Perceptions of the effectiveness of school-based services among mental health therapists

Jolene-Fe Caguicla Balancio
Suzette Carolina Covarrubias

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PERCEPTIONS OF THE EFFECTIVENESS OF SCHOOL-BASED SERVICES AMONG MENTAL HEALTH THERAPISTS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Jolene-Fe Caguicla Balancio
Suzette Carolina Covarrubias
June 2013
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ABSTRACT

The purpose of this research project was to gather the perceptions of mental health therapists regarding the effectiveness of providing school-based services to children and adolescents in grades K-12. The methodology used in this study included face-to-face interviews with fourteen mental health therapists from diverse educational backgrounds and various fields of practice. The type of data used in this study was qualitative and descriptive. Results from this study indicated that school-based services were most effective when they were consistent with the natural environment and led to a sense of empowerment among the clients who receive these services. This study recommends that future studies pay particular attention to the benefits of school-based services in natural environments.
ACKNOWLEDGMENTS

First we would like to acknowledge Mathew Judd, Program Director at Pacific Clinics, Ontario Region for allowing us to conduct our study and for his continued support and encouragement in our educational development. In addition, we would like to acknowledge all the participants in the study who work hard every day to empower children and adolescents through school-based services. We would also like to thank Dr. Thomas Davis, Associate Professor at California State University, San Bernardino, for all the help, guidance, and laughter that eased our stress in order to complete this project. Lastly, we want to acknowledge our cohort, an amazing group of women who showed dedication, hard work, and unconditional support these past two years.
DEDICATION

I would like to dedicate this project to my parents Maria-Fe and Henry Balancio, for instilling in me the values and confidence to be able to pursue my passion of Social Work. Their unconditional love and support has made me into the person I am today. I would also like to dedicate this project to my siblings Jillian, Jamie, Justin, and Rich who have been my support system throughout the entire program. I love you all so much. Lastly, I want to thank my research partner and friend, Suzette Covarrubias. WE DID IT! (Jolene Balancio)

I would like to dedicate this project in loving memory of my grandmother Maria Flora Covarrubias, one of the women who helped me become the person that I am today. I know that you would have been proud of everything I have accomplished so far. I would also like to dedicate this to my mother Esther Covarrubias, my grandfather Constantino Covarrubias, who provided me with unconditional love and support. Lastly, I would like to thank Jolene Balancio for being an amazing researcher partner and friend. Your support and encouragement is what kept me sane throughout this experience. (Suzette Covarrubias)
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CHAPTER ONE

ASSESSMENT

Introduction

The purpose of this research project was to gather the perceptions of mental health therapists regarding the effectiveness of providing school-based services to children and adolescents in grades K-12. This project focused on the perceptions of the effectiveness of school-based services among mental health therapists from diverse educational backgrounds, including Masters of Social Work (MSW), Licensed Clinical Social Workers (LCSW), Marriage Family Therapist (MFT), and Psy D’s.

There are a variety of mental health services that are used among school-aged children and adolescents. By approaching this research from a constructivist paradigm, qualitative data was gathered through interviews from the key informants. Data gathering allowed the key informants to build a construction as to what were the most effective services for school aged children and adolescents grades K-12. The literature explored the different mental health services offered to children and adolescents grades K-12 including school-based and
in-home individual and family therapy, case management, on site psychiatric care, and group therapy. The theory of reasoned action (TRA) was the theoretical orientation in which this located. The results of this research can contribute to social work practice by bringing forth practical knowledge of mental health services that helps contribute to bettering school-based services among children and adolescents.

Research Focus and/or Question

The focus of this project was to identify the perceptions of the effectiveness of school-based services among mental health therapists. This project allowed mental health therapists to share their experiences in working with children and adolescents grades K-12.

Paradigm and Rationale for Chosen Paradigm

In order to gain a better understanding of the perceptions of mental health therapists in providing effective school-based services, it was necessary to contact the key informants who work the closest to children and adolescents grades K-12. These key informants were mental health therapists. The constructivist paradigm allowed for the creation of a
The hermeneutic dialectic circle, which was formed once there was participation from the key informants.

The constructivist paradigm allowed for qualitative data to be gathered through various interviews in which the hermeneutic circle was able to build a subjective construction as to what were the most effective aspects of services when working with school-aged children and adolescents grades K-12. This was the most effective paradigm for this research topic due to the achievement of heavy interaction among the key players and real-life examples of the therapist's experiences in providing these services out in the field.

Literature Review

As stated in the sections above, the focus of the study was to gain insights into the perceptions of mental health therapists who provided school-based services to children and adolescents grades K-12. This section will provide a construct on what is currently found in the literature about school-based services provided to children and adolescents grades K-12. The different mental health services are provided and their importance will be addressed.
Addressing the mental health of children and adolescents grades K-12 is key to ensuring a student’s ability to thrive to their full potential. According to Mellin (2009), one in five children have a DSM-IV TR diagnosable mental health disorder, most of which can cause the child to have significant impairment in family and peer relationships as well as home and school functioning. Reback (2010), states that almost eighty percent of the children and adolescents needing services do not get treated. When proper treatment is not provided, it is likely to affect the child’s educational attainment and puts the child at greater risk for delinquency later on in life (Reback, 2012). In fact, it is estimated that about seventy percent of juvenile delinquents have a mental health disorder (Mellin, 2009).

As described above, the lack of mental health services among children and adolescents may lead to impairments in daily functioning, as well putting the child at higher risks later on in life. However, receiving treatment is not always simple. According to DeRigne (2010), parents of children who are uninsured, report that the lack of health insurance is the number one reason for their child’s mental health needs are not
being met. The high cost of mental health services, makes affording such services difficult for low income and middle class families. However, there are various mental health service programs that are offered for children and families who qualify for Medi-Cal. Many non-profit agencies also provide services on a sliding scale for those families who are low income but are not eligible to qualify for Medi-Cal.

Mental health therapists usually provide an array of services to help meet the mental health needs of children and adolescents grades K-12. The services will be discussed further, in terms of how they are applied when working with this population.

In-school Mental Health Services

School-based mental health services among children and adolescents have increased over the years (Gampetro, Wojciechowski, Amer, 2012). Schools have begun to recognize the impact mental health issues have on a child’s academic performance. In-school services/clinics have grown tremendously out of necessity, from one hundred and twenty in 1980 to over seventeen thousand
school-based clinics in 2005 (Amaral, Geierstanger, Soleimanpour, & Brindis, 2010).

The clientele of in-school mental health services typically present with a various range of problems like poor academics, disruptive classroom behaviors, strained relationships among peers and family, and lack of autonomy (Gampetro, Wojciechowski, Amer, 2012). In-school services are also no stranger to a variety of DSM IV-TR diagnoses from depression and oppositional defiant disorder to Attention Deficit Hyperactivity disorder (ADHD) and bi-polar disorder (Cautilli et al., 2004). Studies show that eighty percent of students, who are in need of mental health services, never get treated due to reasons such as lack of time and transportation, cultural stigma, and/or cost of treatment (Amaral, Geierstanger, Soleimanpour, & Brindis, 2010).

Individual treatment at the schools eliminates transportation issues and students are able to utilize services during school hours (Guo, Wade, Pan, Keller, 2010). Demographics and populations who typically do not seek treatment are able to partake in services offered on the school’s campus. With barriers related to cost, 50-90% of in-school consumers are of low-come status and
uninsured (Guo, Wade, Pan, & Keller, 2010). Despite this fact, students are still receiving effective school-based services through evidence-based practices conducted by mental health therapists. Such services enhance the quality of care and effectiveness across cultures, ethnicities, age, and gender of the students (Kratochwill et al., 2012). Even though such services could be expensive, schools strive to make treatment cost effective and attainable for all students. School-based mental health services are able to gain support from the federal government, Medicaid and other health insurance companies to continue to provide in-school services (Guo, Wade, Pan, Keller, 2010).

According to Hoagwood et al. (2007), since treatment is based in school, there is a greater connection between the mental health services and classroom functioning. Whatever services that are being used or skills that are being taught during treatment, can also be replicated and monitored by teachers in the classroom. This type of collaboration between mental health services and teacher involvement in treatment has shown to not only improve mental health issues, but also classroom performance (Hoagwood et al., 2007).
The functioning of children and adolescents within the family and the family’s involvement in treatment is harder to integrate with in-school services. With parents at work during school hours, conducting family therapy at school is difficult (Guo, Wade, Pan, Keller, 2010), however family involvement in treatment is vital to the success of the student. As mentioned in Carlson and Christenson (2005), a student’s disruptive behavior at school can be problematic to the family, and problems at home can cause trouble in the classroom. In-home services may be the better option for family involvement in treatment.

In-home Mental Health Services

As stated by Mattek, Jorgenson, and Fox (2010), in-home services are becoming more common when providing mental health services to children and adolescents. When providing in-home services, the therapist provides the child and adolescents with the same treatment that they would provide in an office or school setting, but instead the therapist goes into the child’s home. Incorporating in-home mental health service is becoming more widely
used by social workers and other therapist, especially when trying to involve the family into the treatment.

There are many benefits from incorporating in-home services to treatment. As mentioned above, in-home services are often used to increase family participation in treatment. Timmer, Zebell, Culver, and Urquiza (2010), found that bringing treatment into the home allowed both the child and the parent to successfully apply the skills they acquire in therapy. This is largely due to parents practicing the skills in their natural environment with everyday distractions and barriers. Being able to observe the family in their natural setting also gives the therapist a more accurate glimpse into the child and family's functioning as a whole (Mattek, Jorgenson, Fox, 2010). Often times, children and adolescents might act differently when seen at school or in an office due to the expectation to be on their best behavior. When the session is moved to the home, the child or adolescent may feel more comfortable; therefore, are more likely to display their functional impairments. By providing the child or adolescent's treatment in their home, they are more likely to reduce the problematic behavior over time (McWey, 2008).
A benefit to providing treatment in the home also allows for better access to services. For example, low-income families may have difficulty finding transportation to session (Mattek, Jorgenson, Fox, 2010). Providing in-home mental health services also eliminates the need of finding childcare for the family’s younger children. By eliminating these barriers, families are more likely to have higher attendance rates and are more involved in treatment (Mattek, Jorgenson, Fox, 2010). According to a study conducted by Carrasco and Fox (2012), those children in treatment who had higher attendance rates, typically had higher outcomes.

Although there are many advantages to providing in-home mental health services to children and their families, there are also disadvantages that can have an impact on providing treatment. McWey (2008) states that providing treatment in the home might put the therapist in the difficult position of having to deal with multiple family problems as opposed to focusing on the individual child’s treatment plan. Another factor that can be a disadvantage to providing in home services is that the therapist has to expect the unexpected. The therapist is going into the home not knowing who is there or what is
going on (Mattek, Jorgenson, Fox, 2010). There may be more distractions in the home, which can cause the therapist to have less control over the session. The family may also live in an unsafe neighborhood making the service provider feel uneasy. It can be more difficult to keep client’s confidentiality (Mattek, Jorgenson, Fox, 2010). There may be unexpected visitors in the home or curious neighbors who may question why the therapist is visiting the family. This can put the client in an uncomfortable position of having to explain the situation to someone about the services their child is receiving. These factors all contribute to the difficulty of providing realistic in-home services to children and adolescents, as well as their families (Lee et al., 2009).

**Case Management**

Case management is also a service that is provided for children and adolescents who are receiving mental health treatment. Case management is when the therapist or an assigned case manager, link a client to community services and resources that will aid them in treatment. The role of a case manager is to provide the client with information on different types of services such as
medical, legal, and educational, to ensure all basic needs are met (Snowden, Masland, Wallace, Fawley, 2009). The purpose of case management is to help initiate collateral services and to coordinate treatment to ensure a timely delivery (Browne, Cashin, Graham, 2012).

According to Browne, Cashin, and Graham (2012), although the treatment population is children and adolescents, case management can also help the family as a whole. Children and adolescents in treatment, who have families under high levels of stress, typically terminate treatment early, even if progress has not been made. The reason for this may be that the family is focusing on other stressors, and the family’s energy is taken away from the child receiving treatment. Bender, Kapp, and Hahn (2011) suggest that children and adolescents that live in single parent homes often times do not complete treatment. This is an example of how a family’s focus might be redirected and prioritized to other family stressors. In addition, a study found that homeless youth who were receiving case management services had better mental health outcomes and were more likely to participate in their treatment (Bender, Kapp, Hahn, 2011). By providing the youth with resources to help
alleviate daily stressors, clients and adolescents are empowered and are able to be more focused on their mental health treatment. Also, for children and adolescents with severe mental health conditions, case management was shown to prevent future psychiatric hospitalization (Snowden, Masland, Wallace, Fawley, 2009). Incorporating case management to mental health treatment appears to lead to better outcomes overall.

Psychiatric Care

Psychiatric care is also an important factor of school-based mental health services. According to Noggle (2009), with more information on psychopharmacology in the school setting, many treatment plans for children and adolescents include the use of medication. Although medicine has become popular in assisting to regulate behaviors, (i.e. ADHD) mood (i.e. bi-polar disorder) and emotions (i.e. depression), medication is more beneficial if used in conjunction with other mental health services (Noggle, 2009).

Certain medications can help a student be able to focus or concentrate while in the classroom, but what medications are failing to control are the behaviors when a student is no longer in a structured environment. For
example, acting out behaviors or triggers are more likely to occur during recess, lunch breaks or transitioning from one activity to another (Cautilli et al., 2004). In order to make the most out of the medication, children and adolescents should be receiving services such as individual or group therapy. While in therapy, children and adolescents will be able to identify their triggers and enhance their skills to help control their emotions and/or behaviors during unstructured times of the day.

