Institute for Clinical Social Work

Collective Efficacy & Its Influence on School-Based Mental Health Services

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ABSTRACT

It is estimated that between 18 and 22% of children 18 years old and younger experience mental health difficulties. (Maag & Katsiyannis, 2010). Of these children, approximately 5–8% have diagnosable mental disorders or serious emotional disturbances. Unfortunately, only a small proportion of these children receive the mental health services that they need. Schools are often places where children with emotional difficulties can be identified by teachers and referred to mental health professionals in the school system. While more and more school systems are beginning to acknowledge the mental health needs of their students, there are still negative stigmas associated with students who seek mental health services. This study examines how group cohesion and determination impact the sustainability mental health programing in a school system. This phenomenological study also aims to identify the level of involvement of mental health therapists in school-based mental health programs and how the degree of involvement exerts its influence on program effectiveness. Ultimately, the establishment of collective efficacy, as well as how group cohesion and determination affects the overall goal of a sustainable mental health program within a school system, was the goal of this research. Additionally, this research attempts to examine and understand how interpersonal relationships influence collective group cohesion through the lens of relational theory.

For my family

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Chapter I

Introduction

Overview of the Problem

It is estimated that between 18 and 22% of children 18 years old and younger experience mental health difficulties. (Maag & Katsiyannis, 2010). Of these children, approximately 5–8%percent have diagnosable mental disorders or serious emotional disturbances. Unfortunately, only a small proportion of these children receive the mental health services that they need. Schools are often places where children with emotional difficulties can be identified by teachers and referred to mental health professionals in the school system. While more and more school systems are beginning to acknowledge the mental health needs of their students, there are still negative stigmas associated with students who seek mental health services.

Weist and Murray (2007) cited the following from the World Health Organization research: "A prevailing problem is stigma, often about all things related to mental health, which may result in avoidance or minimization of student mental health issues" (p. 6). Thus, stigma is an important deterrent for seeking mental health services. Parents are less likely to feel stigmatized when they are contacted by school personnel and informed in a sensitive, empathic fashion about their child's emotional or academic problem. While some parents may decline services for fear that their child will become "labeled" in the academic setting**,** it is more likely that they will listen to their child's teacher than they

will pursue other resources. Creating a caring school environment for both students and their parents is not just limited to a positive parent/teacher or student/teacher relationship. School settings have the ability to include counselors, social workers, nurses, and school psychologists in a multidisciplinary approach to both identify and address mental health issues. Parents are more likely to be receptive of concerns that school personnel have about a child's need for mental health services than they would be from other sources. Hence, the school setting provides a natural arena for services to be offered and delivered to students in a non-threatening manner.

The No Child Left Behind Act (NCLB) of 2001 was an educational inititive created by federal policy that has significantly overhauled public school education in the United States. The Act was developed to ensure educational success for all children by requiring school systems to meet standards of established learning outcomes. Within NCLB, there are opportunities for the establishment of mental health services. Daly and Burke (2006) wrote,

> The complexities of the provisions of the No Child Left Behind Act have made it difficult for educators, stakeholders, and mental health professionals to understand the legal and practical interface between No Child Left Behind and the school mental health movement (p. 446).

Essentially, it was acknowledged that mental health services are needed, but there have never been clear requirements or guidelines for establishing them. NCLB should provide school systems with clarity of what mental health is, what services are included, and how these services can support the school's mission and each child's capacity to maximally

develop. This guidance can greatly reduce the negativity surrounding the implementation of mental health services within public schools.

It could be argued that schools are places for education, and not for mental health services, which could be otherwise found in the community at large. While this is a strong argument, consideration is not given to children who cannot access outside services for reasons such as lack of insurance, funds for co-pays and sliding scale fees, transportation, and adequate mental health providers within varied communities. Often, educational settings serve as gatekeepers in identifying children who can benefit from mental health services. The cooperation between schools, families, and communities can help circumvent the problem of access to services by providing these services in a school setting. Schallert (2005) discussed the importance of schools and their surrounding communities being able to collaborate with the support systems for children that are already in existance. He wrote that when creating community partnerships, "clear boundaries, protocols, and roles need to be established early and often" (Shallert, 2005, p. 49).

Regarding school mental health services, the use of a multidisciplinary approach is critical. Various diciplines—school social workers, school counselors, psychologists, and nurses—assess students for mental health concerns. Individuals in each of these professions offer their own expertise in the area of mental health. Ideally, a mulitidiciplinary approach to student assesments and treatment must be used to successfully identify students who are in need of mental health care. This approach will increase the likelihood of forward movement and expansion in providing mental health services and programs within a school setting. Collaboration is significant for clinically

licensed school social workers who provide mental health services to students, as they are on the forefront of advocating for students in a school setting. Not only do school social workers understand school culture, but they also know community agencies that provide specific mental health services. They are instrumental in creating positive school-community agency collaborations.

In reality, mulitdisciplinary cooperation is not always feasable, resulting in the fragmentation of services by school professionals. Weist et al. (2006) called for the need for "staff from multiple disciplines to partner in planning and coordinating activities in ways that are consonant with the goals of the school and its many stakeholders" (p. 49). Just as mental health challenges are not exclusive to race, gender, or age, providing appropriate care and services should not be exclusively confined to one specific discipline. Massey and Armstrong (2005) described the reasons that a school venue is critical for both providing behavioral and mental health services. However, they also stated that the "difficulties associated with operating programs in schools often prevent evidence-based practices from being implemented and sustained as intended" (p. 361). They further wrote that these difficulties can include lack of adminstrative support, budget constraints, and not having adequate staff to provide the services needed.

The literature and research have established why mental health services are needed within the public school systems, as well as the complexities that surround the development of comprehensive programs and services. Additionally, scholarship has demonstrated that nationally, school-based mental health programs have been established and continue to be successful with the students they serve. What has not been well defined is how individual schools, including the multidisciplinary teams within them, can

work together to make the recognition of and access to mental health services a priority for students.

Understanding the collective efficacy within a multidisciplinary team is key to understanding the challenges and successes of implementing and sustaining school-based mental health services. Bandura (1997) defined *collective efficacy* as the shared belief of group members in their ability to successfully execute a specific task. Collective efficacy is also tied to the performance, effectiveness, and motivation of a group (Bandura, 1997; Gully, Incalcaterra, Joshi, & Beaubien, 2002). A group that possesses a strong sense of collective efficacy is more likely to set challenging goals and persevere through difficulties to enhance their likelihood of succeeding in meeting their goals (Bandura, 2000).

Goddard (2001) connected collective efficacy with the school environment, writing that the performance capability of a social system as a whole is applicable in a school setting. In a school, collective efficacy is concerned with the entire faculty's perceptions of their ability to positively affect students. Goddard (2001) noted that social cognitive theory assumes that "humans are active shapers of their lives" and that "individuals possess capabilities for self-reflection, vicarious learning, symbolization and self-regulation" (p. 468). Extending these capabilities to groups, he stressed that at a group level, mastery experience, vicarious experience, social persuasion, and affective state functioning are similar to those elements on an individual level. Ultimately, the way in which an individual educator's self-efficacy is enhanced is by observing successful education models. This is also the cause for the achievement of collective efficacy by a group. Bandura (2000) suggested that there is a dichotomy in the measurement of

collective efficacy. In other words, while a group may judge its potential based on a consensus of its collective capability, at the same time, it also makes judgments about the capabilities of individuals to perform their roles.

The psychoanalytic approach of relational theory also lends its model toward a better understanding of group dynamics and interpersonal relationships as viewed from a collective efficacy perspective. Mitchell and Aron (1999) explained that relational approaches are best utilized when there is integration between intrapsychic and interpersonal worlds. Within the framework of relational theory, it is acknowledged that an individual's intrapsychic world is a private inner life that focuses on internal desires, fantasies, and unconscious motivations. The interpersonal world focuses on connections with others, the give and take within relationships, and complex participation in a social realm. While postmodern relational approaches tend to lean more toward a social level of construct and explanation, it is also acknowledged that the formation of the self and personhood would be incomplete without intrapsychic reality (Mitchell & Aron, 1999).

While relational theory is most commonly used in direct clinical practice, the idea that the "self" is a fluid entity that shifts within the context of relationships is critical to understanding group functioning. An individual group member's perspectives and realities influence the larger social and political context that is integral within group dynamics. The relational model emphasizes that the process of change comes through and is influenced by mutuality and respect, attention given to authority and power, and acknowledgement of diversity, all of which are also contributors to group dynamics. Within the therapeutic dyad, relational theory allows for both therapist and patient to explore the unknown and wonder how intrapsychic and interpersonal worlds prohibit or

create changes. The same concepts can be applied in this study, which emphasizes the relational matrix on a broader scale. The personal experience that individuals bring into a group influences the interpersonal interactions and the ability to explore solutions that can generate change.

The current study examines how group cohesion and determination impact the sustainability of a quality mental health program in a school system. This phenomenological study also aims to identify the level of involvement of mental health therapists in school-based mental health programs and how the degree of involvement exerts its influence on program effectiveness. An urban school district in the state of Georgia was awarded a grant to meet the mental health needs of students within 36 school clusters identified in their district. The grant was used, in part, to implement school-based mental health services and establish infrastructure to sustain the implementation at the completion of the grant funding. A stratified sample of nine schools from the larger group of 36 was used in this study. These nine schools were further classified into three elementary schools, three middle schools, and three high schools. Teams of educators in each of these schools, known as learning support resource teams (LSRTs), were tasked with establishing a process for, and making referrals to, school-based mental health services. Led by a licensed mental health therapist, the LSRTs were to meet on a monthly basis to discuss students in need of mental health services as well as to ensure that mental health referrals were generated.

This mixed methods study evaluated the collective efficacy scores of the LSRTs from individual schools charged with implementing school-based mental health services. The study compares collective efficacy scores from schools with different grade levels

(i.e., elementary, middle, and high schools) as well as any variance in scores within the same school levels. Additionally, the number of mental health referrals generated from the selected schools was evaluated to determine if levels of collective efficacy might have influenced the referral numbers. The intent was to determine if higher collective efficacy levels generated a higher number of referrals.

The mental health therapists from each of the identified schools were interviewed to gain a richer understanding of their experiences as the leaders of the implementation process. The qualitative analysis used in this study was to assess the implementation of these services and whether collective efficacy levels had a role in the implementation process. Responses by the mental health therapists were used to further determine if high levels of collective efficacy can differentiate positive perceptions of the creation of mental health services as opposed to a poorly received implementation process. Ultimately, the establishment of collective efficacy, as well as how group cohesion and determination affects the overall goal of a sustainable mental health program within a school system, was the goal of this research. Additionally, this research attempts to examine and understand how interpersonal relationships influence collective group cohesion through the lens of relational theory.

Chapter II

Literature Review

Studies and research regarding children with mental health issues are not new concepts. However, since the tragedy of the Columbine High School shootings in 1999, the need to assess and address the mental health of children has not only fueled the practices of mental health clinicians but has also gained the attention of society at large. For many, schools were no longer considered safe havens of education for children, and scrutiny was placed on the behaviors of children within school settings. In the late 1990s, the Surgeon General provided a comprehensive report about mental health and children, and the importance of providing children with mental health treatment was publically addressed. Within this report, the need for preventative programs for children, as well as their successes, was highlighted.

There is a dearth of literature regarding the best practices of mental health diagnoses and treatment for children that encompasses a myriad of specific programs that can be implemented within a school setting. Literature and research has also shown that when these programs have been implemented within a school setting, they have been met with great success. Further, research has shown that educators who invest the time and energy toward mental health prevention and intervention, as well as understand the specific mental health and mental wellbeing needs of their students, are more inclined to ensure further buy-in for these programs with their colleagues. There is a void in the

literature, however, about how teams of educators specifically work together to ensure successful program implementation. This study is aimed to discover how the perceptions and collective beliefs of educators might influence the provision of mental health services for children within a school setting.

Mental Health Status of Children and Adolescents

Childhood is characterized by periods of transition. Emotional ups and downs are considered a normal response to the changes that children face; however, some experiences are more severe than expected in the course of development, and children who do not cope well with these experiences may be diagnosed as having a mental health disorder (Aviles et al., 2006). The Surgeon General (1999) reported that although mental health problems emerge in families from all social classes and all backgrounds, there are certain factors that lead to greater risks for some children. These include intellectual disabilities, low birth weight, physical problems, a history of mental disorders and/or substance abuse in the family, multigenerational poverty, separation from caregiver, and abuse and/or neglect. Preventive efforts, such as educational and mental health programs for children, have been shown to be useful in lowering the effects that these risk factors have on mental disorders. In addition, early identification and intervention are vital in meeting the needs of these children (Bagdi & Vacca, 2005). School settings are ideally situated for the early detection of disorders because personnel in these settings see children on a regular basis and are able to observe them in a variety of interactions. Primary health care settings also have the potential for recognition of maladjustments because disorders are often manifested in physical symptoms (Brener et al., 2007). The

importance of early detection makes it paramount that school and primary health care providers are educated and trained to recognize early symptoms and have the skills and knowledge to make referrals for specialized care, including psychosocial and pharmacologic treatments (Koller & Bertel, 2006).

The U.S. Surgeon General's report (1999) estimated that nearly 21% of children have a diagnosable mental health disorder with some minimum impairment. About 11% of children/adolescents have a diagnosable mental disorder with significant impairments, which translates to approximately 4 million youth. About 5% of youth suffer from a mental disorder with extreme functional impairment (Shaffer et al., 1996). For youth who are at risk, accessibility can mean the difference between getting help in a timely manner and not getting help at all. Maag and Katsiyannis (2010) reported that only 7–16% of youth who need mental health services actually receive treatment. Youth are less likely to seek services in unfamiliar settings. School-based mental health centers represent an effective means of providing services to children. The availability of these services at an early age also increases the possibility that youth will become users of these services in the future (Burnett-Zeigler & Lyons, 2010). Use of the services increases familiarity and decreases stigma associated with traditional mental health treatment (Jepson et al., 1998).

Models of School-Based Services

Programs that provide services to schools use three models: community-based, school-based, and school-linked (Dryfoos, 1994). These models vary according to comprehensiveness of services, funding sources, governance structures, and the need to integrate with existing services (Carlson et al., 1996).

