VIRGINIA ELEMENTARY PRINCIPALS' PERSPECTIVES ON INTERAGENCY COLLABORATION FOR CHILDREN WITH EMOTIONAL AND BEHAVIORAL DISORDERS

A Dissertation

Presented to

The Faculty of the Curry School of Education

University of Virginia

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Education

---

by

Lynne A. Crotts, B.S., M.A., Ed.S.

May 2015

© Copyright by
Lynne Alison Crotts
All Rights Reserved
May 2015

ABSTRACT

Students with emotional and behavioral disorders (EBD) have challenges that impact their learning or the learning of others in school. Recognizing that schools are a natural and efficient place to offer services and programs for students with EBD, it is critical that we understand the type and process by which services are offered in schools. Interagency collaboration has been shown to be an effective solution to ensuring necessary services are provided; however, there has been limited consideration of the way in which principals view these collaborations. School administrators' perceptions of how services are administered in their school are an important factor to consider, given they are the facilitators of the process. This qualitative study examined the perspectives of 10 elementary school principals from Virginia who are involved in and are responsible for the services provided to students with EBD. Research questions addressed the extent and nature of collaboration, as well as outcomes, contributors, and barriers to implementation. Data collection included a brief questionnaire and semistructured interviews. The system of care concept and the negotiated order theory served as frameworks that guided the design of the study and data analysis. Consistent with these frameworks, the findings highlighted the importance of communication and principals' value of outside professionals' support; however, principals perceived that these external professionals often provided suggestions which did not fit with the school context. Most of the principals perceived it was their responsibility to contact outside agents and to serve as gatekeepers of the school. Ultimately, findings suggested wraparound support and collaboration might help professionals make better-informed decisions regarding services for students with EBD. Taken together, the findings suggest a need for additional

staff development and professional learning opportunities for all stakeholders in order to improve the coordination of services and implementation of contextually appropriate support services.

Department of Educational Leadership, Foundations, and Policy
Curry School of Education
University of Virginia
Charlottesville, Virginia

APPROVAL OF THE DISSERTATION

This dissertation, "Virginia Elementary Principals' Perspectives on Interagency Collaboration for Children With Emotional and Behavioral Disorders" has been approved by the Graduate Faculty of the Curry School of Education in partial fulfillment of the requirements for the degree of Doctor of Education.

____
Catherine Bradshaw, PhD, Advisor

____
Robert Covert, PhD

____
Antoinette Thomas, PhD

____
Pamela D. Tucker, EdD

April 2015

DEDICATION

I would like to dedicate this work to my parents who have always believed in me.

ACKNOWLEDGEMENTS

"There is a magic that is potent beyond human understanding when someone in a position of power extends himself or herself on your behalf, based on nothing more than a belief in your potential. It lights a fire that would take a hurricane to extinguish."

-Rachel Jones on Ben Bradlee

This is the one time I get to acknowledge in writing the people who have helped me on this journey of discovery, so I'm taking advantage of it. I once met a man who had started his dissertation but was unable to finish. He said that to complete a dissertation, you had to have at least one of three things: support from family, friends, or professors. I have been fortunate to have all three.

First to my family, I cannot express my undying love and affection for you all. Mom, you have been my rock and foundation. Ed, your willingness to support me in any way possible means a great deal to me. Dad, your humor got me through many a difficult night of questions—all I had to do was call and ask! Betty, your complete trust and knowingness is a part of me. My brother, Rick, your respect for your little sister is appreciated, and I am eternally grateful.

To my Gathering family: Isis Ringrose, how do you thank someone who has changed your life? Words cannot describe my undying appreciation and gratitude. Ninai Koplan, your love, affection, and joyous hugs are always with me. Esther Kern, a twinkling star, your giggle has made my life better. Eleanor Crichlow, thank you for your constant faith in me. Dawn Anderson, your cards, texts, and calls were always there for me to ponder and enjoy. Sandy DeKay, your constancy is uplifting. Cheryl Henig, we were together at the beginning, middle, and end. You are my teacher of the year. Marylin Riggan, thank you for being there for me. Sarah Oh, you are my inspiration. Rebecca Kneedler, thank you for your infectious and generous spirit. Kay Buchanan and Carole Lohman, where would I be without my trusty seekers of truth? I appreciate your time and energy. You are wonderful librarians, but mostly just amazing people in my life. Sheilah Sprouse, here's a little credit to one of those people who never get enough of it. You are a gift!

I am most appreciative of the principals interviewed who gave time out of their already busy day to help and support me. I am truly grateful for your contributions.

Finally, to my committee chair, Catherine Bradshaw, you came to my rescue when I needed it most, and I will never forget it. Your dedication, determination, and commitment are truly inspiring. Your positivity helped me through this journey. Yes, you do make a difference. Bob Covert, I don't know of anyone else who would spend every Thursday morning with me except you. You helped me to believe everything *you* think! You are my hero. Antoinette Thomas, your unwavering faith and loyalty, calls or emails when I least expected them, will forever be in my heart. Pam Tucker, your dedication to all things administration is truly a sight to behold. Thank you for your insights and well wishes.

TABLE OF CONTENTS

Page

DEDICATION iv
ACKNOWLEDGMENTS v
LIST OF TABLES vii

CHAPTER 1: INTRODUCTION 1

CHAPTER 2: REVIEW OF THE LITERATURE 23

CHAPTER 3: RESEARCH METHODOLOGY 40

CHAPTER 4: RESULTS 59

CHAPTER 5: DISCUSSION 90

REFERENCES 114

APPENDICES 149

A. Senate Joint Resolution No. 47 149

B. 2009 Top 20 Statewide Service Gaps Ranked by CSA Census 153

C. Locale Code Categories 154

D. Script for Superintendents..155

E. Participant Letter of Consent 157

F. Principal Questionnaire.. 158

G. Principal Interview Questions 159

H. Framework Constructs for Data Analysis..161

I. Principals' Definition of Interagency Collaboration.............................163

LIST OF TABLES

TABLE Page

1 System of Care Concept: Guiding Values and Principles 27

2 Requirements for Practice of the Wraparound Process 33

3 Summary of Participant Characteristics and Context.......................................47

4 Summary of Principal Characteristics and Context..60

CHAPTER 1

INTRODUCTION

A growing number of youth in the United States is in need of special services. Data from the U.S. Department of Education (2013) indicate that the number of children in the United States ages 3–21 receiving special education services increased from 4.7 million children in 1990 to 6.4 million in 2010. Understanding the ways schools and outside agencies work with each other within the context of support services for students with emotional and behavioral disorders (EBD), such as an interagency support organization, may lead to a better understanding of more promising avenues to success for students with EBD (Cook, Landrum, Tankersley, & Kauffman, 2003). Collaboration between schools and outside agencies may result in more efficient and effective services in schools and communities and, in turn, may help address statewide demands and expectations (Smrekar & Mawhinney, 1999, p. 444). The range of services provided to students with EBD varies, yet the literature has not specifically described the extent to which the administrators and teachers are engaged in these support structures (Landrum, Tankersley, & Kauffman, 2003). A model that involves all parties in the decision-making process to improve services for elementary students with EBD through deliberate and intentional actions may help children with EBD be more successful in school (Stroul & Blau, 2008).

As administrators continue to face challenges in making schools safe and secure while meeting the academic, social, and emotional needs of every student, it is important to determine whether collective actions between schools and outside agencies make a difference in the lives of students with EBD. Despite all the research and recommendations, little focus has been placed on the roles and perceptions of principals engaged in meeting the needs of students with EBD at the interagency level. Further, limited research has focused on school principals' perceptions of the effectiveness of interagency collaboration in relation to systems of care (Osher, 2002).

Therefore, the purpose of this study was to provide detailed perspectives from elementary principals in public school settings in Virginia concerning interagency collaboration between school professionals and outside specialists (e.g., psychologists, psychiatrists, doctors) for students with EBD in relation to the system of care conceptual framework (Stroul & Friedman, 1986) and the negotiated order theory (Strauss, 1978). An additional aim of this study was to examine the contributors and barriers that prevent interagency collaboration between school agents and outside agents. This work has important implications for school professionals as well as other agents who provide services for children. Due to the increased number of students with EBD in the general education classroom, the need for services provided by various agencies has steadily grown. Interagency collaboration may enhance the participation of the individuals who work with these students and provide higher quality, more appropriate care.

Prevalence of Mental Health Concerns in Youth

In 2013, the U.S. Department of Education (2013) documented more than 6.4 million students ages 3–21 with special needs who are served under the Individuals with

Disabilities Education Act (IDEA, 2004). Of this number, 373,000 or 5.8% of the total enrollment of students have emotional disorders that severely affected their functioning. The Commonwealth of Virginia reported 161,198 students with disabilities; of these, approximately 9000 or 5.58% had EBD (U.S. Department of Education, 2012). Even more significant is the expectancy that by the year 2020, childhood emotional and behavioral disorders will rise by more than 5% (Murthy et al., 2001).

Correlates and Consequences of Mental Health Problems in Childhood

Compared with other students, common risk factors for having an EBD include being male, poor, and/or members of racial/ethnic minority groups, particularly African American (Harry & Klingner, 2006; Kauffman & Landrum, 2009; Scarborough & McCrae, 2010; Skiba, Poloni-Staudinger, Simmons, Fegins-Aziz & Chung, 2005; Stroul & Blau, 2008; Substance Abuse and Mental Health Services Administration [SAMHSA], 2010). Wiley, Siperstein, Forness, and Brigham (2010) documented significant connections between school-level variables, such as lower socioeconomic status and school context, and children's decreased social skills and increased problem behaviors. More than a decade ago, IDEA confirmed that in 1997, African Americans comprised 16% of the total enrollment in elementary and secondary schools while making up 21% of special education enrollments (U.S. Department of Education, Office of Special Education Programs [OSEP], 2007). IDEA acknowledged, however, the misdiagnosis and misplacement of minorities into special education programs and recommended that efforts be made to prevent disproportionate assignments. In spite of these efforts, minority student misrepresentation in special education continues (U.S. Department of Education, 2012). In 2006, African Americans made up approximately 15% of students

in the United States ages 6–21, and they represented approximately 29% of students with an EBD label. Whites made up 61% of the student population ages 6–21, with only 57% identified as EBD. This means African Americans were twice as likely to be identified as EBD compared with white students (Data Accountability Center, 2006). In 2011–2012, African Americans made up 15.3% of the total enrollment in the 3–21-year-old age group while making up 18.7% of special education enrollments (U.S. Department of Education, OSEP, 2013).

Reports by the U.S. Surgeon General (2001), the World Health Organization (Murphy et al., 2001), and the National Institute of Mental Health (2001) have summarized the possible negative effects of emotional and behavioral problems in children. For the millions of youths ages 12–7 who received mental health services and were designated as EBD, the most common reason they received services was depression (46%), followed by problems at home (27.8%), breaking the rules (26.1%), and 20.7% considering or attempting suicide (20.7%; SAMHSA, 2010). Children with EBD are more likely to live in an alternative living arrangement, such as foster care, or to live in single-parent households where the parent is unlikely to have a high school degree or a job; 73% are arrested within 5 years of leaving school (Kauffman & Landrum, 2009; Wagner & Cameto, 2004; Walker, Ramsey, & Gresham, 2004). According to the parents, 38% of these students have been held back a grade at least once; and 40% have gone to five or more schools since starting kindergarten (Wagner & Cameto, 2004). Moreover, children with EBD may experience severe clinical symptoms (Stroul & Blau, 2008), high rates of trauma (Fairbank, Booth, & Curry, 2002), drug abuse, and poor academic achievement (SAMHSA, 2010). Students with EBD receive poorer grades and

fail more courses than students with other disabilities; as a result, these students are retained in their grade level more often than students in other categories of disabilities (Wagner & Cameto, 2004). Academic performance is a significant factor because lower academic performance is associated with significantly higher rates of problem behaviors (Gable & Tonelson, 2010; Reinke & Herman, 2002; Sutherland & Oswald, 2005). In addition, nearly three-quarters of secondary students with EBD have been suspended or expelled from school (Wagner & Cameto, 2004). Also concerning is that approximately 66% of students with EBD struggle academically and feel disengaged from school (Cheney, 2012). Students with EBD often experience limited school success and typically present the most challenges to school personnel. Variations in the behaviors of students with EBD, often due to poor academic, social, and relationship skills, cause negative interactions with their peers and teachers (Kauffman & Landrum, 2009; Walker et al., 2004). Numerous elementary classroom teachers note the time and effort necessary when managing challenging student misbehavior and simply want the student with EBD out of their classroom (Gable & Tonelson, 2010; Murray & Myers, 1998). These detrimental outcomes affect teachers and general education students, as well as students with EBD and their families and communities. When teachers believe they can no longer manage a student's behaviors, a referral to a child study committee may be warranted.

Referrals, Identification Process, and Issues in Assessment

The procedure for identifying a student as EBD typically consists of several stages (Smith, 2007). First, a general education classroom teacher of the student meets with the child study committee or multidisciplinary team, which generally consists of the principal or school administrator, general education teacher, special educator, related

service provider (e.g., physical therapist), someone who can interpret evaluations (e.g., school psychologist), the parent(s)/guardian(s), and others asked to attend at the discretion of the parent(s)/guardian(s) or school. Medical records from doctors may also be used; as a result, medical professionals may be included. The committee offers recommendations to the general education teacher. Since changes to IDEA in 2004, many states have been using a procedure called Response to Intervention (RtI) as a prereferral procedure before formal identification procedures are implemented (IDEA, 2004; National Center on Response to Intervention, 2010). RtI consists of three stages, or levels, designed to monitor and assess students' progress. In the first stage, or Tier 1, the student receives instruction from the general education teacher (McNamara & Hollinger, 2003). In Tier II, group instruction or group remediation is provided. In Tier III, more intensive, individualized interventions are provided. Before the committee refers a child for a special education evaluation, a student must continue through all the levels of instruction. If the student continues to have difficulties, and the committee decides that the interventions were unsuccessful, it may decide that an evaluation of the student should take place to determine eligibility for special education services. A school district representative, such as a school psychologist, school social worker, or central office special education representative, assesses the student and ensures the evaluation procedure is observed (Janz & Banbury, 2009). No standardized test is available to assess whether a child has EBD; however, behavior rating scales, procedures for observing and evaluating behaviors, along with a clinical assessment, may lead to a determination of the type of disability. Ultimately, the decision to label a student as EBD is a matter of judgment from the school personnel, based on the data collected and

comparisons with other students (Kauffman & Landrum, 2006). This evaluation must be completed within 60 days before reporting the results back to the school's child study committee and eligibility is determined.

Teachers may be reluctant to identify students as EBD for several reasons, including the social stigma of the label, ineffective assessment tools and practices, and fear of false identification (Kauffman, 2009; Van Acker, 2010). In a report by the U.S. Surgeon General (2001), Forness (2000) noted that often children are not referred until age 10, even though problems were reported as early as age 5, and age 10 can be too late for intervention. Teachers may be hesitant to refer young students until they demonstrate severe disturbance, because of the limited use of evidence-based practices (or effective intervention strategies) proven to address the academic, behavioral, and emotional needs of students. This hesitancy may lead to poor outcomes (Van Acker, 2010; Wehby, Dodge, Valente, & The Conduct Disorders Research Group, 1993). Nationally, school personnel have identified less than 1% of their students as EBD even though estimates indicate at least 5% of students exhibit an emotional or behavioral disorder (Costello, Egger, & Angold, 2005; Kauffman & Landrum, 2009; Walker, Nishioka, Zeller, Severson & Fell, 2000). SAMHSA (2007) estimated that one in five youth may have an identifiable emotional disturbance.

For some, EBD represents instability (Van Acker, 2010); therefore, general education teachers may not want to have a child with EBD in their classroom. However, some teachers do not refer a student of a suspected disability, because they believe they can work with the student or manage the behavior concern on their own. Some teachers

do not hesitate to refer students, because they think the student may get the support necessary with an Individualized Education Program (Murray & Myers, 1998).

Parents of children with a suspected disability have different issues with identification. Parents may not be able to handle behavior problems at home, so they will refer their child for services through the school (Kline, Simpson, Blesz, Myles, & Carter, 2001). However, parents may not want the stigma of their child labeled as EBD (Crowell, 1993) or they may have concerns that others may view them as having poor parenting skills and will decline services. As a result, parents may not want to take the child to medical professionals, perhaps thinking they may be blamed for the child's behavior (Hyman, 2000).

Additionally, school psychologists may not be inclined to identify a student as EBD (Kelley, 2004). This disinclination may be due to the rate of comorbidity of emotional disabilities with other disabilities, such as speech or language problems, learning disabilities, other health impairments (e.g., attention deficit disorder or attention deficit hyperactivity disorder), anxiety or mood disorders, and substance abuse (Forness, 2000; Rock, Fessler, & Church, 1997). Some school psychologists do not feel prepared to administer tests and interpret assessment results (Rees, Farrell, & Rees, 2003; Van Acker, 2010, p. 5). Moreover, some school psychologists think the EBD special education designation may shield the student from receiving appropriate consequences to disruptive acts in school due to accommodations provided for EBD students (Walker et al., 2000).

Once identified, some administrators may place students in more restrictive environments, such as self-contained classrooms or even special schools (Lane, Wehby,

Little, & Cooley, 2005) without related services such as counseling (LaPoint, 2000). As a result, many students with emotional and behavioral challenges needing specialized instruction through special education programs are not being identified or receiving appropriate services (Landrum et al., 2003).

Services Provided to Students With EBD

Most students with EBD spend a sizable percentage of their school day in the regular education classroom, not in the special education classroom. For example, in 2012, the percentage of students with EBD ages 6–21 who spent 80% or more of their class day in the general education classroom was 43%, those students who spent 40–79% of their day in the general education classroom was 18%, and those students who spent less than 40% of their time in the general education classroom was 20.6 % (Aud et al., 2012). Therefore, school administrators, community members, teachers, parents, and students must acknowledge that for students to learn effectively in the general education or special education classroom, emotional and behavioral problems need to be addressed (Gable & Tonelson, 2010; Van Acker, 2010).

School principals play a strategic role in providing support services for children with mental health needs, because they are the ultimate decision makers as to what services are provided to children in schools. Ensuring productive interaction between all parties is an administrator's primary responsibility (Ubben, Hughes, & Norris, 2001). When school administrators involve relevant members of a student's support team in all aspects of the delivery process, a team can be developed that further enhances cooperation and collaboration (Larson & LaFasto, 1989). However, a 2010 survey completed in Virginia (Gable & Tonelson, 2010) found that principals had limited

knowledge of interactive collaborative services, evidence-based practices, and legal responsibilities in terms of what their teachers should offer students. Additionally, there was a decreased emphasis on these services, because school budgets and resources had decreased and school district specialists were laid off; instead, districts hired educators with little knowledge of special education services and supports. The Virginia Department of Education has not studied the problem.

There is a significant financial cost associated with services for EBD students (Kauffman, 2009). Some professionals believe these costs could be lowered if suitable services were provided within the community (National Center for Youth Law, 2006). Although attractive, closing residential placement facilities and providing services in each community simply has not proven viable (Kauffman & Landrum, 2009). In a 2011 study concerning the development of a plan for community-based children's health services, the Virginia Department of Behavioral Health and Development Services (VDBHDS, 2011) found that comprehensive support services for children in Virginia were complicated and quickly changing. The growth in services is a result of the 1993 Comprehensive Services Act (CSA) for At-Risk Youth and Families (CSA, §2.2-5206). The system of care philosophy and principles are the core of the act; the mission of the Office of Comprehensive Services is to design a collaborative system that focuses on at-risk children (Comprehensive Services Act for At-Risk Youth and Families, 2013). The purpose of the act is "to provide high-quality, child centered, family focused, cost effective, community-based services to high-risk youth and their families" (Virginia Department of Education, 1993). As such, it provides money to localities for high-risk youth services, and local interagency teams manage implementation; states and local

communities are required to match the funding. Medicaid funding may be used to support embedding day treatment providers in schools. Therapeutic day treatment is a program provided for those students with issues related to emotions and behaviors who are eligible for Medicaid funding. This program embeds day treatment providers in schools, and the counselors address disruptive behaviors, while providing individual, small group counseling sessions, or both (National Counseling Group, 2014).

Incorporating mental health professionals into school settings has decreased the rate of young student expulsion from school because of the more positive environment and teachers' increased ability to deal with problem behaviors (Perry, Dunne, McFadden, & Campbell, 2007; Raver, Jones, Li-Grining, Sardin-Adjei & Jones-Lewis, 2007). Teacher confidence and stress have improved as well (Brennan, Bradley, Allen, & Perry, 2007).

Although the need for comprehensive mental health support services is evident and urgent, service delivery programs for EBD children are frequently delivered in a fragmented and often uncoordinated manner, and they are generally lacking in consistency (Adelman & Taylor, 2000; Sadeh, Sullivan, & Cowan, 2014; Van Acker, 2010; VDBHDS, 2011). Eber and Keenan (2004) noted that many children with EBD receive services through special education programs, mental health services, juvenile justice, foster care, and child welfare "with historically dismal outcomes" (p. 502). This is a result of differing structures, philosophies, and resources. This fragmentation or failure of individual agencies further indicates the need for collaborative services that link all stakeholders together in effective interventions and structures to create positive

outcomes for children with EBD (Bradley, Doolittle, & Bartolotta, 2008; Eber & Keenan, 2004; Koyanagi & Gaines, 1993; Stroul & Blau, 2008).

Findings from Gable and Tonelson's study (2010) indicated that 31% of the Virginia state directors surveyed reported implementing mental health services in their schools; however, 20% did not know whether mental health services were currently offered in their schools (p. 37). "Given that one in ten students suffers serious enough mental health problems to negatively affect daily living . . . exploration of collaborative mental health services and supports linked to the culture of the community may be warranted" (Gable & Tonelson, 2010, p. 42).

The System of Care Framework

The landmark *Unclaimed Children Study,* led by Knitzer (1982), reported that two-thirds of all 3 million children with EBD in the United States were receiving inappropriate services or no services at all. This study brought significant attention to children's mental health issues. As a result, Knitzer proposed the system of care framework in 1982 (Duchnowski, Kutash, & Friedman, 2002; Knitzer, 1982; Lourie, 2003). The system of care framework promotes the idea that students with EBD should have access to community-based services and supports (Hernandez & Hodges, 2003, p. 21). As a result, the National Institute of Mental Health funded the Child and Adolescent Service System Program in 1984. This program provided assistance to help create and develop systems of care for children with EBD (Duchnowski et al., 2002; Lourie, Stroul, & Friedman, 1998; Neil, 1997). Since that time, system of care principles have been widely recognized as a "best practice" in public mental health (Lourie, 2003).

Based on Knitzer's proposal, Stroul and Friedman (1986) wrote their seminal work *A System of Care for Children and Youth With Serious Emotional Disturbance*. The system of care framework focuses on changing the structure of the services provided for youth, including coordinating efforts across professional systems, reducing financial burdens to service access, and creating collaborative interagency teams (Blodgett & Behan, 2003; Stroul & Blau, 2008; Stroul & Friedman, 1986). Stroul and Friedman developed the core values and guiding principles that exemplified a holistic support system for children.

The goal of systems of care is to provide the most advanced, effective clinical services and interventions, implemented with fidelity, that are integral to success (Stroul, 2002). Stroul agreed with the notion of having scientifically proven treatments. She warned, however, that most interventions have not been tested on the diverse population of children with many needs, challenges, and co-occurring conditions, who receive multiple services. The scarcity of evaluative research on support programs indicates that few mental health practices meet the American Psychological Association guidelines (Behan & Blodgett, 2003). As a result, several researchers observed important concerns: (a) the context in which evidence-based practices are implemented (Gonzales, Ringeisen, & Chambers, 2002), (b) the possibility of the field becoming evidence based as opposed to system of care based (Hernandez & Hodges (2002), and (c) the fact that not all services have a strong evidence base at this time (Jensen, 2002). Hoagwood, Burns, Kiser, Ringeisen, and Schoenwald (2001) noted that improved clinical results in relation to comparison groups have not been demonstrated. However, some agencies have failed to inform each other, resulting in ambiguity and research not meeting scientific standards

required to classify systems of care as “well established” or “probably efficacious” according to the American Psychological Association’s guidelines (Behan & Blodgett, 2003; Rosenblatt, 2010).

Interagency communication and collaboration are important aspects of a mental health care delivery system, particularly for children and adolescents with serious emotional and behavioral needs (Center for Mental Health Services, 2001). When system of care principles and values are integrated into provider practices through coordinated and valued services, desired outcomes are achieved (U.S. Department of Education, 2005). Some research has suggested that systems of care have resulted in improved behavioral and emotional problems as well as enhanced school performance (Manteuffel, Stephens, Brashears, Krikelyova, & Fisher, 2008). Additionally, most families noted improvement in resources for their children (U.S. Department of Education, 2005). Since systems of care are considered to address collaboration between agencies, it is important to understand principals’ perceptions of working with outside professionals; principals are the critical link among school staff and outside groups (Jehl & Kirst, 1992).

Overview of the Methodology

This exploratory and descriptive study used semistructured interviews with principals to address the research questions. According to Patton (2001), this is the most appropriate research design to inform issues or events when limited knowledge exists. A questionnaire and interviews provided principals’ demographic information and experiences. Interviews further identified principals’ perceptions regarding whether and how interagency collaboration between schools and outside agencies takes place. Perceived positive and negative outcomes of interagency collaboration were solicited.

Open-ended interview responses were analyzed and coded using an interpretivist paradigm with inductive analysis (Patton, 2014; Vazou, Ntoumanis, & Duda, 2005). Using inductive analysis, the researcher sought undiscovered patterns of emergent understandings, reduced data into a summary format, established connections between the research objectives and the findings derived from the data, and developed a framework of the structure for experiences evident in the data (Patton, 2014; Thomas, 2006).

Data analysis methods for describing principals' perspectives used codes to categorize perspectives and data from the interviews. In qualitative research, validity is an important consideration for an interpretivist researcher (Maxwell, 1992). Domains were selected by using system of care principles and guidelines to address validity of the instrument (Stroul, 2002). For example, the concept of having access to comprehensive services and ensuring children with EBD received integrated and coordinated services between all agencies and programs was informed by the system of care concepts (Stroul, 2002).

Research questions. This current study aimed to address the following research questions to better understand principals' perspectives on interagency collaboration in relation to students with EBD in the context of system of care framework and the negotiated order theory:

1. To what extent, and under what conditions, do school principals collaborate with outside professionals on behalf of students with EBD?

2. What is the nature of interagency collaboration between school principals and outside professionals on behalf of students with EBD, as identified by participants?
3. What are the outcomes of interagency collaboration between school principals and outside professionals?
4. What are the contributors and barriers to interagency collaborative services, as identified by participants?
5. How can collaboration between school agencies and outside agencies be improved?