Also in psychiatric care, medication monitoring has to be ensured when utilized by school-based mental health services. By monitoring a child or adolescent while on medication, one can better assess the effects (positive or negative) of the medication (Anderson, Walcott, Reck & Landau, 2009). Through close monitoring, therapists will be able to recommend medication dosages and create treatment plans in accordance to the client’s mood and behaviors while on the medication.

**Group Therapy**

Another modality of treatment that is being used to provide mental health services to children and adolescents is group therapy. In group therapy, children and adolescents with similar problems or impairments are
brought together to work with a therapist and address their issues. According to Wastson, Stern, and Foster (2012), research shows that group therapy can be just as effective as individual treatment, if facilitated properly. Group therapy has become a popular part of treatment which can be seen used with all populations in the mental health field, especially when working with children and adolescents (Metel & Barnes, 2011). Through group therapy and support groups, children and adolescents are given the opportunity to relate to others who may be experiencing similar problems. This may help a child or adolescent feel less embarrassed about being in treatment and find commonality among other members (Thompson & Trice-Black, 2012). In their work with children and adolescents who have experienced domestic violence, Thompson, and Trice-Black (2012), found that group therapy was a good transition for their population. It provides a nurturing place for children of domestic violence to begin rebuilding trust in others.

While receiving mental health services, children and adolescents are often taught skills to help them in their daily functioning such as coping mechanisms, social skills, and anger management techniques. With the use of
group therapy, the child or adolescent is able to apply the skills that they learn from the therapist and practice them with other group members (Rose & Anketell, 2009). This might benefit a child or adolescent who is a visual learner because they are able to carry out the skill upon learning it, which can help the child or adolescent feel more confident in incorporating it into their lives. Another benefit of group treatment is that the group provides its members more resources and ideas for coping (Watson, Stern, Foster, 2012). Children and adolescents are able to hear different perspectives from other group members and can learn from the coping skills that have worked for others.

Many agencies are beginning to implement group therapy because it is cost effective (Metel & Barnes, 2011). In the time that a therapist would have worked with one child or adolescent during an individual session, mental health therapists can work with eight to ten clients at a time. Of course, group sessions are slightly longer than individual sessions, however mental health therapists are still saving time by treating multiple clients at once. Rose and Anketell (2009),
report that longer groups typically have better outcomes, for example, twenty sessions as opposed to six sessions.

Theoretical Orientation

The Theory of Reasoned Action (TRA) views individual's behaviors to be determined by the individual's attitude. As a consequence, positive attitude becomes the antecedent in performing out a behavior (Ajzen, 2012). Viewing the perceptions of the therapist through the TRA framework can determine the attitudes towards certain services.

In school-based mental health, there are several services made available for mental health therapists to utilize. For seasoned mental health therapists who have been in the field for more than one year, preferences of interventions and services may already be established. Through experience, mental health therapists have a familiarity of what works best with certain clients. Using the theory of reasoned action, learning the different attitudes the mental health therapists have towards certain services gives insight to whether or not the service is truly effective with a client. For example, if a mental health therapist has had successful
experiences in utilizing in-home services, the therapist's behavior while conducting in-home services will be more positive and the service is perceived to be more effective. In other words, positive attitude fosters positive behaviors and vice versa while providing services.

While having conducted the study using the TRA framework, the researchers were mindful of the thoughts and attitudes therapists have towards school-based mental health services.

Potential Contribution of Study to Micro and/or Macro Social Work Practice

Studying school-based services provided to children and adolescents grades K-12 by mental health therapists can contribute to social work practice on both micro and macro levels. Learning about the services provided to this population, can help social workers better understand what interventions are being used and what is the most effective. For example, a children and adolescents who have strained relationships with parents and family members may benefit more from home visits. Going into the home will allow the mental health therapists to observe the client or adolescent's
interactions that may be hindering the relationship between family members. This research will allow new mental health therapists to recognize which services work best for a client's presenting problem. Also, by knowing specific situations that can benefit most from certain services, can make creating treatment plans easier for children and adolescents. As for social work practice on a macro level, identifying best practices when working with this population will help the agency produce better outcome measures. In addition, agencies will be able to provide educational programs and trainings to better prepare staff to work with children and adolescents.

Summary

The research focused on perceptions of the effectiveness of school-based services among mental health therapist and the relevance to constructivism was discussed. The literature review provided constructions on the effectiveness of services such as school-based and in-home individual and family therapy, case management, on site psychiatric care and group therapy. By understanding the focus of this study through the theory of reasoned action framework and the influence mental
health therapist’s biases may have on a service, can contribute to social work practice on both a micro and macro level.
CHAPTER TWO

ENGAGEMENT

Introduction

With the constructivist paradigm, the success of the project relied heavily on the engagement stage of the research. Since the paradigm called for face-to-face interaction and qualitative data gathering, building proper rapport, and engaging participants helped create a stronger study. With the advancements that have been made in technology, engagement can also take place through different modes of communication such as e-mail or text messaging. Prior to starting the study, self-preparation was the first step in addressing any possible issues that could have arisen on the researchers' end. Understanding the participant's environment and recognizing any biases helped prevent any large issues from occurring later on in the research. Also, recognizing any diversity, ethical and political issues prior to the study helped enhance the quality of research that was conducted.

Study Site

The research was conducted at Pacific Clinics Ontario region, Children and Family services. This
Ontario site provides mental health services for children and families in co-ordinance with the Ontario-Montclair School District. The clients of this site are either self referred or referred by the client's school. The agency provides a variety of services such as individual, family and group therapy, school-based and in-home services, case management, access to psychiatric services.

Engagement Strategies for Gatekeepers at Research Site

Engagement is important, especially when personally interacting with all the key informants. In order to develop the research focus, engaging with the research site was the first step. While in the engagement phase, the researchers got a better understanding of how the site is run and how it operates on a daily basis. While learning about the research site, the researchers were put in contact with the gatekeepers, who are in relation those who provided mental health services to children and adolescents grades K-12. In this case, the gatekeepers are those who have personal constructions on school-based services for children and adolescents. While engaging the gatekeepers it was necessary that they understood the process of the research study through the constructivist
paradigm. According to Morris (in press), gatekeepers should have verbal and written competency in their respected positions, be committed to the study and be willing to share power. Researchers engaged the site director and Social Work Intern Coordinator through emails, phone calls, and meetings to gain access to Pacific Clinics of Ontario. When in the engagement phase with the gatekeepers, the gatekeepers were aware that their personal constructions would be shared with others. It was also informed to the gatekeepers that it was ok to rethink their constructions throughout the research process. Once the research site and gatekeepers were well informed about the study, it made data collection a lot easier, in terms of gaining access to clinicians, and setting up times for interviews and check in meetings.

Self Preparation

When working with an array of therapists it was important to understand that the participants all carry a heavy caseload. Dealing with school-based services, many of the mental health therapists are out in field during school hours from 8:00am-3:00pm. If the therapist were not able to see their client during school hours, then
home visits take place from 4:00pm-6:00pm. Understanding the key informants busy schedules was imperative to setting up appointments and following through in order to retrieve data. Utilizing good time management skills helped in conducting the research.

It was important to address any biases prior to starting the research. Personal feelings about certain services, or types of therapists were identified and discussed. Researchers explored any biases with the advisor before beginning the study. Also, understanding that the diversity in educational backgrounds among mental health therapists led to different clinical perspectives. The different educational background held by the mental therapists could have cause conflicting views on the best school-based practices. Being acquainted with the different therapeutic titles helped the researchers gain an understanding on different points of view.

Lastly, within the constructivist paradigm, self-preparation included understanding that through interviews and personal interactions, relationships were formed. This occurred as the researchers and key informants became more involved in the study. A
connection was made, as both parties realized the quality of work that was being done from both sides. Self-preparation included learning how to disengage from the population in a healthy manner for example, researchers slowly decreased attendance from meet ups and prepare key informants to be able to meet on their own. Researchers are available as consultants until the group can run on its own.

Diversity Issues

When conducting the study there were issues of diversity that arose. As mentioned before, the hermeneutic circle included mental health therapists from different clinical backgrounds. As a result, their thought process and worldviews were very different when it came to building a construction on best practices when serving school aged children and adolescents.

Another diversity issues also arose when working with various mental health therapists of different cultural and social economic backgrounds. Depending on a person’s upbringing or ethnic culture, areas such as communication can be different among the key informants. The amount of information that was disclosed among the
participants varied depending on how comfortable the participants were about sharing their experiences. While out in field, keeping these diversity issues in mind, helped increase the understanding of each individual participant and allowed the key informants to feel more comfortable throughout the research process.

Ethical Issues

Ethical issues included addressing safety, confidentiality, and that the identities of the participants were protected throughout the course of research. With research conducted in the constructivist paradigm, the chance for ethical issues to arise became greater. The paradigm’s open data gathering and encouragement of sharing constructions among participants, puts confidentiality and anonymity at risk (Morris, in press). Since the mental health therapists were all apart of the same study site, the removing of identifying information, like therapist name or title, may not have been enough to protect the identity of the participant. Also, while conducting research in a close-knit agency like the Ontario region study site, one’s perspective or observation of certain services
could have been easily recognizable to other study participants. As anonymity was at risk, when gathering constructions, it was recognized that certain key players may not have felt comfortable being a part of the study. Lack of participation from informants did not hurt the research, but has been noted in the study (Morris, in press).

As the research continued it was important to recognize the openness of this paradigm when it came to data collection and member checking meetings as confidentiality was also at risk.

The confidentiality among the participants was a topic that was addressed throughout the duration of the ever-changing study. Informed consent was vital and extensive when providing participants the knowledge of the nature and risks of the paradigm.

Never in the study were participants deceived nor were the participants encouraged to continue with the research if they were no longer comfortable. For example, when participating in research a participant might disclose information that may hinder their political or professional self, in which the participant may chose to no longer be a part of the study. The ethical issues that
may have arose at the start of the research were unknown, but knowing the possibilities of what could have occurred helped make sound ethical decisions during research.

Political Issues

Political issues within the constructivism paradigm may not come across as a big of a problem for example, diversity issues. This paradigm required full commitment from both the participants and the researchers; therefore, prior to the study the key informants were aware of the idea of building one joint construction of their perceptions on effective school-based services. Participants were also fully informed that their ideas were to be shared with other participants. By understanding that the construction will be developed as a group, participants were aware that there will be moments of disagreement, but in the end there will be a construction that was to be agreed upon (Morris, in press).

The Role of Technology in Engagement

With the advancements in technology over time, communication has become faster and easier. The use of technology played an active role in engagement, but
within this paradigm, face-to-face interaction is recommended prior to using technology as a source of engagement (Morris, in press).

Since mental health therapists were very busy, once initial engagement has took place, e-mails or phone calls were appropriate to keep in touch with the participants. Also, since it was necessary for all the participants to come up with a construction, group meetings were necessary. The use of technology, such as e-mails, allowed group members to communicate with one another more conveniently. E-mails helped at the engagement phase not only between the researchers and participants, but also between the members of the hermeneutic circle.

Summary

Engagement among the participants was very important especially when working towards building the construction. Engagement strategies were useful throughout the stages of conducting research due to the importance of having the key informants actively participating in the study. Prior to starting the project, self-preparation was very important in order to remain professional throughout the study. Also, any
diversity, ethical, and political issues were identified and addressed to allow for successful engagement.
CHAPTER THREE
IMPLEMENTATION

Introduction
This section will discuss how the research was conducted, analyzed and the completion of the study. For this research, the study participants were mental health therapists who were chosen through convenience sampling. Data was recorded and analyzed with the Atlas.ti program.

Study Participants
The key stakeholders were vital in building a construction to identify the effectiveness of mental health services among school aged children and adolescents grades K-12. Participants were selected all within the Pacific Clinics of Ontario.

Mental Health Therapists
The perceptions of the mental health therapists provided insight into the most effective services provided to children and adolescents. Mental health therapists conduct a variety of services for the population. Mental health therapists are able to go to the school, provide individual therapy, and collaborate with the teachers to better meet the needs of the
children and adolescents. Mental health therapists utilize home visits for individual therapy and as another opportunity to assess the child or adolescent’s interactions with family members. The role of mental health therapists also includes, connecting the child or adolescent to group therapy or resources through case management. Due to the major involvement, the perceptions of mental health therapists became key in building the construction of the effectiveness of mental health services among children and adolescents grades K-12.

Selection of Participants

The selection of the participants affected the validity of the research outcomes. Purposive sampling allowed for the research participants to provide accurate data and information that was most in co-ordinance with the research focus at hand (Morris, in press). Participants were selected at Pacific Clinics-Ontario site, using criterion sampling, which chooses participants based a particular characteristic (Morris, in press). Being a mental health therapist was the criteria used to select participants. In addition to criterion sampling, snowball or chain sampling was used.
to gather key informants to create the hermeneutic circle. This type of sampling started with one stakeholder who was interviewed in regards to the research focus and led the researchers to other key informants (Morris, in press).

Data Gathering

Qualitative data was gathered through interviews of the stakeholders. Prior to beginning the data gathering, informants were given an informed consent, which was signed and agreed upon before the interviews took place.