The community-based services are administered by local clinics that provide information to school personnel and families about services that the clinic can provide. There are no contracts between the schools and clinics, and there are no formal services provided on school premises. Any collaboration between the school and mental health personnel is informal and on an individual case-by-case basis. Referrals made by the school depend on the family's ability and willingness to take the child to the clinic for evaluation and treatment (Dryfoos, 1994, 1995).

The school-linked model is characterized by a contract between a school and a local clinic. The clinic may be responsible for more than one school. Services are provided off school grounds with an administrative structure linking the school to the clinics. The linked centers and schools have an established method of referral, communication, and follow-up to ensure continuity of care. The linked model implies that the mental health service is not administered by the school and, therefore, does not participate in the development of educational systems (Adelman & Taylor, 1999; Carlson et al., 1996). The advantages of the two models described here are that traditional boundaries of therapy and the therapeutic relationship are maintained. Without being on school premises, however, the clinician's ability to observe a child's school functioning and their ability to intervene in and shape the school environment is limited (Adelman & Taylor, 1993).

The school-based model is one where services are delivered directly in the school setting. The clinic works cooperatively with the school and is an integral part of the school. The purpose of the school-based model is to provide maximum access to mental health services in the environment where children spend a great deal of their time

(Burnett-Zeigler & Lyons, 2010). Services can include, but are not limited to, mental health evaluation; psychological and psychiatric consultation; individual, group, and family therapy; and referral to more intensive services. Preventive services such as classroom presentations on mental health and psycho-education are typically found in this model (Flaherty et al., 1996). Some advantages of having services offered on site are increased accessibility to the student, improved quality of care resulting from collaborations between mental health personnel at the school and school personnel, and decreased stigmatization because of the familiarity of schools by parents and members of the community when compared to a community mental health clinic (Heathfield & Clark, 2004). Because the providers are on-site in the school-based model, they can influence the school and classroom environments to better address treatment goals (Gaylord et al., 2005). Structurally, school-based models can be school-supported services or other-supported services. School-supported services are comprehensive health centers that are governed and financed by the school. Given the financial constraints of public schools, these models are rare. More common are the other-supported school-based models, which are services that are provided on-site but are financed by an outside source. These agencies develop partnerships with the schools and jointly govern the program (Carlson et al., 1996).

Adelman and Taylor (1993) suggested that a mental health clinician in a school setting can provide the following: direct intervention, which includes assessment and treatment; consultation with teachers regarding classroom performance; mental health education in the form of presentations to students, parents, and/or teachers regarding common mental health problems that youth face, such as depression and suicidality;

outreach to other local social service agencies; compilation of resources for referral purposes to target particular problem areas; and networking and facilitating coordination of services provided by mental health workers both inside and outside of the school. This level of integration can be best achieved with a regular, on-site presence at the school. The on-site person can also address the issue of family involvement or, more typically, lack of involvement, which often signifies the families' inability to carry out basic support functions, by their availability to parents at the school site. On-site clinicians can also work with schools and families to increase their involvement in the programs (Haynes, 2002).

Atkins et al. (2003) proposed new approaches in promoting adolescent health in schools. By focusing on the unique needs and characteristics of teachers, children, and families, these approaches are able to enhance the effects of treatment. The Teacher Key Opinion Leader (KOL) project, found in Chicago schools, is an example of fully utilizing school resources. The KOL project is based on the idea that new ideas spread throughout social networks. This project used highly respected teachers as KOLs to disseminate trends and information unique to their students to the rest of the school. Professional providers may have the knowledge to help a client but may be less efficient at directing that information directly to whom it may pertain. The study found that there was significantly more use of the suggested strategies from the KOLs as opposed to the ones recommended by the community health providers (Atkins et al., 2003).

There is often public criticism about the lack of family involvement found in schools. This is addressed by a review of the collaboration between Chicago Public Schools and the Illinois Office of Mental Health (Atkins et al., 2003). On-site services

used Positive Attitudes Toward Learning in Schools (PALS), a program designed to increase family involvement. The program developers used parents from the community as consultants to offer a culturally appropriate and sensitive perspective in designing and delivering the services. The developers used the community consultants to facilitate the development of a relationship between families and service providers and to work with families to identify goals that were consistent with their priorities. Over 90% of families assigned to the PALS experimental group classrooms enrolled in clinic-based services, and after 3 months, all remained in the program. After 9 months, 86% remained involved in services. In the control group classrooms, 68% agreed to enroll, and after 3 months, none remained involved in services, suggesting that increased family involvement increases service utilization (Atkins et al., 2003).

A third new approach presented by Atkins et al. (2003) is the System of Care-Chicago (SOC-C). This system used a multitiered model to reduce disruptive behaviors in schools. The first tier is universal intervention available to all students. Teachers, administrators, and a member of the social service agency collaborate on a team to provide positive alternatives to disruptive behaviors, such as after-school programs. The second tier targets students at an elevated risk and require support beyond the school-based universal activities. The third tier is an intensive, wrap-around approach to support students who have not sufficiently benefited from the second-tier interventions. In this model, it is the collaboration of various agencies that allows the schools to organize services and allocate resources where they are most needed.

Current Status of School-Based Services

In 2003, Slade found that school-based health service availability might vary according to school size and geographical location. Urban and larger schools are more likely to attract public funding for mental health services because of the perceived need for care in these schools with greater numbers of economically disadvantaged students. Using a stratified sampling technique, he surveyed 132 schools selected from the Add Health (national survey of schools grades 7–12 in the United States). Overall, Slade (2003) found that approximately half the schools he surveyed did not offer any on-site mental health services, and only about 10% offered all three services. Larger schools, suburban and urban schools, schools in the Northeast, and schools with a greater number of students enrolled in Medicaid were more likely to have accessibility for students to receive mental health services. In comparison, there are a smaller percentage of rural schools offering on-site mental health services to students. The rural schools, however, were as likely as urban and suburban schools to offer the other health services, physical exams, and substance abuse counseling. Potential explanations for this disparity include a gap between urban and rural school systems in the financing of services, lack of accessibility to mental health providers, and fewer children enrolled in special education programs that are linked to funding. Poverty and racial/ethnic background were not linked to mental health counseling availability and utilization.

Weist et al. (2000) added that academicians, university officials, and public health administrators, without consultation or input from community members, often develop school-based programs. Problems and needs vary according to school level and geographic locale. Needs of an inner city school differ from those of a school populated

by youth belonging to a higher socioeconomic class and of those living in suburban or rural areas. They found that behavioral problems and substance abuse were rated as progressively more serious as a child transitions from elementary to high school. Internalizing psychiatric problems, like depression and anxiety, were most serious in high schools. Urban youth were found to encounter more life stressors, including exposure to violence and crime, alcohol and drug abuse, and conflict in families, and they presented with more serious internalizing problems compared to suburban or rural youth. Rural youth reported stressors that included parental unemployment and domestic violence. Barriers to accessing services also need to be considered depending on the population being served. The limitation surrounding the ability to pay for services was rated as a serious barrier for urban and rural youth more so than for suburban youth. Poor knowledge of mental health services was another barrier to accessing services in urban and rural schools. Developing successful efficacious programs is necessary to address the varying needs of targeted students and their community.

School-based services can potentially prevent a child's maladaptive functioning from becoming chronic in nature. Owing to the fact that all children must be educated, the school is not only highly accessible but also a logical setting for undertaking early intervention and prevention (Heathfield & Clark, 2004). With early identification through prevention and remedial services, it is imperative that staff does not prematurely label children, as this may create stigma for using services (Bierman, 2003). Collaboration with school personnel can be more easily accomplished when a mental health clinician is on site at the school. The results have been mixed in the separate systems of schools and mental health agencies' abilities to integrate and collaborate (Heathfield & Clark, 2004).

Carlson et al. (1996) stated, "Existing and emerging services for children in schools, however, have been built on a foundation characterized by professional turf battles" (p. 22). They concluded that if the welfare of children were truly a priority in this society, overcoming barriers for establishing these services would be paramount, and collaboration between school systems and their communities would have been developed.

Evidence to Support Services in Schools

Schools, which are the central structure in children's lives, are ideal places for comprehensive community-based system**s** of care. Schools provide access to services with fewer stigmas, a naturalistic setting to observe students, and an environment in which services can be seamlessly integrated (Pumariega & Vance, 1999; Weist, 2005).

Dryfoos (1994) stated that in the 1990s, over 1,000 school-based health clinics were described as comprehensive centers. What started out as programs to address problems such as teen pregnancy and access to health care have steadily grown and evolved because of the psychogenic origins of many somatic complaints with which students presented. With the increase of students attending school having non-medical problems, school-based centers have had to broaden their scope to include comprehensive programs that prevent, identify, evaluate, and treat social, emotional, and behavioral problems. The growth of these school programs has increased access to services, improved case coordination, and decreased redundancy of services (Adelman & Taylor, 1999). For example, Dryfoos (1994) cited a school-based mental health program funded by the New Jersey School-Based Youth Services Program operated in a New Brunswick high school. Psychologists and social workers provide individual, group, and family

therapy to the youth. The clinic is located in the school and offers recreational activities, mentoring, and social support. Twenty-five percent of the student population has enrolled in the mental health program (Dryfoos, 1994).

Adolescents benefit greatly from having access to mental health services in their schools. As a whole, adolescents are less likely to seek comprehensive services in unfamiliar settings that require extensive planning to access. With services available in schools, parents would no longer need to take time off from work to take their children to appointments. Additionally, parents would no longer have to choose between their children's health and the family's financial status. This is especially important when adolescents have weekly appointments, such as with mental health services or substance use groups (Jepson et al., 1998).

In their 1993 study of Latino 12th graders from a lower socioeconomic area, Adelman and colleagues found that an on-campus clinic can attract a significant number of students. Frequent users of the clinic reported more overall distress, somatization, and depression when compared to moderate users, those who used the clinic once, and non-users. Students who availed themselves to on-site services displayed more frequent temper outbursts, higher rates of drinking alcohol, and increased sexual concerns from the effects of having multiple sex partners, than those who did not seek treatment. It is important to note that ease of access was the most frequently endorsed reason for use. Other factors that influenced the students' decision to use the clinic were that they perceived that the services were helpful, staff members were trustworthy, and confidentiality was maintained. Some of those who chose not to use the clinic believed themselves to be healthy and not require the services provided. It is important to note,

however, that there were still over one-fourth of the nonusers who indicated that they did not seek help because they did not want anyone at school to know about their problems.

Juszczak et al. (2003) found that adolescents are 21 times more likely to visit school-based health centers for mental health reasons than a community health center network. Schools are in a unique situation where mental health services can provide and immediately assess the effectiveness of the interventions. Successful interventions can be gauged not only with a symptoms checklist but with measures of daily functioning, such as improvement on academic performance, improved classroom behavior, and improved conflict resolution with peers (Hoagwood et al., 1996).

In addressing the effectiveness of school-based services, Evans (1999) stated that "many clinicians who work in clinics do not know what the insides of clients' homes or schools look like" (p. 171). Clinic providers have to base much of their evaluation on reports from the child and parent regarding the setting where children spend most of their day, and possibly on the occasional conversation with school staff, obtaining only a glimpse of how the child functions throughout the day. Assessment and evaluations conducted by a school-based clinician can be more thorough (Evans, 1999). Collaboration with school personnel provides valuable information regarding the child's behavior since the school staff members most likely know the child and family. The contact that clinicians have with school personnel is increased because of proximity and convenience of being in the school building. Evans (1999) stated that less time is wasted exchanging phone messages with school personnel and more frequent and effective communications take place. Ponec, Poggi, and Kickel (1998) discussed the value that enhanced communication between the school staff and school-based clinic staff would

have on treatment plans and outcomes.

School-based clinicians have more opportunities to education parents about services that can be provided. More importantly, "clinicians, if trusted by the school, are more likely to be trusted by the parents" (Armbruster et al., 1997, p. 206). They can access school records that contain assessment reports, disciplinary actions, and teachers' reports. In addition, observing children in a naturalistic setting provides firsthand information to the clinician that can be incorporated into the treatment plan. The clinician can observe how the child interacts with authority figures and peers, in and outside of the classroom, to obtain a more complete picture of the child. As such, treatment plans can be more accurately formulated and executed. The school potentially offers a neutral setting that is familiar, accessible, and acceptable to the child and parent and thus leads to more opportunities for comprehensive interventions that include families.

One powerful advantage that school-based services have over services in the community is the ability to provide services across the span of educational levels being proactive, not just reactive, to student needs. Whereas community-based agencies receive referrals and work with students who are already experiencing emotional difficulties, schools can focus on overall mental "wellness" to circumvent future mental health needs. School-based providers can employ preventive intervention strategies that target the entire school population, promote mental health, and focus on positive social and emotional development (Elias & Weissberg, 2000).

Research on School-Based Programs

In their study of service utilization of school-based programs, Adelman et al.

(1993) adapted a version of the Hopkins Symptoms Checklist (HSCL; Derogatis, Lipman, Rickels, Uhelenhuth, & Covi, 1974 as cited in Adelman et al., 1993) to assess levels of distress among those seeking services. They found that only one-third of those with a high level of psychological distress sought services at school, reflecting negative attitudes toward mental health professionals and a preference for dealing with personal matters by speaking with friends and family. Nearly a third of the respondents said they did not utilize services because they did not want anyone in the school to know about their problems. Stefl and Prosperi (1985) have noted that those most in need are often those who perceive and experience most service barriers. Better understanding of the underlying factors for not utilizing services can lead to appropriate interventions that can address those barriers. Armbruster et al. (1997) cited an example of how one program addressed the issue of stigma. In their attempt to engage parents in the treatment interventions, school personnel and clinicians used nonstigmatizing names for the group, such as "parent power."

