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Partners, Politics and Positive Attitudes: A Rural Community-University Partnership to Enhance School-Based Mental Health Services

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Providing Rural School-Based Mental Health Services: Lessons Learned from a Community-University Partnership

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Health

There is a significant lack of adequate mental health services for youth in rural, impoverished areas while there is a substantial need for those services. This paper describes the process of developing and enhancing a collaborative relationship among a university, a health services agency, and a school system that enabled school-based mental health services to be available, accessible, and acceptable in an impoverished, rural community.

Keywords: Rural youth, Youth mental health, Rural mental health, School mental health, University-school collaboration

Introduction

During the 2000's, North Carolina transitioned from a public community mental health system to a public-private partnership in which the public agency divested its role in service delivery to private providers (Gray, 2009). Lacking a critical mass to sustain a business in rural areas, most providers focused on service delivery in urban areas. During this period, a decrease in state funds allocated for mental health services greatly affected the availability of services for individuals with no private insurance or Medicaid, especially in rural areas (Duda & Rash, 2011). In this same article, Duda and Rash address the serious consequences of this change. "Advocates say it is extremely hard to find providers willing to treat the most difficult consumers, and because of the lack of appropriate community-based treatment, many people with acute needs are stuck in limbo — between poor ongoing support and inadequate or non-existent crisis services" (p. 5). This change in service delivery has exacerbated accessibility for youth.

Need for Mental Health Services among Rural Youth

A national survey showed that while 6 to 9% of youth between the ages of 6 and 17 years were found to be experiencing mental health problems, nearly 80% were not receiving services (Kataoka, Zhang, & Wells, 2002). Other estimates claim that about 15% of youth experience mental health disorders, with 7 to 10% prevalence rates for severe disorders, most of whom had never received treatment from either health care or educational providers (Kataoka et al., 2003; Costello, Egger, & Angold, 2005; Jensen et al., 2011). Whereas youth from both rural and urban areas struggle with behavioral and emotional issues, only 13% of rural youth between the ages of 9 and 17 years were found to be receiving mental health services in a survey by Angold and others (2002). Anderson and Gittler (2005) found that approximately 60% of male adolescent in rural communities were in need of mental health services and that two-thirds who needed treatment for both mental health and substance abuse failed to receive these services. Latino and uninsured youth were at

the greatest risk for not receiving services. Rost, Fortney, Fischer and Jeffrey (2002) found that, as compared to urban youth with psychiatric problems, rural youth were less likely to have specialty mental health care (instead of delivery by a primary care physician), have managed mental health care, persist in treatment, receive quality care, and achieve positive outcomes. Chow, Jaffee, and Snowden (2003) concluded in their study of patterns of use of mental health services by youth of Caucasian, African-American, Hispanic, and Asian ethnic groups that poverty contributes to minority youth's limited access and ensuing low usage.

In his article reporting on *The President's New Freedom Commission: Achieving the Promise: Transforming Mental Health Care in America* (2003), Hogan (2003) addressed stigma as a barrier preventing individuals from seeking mental health care, highlighted disparities effecting minority youth and rural residents, emphasized behavior problems in youth in schools as a rationale for improved and expanded mental health services in schools, and discussed the critical lack of available professionals to provide mental health services in rural areas. Barriers preventing treatment of rural youth include social stigma and cultural misperceptions (e.g., people with mental health problems are 'crazy'; people who seek mental health treatment are weak) as well as lack of access to mental health providers (due to lack of insurance and/or financial resources, prohibitive distance, limited transportation, lack of professionals in an isolated area, etc.) (Taras, 2004).

Consequences of Unmet Mental Health Needs

Students with mental health disorders often exhibit disruptive behavior and poor school performance (Atkins et al., 2002; Ball, 2011; Reid, Gonzalez, Nordness, Trout, & Epstein, 2004). Elementary school children with mental health issues are suspended or expelled at three times the rate of their peers (Blackorby & Cameto, 2004). Youth with unmet mental health needs are at risk for a host of problems: gang membership (Corcoran, Washington, & Meyers, 2005), delinquency (Goldstein, Olubadewo, & Redding, 2005), pregnancy (Harden et al., 2007), substance abuse (Cuellar, Markowitz, & Libby, 2004), poverty (Drukker, Gunther, & van Os, 2007), relationship violence (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008), academic failure (Needham, Crosnoe, & Muller, 2004) and school dropout (Hawkins, Catalano, & Arthur, 2002). Psychiatric disorders are highly prevalent in incarcerated youth (Wasserman et al., 2002; Teplin et al., 2002). In rural areas, this means a continuation and exacerbation of the cycles of poverty, unemployment, domestic violence and abuse, and crime. By addressing the mental health needs of rural school-aged children, the likelihood of breaking this cycle greatly increases.

