

# SUSTAINING COMMUNITY MENTAL HEALTH CONSULTATION TO URBAN SCHOOLS

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## Abstract

The goal of this *Think Tank* was to address barriers and facilitators to the implementation of effective programs in schools and community agencies in high poverty urban communities. Mental health consultation to urban schools is widely acknowledged as a promising intervention to close the persistent gap in service use for children living in poverty. However, there is little or no research that describes the complexity of implementing and sustaining effective school-community models. This issue was addressed by examining the implementation of *Links to Learning*, an NIMH-funded study (PI: Atkins) currently in its 4th year, that aligns community providers with parents and teachers to address key predictors of academic and behavioral functioning for children in urban high-poverty schools. The *Think Tank* was organized to provide an overview of the intervention model and its initial and long-term goals, followed by a discussion with participants of key features of the model: the training of community providers and specifically components of the model that appeared most and least compatible with traditional mental health practice, intra- and inter-organizational factors that appear to impact school-agency collaboration, supervision models to enhance agency and school capacity, and research strategies to capture the critical domains of program adaptation, implementation, and sustainability. The overall goal of the discussion was to describe implications for advancing policy, research and practice for the sustainability of effective community mental health services in high poverty urban communities.

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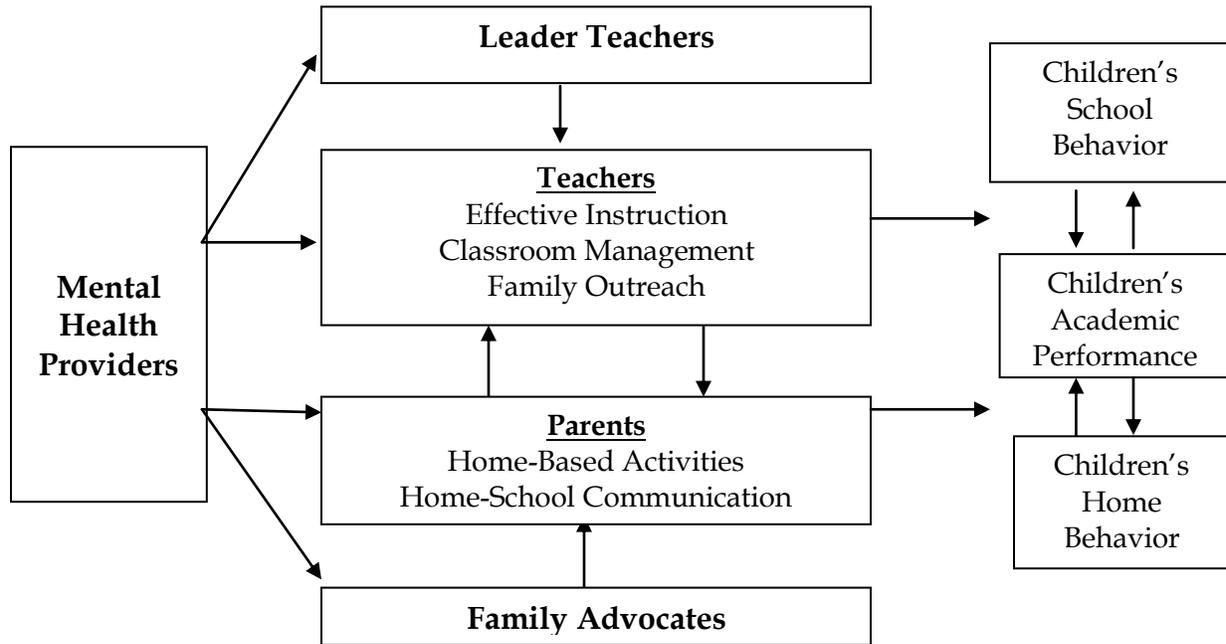
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## The Service Model

The theoretical model for the intervention that served as a focus for this *Think Tank* is displayed in Figure 1. The overall goal of the intervention is to support teachers' use of strategies (effective instruction, classroom management, parent outreach) and parents' use of strategies (home-based activities, home-school communication) that are predictive of children's learning. Intervention occurs within a Medicaid fee-for-service system in which community mental health providers carry a caseload of children diagnosed with a disruptive behavior disorder. Also important to the model is the strategic use of key opinion leader teachers (Atkins et al. 2008) and parent advocates (Atkins et al., 2006; Frazier et al., 2007) to influence teachers and parents, respectively. This model derives from a considerable literature indicating the importance of children's schooling to their mental health and development, which is especially critical for children living in urban low-income communities where mental health services are scarce and schooling highly compromised (Cappella et al., 2008).

