and 17% of 8th graders indicated they had used alcohol within thirty days prior to taking the survey. Compare those statistics with the MTF survey (2014), which found that 9% of 8th graders reported past-month use of alcohol, and 6.5% of 8th graders reported past-month use of marijuana.

The IYS results also showed that 14% of 8th graders reported thinking that it was not at all or only a little wrong to drink alcohol regularly. Further, 36% of 6th graders and 35% of 8th graders reported believing there is only slight to no risk when drinking one or two alcoholic drinks nearly every day. Relatedly, 15% of 8th graders reported that their peers think it is not at all wrong to smoke marijuana. Finally, of the 8th graders surveyed, 17%, 16%, and 15% of them think it is very easy to get alcohol, cigarettes or prescription drugs respectively, with 30% of the people who reported drinking stating that they get their alcohol from their friends.

Table 8. County and State School Climate Survey Data: Student Reported Substance Use

Illinois Youth Survey	County		State	
	6th Grade	8th Grade	6th Grade	8th Grade
Substance Used				
Used Past Year				
Any Substance (Including alcohol, cigarettes, inhalants, or marijuana)	15%	33%	15%	30.2%
Alcohol	11%	32%	11%	27%
Cigarettes	4%	3%	1%	5%
Inhalants	7%	5%	6%	4%
Marijuana	3%	6%	1.5%	10.7%
Any Illicit Drugs (Excluding Marijuana)	N/A	2%	N/A	2%
Crack/Cocaine	N/A	1%	N/A	1%
Hallucinogens/LSD	N/A	1%	N/A	.6%
Ecstasy/MDMA	N/A	1%	N/A	1%
Methamphetamine	N/A	0%	N/A	.3%
Heroin	N/A	0%	N/A	.6%
Any Prescription Drugs to Get High	N/A	4%	N/A	3%
Steroids	N/A	2%	N/A	1%
Prescription Painkillers	N/A	2%	N/A	1%
Other Prescription Drugs	N/A	3%	N/A	2%
Prescription drugs not prescribed to you	N/A	7%	N/A	5%
Over-the-Counter Drugs	N/A	2%	N/A	3%
Used Past 30 Days				
Alcohol	8%	17%	5%	15%
Any Tobacco Products	5%	6%	2%	6%
Cigarettes	2%	1%	.6%	3%
Smokeless tobacco	3%	3%	1%	2.7%
Smoking tobacco (other than cigarettes)	2%	4%	1%	3%
Inhalants	6%	5%	4%	3%
Marijuana	1%	5%	1%	7%
Any Prescripton Drugs to Get High	N/A	1%	N/A	1%
Prescription Painkillers	N/A	1%	N/A	.6%
Other Prescription Drugs	N/A	1%	N/A	.7%
Prescription drugs not prescribed to you	4%	2%	3%	2%
Over-the-Counter Drugs	N/A	1%	N/A	1%

Table 9. County School Climate Survey Data: Student Attitude Toward Substance Use

Personal Disapproval: How wrong do you think it is for someone your age to:					
		Very Wrong	Wrong	A Little Bit Wrong	Not Wrong At All
6th Grade	Drink beer, wine or hard liquor regularly	79%	16%	4%	1%
	Smoke cigarettes	76%	22%	2%	1%
	Smoke Marijuana	89%	7%	2%	2%
	Use prescription drugs not prescribed to them	82%	13%	4%	1%
8th Grade	Drink beer, wine or hard liquor regularly	56%	25%	14%	6%
	Smoke cigarettes	67%	24%	7%	2%
	Smoke Marijuana	69%	16%	9%	6%
	Use prescription drugs not prescribed to them	76%	17%	3%	3%
Perceived Risk Associated with Use: How much do you think people risk harming themselves if they:					
		No Risk	Slight Risk	Moderate Risk	Great Risk
6th Grade	Take one or two drinks of an alcoholic beverage nearly every day	12%	24%	38%	26%
	Have five or more drinks of an alcoholic beverage once or twice a week	6%	22%	32%	39%
	Smoke one or more packs of cigarettes per day	4%	4%	28%	64%
	Smoke marijuana once or twice a week	8%	6%	22%	64%
	Use prescription drugs not prescribed to them	6%	8%	25%	61%
8th Grade	Take one or two drinks of an alcoholic beverage nearly every day	7%	28%	44%	22%
	Have five or more drinks of an alcoholic beverage once or twice a week	7%	16%	31%	45%
	Smoke one or more packs of cigarettes per day	2%	4%	28%	66%

	Smoke marijuana once or twice a week	10%	13%	29%	48%
	Use prescription drugs not prescribed to them	3%	10%	18%	68%
Perceived Peer Disapproval of Use: How wrong do your friends feel it would be for you to:					
		Very Wrong	Wrong	A Little Bit Wrong	Not Wrong At All
6th Grade	Have one or two drinks of an alcoholic beverage nearly every day	66%	23%	8%	2%
	Smoke Tobacco	72%	19%	8%	2%
	Smoke Marijuana	83%	11%	2%	3%
	Use prescription drugs not prescribed to you	73%	21%	3%	2%
8th Grade	Have one or two drinks of an alcoholic beverage nearly every day	50%	24%	17%	9%
	Smoke Tobacco	58%	23%	9%	9%
	Smoke Marijuana	58%	20%	8%	15%
	Use prescription drugs not prescribed to you	65%	22%	4%	9%

Lack of education. Participants indicated that they see a lack of education for children and parents surrounding substance abuse, suicide prevention, and overall life skills. They indicated that this affects children because they are not taught how to get out of the hole they are in and so the cycle continues to repeat itself. Examples of this lack of education include Participant 8's report that, "Well the problem is it's kind of similar to the conversation about sex, nobody wants to talk about that topic either, although we have lots of teenage pregnancy." Further, some participants indicated that there is limited to no education on suicide prevention or other mental health issues. "But, the community has no education about it and no wrap-around services," Participant 11 states,

The first thing I thought of after the initial shock [following a successful suicide] was... we don't have the education here. We have people in schools talking about alcohol and tobacco and other drugs and bullying on occasion. But not suicide prevention... else murdered, what, five people in recent... and [redacted] killed himself. We've had numerous suicides of young people here. There's no education *and* there's no wraparound service for that family so *now* they've buried their child, which must be the most horrific thing in the world to endure.

The theme of lack of education also includes the idea that, according to

Participant 4, children aren't being taught how to get out of the financial hole they are in, because their parents do not know how to do it for themselves. He adds,

Participant 4: These kids are growing up, they're living that life, that... this is... we get handouts, they don't know them as handouts, it's almost entitlement, they feel entitled to have this link card to go purchase food instead of being taught, their parents aren't teaching them how to get out of this hole.

Interviewer: Maybe because the parents don't know how to get out of the hole?

Participant 4: Exactly

Lack of parent support. Lack of parent support was an issue cited by over half of the participants in some way. This includes not only a lack of support *for* the parents but also a lack of support *from* the parents. Beginning with the lack of support for parents, several participants noted that there are not enough home interventions due to the limited number of health providers in town. Participant 3 states that home-based interventions are,

Really, really crucial for the little ones. And, you know if, if I can pick an ideal job I'd love to go in and be like home interventionist or coordinator with these young parents So working on that parent piece to it without making a parent feel that they're inferior or they're doing something wrong. But just giving um support. And we have *so* many grandparents in this community raising their grandchildren. If we could have more support for our grandparents, um, even great-grandparents, great-aunts, great-

uncles raising... someone else's kids, um... they need support as well. A lot of times those children will be taken in by family members and it's not gone through the court system, it's usually temporary guardianship or something of that nature. So, the people that have gone through adoption in the courts sometimes they have more resources available to them, but those that haven't are sort of stuck and are struggling.

One of Participant 9's biggest concerns is that parents are unaware of the things offered in the community, so even when there are resources, parents do not know where to go or how to use them.

I would say, really my biggest concern, and this is just an overall concern is... um, you know I don't always, and I know being a parent is a busy, busy life. Um, but how we get them to be aware of things that are offered in the community. You know, I guess I struggle with that if perhaps they're not getting the newspaper, perhaps they're not looking at Facebook pages, going to the website, you're sending flyers home from the school, you know I don't know how else to get to them.

As stated before, in addition to the lack of support *for* parents, there is a lack of support *from* parents as well. Participant 12 stated in relation to kids and school, "A lot of students- they're kind of raising themselves. You know? Mom and Dad say (and a lot of times it's just one parent) I didn't do well so I don't expect you to do well in school. So..." And another added, "The number one trend I think that I've seen, it is the increase in either absent fathers or poor male role models in the homes. As far as affecting the child's livelihood, or not livelihood but outcomes in life" (Participant 10). He continued,

Well it's not even teenagers I mean it's even younger than that now. I guess looking over 20 years that's, that's the crazy thing I've seen is that those, those, it used to be teenaged 13, 14, 15 years old were the ones that were really rebellious, really didn't respect authority. Now we're seeing that much earlier. And I truly think it's because of the disintegration of the family unit in the *country*. I really don't think it's unique to County. It's just you know we put less and less value on strong families led by moral parents, that's no I know, the definition of family is now an argument point, who would have ever thought that 30 years ago? I mean I think a lot of the problems we're attributing to juveniles can be attributed to that.

Participant 9 also mentioned the changing culture of families, saying,

Right, and in many cases there aren't two parents there. You know, either mom or dad works shift work. Um, mom or dad aren't present in the home, you know, dad might get the kids for so many nights a week, mom might get the kids... you know, it's a very different make up from what it used to be

In addition to the qualitative data gathered surrounding lack of parent support, the county-wide Illinois Youth Survey measured various factors in students, their families, and their communities that may increase or reduce the risk of youth substance abuse. These factors include access to substances and parent communication about expectations not to drink or use drugs. The survey found that 30% of the students reported that their parents do not talk to them about alcohol, tobacco, or marijuana. Additionally, 44% of the students reported that they thought they would not be caught by their parents if they chose to drink alcohol. A further 39% of students reported that if they went to a party where alcohol was served they would not be caught by their parents. Finally, 19% and 16% of 6th and 8th graders respectively indicated that their parents had no clear rules about the use of alcohol and drugs, and 33% of the students who reported drinking indicated they stole the alcohol from their parents.

Rejecting services. There is one final major component of the lack of parent support subtheme: the rejection of services. It was noted that families often slip through the cracks of the mental wellness world when parents exercise their right to reject the services offered to them. In these cases, participants noted that children and/or parents have been identified to receive services either due to a mental illness or due to their low-income level. One participant noted that she worked with a woman who was no longer

able to make rent. This woman's children were invited to join the Head Start program, however,

And so, she's like dealing with all these problems and the kids aren't in head start and we tell her, "you know you should get your kids in Head Start." She won't bring in the information, she won't bring back the... you know what I mean? And there's really no support for to help her other than she has an addiction problem and she... you know... has a problem with childcare at that point, and a problem losing her house, a problem with this and that. So it's hard to force people to bring you in the information to get them services. (Participant 5)

Other participants provided examples of parents rejecting services as well.

Participant 1 said,

Certainly you know, you struggle any time you try to get services into families' homes, because you have some families that don't want you there, as much as you feel like that may be a need, the families may not want that service.

Meanwhile, Participant 4 noted that people will discontinue counseling services at the HRC, although no reason was given as to why services were discontinued. Finally, Participant 3 recounted a time when a mother pulled her student on an IEP out of school so that she could homeschool the student. However the participant felt the mother was actually ignoring the child's educational needs, stating that she wished she could call DCFS but could not because they no longer investigate educational neglect.

Lack of safe places and resources. Some participants indicated their main concern for children revolved around a lack of safe places for them. Specifically, participants felt that there is and has always been a high population of at-risk kids who don't have a place to go or something to do. One such high-risk population includes children who do not have a home. For these children,

We have no resources for emergency shelter. And sometimes I get calls trying to place children that are homeless with roof. You know what I mean? And we have no resources for them and we can't help them because we go up, you know unless they're emancipated. But, so we can't provide like rental assistance to them and then we don't have any type of shelter even for their parents and so they have to go either to [Other County] or [Other County] so I think that is a big problem actually. (Participant 5)

Another participant had the following to say about resources for high-risk children,

There's this high population of at-risk kids that are sort of missing this almost preventative after school place or place to go that's not home, maybe when parents are at work or out of the house for whatever reason, and so kids need something to do. Kids need something to do. I think that's one of the complaints, and I think you'd probably hear that complaint even if they were living in an urban or suburban area, "There's nothing to do." But, in Our Town it's a little harder. There isn't always transportation outside. There's not very much to do in the community. (Participant 8)

Another participant reiterated that there are limited activities for children in the county, adding that such an atmosphere prevents children from truly connecting with others and "leads to youth interacting with negative influences" such as drugs and alcohol (Participant 12). Relatedly, funding is a subject that frequently came up when discussing activities available to children in the community. According to Participant 8,

Social services are always really easy for people to slash and get rid of, which in turn I think affects kind of our most vulnerable and often times kids can't always get the services that they need because we don't always know what that's going to be.

Overwhelmed schools. In the interviews, numerous community members mentioned schools frequently. Most participants had positive comments about the work the school does, but many also noted the school is being asked to take on more and more when it comes to children's wellness. One participant noted that there is a shortage of mental health providers in the county, and so the school is becoming a place where kids

are receiving services, however, she added that “there are systems in place for them [schools] to identify and treat the children, um, but there are so many children that I wonder, are there additional things needed?” (Participant 8).

Another participant, when speaking about the schools, noted the high rate of poverty in the county citing that 45% of people in the county are considered low-income (based on the free and reduced lunch statistics; Participant 3). This participant then added, “So they [the schools] can’t accommodate everyone. Which then becomes really difficult for our families who don’t have a lot of resources; and you have trouble pointing them in the right direction.” Participant 8 echoed this sentiment stating that she is unsure the school is equipped to provide the mental health services children are receiving, and Participant 1 spoke to the special education department’s response to the increased need. Specifically, Participant 1 indicated that despite seeing an increased mental health need among youth social workers in the school district are providing more skills-based supports in the schools rather than intensive therapy. He noted they do this not only because it is difficult for the students to return to class after receiving more intense therapy, but also because it is out of the social workers’ skill and time limits to provide those services during the school day.

Increase in self-harm behaviors. Throughout the interviews, participants noted there had recently been an increase in self-harm behaviors. School-based mental health professionals and clinically-based mental health professionals, along with parents listed cutting as a concern several times. Participant 18 shared that her daughter had been cutting while she was in school and was caught by a teacher. She reflected on how the school handled that situation and said they could not have handled it better. Participant 3,

a school-based professional on the other hand, noted the increase of self-harm and self-injury at the junior high level but added it is difficult for people to understand why more education is important, saying “Sometimes getting people to take that seriously is, you know, this is something that’s going to need to be a continuation of care – not just a one time counseling appointment.” She continued on, saying that she tries to educate the people engaging in those practices and the educators working with them on comprehending why self-injury occurs. However, despite her attempts to provide these services, she often frequently continues to deal with a lack of understanding and continuation of self-injury practices.

Another participant, who worked in a private Catholic medical practice, echoed the increase in the self-harm rate and added that the county has seen an increase in suicides and other self-harm behaviors stating,

We’ve seen hooking for the first time. [That’s] where they actually put metal hooks into their muscles and hang themselves in suspension. So we’ve actually seen that come across. And they see it as glamorous and will take pictures of themselves and posing. Being suspended by hooks. They’ll go through the thigh, they’ll go through the back. (Participant 7)

Alternately, Participant 6, a researcher and member of the mental health board, noted that bullying and suicide are a major concern of hers, adding that there should be, “Early identification or making sure that children know there are resources... safe resources they *can* reach out to for help that they need for a crisis or problem they may be dealing with.” She added that bullying in particular is of such concern for her as she believes it can lead to an increase in self-harm and suicide. The IYS results also lead credence to the need to ensure that children know there are resources they can reach out to for help. Specifically, 65% of 6th graders and 57% of 8th graders report experiencing at

least one type of bullying in the previous year, with 12% of 6th graders and 13% of 8th graders reporting they were intensely bullied (i.e., experienced multiple forms of bullying). Further, of those who were bullied, 51% of 6th graders and 57% of 8th graders reported they were bullied because of their appearance or disability. The IYS also measured youth opinions of their academic environment and found that 16% of 6th graders and 12% of 8th graders missed school at least one time because they felt unsafe. A further 38% of 6th graders and 31% of 8th graders reported that no adult at school cares about them. Finally, 13% of 6th graders and 16% of 8th graders reported that they had no adult (other than a parent) to talk to about important things happening in their life. For more information please refer to Tables 10, 11 and 12.