In 1996, Weist et al. conducted a study to evaluate the treatment outcomes of school-based therapy for inner-city youth in a high school in Baltimore. The sample consisted of 39 students who were enrolled in mental health services and 34 students of a comparison group who did not receive mental health services. The mean age of the treatment group was 15.7 for the 10 male participants and 16.1 for the 29 females. In terms of treatment effects, no significant differences were found for measures of anger and anxiety. Significant treatment effects were found for self-concept and depression. Students in the treatment group showed significant declines in depression and improvements in self-concept from pre- to postintervention. Additionally, students in the

comparison group actually had an increased level in depression at posttest. Although the measures were validated and showed internal consistencies, findings from this study should be viewed as preliminary support for the benefit of school-based mental health services. It was noted that further research is needed to support these findings.

Collective Efficacy

According to Bandura (1997), perceived collective efficacy is concerned with the performance capability of a social system as a whole. Belief of collective efficacy affects the sense of mission and purpose of a system, strength of common commitment to what it seeks to achieve, how well its members work together to produce results, and the group's resiliency in the face of difficulties. (p. 468)

To better understand Bandura's notion of collective efficacy, it is important to know how it derives from his social cognitive theory. This theory is based on the influences of one another toward change, development, and adaptation, as well as that this influence is intentional (Bandura, 2005). He further wrote, "in this view, people are self organizing, proactive, self-regulating, and self reflecting. They are contributors to their life circumstances not just products of them" (Bandura, 2005, p. 1).

Crothers, Hughes, and Morine (2008) wrote that this theory explains how behavioral, personal, and environmental factors all interact with one another, known as Bandura's Triadic Reciprocal Determinism. These interactions are determinates of self-motivation and behavior. Bandura (1986) wrote that psychosocial functioning is explained by reciprocal relationships, and Wood and Bandura (1989) clarified that this reciprocity does not necessarily mean that the relationships are equal. In an

organizational context, the overarching needs of an organization, viewed as its own environmental entity, affect employees and how individuals in turn carry out their function in the organization.

Bandura (2000) debated on the engagement of human agency through collective efficacy. He wrote that human beings are both products and producers of their environments (Bandura, 2000). However, he noted, much of the theorizing on human agency has focused on the personal form, ignoring the proxy and collective forms. He stated that the proxy form is used by individuals when they realize that they "do not have direct control over social conditions and institutional practices that affect their lives," and, therefore, get experts or influential, powerful people to "act on their behalf to get the outcomes they desire" (Bandura, 2000, p. 75). Bandura also wrote that the third form—namely, collective agency—is the basis of perceived collective efficacy. Bandura (2000) suggested that there is a dichotomy in measurement of collective efficacy. In other words, while a group may judge its potential based on a consensus of its collective capability, at the same time, it also makes judgments about the capabilities of individuals to perform their roles. Bandura (2000) noted that the interdependence of these two factors leads to the relative predictiveness of collective efficiency and ultimately decides the achievement of desired goals of the group.

Studies indicate that "a high sense of efficacy promotes a prosocial orientation characterized by cooperativeness, helpfulness and sharing" (Bandura, 2000, p. 77). However, Bandura says it could go either way. In other words, a group that is characterized by a high level of self-doubt among its constituents may not achieve as much as it could have if the self-belief in the group members had been higher. In general,

there is a positive correlation between a group's perceived collective efficacy when there is a motivational investment in shared goals and a stronger resilience in the face of challenging situations. These factors tend to produce far superior performance accomplishments of a group.

Goddard (2001) connected collective efficacy with the school environment, writing that the performance capability of a social system as a whole is applicable in a school setting. In a school, collective efficacy is concerned with the entire faculty's perceptions of their ability to positively affect students. Using Bandura's Social Cognitive Theory at the group level, Goddard addressed three core questions in his study of a school environment. First, does professional mastery experience determine the extent to which past school achievement is related? Second, is there a relationship between collective efficacy and student achievement? Third, what does the term *collective* mean, in terms of the degree of group consensus and its average perception of collective capability?

Goddard (2001) noted that social cognitive theory assumes that "humans are active shapers of their lives" and that "individuals posses capabilities for self reflection, vicarious learning, symbolization and self-regulation" (p. 468). He then extends these capabilities to groups. He stressed that at a group level, mastery experience, vicarious experience, social persuasion, and affective state functioning is similar to that of an individual level. Ultimately, the way in which an individual educator's self-efficacy might be enhanced by observing successful educational models, so also can a groups' collective efficacy.

Social cognitive theory asserts that both individuals and collectives choose to execute courses of action based on belief of capability. Mastery experience, embedded in this theory, has a strong relation to collective efficacy. In other words, small incremental and short-term goals that give a sense of mastery translate into collective efficacy for the group. Such groups benefit from having either a strong formal or informal leader. Goddard (2001) linked the notion of collective efficacy beliefs to the normative environments of schools. He concluded that the higher the collective efficacy, the stronger the "normative press" for the teachers to continue to persist in their efforts to attain high achievement among students.

In his study, Goddard (2001) pointed to an important finding: collective efficacy in terms of *group* consensus is different from the average *individual* perception held by educators of their school faculty's collective capability. The findings of this study indicated that group consensus was not a determining factor for predicting student achievement. Instead, it was the individual perception of group efficacy that pointed to the belief in student achievement. In essence, individual perceptions drive group perceptions. The author stresses that teachers' belief in the collective capability of their school is determined, to a large extent, by the choices they make as individuals.

Collective Efficacy and Organizational Change

The construct of organizational change dovetails with collective efficacy, which underscores that the shared belief of a group's capability is needed for the attainment of change. Bandura (2001) maintained that a strong perception of collective efficacy leads to a group having high effort, motivation, morale, and resilience; they persevere in the

face of resistance and perform at high levels. Bandura (2001) stated, "organizations have to be fast learners and continuously innovative to survive and prosper under rapidly changing technologies and global marketplaces. They face the paradox of preparing for change at the height of success. Slow changers become big losers" (p. 11). Although it is understood that schools and school districts are not a marketplace, Bandura's (2001) statement exemplifies collective efficacy in relation to change. Staffs that are efficaciously inclined are more willing to change and challenge themselves and others in order to achieve, even when they have already experienced success (Bandura, 1993, 2001; Goddard et al., 2000).

Change within an organization, whether it is in the public or private sector, usually comes from outside pressures, such as stakeholders and those who create policy (Ashworth, Boyne, & Delbridge, 2007). Burnes and Jackson (2011) wrote that while most organizations undergo some form of transformation to maintain successful outcomes, over 70% of change initiatives fail. The literature shows that there are numerous approaches to implement organizational change. For example, Covill and Hope (2012) encouraged collective responsibility and goal sharing while adopting and implementing change in an existing work environment. Kotter (1996) outlined an eight-stage process for organizations to positively implement change that include developing a vision for change and communicating this vision to others. Galambos, Dulmus, and Wodarski (2005) discussed five guiding principles for successful organizational change, which include continuing discussion and feedback, preparing the organization for change, and encouraging employees to achieve established goals. None of these approaches can guarantee positive outcomes. However, a key component for success in each of these

approaches is communication between managers and employees. Without this interaction, employee commitment and buy-in to change will not occur.

When change directly affects employees and is not simply ambiguous new policy creation, the results can either have successful outcomes or create turmoil. With change, both the individual worker and the larger working group must evaluate if the proposed change(s) will improve the existing method of service delivery. Policy and organizational changes may make sense and seem reasonable on paper, but humans are not always pragmatic creatures. Neves and Caetano (2009) adhered to the credence that employees are more willing to accept change with enthusiasm as well as commitment if the changes are similar to their own values as employees. They wrote, "Employees' commitment to change can therefore be looked at as a function of the change's fit to the employees' values" (2009, p. 626).

Organizations face an ongoing need for change in order to remain effective in an ever-changing world. Robertson and Seneviratne (1995) maintained that public or government organizations can greatly benefit from strategizing the implementation process. A thoughtful change process that includes input from all employees increases the chances of successful implementation. Therefore, the cooperation of employees is essential for change initiatives (Lewis, 2006). There are three dimensions in which employees effectively respond to change: emotional, cognitive, and intentional (Piderit, 2000). These triadic dimensions influence one another, and negative reactions to these dimensions can impede upon and threaten an effective change process. For example, emotional resistance can invoke feelings of anger or fear, which can cognitively increase

beliefs that change will abolish the positive aspects of an organization, which in turn can create an intentional desire to oppose any changes presented (Piderit, 2000).

Conclusions of Literature

There are many challenges to providing mental health services in a school-based setting, but the potential benefits of these programs is (even) greater. Evaluation of these programs is important to document the coordination of care they bring to serving children and to demonstrate that these programs are truly helping students. Evidence to show that these programs are effective is necessary to their survival and ability to maintain funding (Weist et al., 2000). Despite the importance of program evaluation of school-based clinics, there is a lack of research that evaluates the effectiveness of school-based interventions. There is a gap in the research that links the readiness and implementation of school-based mental health programs with their outcomes. While the need for these services and the push to have them in place are identified, it is important to consider how individual schools will affect the success—and possible failure—of school-based mental health services. This study will attempt to link the collective efficacy of individual schools and their perception of providing school-based mental health services with carrying out the services and ultimately ensuring their sustainability.

Theoretical Framework

This research uses a relational theory perspective to better understand the target population. The premise of relational theory is one of empathy and introspection, which also includes the process of understanding how a person creates his or her realities. While

it can be difficult to maintain objectivity and neutrality when considering multiple points of view, relational theory takes into consideration the need to understand and relate to the experiences of others. Using this theory will allow for the evaluation of behaviors and responses found during the course of this research. A person must talk about his or her thoughts and desires and embark on a process of thorough self-examination. A desired outcome during this research endeavor is to understand how personal behavior can affect and change group dynamics.

Relational theory, the brainchild of Jay Greenberg and Stephen Mitchell, originated in 1983 and secured a firm foothold in the psychoanalytic community in 1988 (Perlman & Frankel, 2009). While the fundamentals of psychoanalysis are based on Freud's drive theory, relational theory evolved through understanding and accepting that interaction with others, not just the internal psyche, influences a person's behavior and personality. Frank (1998) quoted Greenberg and Mitchell's relational perspective as having human interaction that is "the fundamental building blocks *of* life" (pp. 141–153). Perlman and Frankel (2009) best described relational theory by arguing that the "cornerstone of all relational theory is the premise that human beings are born with a primary need for relatedness and communication with other human beings" (p. 108). There are other contributors to the relational perspective whose views do not always agree with Mitchell's own. As he pointed out, the term *relational* "grew and began to accrue to itself many other influences and developments: later advances of self psychology, particularly intersubjectivity theory; social constructivism in its various forms; certain currents within contemporary psychoanalytic hermeneutics; more recent developments in gender theorizing" (Mitchell & Aron, 1999, p. xi). Despite differences in

perspectives, it is generally agreed upon that relational theory is not a random perspective that a few people adhere to; it is grounded with underpinnings of constructivism as well as the concept of contextualism.

A course taught by the International Relations Department at Eastern Mediterranean University in Cyprus discussed the basics of constructivism as written by professor and author Jennifer Sterling-Folker. According to presentation notes from this course, constructivism is the "study of identity formation and how social interaction produces social identities" (Eastern Mediterranean University, n.d., slide 4). To study and understand constructivism from a psychoanalytic viewpoint is to believe in the basic premise that our experiences and personal realities determine who we are. These experiences and realities are a result of how we socially construct our lives. It is understood that there is a need, or a drive, to generate contact with other beings. Social engagement allows us to discover how we affect our world, as well as accept and problem-solve how our world affects us. The continuous process of "give and take" begins to form behavior patterns that we use to further assemble our social relationships.

To put the concept of constructivism into relational theory, Mitchell (1995) expressed his thoughts of what relational constructivism is. He did not think that it was wise, or even possible, to try to separate a person's psyche from his or her social interactions. Rather, Mitchell contended that who we are depends on our interactions and experiences with others. Palombo (2009) wrote in a PowerPoint presentation that constructivism is how "the observer affects what he or she observes" (slide 39). In essence, our interpersonal relationships, and consequently the patterns of behavior they create, are of the utmost significance to relational theory.

Relational theory further builds on the idea of constructivism by acknowledging that, as individuals, we generate our social worlds. Therefore, the realities of each of our worlds cannot be the same. There may be some shared similarities, but no one thinks the exact same way as someone else. We each have distinct personalities. While constructivism is more concerned with the formulation and assembly of our social identities, it is the concept of contextualism that focuses more on interactions and communication with others once we are socially "assembled."

Eric Fox (2009) referenced philosopher Stephen Pepper and his thoughts on contextualism by explaining, "The root metaphor of contextualism is often called the act-in-context or the historic event" (Pepper, 1942, p. 232), and he referred to the commonsense way in which we experience and understand any life event. In essence, everything that we do is put into context with our past and present surroundings and the people in them. The purpose of and meaning placed on a current social situation are dependent on how we have previously perceived the same or similar situations. We are looking for relevancy in what we have already experienced and how it applies to our current circumstances. It is the response to our environment and the need to connect with others—not just inherent biological drives, as Freud believed—that fulfill our personal needs and desire for social connection.

From a relational theory perspective, contextualism refers to our experiences and how we attach meaning to them. Specifically within these experiences, how we interact and communicate with others—both verbally and nonverbally—is very person-centered. It is both internal thoughts and external actions that result in personal reality. We base our responses to others on what we know as our truth and understanding of the world. For

those with whom we interact, their own truths and histories shape their experiences and reactions to us. Personal and social pathologies emerge from an individual's perception of his or her reality, as well as what he or she assumes is the reality of others.

The premise that a person creates his or her own reality does not pertain only to the person being studied. It also includes the personal realities of those with whom any interaction occurs. Similarly, Bandura's social cognitive theory is based on how individuals influence one another toward change, development, and adaptation (Bandura, 2005). Both relational theory and social cognitive theory, which includes collective efficacy, have common themes of how the connectedness of individuals and groups can be determined, in part, through social context. How we understand ourselves, how we perceive others, and how we interpersonally relate are overlapping themes in collective efficacy and relational theory. The combination of both of these ideas allows for a more balanced view between the perceptions of individual and group interactions.