Problem statement. School principals have considerable responsibility for managing their schools and serving as the educational leaders within their school buildings (Dettmer, Knackendoffel, & Thurston, 2013). Administrators also must be involved in collaboration with outside agents, because they are the ones who expedite and encourage collaboration and communication with experts in the community. They help clarify collaborative roles and set schedules to facilitate the provision of services between all parties involved (Dettmer et al., 2013). Only with principals' permission are outside service providers able to come into the school to work with students. Consequently, the role of principals is essential to the successful process of collaboration for students with EBD. Although principals may be central to interagency collaboration, little is known about the actual communication between principals and outside professionals (Gable & Tonelson, 2010). As leaders in the school, principals operate on behalf of all students; therefore, it is essential to attain their perceptions concerning the collaboration and outcomes of interagency collaboration on behalf of students with EBD (Gable &

Tonelson, 2010). The guiding principles in systems of care state that all children with EBD should have access to comprehensive, fully integrated, and coordinated services to address their mental health needs. School administrators play key roles in defining and refining procedures that respond to the needs of students with EBD. To date, solutions developed are insufficient and do not adequately address the problem. Additional research is necessary to explore the nature or context of interagency collaboration between schools and outside professionals to identify approaches for overcoming barriers to care for students with EBD.

Conceptual Framework

Interagency collaboration in the context of meeting the complex needs of students with EBD in school settings is complicated and intricate. The paucity of literature on the topic further complicates efforts to inform educational leaders on this critical enterprise. The conceptual framework for this study builds on an understanding of interagency collaboration in relation to the system of care framework and the negotiated order theory.

The system of care framework is a family- and community-based system organized into a coordinated network to serve and support each individual's serious mental health needs so they can be successful at home, at school, and in society (Stroul & Friedman, 1986). This model serves as a framework for providing support for students with EBD and has some practical application for educators. This framework provides a lens through which principals view how and whether interagency collaboration offers the necessary support for students with EBD. A conceptual framework that provides both practical and theoretical guidelines for administrators is beneficial in building knowledge

about implementation processes in ways that deepen an understanding of interagency collaboration.

Theory isolated from real-life experiences would be less thought provoking and would lack application and value to administrators. The negotiated order theory provides a framework to explore how negotiation processes between school administrators and outside professionals relate to the structure of support systems for students with EBD (Hasenfeld, 2010; Strauss, 1978). Current research demonstrates a need for an exploration into efforts and approaches to interagency collaboration, due to the continuing needs of children with EBD. Collaboration is an important aspect of supporting students, both formally and informally. The term *negotiation* in this concept refers to the attempt to reach an agreement with others through collaboration (Strauss, 1978). Therefore, the system of care framework and the negotiated order theory were both used as the conceptual framework for this study, because they each provided an appropriate context for exploring interagency collaboration for students with EBD.

Definition of Key Terms

To advance the conversation surrounding EBD children, it is important to provide definitions. In some professional literature, terms have been used interchangeably and may be confusing (Behan & Blodgett, 2003). Therefore, the following definitions were used for this study.

Emotional and behavioral disorder. Emotional and behavioral disorder has become the most widely accepted term used by parents and professional organizations to describe individuals who exhibit certain externalizing behaviors (e.g., hyperactivity, aggression, delinquency, noncompliance) or internalizing behaviors (e.g. anorexia or

bulimia, anxiety, depression, or being socially withdrawn; Kauffman & Landrum, 2009; Smith, 2007). However, for the purpose of this paper, the following definition from the Individuals with Disabilities Education Act (2004) will be used:

> Emotionally and behaviorally disturbed means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:
> (a) An inability to learn which cannot be explained by health, sensory, or intellectual factors.
> (b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
> (c) Inappropriate types of behavior or feeling under normal circumstances
> (d) A general pervasive mood of unhappiness or depression; and
> (e) A tendency to develop physical symptoms or fears associated with personal and school problems.

System of care. The system of care concept is not a program with service components but rather a philosophy of how care should be delivered to children. The philosophy provides a guide and organizing framework for system transformation in children's mental health (Stroul, 2002). The comprehensive system of services and supports emphasizes coordination among agencies serving children with mental health needs. The concept was initially constructed for children with EBD; however, it may apply to other populations.

Interagency collaboration. Interagency collaboration is a core principle in systems of care and addresses the policies and practices of organizations, which include groups such as mental health agencies that work with and for schools in a coordinated and integrated way (National Technical Assistance and Evaluation Center for Systems of

Care, 2008). Collaboration is the highest level of interagency relationships (Osher, 2002).

Negotiated order theory. Negotiated order was advanced in the 1960s by Anselm Strauss and his colleagues in the context of small-group collaboration (Maines, 1991; Strauss, 1978). Negotiated order underscores the fluidity and renewal of the organization's characteristics and the changing interactions among participants (Strauss, 1978). A negotiated order exists when involved members in organizations share common definitions of a problem or situation and understand that mutual perceptions and interests join them together (Beaulieu & Pasquero, 2002). Moreover, they will come to an agreement concerning their future interactions together (Nathan & Mitroff, 1991). The negotiated order theory is a useful approach in exploring the process of interagency collaboration between school principals and mental health service providers as they engage and negotiate services for students with EBD.

Significance of the Current Study

Principals have the ultimate authority regarding the types of services provided to students; therefore, it is important to better understand principals' perceptions of the collaborative process and strategies for making it more effective. Considering the number of students with EBD, as well as the impact they may have on other students, classroom teachers, and administrators, significant efforts must be made to better prepare to support students with EBD. Many school districts have a structure in place for working with these students; however, few schools provide a setting in which *all* participants in the child's life work together, including in-school and out-of-school agencies (Gable & Tonelson, 2010). Many studies support the philosophy of systems of

care with regard to interagency collaboration; however, few incorporate qualitative approaches (Stroul & Blau, 2008). Therefore, this study added a qualitative component to explore principals' perspectives on whether and how school agents and outside school agents endeavor to implement collaborative services designed to maximize students with EBD potential in school. Qualitative research was appropriate for this study because it encompasses context, voice, and meaning (Tillman, 2002).

Findings from this study may be used to inform professional practitioners in school districts interested in improving services and developing collaborative relationships with mental health care professionals for students with EBD. Administrators in schools may use findings to make better-informed decisions when reviewing the effectiveness of procedures involving collaboration with outside agencies. School administrators may decide to modify how and when they collaborate with outside agents, thereby enhancing their knowledge about the capabilities and limitations of the other. Conclusions drawn from this study may serve to address the needs of students with EBD by promoting initiatives to improve support services that focuses on service integration. Golden (1991) stated that cross-agency collaboration is an essential approach to systems change when administrations agree to modify current processes, tackle the adoption of new procedures, or address service gaps. However, agencies may still confront barriers and inflexibility, even when there are commonalities in vision and mission. Despite such stumbling blocks between organizations, collaboration is often able to bring about change (Golden, 1991; Stroul & Blau, 2008). In addition to practical applications, findings from this study revealed guidelines for further research with the

purpose of providing a greater understanding and relevance of interagency collaboration for students with EBD.

Organization

This dissertation is organized into five chapters. Chapter 1 provides an introduction and overview of the study necessary to present the main components in subsequent chapters. Chapter 2 introduces a review of the literature regarding the historical background of special education law as related to systems of care and interagency collaboration development, interagency collaboration for children with EBD through the lens of systems of care, and barriers to the implementation of interagency collaboration. Several studies identified for review were published between 1969 and 1990. These were consulted because of their significance in providing a history of support services offered. However, the main studies reviewed were published between 2000 and 2014.

Chapter 3 introduces the research methodology used in the study, and includes the research design. Chapter 4 presents results of the study. Chapter 5 includes a discussion of the findings of the study and implications for school divisions and other agencies, along with recommendations for further research.

CHAPTER 2

REVIEW OF THE LITERATURE

Overview

This chapter provides an overview of legislation for children with disabilities. It reviews the literature on the system of care concept and the negotiated order theory as frameworks for the study. Contributors and barriers associated with interagency collaboration regarding elementary school children who have been formally identified by the special education department in school systems as EBD are also addressed.

Legislation for Children With Disabilities

In 1970, the U.S. Congress passed the first major legislation, Education of the Handicapped Act (PL 91-230), mandating the minimum requirements for a free and appropriate public education for all children with disabilities. States had to comply with PL 91-230 to receive federal financial assistance (Kirk, Gallagher, Anastasiow, & Coleman, 2012). In 1973, the Rehabilitation Act (PL 93-112), restricted to programs receiving federal funds and protected the civil rights of those with disabilities in public settings, including education (Kirk et al., 2012). Section 504 of this act still plays an important part in education, especially for students who may not qualify for special education services under other laws or programs.

In 1975, the landmark Education for All Handicapped Children Act (PL 94-142) also incorporated requirements for a free and appropriate public education for all children with disabilities in addition to many important legislative protections for special needs

children, including parental involvement in the Individualized Education Program, due process for families, and the education of children in the least restrictive environment (Kirk et al., 2012). Congress enacted PL 94-142 in response to concerns that tens of thousands of children with special needs were excluded from receiving an appropriate education (U.S. Department of Education, 2014). Before enactment of the law, U.S. schools educated only one in five children with disabilities, and many states completely excluded some students, including those who were emotionally and behaviorally disturbed. Many children with mental illness or mental retardation were institutionalized in restrictive settings and were provided minimal care rather than being appropriately assessed, effectively educated, and rehabilitated (U.S. Department of Education, 2011).

PL 94-142 has been amended and reauthorized several times since its inception in 1975. For example, the 1990 amendment, Public Law 101-476, now known as the Individuals with Disabilities Act (IDEA), is the preeminent United States special education law. The law regulates how states, school districts, and public agencies must protect the rights of children and provide early intervention for special education and related services to eligible children and youth with disabilities from preschool to age 21 (U.S. Department of Education, 2014).

As part of the federal guidelines, IDEA recognizes and supports a continuum of services in which there is collaboration with other federal, state, and local agencies to avoid duplication of efforts. In 1996, the Early Education Program for Children with Disabilities, originally designated as the Handicapped Children's Early Education Program, was designed to establish model projects for the delivery of special education and services for children from birth through age 8. Currently, the program addresses a

variety of services, including the coordination between public and private agencies (U.S. Department of Education, 2007).

As in the federal government, the Commonwealth of Virginia has recognized the importance of collaboration with the mental health care system. In the fall of 2013, the assault on Virginia Senator Creigh Deeds by his son who suffered from serious mental illness resulted in national attention on mental health services in the United States. The Deeds incident brought the issue of mental illness to public awareness, and the Virginia state government prepared to study what helps and what hinders efforts to support those with serious mental health concerns. A bill (SJ47) introduced by Deeds (Appendix A), and recently passed by the General Assembly, initiated a 4-year legislative study to analyze the state's current mental health care delivery system (www.richmondsunlight.com/bills, 014). Deeds called the mental health reform "incremental change" and stated, "the real work lies ahead on mental health" (Frommer, 2014, p. 1). A continuum of care includes related and integrated services to aid in the provision of appropriate supports for each child (Delorenzo, 2008).

In January 2015, Virginia Governor McAuliffe announced approval for the Governor's Access Plan (GAP), which will provide health services for uninsured Virginians diagnosed with a serious mental illness. According to the Department of Behavioral Health and Developmental Services, GAP will cost $13 million for the first year, and in the following year, the cost for Virginia will be approximately $77 million. The federal government will provide an equal match (www.dbhs.virginia.gov, 2015). Local Community Services Boards will offer funding assistance.

System of Care Framework

The system of care concept was designed to increase coordination and collaboration between all agencies in a holistic manner and to ensure access to fully integrated services for children with EBD (Stroul, 2002). Programs vary in size from small community services to all-inclusive state programs (Illback, Neill, Call, & Andis, 1993; Lourie, 2003). All components are balanced and interrelated; therefore, the entire system is important. Systems include a variety of services, such as mental health services, education services, vocation services, recreational services, health services, social services, and operational services (Stroul & Friedman, 1986).

System of care values and principles. Although the factors and organizational design may differ from state to state or community to community, a system of care includes a set of core values and guiding principles, as shown in Table 1 (Stroul, 2003; Stroul & Friedman, 1986; Stroul & Friedman, 1996).

> Service coordination and interagency collaboration are *elements* of the system of care philosophy, as are family involvement and cultural competence . . . but none of these elements is the sole focus of system of care development . . .. Systems of Care are a range of treatment services and supports guided by a philosophy and supported by an infrastructure. (Stroul, 2002, p. 5)

Initially, states and localities provided services consistent with the system of care concept, such as case management, respite care, and in-home supports (Eber & Keenan, 2004). However, some agencies offered services but lacked coordination with other organizations. This led to unsuccessful service programs (Eber & Keenan, 2004).

Table 1

System of Care Concept: Guiding Values and Principles

<table>
<tr><td rowspan="3">Guiding Principles</td><td colspan="3">Core Values</td></tr>
<tr><td>Inclusive of Family</td><td>Community Based</td><td>Culturally Competent/ Responsive</td></tr>
<tr><td>• Full participation of family
• Comprehensive services that address physical, emotional, social, and educational needs
• Individualized services
• Early identification and intervention</td><td>• Case management
• Smooth transitions to the adult service system
• Integrated and coordinated services
• Least restrictive, appropriate environment</td><td>• Protection and promotion of rights
• Services without regard to race, religion, national origin, sex, physical disability, or other characteristics
• Services sensitive to cultural differences and special needs</td></tr>
</table>

Advocates for systems of care promoted systemic change at the state and federal levels. In 1992, the *Comprehensive Community Mental Health Services for Children and Their Families Program* was developed through federal legislation. This initiative increased access to community-based programs and decreased costly restrictive placements of students with EBD (Hoagwood et al., 2001). Furthermore, provisions in the reauthorization of the Individuals with Disabilities Education Act (1997) support the development of coordinated efforts between systems of care.

Section 300.244 of IDEA regulations, the Coordinated Services System, permits school systems to allocate funds for interagency collaborative support systems for children and their families. IDEA also states that the financial responsibility of each noneducational public agency must precede the financial responsibility of the local educational agency (Eber & Keenan, 2004). This provision allows some states to

develop a range of services that coordinate with school-based services (Pumariega, Winters, & Huffine, 2003).

Although these provisions help states and localities create a wider array of services, few communities are taking advantage of these opportunities (Eber & Keenan, 2004). In light of such prospects, why have multiple agencies failed to provide effective interventions? According to Eber and Keenan (2004), this may be due to the lack of collaboration, state funding, and service development.

Outcomes. Research on systems of care has been varied. The Fort Bragg Study was particularly controversial, because the $94 million project was designed to improve mental health outcomes for referred children and adolescents; however, there were few significant outcomes (Bickman, 1996; Bickman, Bryant, & Summerfelt, 1993; Bickman, Heflinger, Lambert, & Summerfelt, 1996). Specifically, the Fort Bragg community clinicians and agencies were recruited to work with clients through a single contact agency. Services included outpatient psychotherapy, community support services (e.g., home-based counseling), and after-school and day care treatment, as well as more restrictive services for severe problems (e.g., group homes and inpatient mental health treatment). Providers were assigned to families needing services; the providers were individually allowed to determine the type of care necessary, with no limits on cost (Behan & Blodgett, 2003).

The quasi-experimental repeated measures study compared the experimental services in Fort Bragg with two comparison communities. In the Fort Bragg group, 574 children and their families participated, whereas 410 children and their families were members in the two comparison communities. Children were studied for 5 years at 6-

month intervals. Despite no restrictions on cost and flexible services, the study showed only marginal increases in outcomes for children from Fort Bragg, and the cost for children in the systems of care continuum was more expensive than for the children in the comparison group (Bickman, Noser, & Summerfelt, 1999).

Given the lack of significant effects of the system of care program, another system of care study was undertaken in Stark County, Ohio, to determine whether the same results would occur (Bickman et al., 1999). The Stark County study addressed some of the methodological concerns in the Fort Bragg study. In Stark County, there was a coordinated effort among providers, instead of a single provider as in the Fort Bragg study. Children with mental health needs were randomly assigned to a system of service, or families could initiate their own care through the same providers. The children in the experimental group received more services; however, as in the Fort Bragg study, there were no differences in children's symptom level or functional state after 12 months. Further, the service cost was higher in the experimental intervention (Bickman et al., 1999). Bickman and colleagues' (1999) findings demonstrated system-level efforts paid off in system-level benefits. They also argued that system-level indicators of better services are not necessarily connected to conclusive clinical benefits (Bickman et al., 1999).

Although the Fort Bragg and Stark County studies demonstrated a need to question the underlying fundamentals of systems of care, research from Hoagwood et al. (2001) showed that systems of care have improved access to services for individuals and that care is less restrictive. Moreover, Rosenblatt, Attkisson, and Mills (1992) found examples of systems of care preventing residential placement costs. In alignment with

these positive outcomes, the Center for Mental Health Services found that students in systems of care consistently improved in their academics and attendance (Center for Mental Health Services, 1997; 1998; 1999; 2000; 2001).

Although there are successful outcomes in systems of care, the system of care studies do not explain the changes in practice that increase children's actual functioning (Eber & Keenan, 2004). In response to communities' need for the development of community-based support planning for youth with EBD, an innovative system-of-care effort was established called *wraparound* (Burchard & Clark, 1989, 2002; Suter & Bruns, 2009). Wraparound services closely resemble systems of care and reflect the philosophy and practical applications of system of care.

Wraparound Process

Wraparound is an approach to planning and providing support services within systems of care; it is an element of the system-of-care concept. First attributed to Lenore Behar from North Carolina in 1986 (VanDenBerg, Bruns, & Burchard, 1999), wraparound services shares values with systems of care (Stroul & Friedman, 1986), and the terms are often used interchangeably; however, they are different systems of support.

The term *wraparound* was developed from the idea that children and families with a variety of mental health needs warranted a wide range of services, which could be "wrapped around" them to provide the children supports in their own school, home, community, and other environments. Goldman (1998) defined wraparound as

> a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes. (p. 28)

The goal is to provide services for as long as the individual needs them (Burchard, Bruns, & Burchard, 2002). The philosophy-of-care aspect denotes a process or framework (VanDenBerg & Grealish, 1996), not an intervention. Not all children with mental health needs need wraparound services; some may benefit from just one service, such as mentoring (Suter, 2006). However, for those children in need of services from multiple agencies, wraparound services have emerged as an approach to fulfill children's and families' needs. Wraparound is directed at youth who are at risk of leaving their community and receiving services away from their family.

Components. The wraparound approach is based on two lists of core conceptual ingredients (Goldman, 1999). The first list includes core conceptual interrelated elements:

- Voice and choice for youth and family as active partners,
- Team-driven process,
- Community-based services,
- Cultural competency,
- Individualized and strength based,
- Natural supports, both formal and informal,
- Unconditional commitment to continuation of care,
- Collaboration between agencies,
- Flexible resources, and
- Outcome-based services determined through team process (Goldman, 1999; Suter, 2006).

The second set lists wraparound requirements necessary for practice (Goldman, 1999, pp. 32–34; Table 2).

Table 2

Requirements for Practice of the Wraparound Process

1. The community collaborative structure, manages the wraparound process, and establishes the vision and mission.
2. A lead organization is designated to manage the implementation of the wraparound process.
3. A referral system is established to determine the children and families to be included in the wraparound process.
4. Resource coordinators are hired to facilitate the wraparound process; facilitating the team planning process; and managing the implementation of the services/support plan.
5. With the referred child and family, the resource coordinator conducts strengths and needs assessment.
6. The resource coordinator works with the child and family to form a child and family team.
7. The child and family functions as a team, with the child and family engaged in an interactive process to develop a vision, related goals, and an individualized plan
8. The child and family team develops a crisis plan.
9. Within the service/support plan, each goal must have outcomes stated in measurable terms, and the progress on each is monitored.
10. The community collaborative reviews the plans.

Outcomes. Although the wraparound approach has been widely heralded by researchers and policy makers as an effective approach for helping children with EBD, while providing services in their local communities (Burns, Hoagwood, & Maulsby, 1998; Tolan & Dodge, 2005), the model has been poorly defined (Goldman, 1999). This lack of clarity has led to some programs being labeled as wraparound even though they lack the main elements (Rosenblatt, 2010). In addition, researchers are concerned that

there are not enough studies, methodologies are poor, small sample sizes are small, and findings are inconsistent in the studies (Burchard et al., 2002). However, leaders in the mental health field contend that youth with EBD require evidence-based practices along with the development of systems of care and wraparound procedures to provide accessibility and relevant services and supports (SAMHSA, 2005; Tolan & Dodge, 2005).

Negotiated Order Theory

The concept of *negotiated order* was developed in the 1960s by Strauss and colleagues in a classic organizational study of psychiatric hospitals titled "The Hospital and Its Negotiated Order" (Strauss, Schatzman, Ehrlich, Bucher & Sabsin, 1963). Socially constructed, the concept was later expanded to include different types of organizations and as such has direct applicability to the understanding of human service organizations (Strauss, Fagerhaugh, Suczek, & Wiener, 1985). Strauss (1978) maintained that the process of negotiation is central to social order and change. Strauss (1978) argued that organizations rely on negotiations; the negotiations are dependent on the structure of the organization, while at the same time shape the organizational structure. The work the organization has to perform is an important aspect of understanding its evolving structural characteristics (Hasenfeld, 2010). As the work is implemented, it affects the course of services and subsequent efforts (Hasenfeld, 2010, p. 38). "Negotiation enters into how work is defined, as well as how to do it, how much of it to do, who is to do it, how to evaluate it, how and when to read, assess it, and so on" (Strauss et al., 1985, p. 267). The structural context for negotiations includes the number of negotiators, their level of power and what they have at stake in the negotiations, how

the participants view others' actions, and the number and complexity of issues (Nadai & Maeder, 2008; Strauss, 1978). The negotiations are aligned with current practices of communication within organizations.

Additionally, Strauss posited that the nature of negotiations change and are revisited during the process (Hasenfeld, 2010; Strauss et al., 1985). The theory stresses that the negotiations between individual participants are a reflection of the negotiated order among different members and thereby necessitate coordination, because they have different skills, values, interests, and social and professional affiliations (Strauss et al., 1997). Strauss et al. (1985) noted three conditions of negotiations: first, there is some tension between the participants—otherwise, negotiation would be unnecessary. Second, there are, to some degree, opposed or antagonistic interests between the parties. Third, some give and take occurs as a result of the interactions (Nadai & Maeder, 2008).

The negotiated order concept has been criticized by some as mainly concerning the looseness of the term *negotiation,* having a lack of emphasis on structure and the importance of history, and not considering the impact of formal rules in day-to-day life (Allen, 1997; Benson, 1977; Day & Day, 1977; Nadai & Maeder, 2008). One reason they express disapproval may be that Strauss and his colleagues did not provide an ethnographic description of real negotiations in their research documents (Nadai & Maeder, 2008). However, Strauss (1978, p. 237) maintained that terms such as "making trade-offs," "obtaining kickbacks," and "compromising" as underlying processes of negotiations used were inherent in the definition.

Moreover, Strauss (1978) advocated for the focus on the analysis of structural context within which negotiations take place and that it is the researchers' responsibility

to classify the relevant structural assets in the situation (Nadai & Maeder, 2008). Proponents, such as Busch (1982), of the negotiated order perspective argued for the idea of sedimentation where the outcome of previous negotiations develops into a taken-for-granted position (Nadai & Maeder, 2008). Hall and Spencer-Hall (1982) also proposed that history and tradition shaped stakeholders' ideas of negotiation and therefore their behavior (Nadai & Maeder, 2008). This model of human service organizations has much to be commended, because it stresses the importance of socially constructed structures and individuals' work in implementing patterns of interactions (Hasenfeld, 2010). Nonetheless, the role of the institutional environment can be further developed (Hasenfeld, 2010, p. 39).

Consequently, the current study explored this role to better understand how negotiation processes between school principals and outside agents relate to the structure of support systems and collaboration for students with EBD. The way all participants interact and share responsibility for collaboration is important to all members of the process and may be viewed as a negotiated order. Therefore, the negotiated order theory serves as a relevant and noteworthy lens to consider when examining interagency collaboration between school principals and outside professionals, because it applies a perspective for understanding communication and may help clarify reasons for differences in data interpretation. Negotiated order theory and the system of care framework were relevant lenses to use when designing the methods for this study and thereby essential to analyzing the study's data on principals' perceptions of interagency collaboration between school agents and outside agents.

Interagency Collaboration

In the SAMHSA Annual Report to Congress (2005, p. 10), challenges to progress were noted. The report noted that many clinicians are traditional in their approach and are not motivated to participate in collaborative services due to their practices and philosophies. This finding implies mental health agents may need time to alter their procedures. Limitations in the capacity of services and shortages in key services were also noted as a complication, because teams must then concede to lesser services and long waits for services (SAMHSA Annual Report to Congress, 2005). However, when partnerships among child-serving agencies were established, communities were more successful at implementing individualized service plans for children. One example of a successful model involves the inclusion of mental health agents in schools, which allows children and youth better access to services and provides support to personnel in the schools. A final recommendation noted in the SAMHSA Annual Report was leadership at the federal level to further promote collaboration between child-serving agencies to meet the needs of children with EBD (p. 112).

In Virginia, a system of care framework is used as part of the Comprehensive Services Act for At-Risk Youth and Families. In the Commonwealth of Virginia, localities developed community policy and management teams to help with the coordination of community-wide resources and services for at-risk youth and families in compliance with the Comprehensive Services Act. In 2006, the Virginia General Assembly amended the Code of Virginia and required the community policy and management teams to report annually to the Office of Comprehensive Services on

barriers to services for children in the community (Comprehensive Services Act for At-Risk Youth and Families, 2013).

From 2006 to 2009, Virginia's Joint Legislative Audit and Review Commission, the oversight agency of the Assembly, distributed surveys to localities. Results of the FY09 CSA Service Gap Analysis (Comprehensive Services Act for At-Risk Youth and Families, 2013) showed that wraparound services were listed among the top 20 service gaps. See Appendix B for the complete list. The report (Comprehensive Services Act for At-Risk Youth and Families, 2013) also noted barriers to service availability. The two most significant barriers identified in the CSA Service Gap Analysis were the lack of access to flexible funding or startup funding for programs and the lack of collaboration among community stakeholders. Respondents reported they could improve the service array if resources and funding could be pooled together and if they could show the need for certain services to local decision makers.

Other reports show reasons exist for ineffective support, including funding (especially during the economic downturn), resources such as time and personnel, and the lack of interagency collaboration (Ringeisen, Henderson, & Hoagwood, 2003). Clearly, these barriers or gaps in services place students with EBD at a disadvantage. Despite the enactment of the Comprehensive Services Act for At-Risk Youth and Families, guaranteeing the availability of support services for EBD children, students still do not have access to appropriate services (Landrum et al., 2003).

Most of the Comprehensive Services Act coordinators (55%) who responded to the Joint Legislative Audit and Review Commission staff survey stated that when suitable services were not available locally, children were placed outside of their community

frequently or *most of the time.* "Bridging local service gaps could therefore alleviate much of the burden placed on children and localities" (JLARC, 2007, p. 22). This sentiment is echoed in the work of other scholars (Stroul & Blau 2008).

Sheldon-Keller, Koch, Watts, and Leaf (1996) noted fragmentation and unnecessary duplication of services contributes to higher costs of services, especially in rural areas. Parents in rural areas often encounter barriers to mental health support services due to others' perceptions of mental illness (Leaf et al., 1985). The authors found that one-fourth of the participants stated their family members would be upset if their mental health support services were known by others (Leaf et al., 1985). In a presentation at the Virginia Department of Education summit concerning the social service delivery system, Ringeisen and colleagues (2003) noted continuing problems with the service delivery system: (a) inadequate services, (b) fragmentation of services offered, (c) inaccessible services, (d) discontinuity of services, (e) underused services, and (f) accountability. Focusing on gaps in the accessibility of community-based services could reduce program costs by decreasing the number of residential placements for children who can safely and effectively be served in the community (JLARC, 2007).