Transition of Mental Health Services

The past 20 years has revealed an increasing trend of schools providing mental health services for youth (Farmer et al., 2003; Foster et al., 2005). Thus the number and types of mental health services provided by schools have expanded significantly (Lever, Chambers, Stephan, Page & Ghunney, 2010; Masia-Warner, Nangle, & Hansen, 2006; Stephan et al., 2007; Weist et al., 2005). However, schools are often not adequately equipped to handle all the mental health needs of students (Weist & Paternite, 2006) and students in rural areas seem to have had less access to school-based mental health services. Foster and others (2005) found that a greater percentage of schools in rural areas, 89% compared to 81% of the schools in urban areas, reported that all students, not just special education students, were eligible to receive school based mental health services. Yet, a smaller percentage of

rural schools reported that students actually received services (17.9% compared to 22.6%). Another finding revealed that 46.8% of the rural schools had no coordinated effort to address mental health needs compared to 32.3% of the urban schools. Whereas half of the urban schools reported no professional development on child mental health, 63% of the rural schools reported no such professional development.

Another problem is a lack of consensus about the most effective way to integrate mental health services into the already-existing cultures and communities of schools (Adelman & Taylor, 2006; Atkins, Hoagwood, Kutash, & Seidman, 2010; Evans & Weist, 2004) and thus services, are often not responsive to the needs of the individuals (students and staff) within these schools (Hoagwood et al., 2007; Ringeisen, Henderson, & Hoagwood, 2003). This is particularly true of the school environments of communities dealing with significant poverty (Atkins, Hoagwood, Kutash, & Seidman, 2010; Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008).

Developing an Approach to School Based Mental Health in Rural Areas

In 2005, the U. S. Substance Abuse and Mental Health Services Administration (SAMHSA) published *School Mental Health Services in the United States, 2002-2003* (Foster et al., 2005), giving a snapshot of mental health services being offered in schools throughout the country. One of the findings in the SAMHSA report was the lack of a consistent model for the provision of school-based mental health (SBMH) services. That finding corresponds with Kutash, Duchnowski, and Lynn's (2006) observation that the "[a]pplication of SBMH, as it exists today, is not guided by a single conceptual model" (p. 13). However, the authors did identify three predominate perspectives that have shaped the implementation of mental health services in schools. They are the Spectrum of Mental Health Interventions and Treatments (MHS), Interconnected Systems for Meeting the Needs of All Children (ICS), and Application of Positive Behavior Supports to Reduce Challenging Behaviors (PBS). MHS depicts "traditional mental health interventions applied to school settings. These include: promotion and prevention strategies, psychotherapy and other standard treatments for known disorders, psychopharmacology, and maintenance" (Kutash et al., p. 17). The second perspective, ICS, "is composed of three overarching systems: systems of prevention; systems of early intervention; and systems of care for children with the most serious impairments. These three systems collaborate to form an integrated continuum of services for children that include SBMH" (Kutash et al., p. 17). PBS is the third perspective. This perspective supports "positive behavior supports (PBS) and functional behavioral assessment in school settings to both prevent and intervene with challenging behaviors at the school, classroom, and individual level" (Kutash et al., p. 17). The authors conclude that "decision-makers are faced with the selection of programs that best match their particular demographics, resources, and stage of development in delivery of SBMH services" (Kutash et al., p. 13).

Confronting the Issue of Lacking Mental Health Services for Rural Youth

Through a grant from the Kate B. Reynolds Charitable Trust in 2007, East Carolina University (ECU) sought to address the mental health of school-aged youth in the impoverished rural community of Greene County. Since no one approach to providing school based mental health services seemed appropriate for this community, one of the purposes of this project was to implement an approach that would respond to the unique culture and community of Greene County Schools and to determine if availability, accessibility,

and acceptability of school based mental health services would thereby be enhanced. As the community-university partnership evolved, the particular characteristics and specific “personalities” of the community and schools became apparent. The implementation of school based mental health services became a testament to the need for different approaches and the conclusion of Kutash and others (2006) that the selection of an approach must be based on the “personalities” of the school and community.

Although the MHS may overcome the barriers of stigma, transportation, and cost, this model may not work in rural communities because it requires that mental health professionals be housed on-site at the school. Most rural communities do not have the financial resources to maintain a mental health professional at the school and such professionals typically are not located in their communities. For example, there were no licensed psychologists in Greene County when the university was providing school-based services at the elementary, middle and high schools. Also, providing traditional mental health services (i.e., manualized treatment protocols for specific mental health disorders) may not work well when treatment issues involve overwhelming and traumatic life experiences (such as an incarcerated parent, homelessness, and a school destroyed by a tornado). Each of these may require supportive therapy and case management rather than a specific treatment protocol. Whereas the ICS may reach a wide scope of students and students’ significant others, rural communities may be resistant to system-wide changes and parents may be reluctant or unavailable to become involved in treatment initiatives. Finally, although PBS may reach a broad school population and enjoy empirical evidence of effectiveness, it requires school-wide support and implementation to be effective and does not focus on specific mental health problems. Thus it was necessary to develop a unique model of SBMH services to meet the needs of this rural eastern North Carolina community.