Table 10. Bullying and Safety Experiences

Bullying Experiences: During the past year, has another student at school:		
	6th Grade	8th Grade
Bullied you by calling you names	56%	52%
Threatened to hurt you	39%	34%
Bullied you by hitting, punching, kicking, or pushing you	34%	21%
Bullied, harassed or spread rumors about you on the internet or through text messages	25%	31%
Ever bullied (reported at least 1 type of bullying)	65%	57%
Intensely bullied (reported all types of bullying)	12%	13%
During the past year, how many days did you not go to school because you felt you would be unsafe at school or on your way to or from school:		
	6th Grade	8th Grade
0 Days	85%	89%
1 Day	10%	6%
2 or 3 Days	3%	3%
4 or 5 Days	0%	0%
6 or More Days	3%	3%

Table 11. Caring Adults

Is there an adult you know (other than your parent) you could talk to about important things in your life			
	No	Yes, One Adult	Yes, More than One Adult
6th Grade	57%	31%	7%
8th Grade	62%	27%	4%

Table 12. School Climate/Caring Adults

At my school, there is a teacher or some other adult:					
		Not at All True	A Little True	Pretty Much True	Very Much True
6th Grade	Who really cares about me	11%	27%	32%	30%
	Who notices when I'm not there	12%	28%	27%	32%
	Who listens to me when I have something to say	15%	22%	26%	37%
	Who notices if I have trouble learning about something.	12%	26%	27%	34%
8th Grade	Who really cares about me	15%	26%	32%	27%
	Who notices when I'm not there	12%	20%	40%	28%
	Who listens to me when I have something to say	20%	20%	32%	27%
	Who notices if I have trouble learning about something.	20%	24%	29%	27%

Suicide. Despite stating her first concern was the increased bullying, Participant 6 added that bullying often leads to suicide. She further expressed that there has been increased rate of suicide within the county. Indeed, when asked to tell a story about a child that slipped through the cracks, almost half the participants recalled a student who committed suicide at the beginning of the school year. Some participants lamented that he

did not receive the services available to him, while others noted that this was a mark of the increase in self-harm behaviors. Participant 11 said about the suicide, “It was unbelievably horrible,” and Participant 12 said, “That really rocked our community.” Participant 8 added that she fears others will continue to slip through the cracks because “there’s services available, but people not using them, and sometimes there’s the stigma attached to coming [to the HRC]” and she thinks the stigma may prevent children who have been feeling the way this person did they too will not receive the preventative services and will end up hurting themselves as well.

Negative system cycles. Negative system cycles are exo- and macro-level problems that affect the individual children and prevent them from achieving their full potential. These cycles influence how children think and act while perpetuating the cycle of poverty and poor mental wellness in the county. Many participants noted concerns related to negative system cycles. For example, Participant 19 told the story of a teenager who lived in income-based housing with her parents, became pregnant, moved out, and is now looking for income-based housing of her own because she cannot support herself.

Participant 2, a law enforcement official, also spoke of negative system cycles. In doing so, he told the story of a young man struggling financially until he finally got a job.

Several years ago a chain restaurant opened in Out of County Town, which is only 15 miles south of here. And a young man that [law enforcement] dealt with on a regular basis, if not daily, weekly, had gotten a job there when this restaurant opened as a dishwasher. And I was actually happy for him and proud of him because it showed during the month that he worked there we didn’t deal with him. He was busy he had a purpose he was out he had a job to get to, he had a responsibility, and that seemed to be very effective. It had been a month or more and I just asked him in a conversation, “How’re things going, I haven’t seen you which is good, but how are things going?” And he said, “Well actually I quit.” He said it was actually costing him more money to drive the 15 miles and

work a minimum wage job than it was to collect unemployment and sit at home. And I thought then, that's the one striking example that I can give that there's something wrong with our system.

Similar to Participant 2's experience, Participant 5 shared that often times families that she work with cycle on and off of welfare. She made sure to note that it was not because they wanted to be on welfare, but rather because of the lack of supports and the way the system works. [Note that some information has been removed from the story below to protect the confidentiality of the family.]

There's a family that we worked with a lot... [we were] dealing with the youngest daughter in the Early Head Start. They were homeless down in Florida and they moved back here because they had family here... the husband works now, the wife stays at home with the two kids. So, when they moved back they were income eligible for everything. So they did early Head Start, the oldest one was in Head Start and he went on to school. So after the youngest one got done with Early Head Start they tried to get her into Head Start, all of a sudden they were over income so there's no pre-school [in town]. So she missed out on services between the Early Head Start and the Head Start... And so now that the husband got a job, which, *barely* over income, they can't get food from us! ... Basically the kids are kind of missing out on the continuity of the continuing education, interaction, and it is a good program, the Head Start, by being slightly over income when they were already in the program. And when they recertified they were over income. And I didn't think, "They're over income." And I didn't think that was very fair.

Similarly to participant responses, a review of the bicounty community health partnership report, accessed and updated in 2015, also indicated poverty as a major factor contributing to negative system cycles. Specifically, they found that a higher percentage of residents in the county are unemployed relative to for the state as a whole. Further, a higher percentage of residents are enrolled in Medicaid than for the state as a whole. Indeed, the review showed that the ratio of Medicaid enrollees to Medicaid Physicians was 206.9 to 1 in the county, as compared to 82.3 to 1 in the entire state. Relatedly, the

survey referenced in this review demonstrated that 29% of the population in this county is living below 200% of the federal poverty level, as compared to 27% in the state. Further, over the past few years, the socioeconomic conditions within the community have been exacerbated due to a nuclear power plant being depreciated (resulting in fewer local property tax levies) and three major employers within the community closing their local operations. This resulted in higher unemployment rates and additional losses of tax revenue. These companies tended to employ a greater number of individuals from lower socioeconomic statuses, including many individuals representing minority populations within the community

The review also indicated that residents of the county cited they avoided a doctor because of cost. Specifically, rates appeared to be more than twice that of state averages. Relatedly, community members were found to be typically non-compliant with routine secondary screening procedure recommendations more frequently than for the state as whole. Specifically, residents demonstrated avoidance for secondary medical exams that ranged from 20% to 70% higher than state averages, depending upon the type of exam.

Summary. Participants expressed varying concerns for children and adolescents in the county. These concerns included: substance use and abuse, lack of education, lack of parent support, lack of safe places and resources, overwhelmed schools, an increase in self-harm behaviors, and negative system cycles. The overarching theme of this section is the idea that the participants in this study have explicit concerns about children in this county. Participants feel that there needs to be a change in the way these situations are handled because the way things are currently handled is not sufficient in preventing these concerns from arising.

Research Question Three

Given the existing resources in the county and the concerns community members hold for children's wellness, the next step in creating an integrated system of support for mental wellness is to identify potential barriers to creating that system. Research Question Three is as follows: "What are barriers to creating an integrated system of support for children, adolescents, and families?" In speaking with community members, three major areas were identified as weaknesses in promoting mental wellness and supporting children in the county. These three areas are: (a) weaknesses in the community; (b) weaknesses in collaboration; and (c) lack of awareness. Following a discussion of these three major themes, descriptive results from the Interagency Collaboration Activities Scale will be discussed to enhance the understanding of the qualitative themes addressed herein.

Weaknesses in the community. Multiple factors were listed as impacting the community's ability to provide services for children's mental wellness. Community members identified and provided rich descriptions about these weaknesses throughout the interviews, however it is important to keep in mind that as participants identified these weaknesses they commented that they did not feel these were insurmountable. Instead, participants were frequently bringing awareness to areas of weakness such that, with the right support, they would have great potential to be improved. In the end, weaknesses in the community that were identified included: (a) stigma; (b) lack of education; (c) triage and band-aids; (d) resistance to change; (e) lack of parent support for children; (f) lack of resources; (g) macro-system variables; and (h) cycles of weakness.

Stigma. Almost half of the participants interviewed noted there is a stigma in the community against mental illness, which appears to carry over to preventative services and general mental wellness. For example, Participant 3 said that there is a big stigma about what it means to talk to a mental health professional. She stated, “I think that is a big stigma, not just in our community but anywhere,” as she spoke about having to convince a mother that her daughter needed to work not only with the guidance counselor at school, but also with an outside therapist who could provide more intensive supports for the daughter.

Additionally there were commonalities across multiple participants; particularly, Participants 1, 3, 11, 14, 15, 18, and 19 expressed that many people in the community are unwilling to receive services due to the stigma, as that would mean allowing outsiders to know their secrets. Participant 3 stated,

I just sense a lot of resistance and negativity to anything that’s different. And... maybe you know that just comes with small town... You know, “If it was fine for me then it’s fine for this generation,” or “Why do we need to switch things up?” Um, and I think there’s a lot of family ... for lack of a better word, like family secrets. You know? “We’re not supposed to talk about this,” “We’re keeping this within the family,” “We don’t need to involve outsiders.” I think that’s a huge thought pattern here.

Further, Participant 11 noted that despite knowing there is a waiting list at the HRC, she cannot always trust her clients to tell her the truth about not being able to get an appointment there. More interestingly, she noted that part of why people she works with do not want to receive services is because they want to protect their children from the stigma,

I think part of the problem, maybe is there a waiting list at HRC right now? I don’t know. Because I can only take what the families tell me as the truth. You know? And I think part of it is that the parents and one

family specifically *do not* want their family member *told* they have a mental illness. So they think they're protecting their junior high age child from having a stigma placed on them... They won't receive services because that child is not going to *have* a mental illness... It goes back to that stigma. They're rather, I don't know if they'd rather have their child thought of as a criminal. Do you know what I mean? Because when they act out and something bad is going to inevitably happen and the child ends up in the justice system... that's a, "I have a rowdy kid" versus, "I have, my kid's crazy." And I've had parents tell me. "My kid's not crazy." And I say, "Of course not! They have a mental illness, I didn't say they were crazy."

In a similar vein to protecting children from the stigma of having a mental illness, Participant 18 shared that she feels parents are more willing to accept children with severe cognitive disabilities than an invisible mental illness. Indeed, Participant 16 mentioned that it is embarrassing for kids to have to leave class to go see the school counselor. Participant 11's statements illustrate a similar point as well, as she said during the interview:

Participant 11: It's absolutely that, or the lack thereof of both. Because here, and unfortunately probably most places they don't get mental health. Where I work you see someone with a disability, you see a young person with down syndrome and you say, "Oh man."

Interviewer: Because their disability is visible

Participant 11: Yes. They say, "Let's fix this. Oh my God. They have to have a place to live, they have to be taken care of, they have to have medical care." And then I say, okay now this 8 year old... has whatever chronic mental illness they have. This, this person is bipolar, whatever, well that family *they* need to take care of that.

Interviewer: Right. It's the family's job to take care of-

Participant 11: It is absolutely. And they're afraid, even of children, when you have dual diagnosis, families, they're like, "well, we can't have this person because..." Because they're afraid of them because they don't understand.

Finally, Participant 13 subtly mentions the stigma against mental health. He states, “You know, it’s a criminal justice response to a mental health issue,” as he speaks to the number of people he works with who have been arrested or imprisoned for an act they committed due to their mental illness. Participant 11 argues that in the end, the stigma exists due to a lack of understanding what it means to have a mental illness, saying, “And it goes back to education. Why *don’t* our young people understand mental illness?” In trying to speak to exactly that issue, Participant 8 comments that it is hard to get people talking about this and engaging in education because, “Kind of like that stigma that goes along with mental health, people don’t always want to talk about mental illness because it’s not always warm and fuzzy for them. So, it’s really hard to always get parents to engage and to support and participate.”

Lack of education. As stated in the previous subtheme, high levels of stigma still remain in the community due to a lack of education. However, this is not the only area in which a lack of education affects this county. To start, greater education is something needed for both professionals and parents in the county, specifically in educating professionals and parents about what mental illness is and best practices for working with people experiencing mental illness. Several participants felt that lack of education was one of the biggest issues facing the county. As Participant 11 put it “They don’t have any money in that [and] I think that time will be an issue. [But], I think that education will be more of one.”

Participant 3 notes that often times it is primary care doctors who are providing psychiatric medication, however, she adds that the doctors are,

Doing what they can on a mental health level and what they're comfortable with. But their comfort level isn't always there in prescribing meds that are outside of your general anxiety, depression, ADHD type things. And so their level of expertise isn't there.

In continuing with the concept that even professionals need continuing education, Participant 2 spoke about the training law enforcement receives in handling mental health issues. At that time he concluded that the training they receive in *recognizing* mental illness is sufficient, the training they receive in what to do now that they know a mental illness is involved is *not* sufficient. In addition he concludes,

Knowing what is available, playing the middle man in a sense [is good], but for us to be educated about what resources are out there. Beyond maybe what we know as the obvious. The HRC and the ability or resource to have someone hospitalized is kind of the extent of what we do.

In addition to the conversations occurring surrounding the need to ensure adequate education of professionals, there were further statements made about the import of educating parents. Specifically, people who spoke about educating parents discussed the need to help parents understand that getting children's mental health needs met is imperative. For example, Participant 3 reported that despite giving parents the names of available resources and how to access them, parents frequently would not choose to utilize them. When the interviewer confirmed that parents *chose* not to access the resources and rather than not attend because they were unable to afford it, the Participant responded, "Right." Participant 7 reiterated this sentiment, saying,

Those that really need the help, teaching them... how do I put this? To be accountable to get the children where they're supposed to be for the services. Um, often we have no shows of trying to get these children in to be seen, parents very lackadaisical about keeping appointments made.

Participant 12 pointed out that not only do parents of children with mental health concerns need to be educated, so too is there a need to educate parents who have adult children. She said it will be “a challenge” to see why that matters to them, “especially if their kids have moved on.”

Finally, Participant 11 said that overall it is incredibly important to get adults to understand mental wellness and the root causes of mental illness. She stated it is important to encourage dialogue among the stakeholders,

So when things get dicey we think, “Gee, are we taking care of our children?” Some adult is going to raise their hand and say, “No, I don’t think so,” and take care of that. Because to me that is always the hardest thing is to get those adults to understand that kids aren’t going to take care of it themselves with their mental illnesses. We’ve tried that. It’s just not going to happen... *No*, it’s *not* working now. And until you get to the root cause of that, you’re treating the symptoms. You’re treating the symptoms. You’re doing nothing to treat the illness.

Triage and Band-Aids. The Triage and Band-Aids theme captures the participants’ perceptions that the community frequently operates in crisis mode. A term frequently used by community members was “Band-Aids,” as though the community has been putting Band-Aids on problems instead of doing something to permanently solve them. Participant 5 expressed this idea when she reflected,

I don’t see a lot of preventative. Like, uh, it’s a lot of emergency programs, emergency services with food. [For] our rental program – you have to have an eviction notice – but there’s not a lot of housing counseling, like what we’re going to try to get into. Or things that we help people with before they get down. You’re putting them on a Band-Aid instead of doing things so that they can get ahead and stuff. You’re doing emergency, like, here’s \$400 on your light bill so you don’t get shut off.

This community member continued on to say, people who receive Band-Aid type services later prefer the quick fix it provides rather than working toward a more

permanent solution. This, she says, is exacerbated by the fact that people do not realize they are in a cycle that causes them to always need a quick fix.

This sentiment was echoed again and again, from law enforcement professionals to school personnel to parents to mental health professionals. Law enforcement professionals indicated that they often see people with mental illnesses cycling through the system, asserting “Often times the mental health system that we deal with in our crisis situation is a Band-Aid and not necessarily a long term cure.” He further adds that children can be involuntarily committed to the hospital for 72 hours and,

It may be a time to stabilize them to some degree but... generally they seem to be released in a short period of time. And then we're kinda back to square one. Sometimes we experience that we don't have a problem for a little while. But it seems like this is a revolving door.

