"AND KEEP THE CHANGE...": A SCHOOL-BASED COMMUNITY INTERVENTION MODEL

WITH A CASE STUDY FROM AN ULTRA-ORTHODOX/HASSIDIC JEWISH COMMUNITY

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ABSTRACT

Psychologists have long recognized the importance of schools to prevention and intervention efforts with children and families and to overcoming some of the powerful obstacles to their treatment. However, even as the targets of school-based mental health services have progressed from individual assessment and counseling to broad, school-wide programs and school-community partnerships, their outcomes generally remain conceptualized according to individual-student educational and developmental dimensions. For those concerned with schools and interventions, and who have followed the field’s steps toward more systemic, ecological initiatives, the multilevel, community-based, culturally situated (MCBCS) model being pioneered by Schensul and Trickett (2009) represents a conceptual and procedural revolution with the potential to spur a leap in the direction of interventions with multi- and community-level outcomes. The school-based community intervention (SBCI) model extends Schensul and Trickett’s model to a school context, using it to guide collaborative school community interventions that are designed to create sustainable change and capacity at multiple levels of the community. This approach can be particularly useful in situations where schools and the community have historically resisted traditional psychological interventions and programmatic change efforts, and represents a novel approach to that well-documented
challenge. This thesis presents an overview of barriers to care, school- and community-based solutions to them, and the foundations of the MCBS model. It then proposes and outlines the SBCI model as a method of introducing change into a resistant community. A case study will illustrate the SBCI model as implemented through a school-based mental health program servicing the highly insular Ultra-Orthodox and Hassidic Jewish population of Rockland County, NY. The conclusion examines the implications for school psychology research and practice and delineates how the model piloted in this project can be empirically tested.
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TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Previous Literature</td>
<td>2</td>
</tr>
<tr>
<td>Service Gap</td>
<td>2</td>
</tr>
<tr>
<td>Pathways to Care</td>
<td>2</td>
</tr>
<tr>
<td>Community Based Interventions</td>
<td>4</td>
</tr>
<tr>
<td>Schools</td>
<td>6</td>
</tr>
<tr>
<td>School-Based Community Interventions</td>
<td>8</td>
</tr>
<tr>
<td>The Multilevel, Community-Based, Culturally Situated (MCBCS) Model</td>
<td>9</td>
</tr>
<tr>
<td>Schools in a Multilevel Context</td>
<td>10</td>
</tr>
<tr>
<td>II. OPERATIONALIZATION</td>
<td>12</td>
</tr>
<tr>
<td>Overview</td>
<td>12</td>
</tr>
<tr>
<td>SBCI Framework</td>
<td>12</td>
</tr>
<tr>
<td>Multilevel Structure and Goals</td>
<td>12</td>
</tr>
<tr>
<td>Pre-Entry Phase</td>
<td>14</td>
</tr>
<tr>
<td>Stage 1: Ethnography</td>
<td>14</td>
</tr>
<tr>
<td>Stage 2: Partnering</td>
<td>17</td>
</tr>
<tr>
<td>Service Delivery Phase</td>
<td>19</td>
</tr>
<tr>
<td>Stage 3: Intervention Setup/Individual Service</td>
<td>19</td>
</tr>
</tbody>
</table>
Stage 4: Clinician Integration .......................... 22
Stage 5: Ownership ...................................... 24
Scaling Up Phase ........................................... 25
Stage 6: School Network-Building .................... 25
Stage 7: Cross-Level Problem-Solving ............... 26
Impact Phase ............................................... 27
Stage 8: Readiness and Capacity ...................... 27

III. CASE STUDY ........................................... 29
Introduction ............................................... 30
Organizational Setting .................................. 30
Problem ..................................................... 32
Context Description ..................................... 33
Pre-Entry Phase .......................................... 45
Ethnography ............................................... 45
Partnering .................................................. 48
Service Delivery Phase .................................. 50
Intervention Setup ....................................... 50
Service Modality ......................................... 51
Clinician Integration ..................................... 52
Ownership .................................................. 53
Scaling Up Phase .......................................... 56
School Network Building ............................... 56
Cross-Sector Network Building ...................... 58
Impact Phase ............................................... 62
Indicators of Change ..................................... 62
Readiness .................................................... 68
IV. DISCUSSION .................................... 70