Once a stakeholder completed the interview, they then referred another key player who was likely to have a different perspective on the effectiveness of the mental health services provided. This was the beginning of the process of forming the hermeneutic dialectic circle, which was eventually comprised with all the key stakeholders (Morris, in press).

During the interviews, participants were also informed of what other stakeholder’s constructions were regarding the effectiveness of mental health services among school aged children and adolescents grades K-12. Participants were also informed of the constructions of
the literature and of the researchers. By providing this information, participants were able to define their own construction as it related (or not) to other constructions.

Phases of Data Collection

When collecting data, the researchers were the primary research instrument. Once gaining the permission at the research site and engaging key stakeholders, interviews were set up via face-to-face contact, e-mails and phone calls. Collecting the data was contingent upon the questions asked by the researcher and how informative each interview was. According to Morris (in press), the researcher should be prepared for the interview, with questions and proper terminology that is used in the research setting. Proper questions included a variety of open and closed ended questions and knowing when to use each type of question to get the most information.

Questions touched upon a participants experience, values, feelings, and knowledge of the effectiveness of mental health services among school aged children and adolescents grades K-12. Each interview was done individually to ensure each stakeholder was given the
chance to create and build his or her own construction. Once the interview was completed, the constructions were analyzed to determine if any questions needed to be added, refined, or taken out. By doing so, the researchers gained a better understanding of the constructions of the hermeneutic circle. Participants got the chance to review their construction as understood by the researcher and had the chance to validate the content of the construction (Morris, in press).

Once the interviews were completed, the individual constructions were validated, and redundancy among constructions appeared, a member checking meeting was called to order. This was the last stage of building the joint construction. The meeting allowed stakeholders to identify any claims, concerns and issues with the drafted construction (Morris, in press). The participation in the group checking meetings offered credibility to the construction.

Data Recording

When conducting interviews, data recording was a little more difficult. When collecting words versus numbers it was important that a participant’s perspective
was correctly translated. In order to achieve such accuracy, data recording was done through voice recording. Additional information could be obtained through note taking if necessary during or after the interview. A reflective journal, including the researchers' thoughts and feelings throughout the study, was kept to assist in productivity of the research that was conducted. Data was then transcribed into Atlas.ti for record keeping and further analysis.

Data Analysis

Through Atlas.ti the data was readily available for analysis from the bottom-up approach that transformed qualitative data to a theoretical orientation (Morris, in press). When looking at the effectiveness of school-based mental health services, open coding helped identify the common concepts and emotions that were displayed throughout the interviews. Open coding in the constructivist paradigm created links between frameworks among the participants, which was done through systematic comparisons. The shared concepts and emotions were then put together to assist in the joint construction process.
Summary

The participants of the study were identified and were selected through criterion and snowball sampling. The data was gathered through interviews, which were then be analyzed through Atlas.ti and reported back to the participants. Checking meetings were then held to allow for the construction to be built among the hermeneutic circle.
CHAPTER FOUR
EVALUATION

Introduction

This chapter will discuss the analysis of the interviews that was done through open coding. The data interpretation of the research findings will include the perceptions of the mental health therapists on the effectiveness of school-based services. The micro and macro practice implications are also discussed.

Data Analysis

The following Table 1. Demographics, depicts the gender, ethnicity, and educational backgrounds of the study participants.

Table 1. Demographics

<table>
<thead>
<tr>
<th>Variables</th>
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<tbody>
<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
<td>1</td>
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<tr>
<td>Female</td>
<td>13</td>
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<tr>
<td>Nationality</td>
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<tr>
<td>African American</td>
<td>1</td>
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<tr>
<td>Latino/a</td>
<td>11</td>
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<tr>
<td>White/Caucasian</td>
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The following tables, Table 7. In-School, Table 8. In-Home, Table 9. Case Management, Table 10. Psychiatric Care, Table 11. Group Therapy, show the raw data collected at the time of the interviews. The following charts look at people, places, things, ideas and themes that were apparent in each service provided and will be further discussed later in this chapter.

The tables below illustrate the five domains gathered from the study. Table 2. Consistency, focuses on consistency of in-school services. Table 3. Natural Environment, focuses on seeing the child or adolescent in their natural environment when providing in-home services. Table 4. Empowerment, focuses on empowerment among the population through case management. Table 5. Education, focuses on the impact education has on psychiatric services. Lastly, Table 6. Commonality, focuses on the commonality among members in group
therapy. The domains will be interpreted later in the chapter.

Table 2. Consistency

<table>
<thead>
<tr>
<th>Consistency</th>
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<tr>
<td>“Yes there is definitely improvement, especially when we have that communication with the teachers at that school. Definitely can make a difference because we can monitor the symptoms we can provide recommendations to the teacher in the classroom and we can follow up with the teacher on a weekly basis, so yes definitely.” (Participant 7, Interview, February 2013)</td>
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<tr>
<td>“What is most effective is getting into the school seeing them more consistently, meeting with teachers and principal and it seems when getting more people involve it tends to be more productive.” (Participant 12, Interview, February 2013)</td>
</tr>
<tr>
<td>“It makes it more convenient for the worker and the client especially if the parent is non responsive because we can be consistent in the school. You can meet with the client every single week at the same time on the same day with very little interruptions and is most beneficial to the client in most cases.” (Participant 1, Interview, January 2013)</td>
</tr>
<tr>
<td>“The privacy, being able to meet in a room with the client with no distractions I think that that really helps and the client are able to open up more. Like when the client is at home and there are a lot of people there its harder for the client to open up and say what’s really going on in the home.” (Participant 13, Interview, March 2013)</td>
</tr>
<tr>
<td>“I believe if the problem is at school then you can address it. You go there and all of a sudden they remember ‘I got to do this, I got to do that’ you go to the school and they may be acting up but they see you and they remember like ‘oh yeah I gotta do this and that’ hopefully that’s what happening but that’s effective about going to the school.” (Participant 5, Interview, February 2013)</td>
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Table 3. Natural Environment

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<th>Natural Environment</th>
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<tr>
<td>&quot;Being able to see their daily life and interactions with family members. With their kids, brothers, sisters, neighbors it just gives us I think a well rounded information.&quot; (Participant 2, Interview, January 2013)</td>
</tr>
<tr>
<td>&quot;How lenient or strict the parents might be, if they are following through with consequences, so I get to see all of that happening in home where I don’t get to see that at the school.&quot; (Participant 10, Interview, February 2013)</td>
</tr>
<tr>
<td>&quot;Most of the kids are experiencing their problems first at home and then its translate in trouble at school. So going in the home and doing services with the parents have usually been the most effective way to have the kids increase their functioning.” (Participant 8, Interview, February 2013)</td>
</tr>
<tr>
<td>&quot;Because you get to see them in their natural environment. Like when you bring them into a environment like this, its very structured they are not always familiar or comfortable with that but when you are at the home you get the raw self and what’s going on.” (Participant 12, Interview, February 2013)</td>
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<tr>
<td>&quot;In home is the treatment we need to do more of because that’s their environment and that’s where we find whatever is happening as far as the presenting problem, that’s their place to be.” (Participant 1, Interview, January 2013)</td>
</tr>
<tr>
<td>&quot;Also for us as clinicians, can assess more in the home environment and how the child you know, his day to day life what is it all about and get a better understanding what he has to face being at home in different situations with family members or even the community.” (Participant 7, Interview, February 2013)</td>
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Table 4. Empowerment

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<th>Empowering</th>
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<td>&quot;It is most effective when clients actually follow through with resources you give them and you are able to see improvements in their life.&quot; (Participant 12, Interview, February 2013)</td>
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<tr>
<td>&quot;The intentions of case management is to teach client how to access resources independently and to show them how to navigate through system.&quot; (Participant 9, Interview, February 2013)</td>
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<tr>
<td>&quot;Sitting with them, dialing the number and having them ask the questions on the phone, so in the future they can utilize it is effective.&quot; (Participant 6, Interview, February 2013)</td>
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<td>&quot;I think its extremely beneficial and I think many times working with medi cal clients we get a lot of families in here that do not have a concept of having personal rights.&quot; (Participant 5, Interview, February 2013)</td>
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<tr>
<td>&quot;Well hands on encouraging the parent to take an active role even though you are there to support them but to empower them to be resourceful so maybe letting them know they need to make the phone call if they are looking for particular service.&quot; (Participant 2, Interview, January 2013)</td>
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Table 5. Education

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<td>&quot;It is beneficial when the medication is given and taken. It does make it easier and ADHD kid will actually calm down and pay attention to what we are saying and be able to learn from our tools from what we provide them.&quot; (Participant 3, Interview, January 2013)</td>
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<tr>
<td>&quot;Most of the time I would say there is improvement, there is just a few times it was just a matter of trying different medications or trying it our for longer periods of time or they were not consistent in how they were taking it or they didn’t understand the directions.&quot; (Participant 9, Interview, February 2013)</td>
</tr>
<tr>
<td>&quot;Another barrier would be the misconception about psychiatric services and what psychotropic medication is so providing education for the family I think is importance because they are scared, they don’t know how the meds will work, they think the kids will be addicted, there’s a lot of stigma associated with psych services so that’s another major barrier.&quot; (Participant 14, Interview, March 2013)</td>
</tr>
<tr>
<td>&quot;Informing clients of their rights is the most effective thing I can do as a therapist who does not prescribe anything. Helping them use the terms that will get them the medication they need so instead of going in and just saying “I feel sad” well help them explain what sad is and how often so that the psychiatrist could get a better picture and prescribe the right medication.&quot; (Participant 11, Interview, February 2013)</td>
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<tr>
<td>&quot;The benefit of it depends on the client and if they are going to be med compliant and also on the age. I think most of my clients are older but whether they are going to be med compliant or the parents by giving it to the younger ones.” (Participant 4, Interview, January 2013).</td>
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Table 6. Commonality

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<th>Commonality</th>
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<tr>
<td>&quot;Having a common group members come together and talk about issues and struggles and how they succeeded so they were able to form networks and friendships.&quot; (Participant 4, Interview, January 2013)</td>
</tr>
<tr>
<td>&quot;Yes there is improvement because it helps them grow and process things at a deeper level because they have a group that understands and support system that they don't have in the real world with whatever they are going through.&quot; (Participant 14, Interview, March 2013)</td>
</tr>
<tr>
<td>&quot;If you have the experience of how to learn the ways of socializing and respecting others options and learning from them and growing from others then you can take that back to your own house and your own family and you own community.&quot; (Participant 8, Interview, February 2013)</td>
</tr>
<tr>
<td>&quot;I think it was beneficial in the way where they were able to get other peoples perspective so it just wasn't their own.&quot; (Participant 8, Interview, February 2013)</td>
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Data Interpretation

Following the interviews common themes appearing in each of the following, school-based, in-home, case management, psychiatric care and group therapy services were defined and analyzed by the researchers. The open coding allowed links between frameworks among the participants through systematic comparisons. The shared concepts were exemplified through the five common domains that were utilized to build the join construction. The five domains are as followed: Consistency, Natural
Environment, Empowerment, Education, and Commonality. These codes were the staple to which the participants felt were necessary in providing the most effective school-based services.

**Domains**

**Consistency.** Delivering mental health services in the school setting is the main component of providing school-based services. After gathering the perceptions of mental health therapists, researchers found that the consistency of in-school services is what makes them the most effective. There are many elements relate to being consistent in the school setting. The first element is that the client is more accessible. Most students are involved in after school activities and are in school the majority of the day. When asked about in school services, participant one stated,

> It makes it more convenient for the worker and the client, especially if the parent is non responsive because we can be consistent in the school. You can meet with the client every single week at the same time on the same day with very little interruptions and is most beneficial to the client in most cases.

*(Participant 1, Interview, January 2013)*
By seeing the child at school, the mental health therapist is able to see the client on a regular basis because the client and parent do not have to remember about an appointment. That gives the therapist more control over when the sessions are held. For example, in an office setting, the child or adolescent may not feel like attending a therapy session and they ask their parent to not take them. However in the school setting, the mental health therapist is going to them, so treatment more regular.

Another reason as to why consistency makes in-school services more effective is because mental health therapists are better able to monitor the child’s progress. If the client is having problems at school, you are able to identify them and implement interventions in that setting. Participant five shared their perception of how it benefits the client to receive services in the school.

I believe if the problem is at school then you can address it. You go there and all of a sudden they remember ‘I got to do this, I got to do that’ you go to the school and they may be acting up but they see you and they remember like ‘oh yeah I gotta do this
and that' hopefully that's what happening but that's effective about going to the school. (Participant 5, Interview, February 2013)

By having the mental health therapist meet with the child or adolescent at school, they are able to prompt them to utilize the skills they have learned and apply them in the classroom and when interacting with peers. If the skills are not working for the child, they can problem solve with the therapist and come up with other solutions that can be implemented in that setting.

Consistency also contributes to the effectiveness of school-based services in the regard that mental health therapists are able to have constant communication with the child's teacher and other staff members. The client's teacher may have insight into strengths or challenges of the child that may the parent or therapist may be unaware of. During the interview, one participant reported, "What is most effective is getting into the school seeing them more consistently, meeting with teachers and principles and it seems when getting more people involve it tends to be more productive," (Participant 12, Interview, February 2013). By having regular communication with teachers, the therapist is able to build a relationship with other
people in the child’s environment, and can gain a better overall picture of the client’s impairments. Having close communication with teachers can also help the outcomes of treatment. Participant seven stated,

Yes there is definitely improvement, especially when we have that communication with the teachers at that school. Definitely can make a difference because we can monitor the symptoms we can provide recommendations to the teacher in the classroom and we can follow up with the teacher on a weekly basis, so yes definitely. (Participant 7, Interview, February 2013)

If the therapist has a good relationship with the child’s teacher they can get them on board to help implement interventions in the classroom or to make accommodations for the child. By working collaboratively with teachers and school staff, mental health therapists have a better impact on the child’s treatment goals and make the services they provide more effective.