Similarly to law enforcement personnel's' perspective, one professional said the following about practice in the county:

I find we operate only in crisis mode. And I think, I'm biased because I come from a prevention standpoint, and I don't see a lot of, um, and I guess this may be community wide, but I see a lot of, “Is it a crisis? No? Okay then that can be put off.” You know, “We don't need to deal with that.” But in the mean time when we're not dealing with it, it turns into a crisis later because we're not proactively dealing with issues in the community. (Participant 8)

This approach to handling situations as a crisis rather than from a preventative perspective comes across from school personnel as well, especially at the junior high level. One community member verbalized that the school district is limited in what they can provide for services, particularly because of the extremely high ration of students to mental health staff in the school (700:1 rather than the recommended 250:1). This member said, “I feel as though a lot of times I'm just putting Band-Aids on things. And

so prevention and mental health a lot of times takes a back-seat because we're so busy just running around fixing things all the time." (Participant 3). This member followed with, especially at the junior high school, "It's much more of a triage situation."

Resistance to change. Another weakness in the community that several participants talked about was the idea that often times the county struggles with change. There appeared to be two major viewpoints about this theme. The first was that people frequently get stuck in what they're currently doing; however even if they wanted to change they would not have the resources to do so. Participant 5's statement about this aspect was reminiscent of many other participants' assertions. Participant 5 vocalized, "I think you sometimes get people in small towns and counties that have been doing the same program for so long, a certain way, and you throw some change in there, and not pay them real well to do that, and not give them the resources, in order to do these things, makes it difficult."

The second major idea in the resistance to change subtheme was that oftentimes change did not happen because people, especially non-providers, are apathetic. Specifically, Participant 16 states that, "People get in, 'This is the way we live.' Not a rut, but just, you know, this is just the way we are and there'll always be kids with problems and there will always be drugs." She continues on to add that she feels the older generation especially has a hard time with change and is apathetic because they think, "What's the point? What difference is it gonna make? We're Our Town, I mean, you can't do something like that *here*." Finally, Participant 4 enhances this theme by stating that people would absolutely collaborate with others, but they do not have a common goal or mission and they do not show a desire to have one.

Lack of parent support for children. Akin to the resistance to change previously discussed, and similar to the lack of parent support theme under Concern for Children in Research Question Two, is the lack of parent support for children as an overall weakness in the community. Several community members spoke about the environment created by parents in general. Specifically, one parental participant communicated that, “It’s been pretty embarrassing through the years, just the environment of parents... not supporting authority in so many ways” (Participant 16). When asked to provide an example she told the interviewer,

I grew up in more of an environment where if the teachers said I did something wrong in the classroom, I’m in trouble by my parents and I better shape up. And now I see and I *hear* so many parents say, ‘But the teacher is this, that and the other thing, and picks on my kid,’ and they don’t- the *parents* aren’t supporting the teachers and the principals and the authority that... I hear bad talk from parents about the coaches and about the administration and about the teachers. And, the kids, the kids *see* that, they *hear* that. So how are they going to learn to respect authority when their parents don’t respect authority?

Other participants mentioned that there is an increase in the number of single parents, which leads to a lack of parent support for authority. Not only that, but it also leads to single parents having a difficult time disciplining their children. One participant explicated this by giving the following example,

I’ve seen a trend where they want to use the police as a bad guy. And, you know, when someone won’t get up and go to school they want to call the police to rectify that situation. I grew up in a small town, I actually grew up in this county. I cannot even *imagine* my dad saying, “You know, if you don’t get up and get ready to go to school, I’m going to call the police.” That would be the- he- he would tan my hide before that became even a threat. But it has been an increasing call that we hear on the radio is dispatching an officer to a home to get a kid out of bed

Another community member went beyond stating that a number of parents do not provide enough support for children. She spoke about how some parents actively (knowingly or unknowingly) sabotage their children. She referenced the experience she had when one divorced father encouraged his ex-wife to send his son's ADHD medication with him when he had his son for visitation. However, she later discovered that the father was not administering the medication to the son, but rather taking it for himself.

Lack of resources. The most supported category throughout the weaknesses in the community theme is lack of resources. This category was supported both by community members in this study, as well as in a review of existing data. Every participant spoke of lack of resources as a major weakness within the county. One participant went so far as to say,

I guess kind of pie in the sky big dream would be to finally see enough support and fund – and not just monetary support, but support all around, and have enough people where the mental health part and the prevention part, and the social services part, isn't just a bunch of burnt out people who need a vacation. You know, when there's enough support to go around and enough people to do the jobs, to see these services. (Participant 8)

Due to such a large outcry in identifying a lack of resources, this category was divided into three subcategories, specifically: (a) services, (b) funding, and (c) staff.

Services. The lack of services subcategory speaks to a wide range of services that are missing from the community, from prevention to intervention. Regarding prevention, participants reported that programs developed for teens, (e.g., the Teen Reach program) have been canceled due to lack of attendance, funding and staff. To make matters worse, these programs were canceled with nothing to replace them. Additionally, the efforts to provide families with home-based supports (e.g., for teenage mothers, parents of children

with disabilities, or children from low-income families) lack effectiveness (Participant 1).

Further, many participants remarked upon a gap in services particularly in the establishment of safe places and activities for children and adolescents. Participant 3 noted, “There are no support groups for kids,” and Participant 18 similarly opined, “There are no support groups for parents.”

In addition to missing support groups and home-based services, Participant 16 went beyond stating the existing lack of resources by bringing the conversation to the effect this lack has on the children in the community,

I think the vast majority of the kids really don't want to get into trouble. They don't *want* to make their parents and teachers mad at them, they don't *want* to get in trouble with the law. But there's nothing else to do.

Participant 10 echoed that sentiment, agreeing with the notion that when kids have limited access to activities they then behave in ways that leads to trouble. Participant 12 brings this a step further saying that if there were more prevention activities children would have more positive influences in their lives, however, since they do not exist, it, “Allows the negative element to seize the day.” Finally, Participant 12 concludes that there are in general a lack of resources to help people and that the community and the church has done a poor job in training parents and equipping them to meet their children's needs.

Regarding intervention services, Participant 5 noted that, “In this area you have, like, one option. And you have one agency to work with, primarily.” Participant 8 concurred with this idea,

Participant 8: There probably isn't enough for the need. If that makes sense.

Interviewer: So it sounds like what you're saying is, what you have works but there's just not enough of it. There's a higher need than you can meet.

Participant 8: Yes. Yes I would definitely agree with that.

Participant 1 also reiterated this sentiment when he spoke about parents of children with disabilities. At that time he said these parents have to travel long distances to get services, especially parents of children with more severe or rare disabilities. "We have quite a few parents who have gone over to C [one hour away] and seen the developmental pediatrician over there. Some have gone down to S [one hour away]. Especially those in the [Town] area, have gone down to C [one hour away], some go up to P [one hour away] for those services."

Further, when it comes to handling crisis situations, Participant 2 expressed that law enforcement is required to bring children and adolescents into psychiatric facilities outside of the county. They must do this because there are no services available within the county that can adequately support children experiencing a crisis due to their mental illness. The parent who spoke about her daughter previously also talked about this issue in particular. She stated that when the HRC was handling another emergency situation her child's crisis could not be averted or alleviated because there was no other agency that could mediate unless she took her to the in-patient psychiatric hospital in another county.

Funding. Lack of funds was frequently listed as the reason existing services are not maintained to their greatest extent, as well as the reason new initiatives tend to go downhill. Participant 4 and Participant 19 both said, "[Our County]'s struggle is the high poverty rate." Participant 8 and Participant 13 add that the HRC (the main service

provider in the county) is underfunded and therefore understaffed. As such, “there’s long waiting lists and that’s problematic because people who need resources or need intervention need it immediately” (Participant 13). But Participant 11 brought up the point that people only get money when things are already bad, saying,

Unfortunately you get the money when things are that bad. There’s no wellness money... It’s oh, how many have you lost? Three? Here’s your \$200,000. But if you’re saying, “I want to save our children, I want to prevent these terrible things from happening,” they don’t have any money in that.

This is related to the fact that either new services are needed or there needs to be more consistent funding streams for existing services because services that do exist have limited funds. “There *are* more in depth counseling and services for families and kids that are provided, but again that’s a limited number of funds that we have to try and provide that” (Participant 1).

Limited funds often produce another issue, that of high turnover. One participant explained below:

I mean we’ve got the mental health... the Human Resource Center. We’re lucky to have ‘em, but it’s a small agency. They’re funded by the state essentially. The state can’t pay its bills, they have trouble paying their bills, they have trouble retaining people, um, they have trouble, you know, hiring top notch highly skilled counselors a lot of times. Um, there’s a lot of transition, so... while on the one hand they’re a valuable resource, on the other hand they’re... limited in what they can offer because of the lack of funding and the lack of ability to hire long term highly skilled professionals. Um, and by virtue of that we get, we get some services which are better than no services, but we don’t necessarily get top notch highly skilled type of services, or highly specialized services. Um, and so we have to send people out of the county for stuff like that. (Participant 13)

Similarly, Participant 5 tells a story about her friend's child who receives services at the HRC. However, due to limited funds, she says, the HRC

Gets a lot of interns, college students, so they [the kids] get used to those people as counselors and then they're gone... [the kids] struggle, they get used to someone and then they go away.

Lack of funds was also listed as a reason why services, even if they do exist, are not equally accessible for all families. Specifically, many families do not have appropriate transportation to reach necessary services according to Participant 1.

Participant 10 seconded this statement when he said, "You know, we have a lot of poor families, uh, that you know makes transportation difficult when you don't have money to buy a car, pay rent, pay an insurance bill." In other words, people are struggling to meet their basic needs. Participant 5 explains this scenario further,

They [parents] don't want to take time or they don't have transportation or they have a harder time managing their own lives. And so to take that time, something could happen and so the child gets taken out of services. And they don't want to take the child down there, they lose a job, it could be the car breaks down.

In trying to meet their basic needs they cannot afford the money or the time to bring their child to the services they need.

Finally, of special concern to participants was the information received in a follow-up discussion with Participant 20. In that conversation, current funding practices were elaborated further. Specifically, the participant spoke about the many programs and services relying on funds provided by the state contracts. He indicated that every year mental health providers receive letters from the state informing them when contracts will be released. However, these letters also acknowledge that not everyone's contract will be renewed; and further, even if the contract *is* renewed there is no guarantee the program

will receive the same level of funding as the previous year. Participant 20 said that time of year is always “chaos” with many providers concerned that they will not be receiving funds because they are being used as a tool to “achieve political objectives.” In the meantime, he stated, the organization he works for will be,

Working to educate our staff, clients and community about these issues and are encouraging people to contact their state representatives and the governor to motivate them to resolve their political issues as quickly as possible to avoid further limiting the limited resources available to assist people in recovery.

Staff. The subcategory of staff is intimately connected to the ability to fund and resource services within the county. Typical comments about staff included: (a) there is not enough staff or (b) existing staffs have limited schedules. For example, Participant 7 provided the statement,

We do know that trying to get a child into a psychologist or a psychiatrist is very difficult. There’s not enough out there. And if a child has Medicaid then you’re really strapped as to where you can get assistance. A lot of times we’re looking to [Lists three cities, each one hour away].

Some wellness providers within the county were listed as being at full capacity and unable to provide services to any more clients. Other agencies were referred to as “short staffed and bare bones” with people “always overworked and tired” trying to “meet the constant standards and demands that the state makes and don’t necessarily pay you for.” Another comment indicated that the HRC is not fully staffed and has not been for a long time (Participant 11). Therefore it is “The clients that suffer. The children, the kids that suffer, the people that you’re supposed to be helping suffer because there isn’t enough resources” (Participant 8).

One example of the problems having limited staff raises is that of a child who was having a mood episode caused by her mental illness. This is the child referred to earlier in this chapter in the quote on page 67. Due to the limited staff available at the HRC in the county, her mother had to put her into the in-patient facility out of the county. Her mother noted that the HRC does a fantastic job when they are able to help, but she could not help feeling frustrated with the lack of available help in her crisis.

This scenario, while specific to the HRC, is reminiscent of the limited staff in other locations. Participant 1 spoke of the large caseloads social workers and psychologists in the schools have. He said, “Ultimately, we still have to have our social workers and psychologists there for the students and the assessments that we’re required to provide. We can only free up so much of their time in order to do home-based kind of things.” Echoing this statement, Participant 9 remarked,

Schedules are awful full. And also in more, I think you’ll see it more in rural areas. Many live... um, it’s several generations you know, that are living here in our communities. Which is wonderful, but they’re also maybe getting... they’re also trying to help aging parents maybe, they’ve got children they’re trying to raise. You know they’ve got full plates.

Essentially, this subcategory came to life due to the limited funding and services available to members of this rural county. Further, all of these factors are in some way influenced by variables outside of the individuals’ control (in other words, macro-system variables).

Existing data review. In addition to participant responses from these most recent interviews, information from an existing data source – the bicounty public health department review – showed a lack of resources within the county. Specifically, it demonstrated that a higher percentage of this county’s residents cited the number of days

during which their mental health was “not good between 8-30 days” at a rate 20% higher than state averages. Yet the review also indicated that certain specialized services were not available at certain times, within the county, or in accessible ways. Further, the survey found that some community members considered alcohol and drug abuse issues, employment for people with mental illness or developmental disabilities, and the ability to meet basic needs as serious or very serious problems within the county. However, the majority of respondents reported that public transportation, residential services, childcare, and dental care were among the needs identified as serious or very serious problems. The report also noted that the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) has designated the county as a Health Professional Shortage Area for mental health because it exceeds population-to-core-mental health professional ratios, has an unusually high need for mental health services, and has mental health professionals that are over utilized and distant or inaccessible to residents.

Finally, similarly to participant responses in the interviews, the survey referenced within the public health review found that issues of mental health services were not limited to the hospital or mental health facility, as they thought the school and the criminal justice systems were also key players in mental health. Finally, many respondents in the study also reported that there were gaps in the counseling services available through the various providers within the county, and that increasing opportunities for school-based mental health and early-intervention would be beneficial for the county.

Macro-system variables. Two major macro-system variables that were identified in interviews as affecting children in the county are poverty and new governmental mental health and education mandates. Specifically, as mentioned, participants have seen an increase in the poverty level in the county over the past ten years, currently hovering around 45-50%. Some participants felt there is then an increase of younger children with more significant mental health needs as a result of this rising poverty level. Participant 1 posited, “And I don’t know if that’s more related to the economy and stress parents are under or exactly what that is.” National and state income eligibility policies were also identified as interacting with the poverty level in the county. According to Participant 5, the income limit to receive these services is such that people will not qualify for services despite not making enough money to sustain themselves or their family:

Sometimes, they’re usually not eligible by very little... They do get a job and they do start doing good. And then, um, you know, the bills in the winter get really high. They can’t get credit on their power bill, and um, they’ve lost their food stamps. And they can’t qualify for food pantry... There’s not a middle ground. It’s either you’re very poor and qualify for everything or you get ahead a little bit, but you’re not making great money where things are easy. And so there’s not that kind of safety net. Like, basically you go a dollar over [and] everything goes away. And they’re not set up to transition like that.

Other participants cited abuse of existing welfare systems as the predominant negative mental effect of poverty.

I believe that our systems not only allow but in a sense promote the ability to have children and stay at home and not have to work and still benefit through the different welfare systems. And don’t get me wrong I think they’re absolutely needed. I’m not saying that at all. I’m saying that there are people who take advantage of the system and abuse the system beyond what it was intended for... Children come up underneath that umbrella of a life style and mom or dad are depressed. They’re not doing anything in my opinion to work themselves out of it. And likewise the system per se is allowing it and almost encouraging it.

Separately, new governmental mental health and education mandates also affect several systems and individuals within the county. Most prominently, they affect the schools, the HRC, and the court system. To begin, participants expressed that schools are being asked to take on more and more mental health education for children. Participant 4 expressed,

Which really they [schools] should be more focused on education but slowly they're... the mental, social side of it is creeping up in there. Which if you talk to an administrator is they'd say that's one of their biggest struggles. It used to be the kids came here and your job was to teach them. Now you're having to discipline, teach them social responsibility, all the things that kind of happened as you grew up in school. But now you have to focus it and the state's requiring you to do it.