Figure 1: *Links to Learning Service Model*



Discussion Summary

**1) The training of teachers and mental health providers requires concentrated learning strategies including modeling and feedback.**

One of the key features of this model is the concurrent training of teachers and mental health providers on best practices for enhancing learning in classrooms and homes. The overall goal of the training is to cultivate a working alliance among the intervention team members, each of whom has a somewhat different role from the other, and to capitalize on the unique strengths of mental health providers and teachers by providing training targeted to new skills that will further enhance their role within the intervention team. This is accomplished initially through a web-based course for which teachers receive university master credits, which can be used to advance their salary, and mental health providers receive professional development units, which accommodate their licensure requirements. However, more importantly, the web-based course is supplemented with in-person meetings with university staff to make sure that the content is learned. In addition, in the later iteration of this training, key opinion leader teachers attempted the strategies in their classrooms, with the support of a mental health provider assigned to their school, to facilitate learning and enhance collaboration between teachers and mental health providers. This appeared to reinforce the mental health provider role as assisting teachers to implement classroom management practices, provided mental health providers with in vivo practice to enhance their comfort in this role, and to work collaboratively with teachers in their classrooms.

**2) Align program goals with the mission of agencies and schools.**

A core assumption of this model is the need to align the program goals with the mission of the community mental health agency and school. For a community agency, this involves conceptualizing children’s schooling as an important clinical goal and determining that

community outreach, in the form of school-based services, is consistent with their service delivery models. Financial feasibility is also a critical goal for agencies, and therefore reimbursement strategies such as fee-for-service arrangements should be designed to ensure the program's viability. For school staff, it is often necessary to define mental health goals in the language of schooling, and to confirm the importance of school success to children's long-term adjustment and mental health. Although cultivating the buy-in of agency and school leadership is critical to program start-up and viability, cultivating and sustaining the buy-in of mental health providers and teachers requires a frequent return to these issues to ensure the alignment of program goals with the day-to-day work of mental health providers and teachers. The frequent revisiting of these issues with the mental health providers and teachers is especially important because traditional models of mental health practice are more common and more familiar and therefore staff will return to these practices over time. For example, even after sharing with the agency and school stakeholders several years of data indicating that clinic-based services are not responding to needs of children and families, these agencies remain largely clinic-based and school staff often request pull-out counseling services, suggesting that the program goals remain somewhat marginalized to the main activities of agencies and schools.

Because the effectiveness of the model is still being examined, proactive strategies to replicate or approximate the model throughout the community and school have not yet been undertaken. Thus, as the project continues, most providers are supplementing the school-based work with clinic-based services when the school day is over. This has led to conflicts for some providers, who were more familiar and comfortable with clinic-based services and therefore less willing to persist with the school-based services when problems occurred at the school. In addition, at times the agencies' policies were conflicting with core goals of the school-based program. For example, one of the agencies required that families complete intake forms at the agency. When it was clear that many families were unable or unwilling to come to the agency, the intake procedure was changed and an intake worker was assigned to the school to complete these forms.