Lastly, by being able to see the child or adolescent consistently at school, therapy sessions are able to be more private and there are fewer interruptions for the client. The school usually provides therapists with a
room where they can hold sessions to keep the client’s confidentiality. One participant discussed the importance of privacy and how it is easier to keep session private in the school.

The privacy, being able to meet in a room with the client with no distractions I think that that really helps and the client are able to open up more. Like when the client is at home and there are a lot of people there it’s harder for the client to open up and say what’s really going on in the home.

(Participant 13, Interview, March 2013)

By ensuring the child or adolescent’s privacy, they are more willing to talk about their issues and confide in the therapist, as opposed to being afraid of someone overhearing them if a session is being held at home. Consistency is the component that makes in school services most effective. By being consistent, the therapist is able to see the child or adolescent regularly, monitor their progress, collaborate with teachers, and have better control of the client’s privacy.

Natural Environment. When studying the effectiveness of services provided in the home, the interviewees
mentioned the benefits of seeing the clients in their natural environment. The mental health therapists reported that seeing child or adolescent in the home allows for a better assessment. "In home is the treatment we need to do more of because that's their environment and that's where we find whatever is happening as far as the presenting problem. That's their place to be," (Participant 1, Interview, January 2013). By having the client in a comfortable environment, there are more opportunities for mental health therapists to see behaviors and interactions that are unguarded. Going into the home, the therapist is able to see evidence of the presenting problem and gain a full understanding as to why the client is in need of treatment.

Also, us as clinicians, can assess more in the home environment and how the child you know, his day to day life what is it all about and get a better understanding what he has to face being at home and in different situations with family members or even the community. (Participant 7, Interview, February 2013)

The mental health therapists are able to learn more about the child or adolescent through what he or she
experiences at home. Being able to conduct a better assessment allows for more effective school-based services, as therapists are able to get familiar with the child or adolescent in more than one setting.

In the natural environment, the child or adolescent and family are more comfortable; therefore, their interactions and behaviors are more automatic. This allows the mental health therapists to view the client’s every day self. When asking about the effectiveness of in home services Participant two stated, “being able to see the their daily life and interactions with family members. With their kids, brothers, sisters, neighbors, it just gives us, I think, a well-rounded information,” (Participant 2, Interview, January 2013). Children and adolescents spend a majority of their time at home and interacting with family members and siblings, which are where a lot of the behaviors and habits are developed. Being able to see the child or adolescents every day self lets the mental health therapists explore for maladaptive relationships or behavior patterns that are contributing to clients presenting problem. The natural environment helps contribute to the therapeutic process as the child or adolescent’s every day self allows for the mental
health therapist understand better ways to help the child or adolescent. Because you get to see them in their natural environment. Like when you bring them into a environment like this [office], it's very structured they are not always familiar or comfortable with that but when you are at the home you get the raw self and what's going on. (Participant 12, Interview, February 2013)

If conducting sessions in an unfamiliar place, the child or adolescent may not be willing to show true behaviors due to the uncertainty of consequences or reactions to the behaviors. For example, a child or adolescent knows exactly how to get away with bad behavior in the home because the setting is familiar to them, but if a child or adolescent was in a more structured environment, he/she will be more hesitant to act out or show their true self. When children and adolescents do not act naturally, it makes it more difficult for the mental health therapists, making treatment less effective.

Lastly, natural environment allows for more family work. Interacting with the family including brothers, sisters, mom, and dad is especially important, as the
family is where the child or adolescent learns and conducts most of the behaviors.

Most of the kids are experiencing their problems first at home and then its translate in trouble at school. So going in the home and doing services with the parents have usually been the most effective way to have the kids increase their functioning.

( Participant 8, Interview, February 2013)

By being able to pinpoint behaviors within the family that is carrying over into the child or adolescent's classroom, the mental health therapist can help family eliminate behaviors that are preventing client in moving forward in treatment. Doing work with the family gives the mental health therapists a perspective that is not present at school. “How lenient or strict the parents might be, if they are following through with consequences, so I get to see all of that happening in home where I don’t get to see that at the school,”

( Participant 10, Interview, February 2013). Going into the home allows for family treatment and to increase positive interactions, which will foster better behavior and progress with the child and adolescent that can be seen both in the home and at school. The natural
environment that is achieved by providing in-home services contributes to the effectiveness of school-based services through conducting better assessments, the child or adolescent's ability to show their every day self, and the opportunity for significant family work.

**Empowerment.** Providing case management as a part of school-based services is effective due to the empowerment it instills in the client and the family. Case management primarily focuses on the parents and family in relation to the client, rather than the child or adolescent. With parents and families utilize case management in conjunction with individual therapy, there is significant improvement in the child or adolescent. The case management allows the family to feel supported and not alone. According to participant two,

well hands on encouraging the parent to take an active role even though you are there to support them, but to empower them to be resourceful. So maybe letting them know they need to make the phone call if they are looking for particular service.

( Participant 2, Interview, January 2013)

The support that is provided to the family by the mental health therapist helps empower the client to obtain the
resources that are needed to help the child and adolescents family. Support is effective in school-based services, as parents feel more comfortable in their abilities to seek help and provide for their child. By feeling cared for at home, a child or adolescents’ behavior is most likely to improve at school.

In regards to the effectiveness of case management participant five stated “I think its extremely beneficial and I think many times working with medi-cal clients we get a lot of families in here that do not have a concept of having personal rights,” (Participant 5, Interview, February 2013). Through case management, families are able to gain knowledge, not only of their rights to resources, but also learn about their own strengths. In some cases, parents and family members do not know how to look for or communicate their needs. According to participant six, “sitting with them, dialing the number and having them ask the questions on the phone, so in the future they can utilize it, is effective,” (Participant 6, Interview, February 2013). Walking the parents and family through the steps helps in the learning process and provides the families a good foundation to knowing how to access resources. Knowledge can foster confidence,
which promotes a family's ability to seek necessary services to better their situation.

By teaching the families about how to utilize personal strengths to obtain resources empowers the family to be independent. "The intentions of case management is to teach parents and family members how to access resources independently and to show them how to navigate through system," (Participant 9, Interview, February 2013). Often times, the population that is being serviced may experience language barriers or are afraid of the unfamiliar system. Asking for help alone can be very intimidating, making navigating through different resources less appealing for the family. Being there with the family allows the family to feel encouraged and supported and in turn, they are able to achieve their own independence. With case management families gain a sense of control over their lives and are able to obtain necessities to sustain independence from the case manager. Gaining independence is effective in the school-based services as parents are able to better provide for their children. Instead of focusing on the needs of the family as a whole, they are able to direct
their attention to the challenges the child or adolescent is facing.

Case management improves the quality of life by connecting families to needed resources. "It [case management] is most effective when clients actually follow through with resources you give them and you are able to see improvements in their life," (Participant 12, Interview, February 2013). An example of the effects of resources is if a parent is constantly worried about providing food for the family, connecting them to a food bank can enhance their life through preventing hunger and reducing stress. By connecting children and their families to resources can help their situation and allow the family to feel power over their situation. Case management allows the child and their family to feel supported to gain knowledge on how to obtain resources. The new-found knowledge allows the families to gain independence and overall, improve their lives. The empowerment rooted in the service makes case management effective in school-based services.

Education. Upon analyzing psychiatric services, educating the child or adolescent and their family was shown to be an important component to providing effective
psychiatric care. Although mental health therapist do not conduct the psychiatric services for the child or adolescent, there are many areas in which they can educate the child or adolescent and their parents to make the linkage more effective. One of those areas includes educating the family on the impact and improvement that medication can have on the child or adolescent's treatment. During the interview, participant three stated,

> It is beneficial when the medication is given and taken. It does make it easier and ADHD kid will actually calm down and pay attention to what we are saying and be able to learn from our tools from what we provide them. (Participant 3, Interview, January 2013)

Often times, parents do not want their child to be medicated and want therapy to reduce or eliminate all of the child's symptoms. Although this would be ideal, there are some cases where the child or adolescent cannot focus in a session due to their hyperactive symptoms and they are unable to retain the skills that they are learning from the therapist. In cases such as this one, medication is able to reduce the child or adolescent's symptoms and
improve their ability to focus and they can be fully present during therapy sessions. It is important for mental health therapists to educate the family on how psychiatric care will not be replacing mental health services, but enhancing it.

Another area in which mental health therapist should educate the family on is on the importance of medication compliance. In order for the child or adolescents to benefit from psychiatric services, they must follow the directions given to them by the psychiatrist. One participant described why it is important to educate the child or adolescent and the family about being compliant with their medication.

Most of the time I would say there is improvement, there is just a few times it was just a matter of trying different medications or trying it our for longer periods of time or they were not consistent in how they were taking it or they didn’t understand the directions. (Participant 9, Interview, February 2013)

Mental health therapist should ensure that the family clearly understands how the medication should be administered, therefore avoiding inadequate dosage, or
refusal of medication. Medication compliance is also dependent on the client's age. According to participant four,

The benefit of it depends on the client and if they are going to be compliant with their medication and but also on their age. I think most of my clients are older, but whether they are going to be med compliant or not depends on the parents because they're giving it to the younger ones. (Participant 4, Interview, January 2013)

Due to some children or adolescents relying on their parents to administer their medication to them, it is necessary to educate both the child or adolescent and their parents on the importance of being compliant. It then goes back to educating them on the impact that the psychiatric services can have on their overall treatment and reduction of symptoms.

It is also necessary to educate the family that not all medications work the same on every child or adolescent. The family should know that getting referred to psychiatric services involves a collaborative effort from the family, the psychiatrist, and the therapist to find the medication that is the best fit for the child or
adolescent. During the interview one participant accurately described the therapist’s role in helping the client and psychiatrist find the medication that best fits that particular child or adolescent.

Informing clients of their rights is the most effective thing I can do as a therapist who does not prescribe anything. Helping them use the terms that will get them the medication they need so instead of going in and just saying ‘I feel sad’ well help them explain what sad is and how often so that the psychiatrist could get a better picture and prescribe the right medication. (Participant 11, Interview, February 2013)

To reiterate the statement by participant eleven, the therapist can help prepare the client prior to the psychiatric evaluation so that they able to accurately describe their symptoms. By doing so, the psychiatrist will get a better picture of the child or adolescent’s behaviors and therefore be able to prescribe a medication that the child or adolescent will benefit from.

Lastly, it is important for mental health therapists to educate child or adolescent and their families on the overall benefits of psychiatric care to reduce stigma.
associated with psychotropic medications. Due to the vast amount of stigma related to psychiatric care, families are often hesitant to allow their child to be put on medication. Participant fourteen described some of the fears that families may have about psychiatric services.

Another barrier would be the misconception about psychiatric services and what psychotropic medication is so providing education for the family I think is importance because they are scared, they don’t know how the meds will work, they think the kids will be addicted, there’s a lot of stigma associated with psych services so that’s another major barrier. (Participant 14, Interview, March 2013)

By guiding the child or adolescent and their parent’s through the process of receiving psychiatric services and educating them on the impact it can have on the child’s overall improvement, they will feel more at ease and will be more open to the idea of a psychiatric evaluation. By educating families on the benefit of psychiatric care, the importance medication compliance, finding the best fit, and reducing stigma, mental health therapists are able to enhance psychiatric services and therefore
improve the overall effectiveness of school-based services.

**Commonality.** Group therapy can be integrated into the treatment of the child or adolescent. Group therapy is effective in school-based services as the service provides commonality among the children or adolescents. Among school-aged children being in counseling or therapy becomes stigmatized and the client becomes ashamed of receiving services. According to participant four, "having a common group, members come together and talk about issues and struggles and how they succeeded so they were able to form networks and friendships," (Participant 4, Interview, January 2013). With group therapy the client is able to be around other children or adolescents who are also receiving mental health services. The commonality among the group members allows for friendships and relationships to grow among the members. As participant nine stated,

if you have the experience of how to learn the ways of socializing and respecting others opinions and learning from them and growing from others then you can take that back to your own house and your own
family and you own community. (Participant 9, Interview, February 2013)

The commonality shared among members makes it easier for the child or adolescent to connect to one another. The nature of group therapy allows for social skills to group in order to create better relationships inside and outside of group.

Through making friendships and connecting to the members in the group the child or adolescent can hear others experiences similar to their own and are able to gain perspective on the various challenges. As participant eight reported, "I think it was beneficial in the way where they were able to get other peoples perspective so it just wasn't their own," (Participant 8, Interview, February 2013). The commonality in the group makes the perspectives relatable and allows for easier application in one's own personal life. For example, when in a group for depression members may mention personal coping mechanisms that have worked for them in the past. Other group members who can relate may be able to utilize the same coping mechanisms that were shared in the group. Sharing and gaining perspectives can be beneficial to individual treatment.
When the child and adolescent are able to see common perspectives being shared in a safe environment, it allows them to be able to process their own life challenges. As reported by participant fourteen, "...it helps them grow and process things at a deeper level because they have a group that understands and support system that they don't have in the real world with whatever they are going through," (Participant 14, Interview, March 2013). By participating in group the child or adolescent will be able to gain a better understanding of who they are as a person in relation to the mental health challenges he or she is going through. The group members will also be able to help the individual by providing feedback, contributing to the child or adolescents personal processing.