Chapter III

Methodology

Study Design

A concurrent, triangulation, mixed methods approach was used in this phenomenological study. Creswell (2003) wrote that the strategy used with this approach is to have both quantitative and qualitative data collected at the same time. In doing so, the data have equal priority and are integrated during the interpretation stage of the study. Greene, Caracelli, and Graham (1989) wrote that a mixed methods design works best when the "status of the different methods—that is, their relative weight and influence—is equal and when the quantitative and qualitative study components are implemented independently and simultaneously" (p. 259). Ultimately, this approach is used "to obtain different but complementary data on the same topic" (Morse, 1991, p. 122), and it is needed when interpreting results of both qualitative and quantitative data.

The use of a mixed-methods design approach allowed for two ways to focus on the central research question surrounding the relationship between an LSRT's perceived level of collective efficacy to successfully establish mental health services and the actual number of mental health referrals they generated. Understanding that study participants have personal realities and viewpoints, it was imperative that the data collected accurately reflected participant responses. By collecting both quantitative and qualitative data, this study was able to provide a balanced view between the experiences of the

individual school-based therapists responsible for facilitating the LSRT meetings and the perceived collective efficacy of the individual schools that were establishing mental health services. The mixed methods approach for this study objectively assessed the schools' (LSRTs') level of collective efficacy via survey on the concept of perceived efficacy and gathered the subjective experiences of perceived efficacy from the therapists who actually provided the services. Using a combined qualitative and quantitative approach, this researcher was able strengthen and deepen the understanding of the variables of interest and examine potential correlation between them.

Creswell (2003) and Maxcy (2003) both wrote about the pragmatic way in which researchers build their knowledge while using a mixed methods approach and they assert, as described by Howe (1988), that the truth is what works. Mixed methods researchers choose the most appropriate approaches to find the answer(s) to their research question (Tashakkori & Teddlie, 1998), and they find that quantitative and qualitative methods are compatible while conducting research. In essence, the collection of both numerical and verbal data is the best way in which to understand an issue. The mixed methods strategy allows for the confirmation, cross-validation, and corroboration of data within a single study (Creswell & Plano Clark, 2007). These authors further stated that this strategy allows for a shorter collection time, which is an important consideration in time-constricted school settings.

Quantitative research is centered on numerical data (Charles & Mertler, 2002). The quantitative component of this study is viewed and understood from a postpositivist perspective while reviewing variables as well as drawing conclusions from the central research question. In general, a postpositive researcher does not believe that there is

absolute truth but rather is looking at the "probability of the investigators' conjecture" (Palmo, Weikel, & Borsos, 2006, p. 333). Postpositivism influences observation and measurement as well as a theoretical perspective by attempting to enhance objectivity in the research process. The nature of quantitative research involves the isolation and analysis of variables and further investigates their significance in relation to each other. Quantitative research gave the flexibility for this researcher to choose the appropriate data instrument and also to determine which variables to focus on. The survey instrument used should result in high reliability and validity of data scores derived from the collected data.

Creswell (1998) wrote that qualitative research is "an inquiry process of understanding" and that the researcher creates a "complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting" (p. 15). An important distinction between the quantitative and qualitative portions of the study is the constructivist (Guba & Lincoln, 1982) perspective that emerges as the researcher comes to understand the knowledge that has been acquired through qualitative interviewing. Creswell (2008) wrote that the goal of constructivist research is "to rely as much as possible on the participants' views of the situation being studied" (p.8). It is a broad-based study in order for the participants to draw their own meanings and conclusions of the research that is being conducted.

People tend to construct meaning in different ways even when looking at the same phenomenon (Crotty, 1998). The constructivist paradigm is "a perspective that emphasizes how different stakeholders in social settings construct their beliefs" (Schutt, 2006, p. 44). Through the use of standardized, open-ended questions, this researcher

aimed to elicit emerging meanings from the participants. Patton (2002) explained that qualitative content analysis is "any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings" (p. 453). Further, Patton (2002) also defined the primary advantages of the standardized, open-ended interview as the following: (a) questions formulated ahead of time will allow all interviewees to share the same interview experience, (b) data are organized for the sake of clarity, and (c) evaluation of the program is facilitated.

Central Research Question

What is the relationship, if any, between the perceived level of collective efficacy of both individual schools (referral teams within the schools) and school-based therapists to successfully establish mental health services and the number of mental health referrals actually generated by these schools?

Sample Selection

The school district participating in this research, located in the Southeast, was the recipient of an $8 million Safe School/Healthy Students (SS/HS) federal grant. This money was used, in part, to implement mental health services in select schools within the district. The researcher was required to submit an application to the school district requesting permission to conduct research. Permission and support was granted via a letter of cooperation from the school district's central review committee to conduct the research. This study includes both subjects who are school district educators as well as mental health therapists working within a school setting. The criteria for study inclusion

were specific to those schools within the school district that were recipients of the SS/HS grant. Out of 116 schools in the district, only 36 were involved with the SS/HS grant. Information regarding the numbers of referrals received from each school was secondary data that had already been collected by the SS/HS grant. The secondary data only consisted of the number of referrals generated by a school on an annual basis. Because no names are included with these numbers, there were no Health Insurance Portability and Accountability Act (HIPAA) violations to consider.

From the original 36 schools, the principal investigator identified nine schools through stratified sampling for inclusion in this study. The number of mental health referrals generated by the original 36 schools was reviewed. Upon examination of the referral numbers, the final study sample of nine schools was selected, resulting in three schools from each educational level (elementary, middle, and high) that implemented school-based mental health services. One school from each educational level was selected from those with the most referrals generated over the course of the grant, and one school was from each level was selected from those with the least amount of referrals generated during the same time. Finding the average number of referrals per level and choosing the school closest to this number was how the third school was identified for each educational level.

The mental health therapists assigned to the identified schools were licensed mental health clinicians. These clinicians were either licensed clinical social workers (LCSW) or licensed professional counselors (LPC). The researcher intended to interview a minimum of nine mental health therapists. However, three therapists were assigned to more than one of the identified schools, each having two schools in this study. As a

result, only six therapists were interviewed for this study. The three therapists with two schools were asked to respond to the qualitative questions separately for each school they served.

Once the potential schools were selected, the researcher identified the Learning Support Resource Team (LSRT) members and mental health therapists designated at each school. The researcher was required to work within the following parameters set forth by the school district:

- School administrators also had to agree to let their schools participate in the study
- Interviews and surveys could not be conducted or completed during school hours
- Research could only be conducted and completed during an academic year
- The district's name could not be identified in the study

The researcher sent an email to each of the therapists requesting their participation in interviews. The therapists were directed in this email to contact the researcher to express their interest. They were informed that each interview would take between an hour and an hour and a half of their time. The therapists were given a choice to meet in their offices after school hours or, if they preferred, to go to a neutral location such as a reserved room at the public library. Each therapist determined the day, time, and meeting place. Prior to the interviews, each therapist signed a consent form agreeing to participate in the study.

To determine the best day and time to leave the surveys for the LSRT members, the researcher contacted the school administrators. When the surveys were distributed, the participants signed consent forms. Subjects were informed that completing the survey

would take between 10 and 20 minutes of their time, and instructions were given regarding the return of the surveys to the researcher. Each participant was asked to place the completed survey in a provided self-addressed stamped envelope to be mailed to the researcher. Participants were also informed that completion of the survey should not be done during instructional time, per district policy. The research requested that participants return the surveys by mail within a week of receiving them.

Data Collection and Instrumentation

Considering that multiple factors can affect the implementation of school-based mental health services, the collective working relationship among team members and their individual perceptions of their colleagues can be predictors of success or failure. Though each school has the same general rules and guidelines that must be followed per school district policy, each has a unique subsystem in which additional rules and values are applied. Individual school administrators, the willingness of LSRT members to make referrals, and the procedures for gaining permission/access to the students can enhance or inhibit the effectiveness and, ultimately, the sustainability of school-based services.

Quantitative Data

The analysis of referral numbers allowed this researcher to identify the schools that would be asked to participate in this study. The distribution and return of surveys was conducted between April and May 2014. The educators completing the surveys from each school had to be certified school employees in order to participate in the study. The number of participants per school varied as it was left to the discretion of individual

schools to determine who was included on their LSRTs. Table 1 provides the actual number of referrals generated by each school while collaborating with the SS/HS grant. Additionally, the final number of potential participants and the actual number that participated in the quantitative portion of this study break down as shown in Table 1.

The survey given to LSRT members was designed to measure group collective efficacy. The survey instrument was borrowed and modified with permission from Dr. Laura Borgogni, a professor at the University of Rome "La Sapienza," Italy. The specific study from which this instrument was borrowed is entitled *Collective Efficacy and Organizational Commitment in an Italian City Hall* (2009), conducted by Dr. Borgogni and three of her colleagues. Dr. Borgogni used exploratory factor analyses (EFA) to ascertain the internal validity of the scale and SPSS software to conduct the EFA.

Table 1

Referrals and Surveys per School

School	Referrals	Surveys Distributed	Surveys Returned
Elementary 1	103	10	8
Elementary 2	70	5	3
Elementary 3	16	5	3
Middle School 1	124	7	4
Middle School 2	85	6	4
Middle School 3	43	6	4
High School 1	121	6	4
High School 2	60	6	3
High School 3	43	6	3

The quantitative data were collected through a 19-question, six-point Likert scale. The data gathered from this instrument were used to determine the perceived collective efficacy of individual school-based mental health LSRTs. Further; the collected data were compared to the number of referrals from individual schools to see if referrals might be affected by group collective-efficacy perceptions. The questionnaire was distributed to the educators (LSRT members) at each of the schools participating in this research. The measure of the Likert scale asked respondents to rate their confidence level about the following statement: “I believe in my Learning Support Resource Team we are able to…”

Scale ratings included:

1 = Strongly Disagree

2 = Disagree

3 = Tend to Disagree

4 = Tend to Agree

5 = Agree

6 = Strongly Agree

Based on the questions in the survey, four category clusters were delineated in order to further evaluate perceptions of collective efficacy:

1. The unique dynamics within a group that can contribute to productivity and effectiveness.
2. How interpersonal relationships are navigated to improve group cohesion and efficacy.
3. How the misunderstanding and misalignment of goals can significantly hinder the group's success.
4. The degree to which the group uses novel and need-based interventions.

Qualitative Data

The qualitative interviews were also conducted between April and May 2014. Participants had the opportunity to select multiple dates and times that would best meet their needs, to facilitate maximum involvement. This researcher conducted the interviews in neutral locations convenient to the therapists and not on school campuses. The qualitative exploration with the school-based therapists was used in order to: (a) gather

their insights and perceptions of group collective efficacy within their LSRTs; (b) understand how their roles were defined by individual schools; and (c) to understand their perceptions of how involved and invested their schools were regarding the implementation of school-based mental health services. The interviews prompted answers from the therapists about their experiences of immersion in the school cultures of the schools that they served.

In this study, the qualitative design consisted of a semi-structured interview process, and was used to gather information regarding the thoughts, feelings, and reactions of therapists' involved with implementing school-based mental health services. The qualitative component of the concurrent data collection consisted of standardized, open-ended, one-on-one interviews with the therapists from the identified schools that participated in the quantitative survey. The researcher asked questions that were consistent with Patton's (2002) recommendations for standardized, open-ended questions. Patton (2002) writes that a standardized, open-ended interview "consists of a set of questions carefully worded and arranged with the intention of taking each respondent through the same sequence and asking each respondent the same questions with essentially the same words" (p. 342).

Patton (2002) offers an alternative matrix of question options in the domains of behavior and experience, opinion and values, feelings, knowledge, and sensory and demographic background, each of which can be explored in past, present, and future time frames. Patton's matrix of question options was utilized to elicit information regarding personal observations, feelings, and reactions involving the level of involvement of therapists in school-based mental health programs. The qualitative interviews were

designed to complement the administered quantitative survey and included the following prompts:

- How would you describe the degree of group cohesion with the LSRT(s) in which you have worked? Were there problems or barriers to group cohesion? If so, what were they?
- How would you describe the interpersonal relationships on the LSRT(s) in which you have worked? Were team members able to put aside personal needs to meet the needs of others?
- Describe your experience of how the LSRT(s) worked together to overcome obstacles and attain the goal of implementing mental health services.
- Describe a common working strategy that the LSRT used as a way to include suggestions from all LSRT members.
- How effectively do you feel the LSRT(s) with which you have worked were able to solve difficult mental health problems? What were the challenges the team(s) faced in solving difficult mental health problems?
- What was your experience working with the LSRT(s) in regard to the team putting into practice new solutions to mental health issues?

For this part of the research, Max van Manen's phenomenological approach for qualitative research was used. His book, *Researching Lived Experience* (1990), explained that a qualitative researcher "gathers other people's experiences because they allow us to become more experienced ourselves" (p. 62). Following van Manen, the qualitative interviews (a) gathered and explored narrative material from the therapists to develop a

comprehensive understanding of the phenomenon of interest—collective efficacy—and (b) developed conversational relationships with the interviewees to better understand the meaning of their experiences.

When conducting a phenomenological interview, the researcher and the participant are considered partners in the process of discovery. Van Manen's (1990) perspective on qualitative interviews is that formulating good questions before the interview is essential to ensure clarity throughout the interview. Participants were asked the same questions during semi-structured interviews, which captured their subjective experiences in a similar manner.

Once interview data were collected, the transcriptions were checked against the original recordings for accuracy. Van Manen (1990) discussed the use of phenomenological reflection when analyzing qualitative data, and thematic analysis was conducted using the following recommendations:

1. Uncovering the thematic aspects in "life experiences" through description. Themes provide focus, meaning, and a point to lived experience. "Themes are the stars that make up the universes of meaning we live through. By the light of these themes we can navigate and explores such universes" (van Manen, 1990, p. 90).
2. Isolating thematic statements. Three approaches can be used to uncover thematic aspects in these lifeworld descriptions: holistic, selective, and detailed (van Manen, 1990). This requires the researcher to read and analyze interview transcripts for themes in participant experiences.
3. Composing linguistic transformations. The researcher uses creative expressions when themes are articulated. "Composing linguistic transformations is not a

mechanical procedure. Rather, it is a creative, hermeneutic process" (van Manen, 1990, p. 96).

4. Determining essential themes. Essential themes are those that speak to shared experiences of a phenomenon; without them the phenomenon would be altered. These questions must be asked: "Is this phenomenon still the same if we imaginatively change or delete this theme from the phenomenon? Does the phenomenon without this theme lose its fundamental meaning?" (van Manen, 1990, p. 107).