Limitations and Suggestions for Future Research ...... 72

   Barriers to Implementation .......................... 72

   Empirical Validation ............................... 73

Changing Schools’ Perspectives and Roles ............... 75

REFERENCES .......................................... 80

APPENDICES .......................................... 92
LIST OF FIGURES

Figure 1: Bikur Cholim organizational chart................. pg 24

Figure 2: Percentage of schools served by mental health professional, by number of years........................ pg 40

Figure 3: Attitudes toward counselor in school, before and after 08-09 school year, by faculty role ......................... pg 49

Figure 4: Attitudes toward counselor in school, by number of previous years served................................. pg.50
CHAPTER I

INTRODUCTION

“Giving psychology away,” said George Miller (1969, p. 1071) is “no simple task.” Deep resistance to psychological innovations and vast disparities between mental health needs and treatment rates threaten to “undercut any potential public health returns on the incalculable investment of resources” (Ozechowski & Waldron, 2008) made by our society in effective mental health programs and interventions. This thesis presents a brief overview of some of the major obstacles in the “struggle to advance psychology as a means of promoting human welfare” (Miller, 1969, p. 1074) through individual treatment and systemic community initiatives. It discusses the role that schools have played in that struggle, as settings for both implementation of and resistance to innovation, and as contexts that enable circumvention of barriers to care. Finally, the thesis presents a proposal, based on the multi-systems, community-based culturally situated intervention model, for utilizing interventions in school settings to introduce change to an entire community. A case illustration is presented using a school-based counseling program for Ultra-Orthodox and Hassidic Jewish schools in Rockland County, NY. The conclusion examines the implications
for school psychology research and practice and delineates how the model piloted in this project can be empirically tested.

Previous Literature

Service Gap

Mental health’s vast “service gap” (Stefl & Prosperi, 1985) has been a focus of the literature for over half a century (Demyttenaere et al., 2004; Holingshead & Redlich, 1958; Kataoka, Zhang, & Wells, 2002; Kessler et al., 1999; Robins & Regier, DA, 1991; Wang et al., 2005) and the subject of several alarming government reports (National Institute of Mental Health and National Institutes of Health, 1999; President’s New Freedom Commission on Mental Health, 2003). Most adults, and close to 80% of children, with mental health needs receive no care, and many more receive care that is inadequate, or delayed. Even as rates of service utilization increase for the overall population, the gap for ethnic minorities and other underserved populations continues to grow (Wang et al., 2005).

Pathways to Care

In Goldberg and Huxley’s “pathways to care” model (1980), individuals who experience psychological problems must cross multiple “filters” at the intersections of progressive “levels” between the community and treatment (Goldberg & Huxley, 1980; Pavuluri, Luk, & McGee, 1996). Research has identified a range of barriers, both structural and perceptual, that might obstruct the progression toward care at multiple points on that path and
impede treatment (e.g. Kataoka, Zhang, & Wells, 2002; Wang et al., 2005)

The first “filter” is problem identification on the part of individuals. How do they conceptualized the existence of a problem, attribute cause, and consider viable solutions? Barriers that arise at this initial point can include unawareness of symptom severity, cultural differences in behavior norms and thresholds, and religiously- or culturally-shaped explanatory models of distress that dictate non-psychological means of treatment. Even when individuals decide that they wish to pursue some mental health-related solution to an identified problem, other obstacles emerge.

Individuals’ subsequent decisions to actually seek help can be subject to real or perceived structural obstacles, such as: (a) not knowing where to access care (Kazdin, Holland, Crowley, & Breton, 1999; Kessler & Merikangas, 2004; Ozechowski & Waldron, 2008), (b) believing that no one can help (Pavuluri et al., 1996) (c) lacking insurance coverage and/or funds to cover care (Dohrenwend, 1990; Kataoka, Zhang, & Wells, 2002; Wang et al., 2005), or (d) lacking accessible care facilities (Costello, Copeland, Cowell, & Keeler, 2007). Help-seeking decisions are also affected by beliefs and perceptions. Widely held reservations regarding psychological treatment include reluctance to share personal information, concerns over confidentiality (Owens et al., 2002; Pavuluri et al., 1996; Pescosolido, Perry, Martin, Mcleod, & Jensen, 2007), and the real possibility of
stigma (Pescosolido et al., 2007; President’s New Freedom Commission on Mental Health 2003; Rochlen, Whilde, & Hoyer, 2005; Sartorius, 1998; U.S. Surgeon General, 2000; World Psychiatric Association, 1996). Community-specific examples of reluctance include ethnic minority communities’ experiences and anticipation of mistreatment (McLean & Campbell, 2003) in mental health settings and religious communities’ objections to certain philosophical underpinnings of psychology and fear of clinicians’ expressing Freudian hostility to religion.