The commonality found among members, makes group therapy effective in school-based services as it allows children and adolescents to meet and interact with others who are going through the same mental health experiences. The friendships and relationships that are made in the group help the child or adolescent gain a better perspective and allow for a more in-depth process. The
work that is done in-group can carry over to individual therapy.

Implications of Findings for Micro/Macro Practices

Implications of common themes in the data that was gathered regarding school-based services, contributes to micro practice services provided to school aged children and adolescents. By studying the effectiveness of the five different services, the data implied that in order for school-based services to be most effective, there are components that need to be highlighted. For example, by understanding that empowerment is essential in providing case management, the service will be more beneficial not only to the client, but the family overall. By studying the themes that have emerged through the study and implementing them into their everyday practice, mental health therapists will be able to provide the most effective school-based services to school aged children and adolescents.

Macro practice implications of the study include enhancing school-based programs by improving the quality of services that the therapists provide. By utilizing the most effective services the program can have a greater
impact on the population and community in which it serves.

The five domains that were discussed were shared among all study participants. The common outlook on the domains developed the joint construction of what concepts produce the most effective school-based services.

Summary

Through open coding interviews regarding the five-school-based services studied, the researchers were able to produce links between frameworks through systematic comparisons. The commonality between frameworks developed five core domains: consistency, natural environment, empowerment, education, and commonality. The five domains were all agreed upon, creating the construction of the most effective school-based practices.
CHAPTER FIVE
TERMINATION AND FOLLOW UP

Introduction

This chapter outlines the conclusion of the research study, which includes the termination process, communication of findings to study participants, and the dissemination process. The researchers reported the findings of the study to participants during the last member checking meeting. During this time, members of the hermeneutic circle were encouraged to continue building on the construction that was developed. The researchers hope that members of the hermeneutic circle will utilize the concepts of the construction that they built to continue to provide effective school-based services.

Termination of Study

Reporting the joint constructions marked the beginning of termination. Termination in the constructivist paradigm is not equivalent to the end of the research study. Now that the hermeneutic circle has built a joint construction on the effectiveness of mental health services among school aged children and adolescents grades K-12, the hope is for the group to
continue to build and implement the construction. Through continuing with the process, the circle can help enhance mental health services in the school setting without the assistance of the researchers. Empowerment became very important at this stage, as the researchers disengaged from the study and the participants. Researchers provided the group with routines and procedures on how to continue while also offering any supplemental resources (Morris, in press).

Follow up can take place now that the research was reported. Since there was not a true termination, rather disengagement, a follow-up could be done by meeting back or calling to check in with group members. The follow up allows the researchers to see the work and progress that has taken place within the joint construction that was built.

**Communicating Findings to Study Participants and Dissemination Plan**

Once the joint construction was built among the hermeneutic circle, the study was organized in a way to be able to communicate the process of the research and the progress that was made. During the last member checking meeting, the findings were presented among the
hermeneutic circle. Findings will be presented through a verbal presentation. The final report included the overall research topic, the contribution of the research site and a description of all those included in the hermeneutic circle. Also, a summary about the tools that were used to conduct the research, issues that occurred during the process and the construction that was built and agreed upon by the hermeneutic circle, were reported (Morris, in press).

A copy of the research project was also given to the agency director for use of future reference when utilizing mental health services among school aged children and adolescents grades K-12.

Summary

Upon completing data collection and analysis, checking meetings were held to allow for the construction to be built among the hermeneutic circle. Once the joint construction was built, research findings were communicated with the participants via presentation. The member checking meetings marked the beginning stages of the dissemination process. The researchers highly encouraged the study participants to continue to build on
the construction that was developed and to continue to provide effective school-based services among children and adolescents grades K-12.
APPENDIX A

QUESTIONNAIRE
Questions to Mental Health Therapists on the Effectiveness of School-based Services

These questions will be asked to the mental health therapists pertaining to each of the following services: In-school, In-home, Case Management, Group Therapy, Psychiatric Care.

What has been your experience with this service?

Has been particularly effective with this service?

Are there any barriers or roadblocks to providing this service?

What have you observed to be the client’s experience with the service?

• Does it make treatment more convenient for the client?

• Have you seen improvement in client when utilizing this service?

How would you rank the services in regards to the client’s treatment: 1 being most effective – 5 being least effective.

Developed by Jolene-Fe Balancio & Suzette Covarrubias
APPENDIX B

INFORMED CONSENT
Informed Consent

The study in which you are being asked to participate is designed to investigate the effectiveness of school-based services provided by mental health therapists. This study is being conducted by Jolene Balancio and Suzette Covarrubias under the supervision of Dr. Tom Davis, of the College of Social and Behavioral Sciences/Department of Social Work. This study has been approved by the Department of Social Work Sub Committee of the Institutional Review Board, California State University, San Bernardino.

There are two parts of this research study. In the first part of this, you will be asked by way of interview to respond in your own words to several questions regarding the effectiveness of school-based services (i.e. What do you see that has been working with this service?) The interview is approximately 30-60 minutes. Review of the transcribed interview at the participants convenience on a subsequent day should take no more than 10-15 minutes if desired. Each person interviewed will expand the number of opinions and will have the option to comment on others opinions previously reported to the researcher. Your name will not be reported with your responses. It is possible that due to the nature of our research method that your identity may be revealed even with no disclosure of your name.

The second part of the research study is to collaboratively meet to discuss the various constructions gathered from the mental health therapists interviewed. This would be a face to face group meeting with all the study participants the researchers had previously interviewed. Participating in this meeting is completely voluntary, even after participating in the original interviews. You may withdraw from participation in the study at any time. If you would like to receive the group results of this study after its completion (after September, 2013), it will be available at California State University, San Bernardino, Pfau Library. It is expected that the benefits of this study will provide participants and the agency a greater understanding of the effectiveness of the services that they provide. There are no foreseeable risks to participation in the research study and the participants should in no way feel that his or her responses to the interview questions will jeopardize their status as an employee with the agency. If you have any questions or concerns about this study, please feel free to contact Dr. Tom Davis at (909) 537 3839. By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I acknowledge that the group meeting is completely voluntary and that I am not required to participate even after participating in the interview. I also acknowledge that I am at least 18 years of age.

Place a check mark here □

Today’s date: __________________________
APPENDIX C

DEBRIEFING STATEMENT
DEBRIEFING STATEMENT

This study you have just completed was designed to investigate the perceptions of the effectiveness of school-based services among mental health therapists. In this study, each participant was interviewed to develop each person’s individual construct as well as to create a joint construct based upon the member checking meeting. We are particularly interested in finding the effectiveness of school-based services provided by mental health therapists.

Thank you for your participation and for not discussing your individual constructs or the joint construct, with others. If you have any questions about the study, please feel free to contact Professor Dr. Tom Davis at (909) 537 3839. If you would like to obtain a copy of the group results of this study, please contact the CSUSB Pfau Library after September 2013.
APPENDIX D

RAW DATA
<table>
<thead>
<tr>
<th>People</th>
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<tbody>
<tr>
<td>“Establishing relationship with teachers and principles makes school based services effective” (Participant 1, Interview, January 2013)</td>
</tr>
<tr>
<td>“Sometimes the scheduling having time to meet with the teacher can be a barrier, because obviously they are teaching the class so mostly on their own lunchtime or after school, so just kind of arranging the schedule around” (Participant 1, Interview, January 2013)</td>
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<tr>
<td>“Yes there is definitely improvement, especially when we have that communication with the teachers at that school. Definitely can make a difference because we can monitor the symptoms we can provide recommendations to the teacher in the classroom and we can follow up with the teacher on a weekly basis, so yes definitely” (Participant 7, Interview, February 2013)</td>
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<tr>
<td>“What is most effective is getting into the school seeing them more consistently, meeting with teachers and principals and it seems when getting more people involve it tends to be more productive” (Participant 12, Interview, February 2013)</td>
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<tr>
<td>“Also getting the parents more involved. For the parents that don’t work I get them to meet me at they school and I’ll do therapy there or collaterals and that helps with the control environment and get their focus but then again I have to play the waiting game like are they going to show up to the school” (Participant 3, Interview, January 2013)</td>
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<tr>
<td>“Yes there is improvement, however it would be ideal to have the parent involved.” (Participant 4, Interview, January 2013)</td>
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<td>“I would say its more convenient for the client and family because they are not setting appointments it’s a therapist driven activity of setting the appointment and go there to meet it” (Participant 4, Interview, January 2013)</td>
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<td>“Some teachers complain too much about us pulling out the kids” (Participant 5, Interview, February 2013)</td>
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<tr>
<td>“It is convenient since I am able to gather information from the teacher how the kid is doing and see the child for a session as well, so I’m killing 2 birds with one stone. Because sometimes if there’s an issues with the child and they are not telling you and you get the information from someone else (teacher) you can address it right then and there” (Participant 6, Interview, February 2013)</td>
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| “It depends on the school and the people working there. Some schools and some people working there, see mental health as an important aspect
to helping the client and when that is the case its easy, when the school or people you are working with don’t see mental health as important, than academics or don’t want to deal with mental health aspect with what the client is dealing with then that’s where I see the struggle” (Participant 12, Interview, February 2013)

“Whether or not the school is going to be open to it is a barrier, if the teacher is too overwhelmed with state standards, they don’t always cooperate, or they are not always taught or have the training to see that mental health effects the kids that we work with” (Participant 9, Interview, February 2013)

“It makes it more convenient for the worker and the client especially if the parent is non responsive because we can be consistent in the school you can meet with the client every single week at the same time on the same day with very little interruptions and is most beneficial to the client in most cases” (Participant 1, Interview, January 2013)

“If you can get the teachers buy in, and get her to be empathetic, it translates to the child and they are able to see the child in a more positive way if you can do that” (Participant 8, Interview, February 2013)

Places

“You can meet the client where they are at, where they are having challenges” (Participant 1, Interview, January 2013)

“Well I have done it as a part of LAUSD and I have done it as a part of a contracted agency, and it has definitely helped to be a part of the district. They respect you more and know that you need certain resources” (Participant 2, Interview, January 2013)

“It has been positive, because I get another picture of the child in his environment” (Participant 3, Interview, January 2013)

“Frequently they have problems at school so that’s where they need the services at” (Participant 3, Interview, January 2013)

“We go to the school, pull them out of class and provide the service. It is a whole lot easier for the parent and client” (Participant 4, Interview, January 2013)

“Some schools are more flexible than others like teachers letting me go at certain times, or having a room available, most schools are flexible they have rooms available for counselors, but I have had some schools that are not very cooperative” (Participant 6, Interview, February 2013)

“The privacy, being able to meet in a room with the client with no distractions I think that that really helps and the client are able to open up more. Like when the client is at home and there are a lot of people there it’s harder for the client to open up and say what’s really going on in the home” (Participant 13, Interview, March 2013)

“Yes, I always see more improvement when I go to the school I think its
because I get to spend more time with them, it’s a different setting, it more kicked back, relax and I don’t know its just different, its a lot more stressful at the home” (Participant 8, Interview, February 2013)

“You can do a lot of classroom observation, you can redirect right then and there it really helps also with their peer relationships” (Participant 2, Interview, January 2013)

“They enjoy it sometimes because they get to get out of class to talk to someone, there could be more structured compared to the home because the school can provide a room. So you know there is structured environment for the client to really focus on treatment” (Participant 5, Interview, February 2013)

“Well I think if the client is having their most difficult time at the school, then you should address it there, and if they are having the problems at home its nice to see them in that environment and help them adjust in that environment versus doing it in a setting like this in an office and then saying go apply it. You are right there and able to do it with them” (Participant 12, Interview, February 2013)

“It would be more directly with what they are dealing with if you are at the school. If they come to the office you don’t get to see what’s going on at school” (Participant 13, Interview, March 2013)

**Things**

“School schedule and school events. like this week we had benchmark testing so we couldn’t go in till 11:00 so I would say those are the biggest barrier” (Participant 1, Interview, January 2013)

“Some barriers that we face are if child is testing, if the child is absent, once the school gets busy there’s no rooms available for the counselor, so we are stuffed in the corner somewhere to do counseling services” (Participant 6, Interview, February 2013)

**Ideas**

“Advocacy is very important and the school knowing there is someone to help the client” (Participant 1, Interview, January 2013)

“I think the barriers are space and confidentiality” (Participant 3, Interview, January 2013)

“Sometimes the client is working on certain things but does not want to share it with school officials” (Participant 2, Interview, January 2013)

“The clinicians should assist the child to have better communication with the teachers and school members and coordinate services. I think coordinating services is one of the major things we can do for them” (Participant 4, Interview, January 30, 2013)

“Another barrier is a misunderstanding that the clients symptoms and their diagnosis. Not really understanding that the client is not just misbehaving but is actually going through different problems, different emotional problems and situations and really just providing that education
to the school. It's not just an out of control child that wants to misbehave” (Participant 6, Interview, February 2013)

“Yea very convenient for the child because they are right there they love to get out of class and it provides them a little break from their routine” (Participant 5, Interview, February 2013)

“It's a space for them to vent and say they feelings and frustrations and we can help them problem solve what is going on that day, that particular day at school” (Participant 9, Interview, February 2013)

“And it’s a school setting so there is already and understanding of confidentiality and privacy” (Participant 12, Interview, February 2013)