A mixed-methods design model lends itself not only to the "hard" numerical data acquired in this study, but also to the "softer" qualitative data that adds personal meaning and perspective to the findings. Whereas the quantitative data acquired from the educators during this research is systematic and measurable, the qualitative data enriches the study with the addition of personal experiences acquired from the therapists in this phenomenological research. Researchers recognize the need to establish a trustworthy foundation, despite the potential of variances in data analysis, to avoid influencing the data. Koch (1994) writes that qualitative researchers need to be cognizant of their own experiences as well as their personal perceptions and prejudices, which can account for variances during analysis. Following research guidelines for data collection ensures consistency. While the data are both numeric and linguistic, the interpretations should not be contradictory. The use of a post-positive view provides a balance in the data analysis by allowing influence and conjecture as well as isolating quantitative variables that complement themes uncovered during the qualitative analysis.

Chapter IV

Results

In this chapter, the findings of the study will be presented, including a brief outline of the procedures used for the collection of data and thematic analysis of the results. One aspect of this study was to explore how individual schools influence the continuation and sustainability of school-based mental health services implemented within a school district. This study also aimed to identify the level of involvement of mental health therapists in school-based mental health programs and how the degree of involvement influences program effectiveness.

The specific objective of the qualitative portion of this study was to explore the therapists' views of collective efficacy in their schools. This information was then used to examine any differences between their perspectives and those of the schools as a whole. Semi-structured interviews were utilized as the data-gathering instruments. Interviews were conducted with permission from the identified schools, at neutral off-site locations. The interview responses from the six participants were recorded, transcribed, and analyzed.

Data collected from the surveys distributed to the school LSRT members were downloaded to the Statistical Package for the Social Sciences (SPSS) software. Descriptive statistics were used to describe the demographics of the population sample,

and survey data were analyzed by using inferential and descriptive statistics to categorize and summarize the results. Quantitative analysis focused on the participants' views of collective efficacy at their schools. Secondary data (referral numbers already collected) were used to determine if there were any possible correlations between collective efficacy and referral rates. A parametric analysis was used to achieve the level of validity in the findings. The assumptions of normality and homoscedasticity were met through the examination of scatterplots. In keeping with a parametric analysis, the validity was bolstered at the expense of making more assumptions about the data. Both of the assumptions were met through the requirements of a Pearson correlation analysis. A Pearson correlation would ideally utilize 82 participants, and this research only had 36. The objective was to keep with an analysis that did not include the ideal number of participants, yet still seek significance while using the Pearson model.

Qualitative Analysis

Qualitative data were collected through face-to-face, semi-structured interviews with the study participants. The qualitative portion of the study aimed to supplement the quantitative data by enhancing and clarifying the meaning of the responses gathered in the quantitative portion of the study. The qualitative exploration consisted of interviews with school-based mental health therapists to explore their perceptions of group collective efficacy, the definition of their roles are by individual schools, and their perspectives on how involved and invested their schools are regarding the implementation of school-based mental health services.

Interviews were conducted through face-to-face, one-on-one meetings with participants. Participant responses in this study were recorded using an audio recording device, and were later transcribed. Responses were read and reread to develop and establish commonalities, or themes. These responses were then addressed through thematic analysis.

Qualitative Study Participants

Stratified sampling was utilized to select nine schools within the chosen school district for participation in the study. The chosen sample was comprised of three elementary schools, three middle schools, and three high schools located in the service area. The participants in the qualitative portion of this study were six school-based mental health therapists who are immersed in the school culture of each of school they serve. The six interview participants were informed of their rights and asked to sign a consent form. The following descriptions were created utilizing information provided by the participants and field notes created by the researcher.

1. Participant 1 is a bilingual licensed mental health therapist who is a licensed professional counselor (LPC). She has been licensed for 18 years. She reports working as a therapist with the Success for All Students program for the past two years.
2. Participant 2 is a bilingual licensed mental health therapist who is an LPC. She has been licensed for 13 years. Participant 2 has been with the Success for All Students program for three years.

3. Participant 3 is a mental health therapist who is an LPC. She has been licensed for two years. Participant 3 has been with the Success for All Students program for one year.
4. Participant 4 is a mental health therapist who is a licensed clinical social worker (LCSW). She has been licensed for 7 years. Participant 4 has been with the Success for All Students for two years.
5. Participant 5 is a mental health therapist who is licensed as an LPC. She has been licensed for two years. Participant 5 has been with the Success for All Students program for one year.
6. Participant 6 is a mental health therapist who is an LCSW. She has been licensed for 16 years. Participant 6 has been with the Success for All Students program for four years.

Background

Four of the participants reported that they had primarily served the same schools for the duration of their tenure. Three of the participants have been in their role since the onset of the grant, while the other three joined the grant during its second year. From the schools that participated in this study, the total number of students referred for mental health services was 677. There were a total of 189 students referred from elementary schools; 264 referred from middle schools; and 224 referred from high schools. The experiences described by participants tended to vary widely. The participants indicated that substantial distinctions existed between the various schools they served, influenced by the number of students each school referred as well as the grade levels of the students.

Overall, participants reported that staff turnover had not been a significant issue at their respective schools.

Emerging Themes

The qualitative data analysis involved gathering interview data from the mental health therapists and conducting a thematic analysis in order to explore how the therapists viewed collective efficacy in the schools and whether or not this differed from the schools' own views, as determined by the quantitative survey.

The participants' interview responses were recorded and transcribed using MAXQDA, which is software designed to assist researchers in analyzing qualitative data. The software allowed this researcher to categorize data into subsets, resulting in the themes identified below. The transcriptions were analyzed for commonalities, or themes, from the given responses. The themes presented in this chapter were chosen for their relation to the central research question: What is the relationship, if any, between the perceived level of collective efficacy of both individual schools and school-based therapists to successfully establish mental health services and the number of mental health referrals actually generated by these schools? The following five themes emerged from the responses of the six participants:

1. Unique dynamics exist within the LSRT that contribute to productivity and effectiveness.
2. Interpersonal relationships must be navigated to improve the cohesion and efficacy of the LSRT.

3. Misunderstanding and misalignment of goals within the LSRT can significantly hinder the group's success.
4. Participants reported a high degree of self-efficacy in the provision of services using novel and need-based interventions.
5. The presence of on-site mental health therapists was cited as the most important factor for the sustainability of mental health services.

Theme one: Dynamics within LSRTs.

Participants identified specific dynamics that exist within the LSRTs. These dynamics were cited as important factors in the productivity and effectiveness of each group as a whole. The factors identified by participants were categorized as subthemes. The following subthemes were identified:

1. LSRT members are perceived as knowledgeable;
2. some members attend LSRT meetings inconsistently;
3. members are often busy with other job-related tasks; and
4. the contribution of different professional and personal perspectives facilitates problem solving.

LSRT members perceived as knowledgeable.

All participants reported that they considered their fellow LSRT members to be knowledgeable. One participant described the members of the LSRT at two of the schools she served as "very professional… [and] knowledgeable about mental health issues." Another participant characterized her colleagues as "professional" and added that they "had a lot of skill and experience." Two participants also described their colleagues as

"knowledgeable." Another participant indicated that her fellow LSRT members were skilled in identifying students for services, as well as knowledgeable about available resources. The knowledge that was described primarily pertained to the specific professional training and job descriptions held by each of the LSRT members, which included school social workers, school counselors and school psychologists. One participant elaborated by reporting that while she considered the school staff to be "more than capable and competent in their own roles," she believed that a substantial "learning curve" existed for them all. Additionally, while it was reported that the LSRT members generally had a firm grasp of mental health issues and their precipitating causes, historically they referred students to outside services with little to know follow up to ensure the students' and families' needs were met. Very few were able to determine the best way to successfully serve and treat students within the confines of a school setting. However, the consensus of the majority of the LSRT members was that they were committed to finding a way to do so.

Irregular attendance.

Four of the participants cited inconsistent attendance at LSRT meetings as a common issue at their various schools. One participant reported that no members attended LSRT meetings regularly at one of the schools she served. "I I would even show up for the LSRT having emailed them to make sure that they knew that we were having it and that they scheduled it only to find out that…there were no school personnel available to me."

Another reported that the school psychologist and social worker declined participation in the LSRT meetings. Additionally, a participant stated that the primary administrator at one of her schools attended meetings sporadically. Some challenges to establishing regular attendance were that the therapists were unable to establish the guidelines and requirements for participation among the LSRT members and lacked the authority to implement consequences if members did not attend. Overall, the supervisors of the grant did not relay any guidelines for attendance, leaving it up to the participants to determine attendance standards. As a result, no LSRT had the same expectations for regular attendance, which were primarily dictated by the importance placed on the LSRT process by administrators.

Members busy with other priorities and tasks.

All participants reported that members of the LSRT tended to be tasked with many duties within the school. They argued that the burden of these other responsibilities preoccupied the time and attention of school staff. Resultantly, LSRT members had little time to devote to the aims of the LSRT. A participant reported that other LSRT members expressed appreciation for being able to "count on a therapist to be able to take care of the things that they don't have the time to." She continued, "they would like to be able to, but they don't have the opportunity to, because then it conflicts with some other expectation that that administration has." Another participant suggested that a substantial improvement would be "counselors not having to do so many non-counseling duties." Prioritization of mental health services was not just an issue for counselors. A participant reported:

> [The principal] seemed to be pulled a lot of different directions as well with that school, because of a population with higher needs. He was able to identify needs, but it became difficult for him to follow through with making the referrals of identified students.

Additionally, a participant characterized school staff as being "overloaded and really busy and having to keep track of so many things." A different participant supported this assertion when she stated that the psychologists' busy schedules often prevented them from coming to LSRT meetings. The numerous interventions needed for mental health services in schools, as identified and discussed by Adelman and Taylor (1993), suggest that the provision of appropriate and timely services is not exhaustive of monthly LSRT meetings. The successful integration of services requires an ongoing time commitment from each of the team members. Asking for more time from professionals that have very little to give is bound to result in the triage of their job responsibilities. While many of the members supported the implementation of school-based mental health services, their primary job descriptions were not always conducive to the devotion of time needed to ensure success.

Different perspectives in problem solving.

Interview participants reported that various members of the LSRT offered different perspectives to the group. These varied perspectives reportedly aided the group in brainstorming and problem solving. One participant stated, "the social worker would have her perspective, as well as the counselors, the teacher, and myself. We would work out what we thought might be a good plan—a comprehensive plan—for the student."

Another reported, “Different members would make suggestions based on their areas of expertise.” Similarly, another participant expanded on this idea saying, “We did have a lot of different disciplines there [within the LSRT]…so when we came to talk about students we had a lot of different multidisciplinary approaches.” Likewise, another participant extolled the benefits of this aspect of the LSRT commenting, “I think my favorite part about the LSRT process is that everyone’s coming from a different background. And so we can—we can kind of attack all of the areas that need to be.”

Having a multidisciplinary team overall was deemed important by the participants. However, taking into consideration the different commitment levels and participation of each of the professionals involved, not everyone was able to express their ideas and opinions. As a result, one participant’s perspective was that “it was not always a true multidisciplinary approach if not everyone was there. There were times when just a few people—or the most outspoken person—would make decisions”. This was supported when another participant explained, “when people did not get to attend meetings for whatever reason, they became discouraged thinking their opinion didn’t matter anyway.” Ideally, each varying discipline would attend each LSRT meeting. When this did not occur, there was in imbalance of perspectives, creating difficulties in how people perceived the referrals process. A participant sums this idea up by saying, “everyone wanted to be heard, and feelings got hurt or there was a power struggle when this didn’t happen.”

Theme two: Interpersonal relationships within an LSRT.

Participants cited interpersonal relationships as a significant factor in developing cohesion and efficacy within the LSRT. A participant reported, "I think the relationships are what can make this program work in a school." Another echoed this sentiment stating the following:

> It took time for me to understand that I needed to shift my focus from the actual referrals we were supposed to generate in the LSRTs to build[ing] a relationship with them. Once I was able to build a relationship with them… then all of a sudden the referrals started coming in, the relationship was stronger, which allowed for a lot more referrals.

In discussing the importance of interpersonal relationships within the LSRT, several subthemes emerged among participant responses. These subthemes were:

1. personality conflicts,
2. group cohesion,
3. staff resistance, and
4. administrative buy-in and approval.

These subthemes will be discussed in greater detail in the sections to follow.

Personality conflicts.

When discussing the workings of the LSRT, several participants discussed the management of personality conflicts among members. This theme is corroborated in the literature, as Carlson et al. (1996) wrote that services provision could result in turf battles. One participant offered the following observation:

> I think in any system, but particularly in a school, it can be very political. LSRTs where the administrators and the staff have been able to put interpersonal relationships aside have been successful and less successful when they can't. I work at a school where there are two members who openly dislike each other, but they don't bring it into that room. Even though I know there's discord, it hasn't affected the LSRT process.

Another participant offered a similar report, referencing "the politics" of schools, which she reports having to learn to successfully navigate. Yet another participant reported having to act as a mediator between various members of the school faculty to settle personal rifts. A participant indicated that interpersonal conflicts at her school—including a "battle for dominance [within the] LSRT"—ended up "shutting down the process." In discussing personality conflicts at one of her schools, a participant reported, "if there was an issue, people weren't, necessarily, willing to voice that issue… Perhaps they didn't want to have any disagreement or deal with any conflict."

However, a lack of personality conflicts in other schools was associated with positive working relationships within the LSRT. One participant reflected this idea by stating, "There were no conflicts of personalities. I think that was really helpful that we were all friendly with one another." This sentiment was also voiced by another participant who stated, "When we came together, we tried our best to but the students first. It was about them, not about who we didn't like in the room." The lack of personality conflicts is a stepping-stone toward positive collective efficacy.

Group cohesion.

Participants also discussed the level of cohesiveness they experienced within the LSRTs. Half of the participants reported that group cohesion varied significantly between the various schools they served. This supports Wood and Bandura's (1989) findings that within the context of reciprocity, the overarching needs of the group or organization can be affected by the relationships within that culture. One participant attributed good cohesion at one of her schools to members listening to one another's needs. Another attributed group cohesion to the desire of LSRT members to "do all they can" to serve the needs of their school.