There are promising systems of support for children with EBD, yet despite these efforts, students still experience gaps in service (Ringeisen et al., 2003). The available research suggests there are many barriers to the implementation of mental health services for children with EBD, such as the cost of service, family and community members' attitudes about mental health issues, lack of collaboration, and the accessibility of available services. These barriers result in wait lists for service provisions (Goldberg, 1990; Mechanic, 1989; U.S. Department of Health and Human Services, 2005).

Hasenfeld (2010) agreed with Goldberg and Mechanic and stated that collaboration on matters like funding and coordination may increase collaboration on advocacy as well (p. 517).

Furthermore, of the studies reviewed, only one group of researchers surveyed K–12 administrators (Weist, Myers, Danforth, McNeil, Ollendick, & Hawkins, 2000). This study included 72 administrators in the states of Virginia, Maryland, Connecticut, and West Virginia. The goal of the study was to identify trends in problems and resources and to use administrators' ideas about the provision of programs that address community-specific mental health needs of youth. However, various staff completed the surveys, which led to low reliability. Due to different people other than administrators taking the survey, the authors reported the possibility that administrators may have limited knowledge of mental health services in their school system. More research should be done in this area (Stroul & Blau, 2008).

CHAPTER 3

RESEARCH METHODOLOGY

Overview

This chapter reviews the research methodology for the study. It explains why the research design was applicable for this study. The chapter discusses the research sample, the data collection methods, and the data evaluation. Finally, the chapter examines the role of the researcher and provides an overview of the methodology limitations.

Research Design

This study involved a qualitative, inquiry research design to explore interagency collaboration between schools and outside agencies in Virginia for children with EBD as perceived by elementary principals serving these students. The study was designed to address the following five research questions:

1. To what extent, and under what conditions, do school principals collaborate with outside professionals on behalf of students with EBD?
2. What is the nature of interagency collaboration between school principals and outside professionals on behalf of students with EBD, as identified by participants?
3. What are the outcomes of interagency collaboration between school principals and outside professionals?
4. What are the contributors and barriers to interagency collaborative services, as identified by participants?

5. How can collaboration between school agencies and outside agencies be improved?

A qualitative design was determined to be the best method to examine the level of interagency collaboration based on principals' various perspectives. This design focuses on understanding the construction of practices, procedures, and policies within a specific context (Erickson, 1986; Maxwell, 2005). Qualitative studies seek to understand how participants make sense of their experiences (Maxwell, 1996). Seidman (2006) advanced the idea of the in-depth interview as an important way to better understand others' experiences and the meanings they assign to those experiences. Being interested in and understanding one's stories is a basic assumption of interviewers (Seidman, 2006). Although there are limits to understanding others, it is still possible to appreciate others by trying to comprehend their actions in context (Schutz, 1967). Another assumption of interviewing is to understand that the meaning people give to their experience affects their behavior and the way they follow-through on their experience (Blumer, 1969; Mishler, 2000).

A research design that properly reflects a research study's intent can assist in establishing the effective implementation of a study (Maxwell, 2005). However, an unsound design may produce unfounded results. Therefore, interpretivists should not use predetermined data categories, because this strategy may restrict the amount of collected data to be analyzed (Erickson, 1986). Instead, designs should be fluid and adjustable to allow for the interconnection and relationship between design elements to be realized (Maxwell, 2005).

Interpretivist Paradigm

The proposed methods for data collection and analysis were situated in the interpretivist paradigm of qualitative research and were conducted using analytic induction (Erickson, 1986). A *paradigm* is a belief, way of thinking, or philosophical assumption concerning reality, knowledge, methodology, and values that direct the researcher's preferred approach (Greene, 2007). Interpretivists assume reality is observable, uniquely defined, and constructed locally through the lens of the individuals and researcher (Erickson, 1986; Polit & Beck, 2003). They propose that knowledge and meaning is not only what can be observed by the researcher but also what meaning participants give to their behaviors (Guba & Lincoln, 1994). Interpretivists must be aware of their own experiences as they design research and not inflict their individual realities onto others. An interpretivist approach was justified for this study because of the limited literature on administrators' perspectives of interagency collaboration between schools and outside agencies. Also, the interpretivist paradigm assumes there are multiple realities unique to individuals and organizations, and the reader evaluates the findings of the study through the lens of his or her own experiences (Erickson, 1986). This approach provided insight into the issue of interagency collaboration application into practice (Lee, 1999).

The interpretivist paradigm is composed of ontological, epistemological, and methodological assumptions that help guide the researcher's experience (Guba & Lincoln, 1994) and provide the rationale for this study's methodological approach when analyzed together (Erickson, 1986). Ontology examines the context for meaning-making and is thereby the science of existence or nature of being (Erickson, 1986). Guba and

Lincoln (1994) categorized ontological assumptions as exploring the form and nature of reality and what is to be known about it. Epistemology is a division of philosophy that assesses reality and the nature of knowledge (Miles & Huberman, 1994). It assumes that knowledge is formed not only by one's view of reality but also by participants' views of their own behaviors; therefore, knowledge is framed by the researcher's interaction with the participant. Although there are many ways to shape meaning from the same data, no one constructs the same meaning as another (Rein, 1976). In this study, the researcher's interpretation of participant interviews and the participants' meaning-making may have influenced the findings of this study. However, knowledge that augments understanding of others, even though there are various ways to interpret the same phenomena, is still valuable (Erickson, 1986).

Methodological assumptions focused on an individual's perspectives and reality by understanding the phenomena and interpreting the data (Savin-Baden & Howell Major, 2013). It was important to understand the context and meaning of participants' perspectives and reality in this study, because they may have influenced participants' behaviors and actions (Maxwell, 2005).

These assumptions served as a guide for this research. This study examined principals' perspectives on the interagency collaboration between schools and outside agencies for students with EBD; therefore, this method, and subsequent interpretations and assertions made from the data, were appropriate for addressing this issue.

Research Methodology

This study sought to understand the perceptions of elementary school principals regarding interagency collaboration among agents in schools and relevant agents outside

of schools (e.g., psychologists, psychiatrists, or doctors) on the behalf of children with EBD. Specifically, a questionnaire was used to capture demographic information related to the principals, such as the characteristics of the school settings, roles and work experiences in schools, training concerning students with EBD, and knowledge of interagency collaboration. Face-to-face interviews were conducted to explore views, concerns, and perceptions related to the support for and continuation of interagency collaboration in a sample of 10 public school principals in Virginia. Eight school district superintendents or their designees were asked for permission for one or two of their elementary principals to participate in this study. Approval from the University of Virginia's Institutional Review Board was obtained. The goal of this research was to better understand interagency collaboration that may improve the quality of support services for students with EBD.

Participants and Sample Size

Defining participants necessitates attention to the research questions (Cooper & Schindler, 2008). Based on the questions and to lend credibility to this study, a stratified purposive sampling method was used. Specifically, the stratified purposive sample establishes particular comparisons to explain the reasons for similarities and differences between settings, groups, or individuals and to ensure more information-rich details (Patton, 2002). Purposive sampling, commonly used by researchers, relies on the researcher's knowledge of the participants to appropriately select interviewees (Cooper & Schindler, 2008; Polit & Beck, 2003). Consistent with Patton (2002), the school districts were purposefully sampled by locale types (city, suburb, town, rural) and size (large, midsize, and small for city, and suburb locales and fringe, distant, and remote for town

and rural locales), keeping in mind the number of special education students identified as EBD in the school district. A prioritized list of school districts was developed based on these criteria. The locale code was used to indicate a school district's location relative to a populated area (National Center for Education Statistics, 2013). The codes were based on the location of the school buildings, but may not reflect the entire attendance area. See Appendix C for a description of size and locale types (National Center for Education Statistics, 2013).

The specific indicator population for this study was defined as public elementary school principals in the Commonwealth of Virginia. Principals were selected because they have multiple responsibilities, including making procedural decisions and recommendations regarding the attendance of team members at child study meetings. Recruiting efforts involved an attempt to access an equal distribution of principals in various school district sizes and locales. Ten elementary principals from Virginia were asked to participate in the study. These principals represented a diverse array of school districts and were likely to provide valuable information for this study. Virginia was chosen based on location and access to principals and the lead investigator's prior professional experience within the state. Two principals were from the same school districts, because each principal may have different considerations even within the same district. The school district superintendents or their designees were asked to suggest an elementary principal or principals who were best qualified to provide answers to questions concerning interagency collaboration for students with EBD. All of the principals interviewed understood the collaborative process in their school. Although principals also provided consent for follow-up phone calls or emails after the interview if

additional questions or clarifications were needed, only five were contacted for a follow-up statement. Efforts were made in the phrasing of questions and the use of probes to guard against the potential of social desirability of responses (King & Bruner, 2000).

Data Collection

This study explored principals' views on whether and how collaboration with outside agents is used, the contributors and barriers to its implementation, and how collaboration can be improved. After choosing approximately 20 school districts based on size, locale, and number of students with EBD, district websites were reviewed for information pertaining to research procedures within the district. After attaining this information, superintendents were contacted by phone and email and explained the study's parameters. Data collection included a prenotification letter that was sent to the research review committee, superintendent, or designee of each school division chosen for the study, requesting permission to interview a principal or possibly two, within the district. School district guidelines and procedures were followed when conducting the research. Appendix D is a script used when talking with the superintendent. After receiving verbal or written permission from the superintendent by email, the superintendent or his/her designee was asked to contact the principal to inform the person that permission for participation had been granted and that the principal's participation was voluntary. The principal's name and contact information were collected; they were then emailed a consent form (see Appendix E for the Letter of Consent). After receiving the principal's written consent, the principal was emailed a questionnaire to collect demographic information related to the principals, such as the principals' roles and work experiences in schools and training concerning students with EBD and interagency

collaboration. A brief explanation of possible historical events that may affect collaboration with outside agencies was solicited. See Table 3 for a summary of school characteristics and context gleaned from the Principal Questionnaire (Virginia Department of Education School Nutrition Program, 2014). See Appendix F for the Principal Questionnaire. The questionnaires and interviews were completed between January and March 2015.

Table 3

Summary of School Characteristics and Context

	Range	**Mean**	**Median**	**Frequency**
Number of school divisions	8			
Number of principals	10			
Grades:				
Pre-K–5				7
K–5				3
3–5, and Pre-K				1
Student enrollment	300–753	493	485	
Free/reduced lunch percentage	32%–94%	55%	50%	
Size and locale of school divisions				
Fringe, rural				2
Distant, rural				3
Mid-size, suburban				1
Small, city				1
Distant, town				1

Interviews. Face-to-face interviews were conducted with principals to gain a better understanding of participants' opinions, concerns, and perspectives on interagency collaboration through detailed reports (Erickson, 1986). The description of individual experiences or situations is frequently described as "thick" or rich (Denzin, 1989). Attention was given to providing details, providing social and historical contexts, and making sense of emotional content to understand participants' words (Suter, 2012).

The interviews were conducted in a semistructured format and addressed interagency collaboration for students with EBD. Specifically, the interviews explored views, concerns, and perceptions related to the support for and continuation of interagency collaboration. Interviews provided rich descriptions and clarified questions, and the researcher had the ability to return to the participants for further information.

In designing research questions for the interviews, a review of literature was examined related to interagency collaboration, system of care framework, and negotiated order theory. Additionally, questions used while completing an in-class project on interagency collaboration were revisited and revised. Literature on interagency collaboration, negotiated order theory, and the system of care framework, the previous in-class project questions, dissertation committee faculty members, a peer reviewer, memos, and the researcher's analytic journal were used to create, formalize, and finalize the interview questions (see Appendix F). These were submitted to the University of Virginia Institutional Review Board for approval and were approved.

Semistructured interview questions were piloted with outside agents, including a parent, director, and principal of a children's mental health hospital and a medical professional working with children from the hospital. This pilot test allowed for lengthy responses from the research participants. Interview questions for this study were pilot tested with an elementary principal from a district not involved in this study to address wording and consistency, as well as length of time for the interviews. Interview questions were then edited for redundancy of similar questions or were deleted if not relevant.

Data were collected at the principals' schools through in-person interviews that lasted approximately one and one-half hours. Interviews were audio recorded, then transcribed to ensure accuracy. Notes were taken during the interviews and summarized. Interviews for this study provided an opportunity to gain a better understanding of the perspectives of principals; these perspectives would not have been possible with quantitative measures, such as surveys. Principals were asked to write a brief description of their school in cases where they not had answered the question during the interview process. The Participant Letter of Consent (Appendix E) explained the study and ensured the principals that confidentiality was maintained by not identifying the names or schools of the participants in the final analysis. To ensure confidentiality, all personally identifiable information provided by the principals was maintained in a password protected data file; the names of the principals presented here are fictitious to ensure anonymity. The researcher reiterated the procedure before the interview began.

Efforts to ensure effectiveness. In a classic analysis of the objectivity of a research interview, Oakley (1981) maintained that detachment and distance during interviews is bad practice and harmful to the research interview. Effectively conducting interviews requires a personal sensitivity and adaptability while being aware of the design protocol. Therefore, efforts were made to develop rapport and trust with participating administrators to elicit meaningful responses. Document analysis is the examination of physical documents to glean relevant data (Hodder, 2003). Documents are representations of the school organization; therefore, they offered the opportunity to check for corroboration of interview data. If the principals provided documents for

review (e.g., a flyer or a procedural form), these documents were inspected and accepted as evidence of credibility regarding a formalized collaborative process.

Transcription. All interviews were transcribed verbatim to ensure participants were quoted correctly. Participants were given the opportunity to review the transcript of their interview. For this review, the researcher used "selective transcription," whereby the part of the transcript used in the study was sent to the principals for approval. This strategy was used because "the participant's perspective on the phenomenon of interest should unfold as the participant views it" (Marshall & Rossman, 2006, p. 101).

Data Analysis

Qualitative research is directed by philosophical assumptions of qualitative inquiry; that is, to understand a phenomenon, an occurrence, or experience, one must consider the multiple perspectives of participants (Suter, 2012). Qualitative researchers are concerned with making inferences founded on perspectives, so it is vital to get as much information as possible to analyze (Biddix, 2009). The goal of qualitative data analysis is to discover unfolding and developing themes to describe the patterns, perceptions, and understandings as results (Patton, 2002).

The data analysis for this study was consonant with interagency collaboration, the system of care framework (Stroul & Blau, 2008), and the negotiated order theory (Strauss, 1978). The system of care framework and the negotiated order theory were both expected to serve as a critical lens for data analysis by informing the researcher regarding distinctive perspectives, patterns of behavior, and actions of participants stemming from effective or ineffective coordination. Appendix H addresses framework constructs for data analysis. Principal interview data were analyzed by text transcription, and all

perspectives were coded by the discovery of concepts and emerging themes. The data gathered informed conclusions and provided greater insight on whether and how interagency collaboration is necessary for students with EBD based on principals' perceptions.

Methods for data analysis. An analytic framework, or linked concepts and categorizations, is often used in qualitative studies. In this study, an analytic framework was used to understand and relate underlying constructs (Patton, 2002). A *concept* is a labeled piece of significant data that represents events, actions, or interactions. Concepts allow the researcher to group similar material to better understand the data (Seidel, 1985). Content analysis was used to analyze the principal interviews.

Muller (2010) noted that codes, or descriptive names or labels, in data analysis set up a relationship with the participants and recognize current knowledge in the field while taking into account new information. Procedures to assess the interview data—by breaking it down into sections to examine, compare, and look for similarities and differences—consist of several stages (Busch et al., 1994–2012; Muller, 2010). In the initial analysis stage, the level of analysis was determined by using *open coding,* or identifying, defining, and marking the important pieces of text and giving them descriptive names. Data were delineated into master headings and subheadings. By building a descriptive, multifaceted preliminary framework for later analysis, the process better ensured the study's validity (Siedel, 1998). The concepts and dimensions of the data were distinguished and developed. Concepts were recorded even when they appeared in different forms. Concepts that emerged from the data were later grouped into categories. The categories reported and quotations from participants supported the

concepts. After selecting the number and set of concepts, the frequency of concepts was coded. The frequency of a concept may be more revealing and was therefore used in this study.

The level of generalization was also important to consider. By determining the level of implication or generalization, specific words were coded as well as words that had a similar meaning. Keeping the levels in mind, single words, groups of words, and phrases were thoroughly examined when choosing basic labels in the first pass of the transcriptions. After the concepts and categories were defined, the researcher conducted axial coding.

Axial coding, or clustering the data, uses the concepts and categories already developed to confirm that the different concepts and categories generated properly represent the interview responses and examines how the concepts and categories are related (Biddix, 2009). Axial coding is a straightforward way of looking at data to ensure all significant data have been identified. By allowing some flexibility with predetermined codes and adding other relevant categories, new, significant material may be uncovered, which may affect results. Then, translation rules for coding the interviews will be created, which gives the coding process uniformity and congruence. By developing these rules, the researcher was able to systematize the coding process and code. This process helped ensure consistency throughout the translation texts.

The next stage was *selective coding* for integrating, linking, and connecting the data. This stage was used in the last pass before determining the core emergent concept (Muller, 2010). The researcher manually coded the texts by using both an online data analysis tool, which automated the coding process, and reading the text and manually

writing down concept and category occurrences, which helped with error recognition. The organization of collection process and analysis is paramount to making meaning of the data. The researcher used analytic tools to help clarify and provide links within the collected data, including codes.

Methods for Data Collection

The target population for this study was 10 elementary principals in the state of Virginia, selected by the school divisions' superintendents. The accessible population of principals was ascertained from school divisions that were initially selected for their size and locale; ultimately, most of the school divisions were located mainly in central Virginia.

Qualitative data analysis software. The researcher used the web-based qualitative analysis tool, Saturate at www.saturate.com (Sillito, 2013), to perform open coding and organize the text data. This tool improved the efficiency and management of the data. The online format allowed the researcher to import interview transcripts as well as other gathered data, including notes. After entering the data into the online program, the researcher manually coded the data.

Specifically, the data were reviewed for themes, both similarities and differences, in responses. For example, do principals want to collaborate with outside agents? How and to what extent do school administrators work regularly with outside agencies? Do the administrators view interagency collaboration the same way? Considering multiple perspectives allowed construction of a better idea as to how schools and outside agencies work together (or not) and the contributors and barriers to collaboration.

Analytic memos. Stern (2007) stated, "If data are the building blocks of the developing theory, [then] memos are the mortar" (p. 238). Memos were used to record the researcher's observations, information, thoughts, and developing ideas. Memos helped reduce data to a manageable size to help explore, make connections, and develop assertions (Charmaz, 2006). They were continually read and reread, then sorted to organize ideas and make connections and find meaning in data coding. Memos were kept separate from the collected data (Glaser, 1978).

Trustworthiness

Trustworthiness is essential to having an impact on a qualitative study (LaFond, 2005). In qualitative research, as in quantitative, validity is one of the most important considerations for an interpretivist researcher due to the issue of using appropriate standards to ensure validity (Maxwell, 1992). However, qualitative researchers maintain they have rigorous procedures for ensuring validity, albeit different from quantitative procedures (Maxwell, 1992). Guba and Lincoln (1985) equated trustworthiness with scientific rigor through careful documentation of methods, data collection, and analysis. They offered four criteria for evaluating qualitative research: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability. This study was structured to use these alternatives to more traditionally quantitative criteria.

Credibility. Credibility is an important feature of qualitative research, because it increases the internal validity of a study (Lincoln & Guba, 1985; Marshall & Rossman, 2006). Credibility also takes into account the saturation of data, or the state when no new or applicable data emerge, and the adequacy of the database (Saumure & Given, 2008).

There were several ways to attain credibility, including member checking and peer debriefing.

Member checking. In member checking, participants' responses are collected and interpreted and given back to the participant for their review of its accuracy and credibility (Creswell & Miller, 2000). The principals were given the interpretations of their responses to check whether the participants acknowledged the findings to be true to their experiences. They then gave the researcher feedback by email. The emails were kept on file. This process helped ensure accuracy of transcription analysis.

Peer debriefing. Another method used for analyzing data with clarity is peer debriefing. A person not invested in the analysis of data studied the data to probe for any researcher biases, perspectives, or assumptions to help the researcher uncover her stance on data and analysis. By challenging the researcher's assumptions, new perspectives on findings were found. The peer debriefer for this study was a former education professor who had many experiences working with and interpreting data.

Transferability. Transferability is important for considering how results may be generalized or applied to another situation and is parallel to external validity in quantitative studies (Lincoln & Guba, 1985). As much detail as possible was collected, and lengthy, thick, rich descriptions of the interviews and settings helped support intellectual rigor, and establish validity (Miles & Huberman, 1994). Originally used by Ryle (1949) and then by Geertz (1973), the term *thick description* conveyed detailed accounts of experiences wherein the researcher noted patterns in relationships and placed them in context (Holloway, 1997). This process gives the reader a better understanding of the views of the participants (Creswell & Miller, 2000). The researcher was thorough

in describing the research context and assumptions of the research. Readers can decide whether the findings may be transferred to a different context.

Dependability. Dependability, or auditability, is similar to reliability in quantitative research (Lincoln & Guba, 1985). In qualitative research, dependability refers to the extent to which others can check results. By carefully documenting research procedures throughout the study, readers can confirm the data (Padgett, 2008). To verify data in this study, dependability was addressed through the proposal, a written record of the scheduling of interviews, and interview transcripts. A search for contradictions to former data was completed. In this study, the researcher noted the changing contexts with which the research transpired in the setting (Lincoln & Guba, 1985).

Confirmability. Confirmability helps shows the relationship between the data and the findings and conclusions. An audit trail of how decisions were made helps to minimize personal bias (Patton, 2002).

Audit trail. Questions concerning data analysis accuracy were addressed by keeping an organized system of records of interview transcripts, notes, and other relevant information. An audit trail validity procedure was performed whereby all research decisions and activities were documented for later examination for trustworthiness (Creswell & Miller, 2000). Data were searched for consistent or disconfirming evidence based on initial established categories (Creswell & Miller, 2000; Lincoln & Guba, 1985).

Reflexivity. Through reflexivity, the researcher noted personal views, values, and biases that could inform the study. Actions, opinions, biases, and findings made by the researcher were documented. Attending systematically to the investigation shaped the research.

Researcher as Instrument

Qualitative research begins with philosophical assumptions that researchers have stemming from their beliefs, background, and experiences (Creswell, 2007). Qualitative researchers trust their beliefs and understandings when explaining or analyzing events or perceptions (Creswell, 2007; Maxwell, 1992). In qualitative research, the main instrument for data collection and analysis is the researcher; therefore, biases must be addressed (Erickson, 1986). Using an interpretivist approach, researchers must be aware of their own experiences as they design research and not inflict their individual realities onto others. Therefore, it was important to be aware of how assumptions, experiences, paradigms, and views may influence and inform the study.

The researcher's past professional experiences included being an elementary school teacher, an elementary school assistant principal, and an elementary school principal. As a principal, the researcher had considerable experience interviewing staff candidates; therefore the researcher had prior experience interviewing school personnel. These prior experiences provided ample opportunities to develop listening skills, which may have helped the researcher be particularly attuned to nuances in the participants' responses. Moreover, the researcher has a master's degree in counseling, which naturally lends itself to having good listening skills for interviewing others. Additionally, the researcher has an education specialist degree in administration and supervision, which contributed to the knowledge base and experiences of principals. The researcher also has prior personal experience participating in committees involving collaborative efforts with parents, school personnel, and outside agents. The researcher was mindful of these past experiences, both positive and negative, while interviewing principals.

Given the researcher's experiences and interest in the topic of collaboration, the researcher suspected that principals would be aware of and collaborate with outside professionals. The researcher's personal experiences with interagency collaboration were also a strength, as were her personal experiences navigating these systems to support students with EBD. The researcher assumed going into this study that working with others would be beneficial to all stakeholders. The researcher also assumed that the school administration would be responsible for initiating contact with outside professionals to provide support for students. However, the researcher also acknowledged the importance of understanding others' experiences with collaboration. Although biases may exist, every effort was made to be aware of and constantly check for possible preconceptions and judgments that might influence the data collection and subsequent analysis of data.

CHAPTER 4

RESULTS

Overview

This study focused on ascertaining perspectives of 10 elementary principals regarding interagency collaboration on the behalf of students with EBD in the context of the system of care framework and the negotiated order theory. The research questions guided the exploration of the conditions for collaboration, the nature of collaboration, and the outcomes. They also guided exploration of contributors that may promote collaboration and barriers that may hinder collaboration, as well as how collaboration can be improved between schools and outside agencies. Information regarding demographics and contexts of school principals is presented, along with findings based on the analysis of data. All of the principals were given pseudonyms to protect their identities.

Demographics and Contexts of School Principals

Demographic information attained from a questionnaire informed the researcher's study by providing a context for principal perceptions. Table 4 provides a summary of principal characteristics and context. Principal experience ranged from 1 to 19 years. As indicated in Table 4, all 10 principals were classroom teachers for at least 3 years before entering administration; three teachers had 7 years in a general education classroom. Three were former special education teachers who had certification in EBD. One was a former school counselor as well as a former classroom teacher and special education teacher.

Table 4

Summary of Principal Characteristics and Context

	Range	Mean	Median
Years as principal in current school	1–14	6	5
Years as principal in other school	0–15	4	1
Years as former classroom teachers (*n* = 6)	3–13	8	7
Years as former special education teachers (*n* = 4)	3–13	7	6
Years as former counselor (*n* = 1)	1		
Years as teaching college (*n* = 1)	3		
	Number of Principals		
Participation in training for students with EBD	5		
Participation in training for collaboration	4		
Therapeutic day treatment provider in school	10		
Past events hindering collaboration	1		
Past events facilitating collaboration	8		
School has written procedures for collaboration	4		

Two of the principals worked in a regional program for students with EBD, consisting of grades kindergarten through second grade in one school, and grades 3 through 5 in the other school. Six of the principals had not participated in district or school training concerning students with the special education label of emotional and behavioral disorder. Of those who had participated in trainings, the special education director gave the presentations; two attended programs and conferences on behavior issues and mental health issues. Seven had not participated in formal district or school training concerning interagency collaboration. Of those who had participated in district or school training or development programs concerning interagency collaboration, the former counselor met with other school counselors five times a year, and they often focused on community collaboration and interaction with community resources. One of the principals had a student who threatened suicide last year. The school performed a County Public School

Threat Assessment then called on outside agencies, including mental health services, the Sheriff's Department, and the Department of Social Services, to provide support for the student. One principal has participated in a few brief sessions regarding specific agencies.

All of the principals reported the existence of a therapeutic day treatment program in their schools, although not all schools in the districts had therapeutic day treatment providers. Eight principals noted the establishment of the therapeutic day treatment program as contributing to the facilitation of interagency collaboration. Several of the principals reported other contributors to interagency collaboration, including the Community Services Board crisis center, DARE (Drug Abuse Resistance Education), family partnership meetings, Family Assessment and Planning Team (FAPT), Child Protective Services, Juvenile and Domestic Relations court (attendance, CHINS or Child in Need of Services, which has since been replaced by CRA or Children Requiring Assistance), the New Teacher Center, office on youth, and various in-home counseling providers. Two specifically mentioned the need for professional development concerning students with emotional and behavioral needs. One principal noted a natural disaster in the school division as facilitating interagency collaboration.