“It makes it more convenient but it depends on the age of the client as well. Generally teenagers don’t like us going to the school because the stigma of “your crazy, your seeing a therapist you’re crazy” they like to hide us” (Participant 2, Interview, January 2013)

“It becomes difficult sometimes because you don’t want to take them out of class that are important or you get there and they are in an assembly or they are doing something that is particularly important that you can’t pull them out” (Participant 4, Interview, January 2013)

“I believe if the problem is at school then you can address it. You go there and all of a sudden they remember “I got to do this, I got to do that” you go to the school and they may be acting up but they see you and they remember like “oh yeah I gotta do this and that” hopefully that’s what happening but that’s effective about going to the school” (Participant 5, Interview, February 2013)

“I think that sometimes children get embarrassed or get guarded because they don’t want the other kids to know they are getting serviced but then there are some kids that are like showing you to everybody “this is my counselor, and I’m so excited” so I think it kinda depends on the person and reading the client and how they want to address it” (Participant 3, Interview, January 2013)

“The first thing I do when going in to the school is engaging the teacher and being empathetic to the teacher because she is the one who will help me with the child and if I don’t, the child may not improve as much as they would if I engage the teacher and being in the same goal I am in and it is their territory too.” (Participant 7, Interview, February 2013)

“It makes treatment more convenient but depending on the age of the client they may not like it because their problem gets magnified or teachers say like your therapist wants you and everyone’s like “OMG he’s in therapy” so its uncomfortable for the client but convenient because you find them there all the time.” (Participant 12, Interview, February 2013)

“I think it does because they feel, I get this feeling that they see you as the
one person who is one their side. You advocate for them listen and don’t judge them. They really get a lot out of that.” (Participant 5, Interview, February 2013)

<table>
<thead>
<tr>
<th>Themes</th>
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<tbody>
<tr>
<td>“Having the communication with the teachers, the principles, the out reach consultant, helping to coordination information from the school, to the home, having the parent on the same page as the school, so having the communication is what makes it effective” (Participant 2, Interview, January 2013)</td>
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<tr>
<td>“The other big part of it is confidentially and privacy a lot of times you may be in the nurses station in the middle of the cafeteria with no doors or walls you don’t talk about what’s happening because people are walking by, but when you have a room they feel more comfortable talking” (Participant 1, Interview, January 2013)</td>
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<tr>
<td>“Little kids don’t care they are getting out of class, they are happy, especially with teens it becomes a issue. They don’t want you to come to the school because the confidentiality is not there, anybody that is in the office sees them talking to somebody” (Participant 3, Interview, January 2013)</td>
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<tr>
<td>“There is improvement when the teacher is on board” (Participant 4, Interview, January 2013)</td>
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<tr>
<td>“They really do progress quite well and they’re stable, its consistent so it really stays with them” (Participant 5, Interview, February 2013)</td>
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<tr>
<td>“Most of the time your client is at school so you can see them. There’s a designated time and place so you can see them consistently. That’s really successful I guess” (Participant 6, Interview, February 2013)</td>
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<tr>
<td>“Well in-school is most effective when client is experiencing most of their impairments in functioning in the school. so if they are having outbursts at school or social skills at school it is more effective because we can deal with it at school” (Participant 1, Interview, January 2013)</td>
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<tr>
<td>“It makes it more convenient for the worker and the client especially if the parent is non responsive because we can be consistent in the school you can meet with the client every single week at the same time on the same day with very little interruptions and is most beneficial to the client in most cases” (Participant 10, Interview, February 2013)</td>
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<tr>
<td>“What I see is that you get to collaborate with those who surround the child in a more direct way you get to intervene and really see what’s going on and help the child immediately. If you are in the classroom, sometimes its different like hearing it from the teacher through a letter compared to if you are seeing them and speaking to them” (Participant 12, Interview, February 2013)</td>
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Table 8. In-home

<table>
<thead>
<tr>
<th>People</th>
<th>“Linking them to positive relationships with teachers, Pastors, Aunts, Uncles, and Godparents as a natural support system.” (Participant 1, Interview, January 2013)</th>
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<tbody>
<tr>
<td></td>
<td>“It forces the parents and family members to be engaged with services.” (Participant 1, Interview, January 2013)</td>
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<tr>
<td></td>
<td>“Not every one can come in, especially with large families. Aunts and uncles in the home can’t participate, so the ability to do family therapy and do collaterals with them is really helpful.” (Participant 2, Interview, January 2013)</td>
</tr>
<tr>
<td></td>
<td>“Sometimes they have different family members that come and go, neighbors knocking on the door, the dog walking through the living room, I think that that would be the only barriers.” (Participant 3, Interview, January 2013)</td>
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<td></td>
<td>“You can really get an idea of how the family functions and see what to work with in the home.” (Participant 4, Interview, January 2013)</td>
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<td></td>
<td>“How lenient or strict the parents might be, if they are following through with consequences, so I get to see all of that happening in home where I don’t get to see that at the school.” (Participant 10, Interview, February 2013)</td>
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<tr>
<td></td>
<td>“The noise is always a factor, to many people being in the home, a lot of the families are in a 1 bedroom, 2 bedroom apartment or home and just too many people around and its hard to conduct a private session with the client.” (Participant 5, Interview, February 2013)</td>
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<td></td>
<td>“And for the parent I’m sure its more convenient for me to go to the school, but for the child I’m not so sure.” (Participant 6, Interview, February 2013)</td>
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<tr>
<td></td>
<td>“So many times people don’t open up a lot because there’s not that error of professionalism that you get in an office” (Participant 9, Interview, February 2013)</td>
</tr>
<tr>
<td></td>
<td>“Being able to see their daily life and interactions with family members. With their kids, brothers, sisters, neighbors it just gives us I think a well rounded information.” (Participant 2, Interview, January 2013)</td>
</tr>
<tr>
<td></td>
<td>“Most of the kids are experiencing their problems first at home and then its translate in trouble at school. So going in the home and doing services with the parents have usually been the most effective way to have the kids increase their functioning.” (Participant 8, Interview, February 2013)</td>
</tr>
<tr>
<td></td>
<td>“Other barriers I cant think of any right now mostly just if there are too many people or smaller brother and sister they may impact your individual, one and one private session its almost impossible.” (Participant 10, Interview, February 2013)</td>
</tr>
</tbody>
</table>
“So they know that you are not a friend coming over but you are a profession coming to see them.” (Participant 11, Interview, February 2013)

**Places**

“Yes, improvement is faster when providing in home rather than just the office or school based.” (Participant 2, Interview, January 2013)

“Just getting to be with the family at their place, at their home, when they don’t have transportation, when there really is no way for them to get out of the home, just making it more convenient and practical just being there for them.” (Participant 3, Interview, January 2013)

“Being able to see the family in the home. Getting an understanding of the family in their environment.” (Participant 5, Interview, February 2013)

“The good is that you are in the environment and you are able to change the environment that helps the people better functional later.” (Participant 6, Interview, February 2013)

“A lot of homes that we visit tend to not be sanitary.” (Participant 4, Interview, January 2013)

“It is definitely more convenient because you are going to them, so they don’t have appointments to keep because you are going to them.” (Participant 2, Interview, January 2013)

“Sometimes the safety. Some families live in impoverished areas where there is a lot of violence around them, a lot of gangs so we have to be very careful in not saying or doing something that might be perceived as some sort of gang something.” (Participant 7, Interview, February 2013)

“For clients who have identity issues, they don’t want anybody to know where they live so its challenging with those, but I have found that with the younger ones its easier for them.” (Participant 9, Interview, February 2013)

“Sometimes the trigger by be going on in the home and they may act out more at home.” (Participant 11, Interview, February 2013)

“Because you get to see them in their natural environment. Like when you bring them into a environment like this, its very structured they are not always familiar or comfortable with that but when you are at the home you get the raw self and what’s going on.” (Participant 12, Interview, February 2013)

“Most of the kids are experiencing their problems first at home and then its translate in trouble at school. So going in the home and doing services with the parents have usually been the most effective way to have the kids increase their functioning.” (Participant 14, Interview, March 2013)

**Things**

“Client’s welcome you and say, this is my room, this is my house. It helps build a good therapeutic relationship.” (Participant 4, Interview, January 2013)

“You can really get an idea of how the family functions and see what to
work with in the home, however having that lends itself to the session being dysfunctional, not being able to get through anything because of all the distractions the phone rings and addressing the issue like when in the office you don’t answer the phone.” (Participant 2, Interview, January 2013)

“You see a lot of things first hand so they are able to talk about it more.” (Participant 5, Interview, February 2013)

“Transportation, lack of knowledge, and various other reasons, us being able to take it to them is very helpful.” (Participant 6, Interview, February 2013)

“Like the Hispanic culture they always invite you to drink something or eat something and at least from my perspective its good, its okay and you can always reciprocate like if one time they gave you a soda then next time bring them a soda too, something like that but they will invite you in.” (Participant 11, Interview, February 2013)

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<tr>
<td>“You get a better understanding of what the living arrangement is and you don’t just get that inaccurate picture in your head.” (Participant 3, Interview, January 2013)</td>
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<td>“The clinician develops a better understanding and helps the family develop a better understanding of what might be affecting the client.” (Participant 2, Interview, January 2013)</td>
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<td>“It can be a little bit hectic a little bit unstructured and not very contained so that can also work as a disadvantage.” (Participant 2, Interview, January 2013)</td>
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<td>“We have seen improvement because it is more consistent. We can be there every week, verses them coming to the office every week may not be as consistent.” (Participant 4, Interview, January 2013)</td>
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<td>“But things happen phone rings, family shows up, neighbor shows up, and you know you run into the issue of confidentially and you know working with the Latino population, the family doesn’t know how to say we are having a meeting right now can you come back later.” (Participant 5, Interview, February 2013)</td>
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<tr>
<td>“I think that when I see them in the office the environment is more controlled and I have the attention of the family members more than when I am in the home.” (Participant 9, Interview, February 2013)</td>
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<td>“Family Therapy is most effective in the home. Individual therapy in the home is difficulty but if you include everyone you can help them see how they are affecting one another that’s one of the effective formats you can do in the home.” (Participant 6, Interview, February 2013)</td>
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<tr>
<td>“I believe taking our services to the client is one of the best tools available because a lot of them cannot make it to us.” (Participant 4, Interview, January 2013)</td>
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| “I feel like its been a lot more difficult like in the summer when they are
out of school its been very difficult to arrange the schedule. I feel like they don’t want use there so they are trying to rush us out of there.” (Participant 10, Interview, February 2013)

“Its difficult to go into the home, especially when you come from an agency who says that’s what their from, because families are really guarded and especially, I think different nationalities may be even more guarded than others.” (Participant 11, Interview, February 2013)

“How the parent identified the problem can be a barrier. Whether it’s the client or if they have externalized it because if it’s the child they are not more than willing to look at themselves and see how they are contributing to the issue at hand.” (Participant 3, Interview, January 2013)

“The older kids, like high school aged, you can get those kids to engage in services and make that progress despite their parents, but that’s because that’s the natural development at that age anyways but definitely with younger kids its parental involvement.” (Participant 4, Interview, January 2013)

“In home is the treatment we need to do more of because that’s their environment and that’s where we find whatever is happening as far as the presenting problem, that’s their place to be.” (Participant 1, Interview, January 2013)

“It is their home and you are coming into their home and its private to them. They can get hyper vigilant like are you coming in as an investigator, are you looking at everything I’m doing, so its hard for them to hide anything cause everything is out there and they are exposing themselves.” (Participant 11, Interview, February 2013)

“I get the chance to see the parent and child interact and see if the parents corrects the child’s behaviors then give them methods to improve the behaviors by reducing the parents improper parent interactions.” (Participant 13, Interview, March 2013)

“I try and do a home visit just so I can see and meet the family in their home environment and how the family interacts and see the child’s world and the community and the home.” (Participant 14, Interview, March 2013)

“Also for us as clinicians, can assess more in the home environment and how the child you know, his day to day life what is it all about and get a better understanding what he has to face being at home in different situations with family members or even the community.” (Participant 7, Interview, February 2013)

“There is less structure, less confidentiality less trust because anyone can overhear you in the house.” (Participant 4, Interview, January 2013)

“The improvements are enormous because it’s consistent.” (Participant 2, Interview, January 2013)

“I have found that you can get more personal with your clients because you get to see where they live you get to see their day to day environment

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and activities but on the flip side it could also be a little difficult in regards to structure and I think also for them providing services.” (Participant 5, February 2013)

“Time restraints are a barrier…depending on what their schedule is like at school I can go there, take them out of class and do my session with them, but at home its not as consistent.” (Participant 6, Interview, February 2013)

“The matter of having the parents be home when they say they are makes it difficult in scheduling.” (Participant 8, Interview, February 2013)