And Participant 6 doubted that schools were capable of doing so adequately, stating,

The school setting is becoming a setting for the delivery of a wide range of services affecting children's health, mental and otherwise. Um, and I don't- I really can't say to the extent to which that system is at- is equipped with the resources to be able to serve that role. I don't know that that necessarily was education's role in the past so much as it's becoming more so today.

Further, as was mentioned in the lack of resources: staff theme, mental health professionals across the state are being asked to meet new standards and fulfill more roles. However, they do not currently have the resources to do so and the state is not providing any money for the newly announced initiatives. For example, "People are always overworked and tired and, just, to meet the constant standards and demands that the state makes and don't necessarily pay you for... all these unfunded mandates." (Participant 8). Participants frequently mentioned unfunded mandates, however they did not provide specific information about which mandates they were referring to, primarily

discussing the fact that budgeting cuts placed by the Governor were negatively impacting the facilities' ability to employ sufficient staff.

Finally, one community member involved in law enforcement brought up a policy from the 1980s that he asserted is still affecting today's handling of mental illness. Specifically, he recounted the deinstitutionalization of individuals with mental illness. This participant did not question the values behind the deinstitutionalization, however he argued that the individuals who were reintegrated back into society were done so without the necessary skills to be independent and take care of their own mental health. And then, he states, it...

Falls back on the criminal justice system to deal with them initially and the mental health system kind of ends up being at the back end of things when the mental health system needs to be more at the front end of things. And the criminal justice system has kind of become a warehouse for people with mental health issues.

Cycles of weakness. As has been stated previously, there are system factors that cause people to move through various cycles (e.g., recidivism in the criminal justice system, multiple in-patient hospitalizations, and entering and exiting the welfare system). Several community members expressed concern that the triage system and habit of "putting on Band-Aids" to fix a situation is leading children to repeatedly experience these cycles. Participant 3 cited the students she has seen being hospitalized repeatedly. Specifically, she spoke about seeing the same students being hospitalized again and again with little effort made, on both the professionals' and the parents' part, to prevent re-hospitalization. Participant 2 also cites the adolescents and adults he sees taken into police custody, involuntarily hospitalized, and then released into society. Participant 2 has seen this happen so much, often with the same children, that he feels "the systems are

simply passing the buck and pacifying the problem.” This leads individuals to be experiencing the same negative circumstances over and over again. Participant 18 provided a more personal example of this, saying “But they’re [In County Hospital] not seeing these cases a lot so they’re not ready to deal with them. But it was just so frustrating on my part because they’re just going to release her and I get to deal with it.”

Weaknesses in collaboration. Several factors were identified as negatively impacting the community’s ability to collaborate effectively. As with Weaknesses in the Community, many rich descriptions spoke to participants’ views surrounding this theme. The identified weaknesses in collaboration were: (a) communication, (b) funding, (c) follow-through, (d) leadership and direction, and (e) limited time.

Communication. Communication was the most commonly cited area of weakness when it came to collaboration between personnel and/or organizations. Specifically, participants intimated there is a need for more open communication between agencies as there is a lack of collaborative discussion when coordinating services. For example, Participant 8 spoke about collaboration between agencies saying,

I don’t know if streamline is the right word, but I think it could be smoother. Um, I, and I think our county has a lot of good collaboration in it. But sometimes I think it can, I think you can always build upon it. Make it better. And I think it could be easier if people had more open communication between them.

She then added,

There needs to be open communication because I don’t think there always is...I think for the most part, and I don’t want it to sound like there is never or there is rarely, cause there is, but I think sometimes people get kind of caught up in what they’re doing because there’s not enough people (*laughs*) to do everything. So I just think sometimes it’s overlooked.

The need to streamline services was reiterated in several other interviews. For example Participant 1 said, “Sometimes there’s an overlap in service.” Further, Participant 3 bemoaned the fact that there is no continuation of care, “As far as continuing care we don’t really get that. And sometimes it is really hard to get that release with the parents and get it signed, and then have the coordination between professionals.”

Finally, some community members made the point that communication between professionals is not always positive. Specifically Participant 13 noted that although he communicates with the school, he has no main contact there between himself and the school staff. He then added that despite the prominent role in the children’s lives, he holds no sway in the schools decision-making process when they decide whether or not students should be expelled for poor behavior, despite his role in the students’ lives. Participant 7 went a bit further than the previous participant, reporting, “Trying to get this community to work together has always been difficult. [It’s] a name game. A name game community. And that hasn’t changed over the years.” In other words, Participant 7 was explaining that people are reluctant to allow others to step outside of their prescribed roles. When they do need to step outside their roles, they need to do so by making connections with specific people; people who are viewed as decision-makers on the town or county level. Similarly, Participant 16 expressed that, “Sometimes it’s just gossip and it’s just complaining, there’s that negative, there’s just very- people jump on negative things and so sometimes it just turns into this negative talking without being productive.”

Funding. Akin to the lack of funding resources identified within the Weaknesses in Community theme, participants report that collaboration between agencies is similarly

negatively impacted by the limited available funds. For example, although the Mental Health Board in this county is providing funding for six various agencies, Participant 6 does not see this Mental Health Board able to provide services or case management work as other Mental Health Boards do. She says,

They may under the mental health act, you know a board itself can provide services up to a certain length of time. Or, you know, our board does not provide any direct service. There are Mental Health Boards that do. I mean it would be something akin to some case management, but I don't see our board, at least in its current state, and with the- the dollars that we've devoted to administration of the board itself, to be able to do that kind of work.

Other participants said that while the support for collaboration is there, "Funding is always going to be the biggest struggle" (Participant 8). Participant 4 further noted that limited funding constrains the existing practice for everyone within the collaboration, "That's one thing that you run into is that pretty soon the pot runs dry and it's going to be the same thing with everyone else you're collaborating with. I mean no one has an endless budget."

Follow-through. Another identified weakness in the current form of collaboration is the difficulty in getting people to follow-through on ideas or plans. Several participants made this point. Some said, as mentioned previously in the lack of support from parents subtheme, parents will promise they (or their children) will attend counseling but then do not go. Participant 13 shared,

We refer them to the agencies that we know that can help them with their issues. And then we try to hold them accountable and make sure they show up for their appointments. But you know if they don't... they end up back in jail and that doesn't solve the problem.

Other professionals thought one barrier to collaborating with parents is the stigma attached to the HRC. As has been stated before, it is the single largest service provider in the county but as Participant 8 says, “There’s services available, but people not using them, and sometimes there’s the stigma attached to coming here.” Essentially, Participant 8 intimates part of the problem in collaborating around mental health issues is the stigma of having a mental illness and needing help from the HRC to manage that mental illness.

Other professionals however, attributed the lack of follow-through to themselves and their peers. In other words, poor follow-through in receiving services is related to the notion that professionals also have a difficult time making good on promises made or ideas generated rather than on parents choosing not to receive services. Examples of this come from Participants 7 and 8. Participant 8 noted, “I think there’s the support there [in the Community Coalition], it’s just finding that... I don’t know... To follow it [collaborative ideas] through I guess.” And Participant 7 took the concept further making the point, “Often the community has tried to do extra things for the kids and that always seems to fizzle” because personnel did not execute or maintain the initiative well.

Leadership and direction. Another concern when it comes to collaboration within the community is the lack of leadership and direction that occurs when people attempt to collaborate. An example of this is Participant 4’s statement,

Everyone’s doing something but everyone’s doing it differently and there’s really no direction with it.” He adds later, “I think that’s the thing we got to shore up. These collaborations are great but we got to put more meaning behind the collaboration and have more purpose driven statements. And *then* at the end of that is wanting to see results, and how are you measuring those results?”

Participant 6 believed this as well, indicating that the county's biggest struggle when it comes to collaborating is, "Finding a focus and what is the service that we're coordinating. Agreeing to some degree, on what that is or what that need is."

Finally, some participants thought people *are* willing to work together, but they need a leader to actually make something happen,

If they don't have to do too much I know they're very willing to help out. For example, working with this prevention coalition and trying to pull things together and get it so that it's not [My] coalition but that it's the community's coalition is very hard. Because they're willing to show up and support it, but trying to get them to take initiative and do things without me directing it sometimes [is hard]. And I don't have the time, a lot. Um, so that gets difficult. I think people are willing to support, but it's just, you kind of have to go beyond that level of support sometimes.
(Participant 8)

Limited time. The last theme identified in Weaknesses in Collaboration is the notion that there is not enough time. As Participant 9 said, "More and more agencies are getting spread thinner and thinner." Certainly organizations in the community support each other already, Participant 9 added assuredly. But, Participant 4 captured a similar idea when he said, "I mean these are our priorities we still have to do this, we know we want to be part of that Our County collaboration to help but we're already, but we've got these we have to take care of." Unfortunately people within the county are busy and there is only limited time to get together and coordinate services, "Because again with being short staffed and people having to take on all the responsibilities, people just don't have the time to, and they're not willing to give up their own [personal] time" (Participant 8).

Lack of awareness. The final identified barrier to improving mental health services is lack of awareness. More specifically, there appears to be a lack of awareness surrounding the mental health services that exist within the county that could be used to

support children's mental wellness. One law enforcement participant elaborated, "I don't know how many services, again because I guess I don't, I've not had to utilize them, but I'm not sure how many preventative programs we have." Another mental health provider explained that she knows the *organizations* exist, but not specifically what services they offer. For example, Participant 6 said, "I'm not sure what they're [CAA and Sexual Assault Center] currently doing or currently sharing in terms of resources... [and] DOVE I think has had some educational programming too. I'm not sure what theirs is looking like at this point."

In the end, more than half of the participants expressed they were unsure of what preventative programs are available, what intervention programs are available, and the extent to which organizations do or do not collaborate and interact with one another. Essentially community members demonstrated complete familiarity with their own organization, but admitted to not knowing enough about what other organizations do. Participant 8 acknowledged this when she stated, "I think it's funny because if you pulled all of us together and had us list out everything, there would be much more than people know."

Interagency Collaboration Activities Scale. The IACAS self-report questionnaire was administered to participants at the conclusion of the interview. As stated in Chapter Three, this measure was administered to obtain a baseline of current collaborative activities between the agencies within the county, such that it could be administered and compared following implementation of more collaborative practices. This tool measured four constructs of interagency collaborative activities on a five-point scale from *Not at all* (1) to *Very much* (5). Specifically, it measured how agencies shared

(a) financial and physical resources, (b) program development and evaluation, (c) client services, and (d) collaborative policies. Means of each domain are presented in Table 13.

Table 13. Results of Interagency Collaboration Activities Scale

Domain	Question	Mean
Scale 1 (Sharing of financial and physical resources)		2.50
	Funding	2.62
	Purchasing of services	2.50
	Facility space	2.50
	Record keeping and management information systems data	2.40
Scale 2 (Sharing of program development and evaluation)		3.07
	Developing programs or services	3.14
	Program evaluation	2.62
	Staff training	2.93
	Informing the public of available services	3.60
Scale 3 (Sharing of client services)		3.00
	Diagnoses and evaluation/assessment	3.21
	Common intake forms	1.92
	Child and family service plan development	2.58
	Participation in standing interagency committees	3.47
	Information about services	3.80
Scale 4 (Sharing of collaborative policies)		2.88
	Case conferences or case reviews	2.31
	Informal agreements	3.23
	Formal written agreements	3.21
	Voluntary contractual relationships	2.79

The overall results of this measure demonstrated that there were only little to some interagency collaboration activities occurring at the time of the interviews. Statistical analysis of the means resulted in statistically significant differences in the means between Scale 1 and Scale 2, $t(14)=-2.984$, $p<.05$, and statistically significant differences in the means between Scale 1 and Scale 3, $t(14)=-2.430$, $p<.05$. Based on the

results, organizations share the least amount of financial and physical resources and the most information about client services. Results of the Financial and Physical Resources Scale demonstrate that little funds, space, services, or data management systems are shared between agencies. This reflects the qualitative results, which point to funding and available resources as a major weakness within the county.

As stated previously, participants indicated that the majority of interagency collaboration is spent on Program Development and Evaluation. More specifically, participants' results on this scale demonstrate that more time is spent informing the public of available services than on developing shared programs or on evaluations or creating training programs. Overall however, these results show only some collaboration between agencies and speak to the participants' desire for increased communication as evidenced by identified weaknesses in leadership, direction, and communication.

Finally, results of the Client Services and Collaborative Policies scales show that there is some collaboration between agencies related to sharing information about services provided and some informal agreements between agencies made. However, there appear to be no common intake forms used between agencies and little plan development and creation across the agencies. Also, participants' results indicate that while they may occasionally discuss case conferences or reviews, they rarely enter into formal agreements nor are they likely to enter into voluntary contractual relationships. Again these results speak to the qualitative interview results, which say that participants find communication between agencies is limited.

Summary. Three major barriers to creating an integrated system of support were identified throughout the interviews. These were: (a) Weaknesses in the community, (b)

Weaknesses in collaboration, and (c) Lack of awareness. Throughout these three major themes multiple subthemes emerged, most prominent of which was a lack of resources (i.e., services, staff, funding, and time). These weaknesses appear to persist because of two overarching macro-system variables: poverty and governmental regulations.

Additional subthemes that appeared throughout the interviews included lack of parent support, lack of education, resistance to change, and recurring negative life cycles.

Research Question Four

The final research question, Research Question Four, is, “How does one enhance collaborations in rural mental health?” Responses to this question address the following themes: (a) How problems can be solved, (b) Including necessary people, (c) Strengths, and (d) Success stories. Oft cited answers included the need to create: common goals, strong leaders, safe places for children, a more educated community, and a better continuum of care. Following the interview results, participant responses to the Organizational Readiness for Implementing Change measure will be discussed.

How problems can be solved. A common topic of conversation during the interview was how the community could solve existing problems. Oftentimes during the interviews participants discussed these opportunities while speaking about weaknesses the county faced. As such, despite the sometimes depressing conversation about weaknesses, there was oft a tone of hope and a desire for change coursing throughout the interviews. Suggestions for solving problems included the following: (a) increase prevention and intervention services; (b) increase systemic outlooks; (c) increase education; (d) increase collaboration and communication, and (e) increase leadership.

Increase services. Throughout the interviews, the most commonly expressed method for improving children's mental wellness was to increase the services the county is currently providing. More than half of the participants enumerated that they would prefer to see an increase in preventative services, however many participants cited a need for intervention-based services as well.

Prevention. Typically, enhancing and creating more preventative services was identified as the best way to better existing practices in the community. Many people felt that providing preventative programs, such as an after-school center, would be a way to stop negative behaviors from happening. Specifically, participants cited substance abuse and criminal behaviors as the major negative behaviors. People also expressed their hope for more comprehensive preventative client care so that services, "actually help people get into a better situation where they're not dependent.... And they're not so much at risk if one thing goes wrong" (Participant 5). Participant 7 said having programs that give children a place where they can have adult supervision but still be a kid could help to solve the problem. Other people said these types of programming already existed, saying,

You know when I hear kids say, "There's nothing to do," I just... you know we've got a movie theater, we do have endless activities for kids to do here, and my guess is you could go to a bigger city and hear the same thing from kids. You know, it's just, jump in, get involved and you'll find there's lots to do (Participant 9).

This was a rare view, however, as many professionals felt a greater need for more after-school activities because so many programs had recently been cut. The two most mentioned after school activities that were "wonderful but cut" (Participant 7) were: a program run by the largest church in the community, and a Teen Reach program run by the HRC. Participants frequently spoke of a need for creating a safe zone for students

with negative behaviors while also protecting and support kids who do not exhibit the same negative habits.