Nine of the 10 principals reported there were no past events in their school that hindered interagency collaboration. One principal reported that at times it has been difficult to work with Child Protective Services due to confidentiality, personnel, or both. Additionally, she expressed a concern that some parents do not have the time or desire to work with agencies.

The researcher asked all of the principals a preliminary, stage-setting question, "What is your definition of interagency collaboration?" See Appendix I for principals' responses. Two of the principals mentioned the need for wraparound support and that interagency collaboration was an essential aspect of those services. The themes most often cited by most of the participants were constant communication and the development of relationships to meet the needs of students.

Although six principals noted there were no official written procedures for interagency collaboration, analysis of documents provided by some of the principals corroborated an interagency relationship. For example, one principal provided a document for principals, guidance counselors, and teachers noting services provided by the Community Services Board. The goals, services, structure, criteria, and expectations for the therapeutic day treatment program were listed. In addition, Medicaid funding requirements were noted.

Qualitative Findings

The following interview data are presented by the corresponding research question in relation to the negotiated order theory and system of care frameworks.

Research Question 1. To what extent, and under what conditions, do school principals collaborate with outside professionals on behalf of students with EBD?

Conditions for Collaboration in Relation to the Negotiated Order Theory

Consistent with the negotiated order theory, the following two themes emerged: (1) collaboration and negotiations were situationally dependent; and (2) visibility of transactions was clear and overt or sometimes covert. In relation to the system of care framework, the coordination of efforts was perceived as important.

Negotiations. A summary of conditions noted by the principals indicated that collaboration through negotiation was dependent on the situation or child. Planning and implementation of plans was an important consideration. Both formal and informal procedures were necessary, and the parents generally initiated contact with outside agents, although some schools made the effort as well. Negotiations were one-time or multiple, repeated, and often linked when held between school personnel and day treatment providers. However, other professionals rarely, if ever, entered the school building to observe or discuss students with EBD.

All of the participants indicated that they collaborated with outside agencies, some to a greater degree than others. Contrasts were found of when and under what circumstances collaboration was done. Nine of 10 principals noted that collaboration depended on the situation, and they collaborated as needed. For example, principal Moore stated, "I would say we meet two or three times a year. Again, it is mostly on an as-needed basis. That being said, I can tell you that most of the agency heads know me."

Principal Samson suggested,

> A lot of it depends on how the child is doing at school. Like our little girl is doing fabulously. But when some of our other kids are in crisis, then I'm very involved. I'm on a first-name basis with case managers. Frequent phone calls. We work very closely together and try to get the support for the family and for the kids here.

One principal stated she always collaborated, and that collaboration was very important to her and her school faculty. Her school enrollment is fairly large, approximately 500 students, and she does not have an assistant principal. Therefore, she relies heavily on the day treatment provider in the school.

> It's very critical that we work well together. Our school guidance counselor came to this building at the same time that I did, and she had been working as the lead clinician at my previous school for the day treatment program there, so I knew her before. She is very familiar with the program, so she and I are always the ones that head up referring kids to the program. We always invite the Community Services Board people to come to the meetings.

Visibility of transactions. Most of the transactions and interactions between school personnel and outside professionals were clear and overt. Eight of the principals conveyed they were the ones who initiated contact with outside professionals, and two principals said parents initiated contact. Two principals stated that they or someone in their school generally initiated the contact but that some outside agencies also contacted the school. Results of that outreach and interactions varied. One example of principal initiation is from Principal Crane:

> Sometimes we're not aware a child is in counseling. If we're aware and have been a part of it and recommended it to the family, we initiate, because I think it's important for that therapist or agency that is getting ready to work with a child to at least know from our perspective what brings that child or family to them.

Principal Eller stated,

> It depends on the child and the situation. We have invited psychologists, and so forth that the family sees, or medical doctors, but because of their schedules most of the time those people do not come [to meetings]. But, yes, we have invited them depending on the case and the situation. I believe it is our responsibility and their responsibility to contact each other.

An example of parents contacting outside agents comes from Principal Cobb who maintained the parents generally initiate contacts.

> The parent usually [makes the contact]. So it's with parent permission. We take the address and information for the physician that the student is being treated by and then usually the parent will talk to that doctor and the doctor will then call us. But that doesn't happen very often, only twice

> in 10 years, but it has happened. I'm surprised it's not more because we've had more release forms signed than we get release forms back. I can't say that we have ever contacted a physician.

Principal Moore also stated that parents initiate contact with outside professionals.

> They are invited by the parent. We never invite anyone from outside of the schools—doctors, lawyers—without the parents' knowledge. We don't invite them to the meeting. Typically when they do come, it's at the invite of the parent, but we do not invite them, because we have to have the parents' permission to exchange information. Outside agencies rarely come to child study and special ed. meetings, and if they do, it's typically because they are an advocate for the child, or they are court appointed, or they are sent by the FAPT [Family Assessment and Planning Team] team. The school rarely invites anybody.

When asked if the school encourages an outside agent to attend meetings, he replied, "We rarely encourage it . . .. We rarely do that."

Conditions for Collaboration in Relation to the System of Care Framework

In relation to the system of care framework, the coordination of services was a relevant theme that emerged.

Coordination of efforts. Planning for collaboration takes time and effort on the part of school professionals as well as outside providers. Administrators in the school have to fill out paperwork for a child to be eligible for Medicaid and, therefore, therapeutic day treatment provision. All of the principals have filled out Medicaid paperwork, and they all feel that it is worth their time and effort to help support the child. Some of the principals have other written school division policies and procedures, but most of them do not. The principals who have written procedures are appreciative, as the forms make their job responsibilities less challenging. The principals who do not have written procedures have requested them, as they feel it would help give them clarity of rules, roles, and responsibilities.

Planning for coordination. Six principals conveyed there were no written processes or procedures to engage outside service providers other than the release of information from parents so school personnel could talk with an outside professional. Four principals stated there were written procedures for the implementation of collaboration. Two principals are heads of a regional program for children who have the emotional and behavioral disorder label; their written forms deal mainly with student applications to their program from other schools in the region. Another school division has written memorandums of understanding (MoUs). Principal Moore stated that administrators meet several times a year with local agencies to go over the MoUs. Principal Moore described the written procedures as providing a structure for "any agency the school would deal with, which is good, I guess." He explained,

> Once a year, the Director of Child Protective Services will come and explain our memorandum of understanding, which might mean something like, if a child is in crisis this report has to be done, and this person does it. It is chain of command, the protocol. Also under that memorandum of understanding there are things that someone does and somebody else can't do. We have MoUs with everybody. And we do that every year, with mental health people, the Sheriff's Department, the Department of Social Services.

Principal Samson also stated that her school division has a policy manual through student services. They have certain procedures they have to go through.

Principal Fallon's school has written procedures for applying to his regional EBD program. As part of monthly meetings, his teachers discuss the suggestions of outside professionals when discussing specific children, stating,

> That's one reason we do have these monthly meetings, is to have that open communication among the teachers and the outside agencies. Not to say that it's not going on consistently, but so everybody that is sitting at the table will collaboratively and collectively say, "Here's what's coming up.

> Here's what we discussed in the past. Here's the good, the bad, and the ugly. And where do we go from here?"

Implementation of collaborative efforts. To implement interagency collaboration and communication with outside professionals, it takes intentionality and paying attention to who is invited into the school building, according to the principals. Some notice more than others, as evidenced by their attitude of who is invited, when, and how. Several principals call the outside agents themselves, some have their assistant principals communicate with others, some guidance counselors make contact, and some make no contact at all. All of the principals met regularly with their faculty to discuss plans for students with EBD. Sometimes the therapeutic day treatment provider was invited, if the discussion concerned a student on their caseload; however, not all of the therapeutic day treatment providers were invited to meetings. The meetings are sometimes part of RtI or school-based teams.

All of the principals stated they were in constant communication with the therapeutic day treatment provider located in their school. Most of the principals were very hands-on, as Principal Eller stated, sometimes on a weekly, if not daily basis. They liked to be involved in the child's provision of services. However, providers from outside of the school rarely entered the school building, if at all, even when they were invited. Again, in most of the schools it depended on the child's and schools' needs.

Principal Bailey stated,

> I've had varying experiences in conversations with them [outside agents]. Some call me, and I'll call them because they have a long-term investment with the child and again, have that common understanding and goal. And then some don't initiate it or see how the school's input can be relevant in their private counseling sessions. So it varies.

Principal Moore's experience collaborating with outside professionals has mainly been positive, because he tried to be conscientious when contacting outside agents.

> My experiences have been, call them when you need them. Being genuine, letting them know we're not wasting anybody's time. They know that my main priority is to make sure that kids and their families are okay. That I've got a legitimate reason and I am depending on you.

Principal Bailey mentioned RtI as a structured way her teachers discuss implementation plans when she stated,

> Our teachers, through response to intervention (RtI), and the way it is interpreted here at our school is that our teams meet once every 6 school days. We have a 6-day rotation. We call those long-planning meetings. The people who attend the long-planning team meetings are the case manager, the grade level classroom teachers, the intervention specialist, the principal, and the case manager/special-education teacher if there is a child with EBD. Teachers also participate in monthly meetings that are called "data days." Children who are considered to be Tier II or Tier III in RtI, including special education students, are highlighted. The case manager would be the one responsible for calling a psychologist or psychiatrist from outside the school.

Principal Bailey also talked about the therapeutic day treatment counselor provided through Medicaid. She has a caseload of six and "supports students who have behavioral or emotional challenges that impact them in the classroom, nothing instructional."

> So they go through a VICAP (Virginia Independent Clinical Assessment Program), through the Community Services Board and then VICAP makes a recommendation or determination if they fit the program. If they do, then she supports them on a daily basis both in group and individually, in her classroom or in her space, or in the regular classroom.

Principal Eller explained the process of working with others in his school:

> Basically it is a sit-down discussion about what is expected, what is the need? And then generally special services [from Central Office] has typed up a summary, or an agreement with that agency for that particular child or service that is being offered. We don't really have that much to do with

> that process. We talk, and we are at that meeting but we do not have a lot to do with the actual document that is written up. That comes from special services. And TDT [therapeutic day treatment], that's a little different too, because my counselor and I generally will work on that paperwork. Basically that comes through the school division, and they work with the counseling group that is TDT services and decide hours, pay, where those people are placed.

He went on to describe the planning and implementation process through professional learning communities or PLCs used in his school:

> We talk a lot about students in need and we pinpoint certain students periodically throughout those meeting times at grade level meetings. And sometimes the outside agencies are documented in our PLC notes that I keep and my assistant keeps, but again that is nothing as formal as what you may find in a child study meeting. Counselors are sometimes there, the TDT [therapeutic day treatment] counselor is there if we are talking about a TDT child. We have had other outside therapists there. We have invited them to those meetings. We love those meetings. It has been a huge plus to this building.

Research Question 2: What is the nature of interagency collaboration between school principals and outside professionals on behalf of students with EBD, as identified by participants?

Nature of Collaboration in Relation to the Negotiated Order Theory

Consonant with the negotiated order theory, the following themes emerged in relation to the nature of interagency collaboration: (1) similar values, interests, and beliefs about collaboration were noted; (2) principals' role in the collaborative process, policies, and procedures; and (3) negotiations were in alignment with current practices of communication within the school.

Nine of the 10 principals believed they share common beliefs and views with most of the outside professionals about collaboration. They all believed that school personnel and other agents have children's best interests in mind. However, they

believed that each entity has their own viewpoint on how to best attain services. Additionally, principals reported that part of their role as leaders in the school was to be a gatekeeper as to who worked in the school building and what role each person had in the school. Principals believed their role was varied, from being a mediator, encourager, supporter, and leader in the school for interagency collaboration. They all wanted to take the lead and provide the best possible services for their students. All of the principals would like for outside agencies to come to their school and present what they have to offer to the faculty and staff.

Participants' values, interests, and beliefs. Principal Penny believed she and her faculty shared similar perceptions of collaboration. She said, "I feel like in order to meet the needs of the kids, I have an absolute open door policy." She went on to say,

> Last year we had a school social worker that we split half time, because the school social worker could bill for Medicaid, we did not have day treatment. I absolutely think that with the setup this year, in comparison to last year, we are setting the kids up for more success because are able to wraparound them more.

Principal Fallon agrees with Principal Penny and revealed,

> You can't do it by yourself. It's very much necessary. For me they give me a different perspective of how to handle certain situations. So it's not only educating the teacher, but it's educating me. But I also think it's two ways because they're not here every day seeing the improvement or regression of behaviors. So it has to be ongoing, and it has to be a healthy collaboration. Because my focus and my goal is, "we have to do whatever is best for these kids." So I have to reach out to them [outside agencies].

Principal Crane agreed with Principals Penny and Fallon when she noted that as leader of the school, her role in expressing her beliefs about collaboration was critical, a priority.

> My role is to sometimes be the front person that will make those contacts. I think my role is to send a message and communicate that this is critical; that we are part of the community, therefore we work with the community. So that means communicating with teachers, with the guidance counselor. That's my expectation and I need to make sure that my beliefs and expectations are known by all . . .. I would say most people believe the principal's role is really solely the instructional leader and managing the building. I also believe it's my role to lead the "whatever it takes." And to make sure I walk that walk and people know that.

Roles of principal leaders and outside providers. All of the principals believed their leadership position provided them with an opportunity to promote collaboration. They also had expectations concerning outside providers as well. All of the principals stated that the role of outside professionals is to provide support to students and families.

Principal Cobb commented,

> They contact and have communications with teachers, families, and students, and of course with the administrators as well. They don't deal with strategies, they just help with support. And if there are any presenting concerns they will come to me.

Principal Crane affirmed other principals' perception about roles, "I think the bottom line is to help the child or family through the immediate crisis or through long-term therapeutic needs and to coordinate that help as necessary with the school."

Principal Fallon maintained that,

> To sustain an effective a healthy relationship with outside agencies there has to be a clear understanding of the purpose, the goal, open and constant communication. And everyone has to understand their role. It sounds so cliché but you have to understand your role.

Nature of Collaboration in Relation to the System of Care Framework

Consistent with the system of care framework, the following themes emerged as important.

Coordination of services. Although some principals stated collaboration and negotiations with outside agents are aligned, not all had written procedures noting the alignment. However, they still complied with plans developed by school or division personnel. As mentioned previously, although six of the principals did not have access to division-wide written policies and procedures, they still endeavored to coordinate services. For example, Principal Painter stated,

> We have a written crisis plan and in that crisis plan it details how the agencies will . . .. there's a big tree diagram that shows how all the agencies work together to deal with the crisis, but I don't know if there are standard operating procedures or not.

Principal Bailey considered policy in the school division, wanted the school personnel to be respected for their procedures by outside professionals, and stated,

> I don't feel, or we don't as a school, build plans or establish goals based on "What's our policy?" in our minds, obviously with good reason. But I think one of the things that is always in the back of my mind is that I want the education to be left to us. Certainly I want input, but I want us to be recognized as the professionals that we are; and our skills and our services and our support respected for that. We take care of school. I try to be mindful not to infringe upon that in the opposite direction. I would never imagine that if I were to say, the medication needs to be changed, that the doctor is going to do that, because that's their expertise.

However, Principal Eller expressed a strong desire for a written procedure for policy and the interagency process at the division system level. When asked if there were written procedures he stated,

> I wish! No. We brought that up several times to one of the special ed administrators. What is the protocol? We need protocol. What is out

> there? What is written for policy? Special ed. policy? Just policy. And I understand there are unique instances to every situation, but there is no real protocol. Nothing that is definitive enough. There are some little loose things, but it's way too loose. We just started, within the last 6 weeks, a memorandum of understanding with one of the social services because of a situation that occurred here with a staff member. That is the first we have heard of that and we were saying, "Where has that been? Why didn't we have that before?" So hopefully that will go into other areas too. But we have not read the memorandum of understanding. They have read some things to us in a meeting, saying this is what is coming down the pike. But I am eager to see what they come up with.

Research Question 3. What are the outcomes of interagency collaboration between school principals and outside professionals?

Outcomes of Collaboration in Relation to the Negotiated Order Theory

In agreement with the negotiated order theory, opposed interests concerning recommendations emerged as a theme in relation to the outcomes of interagency collaboration. Specifically, principals noted a variety of outcomes due to collaboration with outside professionals working in their schools as well as other providers who were invited to the school by different people. Experiences varied, as the principals had some similar and some different accounts of what collaboration looked like in their schools. A summary of the outcomes noted by the principals suggested that the rules and regulations of each agency may run counter to the collaborative process. They also reported that outside agents were very helpful and supportive because they offered different approaches to assisting students including various strategies, interventions, and preventions. However, they also conveyed concerns about following outside professionals' suggestions, noting a lack of interest in talking with school personnel by some outside professionals.

Lack of interests between professionals. All of the principals stated concerns related to outside professionals' suggestions about interventions for students with EBD. Some of the concerns were due to the lack of outside professionals attending meetings, and some had negative experiences, or as one principal stated, some "growth experiences." For example, Principal Bailey uses the word "consider" very carefully when contemplating outside professionals' suggestions, partially because she has had some negative experiences with outside professionals making suggestions based on the evaluation of the child.

> Our job is to consider those recommendations. And I use the word "consider" very intentionally, because often times, I think we're lucky if someone comes to school and does an actual observation or gathers information from the school staff about the child. More likely, or more often . . . they talk to the child, maybe talk to the parent, and then make a list of recommendations without really any knowledge about the child in school or without any input from the school or knowledge about what happens in school. No direct knowledge I would say. And so, often times their recommendations are not at all consistent with what we see from a child or what our data tells us a child needs. Often times, they make recommendations about things that we're already doing.

Following some agents' suggestions has proven to be challenging for principal Goode as well. She also had the same experience with outside professionals making recommendations that were already implemented in the school, leading her to believe the person had not read any of the documents they were sent. She stated,

> Typically, if they [not therapeutic day treatment in the school] give suggestions, we are already doing many things that they have suggested. Sometimes they will come up with something that isn't practical or workable in this setting, but we always want to listen and try.

Principal Samson conveyed a scenario that would be challenging to implement, as her team stated,

> Sometimes it's challenging to follow outside providers' recommendations. Well, there was a child one year . . . that the recommendation was to rub lotion on her feet multiple times a day and sing a song as you did it. That was a pretty out-there recommendation.

Principal Eller concurred with Principal Samson about being hesitant to implement to others' suggestions and stated,

> Not that their ideas aren't worthwhile or worthy, but sometimes it may be hard to follow-through with their ideas or suggestions within the realm of the school setting. For the most part, I know they are trying to help that child. I remember one professional saying that the teacher that was working with the child in a general ed. classroom needed to stop and sit with the child every 10 minutes and reinforce that child in a one-on-one. And that is impossible to do when you have 26 or 27 other kids. Not to say that the teacher shouldn't be reinforcing that child, but to stop instruction and meet with a child every 10 minutes, we can't do that. We have to find a different way. And the professional that was suggesting that was kind of surprised. As we explained our reasoning, it's not that we wouldn't want to do that; we can't, based on our limitations in personnel. We need to do something a little different. What else can we do? Here's another idea I have.

Principal Moore contended, however, that, "If you have a relationship with them, then no [it's not difficult to follow their suggestions]. Because if you have a problem with their suggestions or recommendations, you can talk. You can share and not be offended."

Principal Painter believed that everyone has the child's best interests in mind, however, she further disclosed,

> It is very difficult [to follow their suggestions]. And again, they tend to make recommendations that they believe are best for the well-being of that child and they may not see it through the same lens that the school system sees it through. And then sometimes we have had recommendations that we have determined that were not appropriate for the child's education. We often have requests from either outside advocates or psychologists, psychiatrists, for specific programs. And we as a school division don't specify programs. We can't guarantee that child will receive a certain

> program but we will do our best to provide something comparable that we believe will help meet the needs of that child.

Outcomes of Collaboration in Relation to the System of Care Framework

Related themes under the system of care framework included coordination of efforts and coordination of services.

Coordination of efforts. All of the principals perceived that students will benefit from the coordination of efforts, ultimately—as it is about the students, and what is best for them, and for the good of the school. Two principals discussed the importance of having a positive, welcoming environment that is more conducive for all.

Principal Fallon commented,

> There are times I'm like, okay guys, let's look at the benefit for the kids. Here's where we need to hash it out. Here is where we need to talk. And we say here's why we don't think it's going to work. Can we do this instead? I always tell the teacher you are still the lead teacher in that class. This is your classroom.

Principal Painter stated, "I definitely think that we would want as much community involvement and support through those organizations as possible, if they can help our kids. I wouldn't see why we wouldn't want to explore avenues to get that help."

Principal Penny also described the value of working with other organizations like Intercept, a provider of wraparound treatment programs for at-risk youth, by stating, "So my vision is to have Intercept serve my [students] next year, because I do value that openness and communication and willingness to go the extra mile to benefit the kids." Principal Penny had two different providers in her school this year: one that communicates and one that does not. Next year she is dropping one of the providers and choosing this one that communicates:

> They send me a weekly report. This is that the cool thing about theirs. And on the report it will list each student, it lists their goals, their therapy, and then it has therapy notes that the therapist provides. Was there a contact made home, yes or no. And then at the bottom there's a section for our new referrals. And it will tell me that it's in progress—left message with mom, no return call—and so I'm able to see, ongoing, like what's going on with our new referrals. And again, the supervisor is here at least once or twice a week.

Coordination of services. Principal Crane mentioned a situation when the school level team went outside the school building to the Community Services Board for a meeting because all the professionals were hearing something different from the parent and they needed everyone to coordinate services. She stated the following,

> We did have one case where there was a large meeting with psychologists and we went to that agency; it was actually the Community Services Board. And this was two years ago that we had a classroom here of ED [emotional and behavioral disorder] kids. And we did have a meeting out at Community Services Board to coordinate with the counselor, the therapist that was seeing the kid, the day treatment staff, and the psychiatrist that was treating him. Because the parent was very good at playing everybody against each other and there was a lot of medicine mismanagement accusations. So everybody needed to hear it. All at the same time.

Research Question 4. What are the contributors and barriers to interagency collaborative services, as identified by the participants?

Contributors and Barriers to Collaboration in Relation to the Negotiated Order Theory and System of Care

In accord with the negotiated order theory, the following themes emerged in relation to the contributors of interagency collaboration: (1) negotiators experience in negotiating contributed to teamwork and communication; and (2) overt transactions or the development of trust in relationships was cited as important. Barriers cited were the number and complexity of issues; time and funding resources; and opposed or lack of

interest between professionals. Under the system of care framework a related theme was the coordination of efforts between professionals. Barriers included the coordination of services, integrated services at the system level, and a financial mechanism for system of care implementation.

Coordination of efforts. All the principals noted contributors and enhancers to collaboration as well as barriers that prevent collaboration. A summary of the contributors included pursuing outreach to various agencies; having frequent and consistent discussions and communications with outside professionals; developing relationships; sharing views, beliefs, and principles with each other; and sharing expectations with all personnel. Communication and the development of relationships were cited as the most important aspects of collaboration.

Although communication was listed as an important contributor, the principals also noted it was a barrier if not done sufficiently. Other barriers to collaboration included the lack of compensation for outside professionals to attend school meetings, lack of transportation to professional businesses such as counseling or the Medicaid office for parents, stigma of labeling children as EBD, outside professionals' making time to collaborate with school personnel, outside professionals' rarely attending school meetings, and a lack of knowledge about what the other has to offer. Examples follow.

Negotiators' experience in negotiating and communicating. Several principals conveyed aspects of experience in teamwork that contributed to collaboration, including communication. Principal Eller made several suggestions, including communication, written procedures, and understanding roles:

Communication. And understanding. And knowing what that person's role is and how they are going to be helping. The ability to collaborate and work with people, adults and kids. Recordkeeping. Evaluating themselves. And being open to suggestions and vice a versa.

Principal Painter agreed with Principal Eller about communication and noted,

I think the biggest piece is communication. And I think that it's great to have representatives from all the agencies that get together and share what possible resources are available for different populations that we serve. But if that communication does not filter down through the individual schools to the individual kids in that process, then there's a breakdown in the communication piece. I think the education piece is crucial. That the parties who serve these kids need to be aware of what supports are out there and what channels we go through to get that child support.

Principal Goode noted communication and its relevance to school. If principals will continually encourage families to apply for Medicaid, the opportunity for assistance is available for children.

I do think communication is very, very important. It's sort of like a marriage; you really have to work on it because you have to have both the school and the agency work together. I have known of schools where it doesn't work. I know several schools where they couldn't keep the clients in. It is hard to keep that capacity because the [Medicaid] process is so arduous. But then again, they are in for a long time. Once they get in, they are in. But I do think that communication piece is important.

Visibility of transactions—clear and overt. Principal Moore noted trust as important when developing relationships. "Trust. And as a former superintendent used to say, no surprises." As part of building that trust, he stated, "When they have some kind of fair, I try to show up, because you want to be visible [overt]. They are going to answer the call, but it's nice to put your name and your face together."

Coordination of services. Unlike Principal Penny, Principal Goode noted that she had a model program for working with therapeutic day treatment providers, because they had all been together for 10 years. She expressed how it was unusual but that she

was grateful for their assistance. She reported being very appreciative of these services. She also stated that when a new school building is opened in 2 years, the therapeutic day treatment providers will have their own space.

> I feel like our situation is kind of a model, because we have had consistent professionals that have been working together for a long time. I think that is very important. If the clinician or the behavior specialist was changing every year I think it would really have a devastating effect on the program because they are building relationships and trust with the families and the school. So I think that longevity and stability are important. If there could be a more user-friendly way to actually go through the [Virginia Independent Clinical Assessment Program] and the eligibility process . . . it really does cut some people out.

Number and complexity of issues. Various complex barriers to interagency collaboration were noted by all of the principals, including communication, time, money, and lack of transportation. Principal Painter mentioned the importance of communication as well when he stated,

> I would say the biggest obstacle right now is there is no direct communication between building administrators and those outside agencies. It's all through namely the school social worker who is connected to all those various groups. And as long as we're not directly communicating with them, we don't have an adequate understanding of what they could offer and they truly don't have an adequate understanding of what we need.

Time and funding for system of care implementation. Principal Goode suggested funding constraints and time as impediments to collaboration. In her 17 years of experience as a principal, she thought money and time were important factors. She stated,

> I would say most times [outside] professionals would not come [to meetings] just due to time restraints. But I also think time is money. I think it is hard to separate those two . . .. Because someone has to pay for them to come . . .. if they are in private practice, they're losing time and money. If they can bill to come, then they probably would come I guess.

> If they [parents] don't have public funding [insurance], it [applying for Medicaid] is an arduous process. For a lot of people, it's just very hard. It is definitely a commitment of the parents to do it.

Integrated services at the system level. Principal Penny revealed inconsistency with providers, noting the turnover rate with some of the outside professionals,

> I feel so disconnected with that side of the house. We used to have monthly meetings with the supervisors. They have had turnover after turnover . . .. So I will honestly tell you there are opportunities for disconnect; there are opportunities for lack of engagement. I really do believe that it comes down to their turnover and the importance that they place on staying in communication.