Psychoeducation and Outreach to Overcome Obstacles

Successful psychoeducational programs such as Alvidrez’s stigma reduction intervention (2005) and the “Real Men, Real Depression” program (Rochlen et al., 2005) have been based on findings that many internal barriers to help seeking are reduced with increased exposure to psychological concepts and prior treatment experiences of one’s own or of one’s friends or family (Hartog & Gow, 2005; Pescosolido et al., 2007; Turner & Liew, 2009). More active approaches include increasing communication between patients and providers, expanded “assertive outreach” programs to reach wider populations and more underserved areas, and the ambitious goal of developing new means of financing mental health services.

Community Based Interventions

The previous approaches start with an existing intervention, aiming to increase access and utilization for individuals in the community. In community psychology the process
is reversed. The starting point is the individual in context; the ensuing, community-based interventions target the individual and the context by focusing on features of the community that can enhance and empower the lives of local citizens (Trickett, 2009a). Community-based interventions are systematic, “planned change” efforts (Schensul, 2009, p. 242) that address local concerns and wellness goals (Trickett, 2009b), prevent disorders (Elias, 1987), empower marginalized groups (Ife, 2002; Prilleltensky & Prilleltensky, 2006; Watts & Flanagan, 2007), and increase capacity for improving wellbeing (Trickett, 2009a) in settings and communities.

Many of the barriers to individual care are avoided in community-based interventions. Community psychology’s bottom-up approach, shaped by its ecological perspective (Kelly, 1968, 2006; Trickett, 2005), participatory approach to planning, and implementing, and studying interventions (e.g., Jason et al., 2004; Wandersman, Kloos, Linney, & Shinn, 2005), and social justice ethic (Rappaport, 1981; Nelson & Prilleltensky, 2004), is much more sensitive to “unheard voices,” and to systematic exclusion and environmental obstacles to resources. The core community psychology concept of prevention (e.g., Cowen, 1991; Greenberg et al., 2003; Stith et al., 2006; Trickett, 1997) was first notion introduced to mental health (Caplan, 1961) because of the inefficiency, inequity, and unfeasibility of providing care based on individually identified need (Albee, 1959, 1968).
Nevertheless, these interventions are subject to their own structural, systemic, and historical sources of resistance forces of resistance that are almost more powerful than forces of change (Beehr, 2002; Nelson & Prilleltensky, 2004; Weick & Quinn, 1999). By their definition, community-based interventions are implemented in collaboration with existing community systems that have their own organizational cultures, webs of interdependence, and patterns of adaptation. Interventions “planned intrusions into the ongoing cultural mores, traditions, institutional arrangements, and locally defined hopes for the future” of the settings in which they are carried out (Trickett, 2009b, p. 259). Individuals are often complacent and/or reluctant to risk the marginalization, labeling, and exclusion that might face challengers of the status quo (Nelson & Prilleltensky, 2004). “Closed systems” might be poorly suited for change, while systems that are too “open,” such as public schools, might have had so much change imposed on them that they resent and resist new efforts (Sarason, 1996). Communities might actively resist adaptation to change, especially if perceived as externally imposed, if they view themselves as oppressed or otherwise threatened by the dominant culture (Sonn & Fisher, 1998).

Schools

Schools represent key settings for children’s development that offer professionals unique access to both children and parents as the “the one community agency in our society that maintains contact with the entire population of children
(excluding, of course, those attending private schools) and which has the potential for contact with the families of these children” (Meyers, Gaughan, & Pitt, 1990, p. 199). They have long been utilized as advantageous contexts for providing psychological services to individuals and families who are unable or uncomfortable seeking treatment from traditional settings (Eiraldi, Mazzuca, Clarke, & Power, 2006; Gresham, 2004; Harrison, Mckay, & Bannon, 2004; Rones & Hoagwood, 2000). The literature has continually broadened its view of the possibilities for mental health services in the schools, all focused on improving students’ educational and developmental outcomes. School psychology, public health, and community psychology researchers have urged school-employed mental health professionals to adopt ecological and systemic perspectives both on what goes on within the school (Adelman & Taylor, 2006; Bowen, 2007; Branden-Muller & Elias, 1991; Ehrhardt-Padgett, Hatzichristou, Kitson, & Meyers, 2003; Greenberg et al., 2003; Weist et al., 2005) and on the school’s place within a broader social context of the community (Bowen & Richman, 2002; Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008; Hoagwood & Johnson, 2003; Natasi, 2000; Sarason & Klaber, 1985).