The Department of Psychology at ECU confronted this issue with its community partners, Greene County Health Care (GCHC) and Greene County Schools (GCS). The lack of a “tried and true” model led to a stronger partnership as the three strived together to find an approach that could significantly benefit the students in three GCS. Through the partnership, needs were identified. ECU then identified resources to help meet those needs. Then, in partnership, representatives from GCS, GCHC, and ECU faculty and staff developed strategies to utilize those resources to address the needs. The university-community partnership in Greene County exemplified the recommendation of Kutash and others (2006) that decision-makers select components of school-based mental health services that best fit the school and community where they are provided.

The partnership included facets of all three perspectives described previously to create a “good fit” for schools in a rural community, namely: the promotion and prevention strategies and therapy aspects of MHS, the overlapping systems from ICS, and the use of behavioral assessments and supports from PBS. It drew from each perspective to allow the flexibility to meet the needs of the rural, impoverished community where the collaborative partnership was formed. This model to meet mental health needs continued to evolve during the tenure of the project.

The purpose of the paper is not so much to discuss the specifics of the mental health services provided, but instead to provide the reader with usable information about the process of developing the collaborative relationships that enabled school-based mental health services to be available, accessible, and acceptable in an impoverished, rural

community.

ECU-Greene County Partnership

The Partners

Three primary partners worked together in this project: ECU, GCHC, and GCS. ECU, located in the county adjoining Greene County, has a tradition of strong regional ties and public outreach, and routinely engages in partnerships supporting public education, health care and human services, cultural activities, and regional development.

GCHC has provided primary health care in Greene County for 38 years, including the Student Health Clinic (SHC), located on the campus of Greene Central High School (GCHS), for 28 years. The SHC provides primary health care to students at the high school, and some middle school students, with a mid-level medical provider (physician's assistant or nurse-practitioner), a lead nurse, a pregnancy counselor, and an adolescent parenting program coordinator.

GCS is located in a small rural county in eastern North Carolina. It is a small school system consisting of a primary school (Pre-K- 2nd grades), an elementary school (3rd-5th grades), a middle school (6th-8th grades) and a high school (9th-12th grades). The total student population at the time of the project was 3,268.

Participants in the Partnership

- A Project Leadership Team (PLT) guided the development and delivery of services. It consisted of representatives from the following collaborating partners: the project investigator (ECU faculty), the project coordinator (ECU staff), GCS personnel (Student Services Director and Lead School Nurse) and the Director of the SHC.
- Students in the elementary, middle and high schools were both directly and indirectly impacted byhh services. Direct services included individual and group counseling, whereas indirect services were provided by interacting with and educating their teachers and family members (including parents, grandparents and siblings).
- University personnel included faculty from the Department of Psychology who were licensed as practicing psychologists and graduate students who were completing either clinical assistantships or practicums.
- Personnel from the elementary, middle and high schools included administrative staff (principals and assistant principals), health clinic staff (nurse practitioners and pregnancy counselors), student support staff (counselors, social workers, and nurses), and teachers and teacher assistants.

Project Measures

In order to determine the effectiveness of an approach that would respond to the unique culture and community of GCS, the following definitions of availability, accessibility, and acceptability were used:

1. Availability- number and types of available services; how often and how long private practitioners, university faculty, graduate students, and undergraduate students were available at each school each semester providing services
2. Accessibility- number and types of services accessed/received; how often and for how long administrative/support staff, teachers, parents, and students accessed/received services
3. Acceptability- how satisfied those groups of consumers were with the services they

accessed/received.

Documenting the Needs

Greene County (GC) is a poor county in eastern North Carolina. During the time period of 2006-2010, 18.3% of GC residents lived in poverty, compared to the state average of 15.5%. The median household income for the same time period was \$41,073 with the state median at \$46,291. About 73% of the students in GCS received free or reduced-price lunch.

GC also has a high proportion of minority residents. The school system exemplified that statistic. With a student population of 924, GCHS had 51.3% of the students identified as African-American and 9.3% as Latino. Greene Middle School's (GMS) student population was 676 with 50.6% African-American and 16% Latino. In the two elementary schools, the student population was 1,668 with 47.6% African-American and 21.3% Latino.

In a supplementary report (U.S. Department of Health and Human Services, 2001), the U.S. Surgeon General stated that one in every five students has an identifiable mental health condition and would benefit from services and supports. Based on a student population of 3,268 during the 2006-2007 school year, it was estimated that 653 students GCS had an identifiable mental health condition. Also, the data from the bi-annual Youth Risk Behavior Survey (YRBS) in 2006-07 revealed a significant need. For example, 20.3% of high school students and 23.7% of middle school students reported feeling "so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities" during the twelve months prior to the survey. Nine % of high school students and 10.3% of middle school students indicated that they seriously considered attempting suicide during the twelve months prior to the survey. Data showed that only twenty students were seen at the SHC for mental health concerns during that year, fully supporting findings that less than 50% of students needing mental health services receive them (National Survey of Children's Health, 2010).