Opposed, antagonistic, or lack of connection between professionals. Principal Moore expressed a common principal concern about medical professionals when he stated,

> You know what I think creates the most problems for schools? Doctors. Doctors have this thing where these children and their parents go to see doctors. And the doctors say, "Go back to that school and get a 504! Go back to that school and get special ed!" They are the worst. They don't understand the process. They don't understand that a parent comes back and says, "My child needs special ed, according to the doctor." That's the kind of thing that makes it hard. People [parents] coming in basically, and bullying you and telling you what you must do. Those are the worst, in my opinion. But I have had it happen so many times, I think, "What are these doctors thinking?"

At first, Principal Cobb was hesitant to state her opinion; however, upon reflection she decided it was important to share. She expressed the same sentiments as Principal Moore.

> We have physicians that tell parents one thing that is totally out of line as far as what we can do legally for students. Doctors will tell parents, the child needs an IEP (Individualized Education Program), that kind of language, when they haven't even been brought up for child study. So the first step, of course, would be a child study meeting, and there's protocol for that, with an eligibility process, to see if they even qualify for an IEP.

> But her doctor has already said to a parent, they need this, when they don't even know the big picture or haven't communicated with the school at all.

Principal Cobb, along with four other principals, talked about the "big picture" when considering working together and barriers to collaboration. Although he likes to collaborate, he stated that school personnel spend a great deal of time with students, and he could not understand why a doctor would not want the opinions of school personnel. He stated,

> I do wish as a parent, and as an educator, that in, specifically the mental health field, that there would be more collaboration between the psychologists, psychiatrists, whatever team of doctors, and the schools, because we work with those students every day and we see the big picture. They get them once a week or once every 2 weeks, and it would be better suited for the students, I would think, if they had more of a background of what we see every day in the classrooms; just to help with the treatment plan. And to give us more insight as well.

Principal Penny again, concurred and offered this scenario that recently occurred at the school with a young boy:

> It was frustrating . . . one of our students had been hospitalized for a week and upon his discharge . . .. What happened when he was there? And then even while he was gone for the 2 weeks most recently, we sat in that meeting . . . and said, "Oh my gosh! If we didn't have [the day treatment provider] here to help keep us in the loop . . .." because once he was in that facility, there was not an attempt to reach out to us. It was frustrating. As he's threatening to kill himself here, and he's threatening to kill himself on the bus, and we're having to have police support, and getting him to the emergency room. [At the hospital], I mean he's being given every food known to man, and Gatorade, bonbons… And the child was just loving it, loving life. And so when we leave, and we hear he is admitted, that pretty much is it. But it was because he said the statement to the intake person; but it discounted everything that we had experienced that afternoon . . .. I mean they were literally getting ready to discharge. And he said, "If you send me home, then I'm going to kill myself." I mean I have video from the bus of what we had experienced that really wasn't being taken into account. So there is a frustration, you know, for an outside agency.

Principal Crane had a similar reaction as a result of attending a meeting along with the guidance counselor and a special education teacher concerning a child being discharged from residential treatment hospital. She disclosed,

> And I tell you that has not been a positive experience, and generally we leave there thinking, "What a waste of time." A child can be hospitalized for 2, 3, 4 days, 2 weeks, and we've been living with that child for sometimes years. And we're dismissed. Which is a shame. Well, there's so much more to a child than a counseling appointment, and I think the hospitalizations are those short-term crisis moments rather than the big picture. I find those short-term hospitalizations to be the detriment. Because . . . the child is angry, the family is angry, and we didn't really accomplish anything. They don't come out of there with a treatment plan that says we're going to release him back into the community and here is a really solid plan that involves all stakeholders. That would be nice. But that's not reality; in my experience.

Research Question 5: How can collaboration between school agencies and outside agencies be improved?

Improvements to Collaboration in Relation to the Negotiated Order Theory

Consistent with the negotiated order theory, the following themes emerged in relation to the nature of interagency collaboration: (1) participants' interests were of note; and (2) negotiations were in alignment with current practices of communication within the school. All of the principals recommended changes to the process of collaboration as well as noticed changes in their perceptions due to collaborations with others. Similarly, they all reported learning from the outside professionals coming into their schools and offering suggestions, particularly the day treatment providers and one-on-one counselors.

Participants' interests. All of the principals would like for outside professionals to come to their school and present their knowledge and experience to the faculty and staff. As a former special education teacher, Principal Eller stated he has had a lot of

experience working with others on the behalf of students with EBD. However, in his extensive professional 30-year career as a principal, he still recognized the need to know more. He disclosed,

> I'm sure there are more things that are out there than what we are actually using and have knowledge of. So it would be nice to know more of what is out there to help us in our quest to do the best for the kids.
>
> He went on to say,
>
> I don't know if it has necessarily changed my view, because I have always felt that collaboration is so important. I think they [outside providers] have opened up our eyes and taught us a lot too, because we have also used them, depending on the person and their service, to enrich the understanding or knowledge and understanding of the staff. We've had them do professional development for us periodically. We have had some come in and talk about working with our male students, things on behavior. We have had them come in and deal with some issues about poverty, for example. We have had social workers, counselors; the TDT [therapeutic day treatment] counselor has done things. We have had an outside autism specialist come in. We have had a behavior therapist come in and do some things about children and tantrums and tell to deal with those. It just depends on the need at the time. Many times it is us calling and asking. Or saying when they are in the building, "Here is a need we have. Would you be able to talk with us at a staff meeting? We have a professional development day coming up, I would like to use you for an hour."

Principal Goode changed her perception of collaboration due to being "open-minded" as she called it and becoming informed of the therapeutic day treatment providers' support. She stated,

> When I first had them [day treatment providers], it was probably 14 years ago, I was honestly clueless about who they are, what they did. An email just came from the pupil services director and said someone needs to do it. Does anyone want to volunteer? And we have these offers from time to time for different things and most times we don't want to deal with one more new thing, but for whatever reason I thought I don't know what this is, but I want to learn more about this. And I'm just so thankful that that is the way it worked because it really has made all the difference. When I came to this building it was my absolute priority, and I mean that.

When noting participants' interests and improvements to collaboration, Principal Fallon cited the importance of communication when he said,

> The importance of communicating between the two agencies is vital for the success of the program. Always ask questions if you don't understand. Not necessarily that I have learned this, but at the end of the day, you are still responsible for what goes on in your building. I'll give any new principal that advice. You can have all of the outside people come and help you that you want, but you have to make those decisions yourself. So I have to think about the long-term goals as well as the short-term goals when working with outside agencies. What are they going to be able to provide immediately? What are they going to be able to provide in the long run that is going to promote success or achievement?

Negotiations are aligned. Principal Moore learned that to negotiate and collaborate more effectively, it is important to develop relationships with outside professionals. Principal Moore said he makes time to get to know them so that when he contacts them, they will want to help. He stated it was not about who had the most power and ultimate authority, but more about what was needed in that moment. He disclosed,

> I learned that there are good people out there who are committed to seeing good things happen for people. And if you have a good working relationship things will be good for people; as long as you have a good working relationship. It's not about who is in control or who is the top dog. It is about keeping the main thing the main thing. And that is helping kids. If you can establish that, you are in good shape.

Principal Samson was reminded of the role of parents and how she can help them. She described what she had learned from working with outside professionals:

> I think it's a good reminder for me of how unstable some parents are and just how lacking in skills they can be. And it has nothing to do with the amount of love they have for their children or anything like that. It's just that they're lacking in parenting skills. And just to see what they [Community Services Board provider] can offer the parents, and to be able for them to tell me, "By the way this mom gets so upset when you call her that she doesn't ask any questions." So the next time I had to suspend the kid I had the parent come back to my office and I said, "I would like to tell

> you what happened." And so she didn't have to ask me any questions. I just said everything I needed to say and so I asked, "Do you understand what happened? Is there anything you want me to clarify?" Thinking that when she was quiet on the phone . . .. Is she mad? Does she not care? Her child keeps doing these things. And she would say, "I don't think to ask questions until I hang up, then I have questions." So the [Community Services Board] person was telling her, "Well, you need to call back and ask questions." So what that's telling me is . . . hmmm. I need to ask her more questions. And that helps with all the parents really.

Improvements to Collaboration in Relation to the System of Care Framework

The coordination of efforts theme emerged consistent with the system of care framework.

Coordination of efforts. Collaboration may improve when participants are full partners. Principal Cobb summarized several principals' perception about the provision of services and the importance of interagency collaboration, both as a principal and as a parent of a struggling child in school. She stated, "I think there are so many students [needing services] and I have seen this in my 20 years in education. More and more students have a need for outside agencies, whether it be counseling services . . . and they aren't all getting it."

Principal Cobb went on to say,

> As a parent, it's very scary when you get that label, but yet your child needs those services. It could be financial reasons, or they could just be parents that just don't want to admit that there's a problem. It could be something as simple as being malnourished so, "I'm not going to get any food tonight." And that causes them more anxiety here at school. I think a lot of our students are in need of more attention than what they are receiving. Mental health is this whole other realm. Trying to get an appointment . . .. It takes months sometimes. I don't know if there are just not that many pediatric treatment facilities. And I guess being in a rural area could be part of it. I had three different doctors' offices that I was trying to get him into. I was waiting for 3 months to get into an office in a nearby larger city, and I ended up going to another city that is close by and that one took about 6 weeks to get into. And I am not an at risk parent,

> you know? So what do people do that can't pay for it or don't have insurance? It may be less about what the school isn't doing and more about what society isn't doing as a whole.

Several suggestions were made, including a recommendation that principals make the effort to intentionally invite outside professionals to meetings and continue to encourage parents to invite the outside agents. Principals also noted that communication with outside professionals was essential; therefore, principals should be visible and available to the outside professionals. Written procedures, including memorandums of understanding, would help the process, and requesting professionals to deliver professional development concerning students with EBD, as well as how to better collaborate with outside agencies would be welcomed.

Summary of Findings

In summary, findings support interagency collaboration between schools and outside agencies. The conditions needed for collaboration as perceived by the principals are communication and an openness and willingness to work as a team toward the betterment of students. All of the principals cited interactions with outside professionals as important; however, they differed in who should initiate the contact, the school, the parents, or the outside agents. Several cited that it depended on the needs of the child. Some principals contacted outside agents only when necessary, and other principals communicated with outside agents on a regular basis. Some believed it was the responsibility of the outside agents to contact the school, whereas others believed they should promote communication either by intentionally inviting the providers themselves or by guiding parents to contact outside professionals and encouraging them to communicate with the school.

Planning and implementation of collaboration was considered essential, and schools had various ways of meeting with outside agents. All of the schools had a day treatment counselor provided through Medicaid funding from the Community Services Board; therefore, interactions with an outside agent occurred daily, if not weekly. All of the principals welcomed outside professionals if the parents invited the agents to school meetings.

In terms of the outcomes of services provided, all of the participants reported that they shared common beliefs with outside professionals as to the importance of supporting children. However, following the suggestions of outside providers was sometimes challenging. Some teachers found it more challenging to follow recommendations than others. Each principal perceived that part of their responsibility as a leader was to be a model for others in their schools. When given the opportunity, the principal would encourage faculty to consider outside recommendations. The principals believed it was their responsibility to guide and direct the collaboration between outside professionals and the school, and ask the question, "Why not?"

Although not all of the principals had written procedures for interagency collaboration, they all perceived that written records would be beneficial to the school to better follow policies and procedures. These reports and memos could be a contribution to collaboration. Other enhancers to interagency collaboration mentioned were communication, trust, and relationship building with outside professionals. Barriers to interagency collaboration included the arduous process of Medicaid paperwork for families. Additionally, many of the principals noted that no outside professionals other than the day treatment providers had entered their schools, much less consulted them to

have a better understanding of a student. Furthermore, some outside professionals provided suggestions that would not work in a school setting. Unfortunately, this sometimes led to school personnel's lack of confidence in outside professionals' opinions.

All of the principals perceived communicating more directly with outside professionals and encouraging the agents to contact the school for advice and suggestions could improve interagency collaboration. All of the principals had learned more about students with EBD, as well as collaboration, as a result of outside agents coming into their schools. Participation in collaborative efforts with outside agents resulted in positive outcomes related to children with EBD. Successful integration of Community Services Board day treatment providers provided support and assistance with students with EBD.

The results also indicated that all of the administrators perceived the provision of wraparound services and collaboration as beneficial because students with EBD were more successful with involvement from everyone on the team. All of the principals felt collaboration with outside professionals was vital; they perceived that they could not do their job as well without others helping and supporting children who struggle emotionally and behaviorally.

CHAPTER 5

DISCUSSION

The literature shows that children with mental health diagnoses and those who are exhibiting serious emotional and behavioral disturbances may benefit from early mental health services that emphasize prevention and intervention approaches in a system of care (Kaufmann & Hepburn, 2007). A system of care approach maintains a guiding set of values and principles of interagency collaboration. When children enter school, the need to engage diverse and multiple interagency partners is important for system-level efforts to address mental health issues (Perry, Kaufmann, Hoover, & Zundel, 2008). The effectiveness of practices and interventions and system-level change was documented and discussed (Stroul & Blau, 2008). Findings from this study suggest outcomes for children will improve if service delivery organizations collaborate to provide coordinated services. There is increasing interest in the role that mental health agents can play in systems of care, because more communities are funding these approaches (Perry et al., 2008). Medicaid often provides the funding for services delivered through systems of care and arranges for day treatment providers in schools, if families meet the criteria.

The literature supports the need for strategies to improve mental health services and suggests interagency collaboration as a way to address concerns (Stroul & Blau, 2008). Although systems of care may provide assistance to families and children, relatively little empirical data has been provided in the literature concerning the ways schools and outside agencies work together to support students with EBD from the perspective of school principals (Smrekar & Mawhinney, 1999). Understanding the roles

and perceptions of school leaders engaged in meeting the needs of students with EBD may lead to greater success for students with EBD (Cook et al., 2003). Therefore, the researcher designed and implemented a research study that provides a description of principals' perceptions of interagency collaboration regarding students with EBD.

A summary of the study and its findings is presented within the context of the review of literature and the framework that informed the study in response to the research questions. After reviewing the purpose of the study and the methodology, findings are summarized and discussed. Implications for practitioners as well as recommendations for further research are reported.

Purpose and Significance of the Study

As leaders in schools, principals play an important role in framing the structure of collaboration between stakeholders. Principals, therefore, have an opportunity to consider and possibly change the range of provisions to better serve students. As the literature suggests, many children with EBD do not have access to appropriate services (Kauffman & Landrum, 2006). A model involving all members may improve services for students with EBD through intentionality, thereby helping these students be more successful in school (Stroul & Blau, 2008). Research also demonstrates the need for principals' perspectives on interagency collaboration, because they are responsible for productive interactions between all participants (Gable & Tonelson, 2010; Ubben, Hughes, & Norris, 2001).

Thus, the purpose of this study was to add to the knowledge base of practitioners and researchers by providing perspectives from elementary principals in public school settings in Virginia regarding interagency collaboration between school professionals and

outside specialists for students with EBD. An additional aim of this study was to examine the contributors and barriers to interagency collaboration between school agents and outside agents.

The introductory chapter outlined five research questions:

1. To what extent, and under what conditions, do school principals collaborate with outside professionals on behalf of students with EBD?
2. What is the nature of interagency collaboration between school principals and outside professionals on behalf of students with EBD, as identified by participants?
3. What are the outcomes of interagency collaboration between school principals and outside professionals?
4. What are the contributors and barriers to interagency collaborative services, as identified by participants?
5. How can collaboration between school agencies and outside agencies be improved?

Methodology

The goal for this study was to investigate how principals perceived interagency collaboration in relation to students with EBD. As such, 10 elementary principals identified by their school superintendents as having knowledge of interagency collaboration were invited to participate in the study. To address the research questions, this exploratory and descriptive qualitative study used a questionnaire and interviews to provide principals' demographic information and experiences. Semistructured, one-on-one interviews further identified principals' perceptions regarding whether and how

interagency collaboration between schools and outside agencies takes place. Perceived positive and negative outcomes of interagency collaboration were solicited. Interview questions and the demographic questionnaire can be found in the Appendices F and G.

Synthesis of Findings

Interagency Collaboration

The system of care framework and negotiated order theory provided the organizational structure for this study as a lens through which to view the changing configuration of services for students, including coordination of efforts across professional systems, thereby creating collaborative interagency teams (Blodgett & Behan, 2003; Strauss, 1978). These frameworks helped the researcher make sense of the findings by providing guidelines as well as an organization for the study. Based on research and experience in child mental health, child welfare, and disabilities, the system of care concept provided a structure for practical applications as well as theoretical guidelines for educators regarding implementation processes for interagency collaboration (Stroul & Blau, 2008; Friedman, 2006). The negotiated order theory offered a framework to explore negotiation processes between school personnel and other professionals as it relates to the structure of support systems for students with EBD (Strauss, 1978).

Given research highlighting the necessity of studying principals' perceptions of interagency collaboration, an analysis of their practices and beliefs was essential. Analysis of the data indicated that interagency collaboration is important, if not critical, to all of the school principals. Although some research pointed to the possibility that administrators may have limited knowledge of mental health services in their schools

(Gable & Tonelson, 2010), this did not appear to be the case in the current study. Interviews indicated that all of the principals not only had extensive knowledge of working with professionals outside of their school; they also had substantial experience working with outside agents in relation to students with EBD as well. However, these principals were specifically chosen as having knowledge of interagency collaboration. Other principals with limited knowledge and experience of communicating with others may well be served to enhance their understanding of collaborating with outside agencies and individuals. The system of care guidelines promote collaboration, however, principals must make the effort to coordinate and facilitate service delivery. The role of a principal in interagency collaboration is complex; therefore, additional support and training may prove helpful.

All of the principals in this study collaborated with outside professionals, particularly the therapeutic day treatment counselors provided by local Community Services Boards, located in each of their buildings. In addition, agencies such as Social Services, the Sheriff's Department, and Child Protective Services were noted as integral partners with schools. These findings support the notion that collaboration is an important aspect of supporting students with EBD.

Conditions Contributing to Interagency Collaboration

The first research question in this investigation aimed to identify conditions necessary for interagency collaboration. The negotiated order theory suggests that negotiators' experiences in negotiating are worth noting (Strauss, 1978). Although findings from Gable and Tonelson's study (2010) indicated that some Virginia state

directors did not know if mental health services were currently offered in their schools, this was not the case with the participants in this study.

The process of negotiation is central to the structure and shape of the organization. As collaboration is implemented, it affects the course of services and subsequent efforts (Hasenfeld, 2010). Principals noted that it was critical for schools to work with outside agencies; therefore, the means by which negotiation occurs is tantamount to its success. This finding suggested that it might be important to consistently include all stakeholders in meetings that concern the care of students with EBD. This finding is consistent with past research with the system of care framework, indicating child serving agencies should coordinate services, service planning, and services provision (Stroul & Friedman, 1986).

The negotiated order theory also specifies how work is defined, as well as how to do it, and who is involved (Strauss et al., 1985). When complex organizations have vague or few goals, challenges are likely to occur (Strauss, 1978). With an integrated approach, these organizations may use a range of participants with different skills, values, interests, and social and professional affiliations and thereby use their expertise in creating goals and responsibilities of each party (Strauss et al., 1997). This research confirmed this approach as principals noted school personnel and outside professionals have important information to offer the other.

Initiation of contact and different perspectives. One aspect of the negotiated order theory states that whom the participants represent is of note as well as how work is defined. Although all of the principals thought they shared the same beliefs with outside professionals, and that they all had children's best interests at heart, each side had their

own perspective of how to best support students with EBD. Principals noted that outside professionals may have perspectives and insights as well additional supports or resources that may not have previously been considered.

The principals valued outside professionals' perspectives even though they sometimes differed on the method to help maximize students' achievements. Several principals noted student mental health concerns have come to the forefront of thought in schools. The involvement of all parties involved with educating the students can provide support for the child within the school and outside the school.

However, the lack of a consensus on how to develop services and the lack of collaboration among community stakeholders (Ringeisen et al., 2003) inhibits productivity. The negotiated order theory considers opposed interests or lack of interest to be of note. Several principals said they had written procedures for collaborating with others, while some wish they had them. Even after requesting procedures from central office, the request was ignored. Strauss (1978) emphasized that alignment of goals, procedures, and processes supported the negotiation process. As actions are continually altered, they must be "worked at" through the processes of give-and-take and diplomacy (Strauss et al., 1963). The necessity of written procedures may be important for some personnel; therefore, time and effort should be placed on the development of memorandums of understanding or other relevant documents that may augment collaboration.

Planning and implementation. Strauss (1978) advocated for the focus to be on the analysis of structural context within which negotiations take place. In response to the changes in IDEA in 2004, Virginia implemented RtI (IDEA, 2004; National Center on

Response to Intervention, 2010). The systems change focuses on problem solving and collaboration (Smith & Eber, 2010). When planning appropriate interventions for students, plans must be carefully designed to meet the needs of the child. For those children in need of services from multiple agencies, wraparound services are an approach to fulfill those needs (Goldman, 1999). Research has shown that when implemented successfully, coordination of efforts between participants creates collaborative interagency teams (Stroul & Friedman, 1986). This research adds to the literature on wraparound services as noted by the participants. Most of the principals suggested the importance of providing services involving all stakeholders. Although one of the principals never invited outside professionals to meetings, he consistently collaborated with others outside of child study meetings.

Nature of Interagency Collaboration

The second research question considered the nature of interagency collaboration as identified by participants. Shared beliefs, unconditional commitment, and coordination of efforts between school and agencies across administrative boundaries are integral to systems of care (Stroul & Blau, 2008). When asked if they shared beliefs with outside agents, all the principals surmised they did. All of the principals perceived everyone as sharing the same beliefs and values about working with children and being an advocate for students' best interests.

Roles of Principal Leaders

School administrators play key roles in defining and cultivating procedures that respond to students' needs. Overwhelmingly, the principals in this study wanted to be the leader of collaborative efforts and believed that outside agents are in the school to

provide overall support for the well-being of the child, including emotional and behavioral suggestions. Literature shows that administrators must be involved in collaboration with outside agents, because they are the ones who represent the school and expedite communication with experts outside of the school (Dettmer et al., 2013). Principals have the opportunity to help clarify collaborative roles to facilitate the provision of services between all parties. The negotiated order theory maintains that clarity of the legitimacy of boundaries is an important aspect to consider through diplomacy (Strauss et al., 1965). Principals must maintain a balance of power between stakeholders according to this theory, and that level of power is exhibited (Strauss et al., 1965). As one principal commented,

> That is where the memorandums of understanding had to come to be. Depending on the agency, they have to be in charge, but the principal has to know everything that is going on. Like the fire department; if they come here, they are going to be in charge. But with a mental health issue, it has to be somewhat equal, because the principal is ultimately going to answer to it. So I like to think that I am aware of what is going on. Where I step aside is, I have to trust that their skills are what is needed to resolve the problem. I need to know that what you were doing is going to help him. Period. So I need to know, but I also have to relinquish any power, if you will, to trust the person to do the right job.

The attempt to reach an agreement with others through collaboration while paying attention to that agents' characteristics as well as noting the changing interactions among participants leads to positive negotiating or interacting (Strauss et al., 1965).

One aim of this study was to explore this role and to better understand how communication and negotiation processes between school principals and outside agents relates to the structure of support systems and collaboration for students with EBD. Gable and Tonelson (2010) stated that although principals may be central to interagency

collaboration, little is known about the actual communication between principals and outside professionals. In light of this previously discussed literature, conclusions drawn from these findings suggest that the role of principals is essential to the successful process of communication for students with EBD. Participants were shown to have experience with and knowledge of negotiating, as evidenced by the following example of a principal's scenario:

> It takes me making it a priority to communicate outside of this room. Just in the last week, I have spoken with our director of student services, who oversees school safety and discipline. I've spoken with our director of special education. She is attending a meeting tomorrow for one of our students in the classroom. I've talked to the director of transportation. And again, a lot of those contacts have to be made, I believe, by my office or by the assistant's office in order to facilitate services for the kids.

As the negotiated order theory maintains, there are options to avoid or discontinue negotiations, because there are always alternative actions available. But according to Strauss (1978), it is a process of give and take. When negotiations align with current practices and procedures, participants interact and share responsibility for collaboration. The system of care framework also maintains that a structure of partnership contributes to a range of treatment services and supports for students. When all members of the process better understand their importance in their respective roles, this may be viewed as a negotiated order. All of the principals commented on their various roles, emphasizing that all stakeholders understand their respective role in the collaborative process.

One principal noted that the school sets the tone for communication and collaboration. Principal Cobb said the therapeutic day treatment providers contact and have communications with teachers, families and students, and the administrators as well. Principal Moore noted, "The director of student services lets everybody know his or her

place. And he does it so that things work for people. So everybody knows their role." All of the principals noted their role and outside professionals' roles in the school in relation to collaboration for students with EBD.

Policies and Procedures

Due to Virginia Governor McAuliffe's Governor's Access Plan, financing for the uninsured who have been diagnosed with a serious mental illness has received state and federal approval. If families apply for Medicaid, children may receive treatment from day treatment providers located in some schools. Some literature states that children with EBD do not receive necessary support through mental health services (Eber & Keenan, 2004). The participants in this study concurred with these findings. Principals cited factors preventing the completion of procedural paperwork, including parents' denial of problems or difficulties with their child, unwillingness to fill out Medicaid paperwork because families do not want others to know their business, prior negative experiences with Medicaid due to a family history of mental illness, rigor necessary to complete paperwork, and not wanting their child to overhear problems in the family. The principals all agreed that a better procedure should be in place to prevent some of these concerns. These conclusions reflect the literature (Crowell, 1993; Hyman, 2000) that states parents may not want to apply for assistance because of concerns outside of school.

As a result of these differing structures, philosophies, and resources, principals have the opportunity to encourage families to request aid to receive assistance from day treatment providers in schools, for example. As the literature suggests, service delivery programs for children with EBD are frequently delivered in a fragmented and often uncoordinated manner (Adelman & Taylor, 2000; Sadeh et al., 2014; Van Acker, 2010;

VDBHDS, 2011). By principals' supporting families and outside providers to work with the school, all stakeholders may help link individuals together to create positive outcomes for children with EBD (Bradley et al., 2008; Eber & Keenan, 2004; Koyanagi & Gaines, 1993; Stroul & Blau, 2008).

Outcomes of Interagency Collaboration

The third research question examined the outcomes of interagency collaboration. As the literature suggests, classroom teachers note the time and effort necessary to manage challenging student behaviors (Gable & Tonelson, 2010; Murray & Myers, 1998). Research also submits that when system of care principles and values are integrated across services, desired outcomes are achieved (Annual Report to Congress, 2005). Principals confirmed these findings by reporting positive outcomes for students when all parties are involved in the process.

Outcomes of Services

Consistent with the literature suggesting the impact of systems of care and an improvement in resources for their children (Annual Report to Congress, 2005), the principals agreed that services may be valuable when all parties work together by listening and respecting each other's perspectives. All of the principals maintained that the therapeutic day treatment providers funded through Medicaid are an invaluable source of support for their schools. However, they varied on the inclusion of the day treatment providers in all meetings. Some of the principals invited the therapeutic day treatment personnel to every meeting concerning one of their students with EBD. Conversely, other principals did not invite them to all meetings. Those principals that invited the therapeutic day treatment providers found their expertise helpful to the school

personnel. These conclusions are consonant with the literature concerning improved outcomes for children when service providers work with schools to implement appropriate services (Stroul & Blau, 2008).