A wide range of school-based prevention and positive youth development programs have been demonstrated to effectively improve students’ academic, social, and emotional outcomes (Ross, Powell, & Elias, 2002; Shinn & Yoshikawa, 2008; Weissberg & O’Brien, 2004). Researchers in school improvement, public health,
and school psychology have developed school-community-parent partnerships that include families, community members, businesses, and other organizations (Adelman & Adelman, 2000; Anderson-Butcher et al., 2008; Bryan, 2005; Elias, Patrikakou, & Weissberg, 2007; Shaul, 2000; Smith, Connell, Wright, Sizer, & Norman, 1997). Collaborations between local mental health agencies have been advanced by Weist (1997), and include various configurations for supporting and expanding the work of the school-employed professionals, including school-based and school-linked mental health programs and all-in-one schools (Adelman, 1993; Meyers & Swerdlik, 2003; Osher & Keenan, 2002; Prodente, Sander, & Weist, 2002; Rones & Hoagwood, 2000; United States Public Health Service, 2000; Waxman, Weist, & Benson, 1999; Weist et al., 2005).

School-Based Community Interventions

Those concerned with schools and interventions have followed the field’s steps toward more systemic, ecological initiatives. The multilevel, community-based, culturally situated (MCBCS) model being pioneered by Schensul and Trickett (2009) represents a conceptual and procedural revolution with the potential to spur a leap in that direction. Applied to school-based interventions, Schensul and Trickett’s model offers a framework within which schools partner with communities to expand the scope not only of their programs’ “units of intervention,” but of their “units of analysis,” as well. The outcomes of these “school-based community interventions” are measurable not only
in terms of individual student progress, but also in terms of "second-order" (Watzlawick, Weakland, & Fisch, 1974) changes in the goals, roles, and power relationships (Dalton, Elias, & Wandersman, 2007; Linney, 1990; Seidman, 1988) within the whole community.

The Multilevel, Community-Based, Culturally Situated (MCBCS) Model

The MCBCS perspective looks at specific interventions as each being "events within systems" (Hawe, Shiell, & Riley, 2009); the true target of change efforts is the "whole community". Rooted in Bronfenbrenner’s (1979, 1989) ecological model that views individual status and well-being within the context of dynamically interrelated structural or social "levels," it seeks to simultaneously and synergistically address change at multiple levels within the community. This approach recognizes that successful change at one part of a system will depend on other forces throughout the system and, in turn, affect those very forces. It allows, indeed demands of, interveners to take a comprehensive look at the community in all its levels in order to choose a starting point for intervention that has the most likelihood of success both at the specific level at which it is implemented and throughout the other levels of the system (Schensul, 2009).

Key elements of this model include: (a) a "dynamic, ecological systems perspective [that] stresses the importance, among other things, of linkages, relationships, feedback loops
and interactions among the system’s parts” (Hawe et al., 2009, p 269); (b) the emphasis on ethnographic and participatory action research methods to develop “local knowledge” of the setting and its culture, history, and social structure; (c) the belief that positive change consists of new relationships, resources, and readiness for further change (Trickett, 2009b), and that empowerment is both a process and an outcome of community interventions (Sofear, 2000)

Schools in a Multilevel Context

In this framework, school-based interventions represent “but one element in [the] larger network of action” (Braa, Monteiro, & Sahay, 2004; Schensul, 2009) within their community context. Within each school or school system, culture, micro-politics, and cycling of resources are all linked to larger community forces that must be understood and appreciated. Conversely, changes made to structures, procedures, and attitudes within schools impact other ecological levels in ways that can be harnessed and coordinated with other efforts and existing community strengths and resources to synergistically maximize outcomes, dissemination, and sustainability.