An important piece of the needs identification and confirmation was done informally. Social conversations with the SHC staff, teachers, counselors, school nurses and school social workers provided valuable input into identifying needs. The PLT met frequently over meals and conducted "reality checks" of the project implementation. No data was gathered, but those conversations confirmed much of what the YRBS indicated. Plus, those conversations helped build trusting relationships between university personnel and strong and visible community leaders that were necessary for ongoing support of the project.

Forming and Growing the Partnership

The SHC provided the initial focal point for the partnership. School-based health centers have a documented history of reaching students that do not stigmatize or alienate them. The partners focused on the development of a Health Psychology (HP) training site in a rural community-based health facility that integrated medical care with mental health services. This aspect of the partnership provided benefits to the partner participants.

- Students who needed mental health services were able to receive them during the school day.
- Teachers had access to the HP doctoral student for consultation.
- Medical professions in the SHC were able to make immediate referrals for mental health concerns while treating medical issues.
- Doctoral students had opportunities to work in a comprehensive health setting with a holistic health approach.

The partnership was strengthened through the interdisciplinary approach in the SHC. For example, when a student had recurring stomach aches that appeared to be stress-related, the medical provider consulted with the HP doctoral student and made a referral for assessment and counseling. Another example involved a student who expressed fear to the counselor, the HP doctoral student, that she might be pregnant. Through immediate consultation with the medical staff, the doctoral student enabled the student to get a pregnancy test. The doctoral student also provided counseling to the student regarding informing her parents. She also referred the student to the SHC pregnancy counselor for other assistance with her pregnancy. This interdisciplinary interaction helped create trust that was evident not only to other participants in the partnership but also to those on the periphery of the partnership.

To grow the partnership beyond the PLT and the SHC, specific outreach to teachers, student support staff, and administrative staff was necessary. Thus, the local partners on the PLT facilitated scheduling educational sessions at the elementary, middle and high schools at the beginning of the school year in Years 2 and 3 of the project. The ECU partners – Psychology faculty (principal investigator) and doctoral students provided information about available services, signs and symptoms of mental health disorders, and effective strategies for classroom management. This outreach helped to galvanize support of administrators and built rapport with the teachers and student support personnel.

Growing the partnership meant engaging in a multi-faceted, ecological approach to mental health services. Providing services to others who are significant in the lives of the students was essential. Therefore, a multitude of services was considered:

1. For students- individual and group counseling; crisis intervention; tutoring; and individual, group, and familial recreational activities;
2. For parents- educational events; family counseling and consultation; and individual, group, and familial recreational activities;
3. For teachers, teacher assistants, administrative and student support staff- training sessions; individual consultation on students; and behavioral consultation (including observation, feedback, modeling of teaching strategies, and writing of individual and class lesson plans and behavior plans).

The growth of the partnership was not always smooth. Overcoming some of the challenges in maintaining the partnership led to a number of lessons learned.

Lessons Learned

University partners had to make a paradigm shift to provide services in the community. They had to get beyond farmer Ray Kinsella's thought from the movie *Field of Dreams* that "If you build it, he will come" (he being the child with mental health needs). Rather than simply making mental health services available in the school, the university partners had to consider many variables.

Lesson #1

A key attribute of a mental health provider is a friendly, easy-going personality. This attribute enables the provider to develop positive relationships with health center and school personnel increasing the likelihood of referrals. That type of personality also helps develop positive relationships with students who are likely to share with their friends. In the original implementation of the project, a competent professional therapist sat idle in the SHC because she was not very friendly and thus not well received. This was significant in a rural setting where relationships were key in all aspects of the community. In the second

year a doctoral student in the same position with a friendly, out-going personality had an extensive waiting list for her services.

Lesson #2

Partners need to be cautious about making assumptions. For example, it was assumed that a professional therapist who could bill for Medicaid would have a large number of clients. However, most of the students seen in the SHC were uninsured, having neither Medicaid nor private insurance. Students in poverty are more likely to be uninsured (Allison et al., 2007). Rather than use a licensed therapist, a doctoral student was recruited to provide mental health services as part of a practicum placement under faculty supervision.

Lesson #3

There is a significant lack of mental health providers who are willing to locate to and work in rural areas for extended periods of time. Although the SHC has sought over the years to provide mental health counseling, it was difficult to recruit licensed personnel and maintain full-time psychology services on a long-term basis. Sometimes located near rural areas are valuable but often untapped university resources that can assist in meeting these needs. Using students pursuing their doctoral degrees in health psychology provided a steady stream of high quality providers with outstanding credentials from all across the country. Doctoral students also provided a level of energy and creativity that is a valuable resource when forging new partnerships. ECU had a newly developed HP doctoral program and thus had a strong motivation to create appropriate health-related practicum sites that be developed into APA accredited internships.