Following Suggestions From Outside Professionals

The negotiated order theory maintains that participants view others' actions when negotiating. Likewise, there must be some tension between the participants; otherwise, negotiation would be unnecessary (Strauss, 1978). Additionally, there are, to some degree, opposed or antagonistic interests between the stakeholders as a result of the interactions (Nadai & Maeder, 2008). The principals' perceptions of their experiences of collaborating with others concurred with this previous research. Although all of the principals noted positive experiences with outside professionals, they all had negative experiences as well as a result of opposing interests. For example, when asked if it was challenging to follow outside professionals suggestions if offered, one principal stated, "Sometimes yes, sometimes no. I would say the local child development clinic generally does a great job with extensive recommendations that are appropriate in the school setting." She went on to say,

> Sometimes children go there for a full evaluation that might've been driven by social services, might have been driven by crisis; it might have been driven by an individual therapist that recommends that. It could be court ordered, it could be parent initiated. Their recommendations tend to be thorough and very appropriate for the school setting and not hard to implement. But some agencies come back with a recommendation that they just need an IEP. There's nothing magical about an IEP. It's not the magic pill.

The negotiated order theory considers the nature of respective stakes in negotiations. When negotiators or participants do not consider all parties' perspectives,

services may be challenging to implement. In scenarios such as these, it would behoove outside professionals to work with school professionals to get a more holistic understanding of what works in schools.

The system of care framework also offers empirical support for these conclusions and may further explain this finding (Stroul & Blau, 2008). Flexibility when implementing the system of care concept and philosophy may help participants change and evolve over time. Through intentional attention to reflection on the other, service delivery providers can adapt more easily to changing needs.

Contributors and Barriers to Interagency Collaboration

The fourth research question in this study explored contributors and barriers to interagency collaborative services. Principals conveyed that when all participants in the collaborative process worked together as a team, students were the beneficiaries. As cited earlier, Golden (1991) stated that cross-agency collaboration is an essential approach to systems change when administrations agree to modify current processes and procedures, or address service gaps. However, agencies may still confront barriers, even when there are commonalities in vision and mission. This is consistent with the literature on systems of care concerning the importance of collaborating together to address the needs of children (Stroul & Blau, 2008).

Contributors

Principals cited several contributors to interagency collaboration. These included wraparound services, the development of relationships with outside professionals, and communication.

Wraparound services. Several principals conveyed wraparound services as contributors to collaboration, which is congruent with the literature on systems of care supporting the idea of providing these services (Stroul & Blau, 2008). As one principal said, "I think, there are the students who definitely need that wraparound support. And so the interagency collaboration is essential to that. If you're going to approximate that in any way then it can't just happen at school."

Relationships. The development of relationships and trust was of utmost importance to all of the principals. The maintenance of relationships with parents as well as outside professionals can make a difference when students or the school needs assistance. As one principal stated, "Really it is about those relationships. But you have to understand your students as well . . .. And I had to do that whole thing with this staff. Because the culture always a difference."

Communication. All of the principals stated communication with others was an important contributor to the success of collaborative efforts. It could also be seen as a barrier to collaboration if there was not a direct connection. One principal expressed concern that there was no direct contact with the outside professionals. In his school division, the school division's social worker made the contact.

Barriers

Principals noted challenges with collaboration, which was corroborated in the literature. The negotiated order theory cites the number and complexity of issues to be of importance (Nadai & Maeder, 2008; Strauss, 1978). Various components may impact collaboration between schools and outside agencies, including a lack of knowledge and

understanding of school's policies and procedures, time, funding, a common interest in collaboration, and relationships between the principals and the outside agents.

Lack of knowledge about the other. Some critics have questioned school personnel's ability to correctly identify children with mental health issues (Nelson, Sprague, Jolivette, & Smith, 2009). However, school professionals stated the same can be said of some outside professionals. One principal expressed the sentiments of all the participants when she said,

> They call and ask for school records and that's the extent of it. Which again is a shame. We've been living with the child for months or years for 7 hours a day or whatever it is, and I think it's a missed opportunity to not find out what that child is like in a school setting. What are the things that work or don't work? What are the behaviors that are fueling the crisis at the moment that has resulted in hospitalization?

Time. Principals stated their understanding of the time it takes outside professionals to work with students and attend meetings in schools. Furthermore, many mental health care agents are traditional in their approach and are not motivated to participate in collaborative services due to their practices and philosophies, implying the need for time to modify their procedures (U.S. Department of Health and Human Services, 2005).

Funding. As mentioned earlier, Medicaid procedural issues are practically significant and often result in a shortage of services provided to children due to a shortage of slots for children, parents' unwillingness to fill out paperwork, or a misunderstanding of the process.

Improvements

The fifth research question addressed promising improvements to interagency collaboration by school professionals and outside agencies. As the system of care literature suggests, when principles and values are integrated into practice through coordinated services, desired outcomes are achieved (Annual Report to Congress, 2005). When participants are full partners in the delivery of services and there is coordination of efforts between contributors, changes in practice may occur that would better children's functioning in the classroom (Eber & Keenan, 2004). Conclusions drawn from this study provide support for integrated services at a system level as well as individual school level. If negotiations or communications are revisited during the process, there may be greater access to community services (Strauss et al., 1985; Hasenfeld, 2010).

Theoretical Frameworks

To address the research questions, the system of care concept and the negotiated order theory were considered as appropriate lenses through which to analyze the principals' perspectives about collaboration. Stroul (2008) suggested that systems of care have improved access to services for individuals. Although the system of care concept centers on a systems level, it also allowed for a practical application as noted by individual accounts.

One of the challenges with choosing the negotiated order framework was that it is frequently associated with the medical field and hospitals. However, it was also relevant to the education field, in large part due to human service aspects. As the work the organizations perform and negotiation is central to collaboration in this theory, it was

found to be applicable to this study. Therefore, both the system of care concept and negotiated order theory were complementary and appropriate frameworks for this study.

Implications

Children with EBD face more challenges than ever before. This research is timely, relevant, and important for schools, because the presence of these students in the general education classroom has increased, and teachers and support personnel need more knowledge to learn new insights and make informed decisions about students' care. Classroom teachers need guidance and help to deal with some students' complex needs. Through collaboration, more support can be found through other practitioners with a different skill set.

Conclusions drawn from this study may promote understanding about the other, thereby enhancing the relationship between all stakeholders. This study contributes to the literature in that it lays out a direction for future research, as it explored the perceptions of the educational leaders ultimately responsible for the interaction between school team members and professionals outside of school. Real-life accounts provide practical suggestions for implementing interactive collaborative services, as well as options for policy and procedures. As a result, school administrators may choose to modify how and when they collaborate with other professionals to address barriers and foster the wellness of children.

This study represents a small part of the continued effort to enhance students' mental health and competence. It strengthens the study of students with EBD, filling the paucity of literature regarding principals' perceptions of interagency collaboration on students with emotional and behavioral challenges. Although the sample size was small,

perhaps studies such as this one, which concentrate on practical school experiences, could be used to effect systemwide change.

The process of communication can be strengthened and improved, thereby making the procedures of collaboration more effective through the solicitation of meaningful and purposeful dialogue between all stakeholders. With partnerships, shared purpose and beliefs, and intentional invitations to all stakeholders working with children with EBD, improvement in collaborative efforts can be made.

Recommendations

Generalizations from outcome data will be referenced to make recommendations to school practitioners as well as agency professionals who work with children. After examining the responses of the principals, it may be helpful for administrators in school districts to assess how and why they collaborate with outside agencies. As principals lead schools, part of their role is to create and communicate a view of collaboration that enhances support services for students with EBD. Interagency collaboration may be a useful application for administrators in schools.

Recommendations for School Practitioners

These guidelines may improve collaboration and standards of practice, thereby generating a system of interrelated resources for school and outside professionals, as well as parents and their children.

- Initiate and maintain close communication with outside professionals to facilitate collaboration and increase informed dialogue.
- Endeavor to include outside professionals in meetings concerning students with EBD. Be proactive in reaching out to other professionals.

- Advocate for resources, such as day treatment providers in schools to support children's behavioral health needs.
- Prompt parents to encourage outside professionals to contact school personnel to get a more comprehensive understanding of the child.
- Establish policies, procedures, and memorandums of understanding for better clarification and service delivery.
- Clarify roles and agreements with collaborators.
- Facilitate wraparound viewpoint and teamwork between school personnel and outside professionals regarding students with EBD in the school as well as the school division.
- Consonant with the system of care framework, encourage a broader continuum of supports through RtI that are preventative, not just an outsourcing of services.
- Consider more formal procedures for collaborating with outside professionals, including scheduling regular meetings. As indicated by several principals, leaders and teachers are addressing problem issues with students of concern; however, coordination of efforts helps individuals work together.
- Explore opportunities for informational sessions for school community devoted to a greater understanding of services offered. This allows for enhanced discussions regarding the best plan for students with EBD.
- Conduct informational sessions for outside child service agencies designed to develop strategies and increase an understanding of the policies and procedures of the special education process and what works in school settings. This allows for

the creation of teams that promote engagement and understanding by professionals both in schools and outside of schools.

- Be visible and actively involved on teams to cultivate trust and relationships.

Recommendations for Outside Professionals and Participating Agencies

- Initiate and maintain close communication with school professionals to facilitate collaboration and build the capacity of school professionals to work with children who have challenging behaviors.
- Be aware of school policies and procedures regarding the identification and evaluation of students with EBD.
- Request and read reports from school professionals to attain a more accurate history, background, and assessment information concerning students.
- Conduct staff development and professional learning opportunities for school professionals designed to increase an understanding of guidelines and services offered.

Strengths and Limitations

Acknowledgement and identification of limitations and strengths of the research are important aspects to processing and analyzing outcomes. This study was informed by reflecting on the researcher's personal experiences as an elementary administrator. Consequently, efforts to describe participants' perspectives and construct meanings were inevitably influenced by an awareness of administrative perspectives. The researcher's own professional experiences as an administrator were important in that they provided credibility to the study and helped elucidate understanding of the principals' perspectives. However, the researcher attempted to maintain a neutral tone in the phrasing of questions

and used probes to guard against the potential of social desirability of responses (King & Bruner, 2000). These experiences and reflections, along with an in-depth analysis of key issues, addressed the question of how schools can be more effective collaborators with outside agencies to better support students with EBD.

Inferences drawn from this study were made cautiously due to several limitations. First, to address concerns that administrators may have a limited knowledge of interactive collaborative services (Gable & Tonelson, 2010), purposive sampling was used. Superintendents were asked to choose a principal or principals that had the most knowledge about students with EBD and interagency collaboration. Selection bias may not allow for diverse perspectives from many participants, and other participants' viewpoints may produce different findings. Second, this study was conducted in eight different school districts in the Commonwealth of Virginia; therefore, generalizations to other schools, in other school districts, in other states may not be warranted. Although the findings of this study may not generalize to interagency collaboration across counties, states, or private schools, it may provide valuable and practical information regarding the benefits of collaborating between schools and outside agencies. Finally, these results may not be generalizable across all schools; however, they may offer insights on the characteristics and contexts of collaboration, and contribute to the system of care and negotiated order theoretical frameworks as they encourage reflection and inquiry.

Implications and Directions for Further Study

The scarcity of evaluative research on support programs indicates that few mental health practices meet the American Psychological Association guidelines (Behan & Blodgett, 2003). This research may be considered important, because it can guide

decision making regarding interagency collaboration between schools and outside agencies. The literature states more information is necessary emphasizing the improvement of interagency collaboration (Hasenfeld, 2010).

The findings of this study are promising. As a result of this study's findings, there are many research ideas that are worth pursuing. Suggestions are listed in the following bullets.

- Findings warrant the need for additional qualitative studies to seek perceptions from outside agents through qualitative methods of research. A principal who said that he received multiple requests for the completion of a survey, which would take an hour, reinforced this view. He stated that he did not have an hour in his day to complete a survey. However, he took an hour to talk with the researcher.
- Case studies on individual students may assist in the identification of aspects affecting all students including those with EBD.
- A research study exploring the perceptions of outside care providers such as Child Protective Services, Social Service providers, Community Services Board counselors, therapeutic day treatment providers, child psychologists, child psychiatrists, pediatricians, deputies from Sheriff's Departments, educational diagnosticians, advocates, and attorneys will build on the foundation provided by this study. Meaningful information could be obtained to gain further knowledge and insight into the development of interagency collaboration.

- Studies with a larger sample size from various school levels with a greater variety of locales and sizes of school divisions would provide a basis for comparison and differentiation of support mechanisms to improve outcomes of collaboration.

Conclusion

As the number of students needing support services increases, school administrators interested in improving services and developing collaborative relationships with mental health care professionals for students with EBD, principals may make better informed decisions if procedures involving collaboration with outside agents is reviewed. By promoting initiatives to improve support services that focuses on service integration, students with EBD may be provided with an improved educational environment thereby contributing to their overall success.

REFERENCES

Adams, K., & Christenson, S. (2000). Trust and the family-school relationship: Examination of parent–teacher differences in elementary and secondary grades. *Journal of School Psychology, 38*(5), 477–497. doi: 10.1016/S0022 4405(00)00048-0

Adelman, H. S., & Taylor, L. (2000). Shaping the future of mental health in schools. *Psychology in the Schools, 37,* 49–60. doi: 10.1002/(SICI)1520-6807(200001)37:1<49::AID-PITS6>3.0.CO;2–0

Allen, D. (1997). The nursing–medical boundary: A negotiated order? *Sociology of Health & Illness*, *19*(4), 498–520. doi: 10.1111/j.1467-9566.1997.tb00415.x

Aud, S., Hussar, W., Johnson, F., Kena, G., Roth, E., Manning, E., . . . Zhang, J. (2012). *The condition of education 2012* (NCES 2012-045). Washington, DC: U.S. Department of Education, National Center for Education Statistics. Retrieved August 2014 from http://nces.ed.gov/pubsearch

Beaulieu, S., & Pasquero, J. (2002). Reintroducing stakeholder dynamics in stakeholder thinking: a negotiated-order perspective. In *Unfolding stakeholder thinking: Theory, responsibility and engagement* (pp. 101–118). Sheffield, UK: Greenleaf Publishing, in association with GSE Research.

Behan, K., & Blodgett, C. (2003). Children's mental health. In *A literature review and resource guide for evidence-based best and promising mental health practices* (pp. 7–32). Spokane, WA: Washington Institute for Mental Illness Research and Training.

Benson, K. J. (1977). Innovation and crisis in organizational analysis. *Sociological Quarterly, 18,* 5–18. doi: 10.1111/j.1533-8525.1977.tb02158.x

Bertelsen, O. W., & Bodker, S. (2003). Activity theory. In J. M. Carroll (Ed.), *HCI models theories, and frameworks: Toward a multidisciplinary science* (pp. 291–324). San Francisco, CA: Morgan Kaufmann.

Bickman, L. (1996). A continuum of care: More is not always better. *American Psychologist, 51,* 921–933. doi: 10.1037/0003-066X.51.7.689

Bickman, L., Bryant, D., & Summerfelt, W. T. (1993). *Final report of the quality study of the Fort Bragg evaluation project.* Nashville, TN: Center for Mental Health Policy, Vanderbilt University.

Bickman, L., Heflinger, C. A., Lambert, E. W., & Summerfelt, W. T. (1996). The Fort Bragg managed care experiment: Short term impact on psychopathology. *Journal of Child and Family Studies, 5*(2), 137–160. doi:10.1007/bf02237936

Bickman, L., Noser, K., & Summerfelt, W. (1999). Long-term effect of a system of care on children and adolescents. *Journal of Behavioral Health Services and Research, 26,* 185–202. doi: 10.1007/BF02287490

Biddix, J. P. (2009). *Research rundowns: Qualitative coding and analysis.* Retrieved from http://researchrundowns.wordpress.com/qual/qualitative-coding-analysis/

Blanchett, W. (2006). Disproportionate representation of African American students in special education: Acknowledging the role of white privilege and racism. *Educational Researcher, 35*(6), 24–28. doi: 10.3102/0013189X035006024

Behan, K., & Blodgett, C. (2003). Children's mental health. In *A Literature Review and Resource Guide for Evidence-Based Best and Promising Mental Health Practices* (pp. 7–32). Spokane, WA: Institute for Mental Illness Research and Training.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.

Booker, K. C. (2009). Shifting priorities: Reflections on teaching qualitative research methods. The qualitative report. 14(3), 389–394. Retrieved from http://www.nova.edu/ssss/QR/QR14–3/booker.pdf

Borduin, C. M., Heiblum, N., Jones, M. R., & Grabe, S. A. (2000). Community-based treatments of serious antisocial behavior in adolescents. In W. E. Martin, Jr. & J. L. Swartz-Kulstad (Eds.), *Person–environment psychology and mental health: Assessment and intervention* (pp. 113–141). Mahwah, NJ: Lawrence Erlbaum Associates.

Boyd, M. (Ed.). (2008). *Psychiatric nursing: Contemporary practice* (4th ed). Philadelphia, PA: Wolters Kluwer Health. Lippincott, Williams & Wilkins.

Bradley, R., Doolittle, J., & Bartolotta, R. (2008). Building on the data and adding to the discussion: The experiences and outcomes of students with emotional disturbance. *Journal of Behavior Education, 17,* 4–23. doi: 10.1007/210864–007–9058–6

Brennan, E. M., Bradley, J. R., Allen, M. D., & Perry, D. F. (2008). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. *Early Education and Development, 19*(6), 982–1022. doi: 10.1080/10409280801975834

Burchard, J. D., & Clark, R. T. (1989). Individualized approaches to treatment: Project Wraparound. In A. Algarin, R. M. Friedman, A. J. Duchnowski, K. M. Kutash, S. E. Silver, & M. K. Johnson (Eds.), *2nd annual conference proceedings of the research and training center for children's mental health: Children's mental health services and policy: Building a research base* (pp. 162–178). Tampa, FL: Florida Mental Health Institute.

Burchard, J. D., & Clark, R. T. (2006). Building on practice-based evidence: Using expert perspectives to define the wraparound process. *Psychiatric Services 57*(11), 1579–1585. Retrieved from http://www.pathwaysrtc.pdx.edu/pdf/pbBuildingOnPractice-BasedEvidence.pdf

Burchard, J. D., Bruns, E. J., & Burchard, S. N. (2002). The wraparound approach. In B. Burns & K. Hoagwood (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders* (pp. 69–90). New York, NY: Oxford University Press. doi: 10.1093/acprof:oso/9780195134575.003.0004

Burns, B. J. & Goldman, S. K. (Eds.). (1998). Promising practices in wraparound for children with serious emotional disturbance and their families. *Systems of care: Promising practices in children's mental health, 1998 Series, Volume IV.* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Burns, B. J., Hoagwood, K., & Maulsby, L. T. (1998). Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions. In M. H. Epstein, K. Kutash & A. Duchnowski (Eds.), *Outcomes for children and youth with behavioral and emotional disorders and their families: Programs and evaluation best practices* (pp. 685–707). Austin, TX: Pro-Ed, Inc.

Busch, C., De Maret, P. S., Flynn, T., Kellum, R., Le, S., Meyers, B., . . . Palmquist, M. (1994—2012). *Content analysis.* Retrieved from writing@CSU. Colorado State University. Available at http://writing.colostate.edu/guides/guide.cfm?guideid=61

Busch, L. (1982). History, negotiation and structure and agricultural research. *Urban Life, 11*, 368–384.

Center for Mental Health Services. (1997). *Annual report to Congress on the evaluation of the comprehensive community mental health services for children and their families program, 1997.* Atlanta, GA: Macro International Inc.

Center for Mental Health Services. (1998). *Annual report to Congress on the evaluation of the comprehensive community mental health services for children and their families program, 1998.* Atlanta, GA: Macro International Inc.

Center for Mental Health Services. (1999). *Annual report to Congress on the evaluation of the comprehensive community mental health services for children and their families program, 1999.* Atlanta, GA: ORC Macro.

Center for Mental Health Services. (2000). *Annual report to Congress on the evaluation of the comprehensive community mental health services for children and their families program, 2000.* Atlanta, GA: ORC Macro.

Center for Mental Health Services. (2001). *Annual report to Congress on the evaluation of the comprehensive community mental health services for children and their families program, 2001.* Atlanta, GA: ORC Macro.

Charles, D. (August 30, 2007). Report faults Virginia Tech response in shootings. *Reuters.* Archived from the original on January 10, 2009. Retrieved from http://www.reuters.com/article/2007/08/30/us-usa-shooting-report-idUSN2925438020070830

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks, CA: Sage Publications Inc.

Cheney, D. (2012). Transition tips for students with emotional or behavioral disorders. *Intervention in School and Clinic, 48,* 22–29. doi: 10.1177/1053451212443149

Cheney, D., & Bullis, M. (2004). The school to community transition of adolescents with emotional and behavioral disorders. In R. B. Rutherford, M. M. Quinn, & S. R. Mathur (Eds.), *Handbook of Research in Emotional and Behavioral Disorders* (pp. 369–384). New York, NY: Guilford.

Child and Adolescent Health Measurement Initiative. (2006). *2005/2006 national survey of children with special health care needs.* Data Resource Center for Child and Adolescent Health website. Retrieved from www.cshcndata.org

Christner, R. W., & Mennuti, R. B. (2009). School-based mental health: A practitioner's guide to comparative practices. New York, NY: Routledge.

CNN Library (2014). Virginia Tech shootings fast facts. Retrieved from http://www.cnn.com/2013/10/31/us/virginia-tech-shootings-fast-facts/

Codrington, J., & Fairchild, H.H. (2012). Special education and the mis-education of African American children: A call to action. Retrieved from http://www.abpsi.org/pdf/specialedpositionpaper021312.pdf

Coffee, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies.* Thousand Oaks, CA: Sage Publications Inc.

Comprehensive Services Act Critical Service Gap Survey. FY08, FY09. Retrieved Jun 2013 from http://leg2.state.va.us/dls/h&sdocs.nsf/fc86c2b17a1cf388852570f9006f1299/e586587f0a4a5396852575cb006dc852/$FILE/RD144.pdf

Comprehensive Services Act for At-Risk Youth and Families (2011). A plan for community-based children's behavioral health services in Virginia. Retrieved from http://www.dbhds.virginia.gov/library/document-library/cfs%20child%20and%20family%20-%20plan%20for%20behavioral%20health%20services.pdf

Cook, B. G., Landrum, T. J., Tankersley, M., & Kauffman, J. M. (2003). Bringing research to bear on practice: Effecting evidence-based instruction for students with emotional or behavioral disorders. *Education and Treatment of Children, 26,* 345–361.

Cooper, C. R., & Schindler, P. S. (2008). *Business research methods* (10th ed.). Boston, MA: McGraw-Hill.

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Grounded theory procedures and techniques.* Thousand Oaks, CA: Sage Publications Inc.

Costello, E. J., Egger, H. H., & Angold, A. (2005). One-year research update review: The epidemiology of child and adolescent psychiatric disorders: Methods and public health burden. *Journal of the American Academy of Child and Adolescent Psychiatry, 44,* 972–986. doi: http://dx.doi.org/10.1097/01.chi.0000172552.41596.6f

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice, 39*(3), 124–130. doi: 10.1207/s15430421tip3903_2

Creswell, J. W. (2005). *Educational research.* Newark, NJ: Pearson.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications Inc.

Crowell, A. (1993). Contrasting perspectives on programming for students with emotional disturbance and behavior disorders in Mississippi. *Behavioral Disorders, 18*(3), 228–230.

Cumblad, C. (1996). The pathways children and families follow prior to, during, and after contact with an intensive, family-based, social service intervention in urban settings (Unpublished doctoral dissertation). Northern Illinois University, DeKalb, Illinois.

Data Accountability Center. (2006). Data Accountability Center. (2011). *Historical state-level IDEA data files.* Retrieved from http://tadnet.public.tadnet.org/pages/712

Day, R., & Day, J. V. (1977). A review of the current state of negotiated order theory: An appreciation and a critique. *Sociological Quarterly, 18,* 126–142. doi: 10.1111/j.1533–8525.1977.tb02165.x

Delorenzo, J. P. (2008). *Special education continuum of services for school age students with disabilities.* Retrieved from http://www.questar.org/services/rse-tasc-ii/presentations/iep/Special-Education-Continuum-of-Services.pdf

Denzin, N. K. (1989). *Interpretive interactionism* (2nd ed.). Thousand Oaks, CA: Sage Publications Inc.

Denzin, N. K., & Lincoln, Y. S. (2005). The discipline and practice of qualitative research. In. N. K. Denzin, & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 1–19). Thousand Oaks, CA: Sage Publications Inc.

Dettmer, P., Knackendoffel, A. P., & Thurston, L. P. (2013). *Collaboration, consultation, and teamwork for students with special needs*. Columbus, OH: Pearson Higher Ed.

Duchnowski, A. J., Kutash, K., & Friedman. R. M. (2002). Community-based interventions in a system of care and outcomes framework. *Community Treatment for Youth, 1*(9), 16–40.

Duke, D. L. (1986). *School leadership and instructional improvement.* New York, NY: Random House.

Eber, L., & Keenan, S. (2004). Collaboration with other agencies. Wraparound and systems of care for children and youths with emotional and behavior disorders. In B. Rutherford, Jr., M. Quinn, R. Mathur (Eds.), *Handbook of research in emotional and behavioral disorders* (pp. 502–518). New York, NY: Guilford Press.

Erickson, F. (1986). Qualitative methods in research on teaching. In M. C. Wittrock (Ed.), *Handbook of research on teaching* (3rd ed., pp. 119–161). New York, NY: Macmillan.

Fairbank, J. A., Booth, S. R., & Curry, J. F. (2002). Integrated cognitive-behavior therapy for traumatic stress symptoms and substance abuse. *Community Treatment for Youth, 1*(9), 198–212.

Forness, S. R. (2000). Panel presentation: Juvenile justice and identification of mental health needs. In the report of the surgeon general's conference on children's mental health: A national action agenda. Washington, DC: US Department of Health and Human Services; US Department of Education; US Department of Justice. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK44232/

Foster, W. (1989). *School leaders as transformational intellectuals: A theoretical argument.* Paper presented at the annual meeting of the American Educational Research Association, San Francisco, CA.

Friedman, R. M. (2001). The practice of psychology with children, adolescents, and their families: A look to the future. In J. N. Hughes, A. M. LaGreca & J. C. Conoley (Eds.), *Handbook of psychological services for children and adolescents* (pp. 3–22). New York, NY: Oxford University Press.

Frommer, F. (2014, March 31). Creigh Deeds: 'Real work lies ahead' on mental health. Retrieved from http://www.huffingtonpost.com/2014/03/31/creigh-deeds-mental-health_n_5065449.html

Gable, R. A., & Tonelson, S. W. (2010, August 23). *Perspectives on programs and services for students with emotional disabilities* [Powerpoint slides]. Retrieved from http://www.doe.virginia.gov/special_ed/disabilities/emotion_disability/presentation_robert_gable_and_stephen_tonelson.pdf

Gable, R. A., & Tonelson, S. W. (2010, August). *Summit on better serving students with emotional disabilities.* Presentation sponsored by the Virginia Department of Education, Charlottesville, VA.