This feeling was reiterated several times by mental health professionals and parents who argued that a center that offers, “one on one relationships, getting to know those kids on a personal level and maybe giving them a picture that there’s a better way, maybe will help them” (Participant 16). Participant 16 continued in this vein, advocating for a youth center in the community that is,

A safe place, it’s a great environment. Surrounded by leaders of the community that care about kids, that want to make relationships with them, that you know, even if they have a rough home life there’s someone at the youth center that cares about them. That they can talk to that can direct them down the right path. But also, not just a hangout youth center, but also a youth center that has really great *fun* activities... The youth center I’m envisioning would have, like, three story laser tag, or re-ball, or rock climbing walls, an indoor/outdoor skate park for the BMX biking kids, the trick bikes and for the skateboarders because they’re kicked out of everywhere they go. Everywhere you look no skateboarding signs are everywhere. And they tend to be, not always, but they tend to be the rougher crowd of kids and they’re the ones that tend to be kicked out. So if we had a facility where they were welcomed and encouraged to do what they’re great at, and they have fun doing, and yet it’s strategically surrounded by wonderful people that care about them. As they come and I picture some great youth leaders hanging out there. Just on the bleachers... Just talking to them, small talk and you know eventually developing relationships with some of these kids. And I think that’s where it would begin. So having, like, fun opportunities at the youth center as well as just the casual hangout. Also, I wanted to have a counseling room, and a tutoring room. And all run by volunteers. Like volunteer police officers that can help with security, they can just hang out with the kids so the kids see that the police officers aren’t out to get them. That they want to help them. They want to see them have healthy productive lives. And if they can see the police officers in that kind of light versus “they’re chasing me down and putting me in prison.” I think that would be helpful. And then have volunteer teachers that come in to tutor, because tutoring is expensive. I think most people around here can’t *afford* to have their kids have a tutor

Other prevention ideas included providing more home-based services. As an example, Participant 1 stated, “I think we have a need to provide more of those home-based supports than what we’re currently providing” so that they can help “educate parents on the type of things they can do in the home environment to not just deal with crises when they occur, but really to teach social skills.” Participants 5 and 6 agreed with this statement. These participants argued that it would also be very beneficial to get more kids involved in preventative services like Head Start (Participant 5), and, “To have family involvement and find ways of involving families. Because that’s really the first provider or the first educator of a child is gonna come through the family” (Participant 6). Finally, participants expressed that increasing community outreach to all people would provide more opportunities for prevention and would get more people, families and professionals alike, involved in preventative practices.

Intervention. In addition to expressing a desire for more preventative services, many community members – almost half – spoke of the need for an increase in the range of intervention services. In other words, participants indicated that the community needs more services that address already existing mental wellness concerns (e.g., mental illness, emergency resources, and children with disabilities). The most mentioned types of intervention resources listed were: (a) support groups, (b) home interventions, and (c) emergency resources.

Support groups were often listed as necessary for the people raising children. A few participants spoke to this, with one saying “And we have *so* many grandparents in this community raising their grandchildren” (Participant 3). Remembering the quote from Participant 3 on Page 85, many extended family members are taking in young children

whose parents are unable to support them, typically for a temporary amount of time. Despite the temporary nature of some of those arrangements, however, Participant 3 argued that often times she sees these older, extended family members struggling to access resources for the children and become stuck.

Other types of potential support groups were mentioned as well. One parent in particular mentioned that as a mother of a child with an Emotional Disability, she would have appreciated knowing that there were other parents out there going through similar experiences as she was while her daughter was growing up. “I would have liked to have a support group, that would have been nice, to have other parents to talk to. To say, how are you handling this? What are you doing?” (Participant 18). She continued on to say that she recently heard that her friend’s sister has a child with the same diagnosis as her daughter, and she had reached out to contact that mother to give her the support she wished she had at the time.

Another type of support suggested was programming specifically for students. This tended to include after school programs that encompassed all children as well as something that aids students as they seek a college education. One mental health professional said, “I’m always a little biased on needing that after school program, but I’m not the only one who says that” (Participant 8). Another community member made the point,

I would love to see initiatives that would take some of these students and allow them to not just have it [college] as a pipe dream, but if you do well in school, if you keep your nose clean, we’re going to help you get through school, you know? (Participant 12)

He begins discussing the ideal program by describing what a neighboring county created, in which they choose two seventh-grade students and have an intensive process that follows them until they graduate. Then, once they do, the program provides the students with a scholarship. He adds, “There’s some real success stories that were projected in 7th grade to wash out, that actually ended up having their education paid for.” His reasoning behind this is similar to that of other participants’ desires for an after school program for students, “I think somehow to help students realize that if you live like you should. If you work hard, if you keep your nose clean, we will be there for you. I think that’s a huge deal.”

Participants also discussed home interventions and emergency resources. Participant 3 felt that, especially for teenage parents these types of services could be especially helpful. She noted that she is starting to work with the children of the teenage mothers that she had worked with previously, and that she sees similar patterns of behavior happening with the young children. Often times these young parents need help with basic services as well (e.g., emergency shelter, food, housing). Participant 5 indicated she thought that if you provide people the basic services they need people can then focus on things beyond getting out of the dire straights they are in and more on how to escape the negative cycles they face.

Increase systemic outlook. A second method participants thought might be used to enhance collaboration and improve service delivery is to change the way people view mental wellness. Participants argued that by looking at issues from a systemic perspective, a macro-level perspective, they have the potential to break the negative

cycles they mentioned as existing under weaknesses in the community. The argument frequently made was that these negative cycles exist, and to solve the problem,

A lot of it's breaking the cycle of substance abuse. Breaking the cycle of domestic violence kind of issues. Those are not necessarily directly related but they're kind of directly related. So, you know, finding a way to break that cycle. 'Cause a lot of the kids are kind of, uh, victims of abuse and neglect. And then those abuse and neglect issues turn into criminal justice issues later. (Participant 13)

This participant then provided an example of programming that already exists in the county and uses this ecological approach to address criminal issues on the adult level,

We have a drug court here in The County, and it's, it's almost like a microcosm of how to address the problem, because there's a couple- well there's 3 participants in it now... If the drug court participants aren't successful in straightening out their lives then we'll almost assuredly see their kids here. I feel like if they are successful in addressing their problems and gettin' themselves back to being productive citizens and responsible, then there's hope for maybe their kids won't follow in the negative footsteps but follow in the positive footsteps.

Finally, Participant 13 closed by saying, "Because a lot of their criminal behavior is a result of how they view things, how they think about things. And so we try to address their criminological thinking and change their attitudes."

Participant 3 provided another reason for taking a systemic outlook on addressing mental health issues. She stated, if there were such an approach, "I think there would be such a better continuation of care" and they could reach more children. She then added that this approach would require more people, but,

With more people you could have more of a systematic approach to things. Having a multi-tiered system of support is crucial rather than, for example me running around to this teacher to go to the principal to call the school resource officer and you know, if we had a system in place with people that were able to do it, I think we could really do some good work

Participant 1 extended this idea, saying that taking a multi-tiered approach in the schools could help alleviate problems because it would allow professionals to provide more appropriate and effective services in the schools. Further, if this were brought into the rest of the county he thought they would, “get the most bang for our buck.” He added that there are services the schools are expected to provide that really should not actually be given to students, for example treating children who have been sexually abused. He said,

Let’s stop pretending we’re going to do that and we need to be up front with parents and tell them listen, that’s a service you’re going to have to get outside of school it doesn’t make sense for that to be provided in the school setting... I think everybody sitting down and talking together about okay, what kind of supports can we provide? What makes the most sense?

In other words, if everyone in the county were able to sit down and talk about the kinds of supports they can provide then they will be better able to support children’s mental wellness. This is because it can be supported at school, at home, and with other professional support from agencies in the county.

Increase education. Almost every person interviewed mentioned increasing educative practices as a method for solving community wellness problems. Specifically, participants thought there should be more education about available resources in the county. This concept often arose in conjunction with the idea that there is a lack of education in the community about available resources and limited true knowledge surrounding what mental wellness/illness actually are. Participant 2 noted law enforcement especially should be, “educated on what’s available out there or the resources to get them to, again I think often times we are the first contact and... the first step in providing any type of care.” Similarly to the need to be educated on the available resources in the county, several participants said it was important for professionals to be

made aware of other people's roles and experiences with mental illness in the community. An example of this would be for mental health professionals to speak directly with law enforcement officials to openly discuss the scenarios that police are seeing on a day-to-day basis. Then, the mental health professionals might be able to better teach the law enforcement officers effective tools for handling the situations they encounter (Participant 2).

Other people mentioned that it is not only professionals who need to be more aware of available resources, but also the parents. Participant 1 expressed, "I think there are certainly things that we can provide to parents in terms of that professional development." And Participant 5 added that providing people more financial education would allow them to work their way out of the hole they find themselves in.

Regarding mental health education, Participant 6 reflected,

I think we've tried to increase over time the educational aspect or what we might be doing in the community to raise awareness about mental health or providing some sort of education or forums for when people *can* get together, but you know, potentially there could be more of that kind of thing happening

Participant 3 reiterated that point stating, improved mental wellness,

Starts with awareness. It starts with people understanding that this is something that's important and that it impacts families and it impacts lives and if we can do something to alleviate the struggles that people are going through, um, then that would be just fantastic

Finally, Participant 11 added the importance of educating people on how to recognize and work with somebody experiencing a crisis due to a mental illness,

And I think [S] working with her agency with this Mental Health First Aid. If they can get that to those who work with younger children and somehow incorporate that into some curriculum for younger children, then

I think they're going to start seeing *tangible*, viable, measureable, you know, results from all of that.

Increase collaboration and communication. Many participants indicated that increasing and/or improving the collaborative and communicative practices in the county would be important for creating sustained change. The most frequently stated need in this theme was the need to find a better way to connect people with resources. This was closely followed by the need to create meaning and direction behind a collaboration, as well as the need to make mental wellness a community wide concern.

The prominent theme of making a change to connect families with and using resources more frequently was most often brought up during discussions with participants expressing frustration with recommending resources but not knowing if people were using them. Participant 11 went so far as to state, "I can only take what the families tell me as the truth." In reaction to these types of thoughts, some participants indicated they would be beginning some of the change they want to see prior to an official collaboration between professionals. One participant in particular stated his organization wanted to see, "If there's some way that we can help either facilitate getting kids or families connected with service, or [ourselves] providing service in a different way" (Participant 1) because he felt that was the best way to improve child outcomes. Further, Participant 6 posited that increasing communication between agencies could help to increase attendance and connections with parents.

Community members involved in this research also found it important for there be an established meaning and direction behind the collaborations that form. Participant 11 stated,

I think we'd have to pull together the key players, meaning the school system, the mental health professionals, the faith communities, all of these people getting, and I hate to use this term because I myself have been beat to death with it, and get a task force together that says, what, what is it?

Participant 4 took it a step further than the previous example, noting that it is important to state what the collaboration's goals and direction are. He provided an example using the YMCA and the Library as a portrait of a good collaboration.

We're going to sit down and say what our goals are. How we're going to measure the impact. We can go do it the same way. And if the library needs to turn in something for funding, say they did this with the Y and this is their measurable impact, they want to turn in something that's going to be the same.

Participant 4 then expanded on this idea a bit, adding there needs to be a leader for this, whether it be an individual or an organization, and he is willing to nominate his organization to be that directing leader. Another participant took this idea even further, stating that when there is a better vision for what mental health services in the county will look like they will find, "better solutions to make sure we're maximizing the dollars we have" and "help either facilitate getting kids or families connected with service, or [with] providing service in a different way" (Participant 1).

Finally, it is important to the mental health professionals in the community that mental wellness become a community-wide concern. Their hope is that,

If there were a more formal collaborative formed around these issues, certainly it could improve communication or increase or enhance communication among organizations, but I think that there would also be a wider emphasis in the community at large in just *communicating* about issues with the public... It isn't communications happening between organizations about a specific child but rather it's something that we all should be concerned with. (Participant 8)

This may be difficult however, due to the identified weakness in communication, which serves as a barrier to collaborations. Specifically, one professional said,

I don't hear as much what's going on in the school system unless it's a major thing that hit the paper. It's amazing how much you lose on what's going on in the community as you go through those phases of life.
(Participant 7)

Perhaps though, if one increased the communication and collaboration that exists throughout the community, the providers might be able to “increase family involvement and really reach the families who aren't more involved right now” (Participant 9).

Increase leadership. Referenced in the previous theme, when forming a collaboration community members feel it is necessary for someone to “take that initial step and be willing to already have it [the goals] outlined out” (Participant 4).

Unfortunately, as Participant 8 pointed out, people in the community will not do things without a strong leader, “That full-time person or your cheerleader or champion in your corner who is constantly getting people to support you and I don't think we have that a lot of times.” Participant 16 reiterated this sentiment stating,

I think maybe we need more leadership in a positive sense. Because there's a lot of following and rallying around certain things, but maybe we just need, like I said, there are these few great younger parents, professionals that are starting, I see, starting to make changes. And maybe we just need more of that and then there'll be more support.

Participant 3 also felt that, “To have someone over it to say, alright here's what we're going to do. To take the lead” would be one of the most important things that could enhance new collaborative efforts. Many other community members felt the same way, and several participants volunteered themselves or their organization as the type of

person who could and would be willing to step up. In stepping up, so to speak, participants demonstrated their commitment to creating change in the community.

Including necessary people. In discussing how to create change in the community, several people mentioned specific organizations and professionals as important to include. If this subject did not arise naturally in the conversation, participants were asked explicitly to state who they felt should be included in the conversation about children's wellness in the county. Table 14 shows the organizations that were listed as most beneficial to include, broken down by category and type of care provided. As might be expected given the number of services it provides, the HRC was one of the most frequently mentioned organizations to include.

Table 14. Organizations to Include in Future Collaborative Efforts

Major Organizations	Specific Roles In Organizations
Faith-based organizations	
	Youth pastors
	Athletic association
	Pastors of churches
Law enforcement	
	Police officers
	Police chiefs
	Sheriff
	State's attorney
	Probation officers
Schools	
	Teachers
	Guidance counselors
	Principals
	Special Education Association
	High school students
Human Resource Center	
	Director of HRC
	Clinical coordinator
Medical Personnel	
	Catholic Medical Association
	Pediatricians
	Family doctors
	ER staff
Businesses	
	Rotary Club
	Chamber of commerce
YMCA	
Community Action	
DOVE/BABES	
Parents	

Strengths. Throughout the interviews, it became clear that the county maintains a number of strengths and positive supports that aids members in their work and serves as tools for enhancing the change the community hopes to create. As participants spoke of these strengths it became clear that they felt they were being underutilized, could serve as models for other systems, or had opportunities to be made even stronger. As Participant 3 stated,

I think we have a lot of really good resources within our community. It seems like there's a lot of overlap with individuals and groups trying to do this, trying to do that. So I think that if we get everyone together and we're working for one common cause we could do really good. Because everyone's out there trying to do a little something, so coming together I think would be a strength.

Several strengths were identified in speaking with community members, including: (a) positive organizational supports; (b) positive organizational relationships; (c) positive personnel supports; (d) desire to make an impact; (e) desire to communicate; (f) investment in the county; and (g) positive organizational potential.

Positive organizational supports. Positive organizational supports are practices and programs that already exist within the county that are considered to be making a difference. Examples of this include the fact that a variety of services are available at the HRC and there are, “people out in the public and in the community working with different organizations ... [helping] us to get us recognized and people to be okay to call and refer here” (Participant 8). Other organizations listed as providing significantly to the community include the YMCA for providing children a place where they can go to feel “safe” (Participant 4), as well as law enforcement agencies - as they help the community prevent the use of underage substance use/abuse and instances of drinking and driving.

A final example of positive organizational supports includes existing systems of support for children and their families. In other words, organizations such as the drug court, which creates a “change [that] is more long lasting and hopefully permanent” (Participant 13). It also includes the tiered behavior management system, Positive Behavior Interventions and Supports, used in the schools. These types of programs have, according to participants, shown some evidence of positive change within the community. In fact, the education system was frequently cited as one of the strongest positive organizational supports because the staff have been able to safeguard and provide services for the children during crisis situations (e.g., following individuals’ self-harm or suicide). Adding to that strength is the schools’ ability to simultaneously communicate well with parents about their child’s progress in school. Participant 6 went so far as to acknowledge that the education system in the community has begun providing services that go well beyond the education of a child and “there are systems in place for them to identify and treat the children.”

Positive organizational relationships. Positive organizational relationships are related to positive organizational supports in that they are relationships organizations have built between each other for support and communication. While it was consistently acknowledged that communication could be improved between agencies, it did not preclude the fact that the majority of participants felt there were strong personal connections between the agencies. For example, Participant 7 explained her office works, “closely with the school nurse, with some of the patients that we have that she also oversees. So good working relationship there.” Further, relationships are not reserved to communicating about patients. Of note, the special education association serving the

county holds a number of trainings for professionals *and* parents (Participant 1).