Most participants tended to describe cohesion as the LSRT's ability to come together as a collective unit. A participant stated, "cohesion varied in my schools. The elementary school was very cohesive and willing to work together to think of creative ways to serve the students." Another expressed a similar point, saying, "I think there was great group cohesion. Everyone was willing to brainstorm and seemed really focused on just coming together and thinking of solutions." She also reported that cohesion has been consistent at one of her schools, and attributed it to "a lot of buy-in, and everyone work[ing] really well as a team at that school." She continued, "I think a lot of it comes down to the personalities and professionalism of the administrators and staff at the schools."

Staff resistance.

Bandura (2000) wrote that when there are high levels of self-doubt within a group, achievement levels tend to decline. The overall accomplishments of a group are

higher when all of its members are invested in its core beliefs and goals. Several participants who reported experiencing resistance from faculty members at the schools they served identified lack of group investment. One participant stated, “they were somewhat resistant to anyone from the outside coming into their school.” Another described staff members at one of her schools as “totally distant and not even caring.”

Another participant discussed classroom teacher’s resistance outside of the LSRT setting; she stated, “there was a good portion of the teachers [who felt] they knew what they were doing in their classrooms. They didn’t need me to tell them anything.” Another participant also stated that schools were hesitant to embrace new practices or services offered to them through the school-based mental health program.

Administrative buy-in and approval.

Four of the six participants also discussed the impact of buy-in and approval among school administrators in determining program success. Participants argued that the success of the LSRT was largely related to the tone set by the administrative faculty. A participant also reported her school was “in larger part, driven by the administrative culture there. They weren’t very bought in, and therefore they didn’t support any referrals that were given to us.” Similarly, another participant reported, “often times, I felt the administrators at some of the other schools didn’t really get it, and ended up being somewhat peripheral.” She continued, “it really depended on the team at the school… the school system is a culture, and the cultures change as administrators change.”

Conversely, some participants reported working under supportive administrations. One participant reported the following:

> I think a big part of the LSRT success was that the principal was so bought in. It was as if she gave them permission to use our services in the way that they did. She absolutely affected the cohesion of that LSRT. There was a very high rate of referrals at that school.

A different participant recalled, "the principal came to every LSRT meeting. She didn't miss one." Yet another participant stated, "the social worker was there off and on, as well as the two counselors. The administrator, though, was there at every meeting—he was very consistent, very bought in." Another participant recalled a similar dynamic, stating, "If one of the administrators missed a meeting they would send me an e-mail and just ask for an update. They definitely wanted to have their hands in the process and know what was going on in their school."

Participants also discussed their efforts to please members of the administration in an effort to increase the level of support for their program. One participant expressed this point when she stated, "the administrators know that if we're handling it they don't have to worry about it. That pleases them." A participant who had a change in leadership in one of her schools discussed the miscommunication she had with the new administrator.

> I thought that by handling things as I always did was still okay to do. The new administrator didn't want that—he was more of a micromanager. I had to find a different way to work with him so he was happy and still be successful at my job.

From the discussion with the participants regarding administration, the researcher concluded that they felt that the school administrators greatly influenced not only successful working relationships and perceptions among LSRT members, but also the overall success of program implementation.

Theme three: The misunderstanding and misalignment of goals.

Participants identified misunderstanding and disagreement as impediments to the group goals of the LSRT operation. Several participants described the problems that arose from discrepant conceptualizations of the groups' aims. Among their responses, three subthemes emerged as problematic occurrences: (a) inappropriate referrals and misunderstanding of criteria; (b) focus on school-wide needs versus student-focused needs; and (c) emphasis on academic and behavioral rather than mental health issues. These subthemes will be discussed in greater detail in the sections to follow.

Inappropriate referrals and misunderstanding of criteria.

Half of the participants stated that the efficiency of the LSRT was negatively impacted when faculty members did not have a clear understanding of program criteria and therefore made inappropriate referrals for the program. One participant reported the following about the staff at one of her schools:

> [They] needed to be constantly reminded of the referral process, of eligibility criteria. [They were] sending in referrals that didn't meet the eligibility criteria, and were disappointed when I didn't provide services to that family. I found that almost every LSRT meeting I would have to give a recap of what my role was and the services I could and could not provide. I had to reiterate the eligibility criteria and how to make a referral."

She explained, "they were pretty receptive whenever I reminded them. It was just that I would have to do it over and over." A different participant expressed a similar

experience, saying, “it was sometimes difficult to help them to understand the criteria, and for some reason the referral process was difficult for them to understand.” Another participant also reported inappropriate referrals from staff at her school, attributing the referrals not to a misunderstanding of the criteria but to overloaded counselors who were just looking for help with difficult students.

School-wide needs vs. student need.

Participants also referenced the dichotomy between focusing on the needs of individual students and focusing on school-wide needs. A participant indicated that LSRT meetings tended to transition from one focus to the other in a natural segue. Conversely, tension between these two foci produced negative results for other participants. A participant cited differences in opinion about what the group’s focus should be as the cause of member attrition in one of the LSRTs in which she participated. She recounted , “We started out having a school psychologist and a school social worker that attended. When the direction of the LSRT changed to discussing more school-wide issues and less on individual students, they both stopped attending.”

A different participant discussed a similar experience, remarking that some of the educators with whom she worked “didn’t understand why we couldn’t just go over the students they had identified, the ones we were working with, and be done.” These attitudes and difficulties show that the multi-tiered system of care model, as discussed by Atkins et al. (2003), would have been helpful during the LSRT process. Understanding that universal solutions could be discussed before jumping to more intensive services would have helped educators become more aware that mental health issues were systemic

and not isolated instances.

Academic or behavioral versus mental health focus.

Several participants noted the distinction between focusing on academic, behavioral, or mental health issues. Discrepancies in emphasis between these various categories tended to lead to frustration and unmet expectations. A participant stated, "the high school was mainly concerned with looking well academically, and not very interested looking for solutions to mental health issues." Another participant explained this concept in detail, reporting the following:

> At my school, if they were not passing their grades, or if they were not improving their grades, then I wasn't doing a good job and there was something wrong with what I was doing. I found I was trying to educate them in a way that would not seem like it was an excuse, but at the same time let them see that while their expertise and experience in education was wonderful, it was not necessarily comparable to my expertise and experience in mental health and treating disorders. That was a piece that was incredibly difficult and caused a lot of conflict for me at this particular school.

A different participant expressed a similar point, noting that children were often referred who only presented with academic needs and not the mental health needs stipulated in the criteria.

In addition to academic concerns, participants also identified behavioral control as the priority for some schools. One participant reported, "at my school, it was more of a way for them to ameliorate any nuisance behavior." Another described a similar situation

when discussing a student with which she was asked to work, reporting that students often had “severe mental health issues and the school would view them very narrowly as having oppositional behavior. I viewed this as having more extensive mental health issues.” She continued, “My approach was different from the school's approach. I quickly came to realize that they don't see mental health the same way that a therapist or a counselor would view it.”

Theme four: Self-efficacy in novel and need-based service provisions.

Participants reported a high degree of confidence in their ability to deliver services that positively impact their students. Participants also discussed the use of new, creative interventions in response to the specific needs of their student populations. In discussing the implementation and provision of services, several subthemes emerged among participant responses. These subthemes were:

1. high personal efficacy,
2. group openness to new solutions and ideas,
3. the use of groups and presentations to address identified needs, and
4. the impact of family involvement in the success of their efforts.

These subthemes will be discussed in greater detail in the sections to follow.

High personal efficacy.

Participants unilaterally expressed a high degree of confidence in their positive influence upon the lives of the students they have served. One participant reported the following:

> I feel like I have been able to give them hope when they may have thought that an issue that was too great and they were never going to be able to get over it. I feel like I've also helped them realize that they can be empowered to be able to deal with certain issues—whether it was depression, anxiety, family issues, or just helping them get in touch with those coping skills. I think just being a caring, supportive adult who listened was really important.

She also listed having self-control, making wise choices, and relating to other people in a loving and responsible manner as skills with which she has been able to equip her students.

Another participant argued, "I think providing a child with a safe place that they can do what they need to do therapeutically will incite positive change." A different participant indicated that when she became discouraged by a lack of progress, a sudden breakthrough or improvement in a child would renew her faith. This participant stated, "I hoped that I touched their lives in giving them a new perspective on things, and explaining things in a way that nobody else probably was explaining it to them in the school system." Another participant similarly reported, "I can definitely say in most of the students I've seen some improvement, whether it be small or large."

Openness to solutions and ideas.

Participants tended to characterize their LSRTs and the schools as a whole as open to learning about and experimenting with new ideas and solutions to problems. One participant offered the observation that "they were very open to new ideas. If I suggested a group or bringing in outside trainers through our other peripheral programs the grant

offered, their perspective was ‘anything that would benefit our students, we’re open to it.’” Another participant offered a similar account stating, “my school was open to really any solution that would work; that would help ameliorate student barriers to being successful.” A different participant reported that an administrator with whom she had worked was very open to bringing in experts to share their knowledge with teachers at the school. Another participant related that her schools were “always wanting to hear from new people.” Another participant similarly reported, “I think within the LSRT that they were awesome about trying new things. If I made any recommendations they were mostly receptive to it, and they would get on it.”

Conversely, one participant discussed the lack of openness and willingness to explore new ideas exhibited by the faculty in one of her assigned schools. This participant stated that one of her schools “was not very interested in learning from any professional, whether it be from our program, or outside professionals. They did not want to discuss any new ideas whatsoever.”

Using groups and presentations to address school and student needs.

Several participants noted the use of psychoeducational groups to address identified needs within their schools. A participant reported that LSRT members identified common issues among their populations, such as anger management and social skills, and brought these needs to the attention of the LSRT to develop a psychoeducational group. This participant also stated that the LSRT members were “very effective in using those interventions to address [the identified] issues.”
Another participant explained this concept in detail, stating the following:

> If we needed a girls' group, we would have someone come in from Girl Talk or other agencies to address any needs the girls had. We could come together, and talk and figure out the specific needs. We identified a specific need last year there for a lot of parental education on certain things, such as identifying there was a lot of cutting going on in the schools. So the social worker and I developed a presentation for the parents and addressed: What are the risk factors? What do you do when you notice this? What's going on? We were able to bring in some extra help for that particular need, and the school was very open to identifying those needs, very good at doing that.

Further, this participant indicated that she was asked to offer presentations to address faculty-related needs. Similarly, another participant reported that the creation of parenting classes and a substance-abuse presentation to educate parents in one of her schools was "very successful."

Family involvement.

As discussed in Dryfoos (1994, 1995), a family's ability and willingness to seek evaluation and/or treatment for their child is key. Half of the participants made note of the importance of family participation in determining the outcome of their interventions. A participant discussed being "thrown out there" to solve problems with a child despite having minimal interaction with the parents. Another participant described lack of parental involvement as the largest barrier she encountered at one of her schools. In discussing this matter, she stated the following:

> A lot of times I would develop great treatment plans, and the teacher might be receptive to trying some new things in the classroom. When the child would go home to the same circumstances, nothing would change. And so, you could see glimpses of progress, but for some of those kids, without their families changing, we weren't going to see huge improvements in behavior.

A different participant identified family buy-in as a main challenge, reporting that members of the LSRT often found themselves thinking, "we're all working harder with this child than the family is."

Theme five: The need for in-house mental health therapists.

Participants were asked to offer suggestions for the sustainability of school-based mental health services. Four of the participants specifically suggested the implementation of on-site mental health therapists to address student needs. One recommended the implementation of an in-school mental health therapist to "to provide in-school services, to be there for crisis management" and "to be available as an adjunct to the social workers and the counselors." Another argued for the hiring of on-site therapists so that students can be served in the school setting, as opposed to being served by private providers. Similarly, another participant also championed the hiring of more mental health personnel. She argued that whereas school counselors are trained in "preventative guidance lessons," mental health personnel would be helpful in offering students short-term counseling services. Another participant expressed a similar point, arguing that clear policy needs to be established to distinguish between the roles of guidance counselors and mental health professionals.

As a caveat to this discussion, several participants noted the funding implications of implementing additional mental health personnel. One participant noted, “I guess, the main obstacle would be finding funding, through grants or private providers to be able to hire somebody to do this job full-time.” Another participant offered, “I would recommend—particularly for the Title I schools—that they use discretionary funds to have a mental health therapist on staff, whether it’s a contractor that comes one day a week, or a full-time position.” A different participant maintained that by recognizing the value of mental health services and the need for student support, schools might be more apt to locate funding for these services.

Quantitative Analysis

Data management.

To examine the statistical correlation between the perceived collective efficacy to establish mental health services and the number of mental health referrals for each school over the course of 4 years, data were collected from 35 LSRT participants. A composite score was created to measure perceived efficacy, and Cronbach's alpha reliability testing was conducted on this newly created subscale. George and Mallery's (2010) guidelines for Cronbach's alpha reliability were used, where reliability $\geq .90$ is excellent, $\geq .80$ is good, $\geq .70$ is acceptable, $\geq .60$ is questionable, $\geq .50$ is poor, and $< .50$ is unacceptable. The collective efficacy score was created as the mean of all survey items, and had a Cronbach's alpha reliability of .94, indicating an excellent degree of reliability for this scale.

Sample information.

Data were collected from 35 LSRT participants with nearly equal amounts from elementary (n = 13, 37%), middle (n = 12, 34%), and high schools (n = 10, 29%). Referrals were counted from the participants' respective schools over the course of 4 years, and these values ranged from 16 to 124, with an average of 80.37 referrals in 4 years (*SD* = 35.17). The proportional representation of each school type is presented in Table 2, while the spread and central tendency for the number of referrals are presented in Table 2.

Table 2

Frequencies and Percentages for Nominal Variables

Variables	*n*	%
School Type		
Elementary	14	37
Middle	12	34
High	10	29

Note. Due to rounding error, percentages may not add up to 100.