This approach can be particularly useful in situations where schools and the community have historically resisted traditional psychological interventions and programmatic change efforts, and represents a novel approach to that well-documented challenge. The following chapter presents the key aspects of the framework within which this intervention is proposed, the multi-
systems, community-based, culturally situated (MCBCS) model, and describes how school-based programs can use that framework to effect change within an entire community. This is followed by a case illustration using a program servicing the insular Ultra-Orthodox and Hassidic Jewish population in New York.
CHAPTER II

OPERATIONALIZATION

Overview

SBCI Framework

The school-based community intervention (SBCI) framework is rooted in Schensul and Trickett’s multi-level community based culturally situated intervention model (Hawe et al., 2009; Schensul, 2009; Schensul & Trickett, 2009; Trickett, 2009b). Rather than a prescriptive model, it is a heuristic guide to aid the process of developing community interventions through the schools.

SBCI consists of eight phases. To stress the importance of remembering the “big picture,” they have been organized by the mnemonic “EPIC OSCaR”:

1. Ethnography
2. Partnering
3. Intervention Setup and service delivery
4. Counselor integration
5. Ownership
6. School network-building
7. Cross-network problem-solving, and
8. Readiness

Multilevel Structure and Goals

Interventions, from an ecologically based perspective, can achieve multilevel goals without necessarily being multilevel in
their preliminary actions (Trickett, 2009). By utilizing the substantial interdependence between community members and their environment, multilevel community-based interventions can effect positive outcomes in a target population while simultaneously creating collaborative, empowering relationships among the groups, organizations, and community members whom the interventions involve (Best et al., 2003; Kelly, 2006).

School-based initiatives that are developed within a multilevel community framework resemble traditional school-based programs in the way that they target individual, or groups of, students with their intervention delivery. Being multilevel, however, those interventions differ in that they are designed to not only use schools for their implementational value as intervention sites, but also to utilize schools’ socio-cultural centrality within the community in order to maximize the impact of the intervention as a whole. Schools represent the embodiment of communities’ hopes for their own futures and for those of their respective value systems. This makes schools powerful “cultural hooks” (c.f., Schensul et al., 2009): entities whose existing cultural value can be leveraged by planners to increase the prominence of additional, less prominent bodies or issues related to the intervention.

SBCI planners can attract individuals and groups from a range of community levels and sectors whose individual positions and interests variously intersect those of the school systems. This enables them to facilitate second-order community change by
organizing this new body of stakeholders and guiding it through a process of problem-solving that provides its members with the resources and readiness to engage in future problem-solving (Trickett, 2009b).

In addition, by framing community mental health issues as specific school-based issues rather than as broad, community problems, SBCI planners avoid some of the defensive resistance that is often spurred by sweeping community critiques.

Pre-Entry Phase

Stage 1: Ethnography

The Ethnographic Inquiry Process

Perhaps the most fundamental component of SBCI is that it be planned and implemented based on thorough, nuanced, appreciation of the local community context (Trickett, 2009). Although the intervention is designed to be implemented by a community mental health agency—alone or with community consultants—implementers must not assume that their being located within or serving the community will provide them with the necessary ecological appreciation. That level of understanding is best obtained, and most effectively described and monitored, using ethnography (Schensul, 2009). Ethnographic research allows the intervention team to learn how to become true community “insiders” by building reciprocal, trusting relationships and developing local knowledge of the community’s culture, politics, economy, history and institutions (Schensul, 2009). The team immerses itself in numerous facets of community life while
simultaneously stepping back to reflect. As team members amass “samples” of experiences, interactions, and observations—through participant observation, surveys, in-depth interviews, and other methods of qualitative inquiry—they share and reflect on their findings and check them with local “experts” to construct a cohesive and authentic model of the local community from the perspective of its members (Le Compte & Schensul, 1999).

**Ethnographic Goals**

*Understanding community culture.* One goal of the ethnographic process is to develop a deep appreciation for the local culture. This helps intervention developers to identify target issues that are important to community members—both collaborators and recipients—and to increase buy-in and effectiveness by creating interventions that are culturally sensitive and meaningful. To develop that appreciation, the intervention team studies local beliefs, norms, practices and rituals, history, and linguistic dynamics. They explore the community’s attitudes toward mental health wellness and identify social, cultural, and religious sources of mental health-related stigma. The team also seeks to determine the value that the culture places on schooling, and the specific socialization, academic, and religious functions that schools and educators assume. This inquiry also looks at relevant cultural differences within the community. In communities that appear to outsiders as more homogenous, those differences might require some degree of cultural fluency to discern. Intervention developers should be
able to identify the culturally distinguishing issues and to understand how the various local schools and their populations reflect those differences.