Additionally, every participant who discussed the connection between agencies expressed the desire to communicate and work more closely with the other organizations. For example,

The church would love to be actively involved and engaged in opportunities along the way. You've got to watch that line, separation between church and state, we realize that. But I think there is a lot that the school district has used [the church] building on multiple occasions for. (Participant 12)

Positive personnel supports. The subtheme positive personnel supports is representative of the idea that there are people in the community who have strong intrapersonal characteristics and who also work in a provider role. Essentially, these are people who are self- or peer-identified as leaders, change makers, and resources. Participant 3, for example, notes that she is “someone that [parents have] worked with and hopefully that they can trust has their child’s best interest at heart so I think that’s, that’s really crucial.” While Participant 16 reflects that throughout the community, and especially with the professionals, there is a strong desire to support the children and ensure that they do well. Bringing that thought further is one participant who stated,

I do think the county itself and the people in it are willing to, and do, step up, um, to meet a whole range of needs. And you know I can think of specific instances where an organization recognizes a need and reaches out to another organization for assistance, and they’re going to say yes, we’re going to help you

Desire to make an impact. Similarly to positive personnel supports, interviews demonstrated that people in the community have a strong desire to make a positive impact on children. Greater than half of the participants hoped they, and other professionals would make a strong impact on children. Moreover, this desire extended

from professional to parent. For example Participant 18, a mother, explained she has gone down to Springfield to lobby at the capital for mental health policy reform. “So,” she finished, “it’s just whenever I get the chance I speak at that stuff.” Other participants noted similar actions. Ways to make an impact ranged from one participant who measures the impact of services to find new and more efficient methods, to another participant who, despite her limited time, continues to organize prevention coalitions and lunch programs in the summer. Finally, many participants clearly stated that no matter what happens, they will be persistent and passionate about

Pushing forward hoping that we can bring people in with us that continue to collaborate with us and hope that they’ll bring others with them. And so it’s not going to be difficult, again like I said, even if we didn’t have anybody collaborating we’re still going to do our mission. Finding a way to do it and impact we can, when we can, how we can, with what we can.
(Participant 4)

Desire to communicate. In addition to a desire to make an impact, community members expressed a desire to increase communication between agencies. For example, Participant 10 made the following statement, “people are so open and willing to speak with each other. You know, and really connect with each other.” Participant 11, on the other hand, acknowledged people have differing viewpoints but that they have similar overall goals, “I think there’s a lot of people here who would be willing to talk to you that can give you very different um, information. You know? Perspectives.” Because, “when things go badly everybody shows up. Their motivation is to help and I think it’s a pure motivation to help. I also think that when they have the information in their hands that they will proactively participate in the solution.”

Investment in the county. These desires to communicate and make an impact may partially extend from community members' strong investment in the county. Many of the participants live in the community and several of the participants were born and raised there. Participant 2 felt so passionately he said, "I'm born and raised here and so I have a probably stronger community investment than the average person does." Several community members echoed this thought though, exemplifying that he is not alone in such feelings.

Positive organizational potential. The final strength identified within the community was positive organizational potential. In other words, this is the idea that there are organizations that, despite the barriers they face, are making positive changes and moves in the community. An example of this is a coalition that recently received a grant to combat the rising use of drugs in the county. Another example is when the church reached out to the community following the suicide of a high school student. Although the church was reaching out in comfort, according to Participant 12 they were also able to identify children who, "Weren't saying, 'I'm thinking about going home and thinking about killing myself tonight, but I have. That has crossed my thought process. And you know I have sometimes thought that wouldn't it just be easier.'" And because of the suicide and the resulting after shocks, several parents, the faith community, and the HRC are all attempting to reach out and spread education and awareness about suicide prevention.

Success stories. During the interviews, community members had the opportunity to speak about the success stories they witnessed when families were served by the current system of care. In speaking of these stories, it became clear people were able to

succeed when they were given a plan that involved numerous team members coming together to form a collaborative plan of care specifically for that person or family. One story discussed the connection developed between a therapist, a parent, a guidance counselor, and the special education association that serves the county. Participant 3 recounted this story, speaking about how she was able to help reduce the stigma the parent had against therapy via education. Also, according to Participant 3, thanks to the various service providers who became involved in that specific case, the girl's social skills are much better. After her recounting of the success story finished, Participant 3 added, "If we could do that for every kid that would be great. I mean she's done much better. She's not exactly where she needs to be but she's not doing the bizarre social behaviors that she used to. It's starting to click."

Several other participants spoke of the times when the whole town appeared to wrap around and support people. For example, as a result of the community coming together for one homeless family, the father was able to receive mental health services, the family was able to find housing, and "together they were able to return to their feet." (Participant 11). Even the businesses were noted to be working together to support children with disabilities. For example, by creating a safe place within a high school club attached to the Rotary, a student with Autism was able to flourish and end his high school career by presenting to others about his disability and applying for and receiving grants that will allow him to attend a state university (Participant 12).

Organizational Readiness for Implementing Change. Similarly to the IACAS, the ORIC self-report questionnaire was administered to participants at the conclusion of the interview as a baseline measure of their organization's readiness for change. This tool

measured participants' perceptions of their organization's readiness to change.

Specifically, it measured items such as participants' confidence in their ability to keep track of progress while implementing change, as well as their confidence that people will do whatever it takes to implement change. Measuring participant responses to questions on a five-point scale from *Disagree* (1) to *Agree* (5), results of this questionnaire are presented in Table 15 and indicate that overall participants *Somewhat Agree* that their organizations are ready to change.

Table 15. Results of the ORIC

Question: People who work here...	Mean Answer
Feel confident that the organization can get people invested in implementing this change	4.06
Are committed to implementing this change	4.29
Feel confident that they can keep track of progress in implementing this change	3.76
Will do whatever it takes to implement this change	4.00
Feel confident that the organization can support people as they adjust to this change	4.12
Want to implement this change	4.18
Feel confident that they can keep the momentum going in implementing this change	3.82
People who work here feel confident that they can handle the challenges that might arise in implementing this change	3.71
Are determined to implement this change	3.88
Feel confident that they can coordinate tasks so that implementation goes smoothly	3.76
Are motivated to implement this change	4.00
Feel confident that they can manage the politics of implementing this change	3.41

Specifically, at the time of the interview, participants felt most confident that people within their organizations are committed to implementing change. However, participants

felt least confident that they could manage the politics of change or that they could handle challenges that can arise when implementing change. These results resonate with the confidence participants expressed in the community's desire to make an impact and support children.

Summary. In answer to Research Question Four, which asks, "How does one enhance collaborations in rural mental health?" the following themes were identified: (a) How problems can be solved, (b) Including necessary people, (c) Strengths, and (d) Success stories. When discussing these topics, community members most often stated their hopes and goals for the County as they continue to push forward with new mental wellness efforts. Commonly stated methods of solving the problem within the four identified categories included: utilizing strong leaders, building safe places for children, utilizing the strengths that exist, and creating a more educated community and a better continuum of care. In the end, participants hoped that engaging in these activities would allow the mental health professionals in the community to reach more children and adolescents.

CHAPTER FIVE

DISCUSSION

The goal in case study is to allow for natural settings, multiple sources of data, inductive data analysis, emergent design, and holistic accounts to provide an in-depth examination and analysis of a bounded community (Creswell, 2009; Merriam, 2009). The purpose of this case study was to understand how community members beginning a collaborative effort identify, define, and act upon their main goals for providing systemic mental health support for children ages 0-18. In doing so, this study sought answers to four questions: (1) Are there supportive services and resources that already exist within the county and can be built upon?, (2) From the community standpoint, what do community members see as the biggest concern for youth and the system currently serving them?, (3) What are barriers to creating an integrated system of support for children, adolescents, and families?, and (4) How does one enhance collaborations in rural mental health?

Several common themes arose from these questions. To begin, this study identified that some mental wellness practices already exist within this county, however they are operating in limited capacity and therefore are inadequately equipped to serve the role they are being asked to perform. Specifically, providers are unable to address successfully community concerns for children surrounding substance abuse, lack of safe

places and resources, increases in self-harm behaviors, and a lack of parent support and education. These results may have been found due to the identified areas of weakness such as a lack of resources in the county, especially in relation to services, funding, time, and staffing.

Other identified weaknesses that may contribute to the high concern for children's mental wellness are the high levels of stigma that exist in the county, lack of education about mental health issues, and resistance to change. These findings are concurrent with the discussions of rural mental health in the literature (Fox, Merwin, & Blank, 1995; Giron-Herrera et al., 2013; Mukolo, Heflinger, & Wallston, 2010; Pescosolido, Perry, Martin, McLeod, & Jensen, 2007; Philo, Parr, & Burns, 2003). Essentially, these findings discussed that rural areas typically demonstrate high levels of stigma against receiving mental health services in part due to because of a lack of education surrounding what mental wellness is. Identified weaknesses specific to the county in question included a lack of leadership, direction, and follow through. It may be important to note that research demonstrates a high prevalence of comorbidity between drug use disorders and mental illnesses (Hawkins, 2009). Given that "persons diagnosed with mood or anxiety disorders are about twice as likely to suffer also from a drug use disorder" (National Institute on Drug Abuse, 2010, p. 2) this may be considered a key area of concern not only in addressing the needs of people with mental illness, but also in educating community members and practitioners about children's mental wellness. This could be especially important given participants' statements that parents would rather have their child be labeled a criminal rather than "crazy."

Community members also emphasized the role the school system plays in children's lives. In addition to communicating that school staff are important to include in any collaboration, participants noted that more and more frequently staff are being asked to perform duties outside of the realm of academic education. This notion is evidenced in state standards establishing social emotional learning as a part of educational policy (Dusenbury, Weissberg, Goren, & Domitrovich, 2014) as well as in calls for action and advocacy by organizations such as the National Association of School Psychologists (NASP; 2010) and the American School Counselor Association (ASCA; 2004). However, as both NASP and Anderson-Butcher & Ashton (2004) state, it is not possible for any one agency or professional to succeed alone in addressing the multifaceted student needs. Given the impact various system levels have on child development (Bronfenbrenner, 1979; Epstein 1995) this suggests that, as this study finds, it is necessary if not vital for schools, community organizations, and parents to work together to address the mental wellness of children in rural areas.

Finally, this study demonstrated that in order to create sustainable change within the county, members must utilize context specific approaches, as is suggested by Meyers et al. (2015). Context specific approaches for this county include utilizing strong leaders, creating safe places for children, using existing strengths in organizations and personnel, and creating a better continuum of care. Also concurrent with previous findings (Hobbs, 1994), participants in this study indicated it is important to enhance communication between agencies and community members. Opportunities and methods for doing so are discussed below.

Implications for the Community

One final critical question is: what can the county of *this* study do to continue promoting children's wellness? In other words, in looking at the literature, what is available or recommended to support the community in addressing its concerns? This section addresses this question in several ways; first by taking a broad perspective on potential changes and then narrowing in on the specific community concerns of substance abuse, reducing stigma and increasing education and parent involvement, creating safe places for children, supporting overwhelmed schools, and reducing self-harm behaviors.

Macro-level suggestions for change. Included in this sections are macro-level suggestions for change. These include creating sustainable changes through systems level approaches.

Implementing systems-level approaches. As described by participants, the system currently in place in this county takes a medical model approach to treating mental health much more so than it does a public health model approach. In other words, although the county has some preventative practices in place, most of the services available rely on a wait-to-fail methodology rather than on preventing the "failure" in the first place. This is exemplified in the interviews with the many participants who referenced the triage situations they face and the Band-Aids they put on symptoms rather than actually solving things. Perhaps participant 8 put it best when she stated,

I find we operate only in crisis mode... I see a lot of, "Is it a crisis? No? Okay then that can be put off... We don't need to deal with that." But in the meantime, when we're not dealing with it it turns into a crisis later. Because we're not proactively dealing with issues in the community.

However, many researchers argue that using this medical model approach only causes negative results for children with mental health concerns and practitioners should be using a preventative approach based on the public health model. For example, in addressing similar issues faced by school psychologists (i.e., worries about increases in violence and stigma, as well as under-serving students with behavioral and emotional impairments due to under-utilization and poorly coordinated systems of care), Strein, Hoagwood, and Cohn (2003) stated that these problems are best addressed by changing the psychological service delivery on a system-wide level. Specifically, they argue that by making society the “client,” service providers are able to address the societal or community level risk factors that affect and interact with the individual level risk factors (Strein et al., 2003).

Many participants in this study noted their concern that the same people are returning through the system of care over and over again, often due to the community level risk factors (e.g., poverty) interacting with the individual-level risk factors (e.g., teen-pregnancy, substance abuse). Further, the data suggests that mental health support, as much as it is needed, is not a priority in the county given the high levels of stigma and resistance to change providers are currently experiencing. Participants recognized that they need to overcome these barriers before a positive difference can be made, however they demonstrated difficulty in providing suggestions beyond ‘more education’ for how to make that change. One possibility for change is with the public health model’s emphasis on three-tiers of prevention, because within this type of model positive behaviors can be strengthened and negative instances such as violence can be reduced (Strein, Hoagwood, & Cohn, 2003). A specific example of this involves the work of Bell

and colleagues (2014). These researchers created culture-specific interventions that addressed student needs by reducing the individualized punishment (medical model) and increasing the prevention activities across three tiers (public health model; Bell, Summerville, Nastasi, Patterson, & Earnshaw, 2014). In making those systems changes, the researchers were able to increase psychological well-being of students while simultaneously changing the attitude of staff and alter their mind-sets towards the need for more preventative supports. Although that intervention took place within the school system, it is possible to see that similar effects may occur when implemented on a community wide scale. These effects may then lead to changes that the participants in this study hoped to see, such as: an increase in understanding and acceptance of mental wellness, increase in parent support for children, reduction in negative behaviors such as bullying and self harm, as well as a reduction in substance abuse.

As part of using the public health model's tiered intervention system, the community can identify common denominators to rally around. In other words, more people accessing services is not going to solve this county's problem alone because the issues are interconnected. By looking at the big picture and finding commonalities between these major identified weaknesses, participants can move beyond putting out fires and rally around a single project or cause for change. After all, as was stated in the interviews, the county is already strapped thin in terms of the number of people they can service. Taking on a single issue with interagency collaboration can allow them to look at issues from a systems-level perspective while simultaneously reducing the impact of these perceived weaknesses.

Creating sustainable change. One concern of the participants was the community's ability to create sustainable change. Although never stated outright, this can be gathered from the combined statements that the community does not have a leader and that people will often come up with ideas but they tend to "fizzle out" as Participant 7 stated. Participant 7 further indicated that the new initiatives would fail primarily because they were not well organized or maintained. Additionally, participants indicated failure also occurred due to lack of leadership, lack of appropriate tools, and a lack of readiness for change. Much research conducted within the realm of implementation science has sought to understand exactly why those types of initiatives tend to fail. One researcher posited that it was due to a lack of capacity (Leeman et al., 2015). Using a framework discussed in Chapter Two and conceived of by Wandersman and colleagues (2008), called Evidence-Based System for Innovation Support (EBSIS), Leeman and colleagues (2015) argued that when equipped with the appropriate tools and strategies for change, participants are much more likely to adopt and implement evidence based interventions with integrity. Further, the researchers reviewed relevant literature and found that when practitioners' capacity to understand and implement change was increased, so too was the success and longevity of new initiatives (Leeman et al., 2015).

In response to the capacity and leadership concerns, the community should consider different systems models of leadership. There are several examples of effective leadership and its benefits in the literature. Particularly, the community is referred to Marzano, Waters, and McNulty's book School Leadership that Works (2005), along with research conducted by Waters, Marzano, and McNulty in 2003. The research conducted by these scholars describes the theory that effective leadership means knowing when to

do something and how to do it, as well as utilizing change agency, teamwork, continuous improvement, trust building, and eradication of short-term goals. Although this leadership is explained for use in schools, communities can modify this approach to suit their own contextual needs as they were described in the results. Another model of leadership stems from Bolman and Deal (2010). This model in particular examines the various frameworks that should be used in order to create sustainable change. Specifically, this model references schools should become a part of the human resource frame (i.e., building relationships and empowering self), the structural frame (student discipline), the symbolic frame (providing accurate feedback), and the ethical and valued them (Bolman & Deal, 2010). In incorporating one of these leadership models, or a similar model, the county may be able to approach their work from a systemic perspective while simultaneously building capacity and receiving on-going implementation support.