Lesson #4

An important component of providing mental health services in schools is visibility. In the first year of the grant, the idea of classroom consultation was not widely accepted by the teachers. So, in the second year, the principal investigator conducted presentations at the beginning of the school year and introduced the three doctoral students in each of the four schools in the county. The visibility and availability of the principal investigator and the doctoral students were important to teachers and students as evidenced by the acceptance of the unique services offered. Direct classroom involvement enhanced teacher skill in preventing problem situations and handling difficulties as they occurred. The benefits were threefold. First, it increased the visibility of the ECU staff so that GCS faculty and staff recognized them and greeted them enthusiastically when they were in each school. Second, the practical information provided to teachers in classrooms made them eager for more. Third, it enabled the teachers to recognize not only the role of the doctoral students but also the significant knowledge and skills that they had to offer.

Lesson #5

Regular contact among partners is essential to building and maintaining relationships. After the first year, frequent meetings with the PLT were found to be crucial. The local members of this team knew the culture of the community, a small rural county in which the majority of the people knew each other. Before beginning a new initiative, it was essential to meet with these members to see how to approach the administrators and to find out what type of roadblocks might be encountered. It was important to gain the trust of the administration and to work jointly with administrators. The PLT greatly facilitated that process. Rather than being the ECU “experts” who would improve GCS, it was necessary

to become part of a team to decide how to better serve the students. This team approach aided access to students (e.g., release time for students to go to group and individual counseling), teachers, other school personnel and parents. By taking the time to build positive relationships with people on this team, their trust was earned and they were willing to champion the cause, even when others were initially against these ideas.

Lesson #6

A broad definition of mental health is necessary, one that goes beyond a simple clinical-based model. There were components focusing on the home, classroom, and school environments. Behavioral components were included to help teachers and students change behaviors. Providing instruction, assistance and support to teachers in the area of classroom behavioral management has been shown to be predictive of improvements in students' future behavior and academic performance (Atkins, Hoagwood, Kutash, & Seidman, 2010; LaRusso et al., 2009; Pianta & Allen, 2008). Integrating mental health providers into classrooms to serve as 'educational enhancers' tends to not only have benefits in terms of the improvement of implementation but with relationship building as well (Atkins et al., 2006; Atkins, Hoagwood, Kutash, & Seidman, 2010). Finally, since the school's primary focus is academic achievement a tutoring program was instituted to assist with the academic progress of students. Through the group work with middle school students, the HP doctoral student recognized a need to assist the students with homework. While assisting with homework is not a direct mental health intervention, the PLT determined that instituting a tutoring program would help students with their self-esteem and build further rapport with school personnel. With assistance from the doctoral student, the principal investigator recruited and trained undergraduate students as tutors. GCMS paid for criminal background checks and drug screenings. ECU provided academic credit for the tutors and the grant provided funds to reimburse tutors for transportation. This became an ongoing tutoring program which the middle school staff greatly appreciated and credited with improved end-of-grade testing scores. The principal of the middle school recognized the principal investigator and the tutors by presenting them with the "Volunteer of the Year Award".

Lesson #7

Parent involvement is often a major hurdle to overcome. Initial attempts to involve parents in the project produced little success. These efforts mirrored school personnel's difficulties in recruiting parents and maintaining their involvement. To address that barrier, dinner was provided with a presentation at a Parent Advisory Committee Meeting. During the dinner, suggestions from parents were requested. One parent suggested the idea of a "Family Fair." Thus, a "Family Fair" was planned on a Saturday just before the beginning of school and held at GCMS, providing educational and interactive activities for parents and their children. Parents were so responsive and excited about this event that two were planned, with over 30 parents and 30 children at each one. Each "Family Fair" involved recruiting and training ECU undergraduate student volunteers to conduct registration, provide activities while parents attended educational activities, serve food, and translate for Hispanic-speaking parents. Prior to the events, these volunteers also planned activities for these children, made signs, decorations and other materials, and solicited monetary and other donations (free items, gift certificates, etc.) from local businesses to use as raffle prizes.

Lesson #8

Poverty is often a significant issue facing the provision of mental health services in a rural county. Poverty stressors negatively affect physical health, mental health, and academic achievement (Richardson, 2007). Students in poverty frequently come to school ill-prepared to learn and face many challenges. In order to deal with the poverty of the students, the social worker was assisted in fund-raising projects that aided students. For Thanksgiving, the principal investigator recruited undergraduate ECU students to approach local food stores to obtain gift certificates for turkeys to donate to families at GCMS. At Christmas, the ECU team bought clothes for families to give their children and donated \$100 to a high school student who lost her grandmother and her home in a fire. At the family fairs, all the parents had the opportunity to obtain a basket of school supplies for their children.

Lesson #9

Gaining access to students who need to receive mental health counseling can be a significant challenge. Students have classes during the school day. In rural communities, school busses are the primary transportation to and from school. Therefore, it was not feasible for students to stay after school. This required some creative problem-solving. The doctoral student in the middle school addressed this issue by incorporating a literacy component in the group counseling sessions. Students were able to receive academic credit while participating in counseling sessions. The doctoral student also generated good will at the school due to her willingness to attend school meetings, participate in home visits, and proctor exams in response to requests from school personnel.