“Most cases its convenient but I feel that there is also they can be too comfortable and boundaries have to be set really clear. You come to the home and you are there the boundaries could be blurred.” (Participant 11, Interview, February 2013)
**Table 9. Case Management**

| People | “As a social worker I think its good cause we see things more in a system perspective.” (Participant 1, Interview, January 2013)  
|        | “Help client find positive relationships to connect with if that’s a pastor teacher uncle aunt godparent and pull strength from that connection.” (Participant 1, Interview, January 2013)  
|        | “It is difficult to balance with a family with high need case management and mental health servicesluckily we have people here to do the case management.” (Participant 2, Interview, January 2013)  
|        | “Sometimes some client start perceiving the social worker as a case manager instead of a therapist so I think learning to differentiate that is important because sometimes we can help you with this but therapy is still our focus.” (Participant 2, Interview, January 2013)  
|        | “The families we do work with are low income so the need for case management is high.” (Participant 3, Interview, January 2013)  
|        | “It’s hard sometimes to provide it myself, but the case manager that you get may not have the same idea as you so it’s a struggle like what is it that you want to accomplish with the Case management but I do think that it is important.” (Participant 5, Interview, February 2013)  
|        | “And if you have some one working with you just making sure you are both working for the same goal and what is going to best serve the client.” (Participant 11, Interview, February 2013)  
| Places | “In San Bernardino there are a lot less resources, or they are not as public. We have to be resourceful in finding those. There are more resources in LA then here in San Bernardino.” (Participant 2, Interview, January 2013)  
|        | “One of the major problems is in the school setting and if we can get services there, that can really help with the overall functioning of the child.” (Participant 1, Interview, January 2013)  
|        | “A barrier in linking a family to food banks is that the family doesn’t always have transportation to bring the stuff back.” (Participant 2, Interview, January 2013)  
|        | “Sometimes linking them to community centers but it depends on the client and if they are interested. The ones that I have, who had interest in the community center have taking full advantage of it and go every day after school and enjoy it, but those are rare.” (Participant 2, Interview, January 2013)  
|        | “The flexibility of the resources that we connect them to because most of them are aware we are a mental health agency so they are more flexible and getting our clients into a certain program per se.” (Participant 6, Interview, February 2013)  
|        | “Usually as a therapist on the case if is do provide CM like providing...” |
resources to community events like when I used to work FSP it was a lot of Case Management it was literally picking up the client and taking them to get what they needed that day. One time I drove out all the way out to UCLA medical center for the client to get psychiatric services.”
(Participant 13, Interview, March 2013)
“Connecting them to resources such as food, clothing, domestic violence, House of Ruth, so that myself has been challenging but I like it. It gives you a sense of satisfaction because its learning another way to connect with that.” (Participant 14, Interview, March 2013)

| Things | “Limited resources can be a barrier, depending on what client is asking for. With economy and housing becoming unaffordable I can imagine that’s probably an issue.” (Participant 1, Interview, January 2013) “If they are worried about paying the bills or providing food, you can’t always focus on the therapy aspect.” (Participant 2, Interview, January 2013) “The big barrier is now with the economy there aren’t many things out there so it makes it very difficult to be able to provide the service when there aren’t services out there.” (Participant 3, Interview, January 2013) “I get really involved with it and sometimes it’s challenging for me because I want to give them so much but their funds may not be available to them so financially they may not be able to do it but “its so wonderful” but they just can’t do it so that’s a little challenging.” (Participant 4, January 2013) “No one has money and unfortunately some programs are not free and some of our families cannot afford it. They would love to, but they just can’t. I think it is mostly financial.” (Participant 5, Interview, February 2013) “The lack of money on the family can hurt the client more because they feel bad they cannot participate.” (Participant 11, Interview, February 2013) |
| Ideas | “It is most effective when clients actually follow through with resources you give them and you are able to see improvements in their life.” (Participant 12, Interview, February 2013) “The intentions of case management is to teach client how to access resources independently and to show them how to navigate through system.” (Participant 9, Interview, February 2013) “Yes there is improvement when providing case management. When you have stability, it definitely helps, especially with the parents with how they are able to cope and deal with the client.” (Participant 2, Interview, January 2013) “There are a lot of needs for different resources and sometimes getting the information and resources is not very easy.” (Participant 4, Interview, January 2013) |
“Sometimes having difficulty with the parents following through with the referrals and we actually have to take them by their hand and “go ahead make the phone call, go ahead fill out that paper work” but um I think that is the major barrier, the lack of follow through or the fear of asking for services is another issue.” (Participant 3, Interview, January 2013)

“Sitting with them, dialing the number and having them ask the questions on the phone, so in the future they can utilize it is effective.” (Participant 6, Interview, February 2013)

“A lot of times what I look for, for the benefit of the client would be extra curricular activities and I think its so hard to because financially they have to pay, even if its at a low cost its still not affordable for these families.” (Participant 4, Interview, January 2013)

“I guess helping them see the need. A lot of families don’t see the need that they need tutoring or they need to go to the food banks or go on welfare or whatever it is.” (Participant 5, Interview, February 2013)

“Its definitely about getting rid of the immediacy of the crises so that you can work with what brought the kid or family to where they are now.” (Participant 11, Interview, February 2013)

“A lot of time they don’t follow though with it so you are running circle with them but when they do follow through and they get the services they need to be able to function better like they client is in tutoring and is getting better school grades cause they understand so they are not acting as much, so yea it helps get the parents on board with it.” (Participant 6, Interview, February 2013)

“When you really listen to what they need and you specifically... I google a lot so just looking it up and actually calling the place and finding out what are your fees, how does someone go about getting your services, that is effective. So I just don’t give a resource I know what’s behind it.” (Participant 14, Interview, March 2013)

“You do collaterals but a lot of them its like “we are going to go, I’m going to be there but you need to ask questions” and if I just tell them the resources its like “I didn’t go, I didn’t feel good I didn’t have transportation” it hasn’t really been positive from my part. I’m not going to stop helping them because it may not help one but it could help someone else.” (Participant 13, Interview, March 2013)

“The most effective Case Management is when I engage the parent in the Case Management. I don’t find it for them, they find it with me. Finding the appropriate level of my help and their help, what are they capable of doing vs. me handing them phone numbers and the level of how they would handle that. So evaluating their current stress level, their knowledge of the internet their comfort in getting on the phone to follow thorough, like just those things though conversation and deciding what they will be able to do and how I will be able to help them.” (Participant 4, Interview, January 2013)
"I think its extremely beneficial and I think many times working with medical clients we get a lot of families in here that do not have a concept of having personal rights." (Participant 5, Interview, February 2013)

"For lower SES families especially families on medical they are told over and over again that you don’t deserve anything or get denied because they are on medical so they don’t have that kind of empowerment to be able to say “I can find this myself”.” (Participant 3, Interview, January 2013)

"It's important to model for them questions to ask so they can feel confident when calling or for any type of Case Management or referral that has been given to them so its important to hold their hand and help them and explain what the referral is about.” (Participant 5, Interview, February 2013)

"Time is a barrier because it’s a service that’s very focused. You can provide therapy and Case Management at the same time because that can overwhelm them. You know you want to be able to provide one service at a time.” (Participant 7, Interview, February 2013)

"I feel that with some families once you give the family one resources then they want you to give them the next one and the next one they don’t seek it out themselves so its taking that step back and telling them where they can find them and have them do it themselves.” (Participant 12, Interview, February 2013)

"Well hands on encouraging the parent to take an active role even though you are there to support them but to empower them to be resourceful so maybe letting them know they need to make the phone call if they are looking for particular service.” (Participant 2, Interview, January 2013)

Themes

"The effectiveness of case management is just providing more stability in the home so the parents are better able to manage the symptoms of the children because they don’t have that extra worry.” (Participant 1, Interview, January 2013)

"The biggest barriers is that there are not a lot of resources out there now and primarily cause of the economy.” (Participant 2, Interview, January 2013)

"I feel we need more resources in San Bernardino County for our low income impoverished families.” (Participant 3, Interview, January 2013)

"I think that when you mix therapy and Case Management there’s a barrier in regards to playing that double role.” (Participant 4, Interview, January 2013)

"Yes absolutely, there is improvement because they have additional support that they didn’t even know was there.” (Participant 5, Interview, February 2013)

"I feel like I actually have to take them by the hand. There are few families that actually follow through with them so it’s the motivation you give them.” (Participant 6, Interview, February 2013)
“When we link them up to food, clothing and that kind of stuff it reduces stress immediately and that always helps but especially when we link them to additional support services that give the parents a little rest, help gives kids structure we see rapid improvement.” (Participant 12, Interview, February 2013)

“Sometimes they can be unstable but that can be the least of their worries if there’s no food. So if you connect them to a food bank or go with them to get the food that relieves them and brings an effective result in Case Management.” (Participant 10, Interview, February 2013)

“A lot of our families need support when it comes to resources in the community or linking them to resources they did not know existed and sometimes helping them gain confidence in asking for services or teaching them to write a letter you know without you supporting them they might not do it.” (Participant 9, Interview, February 2013)
Table 10. Psychiatric Care

| People | “The clinician and psychiatrist may not always see eye to eye.” (Participant 1, Interview, January 2013) |
|        | “The family may not want medications because they are concerned with side effects.” (Participant 3, Interview, January 2013) |
|        | “I’ve link a few and thankfully we have the psychiatrist here on site and we can consult so that has been very helpful to you know for some kids I don’t know if they should be medicated or not, so I’m able to consult with him and he can let me know if it’s a good referral or no he does not recommend it.” (Participant 2, Interview, January 2013) |
|        | “Parents not wanting the child to take medication can be a barrier. They think its going to be permanent or something is seriously wrong with the child, like “why haven’t you been able to fix them” yeah that’s pretty much it.” (Participant 2, Interview, January 2013) |
|        | “It is most effective when the doctor is open and you able to meet with the doctor and give him your point of view and let him see what we are seeing because they may only be seeing them for half an hour of 20 minutes but we seen kid for like months so we have a better perspective of the client and what their symptoms and behaviors are.” (Participant 4, Interview, January 2013) |
|        | “There are some kids that are present symptoms of ADHD then you give them medicine and they knock out the whole day, then you know its not ADHD.” (Participant 5, Interview, February 2013) |
|        | “But I don’t believe in those parents who are just like here take care of my kid and give them medication. That’s not effective because those parents just don’t want to deal with them so they will just have them on medication because they don’t want to deal with them.” (Participant 7, Interview, February 2013) |
|        | “Well when they are open and willing to take it and try it some of their symptoms go away or they are easier to manage. And you see a client that’s happier and a parent or school that’s happier and everyone’s sees an improvement so that has been good.” (Participant 9, Interview, February 2013) |
|        | “Sometimes the psychiatrist only takes what they hear from that session so its hard to get across to them a full scope picture and get across to them what the clients needs are so I kinda think it depends on the psychiatrist and how willing they are to spend the time with the therapist who obviously sees the client more often than them to make the decision on what’s going on.” (Participant 12, Interview, February 2013) |
|        | “The family can also be a barrier if they’re not open to it and are like “no meds, no meds, no meds,” but if the meds can help why wouldn’t you be
open to that so I think that’s also a barrier.” (Participant 14, Interview, March 2013)

“Is very easy to refer to service. It’s a smooth process and the people that work here that provide psychiatric services are very efficient and good workers. They keep in touch with the families make sure med appointments are set in stone, work very hard to make sure meds are consistent when meds are prescribed.” (Participant 13, Interview, March 2013)

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<td>“It is helpful that we provide psychiatric services here, the case management, and the therapy are all here.” (Participant 3, Interview, January 2013)</td>
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<tr>
<td>“Its one of the major advantages we have, we can refer the client to psychiatric services not elsewhere but here in the office so its easier to coordinate all the information and everyone is aware what is going on with the client.” (Participant 1, Interview, January 2013)</td>
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<td>“Um, here in the office its easy because the doctor comes in and we have a really good nurse who is able to squeeze in emergencies or “we need to get this kid in to see the doctor immediately” he will move things around to accommodate the urgency of the client. Its easy here but I don’t know about the other places.” (Participant 5, Interview, February 2013)</td>
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<td>“I don’t know how other programs are but, the services that we provide are above the expectations, than going to a private care facility because even those we only offer it once a month we make sure the kids have good services and if there’s an issue they can always make a phone call and try to resolve it.” (Participant 12, Interview, February 2013)</td>
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<td>“For clients with mood disorders help stabilizes the mood which is the concern with teens and the possibility of self harm and engaging in cutting, I think that the anti depressants help with that and reduce symptoms which reduces my stress and providing care for client.” (Participant 1, Interview, January 2013)</td>
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<td>“I think its just the scheduling its limited because its not every day that the psychiatrist is here, its just once a week so sometimes families do not have the transportation to be able to make it to the office that one visit per month uh I think that’s one of the barriers.” (Participant 6, Interview, February 2013)</td>
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<tr>
<td>“Transportation can be a barrier. Sometimes clinicians have to pick them up and make sure they make it to their session.” (Participant 2, Interview, January 2013)</td>
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<td>“The benefit of it depends on the client and if they are going to be med compliant and also on the age. I think most of my clients are older but whether they are going to be med compliant or the parents by giving it to the younger ones.” (Participant 8, Interview, February 2013)</td>
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<td>Just their ability to focus more in our sessions increases with medication.” (Participant 4, Interview, January 2013)</td>
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“Most of the time I would say there is improvement, there is just a few times it was just a matter of trying different medications or trying it our for longer periods of time or they were not consistent in how they were taking it or they didn’t understand the directions.” (Participant 7, Interview, February 2013)