Understanding community social ecology. Another goal in studying the community's ecology is to develop and articulate a “multilevel conception of community life” (Trickett 2009, pg 261). This requires identifying the networks, organizations, regulatory bodies, policy makers, and power brokers that influence and are intersected by community residents. By the end of this process, the team will have identified a number of interested and well-networked networked potential allies and other individual, organizational, and environmental resources that can facilitate change.

Understanding schools in communities. Particular attention is devoted in this regard to the position that schools hold within the community system. This includes consideration of the extent of schools’ interdependence within the community system, through other schools, community organizations, government agencies, religious institutions, school districts, and parents and parent groups. It also involves understanding the cycling of community resources to schools as well as the patterns of schools’ adaptations to changing district requirements or student makeup, school systems’ responses to changes in government requirements (Dalton et al., 2007), and community adaptations to school changes.
In addition to schools’ context within the grounded-community ecology, interventionists seek to understand their interdependence with the non-local, organizational communities within which they are also embedded (Arum, 2000). These “organizational fields” (Warren, 1967; Scott, 1994) are comprised of structurally equivalent institutions (e.g., other schools) or intersecting bodies (e.g., regulating agencies, union associations, and professional schools). They help shape schools’ resource allocations, diffusion of innovations, and educational policy—often more than local community forces—through court actions, state statutes, federal legislation, and union negotiations (Arum, 2000).

Stage 2: Partnering

The next phase of the SBCI process builds upon the insights and relationships that were developed in the ethnographic process. Using its newly acquired cultural understanding and “ecological map,” the intervention team identifies various individuals, groups, and organizations as potential partners for the upcoming stages.

Community partners. Planners seek specifically to identify “front line problem-solvers” community members at various ecological levels whose professional or lay work is located at the boundaries across which communities or constituents interface to confront differences. These individuals can be community organizers, politicians, educators, or religious leaders. They serve as key sources of innovation and information and are
important components of community-wide change (Agar 2007; Hawe et al. 1997; Hawe and Shiell 2000). Potential partners within the larger community system are identified based on their own, personal characteristics and those of the organizations to which they belong. These can include interest in the intervention topic, understanding of the relevant community ecology, and communal influence and connectedness.

School system partners. Partnerships with the school systems are initially formed around the service delivery component of the intervention, but are developed with an eye toward continued, second-order change. Selecting school partners requires a nuanced understanding of the individual schools’ places within the external, system- and community-wide sociopolitical dynamics. It also requires understanding of those schools’ internal dynamics (Harding, 2004; Jordan et al., 2005). Schools that are likely to readily embrace the services have value as partners in the initial stages, as they allow for early success and a “safe” rollout of services. However, in resistant communities such open-minded schools might stand outside of the insular core that the model aims to influence. More valuable to this process are the schools that are embedded within community segments that have previously been obstacles to change (c.f. Lewin, 1947). Those schools—assuming that their administration and teachers are motivated and parents are minimally engaged—have strong potential for transforming resistance to mental health
help into influential support if they can be convinced to participate.

Service Delivery Phase

Stage 3: Intervention Setup/Individual Service

The two primary goals of this stage are: (a) to build capacity for mental health promotion in schools by developing mental health-related roles among school personnel, creating activity settings for service provision, and paving pathways to mental healthcare for students and families; and (b) to begin exposing parents, students, and school stakeholders to mental health providers and services.

It is at this stage, as well, that the divergence between the intervention’s direct targets of action and its goals for more extensive and extended impact becomes more recognizable. From an ecological systems perspective, individual units of intervention such as counseling, consultation, or prevention group sessions, in and of themselves—even if they are effective—provide only collateral benefit. Their real relevance is as events (Hawe et al., 2009), in context of the school systems in which they are performed, and within their larger community suprasystems.

Service Modality

The actual format and modality of initial service delivery will depend greatly on the individual schools in which they are provided. Of course, schools should be encouraged to utilize services that are efficient and evidence-based. However, methods
that are optimal in some, or even most, settings might not be acceptable or appropriate in others. Planners and counselors will therefore make such choices together with the school representatives taking into account the schools’ needs, the cultures of the school and the parent body, and the school structure.