Lesson #10

Continuum of care is a difficult but necessary issue to address. The doctoral student counselors provided services only one day a week. Since this was a practicum placement, the doctoral student had classes to attend and/or another internship on other days of the week. Therefore, it was important to work closely with the existing student support staff (e.g., counselors, social workers, nurses) to address needs arising on the days when the doctoral student counselor was not available. The principal investigator and doctoral students had to become familiar with and follow the emergency policy and procedures of the schools. Consequently, the partners developed a plan to address student emergencies on days when the doctoral student counselors were not available. Of note is that the schools had to use the local mental health management entity's mobile crisis team only twice during the three years of the partnership.

Lesson #11

Finding a way to extend the impact of mental health counseling into the classroom is a crucial element to insuring success of the program. This was accomplished by communicating with teachers through email and sending them check sheets with specific problem behaviors that were identified in their referrals. Teachers were asked to provide feedback regarding these problem behaviors and on progress made by the students. Students were rewarded for changing behaviors in the counseling sessions and in the classroom with points exchangeable for small prizes (pencils, pens, candy, etc.). Teachers were rewarded for providing feedback with gift baskets and other small tokens of appreciation. At the end of every college semester (midyear and end-of-year), the school staff of both the middle and high schools had parties for the doctoral students (with lunch, cards, gifts, picture

taking, etc.) and the university staff provided treats for the school staff (specialty cupcakes, cookies, thank you cards, etc.).

Lesson #12

Rural, impoverished communities often experience more than their share of disasters. This was certainly true of GC. In the spring of the third year of the grant, a tornado destroyed the middle school. Occurring just before spring break meant that the students were out of school for an extra week. Other middle school students might have regarded this as a wonderful circumstance- an extra week of spring break! However, for many of these students, it was a difficult week in a tough environment without the support of peers and personnel at the middle school. Many also missed their therapists and tutors.

These extenuating circumstances required the project team to be flexible. A meeting with student support staff at the middle school determined needed resources and training. A faculty member from the ECU psychology department who was an expert on trauma came to the school to provide support and assistance. The principal investigator and this faculty member spent the day with the middle school teachers as they were salvaging what was left in their classrooms after the tornado, providing support and on-the-spot counseling. The principal investigator and two of the doctoral students were among several mental health volunteers who showed up on the first day back to school for students. Every volunteer wore a T-shirt donated by the ECU bookstore so they could be readily identified by students who were in need of counseling or just someone to talk to. The principal investigator donated wrist bands to all the middle and high school students bearing the principal's motto, "If it is to be, it is up to us."

Impact of the Partnership

Sustainability is an issue in rural communities. All too often, the community partners are provided with short-term programs that last maybe a semester or a year. The university partners leave and the community is left with no resources to continue the implementation of the program. Because the university, school, and student health center partners were committed to the partnership, efforts to continue the partnership were initiated early in the project. The principal investigator secured another grant, a four-year Title V federal grant. The director of the school-based health clinic, which has been funded by grants for nearly 30 years, identified grant monies to pay for doctoral students to continue to provide counseling for students. The school system continued to devote staff time and effort to the partnership.

At the onset of this project, several disciplines were involved from GCS, but psychology was the only discipline represented from ECU. As the grant progressed and during the continuation of the effort, other ECU departments became involved including: Rehabilitation Counseling (both faculty and students) and Counselor Education (student). Psychology doctoral students from a second university, Fielding Graduate University (FGU), were also involved.

Initially, grant funds accounted for half of the funding for student involvement in this project. The grant funded half of two doctoral assistantships enabling two doctoral students to provide counseling and consultation. It also funded half of a master's assistantship to assist with research. Now, ECU supports a third half-time assistantship and several additional students through practicum placements (for which students do not get paid). Additionally, FGU provides two doctoral internship students who also do not receive

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financial compensation. The school-based health clinic at GCHS also provides funding for one student to provide counseling each semester. The grant funded a private consultant to provide both counseling and behavioral consultation one day a week. After the grant, GCS hired this consultant and a behavioral assistant to that consultant for one day a week.

The involvement of ECU, FI and GCS combined with attainment of additional grant funding illustrates how the initial grant provided seed money that expanded the services as the partnership grew. The commitment to sustain the project by partners from all three agencies speaks to the quality and the depth of the partnership.

Project Outcomes

Availability (number and types of available services; how often and how long private practitioners, university faculty, graduate students, and undergraduate students were available at each school each semester providing services) and accessibility (number and types of services accessed/received; how often and for how long administrative/support staff, teachers, parents, and students accessed/received services) are delineated over the three year period in which the project was implemented (see Tables 1, 2, and 3).

The growth in the number, variety, frequency, and duration of services available indicates the increased capability and willingness of the university partners to make services available to the consumers and of the school partners to make space and provisions for the service providers. The growth in the number, variety, frequency, and duration of services accessed by the school partners/participants indicates their willingness to invest time and resources into consuming these services thereby acknowledging their value.