Table 3

Means and Standard Deviations for Continuous Variables

Variable	*M*	*SD*
Referrals	80.37	35.17

Data Analysis

To statistically examine the research question, a Pearson product-moment correlation was conducted. Scores for each participant's overall perception of his or her school's efficacy in establishing mental health services was assessed for a correlation with the school's number of mental health referrals. Prior to analysis, the assumptions of the Pearson product-moment correlation were assessed. The Pearson correlation assumes that data is normally distributed about the line of best fit between the two variables, and that error terms are nearly equal from one end of the line to the other. These assumptions are known as normality and homoscedasticity, respectively. Both assumptions were assessed using scatterplots, and the assumptions were met.

Results of the Pearson product-moment correlation indicated a significant correlation between participants' perceptions of schools' efficacy in successfully establishing mental health services and the number of mental health referrals that were actually generated (p = .003). Using Cohen's (1988) guidelines for interpreting correlation coefficients, the coefficient of .48 indicated a medium (but almost large) positive association. Thus, as perceptions of collective efficacy increased, the number of referrals increased in tandem. Table 4 provides results of this analysis.

Table 4

Pearson Product-Moment Correlation between Referrals and Collective Efficacy

	Referrals	
	p	***r***
Collective Efficacy Perceptions	.003	.48*

Each theme from the qualitative results was examined for corresponding items on the efficacy assessment. Themes one through four corresponded with specific items on the assessment, while theme five did not correspond with any, and was not included in the following analyses. To examine the relationships between these themes, as represented by the efficacy scale's items, four additional Pearson product-moment correlations were conducted—each assessing one theme's relationship with referral rates.

The first identified theme from the qualitative interviews indicated that participants felt unique dynamics within the LSRT contribute to productivity and effectiveness. Theme one was represented through questions 5, 8, 17, 18, and 19 on the survey instrument:

- Meet regularly, even in times of work overload
- Perform effectively all tasks, even with limited resources (i.e., financial, technical, personal)
- Learn from more experienced colleagues, even those who are not in our chosen profession
- Provide our school with high-quality mental health services despite the scarcity of resources (i.e., funds, personnel)
- Simplify bureaucratic procedures to reduce student wait time for services

A Pearson product-moment correlation was conducted between this newly created scale and the number of referrals, and the results indicated a significant correlation (p = .010, r = .43). Using Cohen's (1988) guidelines for interpreting correlation coefficients, the coefficient of .43 indicated a medium positive association. As endorsement of this theme increased, referrals for the respective school also increased.

The second identified theme from the qualitative interviews indicated that participants felt interpersonal relationships must be navigated to improve the cohesion and efficacy of the LSRT. This theme was represented through questions 7, 9, 10, 11, and 12 on the survey instrument:

- Respect all members, even those I perceive as less likeable
- Support each other, assuring our maximum effort to pursue our goals
- Keep a good work climate, even during tense moments
- Leave aside our personal needs to meet the needs of others
- Share our experiences—not only the personal ones, but also the professional ones

A Pearson product-moment correlation was conducted between this newly created scale and the number of referrals, and the results indicated a significant correlation (p = .001, r = .55). Using Cohen's (1988) guidelines for interpreting correlation coefficients, the coefficient of .55 indicated a large positive association. As endorsement of this theme increased, referrals for the respective school increased.

The third identified theme from the qualitative interviews indicated that participants felt the misunderstanding and misalignment of goals within the LSRT can significantly hinder the group's success. This theme was represented through questions 1, 2, 3, 4, and 13 on the survey instrument:

- Assure we give our maximum effort in order to overcome obstacles
- Define a common working strategy by taking into account suggestions from all members
- Involve all colleagues to attain common goals, even the most individualist among us

- Implement the most suitable strategy to attain our goals
- Practice problem solving, even for the most difficult mental health issues raised by our LSRT

A Pearson product-moment correlation was conducted between this newly created scale and the number of referrals, and the results indicated a significant correlation (p = .022, r = .39). Using Cohen's (1988) guidelines for interpreting correlation coefficients, the coefficient of .39 indicated a medium positive association. As endorsement of this theme increased, referrals for the respective school increased.

The fourth identified theme from the qualitative interviews indicated that participants reported a high degree of self-efficacy in the provision of services using novel and need-based interventions. This theme was represented through questions 6, 14, 15, and 16 on the survey instrument:

- Manage student mental health concerns effectively
- Find alternative solutions to quickly address the need for mental health services
- Put into practice new solutions to mental health issues, even when we have well-established procedures
- Simplify the implementation of mental health services by using new methods and/or technologies

A Pearson product-moment correlation was conducted between this newly created scale and the number of referrals, and the results indicated a significant correlation (p = .034, r = .36). Using Cohen's (1988) guidelines for interpreting correlation coefficients, the coefficient of .36 indicated a medium positive association. As endorsement of this theme increased, referrals for the respective school increased.

Results of the correlation analyses between the four themes and referrals are presented in Table 5. Figure 1 provides a visual representation of the strength of each theme's correlation with referrals.

Table 5
Pearson Product-Moment Correlations between Subscales for the Four Themes and Referrals

	Correlation with referrals	
Subscale	*r*	*p*
Theme 1	.43	.010
Theme 2	.55	.001
Theme 3	.39	.022
Theme 4	.36	.034

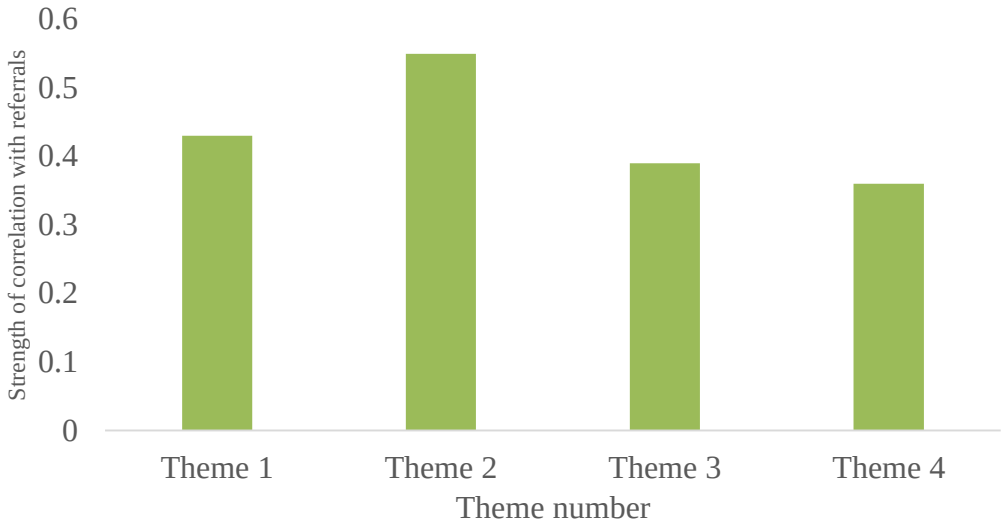

Figure 1. Pearson's *r* strength of correlation with number of referrals.

Summary of Qualitative and Quantitative Analysis

A clear correlation between perceived collective efficacy in a given school and the actual number of referrals generated has been shown in this study. Qualitative and quantitative data provided both personal perspectives and positive correlations about the

implications of group dynamics and how they influence group collective efficacy. Bandura (1997) wrote that the key components of collective efficacy include mission and purpose, strength, and common commitment, as well as the ability for a group to work together to produce positive results. It has also been discussed that behavioral, personal, and environmental factors—known as Bandura's triadic reciprocal determinism—influence how individuals function within an organization and its goals (Crothers, Hughes, and Morine, 2008).

Within the context of this study, the commonality among the schools and school-based therapists that participated was the implementation of mental health services within a school setting. Specifically, this was the primary purpose of the LSRTs within individual schools. Strength, commitment, and the ability of the LSRTs were clearly identified from the themes that emerged. Additionally, the individuals within LSRTs and their influence on the overarching goal of implementing school-based mental health services were also discussed. As previously identified by Goddard (2001), collective efficacy is linked to the "norms" of school environments. This study ascertained that when a school set the expectation to successfully implement school-based mental health services, it was more likely there would be a cohesive LSRT. Teams in schools with clear expectations for success not only believed in the importance of providing services to students in need but also worked collectively to achieve success. Quantified data showed a positive correlation between greater perceptions of collective efficacy and the amount of referrals generated from these schools. Likewise, lower rates of collective efficacy resulted in fewer referrals generated.

These personal insights and correlations also gave credence to how relational theory is applicable to group relationships. Embedded in relational theory are the concepts of empathy and introspection, which create a framework to better understand how individuals and groups create their own realities. Each of the LSRT members presented with different professional backgrounds that shaped their approach to implementing school-based mental health services. Ideally, each LSRT should have taken a multidisciplinary team approach to address the mental health needs of students and the schools at large. Successful LSRTs affirmed the importance of each team member's contribution. Additionally, new ideas were more readily considered and the buy-in of administrators was paramount. When there was fragmentation in an LSRT between disciplines and service implementation, the reality was that implementation and service delivery were secondary to primary job responsibilities and overcoming obstacles proved to be difficult.

Before data collection and analysis, this researcher had not considered the personal understanding and experience that would be gained from working through the lens of relational theory. The research became two-fold, understanding the concept of collective efficacy from the experience of the participants and also that personal meaning was attached from the communication that occurred between the researcher and the participants during the qualitative data collection. All of the participants were asked the same questions, yet each interview experience had unique characteristics.

As an experienced clinician, the researcher found that the interviews conducted with the more experienced clinicians were smoother and easier to understand. The context in which they described their experiences was relatable based on the researcher's

similar experiences. The researcher found personal significance in the trials and tribulations as well as the process from which these clinicians drew meaning and understanding. The less experienced clinicians were more hesitant with their answers and did not include as much elaboration. The researcher had to consider her role in this hesitancy, such as whether the participants felt intimidated and responded accordingly or how the professional experiences of the researcher and participants differed. A fundamental premise of relational theory is that understanding the purpose and meaning of interactions with others depends on the relevance it has on our past and present life experiences. Yet despite the noted differences in the interview process, there was a common need for all of the participants to convey their experiences and for the researcher to understand and connect with them.

Chapter V

Discussion and Conclusion

Discussion

The data collected from both the therapists and school LSRT members used in this study substantiated the overarching research purpose of determining the relationship between perceived levels of collective efficacy and the successful establishment of mental health services and the number of mental health referrals actually generated by the identified schools. Subsequently, the concept of collective efficacy has been applied to relational theory in a broader perspective. Bandura's social learning theory and relational theory are social constructivist in nature as both draw from the basic premise that people create meaning through interactions with each other and objects in the environment. The epistemological overlap of these theories includes the belief that our realities are constructed through human interaction and it is through these interactions that social structure is formed.

While relational theory is most commonly used to better understand the therapeutic dyad, its concepts can be expanded to group dynamics as they relate to organizational systems, including schools. In *Relationality: From Attachment to Intersubjectivity* (2000), Mitchell discusses that human connectedness is most evident through affect and behavior. Not only are we regulating our own affect and behavior, but our behavior also shapes the responses others have toward us. As such, the line of

distinction between the "I and You" dyad becomes blurred, creating an I-you dyad. Mitchell (2000) writes:

> Powerful emotional experiences are registered in a fashion in which what I am feeling and what you are feeling are not sorted out independently, but rather form a unity, the totality of which I experience as me… [and]…actions and interactions function without an organized conceptualization of self and other. On this level, the question, "Who started it?" is meaningless, because the actions of each participant have evolved, through microadaptations, in complementarity to those of others (p. 62).

Relational theory in its traditional form is a relational configuration between "the self, the other, and the space between the two" (Mitchell, 1988, p. 33), meaning the poles of self and other depend on each other. Objects cannot be internalized without a self; there is no self without a matrix of relationships; and both the self and object need psychic space to fulfill their roles. Mitchell further explains that we, as humans, strive to sustain relational configurations: "There is a powerful need to preserve an abiding sense of oneself as associated with, positioned in terms of, related to, a matrix of other people, in terms of actual transactions as well as internal presences" (p.33). Using Bandura's central guiding element of social cognitive theory—as previously discussed by Crothers, Hughes, and Morine (2008)—the self is created from the triadic reciprocality between behavior, cognition, and the environment. These factors represent components of a system. "From the relational theory perspective, the components at the personal level are, self-reflection, empathy, symbolization, and self-regulation. At the group level, they (the components) are experience of mastery, empathy, social persuasion, and affectivity"

(personal communication with J. Palombo, January 19, 2015). Effectively, both social cognitive theory and relational theory recognize that a person's behavior (individual) and environment (system) simultaneously create and affect each other.

Both of these configurations lend themselves to the exploration of how the self relates in a collective group or system. Collective efficacy centers on the shared belief of a group's capability to create change. Similarly, relational theory focuses on interpersonal interactions to catalyze change. Just as in individual therapy, groups and/or systems cannot experience change until they know what is in the way of change. This research has focused on how collective efficacy can drive the performance of a group toward optimal, or less than optimal, success. The personal perspectives of the therapists interviewed allowed for an intimate look at the inner workings of the LSRTs, and how individuals may have influenced how the LSRTs operated. The ultimate goal of successful service delivery was dependent on how these groups functioned as a team.

Themes one and two: Dynamics within an LSRT and interpersonal relationships within an LSRT.

Mitchell (1988) writes that relational configurations can be comprised of both individual and group interpersonal relationships. It is through social context that individuals comprehend the significance of how they understand themselves, how they perceive others, and how to relate interpersonally (Mitchell, 1988). The qualitative themes that emerged from the findings—indicating that unique dynamics exist within LSRTs and contribute to productivity and effectiveness and interpersonal relationships must be navigated to improve the cohesion and efficacy of an LSRT—underscore

Mitchell's views by showing that these interpersonal relationships contribute to overall collective efficacy. Bandura (2001) writes, "perceived collective efficacy is an emergent group-level property, not simply the sum of the efficacy beliefs of individual members" (p. 14). Ultimately, groups have to rely on their members to accomplish goals. Groups or systems cannot perform all desired functions without the interpersonal relationships of their members. There were schools in which therapists reported that their perceptions that collective efficacy in the LSRTs was not strong. This information suggests that poor relationships or lack of relationships within LSRTs hinders group cohesion, ultimately affecting outcomes for students in need of mental health services. Data from the study demonstrate that lower collective efficacy scores produced lower referral rates.