Finally, similarly to capacity building, other studies suggest that on-going implementation support in community settings may be a key to sustaining interventions and meet the mental health needs of youth (Lyon, Frazier, Mehta, Atkins, & Weisbach, 2011). For example, Lyon and colleagues (2011) found that facilitators to sustainability included a positive implementation climate, efforts to maximize the fit between the intervention and the setting, high levels of use during supported implementation, and positive staff perceptions about these strategies. Another study designed to understand what factors promote sustainability found that when trying to transfer research results into clinical practice, active implementation support was pivotal in creating sustained change (Forsner et al., 2010). Specifically, they found that change agents must not only

disseminate information and educate others about the change, they must also engage in regular meetings, set goals, give feedback, and provide workshops in which people can discuss progress and successful strategies. In the end, this allowed them to meet and adapt to local needs.

The concern for the community of this study then, is how much personnel support, time, and funding would these types of changes take? Given that participants listed these three factors as major areas of concern, it is imperative they be taken into account when change is being implemented. Unfortunately, there is not much focus in the existing research that speaks to where communities can receive these sources. However, participants frequently suggested that if there was a leader of this project, someone who was able to devote much of his or her time to the project, then a new initiative would be much more likely to succeed. In that role, the community member could perform formative and summative evaluations throughout the change process to ensure those factors that encourage sustainability are in place. Finally, when considering potential methods for creating macro-level change and contemplating micro-level program change, it is important that the community continue to take their individual context into account. In doing so they are more likely to create a sustainable, collaborative change because they are speaking to *their own* needs.

Micro-level suggestions for change. Presented below are micro-level suggestions for change. These include changes the community can make for macro level issues such as substance abuse, stigma and lack of education, limited safe spaces, and overwhelmed schools. It additionally addresses changes that can lead to a reduction in self-harm behaviors and enhanced community collaborations and communications.

Regarding substance abuse. Substance abuse is most prevalent among adolescents and emerging adults, with 71% of youth having tried alcohol by 12th grade, 42% having tried cigarettes, and 43% having tried marijuana (Johnston, Bachman, O'Malley, & Schulenberg, 2011). As such, much research has focused on preventative and intervention practices related to substance abuse disorders in adolescents (Sussman, 2011). Further, Hawkins (2009) found that substance abuse disorders are frequently comorbid with mental health disorders; and, given these disorders generally begin in childhood or adolescence, both mental health and substance use disorders can be considered developmental disorders.

When it comes to treating substance abuse disorders, Sussman (2011) argues that a continuum of care model would be the most likely model to reduce substance abuse in teens as they typically consider multiple options extending from prevention to treatment alternatives. In using this approach, providers may be able to stop the current substance abuse (treatment) to facilitate recovery of functioning while simultaneously preventing future substance abuse from occurring (prevention). In all, research on ideal programs for teens still varies. Despite this variation however, there are some prevention programs with some evidence effectiveness, which include: school-based educational programs, family-based programs, and mass media programming (Sussman, 2011). Pentz (1995) suggests that using a combination of school-based *and* family programming may double the percent of children who reduce drug use and maintain that reduction over a longer time period. Tobler et al. (2000) move a step further suggesting that combining those two types of programming with additional involvement of community organizations is a way to further maximize prevention effects.

Regarding treatment approaches, Liddle and colleagues (2009) put forward that there is no one superior type of treatment for teens. Although they also argue a combined approach that encompasses programs similar to Alcoholics Anonymous, such as the Therapeutic Community approach, family therapy, or cognitive behavioral therapy may be most effective long term (Liddle, Rowe, Dakof, & Henderson, 2009). Other studies, however, have found that the most effective programs in reducing substance abuse will utilize nine key elements: (1) conduct comprehensive assessments covering psychological and medical problems, family functioning, and other aspects of youth's lives, (2) address all areas of youths' lives (i.e., school, home, public activities), (3) involve parents in youths' drug use treatment, (4) reflect developmental differences between teens and adults, (5) build climates of trust, (6) utilize staff well-trained in understanding adolescent development, co-morbidity issues, and substance use, (7) address gender and cultural competence, (8) include information on continuing care, and (9) include rigorous evaluation to measure success and improve treatment (Brannigan, Schackman, Falco, & Millman, 2004).

As the community continues to tackle these types of programming, based on this data this researcher recommends that the county should consider also an integrated treatment approach to treating substance abuse and mental illness that appear comorbidly. They may do so by coordinating providers, parents, and teens, in addition to creating shared goals, measuring success rates, and implementing specific evaluation practices. The county can address some important concerns when utilizing an integrated treatment approach. Recall that several participants indicated there is a high correlation in the county between people who abuse substances and people who have a mental illness.

Further refer back to research question three, and the fact that people with both disorders often times have negative interactions with the police during crisis situations and may even be involuntarily hospitalized in a psychiatric facility only to be released and start the cycle over again. Integrated intervention for the two disorders has proven to be effective (Brannigan et al., 2004), and successful service delivery may reduce the number of times law enforcement has to provide crisis intervention for people in the community, another oft stated concern.

Reducing stigma and increasing education. One important participant concern to address is that of high levels of stigma and low levels of education surrounding mental health and mental wellness. Because of this lack of education and high stigma, they felt that families are not being connected with the mental health support that they need. Although community members identified some efforts to change those levels through initiatives such as Mental Health First Aid, other participants still commented that parents in the community would rather have their child be a criminal than have a mental illness. There has been some recent evidence that the majority of the public understands that mental illnesses are medical problems, but the public still overwhelmingly rejects those people who experience a mental illness (Pescosolido, Medina, Martin, & Long, 2013). If this is the case, then educating people about mental illness being a “true” disease is less important than creating and/or using educational campaigns focusing on ensuring inclusion (Pescosolido et al., 2010; Pescosolido et al., 2013; Read, Haslam, Sayce, & Davies, 2006; Schomerus et al., 2012). Given this call to action, efforts to reduce stigma must address also the larger cultural contexts of misunderstanding, inclusion, and

tolerance in order to prevent continual negative reinforcement from larger culture (Pescosolido et al., 2013).

One study addressing the education and equality approach to understanding mental illness and reducing stigma found positive results in using a youth-led model called The S.P.E.A.K. Program (i.e., Share, Peace, Equality, Awareness, Knowledge; Bulanda, Bruhn, Byro-Johnson, & Zentmey, 2014). Youth-led approaches such as this have been demonstrated to have lasting effects on children and their community because they help to build youths' strengths, decision-making skills, critical thinking processes, and contributions to society (Delgado & Staples, 2008). Another youth-led stigma reduction program study, LETS (Lets Erase the Stigma), had findings such that youth participating in the program demonstrated more acceptance of mental illnesses, performed higher proportions of positive anti-stigma actions, showed less social distancing of people with mental illness, and had better attitudes about mental illness (Murman et al., 2014). Authors of this study posited the success of the program may have been due to greater inter-group contact, in other words contact between people with mental illness and people without. As such, this may have resulted in increased knowledge, empathy enhancement (e.g., perspective taking), and anxiety reduction (Murman et al., 2014). They further suggested that prevention and early education are key in reducing stigma as that can prevent negative attitudes from becoming deeply ingrained prior to adulthood. Encouraging early education could be especially important in this county, considering the stated difficulty participants anticipate in getting parents who have adult children to understand the need for preventative mental health support. If

it is possible to get children and young parents aware of this, it may give the community the push it needs in order to sustain change and increase prevention efforts.

Other studies examining stigma among the adult population demonstrate similar results. Specifically, they demonstrate that personal experience with persons with mental illness should be integral to anti-stigma campaigns as they can help to reduce fear and increase benevolence (Flanagan & Davidson, 2009; Spagnolo, Murphy, & Librera, 2008). Similar research noted however that the greatest impact of educational programs occurs when contact between groups is targeted, local, credible, and continuous (Corrigan, 2012). This is likely because unlike education alone, which changes just attitudes, contact with people experiencing mental illness has the capacity to change both attitudes *and* behavior (Overton & Medina, 2008). It is possible then, that when interventions such as these occur, parental support for children's mental wellness will also increase.

Increasing safe places and resources for children. In conversations with participants there were many services that were identified as existing in the county, however there also appeared to be a strong need to increase the preventative practices and provide more things for children to do when not in school. This especially appeared to be the case when participants spoke about their concern for children. Often when discussing the available resources for children participants appeared to reflect on the underlying question, "are we actually equipped to serve our children?" Unfortunately the answer frequently appeared to be "no." It is known that rural areas tend to be smaller, under-resourced versions of their urban counterparts (National Association for Rural Mental Health, 2001), and it appears participants felt this way too, often stating, that because they are in a rural area there are limited activities for kids to do and so they get in trouble.

Not only that, but given the Illinois Youth Survey administered to the children, it appears that quite a few children are turning to substance abuse and many of the adults within the community are attributing this to a lack of resources available to them once they are not in school. One way to alleviate this concern is to increase the after-school or extracurricular activities available to youth.

Participation in after-school or extracurricular activities has been shown to help increase positive social behaviors and reduce problem behaviors, while programs with academic components have demonstrated results in improving outcomes in reading and math (Durlak, Weissberg, & Pachan, 2010). Further, child and adolescent participation in extracurricular activities has been shown to: build self-confidence and self-esteem (Bungay & Vella-Burrows, 2013); enhance interpersonal, communication, and decision-making skills (Rubin, Bommer, & Baldwin, 2002); and to increase social support systems, neighborhood cohesion, social skills, and social relationships (Anderson, Scrimshaw, Fullilove, & Fielding, 2003). Research conducted in rural America by Elder and Conger (2000) concurs with those results, indicating that engaging in after-school activities will create positive experiences that reinforce positive images of self. The researchers posit this is because participation in extracurriculars can produce new student visions of the future by deepening awareness of their personal strengths and opportunities. They further report that not only will these activities instill a sense of belonging and self-worth in children, they will also act as powerful “recasting activities” (Elder & Conger, 2000, p. 181) in that they help kids change identities, plans, and life courses. Although it is important to make note that Elder and Conger indicate that while these changes can happen, they do not always happen for every child.

Despite the plethora of research indicating the positive effects of after-school and extracurricular programming, the literature base does not provide specific suggestions for communities or schools as they work toward building upon existing resources to create these activities. However this community has numerous strengths that it can build upon in order to create, enhance, and sustain these activities. Specifically, their strengths include strong positive relationships between individual community members, self-identified leaders, and existing organizations with the potential to be enhanced (i.e., the YMCA, the HRC, the schools, and the Faith Community). Further, given participants strong desire for change and commitment to their community, they may be appeal to their pride and common desire to build a safer place for children thereby jumping over the first hurdle of raising funds and gaining public support for creating a new program or enhancing an old one.

Reflecting upon the listed strength of individuals' strong levels of investment within the community and the desire to make a change, it is suggested that the community partners work together to combine resources (e.g., time, staff, funding, and space) to create such an after-school initiative. While there have been concerns in the level of quality such approaches can provide (Halpern, 1999), there are also noted ways to improve such programs. For example, creating shared goals, acknowledging and supporting the diversity of sponsors and program types, establishing minimum standards, creating a stable front-line staff, and the development of block grants from child care and social service agencies or from funding sources such as Title I have been provided as methods for improving community collaborations (Halpern, 1999).

Supporting schools. The data from this study suggests that participants feel a deep connection with the schools in this county. They frequently stated that the school has been a fantastic support, either for their own child or for a child they work with. However participants also felt that the schools may be overwhelmed in trying to provide all the mental health services in addition to the academic services. As has been noted previously, parent and community involvement is critical for supporting schools (Anderson-Butcher & Ashton, 2004). By partnering together, community members are able to create opportunities for children that allow them to develop critical social, emotional, and academic competencies (Albright, Weissberg, & Dusenbury, 2011). Unfortunately, there has not been one formula developed that describes how to best create a successful school family partnership, despite the overwhelming evidence of their effectiveness (Albright et al., 2011). However, Albright and colleagues (2011) do list the four key characteristics that can help families support schools: (1) child-centered communication; (2) constructive communication; (3) clear and concrete guidelines and strategies, and (4) continual, ongoing communication.

In addition to using these four characteristics, Albright and colleagues (2013) posit that schools can create positions within the organizations that are specifically focused on the school-family partnership, while simultaneously creating a school-wide committee focused on making social-emotional learning a priority. In doing so, they argue, a team representative of the community (not just the school) will be involved in planning and decision-making so that things run smoothly and do not become overwhelming. Other researchers argue that schools should focus on relationships, not just with parents, but with community members such that they create an integrated

approach that “spans Bronfenbrenner’s ecological systems” (Mapp & Hong, 2010, p. 360). Specifically, Mapp & Hong (2010) state that creating these partnerships establishes relationships of trust and mutual respect while they work as partners to support children’s learning (mesosystem), in which families can become leaders within the school and the community, and the overall school culture shifts to parent-centric (exosystem).

Reducing self-harm behaviors. Research indicates only a minority of children and adolescents who experience suicidal thoughts or self-harm come to the attention of any health service provider (Michelmore & Hindley, 2012; Paul & Hill, 2013). This was evidenced as well during the interviews of this study – following the suicide of a peer the faith community and mental health counselors identified several young people who had never before come to their attention but had experienced self-harm or suicidal thoughts in the past or were experiencing them currently. Several suggestions have been made in the literature to counteract this barrier to receiving treatment. Given that just having a diagnosis of a mental illness does not increase help-seeking behavior, Michelmore & Hindley (2012) suggest school-based screening programs be used to detect mental illness and suicidal thoughts. In conjunction with the screening, these researchers argue that mental health services, from the school or the community, be available to provide timely assessments for at-risk individuals and to engage in home-based treatments (e.g., school-based crisis teams, Signs of Suicide, psychoeducation with teachers and students during suicide awareness week, NASP PREPaRE training).

Other researchers indicate that there is a need for both preventative and treatment options when it comes to averting suicide and self-harm behaviors (Brent et al., 2013). Specifically, Brent and colleagues’ (2013) review of intervention studies discovered that

when these types of studies had a longer dose of treatment and involvement of the family or a supportive community (i.e., Mentalization-Based Therapy and integrated-cognitive behavioral therapy), meaning that there was a mobilization of the community and of families, they were more successful in reducing suicidal ideation and self-harm behaviors. Further, the researchers found that when care coordination, access to care, and greater intensity of treatment occurred during the high-risk period in suicidal ideation it reduced the suicide rate in adults. As such, if the community can establish successful coordination and communication between agencies, then service providers are more likely to see a reduction in these types of self-harm behaviors.

Creating collaboration and enhancing communication. Participants in this study spoke frequently about the communication between service providers and the existing collaborations between agencies. However, in referring back to Figures 1-3, on pages 70-72, it is demonstrated that much of the connections between agencies are informal or one-sided at best. This is also reflected in the often stated desire for better communication between agencies. Although participants felt that they had good relationships with their peers, they still felt the collaborations they were engaging in were not meeting their expectations.

In addition to the desire to enhance collaboration between agencies, one way to reduce many of previously listed concerns is also to enhance communication and creating collaborative efforts between various community members. Research on the techniques for the capacity-building needed to be able to enact such programming has been described as nascent, however (Leeman et al., 2015). As discussed briefly in previous sections, Leeman and colleagues (2015) argue that capacity building is the primary tool

that enables prevention support to affect the adoption and implementation of evidence-based interventions. Within their study, these researchers identified strategies and structures that help to build capacity within the community in order to adopt and implement evidence-based interventions. For example, they list peer networking, providing incentives, increasing tools and training dosages, and using a collaborative/proactive design (Leeman et al., 2015). Finally, the researchers (Leeman et al., 2015) note that in order to create interventions they must (1) assess the context; (2) engage in a team; (3) select an intervention; (4) adapt the intervention to their setting; (5) integrate the intervention; (6) evaluate; and (7) sustain the intervention. These same methods may be useful in increasing communication and creating a collaboration between community partners, especially if one views that new collaborative as an intervention.