### **3) Articulate core program elements and establish measures of implementation fidelity.**

The identification of core program features is an iterative process, whereby the assumed core features of the model are operationalized through various fidelity measures, including checklists listing key program components, and charts and calendars to document program use. These core features are discussed through supervision and program monitoring, adapted from a supervision model developed for Multisystemic Therapy (Schoenwald et al., 2008), to identify additional features related to high program fidelity, and to overcome apparent barriers to effective implementation. These adapted program features should not replace core programs goals (e.g., the need for each student to be provided materials specific to their instructional level), which remain constant throughout, but to some extent the decision as to what are the core features may be somewhat arbitrary as it is difficult at times to know *a priori* which features will be most important to program outcomes. Because we have allowed the model to be adapted by teachers and providers, it is necessary to identify core elements that did not change despite adaptations. If core elements change as the study progresses, then there may not be time to evaluate the new model. For example, as this service model has evolved, we have become more aware of the complexity of the collaborative process between mental health providers and teachers and the ensuing changing roles of providers. These factors represent a new set of core features of the model that have not yet been operationalized or measured sufficiently.

**4) Taking the model to scale will reveal a new set of program features that are difficult to anticipate.**

The tension between the need for adaptation to address unique features of settings, and the need for a consistent set of core elements to determine that there is an intervention to evaluate, is especially critical to document and study to prepare the model for replication and going to scale. To take a model to scale requires both a specification of the core features of the model and also an appreciation of how different settings and policies might impact the implementation of the model. For example, states differ in the extent to which school-based models are supported, with some states having very active school-based models and others having very few of these models. Thus, the test for this service model is the extent to which the core principles are adaptable to differences across systems and settings. We need to capture how the core elements will operate across different settings and systems, suggesting the need for an iterative research strategy that accounts for local adaptations that support effective program implementation.

**5) The shifting perspective of mental health providers' roles is important to measure.**

Job analysis was discussed as a potential method to study the process through which mental health providers reconceptualize their role and then identify with new roles and responsibilities. Job analysis involves specifying the tasks associated with a job and prioritizing their importance to effective outcomes. Similarly, job analysis could identify features of the mental health provider role that is more or less acceptable to teachers, which could contribute to improving the collaboration of mental health providers and teachers. For a service model such as this one that may require many changes in perceived roles for mental health providers, this analysis could be helpful to quantify the amount of change experienced by a provider and the extent to which the new role is becoming more acceptable over time. In addition, job analysis could help to identify the expertise of university consultants that match specific tasks associated with the new role, or the need to identify other consultants if key functions are not adequately represented on the research team. The goal for these consultants is to train and support the school-based intervention team on these key features related to their expertise (e.g., implementing a classroom management program or conducting a curriculum-based assessment) and to transfer these responsibilities to indigenous supports (e.g., clinical supervision by an agency supervisor rather than a university consultant). This process loops back to the need for organizational buy-in for the model, to ensure that there are appropriate resources and personnel to restructure the time of agency and school staff to allow them to assume these responsibilities.

**6) The school's commitment to the model is enhanced by a strong presence of agency and university staff but ultimately it is important to leverage indigenous resources to sustain the program.**

Early in program implementation and development, the presence of university consultants and community mental health agency staff at the school is necessary to indicate the commitment to the school and to develop the personal relationships necessary to adapt the program to the needs of the setting. As agency staff are learning the model, university staff need to have a dominant presence at the school, in part to respond to emerging needs, and to model key features of the program for teachers and agency providers. As agency staff become more comfortable and effective in their roles, university staff can reduce their presence at the school while remaining available to model new features of the program as they become apparent. This can lead to some

tension between university consultants and agency staff regarding the timing and nature of the transfer of authority from university consultant to agency provider. These issues are not unexpected and need to be addressed through open dialogue during supervision meetings and other times as needed, to avoid problems festering and interfering with staff adoption of program roles and responsibilities.

**7) School-based service models such as this one are an example of how services can be redesigned to enhance their impact on children's daily lives.**

The large question that this project addresses is the need for a paradigm shift in our conceptualization of the role and function of mental health services for children and families. To that extent, this school-based service model is an exemplar of a model that addresses meaningful aspects of children's lives. Other goals could be added to this model, such as enhancing parents' access to other services. However, more importantly, if the primary goal to enhance children's schooling is accomplished this would be an important achievement whether or not other goals, such as accessing other services, are reached. Overall, the major objective of this model is to develop a service that is responsive to the needs of children and families living in high poverty urban communities. Therefore, to that end, further specification of the model to address the many urgent needs of children and families is expected.

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