Acceptability (how satisfied those groups of consumers were with the services they accessed/received) is demonstrated by the following sampling of comments made by various partners/participants in response to several components of the project.

Counseling Program:

“The students served were very interested and engaged when they worked with Albee. [What I liked best about Albee was her] *can do* and *will do* attitude. She was a very willing collaborator and contributor to our team.” *Principal*

“The reasons these services and the partnership with the university is so vital is that most all of our students are economically disadvantaged...The services provided by our doctoral students have had a positive effect on our children and their learning capacity...These opportunities have increased their overall well-being beyond the classroom, and we continue to see improvement in many students’ attitude and effort in their studies, as well as in their relationships with their peers and teachers.” *Principal*

“The real impact of these sessions won’t be determined immediately; however, discipline and attendance of some of the students that were served did improve ...I strongly support this partnership and based on previous services feel it will have a positive impact on student outcomes...” *Principal*

Tutoring Program:

“I hope that we can continue this much needed and much appreciated service for years to come. The tutors who have come consistently have made a difference for our students. They also like the reward system that was set up.” *Assistant Principal*

“I have thoroughly enjoyed this experience...Tutoring the children in Greene County has been a very humbling experience...My experience tutoring...has been an enlightening

experience in which I learned valuable lessons about building relationships with others. Tutoring...this semester was a very rewarding experience that I learned a lot from...While I was attempting to inspire them in school they also seemed to inspire me.” 3 Undergraduate Students

Table 1
Service Providers, Availability, & Accessibility in the 2008/2009 School Year

2008-2009 School Year		
Training/Service Providers	Availability	Accessibility
ECU and other College Faculty	<i>Licensed Clinical Psychologist Supervisor: 2 hours per week for supervision and as needed for parent/ staff training</i> <i>Director of child psychiatry at ECU School of Medicine: 2 hours total for staff training</i>	<i>Licensed Clinical Psychologist Supervisor: Conducted focus group with 8 students in the SGA and 16 high school faculty and surveyed over 260 school personnel to assess need and promote awareness</i> Supervised doctoral student 3 hours per week for the school year Conducted 2 hour training for 30 student support staff Conducted parent education group for 3 parents of high school females <i>Director of child psychiatry at ECU School of Medicine: Conducted 2 hour training for 30 student support staff</i>
Clinical Psychological Associate	1.5 days a week for therapy at the high school-based clinic	Conducted therapy with 6 high school students
Psychology Doctoral Student(s)	<i>Pediatric School Psychology Doctoral Student: 1 day per week at elementary school</i>	<i>Pediatric School Psychology Doctoral Student: conducted therapy with 14 elementary and 1 middle school students</i>
Masters Student(s)	<i>Exercise and Sports Science Masters Student: 2 hours per week for 6 weeks for assessment and treatment</i>	<i>Exercise and Sports Science Masters Student: assessed 40 and provided treatment for 6 high school students who were sedentary and overweight</i>

Family Fair:

“I cannot tell you how valuable your information was to me. Last night I had the pleasure of having the best conversation with my son that I have had in at least three years. Thank you so, so, much.” *Parent*

“Just thought I would let you know, your info and my new skills (thanks to you) are still working. I am seriously impressed. In a new found thankfulness my son even thanked me for learning these skills.” *Same Parent, follow-up*

“Today, Brandy and I used your techniques on my 18 month old grandson Nicholas. He

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wouldn't eat and I told him I would take him to see the chickens (he loves them) if he would eat three bites. We used the excitement technique and he ate and ate much more than three bites. I have to tell you that I have loved watching your methods work last night and today. It is very close to magic." *Grandparent*

Table 2
Service Providers, Availability, & Accessibility in the 2009/2010 School Year

2009-2010 School Year		
Training/Service Providers	Availability	Accessibility
Clinical Psychological Associate	1 day a week for therapy and behavioral consultation at the middle school	worked with psychology doctoral student to conduct individual or group therapy for 36 middle school students, including contact with 25 teachers and 40 parents
Psychology Doctoral Student(s)	<i>Pediatric School Psychology Doctoral Student:</i> 1 day per week at high school for therapy <i>Pediatric School Psychology Doctoral Student:</i> 1 day per week during first semester, 2 days per week during second semester at middle school for therapy. <i>Pediatric School Psychology Doctoral Student:</i> 1 day per week at middle school for behavior consultation	<i>Pediatric School Psychology Doctoral Student:</i> conducted therapy for 17 high school students <i>Pediatric School Psychology Doctoral Student:</i> worked with clinical psychological associate to conduct individual or group therapy for 36 middle school students, including contact with 25 teachers and 40 parents <i>Pediatric School Psychology Doctoral Student:</i> conducted behavioral consultation with teachers affecting 183 middle school students
Masters/ other Graduate Student(s)	<i>Non-Degree Seeking Graduate Student:</i> ½ day every 2 weeks at middle school for behavior consultation	<i>Non-Degree Seeking Graduate Student:</i> conducted behavioral consultation with a speech therapist, special education teacher, and an aide for one special needs middle school child
Undergraduate Volunteers	<i>Volunteer Mentor:</i> available ½ day per week for one semester <i>Volunteer Tutors:</i> 8 undergraduate volunteers available 1-2 days per week.	<i>Volunteer Mentor:</i> spent ½ day per week mentoring one high school student. <i>Volunteer Tutors:</i> conducted academic tutoring 1-2 days per week for a semester for 14 middle school students