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<td>“I am not an advocate for medication by any means, but I am more concerned about referring for a client with depression then a client with ADHD.” (Participant 1, Interview, January 2013)</td>
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<td>“It helps the client stabilize mood and help regulate quicker than the insight work as we are doing as therapists.” (Participant 1, Interview, January 2013)</td>
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<td>“If there is any imminent danger the client may be in, which is suicide, homicide, or hallucinations then u want to get them evaluated for medication and if there is a need for resources then there’s the linkage.” (Participant 2, Interview, January 2013)</td>
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<td>“As you all know the medication component is one of the most important ones to provide stability for the client, and without having that piece, progress is minimum so when we do have psychiatric services we can see major changes in the progress.” (Participant 5, Interview, February 6, 2013)</td>
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<td>“Another barrier would be the misconception about psychiatric services and what psychotropic medication is so providing education for the family I think is importance because they are scared, they don’t know how the meds will work, they think the kids will be addicted, there’s a lot of stigma associated with psych services so that’s another major barrier.” (Participant 12, Interview, February 2013)</td>
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<td>“Yes definitely, there is improvement especially when all behavior interventions are not working or it is not making the progress we want and then we introduce medication the improvement is major we do see the difference how all the components work together.” (Participant 3, Interview, January 2013)</td>
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<td>“So I have clients tell me that they are glad to be taking meds, they are able to focus more in class, sleep better at night or they are not as anxious.” (Participant 11, Interview, February 2013)</td>
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<td>“Informing clients of their rights is the most effective thing I can do as a therapist who does not prescribe anything. Helping them use the terms that will get them the medication they need so instead of going in and just saying “i feel sad” well help them explain what sad is and how often so that the psychiatrist could get a better picture and prescribe the right medication.” (Participant 4, Interview, January 2013)</td>
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<td>“A barrier with referrals is that a lot of psychiatrists don’t want to talk to you. They want to do their own assessment and their own stuff. So that part is the biggest barrier because you don’t have the communication to talk and get the medication to the right dosage fast.” (Participant 9,</td>
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Interview, February 2013)

"Here it has been better but in the other agencies it is difficult to even consult with them and one of them if they have a different view or clinical picture than you do then its about finding that middle ground.” (Participant 10, Interview, February 2013)

“If they are older and there is a stigma of not wanting to be on med, it is difficult to motivate them to be compliant.” (Participant 9, Interview, February 2013)

“Every single case is unique even if they present the same symptoms not everybody responds to the medication.” (Participant 2, Interview, January 2013)

“Its you have to outweigh the risk there its weight gain or you know or hallucinations with suicidal ideations so its like well as manage the weight so there might be two negatives on one sides but its which ones the better negative. Depends on how you look at it. Like am I a found believer in mediation? No, but there are symptoms that really do need it.” (Participant 3, January 2013)

“Yes there is a big improvement, like if voices go away, they can concentrate on their work. They can sleep better, enuresis goes away, so yeah I don’t see any downside in psych services. I think if you need it, its there so take advantage of it you know.” (Participant 10, Interview, February 2013)

“It is important to get buy in from the parent that this is serious, its not just the child being disobedient of isolating for reasons XYZ, but they are isolating for a reason so they get to understand the serious the of the diagnosis when they get to the psychiatrist for those who are not they get a little scared but interventions are important to help them and educate them not exacerbate their anxiety.” (Participant 12, Interview, February 2013)

“It’s something that I don’t easily go to, but I see the benefit. Some issues or symptoms are so sever they need that service to get better. But I don’t like to go to psych services right away unless I have actually tried other non medicine treatment.” (Participant 13, Interview, March 2013)

“The one barrier I see if you disagree with diagnosis or the diagnosis doesn’t match and you don’t agree with the doctor but you can definitely discuss with the psychiatrist and make a point or case with what you, cause you get to see the client you see them at home, you are more in tune with the client, just like how a mom is. The psychiatrist only goes by what they are listening to. That is why you have to report everything you see.” (Participant 4, Interview, January 2013)

Themes

"It's comprehensive because they are getting the mental health and psychiatric services together and we are coordinating information so we know how the progress is. We don't have to call an outside agency to know what's going on with the medication regimen and we can monitor
that they are adhering to their medication.” (Participant 1, Interview, January 2013)

“I see improvement, if they are referred to medication it’s because they need it. I could be doing all these coping skills and if they need meds its not going to make a difference because if they are bouncing off the walls and I’m teaching them how to relax, they need to have something else and get them to calm down. But I have seen improvement in most of my clients to take meds.” (Participant 2, Interview, January 2013)

“When the medication is right it makes a world of difference because the client can sit there and function in session. They can sit still long enough or not cry the whole session and be able to talk about what’s going on it really just depends on how quickly they get on the right medication or dosage.” (Participant 3, Interview, January 2013)

“The parents not wanting the kid to be medicated can interfere, which is understandable, but sometimes they really just don’t want their kids on meds and they really need them. We can’t really talk them into it but just providing them the information and why its beneficial. I think that’s the biggest hurdle we have to jump.” (Participant 6, Interview, February 2013)

“Sometimes the psychiatrist is limited in time to see the client but you know its important to consult with them but that can be difficult because their days are very limited they are only here 1 or 2 days so their schedule is packed.” (Participant 12, Interview, February 2013)

“If you are talking about them getting better, it depends if they buy into the medication and its essential for them then they are going to benefit. Some may not, there is a stigma to it. Some may not follow the directions or want to take it and it may not enhance treatment.” (Participant 14, Interview, March 2013)
Table 11. Group Therapy

<p>| People | “I think the kids benefit the most from hearing other kids other teenagers having depression. I remember one kid saying “I though I was the only one that felt that way.” They see they are not the only one and there are other kids with similar issues and they can talk about it and bring it up with their peers.” (Participant 1, Interview, January 2013) “In the group setting there are a lot of personalities. So some people may take over the group and when they leave they talk more and you have others that are shy and introverted and they don’t necessarily come out so biggest roadblock is balancing the groups personalities and letting everyone have their time to say and speak and feel comfortable doing so.” (Participant 2, Interview, January 2013) “It has definitely worked with suicidal teens who self injure and have drug and alcohol issues so when they go to group they feel connected to one another and that they are not the only ones out there.” (Participant 3, Interview, January 2013) “You can get more people into therapy. In 2 hours instead of seeing 2 people you can see 5 or 8.” (Participant 4, Interview, January 2013) “Having a common group members come together and talk about issues and struggles and how they succeeded so they were able to form networks and friendships.” (Participant 4, Interview, January 2013) “It can be a barrier when you have a really mixed group of kids, shy kids, out going kids and the out going kids will like over talk and the quiet kids don’t so you don’t have a widespread how the services are given or taken.” (Participant 12, Interview, February 2013) |
| Places | “We did one here last summer and I’ve done them when I was interning in LA. I think they are very effective when it comes to normalizing experiences.” (Participant 4, Interview, January 2013) “If transportation wasn’t a big issue with the population that we work with I would probably do more groups in the office.” (Participant 2, Interview, January 2013) “Transportation is a barrier. For example there a lot of the families do not have transportation so they would have to take the bus here for therapy and for a lot of families they know its beneficial and helpful they just cannot bring themselves to do it or they cannot afford to buy the bus ticket for all 5 of the family members.” (Participant 1, Interview, January 2013) “I also think in certain agencies, it’s harder to do because of transportation especially here we run into that because we are community based org so our family’s don’t always have the resources or transportation to get them here and our clients are all over the place.” |</p>
<table>
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<th>Things</th>
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<td>(Participant 3, Interview, January 2013)</td>
<td>“Yeah one of the barrier is lack of time in order to create group in this setting you have to use so much time for the group and figure out how to bill for each individual client that came to the group and you can’t capture the billing for all the clients who came to the group for this amount of time.” (Participant 4, Interview, January 2013)</td>
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<td>(Participant 6, Interview, February 2013)</td>
<td>I’ve facilitated groups on social skills, anger management, parenting, bereavement, life skills, etc.” (Participant 1, Interview, January 2013)</td>
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<td>(Participant 6, Interview, February 2013)</td>
<td>“I have done a lot of group therapy that surrounds teen suicide and drug and alcohol.”</td>
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<td>(Participant 12, Interview, February 2013)</td>
<td>“I think, at the time I worked with the co leader and that was helpful, bringing snacks would get them to come and also just doing fun things, or things they would enjoy.”</td>
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<td>(Participant 1, Interview, January 2013)</td>
<td>“It teaches them to problem solving and solving problems in and outside of group.” (Participant 1, Interview, January 2013)</td>
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<td>(Participant 1, Interview, January 2013)</td>
<td>“It takes the client take a long time to open up and they hide behind mask and not participate in the group process until someone confronts that person.” (Participant 4, Interview, January 2013)</td>
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<td>(Participant 2, Interview, January 2013)</td>
<td>“It is hard to keep confidentiality within the group.” (Participant 2, Interview, January 2013)</td>
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<td>(Participant 3, Interview, January 2013)</td>
<td>“Transportation is a barrier. Even when in the schools, teachers sometimes do not want the client to participate and finding a common schedule so that they can participate.” (Participant 3, Interview, January 2013)</td>
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<td>(Participant 4, Interview, January 2013)</td>
<td>“It also helps conceptualize some of the things that we talk about with others and it helps them be able to share “oh I did this and it helped” so to have that experience was positive.” (Participant 4, Interview, January 2013)</td>
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<td>(Participant 5, February 2013)</td>
<td>“Just allowing each person to participate and give their own feedback and express them selves openly without fearing judgment or being criticized I think that’s a major advantage, having a place that they can actually express what they are feeling.” (Participant 5, February 2013)</td>
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<tr>
<td>(Participant 12, Interview, March 2013)</td>
<td>“Honesty, because when working with teens, if you are not honest with your experience with your experiences with drug and alcohol or suicide ideations then they are not going to be. So being as honest as you can be in the room and being honest that you are not the expert of their life kind of helps them talk about it and function as a group and problem solve themselves.” (Participant 12, Interview, March 2013)</td>
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|                                                                        | “That aspect in itself is so powerful that when you meet with them
individually you don’t have to convince them they are the only one. You take steps forward with group therapy and definitely convenient and helpful with many clients.” (Participant 2, Interview, January 2013)

“Yes there is improvement because it helps them grow and process things at a deeper level because they have a group that understands and support system that they don’t have In the real world with whatever they are going through.” (Participant 14, Interview, March 2013)

“Not making it so much like therapy, like sit down lets do a check in made it more effective, well we did but more informally.” (Participant 8, Interview, February 2013)

“There were in the fact that why it wasn’t so successful was because we didn’t have many participants and I think part of the reason was that it was summer time and for teenagers they were out of school, they didn’t want to come an extra hour out of their time to participate and they just really didn’t want to do it. So I think the time of day and the season was also a little difficult.” (Participant 6, Interview, February 2013)

“There are specific goals where a group can broaden the horizon and get the client to generalize and use their coping skills on a different level. It gives them another way to apply everything you are teaching the individual and the family.” (Participant 7, Interview, February 2013)

“It usually takes more time in documentation than what you get paid for in terms of medical reimbursement. It becomes cumbersome and usually the clinicians that work here have a tight case load so its harder.” (Participant 1, Interview, January 2013)

“I would say it depends on the issue they are dealing with but in general with anger management groups and social skills groups, usually the kids do really well working with peers going through the same thing.” (Participant 10, Interview, February 2013)

“If individuals who are open to new ways to helping themselves and learning from others I think it can be beneficial and I think the beauty of it is that it can transfer back into their real life.” (Participant 3, January 2013)

“If you have the experience of how to learn the ways of socializing and respecting others options and learning from them and growing from others then you can take that back to your own house and your own family and you own community.” (Participant 8, Interview, February 2013)

Themes

“They have that commonality about talking about coping skills and if your friend is doing it then it makes it easier for you to do it too.” (Participant 1, Interview, January 2013)

“It is very helpful because the way the children understand and see that they are not the only ones going through the situation, they can identify with that is going on with other kids their own age and for the family, for
the parents to get a better understanding of their children’s functioning.” (Participant 3, personal communication, January 30, 2013)
“I think it is under utilized, but it is harder to schedule with kids.” (Participant 2, Interview, January 2013)
“The biggest barrier is the transportation issue. When we did that group we actually had to pick them all up and take them back home so that’s time consuming.” (Participant 4, Interview, January 2013)
“It does and it also normalizes because there are other people in the same boat.” (Participant 5, Interview, February 2013)
“I think it was beneficial in the way where they were able to get other peoples perspective so it just wasn’t their own.” (Participant 8, Interview, February 2013)
“Um, confidentiality is always a tough one.” (Participant 6, Interview, February 2013)
“Well it feels like you are not alone, so I see the idea that you have other people that are going through the same thing as you so yeah I think it is a great idea.” (Participant 6, Interview, February 2013)
“It also helps stabilizes the problem and allow them to see that people are in the same situation they are, they have a support when going to group it normalizes the problem. They get a lot of support I think.” (Participant 10, Interview, February 2013)
“What I love about group therapy I love to see, the benefit I see, even in ourselves when you see someone experiencing the same thing you are, or talking to you, or feeling commonality with other people helps you grow rather than hearing it from a therapist.” (Participant 14, Interview, March 2013)
REFERENCES


This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:
   Team Effort: Jolene-Fe Balancio & Suzette Covarrubias

2. Data Entry and Analysis:
   Team Effort: Jolene-Fe Balancio & Suzette Covarrubias

3. Writing Report and Presentation of Findings:
   a. Introduction and Literature
      Team Effort: Jolene-Fe Balancio & Suzette Covarrubias
   b. Methods
      Team Effort: Jolene-Fe Balancio & Suzette Covarrubias
   c. Results
      Team Effort: Jolene-Fe Balancio & Suzette Covarrubias
   d. Discussion
      Team Effort: Jolene-Fe Balancio & Suzette Covarrubias