In increasing communication and collaboration it is also important to remember to use formative and summative evaluations. Participant 4 explicitly called for such a technique to be used during the change so as to ensure that change was actually being made and that the community was still on track to meet their goals. Formative and summative evaluations are also important because they can ensure that the community members continue communicating with each other to discuss problems, techniques that worked in the past, and potential new solutions (Forsner, 2011).

Limitations of the Study

There are several limitations of this study. To begin, this is a case study of one rural county in the Midwest. As such, while the study may reflect some similarities to other communities, the transferability of this study to other rural areas is unknown.

Another limitation is that some community members recommended by participants as important to the collaborative process were either unable to be reached or declined to be interviewed. Specifically, several members of the faith community and doctors from the general practice and the hospital were not interviewed, however they were listed as key people in the community. Therefore, although the data reached a saturation point after which no new stories or concerns were raised, there is the possibility that those members not interviewed may have added significant new data to the discussion.

A third limitation to this study is the concept of social desirability. Participants from a relatively insular community were speaking to an outsider about their perceived strengths and weaknesses. Although the interviews appeared to be fairly candid and at times emotional, it is possible that not all participants provided their completely honest opinion about how mental health is handled in the community. Finally, a limitation to this study is that there was no separate coder or auditor during the analysis of the public data or the quantitative data. Although those types of data are less open to interpretation, the use of a coder or auditor may have provided a more thorough triangulation of the data.

Implications for Future Research

Given that limited research about collaborations in rural areas exists, further investigation using both exploratory qualitative research methods and more in depth quantitative research methods is necessary. One avenue of investigation would be to examine more than one county at a time as they go through the process of creating interagency collaborations. There are several counties throughout the rural Midwest that have similar goals but are in different stages of creating community wide collaborations designed to address mental health care. A study that compares and contrasts, for example,

three counties in the beginning, middle, and advanced stages of community mental health collaboration might prove groundbreaking in understanding the most effective techniques for creating collaborations. There are also initiatives in urban areas in the northeast region of the United States that are working to connect schools with mental health agencies more closely. Investigating how similarly and differently these collaboratives develop may provide more generalizable data for enhancing mental health services in a public health model.

It is also important to continue research with the quantitative measures used within this study. Specifically, how do results from the ORIC and the IACAS compare within counties and across counties as the community's move toward a more systems-level approach to providing services? In analyzing these results and comparing them with the success or failure of such initiatives, researchers may be able to find key stages in establishing preventative systems of care.

Further, in trying to create systems such as this, many micro-level interventions are going to be created (e.g., substance abuse prevention programs, suicide prevention programs, mental wellness education programs, and stigma reduction programs). Future researchers should carefully study the effects of these programs. This avenue of research will be especially important because implementing these types of programs in rural areas has been little studied, just as little is known about the effects of implementing these programs as a part of a system of care rather than as an individual program.

Finally, longitudinal studies should be conducted that assess the implementation of a community wide, public health model for mental wellness. These studies should be conducted in rural, urban, and suburban areas, so that results can be generalized across

multiple populations. In addition, these studies would provide a workable knowledge base for the various steps needed to implement such a change. There has not been one single script developed, and while that may be impossible given the varying contextual factors, it is likely that there will be some key tenants to creating long-term, sustainable change that works.

In summary, this study examined one Midwest, rural county's readiness to create a community-wide collaboration that supports mental wellness for children 0-18. Despite several identified weaknesses this county has numerous strengths it can build upon, including the community members' desire to create a lasting change that supports children and their families. Overall, it appears that taking on an evidence-based, preventative, and collaborative approach toward mental health care has the potential to create lasting change not only within the county of this study, but in similar communities as well.

APPENDIX A
INTERVIEW PROTOCOL

INTERVIEW PROTOCOL

Thank you for agreeing to participate in this interview. In the next 30-40 minutes I will be asking you some questions about your experience with the mental health collaboration efforts in DeWitt County and your thoughts about mental health services available in DeWitt County. I will not use your name and I ask that you try not to use any names in your responses to these questions. However, if you do, know that those names will be given a pseudonym during the transcription process so that I can keep the identity of those participating in this research private.

You do not have to participate in this interview if you do not wish to, and there will be no penalty. If you choose to be interviewed you can skip any question that you do not wish to respond to with no penalty. If you decide at any time that you would not like to be interviewed, you can discontinue the interview with no penalty. Do you still agree to be interviewed (if no, the discussion stops)? Are you OK with being recorded (if no, then the interview proceeds but is not recorded)?

Date:

Location:

Interviewer:

Interviewee:

The interview will begin by going over the informed consent form. The interviewer will remind the interviewee not to mention the name of the county involved with the collaboration.

Key Informant Interview

1. Do you consent to audio-recording?
2. I would like to start off by collecting some background information. Please describe, generally, the setting in which you work and how many years you have been professionally involved with providing services such as yours.
 - a. **Follow up questions may include:**
 - i. What has been your role and experience with children and adolescents?
 - ii. What resources and/or practices currently exist at your organization to promote children's mental health and well-being?
 - b. What do you think of the delivery system for children's mental health services?
 - i. **Follow up question may include:**
 1. How might the system be affected by collaboration between community partners?
3. I would now like to identify areas of improvement for collaboration and the provision of mental health services to children

- a. Please tell me about your biggest concerns for children and adolescents in the community
 - b. How do you think those problems could be fixed?
 - i. **Follow up questions may include:**
 1. Please identify services, if any, within the county you feel do not exist but should
 2. Please identify services if any, within your organization you feel do not exist but should
 - c. What do you think will be the county's biggest struggle when it tries to coordinate services?
 - i. **Follow up question may include:**
 1. What will be your organization's biggest struggle when it tries to collaborate with others?
 2. Please tell me about a child or family that may have slipped through the cracks
 - a. **Follow up question may include:**
 - i. Why do you think they slipped through the cracks?
4. Now I would like to identify helpers of collaboration
 - a. What do you think will be the county's strengths when people do try to collaborate?
 - i. **Follow up question may include:**
 1. What is your organization's biggest strength?
 2. What do you most contribute to the collaboration?
 3. Please tell me a "success" story, a story about a child or family that was served well by your system of care?
 5. Next I would like to identify your goals for this project. What do you hope is the end result?
 - a. **Follow up questions may include:**
 - i. Why do you want to be a part of the change process?
 - ii. How do you see yourself participating in the change?
 - iii. What changes should be made in order for the system to change?
 1. What questions do you think need to be answered for changes to take place?
 2. What changes will need to take place within your organization?
 6. If you were in charge, who would you be sure to include? Who else is passionate about children's mental health?
 7. How would you prefer I keep in touch with you as we continue?

APPENDIX B

MEASURE: ORGANIZATIONAL READINESS FOR CHANGE

	1	2	3	4	5
	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree
1. People who work here feel confident that the organization can get people invested in implementing this change.	1	2	3	4	5
2. People who work here are committed to implementing this change.	1	2	3	4	5
3. People who work here feel confident that they can keep track of progress in implementing this change.	1	2	3	4	5
4. People who work here will do whatever it takes to implement this change.	1	2	3	4	5
5. People who work here feel confident that the organization can support people as they adjust to this change.	1	2	3	4	5
6. People who work here want to implement this change.	1	2	3	4	5
7. People who work here feel confident that they can keep the momentum going in implementing this change.	1	2	3	4	5
8. People who work here feel confident that they can handle the challenges that might arise in implementing this change.	1	2	3	4	5
9. People who work here are determined to implement this change.	1	2	3	4	5
10. People who work here feel confident that they can coordinate tasks so that implementation goes smoothly.	1	2	3	4	5
11. People who work here are motivated to implement this change.	1	2	3	4	5
12. People who work here feel confident that they can manage the politics of implementing this change.	1	2	3	4	5

APPENDIX C

MEASURE: INTERAGENCY COLLABORATION ACTIVITIES SCALE

Collaborative Activities

To what extent does your organization SHARE with other child-serving organizations in:

	Not at all	Little	Somewhat	Considerable	Very Much	Don't Know
1. Funding.	1	2	3	4	5	DK
2. Purchasing of services.	1	2	3	4	5	DK
3. Facility space.	1	2	3	4	5	DK
4. Record keeping and management information systems data.	1	2	3	4	5	DK
5. Developing programs or services.	1	2	3	4	5	DK
6. Program evaluation.	1	2	3	4	5	DK
7. Staff training.	1	2	3	4	5	DK
8. Informing the public of available services.	1	2	3	4	5	DK
9. Diagnoses and evaluation/assessment.	1	2	3	4	5	DK
10. Common intake forms.	1	2	3	4	5	DK
11. Child and family service plan development.	1	2	3	4	5	DK
12. Participation in standing interagency committees.	1	2	3	4	5	DK
13. Information about services.	1	2	3	4	5	DK
14. Case conferences or case reviews.	1	2	3	4	5	DK
15. Informal agreements.	1	2	3	4	5	DK
16. Formal written agreements.	1	2	3	4	5	DK
17. Voluntary contractual relationships.	1	2	3	4	5	DK

APPENDIX D
RECRUITMENT EMAIL

Dear County Community Member,

The purpose of this email is to briefly introduce myself, Adria “Casey” McPherson, the work I am doing with Sharon Mills, and to request your participation in this work. As you may or may not know, for my dissertation research (under the supervision of Dr. David Shriberg in the Department of School Psychology at Loyola University of Chicago), I am examining how a rural county can develop, implement, and sustain a collaborative between children’s mental healthcare providers. I am hoping to help create a model of countywide mental health services provision for children that is both multi-tiered and preventative in nature. Moreover, I am hoping to thoroughly examine the system that exists within the county so that providers can continue to provide and improve upon the exceptional services that exist already.

I am requesting your participation in this research because you have valuable insight as to the culture of the community and how services are currently being implemented. In addition, you have valuable insight into how mental healthcare services impact students’ well-being and what can be done to improve their distribution. Specifically, I am requesting your participation in an interview on these topics. I will be interviewing you and may have an assistant with me to take notes. The interview will take place in a private location, and at a time and place of your choice. Please note the place needs to be private for confidentiality purposes.

For more information regarding the study, please see the attached consent form, which you will be asked to sign at the start of the interview should you desire to participate.

If you have questions about this research study, please feel free to contact Casey McPherson at amcpherson1@luc.edu or the faculty sponsor Dr. David Shriberg at dshribe@luc.edu. If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

If you wish to participate, please contact Casey McPherson directly at amcpherson1@luc.edu.

Thank you,
Casey McPherson

APPENDIX E
INFORMED CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH

Project Title: Collaborative community prevention: An ecological approach to mental health support for children in rural America

Researcher: Adria Casey McPherson

Introduction:

You are being asked to participate in a research study being conducted by Adria Casey McPherson, for a dissertation under the supervision of Dr. David Shriberg in the Department of School Psychology at Loyola University of Chicago. You are being asked to participate because you are currently participating in a collaborative that is a part of the researcher's dissertation project.

Please read this form carefully and ask any questions you may have before deciding whether to participate in the study.

Purpose:

The purpose of this study is to interview citizens of DeWitt County in order to learn about their perspectives on how to create an ideal collaborative between professional mental health providers and ways to improve upon services currently available for children. Further, the purpose of this data collection is for dissertation research.

Procedures:

If you participate in this study, you will be asked to complete an interview that is expected to last approximately 30-45 minutes. Interview questions have been designed to investigate perceptions of the collaborative process, future goals for the collaborative, and your motivation for participating in the collaboration. With your permission (you are free to decline), all interviews will be audiotaped. Following the interview you will be asked to fill out two forms speaking to the levels of collaboration and the readiness for change within DeWitt County. Once interviews and forms have been completed, the findings will be shared with the County Mental Health Collaborative and others who have been closely involved with providing mental health services for children. Further, data may be submitted for publication in an academic journal.

Risks/Benefits:

There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life. A direct benefit to you from participation is that the data obtained may help the collaboration to provide enhanced services for children. An indirect benefit from your participation is that the data will add to a gap in the research as to how a mental healthcare collaboration might work and is sustained over time, and how it impacts student well-being.

Confidentiality:

If you give permission to be audiotaped, all audiofiles will be uploaded into a password-protected computer only accessible by the researcher and her volunteer graduate assistant. If you elect not to be audiotaped, the interviewers will make notes that will ultimately be entered into a password-protected computer. The interviewer will not ask your name or any other identifying information. At the conclusion of this study, all audiofiles and any other data files generated associated with this study will be deleted.

Voluntary Participation:

Participation in this study is voluntary. If you do not want to be included in this study you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

Contacts and Questions:

If you have questions about this dissertation research study, please feel free to contact Adria Casey McPherson at amcpherson1@luc.edu or her faculty sponsor Dr. David Shriberg at dshribe@luc.edu. If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

Statement of Consent:

Your signature below indicates that you have read the information provided above, have had an opportunity to ask questions, and wish to participate in this research study. You will be given a copy of this form to keep for your records.

Participant's Signature

Date

Researcher's Signature

Date

*If you have agreed to participate in this study, please **check** the appropriate space regarding your audiotape preferences.*

_____ I **AGREE** to allow my interview to be audiotaped for research purposes.

_____ I **DO NOT AGREE** to allow my interview to be audiotaped for research purposes.

APPENDIX F
SECONDARY CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH

Project Title: Collaborative community prevention: An ecological approach to mental health support for children in rural America

Researcher: Adria Casey McPherson

Introduction:

You are being asked to participate in a research study being conducted by Adria Casey McPherson, for a dissertation under the supervision of Dr. David Shriberg in the Department of School Psychology at Loyola University of Chicago. You are being asked to participate because you previously participated in an interview with this researcher about forming a collaboration for mental health support within DeWitt County.

Please read this form carefully and ask any questions you may have before deciding whether to participate in the study.

Purpose:

The purpose of this study is to confirm the interpretation of the previous interview with you in order to fully understand your perspective on how to create an ideal collaborative between professional mental health providers and ways to improve upon services currently available for children. Further, the purpose of this data collection is for dissertation research.

Procedures:

If you participate in this study, you will be asked to take approximately 10-15 minutes to review the results of your previous interview and confirm or correct the researcher's understanding of the results. This will take place over the phone and will be private so as to protect the confidentiality of the conversation. Questions have been designed to ensure the researcher's understanding of participants' perceptions of the collaborative process, future goals for the collaborative, and your motivation for participating in the collaboration. Once confirmed, the findings will be shared with the County Mental Health Collaborative and others who have been closely involved with providing mental health services for children. Further, data may be submitted for publication in an academic journal.

Risks/Benefits:

There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life. A direct benefit to you from participation is that the data obtained may help the collaboration to provide enhanced services for children. An indirect benefit from your participation is that the data will add to a gap in the research as to how a mental healthcare collaboration might work and is sustained over time, and how it impacts student well-being.

Confidentiality:

Hand notes will be taken during this conversation. No identifying information will be included in these hand notes. Any names used will be replaced with codes. All notes will be destroyed upon the conclusion of the study.

Voluntary Participation:

Participation in this study is voluntary. If you do not want to be included in this study you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

If you currently have a relationship with the researcher or are receiving services from the cooperating research institution, your decision to participate or not will have no affect on your current relationship or the services you are currently receiving.

Contacts and Questions:

If you have questions about this dissertation research study, please feel free to contact Adria Casey McPherson at amcpherson1@luc.edu or her faculty sponsor Dr. David Shriberg at dshribe@luc.edu. If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

Statement of Consent:

Your signature below indicates that you have read the information provided above, have had an opportunity to ask questions, and wish to participate in this research study. You will be given a copy of this form to keep for your records.

Participant's Signature

Date

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VITA

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While a graduate student, Dr. McPherson presented numerous times at several National Association of School Psychologists Annual Conferences; these presentations included posters, papers and symposiums. Further, while at Loyola, Dr. McPherson was chosen to serve as the editorial assistant for the *Journal of Psychological and Educational Consultation*. Dr. McPherson was also awarded a grant from Loyola University Chicago's School of Education for her dissertation work, as well as from the community in which she conducted the research.

Currently, Dr. McPherson is a pre-doctoral intern in school psychology. She is placed within Township High School District 211 at Fremd High School. Upon completion of her internship, she looks forward to joining the faculty at California State University – Monterey Bay as an assistant professor in the fall of 2016.