Table 3
 Service Providers, Availability, & Accessibility in the 2010/2011 School Year

2010-2011 School Year		
Training/Service Providers	Availability	Accessibility
ECU and other College Faculty	<p><i>Licensed Clinical Psychologist Supervisor:</i> 8 hours per week for supervision and as needed for parent/staff training</p> <p><i>ECU Child Psychiatry Faculty:</i> 1 day presentation on the signs and symptoms of mental illness and the development of a DVD of the presentation</p> <p><i>ECU Medical Communications Faculty:</i> one 6-hour day to create DVD</p> <p><i>Clinical Supervisor and ECU Psychology Faculty:</i> One 6-hour day for post-tornado trauma intervention</p> <p><i>North Carolina Wesleyan College Faculty:</i> one 6-hour day for presentation at the Family Fair</p>	<p><i>Licensed Clinical Psychologist Supervisor:</i> Supervised 8 hours per week for the school year</p> <p>Conducted training for over 315 faculty, staff, and administrators at the high school, middle school and elementary school</p> <p>Conducted training for 55 parents.</p> <p><i>ECU Child Psychiatry Faculty:</i> presented at the middle school about the signs and symptoms of mental illness for about 65 faculty</p> <p>Created a DVD of that presentation for about 60 people at both the high school and elementary</p> <p><i>ECU Medical Communications Faculty:</i> Created a DVD at the middle and high school which was shown to 65 faculty at the middle school</p> <p><i>Clinical Supervisor and ECU Psychology Faculty:</i> Provided post-tornado trauma intervention to approximately 85 administrative personnel, student support staff, and faculty in Greene County Schools.</p> <p><i>North Carolina Wesleyan College Faculty:</i> 1 day presentation at the Family Fair about Social Media for 20 parents and 29 children</p>
Clinical Psychological Associate	1 day a week for therapy and behavioral consultation at the middle school	Worked with 2 Pediatric School Psychology students to conduct individual or group therapy for 28 middle school students
Psychology Doctoral Student(s)	<p>Pediatric School Psychology Doctoral Student: 1 day per week at elementary school for therapy</p> <p>Pediatric School Psychology Doctoral Student: 1 day per week during first semester at middle school for therapy.</p> <p>Pediatric School Psychology Doctoral Student: 1 day per week during second semester at middle school for therapy</p> <p>Clinical health Psychology Doctoral Student: 1 day per week at the high school</p>	<p>Pediatric School Psychology Doctoral Students: 2 Pediatric School Psychology students worked with clinical psychological associate to conduct individual or group therapy for 28 middle school students</p> <p>Pediatric School Psychology Doctoral Student: provided individual therapy for 3 elementary school students</p> <p>Clinical health Psychology Doctoral Student: conducted therapy for 17 high school students</p>

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Table 3 Continued...

2010-2011 School Year		
Training/Service Providers	Availability	Accessibility
Masters/other Graduate Student(s)		
Undergraduate Volunteers	Volunteer Tutors: 35 undergraduate volunteers available 1-2 days per week. Family Fair Volunteers: 53 undergraduate volunteers for entire day of family fairs	Volunteer Tutors: conducted academic tutoring 1-2 days per week for 47 middle school students. Family Fair Volunteers: provided recreational activities and other services supporting the family fairs for 82 children.

Conclusion

Documented components of the success of SBMHS include the collaborative relationships that are developed among partners from various disciplines and agencies, services that respond to the identified needs of the community, emphasis on providing a continuum of services to address a variety of needs, and continuing evaluation of the effectiveness of the services provided (Weist & Albus, 2004; Owens, Himawan, & Abbott, 2008). Owens, Himawan, and Abbott (2008) conclude that the development of a partnership which includes effective communication, sharing of leadership, collaborative decision-making, mutual respect and trust across disciplines and agencies is a necessary prerequisite to successful implementation of school-based services. Several other researchers reached consensus that 'program champions' or administrators that are supportive and enthusiastic about the services being provided are another necessary prerequisite to successful implementation (Atkins et al., 2003; Kam, Greenberg, & Walls, 2003; Owens, Himawan, & Abbott, 2008). A key to success is that school personnel must experience "payback" for their efforts. Therefore, competent service providers are necessary to deliver interventions that are understandable and effective (Han & Weiss, 2005; Owens, Himawan, & Abbott, 2008). All of this was successfully accomplished in a partnership between a university and an impoverished rural community.

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