Geertz, C. (1973). *The interpretation of cultures.* New York, NY: Basic Books.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A.L (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago, IL: Aldine Publications.

Goldberg, D. (1990). Reasons for misdiagnosis. In N. Sartorius, D. Goldberg, G. De Girolamo, J. Silva, Y. Lecrubier, & U. Wittchen (Eds.), *Psychological disorders in general medical settings* (pp. 139–145). Toronto, Canada: Hogrefe & Huber.

Golden, O. (1991). Collaboration as a means not an end: Serving disadvantaged families and children. In Lisbeth B. Schorr, Deborah Both, & Carol Copple (Eds.), *Effective services for young children: Report of a workshop* (pp. 84–104). Washington, DC: National Academy Press.

Goldman, S. K. (1999). The conceptual framework for wraparound: Definition, values, essential elements, and requirements for practice. In B. J. Burns & S. K. Goldman (Eds.), *Systems of care: Promising practices in children's mental health, 1998 Series, Volume IV* (pp. 27–34). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research. Available at http://cecp.air.org/promisingpractices/1998monographs/vol4.pdf

Gonzales, J. J., Ringeisen, H. L., & Chambers, D. A. (2002). The tangled and thorny paths of science to practice: Tension in interpreting and applying "evidence." *Clinical Psychology: Science and Practice, 9,* 204–220. doi: 10.1093/clipsy/9.2.204

Greene, J. C. (2007). *Mixed methods in social inquiry.* San Francisco, CA: John Wiley & Sons Inc.

Guba, E. G., & Lincoln, Y. S. (1992). Epistemological and methodological bases of naturalistic inquiry. *Education Communication and Technology Journal, 30,* 233–252.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). London, UK: Sage Publications Inc.

Hall, P. M., & Spencer-Hall, D. A. (1982). The social conditions of the negotiated order. *Journal of Contemporary Ethnography*, *11*(3), 328–349.

Harry, B., & Klingner, J. (2006). *Why are so many minority students in special education? Understanding race and disability in schools.* New York, NY: Teachers College Press.

Hasenfeld, Y. (2010). *Human services as complex organizations* (2nd ed.) Los Angeles, CA: Sage.

Hernandez, M., & Hodges, S. (2003). Building upon the theory of change for systems for care. *Journal of Emotional and Behavioral Disorders, 11,* 19–26. doi: 10.1177/106342660301100104

Heylighen, F., & Joslyn, C. (1992). What is systems theory? *Principia Cybernetica Web.* Retrieved from http://pespmc1.vub.ac.be/systheor.html

Hill, E. B. (1996). *Comprehensive services for students with serious emotional disturbance: An analysis of state legislation and policy* (Ed.D. dissertation) Retrieved from Dissertations & Theses: Full Text. (Publication No. AAT 9622285).

Hoagwood, K., Burns, B. J., Kiser, I., Rigneisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52,* 1179–1190. doi: 10.1176/appi.ps.52.9.1179

Hodder, I. (2003). The interpretation of documents and material culture. *Collecting and interpreting qualitative materials*, *2*, 155-175.

Hogan, M. F. (2003). New Freedom Commission report: the President's New Freedom Commission: recommendations to transform mental health care in America. *Psychiatric Services*, *54*(11), 1467-1474.

Holloway, I. (1997). *Basic concepts for qualitative research.* London, UK: Blackwell Science.

Hyman, S. E. (2000). *Panel presentation: Juvenile justice and identification of mental health needs. In the report of the surgeon general's conference on children's mental health: A national action agenda.* Washington, DC: US Department of Health and Human Services; US Department of Education; US Department of Justice. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK44232/

Illback, R., Neill, T., Call, J., & Andis, P. (1993). Description and formative evaluation of the Kentucky IMPACT program for children with serious emotional disturbance. *Special Services in the Schools, 7*(2), 87–109. doi: 10.1300/J008v07n02-06

Individuals with Disabilities Education Act of 1997 Regulations, 34 C.F.R. 300.347(5)(i). (1998).

Individuals with Disabilities Education Improvement Act (IDEA). (2004). *Public Law* 108–446.

Janz, J. R., & Banbury, M. M. (2009). Challenges in classifying students with emotional disturbance: Perspectives of appraisal professionals. *Spaces for Difference: An Interdisciplinary Journal, 2*(1), 16–34. Retrieved from https://escholarship.org/uc/item/5734n13w

Jehl, J., & Kirst, M. (1992). Getting ready to provide school-linked services: What schools must do. *The future of children: School linked services 2*(1), 95–106.

Jensen, O. (2001, November 7). Presentation at: The Seventeenth Annual Rosalynn Carter Symposium on Mental Health Policy. Youth in crisis: Uniting for action. Atlanta, GA.

Joint Legislative Audit and Review Commission to the Governor and the General Assembly of Virginia (JLARC). (2007). *Evaluation of children's residential services delivered through the comprehensive services act.* House Document No. 12. Retrieved from http://jlarc.virginia.gov/reports/RPT346.PDF

Johnson, B. L., Jr. (1998). Organizing for collaboration. A reconsideration of some basic organizing principles. In D. Pounder (Ed.), *Restructuring schools for collaboration* (pp. 9–26). Albany, NY: State University of New York Press.

Johnson, B. L., Jr., & Galvin, P. F. (1997). Conceptualizing school collaboratives and inter-organizational relationships: A consideration of public choice and organizational economics frameworks. In P. A. Cordeiro (Ed.), *Boundary crossings: Educational partnerships and school leadership* (pp. 99–113). San Francisco, CA: Jossey-Bass.

Kauffman, J. M. (2009). Emotional/behavioral disorders. Retrieved from http://www.education.com/reference/article/emotionalbehavioral-disorders/

Kauffman, J. M., & Landrum, T. J. (2006). *Children and youth with emotional and behavioral disorders: A history of their education.* Austin, TX: Pro-Ed.

Kauffman, J. M., & Landrum, T. J. (2009). *Characteristics of emotional and behavioral disorders of children and youth* (9th ed.). Upper Saddle River, NJ: Prentice Hall.

Kaufman, R. K., & Hepburn, K. S. (2007). Early childhood mental health services and supports through a systems approach. In B. A. Stroul & R. M. Friedman (Series Eds.) & D. F. Perry, R. K. Kaufman, & J. Knitzer (Vol. Eds.), *Systems of care for children's mental health series: Social and emotional health in early childhood:*

Building bridges between services and systems (pp. 121–146). Baltimore, MD: Paul H. Brooks Publishing.

Keaton, P. (2014). *Documentation to the NCES common core of data local education agency universe survey: School year 2012–13 provisional version 1a (NCES 2015–008).* U.S. Department of Education. Washington, DC: National Center for Education Statistics. Retrieved from http://nces.ed.gov/ccd/pdf/psu12pgen.pdf

Kelley, M. L. (2004). Assessment of children's behavior in the school setting. In M. L. Kelley & D. Reitman (Eds.), *AABT clinical assessment series: Practitioner's guide to empirically based measures of school behavior* (pp. 7–22). Los Angeles, CA: Plenum Publishing.

Khandkar, S. H. *Open coding.* Retrieved from http://pages.cpsc.ucalgary.ca/~saul/wiki/uploads/CPSC681/opencoding.pdf

King, M, F., & Bruner, G. C. (2000). Social desirability bias: A neglected aspect of validity testing. *Psychology and Marketing*, 17, 79–103.

Kirk, S., Gallagher, J., Coleman, M. R., & Anastasiow, N. (2012). *Educating exceptional children* (13th ed.). Belmont, CA: Cengage.

Kline, S., Simpson, R., Blesz, D., Myles, B., & Carter, W. (2001). School reform and multicultural learners with emotional and behavior disorders: Issues, challenges, and solutions. In C. Utley & F. Obiakor (Eds.), *Special education, multicultural education, and school reform: Components of quality education for learners with mild disabilities* (pp. 118–139). Springfield, IL: Charles C. Thomas.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services.* Washington, DC: Children's Defense Fund.

Koop, C. E., & Lundberg, G. (1992). Violence in America: A public health emergency: Time to bite the bullet back. *JAMA, 267,* 3075–3076. doi: 10.1001/jama.1992.03480220093036

Koyanagi, C., & Gaines, S. (1993). *All systems failure: An examination of the results of neglecting the needs of children with serious emotional disturbances.* Arlington, VA: National Mental Health Association.

Kuhn, A. (1974). *The logic of social systems.* San Francisco, CA: Jossey-Bass.

LaFond, J. Q. (2005). *Preventing sexual violence: How society should cope with sex offenders*. Washington, DC: American Psychological Association.

Landrum, T. J., Tankersley, M., & Kauffman, J. M. (2003). What is special about special education for students with emotional or behavioral disorders? *Journal of Special Education, 37,* 148–156. doi: 10.1177/00224669030370030401

Lane, K., Wehby, J., Little, M., & Cooley, C. (2005). Academic, social, and behavioral profiles of students with emotional and behavioral disorders educated and self-contained classrooms and self-contained schools: Part I—Are they more alike than different? *Behavioral disorders, 30*(4), 349–361.

LaPoint, V. (2000). *Panel presentation: Juvenile justice and identification of mental health needs. In the report of the surgeon general's conference on children's mental health: A national action agenda.* Washington, DC: US Department of

Health and Human Services; US Department of Education; US Department of Justice. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK44232/

Larson, C. D., & LaFasto, F. M. (1989). *Teamwork: What must go right/what can go wrong.* Newbury Park, CA: Sage.

Leaf, P. J., Livingston, M. M., Tischler, G. L., Weissman, M. M., Holzer III, C. E., & Myers, J. K. (1985). Contact with health professionals for the treatment of psychiatric and emotional problems. *Medical Care, 23*(12), 1322-1337.

Lee, A. S. (1999). Rigor and relevance and MIS research: Beyond the approach of positivism alone. *MIS Quarterly, 23*(1), 29–33. doi: 10.2307/249407

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage Publications.

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity and naturalistic evaluation. In D. D. Williams (Ed.), *Naturalistic evaluation* (pp. 73–84). San Francisco, CA: Jossey-Bass.

Lonigan, C. J., & Elbert, J. C. (1998). Empirically supported psychosocial interventions for children [Special issue]. *Journal of Clinical Child Psychology, 2*(2), 138–145.

Losen, D. J., & Orfield, G. (2002). *Racial inequity in special education.* Cambridge, MA: Harvard Education Publishing Group. doi: 10.1207/s15374424jccp2702-1

Lourie, I. (2003). A history of community child mental health. In A. J. Pumariega & N. C. Winters (Eds.), *The handbook of child and adolescent systems of care: The new community psychiatry,* (pp. 1–16). San Francisco, CA: Jossey-Bass.

Lourie, I., Stroul, B. A. & Friedman, R. M. (1998). Community-based systems of care: From advocacy to outcomes. In M. H. Epstein & K. Kutash (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 3–19). Austin, TX: PRO-ED, Inc.

Maines, D. R. (Ed.) (1991). *Social organization and social process: Essays in honor of Anselm Strauss.* New York, NY: Transaction Publishers.

Manteuffel, B., Stephens, R., Brashears, R., Krikelyova, A., & Fisher, S. (2008). Evaluation results and systems of care: A review. In B. Stroul & G. Blau (Eds.), *The system of care handbook: Transforming mental health services for children, youth and families* (pp. 3–24). Baltimore, MD: Paul H. Brookes Publishing Co.

Marshall, C., & Rossman, G. (2006). *Designing qualitative research.* Thousand Oaks, CA: Sage Publications.

Massengill Report. (2007, August). *Mass shootings at Virginia Tech: Report of the review panel, Presented to Governor Kaine, Commonwealth of Virginia.* Retrieved from http://www.washingtonpost.com/wp-srv/metro/documents/vatechreport.pdf

Maxwell, J. A. (1992). Understanding and validity in qualitative research. *Harvard Educational Review, 62*(3), 279–300.

Maxwell, J. A. (1996). *Qualitative research design: An interactive approach.* Thousand Oaks, CA: Sage Publications.

Maxwell, J. A. (2005). *Qualitative research design.* Thousand Oaks, CA: Sage Publications.

McNamara, K., & Hollinger, C. (2003). Intervention-based assessment: Evaluation rates and eligibility findings. *Exceptional Children, 69,* 181–193. doi: *10.1177/001440290306900204*

Mechanic, D. (1989). *Mental health and social policy* (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.

Miles, M., & Huberman, A. M. (1994). *Qualitative data analysis.* Thousand Oaks, CA: Sage Publications Inc.

Mishler, E. G. (1986). Meaning in context: Is there any other kind? *Harvard Educational Review, 49*(1), 1–19.

Mishler, E. G. (2000). Validation in inquiry-guided research: The role of exemplars in narrative studies. *Acts of inquiry in qualitative research*, 119-146.

Muller, M. (2010, February). Grounded theory method. Presentation at HCIC, Winter Park, CO.

Murray, B. A., & Myers, M. A. (1998). Conduct disorders and the special education trap. *Education Digest, 63*(8), 48–53.

Murthy, R. S., Bertolote, J. M., Epping-Jordan, J., Funk, M., Prentice, T., & Saraceno, B. (2001). *The world health report 2001: Mental health: New understanding, new hope.* Geneva, Switzerland: World Health Organization.

Nadai, E., & Maeder, C. (2008). Negotiations at all points? Interaction and organization. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 9*(1), Art. 32. Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/337/735

Nathan, M. L., & Mitroff, I. I. (1991). The use of negotiated order theory as a tool for the analysis and development of an in organizational field. *Journal of Applied Behavioral Science 27*(2), 163–180. doi: 10.1177/0021886391272002

National Association of School Psychologists. (2005). *Position statement on students with emotional behavioral disorders.* Retrieved from http://www4.smsd.org/kathygaskey/docs/Doc-11786.pdf

National Center for Education Statistics (2013). *Common core of data: Local education agency (school district) universe survey data.* Retrieved from http://nces.ed.gov/ccd/pubagency.asp

National Center for Youth Law (2006) *New national data shows racial disparities in school discipline.* Retrieved from http://www.youthlaw.org/publications/yln/2006/apr_jun_2006/new_national_dat shows_racial_disparities_in_school_discipline.

National Center on Response to Intervention. (2010, March). *Essential components of RtI—A closer look at response to intervention.* Washington, DC: U.S. Department of Education, Office of Special Education Programs National Center on Response to Intervention.

National Technical Assistance and Evaluation Center for Systems of Care (2008). *Interagency collaboration.* Retrieved from https://www.childwelfare.gov/pubs/acloserlook/interagency/

Neil, T. K. (1997). Integrating services for children with severe emotional disabilities through coordination. In Illback, R. J., Cobb, C. T., & Joseph, J. H. M. *Integrated services for children and families: Opportunities for psychological practice* (pp. 157–190). Washington, DC: American Psychological Association.

O'Neal, T. (2014, March). State Inspector General Report on Sen. Creigh Deeds Case Released. Retrieved from http://wvtf.org/post/state-inspector-general-report-sen-creigh-deeds-case-released

Oakley, J. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), *Doing feminist research* (pp. 30–61). London, UK: Routledge and Kegan Paul.

Office of Comprehensive Services. (2013, April). *Virginia's system of care: A presentation for the state executive council for the comprehensive services act.* Retrieved from http://www.cpe.vt.edu/ocs/sessions/csa-meetingsec.pdf

Office of the Surgeon General (US); Center for Mental Health Services (US); National Institute of Mental Health (US). (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General.* Rockville (MD): Substance Abuse and Mental Health Services Administration (US). Available from: http://www.ncbi.nlm.nih.gov/books/NBK44243/

Osher, D. M. (2002). Creating comprehensive and collaborative systems. *Journal of Child and Family Studies, 11*(1), 91–99. doi: 10.1023/A:1014771612802

Padgett, D. (2008). *Qualitative methods and social work research.* Los Angeles, CA: Sage Publications, Inc.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Patton, M. Q. (2014). *Qualitative research and evaluation methods* (4th ed.). Thousand Oaks, CA: Sage Publications Inc.

Perry, D. F., Dunne, M. C., McFadden, L., & Campbell, D. (2007). Reducing the risk for preschool expulsion: Mental health consultation for young children with challenging behavior. *Journal of Child and Family Studies, 17,* 44–54. doi: 10. 1007/s10826-007-9140–7

Perry, D. S., Kaufman, R. K., Hoover, S., & Zundel, C. (2008). Services for young children and their families in systems of care. In B. A. Stroul & G. M. Blau (Eds.), *The system of care handbook: Transforming mental health services for children, youth, and families* (pp. 491–515). Baltimore, MD: Paul H. Brooks Publishing.

Polit, D. F., & Beck, C. T. (2003). The content validity index: are you sure you know what's being reported? Critique and recommendations. *Research in nursing & health*, *29*(5), 489–497. doi: 10.1002/nur.20147

Pumariega, A. J., Winters, N. C., & Huffine, C. (2003). The evolution of systems of care for children's mental health: Forty years of community child and adolescent psychiatry. *Community Mental Health Journal, 39*(5), 399–425. doi: 10.1023/A:1025808902438

Raver, C. C., Jones, S., Li-Grining, C., Sardin-Adjei, Le, & Jones-Lewis, D. (2007, March). *Mental health consultation as a pathway to improving preschool classroom practices: Preliminary findings from a randomized trial implemented in Head Start settings.* Paper presented at the 20th Annual Research Conference:

A System of Care for Children's Mental Health: Expanding the Research Base, Tampa, FL.

Rees, C., Farrell, P., & Rees, P. (2003). Coping with complexity: How do educational psychologists assess students with emotional and behavioural difficulties? *Educational Psychology in Practice, 19*(1), 35–47. doi: 10.1080/0266736032000061198

Rein, M. (1976). *Social science and public policy.* New York, NY: Penguin Books.

Reinke, W. M., & Herman, K. C. (2002). A research agenda for school violence prevention. *American Psychologist*, 57(10), 796–797. doi.org/10.1037/0003-066X.57.10.796

Ringeisen, H., Henderson, K., & Hoagwood, K. (2003). Context matters: Schools and the "research to practice gap" in children's mental health. *School Psychology Review, 32*(2), 153–169.

Rock, E., Fessler, M., & Church, R. (1997). The concomitance of learning disabilities and emotional/behavioral disorders: A conceptual model. *Journal of Learning Disabilities, 30*(3), 245–263. doi: 10.1177/002221949703000302

Rosenblatt, A., Attkisson, C., & Mills, N. (1992). *The California AB377 evaluation: Three-year summary report.* San Francisco: the University of California.

Rosenblatt, A. (1996). Bows and ribbons, tape and twine: Wrapping the wraparound process for children with multi-system needs. *Journal of Child and Family Studies*, *5*(1), 101–116.

Rosenblatt, A. (1998). Assessing the child and family outcomes of systems of care for youth with serious emotional disturbance. In M. Epstein, K. Kutash, and A. Duchnowski (Eds.), *Outcomes for children and youth with behavioral and emotional disorders and their families* (pp. 329–362). Austin, TX: Pro-Ed, Inc.

Rosenblatt, A. (2010). If it walks like a duck and quacks like a duck then must it be a rabbit? Programs, systems and a cumulative science of children's mental health services. *Evaluation and Program Planning, 33*(1), 14–17. doi:10.1016/j.evalprogplan.2009.06.002

Ryle, G. (1949). *The Concept of Mind.* London, UK: Hutchinson.

Sadeh, S., Sullivan, A. L., & Cowan, K. C. (2014). 2014 Convention news. Washington, DC, February 18–21. Presenters up close: Identification of emotional disturbance in practice. *NASP Communiqué, 12*(3). http://www.nasponline.org/publications/cq/42/3/presenters.aspx

Saumure, K. & Given, L. M. (2008). Data saturation. *Sage encyclopedia of qualitative research methods.* Thousand Oaks, CA: Sage Publications Inc. doi: 10. 4135/9781412963909

Savin-Baden, M., & Howell Major, C. (2013). *Qualitative research: The essential guide to theory and practice.* New York, NY: Routledge.

Scarborough, A. A., & McCrae, J. S. (2010). School-age special education outcomes of infants and toddlers investigated for maltreatment. *Children and Youth Services Review, 32*(1), 80–88. doi:10.1016/j.childyouth.2009.07.015.

Schutz, A. (1967). *The phenomenology of the social world* (G. Walsh & F. Lenhert, Trans.). Chicago, IL: Northwestern University Press.

Seidel, J. V. (1998). *Qualitative data analysis.* Colorado Springs, CO: Qualis Research. Retrieved from ftp://ftp.qualisresearch.com/pub/qda.pdf

Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (3rd ed.) New York, NY: Teachers College Press.

Sheldon-Keller, A. E. R., Koch, J. R., Watts, A. C., & Leaf, P. J. (1996). The provision of services for rural youth with serious emotional and behavioral problems: Virginia's comprehensive services act. *Community Mental Health Journal, 23*, 263–278. doi: 10.1007/BF02251047

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), 63–75.

Sillito, J. (2013) Saturate (version 2.0). [Mobile application software]. Retrieved from http://www.saturateapp.com

Skiba, R. J., Poloni-Staudinger, L., Simmons, A. B., Feggins-Azziz, L., & Chung, C. (2005). Unproven links: Can poverty explain ethnic disproportionality in special education? *The Journal of Special Education, 39*(3), 130–144. doi: 10.1177/00224669050390030101.

Smith, D. D. (2007). *Introduction to special education: Making a difference* (6th ed.). Boston, MA: Allyn & Bacon.

Smrekar, C. E., & Mawhinney, H. B. (1999). Integrated services: Challenges in linking schools, families, and communities. In J. Murphy & K. S. Louis (Eds.), *Handbook of research on educational administration* (pp. 443–461). San Francisco, CA: Jossey Bass.

Snyder, T. D., & Dillow, S. A. (2013). *Digest of Education Statistics 2012.* NCES 2014-015. Washington, DC: National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education. Retrieved from http://nces.ed.gov/pubs2014/2014015.pdf

Stake, R. (1995). *The art of case study research.* Thousand Oaks, CA: Sage Publications Inc.

Stern, P. N. (2007). On solid ground: Essential properties for growing grounded theory. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (pp. 114–126). London, UK: Sage.

Strauss, A. C., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Thousand Oaks, CA: Sage Publications Inc.

Strauss, A. L. (1978). Negotiations. Varieties, contexts, processes, and social order. San Francisco, CA: Jossey-Bass.

Strauss, A. L., Fagerhaugh, S., Suczek, B., & Wiener, C. L. (1985). *Social organization of medical work.* Chicago, IL: University of Chicago Press.

Strauss, A. L., Schatzman, L., Ehrlich, D., Bucher, R., & Sabsin, M. (1963). The hospital and its negotiated order. In E. Freidson (Ed.). *The hospital in modern society* (pp. 147–169). New York, NY: MacMillan.

Stroul, B. A. (2002). *Issue brief—Systems of care: A framework for system reform in children's mental health.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Stroul, B. A. (2003). Systems of care. A framework for children's mental health care. In A. J. Pumariega & N. C. Wingers (Eds.), *The handbook of child and adolescent systems of care: The new community psychology* (pp. 17–34). San Francisco, CA: Jossey-Bass.

Stroul, B. A., & Blau, G.M. (2008). *The system of care handbook: Transforming mental health services for children, youth, and families.* Baltimore, MD: Paul H. Brookes Publishing.

Stroul, B. A., & Friedman, R. M. (1986). *A system of care for severely emotionally disturbed children and youth.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Stroul, B. A., & Friedman, R. M. (1996). The system of care concept and philosophy. In B. A. Stroul (Ed.), *Children's Mental Health: Creating Systems of Care in a Changing Society,* (pp. 3–21). Baltimore, MD: Paul H. Brookes Publishing.

Stroul, B. A., & Friedman, R. M. (2011). *Effective strategies for expanding the system of care approach. A report on the study of strategies for expanding systems of care.* Atlanta, GA: ICF Macro.

Substance Abuse and Mental Health Services Administration. (2012). *Mental Health, United States, 2010*. HHS Publication No. (SMA) 12-4681. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Suter, W. N. (2012). *Introduction to educational research: A critical thinking approach* (2nd ed). Thousand Oaks, CA: Sage.

Suter, J. C. (2006). *The wraparound puzzle: Confirmatory factor analysis of the wraparound fidelity index* (Unpublished PhD dissertation). The University of Vermont, Burlington.

Suter, J., & Bruns, E. (2009). Effectiveness of the wraparound process for children with emotional and behavioral disorders: A meta-analysis. *Clinical Child & Family Psychology Review, 12*(4), 336–351. doi:10.1007/s10567-009-0059-y

Sutherland, K. S., & Oswald, D. P. (2005). The relationship between teacher and student behavior in classrooms for students with emotional and behavioral disorders: Transactional processes. *Journal of Child and Family Studies*, *14*(1), 1–14. doi: 10.1007/s10826-005-1106-z

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of evaluation, 27,* 237–246. doi: 10. 1177/1098214005283748

Tillman, L. (2002). Culturally sensitive research approaches: An African-American perspective. *Educational Researcher, 31,* 3–12. doi: 10.3102/0013189X031009003

Tolan, P. H., & Dodge, K. A. (2005). Children's mental health as a primary care and concern: A system for comprehensive support and service. *The American Psychologist, 60*(6), 601. doi: 10.1037/0003-066X.60.6.601

TriData Division. (2009, November). *Mass shootings at Virginia Tech: Addendum to the report of the review panel.* Retrieved from http://scholar.lib.vt.edu/prevail/docs/April16ReportRev20091204.pdf

U.S. Department of Commerce, U.S. Census Bureau. (2007). *State single year of age and sex population estimates—Resident.* Retrieved from https://www.ideadata.org/Archive/ARCArchive.asp

U.S. Department of Education (2014). Early intervention program for infants and toddlers with disabilities. Retrieved from http://www2.ed.gov/programs/osepeip/index.html

U.S. Department of Education, Office of Special Education Programs. *Annual report to Congress on the implementation of the Individuals with Disabilities Education Act, selected years, 1992 through 2006, and Individuals with Disabilities Education Act (IDEA) database.* Retrieved from https://nces.ed.gov/programs/digest/d13/tables/dt13_204.70.asp National Center for Education Statistics, Common Core of Data (CCD). *State nonfiscal survey of public elementary/secondary education, 2011–2012.*

U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. (2012). *31st Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2009, Parts B and C. 2009.* Washington, DC: Author. Retrieved from http://www2.ed.gov/about/reports/annual/osep/2009/parts-b-c/31st-idea-arc.pdf

U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. (2007). *27th Annual (2005) report to Congress on the implementation of the Individuals with Disabilities Education Act* (Vol. 1). Washington, DC: Author.

U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. (1999). *Prevention strategies that work. What administrators can do to promote positive student behavior.* Retrieved from http://cecp.air.org/preventionstrategies/prevent.pdf

U.S. Department of Education, Office of Special Education Programs, Individuals with Disabilities Education Act (IDEA) database. (2012). *Table 204.60. Percentage distribution of students 6 to 21 years old served under Individuals with Disabilities Education Act (IDEA), Part B, by educational environment and type of disability: Selected years, fall 1989 through fall 2011.* Retrieved from https://nces.ed.gov/programs/digest/d13/tables/dt13_204.60.asp

U.S. Department of Education, Office of Special Education Programs, Individuals with Disabilities Education Act (IDEA) database. (2013). Retrieved from http://nces.ed.gov/ccd/pdf/STnonfis101agen.pdf; and National Center for Education Statistics, Common Core of Data (CCD), "State Nonfiscal Survey of Public Elementary/Secondary Education," 2010–11 and 2011–12. (This table was prepared June 2013.)