A fundamental foundation of relational theory is that individuals are inherently interactive with others and instinctively pursue social and emotional ties outside of the self. Likewise, collective efficacy is a social construct in which the environment plays as much of a role as belief in oneself (Bandura, 2001; Tschannen-Moran & Barr, 2004). Interview participants generally agreed that the schools in which they worked were interested in new ideas and solutions to address the mental health needs of their students. Within the relational model, awareness and change come through "not knowing" and "wondering together." School leaders who encouraged sharing the knowledge that was available through the multi- disciplinary team approach of the LSRTs also encouraged "wondering together." This created a platform of relating to one another through both experience and opinion, which opened discussions for addressing the mental health needs of students. The connections created among team members stimulated change within the LSRT system. The schools where LSRTs did not meet regularly and were not willing to

consider new ideas did not lend themselves to change. This resistance stifled the beliefs of team members regarding the possibility and importance of change in implementing mental health services.

Contemporary relational theorists have argued that in the relational matrix, individuals are shaped by the patterns of the prevailing culture (Bonovitz, 2005; Layton, 2002, 2004). Stern (1997) supports this understanding about the relational perspective of human experience by writing that it is "the joint creation of interacting influences from within and without—from the ephemera of social life and the more enduring structures of one's inner world" (quoted in Bonovitz, 2005, p. 59). Efficacy is also interdependent with the social environment. Levels of motivation, affective states, and actions are based more on what a person believes rather than what is objectively true (Bandura, 1997). In the context of both relational theory and collective efficacy, social interactions influence and shape the goals and outcomes of people's lives.

As previously mentioned, the therapists in this study were ultimately responsible for the oversight and leadership of the LSRTs. Leadership inexperience or apprehension of being in a leadership role can greatly affect group success. Participants in the quantitative survey supported the need for leadership by indicating that positive working environments (even during tense moments), sharing personal and professional experiences without fear of backlash, and respecting all LSRT members—including those perceived as less likeable—were needed for positive collective efficacy.

A leader needs to be aware of these potential conflicts and have the ability to help teams navigate interpersonal relationships. This research would benefit from further discussion with the therapists to explore how their leadership style and organizational skills influenced their LSRTs.

Theme three: The misunderstanding and misalignment of goals.

Continuing with the concept of how personal experiences and societal influences impact the social world, another theme that emerged was that the misunderstanding and misalignment of goals—specifically, being open to solutions and ideas for mental health services—varied in the schools that participated in this study. The therapists interviewed discussed how administrators affected the culture of the schools; if administrators placed importance on addressing mental health needs, LSRTs exhibited a stronger team effort toward implementation. Quantitative data also substantiated this theme through participant responses indicating that when an LSRT misunderstands and/or misaligns goals, its success is significantly hindered. When maximum effort was given to overcome obstacles, establish a common working strategy and resolve difficult student mental health issues, overall collective efficacy increased.

Administrators who took a peripheral stance in implementing mental health services set a negative tone for the LSRTs, which resulted in an unclear understanding of program criteria and discouraged LSRTs from meeting regularly. The subjective world of one person—in this case, the administrator—had the capacity to either positively or negatively influence members in an LSRT group. Similarly, the quantitative results in this study corresponded with the theme in that the misalignment of goals corresponds to

lower collective efficacy scores and referrals. Hence, negative views of administrators directly impacted the views of LSRTs, leading to fewer referrals.

Theme four: Self-efficacy found in novel and need-based service provisions.

Another theme that emerged was that therapists reported a high degree of self-efficacy in the provision of services when they used novel and need-based interventions. This theme was affirmed in the qualitative data by therapists, and includes responses related to personal efficacy, LSRTs openness to solutions and ideas, and how family involvement influenced therapeutic interventions. Clinicians reported that they had a high degree of confidence in their ability to deliver therapeutic services to students. Their confidence decreased the worry that inadequate or inappropriate services would be provided and increased trust that mental health interventions were likely to yield positive results from students. As Armbruster (1997) discussed, if clinicians are trusted by the school system to provide quality mental health services, the parents of students needing these services are more likely to trust the clinicians as well. Perhaps one of the most poignant thoughts conveyed by the one of the therapists was that a school could be a cohesive team and have the desire to help students in need, but no matter what the school did, a family might not be receptive to making positive changes in how they interact with their child. Mitchell (1988) wrote, "the person is comprehensible only within the tapestry of relationships, past and present…the figure is always in the tapestry, and the threads of the tapestry (via identifications and introjections) are always in the figure" (p. 3). The school, for children, is just one thread in the tapestry of their lives.

Conflict is implied in relatedness, and relational-model theories use relationship connections and patterns to find meanings and solutions (Mitchell, 1988). Bandura (1993) described people with social efficacy as being able to seek and build relationships that help reduce the impact of stressors. A staff that builds professional and personal relationships reduces each member's stress and, therefore, empowers efficacy building. A team effort to identify and address the mental health needs of students is beneficial for any educator with whom students interact. This effort required LSRTs to be open to new solutions and ideas for addressing mental health needs.

Theme five: The need for in-house mental health therapists.

A final theme identified the institution of on-site mental health therapists as the most important factor for the sustainability of mental health services. The therapists interviewed for this research were responsible for introducing and implementing school-based mental health services in their assigned schools. Each therapist was cognizant of the fact that implementation was time limited, as the grant funding was only budgeted for a specific amount of time. While there was common frustration regarding the processes of implementation and leading the LSRTs, the therapists agreed that the services they provided were very much needed. Therapists recognized the need to have a "go-to" person to provide crisis management and advice regarding the mental health of students. While many school social workers, counselors, and psychologists are trained in this area, their job descriptions do not allow for mental health to be their primary focus. For some of the therapists, push back and disinterest from the other counseling professions stemmed from the lack of policies differentiating the therapists' role from the roles of the

other counseling professionals. The theme regarding on-site mental health therapists was indeed seen as important by the therapists.

Establishing on-site mental health therapists would require a paradigm shift for school systems. This shift would need to primarily focus on overcoming the obstacle of finding money to permanently fund therapists. The inclusion of therapists in school funding would also require the establishment of clear policy regarding who would provide the services as well as how school-based services would be incorporated into the educational system, which would require numerous systemic changes. The concept of change, in the relational model, emphasizes interaction and intersubjectivity. Intersubjectivity, a term coined by Atwood and Stolorow (1984), is the interaction and interplay between subjective worlds. There is an intrapsychic understanding that intersubjectivity is where human experiences take place. The intersubjective world is overwhelmingly dependent on the context of one's personal world and experiences. Thereby, the construction of larger social meanings is tied to individual intersubjectivity. The conditions for change begin with personal views and how they coincide with the views of others.

Relationship building within each of the schools was crucial for the success of mental health services. Therapists noted that each school had its own culture, and they found they had to adapt to each school differently. The group experience changed when new members were added and when members left. Some of the participants also noted that there were administrative changes in their schools during the course of their tenure. As a result, there was an added challenge of continuing the momentum of successful service delivery if a new administrator was not as receptive as the previous one. Ongoing

support is needed from administrators, as they are ultimately responsible for the day-to-day management of their schools.

Limitations of the Study

There have been numerous studies that have documented collective efficacy and its contributions toward group processes and performance (Gully et al., 2004). This was a phenomenological study that focused on perceptions of collective efficacy and how they influenced the implementation of mental health services within a specified cluster of schools. The sample size of schools, educators, and therapists used in this study was fitting for the identified school district and the federal grant awarded to the district to implement mental health services. While the findings in this study were significant based on the central research question, the results may not be generalizable even if the study design were duplicated. School districts, in general, vary in their guiding principles, mission statements, and visions. Additionally, the population size and student demographics of the schools used in this research may not be similar in a duplicate study. Districts that are awarded similar grants for school-based mental health implementation may differ in their overall rules, regulations, and guidelines. The utilization of grant money and identification of schools as beneficiaries for implementing school-based mental health services may also vary.

The need for school-based mental health services is subjective. Research shows that numerous successful mental health interventions have been utilized in school systems. However, there has been no formal consensus on how to address marrying the education of students and the school-based mental health services they need. This study

was not addressing specific interventions or their results, which may have influenced the collective efficacy perceptions of the schools. The efficacy levels of the schools might be different if specific interventions were being used and measured.

It should also be acknowledged that there was potential for bias based on the proximity of firsthand knowledge from working as a therapist in the school system; however, at the time of this research, the researcher had not been employed within the school system for over two years and her professional relationships with school personnel were no longer those of work colleagues. Although the survey instrument was anonymous and the interviews were confidential, there is the possibility that participants may have stated or answered questions in a way that leaned toward what they thought the researcher wanted to hear. Although this researcher believes that bias was not detected, it would be beneficial to duplicate this study with the same or similar participants to determine if the results are comparable. Further, duplicating this study with several schools from different districts would validate findings and be beneficial to future research on collective efficacy.

Implications for Social Work Practice and Policy

Social workers are agents of advocacy and change. As such, they encourage clients to analyze and contemplate not only how personal decisions influence their lives, but also how the world at large can influence these decisions. The practice of clinical social work should not be defined only as a one-on-one relationship with a client and their subjective world. Clinical practice should also include the fundamental practice of advocacy. Clinical social workers are revered for their multi-faceted abilities to practice

their profession and to stimulate change. An important aspect of this study highlighted that clinical social workers can be expected to implement new ideas and practices. Clinical skills and expertise are needed to make the process successful. The root of advocacy, in this research, was to make sure that students who needed mental health services received them.

Schools are non-traditional venues for both the provision of therapeutic services and for mental health therapists to be based. Clinical social workers must work with multiple disciplines in school settings, such as counselors, psychologists, and educators, whose underlying focus is education. While the education of students is important to school-based therapists, mental health is their underlying focus. School systems are beginning to recognize that the mental health needs of students significantly impact their ability to learn. Additionally, it is acknowledged that not all children and their families are able to access outside resources to address these concerns. With priority placed on the requirements for schools to meet academic achievement levels, meet testing guidelines, and ensure student attendance, resources are few and budgets are thin. Clinical social work practice often takes a backseat in the educational arena.

Appropriate evaluations are needed to identify mental health issues, and clinical social workers are capable of providing such evaluations within a school setting. Furthermore, the ability to provide the needed services falls within the realm of a school-based clinical social worker. This study shows that when outside money can be allocated for school-based mental health services, the door for service provision opens. Understanding that each discipline that comprises an LSRT has its own guidelines and that the professionals within these disciplines bring their own perspectives and practical

experiences to a group is paramount. However, it takes a professionally skilled leader to ensure that these multiple disciplines share a common goal—and, more importantly, to ensure that the goal is achieved. The expertise of clinical social workers includes group management, policy creation and implementation, conflict resolution, and creative thinking, all of which are required when implementing programs such as the school-based mental health services discussed in this study.

Conclusion

A relational theory perspective allows clinical social workers to expand the traditional therapeutic dyad into group relationships. Human beings and their environments are interdependent; they shape and are shaped by one another. With this understanding, a clinical social work perspective can acknowledge that intersubjectivity is not confined to existing social relationships or one-on-one relationships but can also expand to the possibility of social change. There is a unique yet complementary dichotomy between relational theory and collective efficacy. In this study, a mental shift was needed between the ideas for implementing school-based mental health services and actually implementing them. This was a natural fit, or way of thinking, for some LSRT members. For others, however, an adjustment was needed in how they viewed school-based mental health services. It can be concluded that when there was a collective "mental shift," the collective efficacy of the LSRTs was more likely to be higher.

Based on relational and collective efficacy theories, the anticipated findings that greater group cohesion within an LSRT and overall feelings of collective efficacy generated more referrals were indeed revealed. Thus, the overarching research question of finding a relationship between perceived levels of collective efficacy of individual

schools and school-based therapists and referral numbers was supported. This research should also have considered the assumption that more referrals equated to a more successful implementation of school-based mental health services. This researcher was focusing on higher numbers of referrals along with higher levels of perceived efficacy as the indicators of success. While group efficacy and how LSRT members relate to one another are arguably the most important factors to successful implementation, individual perceptions of success should not be overlooked. Therapists, as found in the emerging qualitative themes, reported a high degree of self-efficacy in their provision of services through the use of novel and need-based interventions. Success, for them, could also be found on the micro-level of individual therapy provided to the students in their schools—not necessarily in the number of students they served.

Collective efficacy, as related to overall group success, has been researched and documented in numerous studies since Bandura proposed this concept as an extension of his social cognitive theory. Reinforcing literature cited earlier in this research, Bandura (2001) stated, "organizations have to be fast learners and continuously innovative to survive and prosper under rapidly changing technologies and global marketplaces. They face the paradox of preparing for change at the height of success. Slow changers become big losers" (p. 11). In order for school-based mental health models to be considered successful, policy makers, school personnel, and funding sources must be cognizant of what they consider success, and make changes as needed to ensure that their goals are met. Successful school-based mental health programming has been researched in conjunction with group beliefs that change can occur if everyone works together toward a common goal. This speaks to how a system can change, as defined by Bandura above.

The value of this study is that another example of how collective efficacy works has been reported, in consideration of how individual personality traits and realities influence group efficacy and/or systems. Policy makers and school personnel can use this information when considering and evaluating how these realities may influence program implementation and future funding decisions.

Implementing school-based mental health services should be a thoughtful process to ensure the full support of individual schools as well as school systems as a whole. School personnel responsible for service implementation and delivery must be included in the program design for their schools. A recommendation for funding sources prior to investing in program development would be to measure group cohesion as a potential marker for positive outcomes. Additionally, training school personnel, especially those providing direct services, on best practice strategies will increase the motivation and utility to refer students that are in need of mental health services. Collective efficacy should be evaluated on a regular basis to ensure that areas of concern in regards to group solidarity and functioning are identified and addressed.

Clinical social workers understand that they must recognize the personal perspectives of others and how these perspectives can affect the cohesiveness of a group. Ultimately, there was a need for children to receive mental health services within their schools. This should not be dependent on whether a group deems it important enough to acknowledge. It is crucial that the mental health needs of children are met. Not only can clinical social workers assist teams of professionals in achieving this goal, they can also provide these much-needed services.

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