U.S. Department of Education, Office of Special Education Programs. *Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act,* selected years, 1992 through 2006, and Individuals with Disabilities Education Act (IDEA) database. Retrieved from http://tadnet.public.tadnet.org/pages/712. National Center for Education Statistics, Statistics of Public Elementary and Secondary School Systems, 1977–78 and 1980–81; Common Core of Data (CCD). State nonfiscal survey of public

elementary/secondary education. 1990–91 through 2011–12. (This table was prepared April 2013.)

U.S. Department of Education, Office of Special Education Programs. (2007). *Number and percentage of children ages 3 to 5 and ages 6 to 21 served under the Individuals with Disabilities Education Act (IDEA), by race/ethnicity and type of disability: 2007.* Washington, DC: Author.

U.S. Department of Education. (2010). *29th Annual report to Congress on the implementation of the Individuals with Disabilities Education Act, 2007.* Washington, DC: Author.

U.S. Department of Education. (2012). 2012 IDEA Part B Child Count and Educational Environments [Data file]. Retrieved from https://explore.data.gov/Education/2012-IDEA-Part-B-Child-Count-and-Educational-Envir/5t72–4535

U.S. Department of Education. (2014). *Early intervention program for infants and toddlers with disabilities.* Retrieved from http://www2.ed.gov/programs/osepeip/index.html

U.S. Department of Health and Human Services (2000). *Report of the Surgeon General's conference on children's mental health: A national action agenda*. Washington, DC: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (2005). *The comprehensive community mental health services for children and their families program: Evaluation findings: Annual report to Congress.* Retrieved from http://store.samhsa.gov/shin/content//SMA10-4536/SMA10-4536.pdf

Ubben, G. C., Hughes, L. W., & Norris, C. J. (2001). *The principal: Creative leadership for effective schools* (4th ed.). Boston, MA: Allyn and Bacon.

Van Acker, R. (2010, August). *Summit on better serving students with emotional disabilities.* Presentation sponsored by the Virginia Department of Education in Charlottesville, VA.

VanDenBerg, J. E., & Grealish, M. E. (1996). Individualized services and supports through the wraparound process: Philosophy and procedures. *Journal of Child and Family Studies, 5*(1), 7–21. doi: 10.1007/BF02234675

VanDenBerg, J., Bruns, E., & Burchard, J. (1999). History of the wraparound process. *Promising Practices in Wraparound for Children with Serious Emotional Disturbance and their Families, 4,* 19–26.

Vazou, S., Ntoumanis, N., & Duda, J. L. (2005). Peer motivational climate in youth sport: A qualitative inquiry. *Psychology of sport and Exercise, 6,* 497–516. doi: 10.1016/j.psychsport.2004.03.005.

Virginia Department of Education (2014–2015). *National School Lunch Program (NSLP) Free and Reduced Price Eligibility Report.* Retrieved from http://doe.virginia.gov/support/nutrition/statistics/index.shtml

Virginia Department of Behavioral Health and Developmental Services (2011). *A plan for community-based children's behavioral health services in Virginia.* Retrieved from http://www.dbhds.virginia.gov/library/document-library/cfs%20child%20and%20family%20-%20plan%20for%20behavioral%20health%20services.pdf

Virginia Department of Behavioral Health and Developmental Services (2015, January). *Governor McAuliffe launches GAP to help most vulnerable Virginians struggling with serious mental illness.* Retrieved from http://www.dbhds.virginia.gov/about-dbhds/news-and-press-releases/news/2015/01/14/16/05/gap-launch

Virginia Department of Education (1993). *Student and school support: Comprehensive services act for at risk youth and families.* Retrieved from http://www.doe.virginia.gov/support/comprehensive_services_act/

Virginia Department of Education School Nutrition Program (2014). Virginia Department of Education, Office of School Nutrition Programs, School Year 2014–2015, National School Lunch Program (NSLP), *Free and reduced price eligibility report, division level.* Retrieved from http://doe.virginia.gov/support/nutrition/statistics/free_reduced_eligibility/2014-2015/divisions/frpe_div_report_sy2014-15.pdf

Wagner, M. M., & Cameto, R. (2004). The characteristics, experiences, and outcomes of youth with emotional disturbances. *NLTS-2 Data Brief, 3*(2). Minneapolis, MN: National Center on Secondary Education and Transition, University of Minnesota.

Wagner, M. M., & Newman L. (2012). Longitudinal transition outcomes of youth with emotional disturbances. *Psychiatric Rehabilitation Journal 35*(3), 2012, 199–208. doi.org/10.2975/35.3.2012.199.208

Walker, H. M., Nishioka, V., Zeller, R., Severson, H., & Fell, E. (2000). Causal factors and potential solutions for the persistent under identification of students having emotional or behavioral disorders in the context of schooling. *Assessment for Effective Intervention, 26(1),* 29–39. doi: 10.1177/073724770002600105

Walker, H. M., Ramsey, E., & Gresham, F. M. (2004). *Antisocial behavior in school: Evidence-based practices* (2nd ed.) Belmont, CA: Wadsworth/Thomson.

Wehby, J. H., Dodge, K. A., Valente, E., & The Conduct Disorders Research Group (1993). School behavior of first grade children identified as at-risk for development of conduct problems. *Behavioral Disorders, 19,* 67–78.

Weist, M. D., Myers, C. P., Danforth, J., McNeil, D. W., Ollendick, T. H., & Hawkins, R. (2000). Expanded school mental health services: Assessing needs related to school level and geography. *Community Mental Health Journal, 36*(3), 259–273. doi: 10.1023/A:1001957130982

Wiley, A., Siperstein, G., Forness, S., & Brigham, F. (2010). School context and the problem behavior and social skills of students with emotional disturbance. *Journal Of Child & Family Studies, 19*(4), 451-461. doi:10.1007/s10826-009-9316-4

APPENDICES

Appendix A

SENATE JOINT RESOLUTION NO. 47
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Joint Conference Committee on March 8, 2014)
(Patron Prior to Substitute--Senator Deeds)

Establishing a joint subcommittee to study mental health services in the Commonwealth in the twenty-first century. Report.

WHEREAS, the provision of mental health services has been a core responsibility of the Commonwealth of Virginia since 1776, with the establishment of the nation's first publicly supported state mental institution in Williamsburg; and

WHEREAS, the Commonwealth appropriated $585 million for behavioral health services provided through the Department of Behavioral Health and Developmental Services (the Department) in fiscal year 2013, and of this total amount, 52 percent was provided to serve 1,203 individuals treated in state mental health facilities and the remaining 48 percent provided services for 146,503 individuals living in the community; and

WHEREAS, the current system of care should be reexamined to ensure that resources are aligned to serve the most individuals with behavioral health issues in the most appropriate settings along the continuum of care funded by the Department; and

WHEREAS, in the twenty-first century, the Commonwealth is challenged to provide mental health care through a complex and often confusing array of facilities, programs, and services for individuals with a broad range of mental health needs, including persons requiring voluntary and involuntary, emergency, short-term, forensic, and long-term mental health care in both inpatient and outpatient settings in the public and private sectors; and

WHEREAS, the Commonwealth, since the report of the Hirst Commission over 40 years ago, has made a commitment to provide a system of community-based care for the mentally ill; and

WHEREAS, the fulfillment of that commitment requires that every individual and family experiencing a mental health crisis has access to emergency mental health services without delay; and

WHEREAS, the resources available to local and regional Community Services Board’s and behavioral health authorities have not kept pace with the increasing number of persons in need of services as, despite those increasing needs, the Department has

reduced the number of beds in state facilities and private hospitals have often lacked the resources and reimbursement mechanisms needed to fill the gaps when called upon; and

WHEREAS, many persons in need of crisis intervention and emergency mental health treatment have been unable to access treatment and support services on a timely basis, and at the same time a significant number of persons with mental illness commit various offenses, in many cases minor, nonviolent offenses, and are arrested by law-enforcement officers, brought before the courts, and held in jails or juvenile detention facilities rather than being provided with the necessary treatment in the most appropriate setting in order to prevent their entry into the criminal justice system; and

WHEREAS, in July 2013, an estimated 23.5 percent of Virginia's local and regional jail population, or 6,346 offenders, were estimated to be mentally ill, and of these offenders, 56 percent, or 3,555 offenders, were estimated to be seriously mentally ill, according to the annual jail mental health survey conducted by the State Compensation Board in cooperation with the Department; and

WHEREAS, the Commonwealth has provided significant resources to both local and regional Community Services Boards and behavioral health authorities and to local and regional jails and juvenile detention centers, including a significant fiscal incentive through the reimbursement of up to one-half of the capital cost of construction or enlargement of regional jails, but no comparable incentive for the development of mental health facilities at the community level that may be needed to serve persons with serious mental illness has been provided; and

WHEREAS, significant changes have occurred in recent years in the legal and regulatory framework, federal and state reimbursement structures, and service delivery systems, both public and private, for mental health care, including the largely unintended consequences of the increasing involvement of persons with mental illness in the criminal justice system; and

WHEREAS, there is a need for the General Assembly to consider the types of facilities, programs, and services and appropriate financing mechanisms that will be needed in the twenty-first century to provide mental health care, both in traditional mental health delivery systems and in the criminal justice system; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee be established to study mental health services in the Commonwealth in the twenty-first century. The joint subcommittee shall consist of 12 legislative members. Members shall be appointed as follows: five members of the Senate, of whom two shall be members of the Senate Committee on Education and Health, two shall be members of the Senate Committee on Finance, and one shall be a member at-large, to be appointed by the Senate Committee on Rules; and seven members of the House of Delegates, of whom two shall be members of the House Committee on Health, Welfare and Institutions, two shall be members of the House Committee on Appropriations, and three shall be

members at-large, to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates. The joint subcommittee shall elect a chairman and vice-chairman from among its membership, who shall be members of the General Assembly.

The joint subcommittee may appoint work groups to assist it with its work. In conducting its study, the joint subcommittee shall (i) review and coordinate with the work of the Governor's Task Force on Improving Mental Health Services and Crisis Response; (ii) review the laws of the Commonwealth governing the provision of mental health services, including involuntary commitment of persons in need of mental health care; (iii) assess the systems of publicly funded mental health services, including emergency, forensic, and long-term mental health care and the services provided by local and regional jails and juvenile detention facilities; (iv) identify gaps in services and the types of facilities and services that will be needed to serve the needs of the Commonwealth in the twenty-first century; (v) examine and incorporate the objectives of House Joint Resolution 240 (1996) and House Joint Resolution 225 (1998) into its study; (vi) review and consider the report The Behavioral Health Services Study Commission: A Study of Virginia's Publicly Funded Behavioral Health Services in the 21st Century; and (vii) recommend statutory or regulatory changes needed to improve access to services, the quality of services, and outcomes for individuals in need of services.

In reviewing the need for facility beds at the community level, the joint subcommittee shall give consideration to whether the current fiscal incentives for expanding regional jail capacity should be eliminated and replaced with a new incentive for construction, renovation, or enlargement of community mental health facilities or programs, which may or may not be co-located with selected jails on a regional basis. The joint subcommittee shall consider the appropriate location of such facilities; cooperative arrangements with Community Services Boards, behavioral health authorities, and public and private hospitals; licensing, staffing, and funding requirements; and the statutory and administrative arrangements for the governance of such facilities. The joint subcommittee shall give consideration to the development of such facilities or programs on a pilot basis. Administrative staff support shall be provided by the Office of the Clerk of the Senate.

Legal, research, policy analysis, and other services as requested by the joint subcommittee shall be provided by the Division of Legislative Services. Technical assistance shall be provided by the Office of the Executive Secretary of the Supreme Court of Virginia, the Office of the Attorney General, the Offices of the Secretaries of Health and Human Resources and Public Safety, and the staffs of the Senate Finance and House Appropriations Committees, upon request. All agencies of the Commonwealth shall provide assistance to the joint subcommittee for this study, upon request.

The direct costs of this study shall not exceed $72,560 for each year without approval as set out in this resolution. Of this amount an estimated $50,000 is allocated for speakers, materials, and other resources. Approval for unbudgeted nonmember-related expenses shall require the written authorization of the chairman of the joint subcommittee and the

respective Clerk. If a companion joint resolution of the other chamber is agreed to, written authorization of both Clerks shall be required.

No recommendation of the joint subcommittee shall be adopted if a majority of the Senate members or a majority of the House members appointed to the joint subcommittee (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the joint subcommittee.

The joint subcommittee shall submit its interim report by December 1, 2015, to the Governor and the General Assembly and its final report by December 1, 2017, to the Governor and 2018 Regular Session of the General Assembly. The interim and final reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may approve or disapprove expenditures for this study, extend or delay the period for the conduct of the study, or authorize additional meetings during the 2014 and 2017 interims.

Appendix B

2009 Top 20 Statewide Service Gaps Ranked by CSA Census

- Crisis Intervention and Stabilization
- Intensive Substance Abuse Services
- Emergency Shelter Care
- Acute Psychiatric Hospitalization
- Regular Foster Care/Family Care
- Parenting/Family Skills Training
- Transportation
- Psychiatric Assessment
- Respite
- Family Assessment
- Housing
- After School Recreational
- Alternative Ed Day Programs
- Supervised Individual Living
- Substance Abuse Prevention
- Child & Family Advocacy
- Parent & Family Mentoring
- Short-term Diagnosis Assess
- Developmental Prevention
- Wraparound Services
- Housing for Special Populations

Source: Results of FY09 Gap Analysis (CSA, 2009)

Appendix C

Locale Code Categories

Locale Code Category		**Description**
City	Large	Territory inside urbanized area and city with population of 250,000 or more.
	Midsize	Territory inside urbanized are and city with population between 100,000 and 250,000.
	Small	Territory inside urbanized area and city with population less than 100,000.
Suburb	Large	Territory outside a city and inside an urban area with population of 250,000 or more.
	Midsize	Territory outside a city and inside an urban area with population between 100,000 and 250,000.
	Small	Territory outside a city and inside an urban area with population less than 100,000.
Town	Fringe	Territory inside an urban cluster that is 10 miles from an urban area.
	Distant	Territory inside an urban cluster that is more than 10 miles and less than 35 miles from an urban area.
	Remote	Territory inside an urban cluster that is more than 35 miles from an urban area.
Rural	Fringe	Territory as defined by the Census that is less than 5 miles from an urban area, and rural territory that is less than 2.5 miles from an urban cluster.
	Distant	Territory as defined by the Census that is more than 5 miles but less than 25 miles from an urban area, and rural territory that is more than 2.5 miles but less than 10 miles from an urban cluster.
	Remote	Territory as defined by the Census that is more than 25 miles from an urban area and more than 10 miles from an urban cluster.

Appendix D

Script for Superintendents

Hello,

My name is Lynne Crotts and I am a doctoral student from the Curry School at the University of Virginia. I am conducting a research study on interagency collaboration between schools and outside agencies. This study will try to understand principals' perspectives regarding collaboration with outside professionals, such as mental health agents, on the behalf of special education students with the label of emotional and behavioral disorder. I would like to interview an elementary principal who you or your designee, such as the Special Education Director, would recommend, as being knowledgeable on this topic. If you have two principals you would like for me to interview, that would be preferred, however, one person is fine. The principal would need to have special education students with EBD in their school.

It will consider policies and procedures regarding collaboration, and how this transfers to decision-making practices. I hope to understand what factors impact administrators' decisions when choosing to collaborate, or not, with outside agencies. I hope the results of the study will be useful in a practical sense, but also in guiding future research. I hope to share my results by publishing them in an educational journal. I will also send you and the principal an Executive Summary of the findings at the end of the research study.

The principal's participation is completely voluntary and there is no penalty if the person chooses not to participate. With your approval I will email the principal a "Participant Letter of Request", and after receiving their signature I will send the person a questionnaire. I will then set up a time to meet to have a face-to-face interview that should last approximately one hour. I would like to set up the interview as soon as possible, preferably within the next week. I have attached the questionnaire and sample interview questions, however, I ask that you please not share these with the principal.

I will be careful to protect the principal's identity and privacy. I will record the interviews and take hand written notes. However, information that may identify the principal (such as their name or place of work) will not be used in final documents. The typed interviews will not contain any mention of their name, and any identifying information from the interview will be removed. All documents will be kept private and secure. Any physical notes will be stored in a locked vault and transcriptions will be kept on a password-protected computer. Data from the interviews will be kept for one year and after that time, will be destroyed.

If you have questions regarding the study, you may also contact Dr. Catherine Bradshaw at the University of Virginia. The Institutional Review Board at the University of Virginia has approved this project.

Appendix E

Participant Letter of Consent

Participant Letter of Consent

Date:

Dear Colleague,

I am inviting you to participate in a research study on interagency collaboration between schools and outside agencies. This study is being conducted by Lynne Crotts, a doctoral student from the Curry School of Education at the University of Virginia. The superintendent has given his/her approval for you to participate, however, your participation is completely voluntary and there is no penalty if you do not participate. You have the right to withdraw from the study at any time without any consequences by writing an email or talking with me. If you agree to participate, I will call you to set up a time to meet. The interview should take approximately one hour unless you choose to have more time.

This study seeks to understand principals' perspectives regarding collaboration with outside organizations, such as mental health agencies, on the behalf of special education students with the label of emotionally and behaviorally disturbed. It will consider policies and procedures regarding collaboration, and how this transfers to decision-making practices. Through your participation I hope to understand the contributors and barriers to interagency collaboration. Although there are no direct benefits, I will send you an Executive Summary of the findings.

I will be careful to protect your identity and privacy, so there are minimal risks. Information that may identify you (such as your name or place of work) will not be used in final documents. Any identifying information from the interview will be removed. All documents will be kept private and secure. Any physical notes will be stored in a locked vault and transcriptions will be kept on a password-protected computer. Data from the interviews will be kept for one year and after that time, will be destroyed.

If you have questions about the study or need more information, please contact me by phone at 434-825-4934 or by email at lac6t@virginia.edu. If you have questions regarding your rights as a participant in this research, please contact Dr. Catherine Bradshaw at cpb8g@virginia.edu. The Institutional Review Board for the Social and Behavioral Sciences (IRB) at the University of Virginia has approved this project, however, you may contact Dr. Tonya Moon, the chair of the IRB, at 434-924-5999 or irbsbshelp@virginia.edu about your rights in the study. The website is www.virginia.edu/vpr/irb/sbs.

If you consent to being interviewed, please respond with your signature and a yes or no answer as soon as possible.

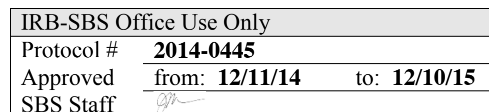
Agreement:
I agree to participate in the research study described above.

Signature:____ Date:___________________

You will receive a copy of this form for your records.

All the best,

Lynne Crotts
Administration and Supervision Doctoral Student
Curry School, University of Virginia



IRB-SBS Office Use Only		
Protocol #	**2014-0445**	
Approved	from: **12/11/14**	to: **12/10/15**
SBS Staff		

Appendix F

Principal Questionnaire

Principal Experience:

___ Years served as principal of your current school

___ Years served as principal of another school

What was your role before becoming a principal, for example, 5th grade teacher for 5 years; school counselor for 7 years; etc.?

Have you participated in any district or school training or development program concerning students with the emotional and behavioral disorder special education label? If yes, please describe.

Have you participated in any district or school training or development program concerning interagency collaboration? If yes, please describe.

Have there been any past events in your school that may have facilitated interagency collaboration? If yes, please describe.

Have there been any past events in your school that may prevent interagency collaboration? If yes, please describe.

How many students in your school have the special education label of emotional and behavioral disorder?

Briefly describe your school in your own words.

Appendix G

Principal Interview Questions

What is your definition of interagency collaboration?

I.

1. What does interagency collaboration look like in your school?
    - A. How is it structured?
        - --What are the procedures or support systems provided for students with the label of emotional or behavioral disorder?
        - --Are these procedures implemented with regularity in your school?
    - B. How are you involved?
        - How much are you involved?
2. Who is invited to the child study meetings?
    - A. How do you decide who should attend the meetings?
    - B. Who comes to the meeting?
    - C. Who else is involved?
    - D. How are they involved?
3. Which agents provide these services?
    - A. Who are the community service agents working with you, your teachers, or students in your school?
    - B. -What is the role of the outside professionals or providers?
4. Who coordinates the services provided?
5. What strategies do you use to obtain services?
    - A. Who initiates the contact with an outside professional? When and why?
    - B. Are there written procedures for the process?

7. How is collaboration planned and implemented?
8. How are community/outside professionals utilized to provide formal support for students with EBD?
9. Are these procedures implemented with regularity in your school?
    - A. To what extent are the outside service providers engaged in collaborating with you or others working in the school?

II.

1. Is there a workspace provided for the professionals? Are there any problems with providing them a workspace?
    - A. Is there any intrusion on you or the school staff by the professionals working in your building?
2. As leader of the school, what role do you play in collaborating with outside agents?
    - A. What are your beliefs about collaborating with professionals outside of your school or the district's central office?
    - B. How often do you collaborate with outside agents?
    - C. How important to you is collaboration with outside agents in your school? Is it a priority?

3. To what extent do school personnel who typically care for students with EBD perceive these services as important?
4. What has been your experience collaborating with outside professionals in your school?
    A. Do you have any concerns about outside professionals providing services in your school?
    B. Do you have authority over them when they are in your building? Who do they answer to - you or someone outside of your school?
    C. Or do they have any authority over you or must you do what they say when they are working in your building?
5. Do you believe you share common views or beliefs with outside professionals of how to support and work with students with EBD in schools? Please explain.

III.
1. Do you believe the professionals from outside the school provide valuable services to students with EBD? If so, please describe your beliefs and why.
2. How would you describe the outside professionals' services?
3. Is it challenging to follow outside professionals' suggestions, if offered? If so, please explain.
4. Do you see a benefit from collaborating with outside agencies? If so, what are the benefits?
5. Can you provide me with a concrete case where collaboration was utilized?

IV.
1. What enhances or contributes to interagency collaboration?
2. What are the perceived factors preventing service delivery to students with EBD?
    A. What resources (e.g. personnel, money, time) do you have to provide services?
    B. Are any of these resources a factor when providing services for students with EBD?

V.
1. Do you have any suggestions for how collaboration can be improved?
    A. What steps would you take to collaborate with outside agents to a greater degree?
2. What would you change if you were in the position to change the current procedure?

***

Describe what you've learned from working with outside professionals. What examples can you give?

If you have experienced outside professionals coming into your school, have you changed your view of collaboration as a result of them working in your building? Please explain.

Is there anything else I need to know or understand?

Appendix H

Framework Constructs for Data Analysis

RQ1: To what extent, and under what conditions, do school principals collaborate with outside professionals on behalf of students with EBD?

Framework Constructs	
Negotiated Order Theory	• Negotiations are one-shot, repeated, sequential, serial, multiple, linked • Visibility of transactions—overt or covert
System of Care	• Coordination of efforts between participants—participants are full partners in delivery of services

RQ2: What is the nature of interagency collaboration between school principals and outside professionals on behalf of students with EBD, as identified by participants?

Framework Constructs	
Negotiated Order Theory	• Participants values, interests, beliefs • Level, balance of power exhibited • Clarity of legitimacy of boundaries of issues negotiated • Negotiations are aligned with current practices of communication within organization
System of Care	• Coordination of services

RQ3: What are the outcomes of interagency collaboration between school principals and outside professionals?

Framework Constructs	
Negotiated Order Theory	• Opposed or antagonistic interests between the parties—lack of interest
System of Care	• Coordination of efforts between participants—participants are full partners in delivery of services • Coordination of services

RQ4: What are the contributors and barriers to interagency collaborative services, as identified by participants?

Framework Constructs	
Negotiated Order Theory	• Negotiators experience in negotiating • Visibility of transactions—overt or covert • Number and complexity of issues • Time, resources—money • Opposed or antagonistic interests between the parties—lack of interest
System of Care	• Coordination of efforts between participants—participants are full partners in delivery of services • Coordination of services • Integrated services at system level: link between school and agencies across administrative boundaries • Financial mechanism for system of care implementation

RQ5: How can collaboration between school agencies and outside agencies be improved?

Framework Constructs	
Negotiated Order Theory	• Participants values, interests, beliefs • Negotiations are aligned with current practices of communication within organization
System of Care	• Coordination of efforts between participants --participants are full partners in delivery of services

Appendix I

Principals' Definition of Interagency Collaboration

Principal Bailey:

I think there are the students who definitely need wraparound support, and interagency collaboration is essential to that. If you're going to approximate that in any way, then it can't just happen at school. There are also students who need in-home supports. You know you're not going to run into that with a student with a learning disability, typically, that impacts school. But students with ED, their disability is pervasive across settings, and so often those supports are in place, maybe before they become identified. But definitely throughout their school career, those opportunities exist.

Principal Cobb:

Coming together as a team to help a student with strategies. And again we really don't have guidance or training on how to have that happen as a team. We collaborate with our community services board, and parents on our own will; just what we see needs to be done in our school.

Principal Crane:

I would say collaborative work where is there a two-way street of communication for the express purpose of having a positive impact with the child and or family. I am a huge believer that the child doesn't come here in isolation. They are part of a dynamic that we can impact and sometimes the interagency effort may be working with the parent. Maybe hooking them up with resources, so it's a dialogue.

Principal Eller:

Interagency collaboration is when the school or agency works collaboratively together to benefit a child or a program and that can be anything from outside counseling services, social services to just a wide variety of social agencies or agencies.

Principal Fallon:

The simple definition that comes to mind is at least two different agencies working together, and that agency could be a school or some type of organization working smoothly, effectively, and consistently in order to achieve a main goal of purpose. The ones I've worked with in the past, we were in constant communication, whether it's through email or it's the telephone or via text. I think it's constant communication in order to do what's best for the need we have.

Principal Goode:

It is schools working for a mutual goal with agencies around the community, to provide support for students.

Principal Moore:

A partnership between the school and whatever the agency is, working for the betterment of children. And probably the best example I can give right now, because I have a great working relationship, is with the Sheriff's Department. We have an assigned officer and he and I have a good working relationship. If anything goes on involving these kids, I can call him. And if I need the sheriff's department to intervene, I can count on him. Hands-down. I would say the Department of Social Services, especially when this one person was here… The guidance counselor interacts with them more than I do, but if I have a kid in crisis I know I can count on them.

Principal Painter:

My understanding of interagency collaboration is a pooling of community resources together to meet the needs of the population that we serve. So that interagency collaboration can be helpful with specific families and also with specific kids who have needs that go beyond what we can offer in the school setting.

Principal Penny:

I guess it's going to depend on the agency, but ultimately it's different groups of people coming together to find out what's best for kids. What resources, what best practices, what strategies, in order to have the kids be successful.

Principal Samson:

I guess I look at that as working with agencies to support students in our building. Sometimes it's talking with agencies. The child might be okay at school but we may want to talk with professionals about ways to help them with whatever they're working with the child on. It goes both ways.