For example, schools that have never before employed a mental health professional and whose parent bodies belong to cultures that are resistant to psychological services might have to initially set up the services in a more supportive model rather than one that addresses specific pathologies. Schools in insular communities, where resistance to mental health services arises from fear of stigma and concerns over confidentiality might be averse to group-based services. Religious schools might be comfortable with counselors “fixing” their “problem” children, but might be more reticent with regard to consultation, where the professionals, who might not be perceived as appreciating the educational mission of the school, are providing input into the students’ education.

Delivery Considerations

Regardless of the specific intervention or program that is implemented, it must be planned and implemented in a way that allows the service to become integrated within the culture of the school such that it is sustainable and has maximal impact. This requires that planners connect the service delivery and planning with some aspect of the existing infrastructure of the school.
For instance, a counseling program might specify an administrator or influential teacher to be the liaison between the school and the intervention team. This has practical benefits in terms of coordinating referrals and navigating the logistical and micro-political landscape of the school. However, it also represents the expansion of an existing school role to include mental health functions such that those functions can become permanently integrated within the school activities and culture.

Additionally, whatever form of intervention is delivered, it should be structured in a way that includes parents. Beyond the value of parental involvement for the services themselves, this component creates a context for later work toward empowerment parents and involving them in participatory communal research.

Service Impact

In the context of the wider intervention, however, the specific elements of how the services are initially delivered are less important than that they are in fact being delivered and having an impact across the school system. Bringing mental health services into schools that previously did not have them means creating new activity settings, or time- and space-bound behavior patterns (Hawe et al., 2009), within the school structure, such as counseling sessions, group meetings, consultation contexts, referral procedures, and monitoring processes. As these patterns become routinized, their regular participants will develop roles, interpersonal relationships, symbols and intersubjective meanings
related to their mental health and support functions (O’Donnell, Tharp, & Wilson, 1993).

However, these changes are not limited to the specific participants. While the activity settings might be relatively circumscribed, schools are ecological systems whose different parts form relationships, interactions, and feedback loops that follow the principles of system dynamics (Hawe et al., 2009; Trickett & Birman, 1989; Trickett, Kelly, & Todd, 1972). The very exposure of faculty and students to these services being performed with others can, over time change the school’s general sense of “how we gets things done here” (Krueger & Parish, 1982, p. 133) in a way that includes utilizing mental health services both in and out of school. That exposure will also influence parents, faculty members, and other stakeholders to more readily utilize mental health services for themselves and their own families.

Stage 4: Clinician Integration

Extended Ethnographic Inquiry

The clinician integration process is in many ways a micro-systemic mirror of the initial ethnography stage. During this process, the clinician (or counselor, consultant, etc., depending on the professional role assumed) works to build trust, deepen relationships, and become embedded within the culture and social network of the school. This allows the clinician to more thoroughly integrate his or her work within the overall function and mission of the school, making it both more effective and more
likely to be sustained. It also helps deepen the sense of alliance between the school and the planning agency as organizations, and between the clinician and administrators as individuals.

This integration and alliance will be crucial for subsequent scaling-up efforts that will call upon schools and administrators to expand their involvement in the intervention in ways that they might be reluctant to without the encouragement and support of trusted allies. Becoming an insider within the school also allows the clinician to expand the team’s initial ethnographic inquiry to include a closer focus on the schools. Embedded clinicians gain new insight into how members of their school system see the community from their unique perspective. They are able to appreciate intergroup dynamics that are not obvious to outsiders but that powerfully shape school cultures and often reflect larger group conflicts within the community.

Ethnographic Intervention Evaluation

At this stage, clinicians are also positioned to begin the continual process of ethnographic evaluation of the intervention. This process, as Schensul describes (2009, pg. 245), involves producing observations about the “interactions of ‘units’ (people, organizations and material culture)” related to the intervention. It also involves studying the “emergent processes of adoption, adaptation, implementation and sustainability” in relation to the intervention’s complex and changing social context (Schensul, 2009, p. 245).
Process Considerations

Individual-school systems are far more closed than their community suprasystems, and becoming integrated within them will present clinicians with challenges that they and the intervention planners did not face during the initial, formative ethnography process. The very entry of a clinician into a school can throw that system into disequilibrium that might be met with unsupportive responses from the school system, such as closely monitoring or, alternatively, ignoring the clinician and exerting various forms of pressure on him or her to conform to the school’s cultural norms (Reiger & Hamilton, 2008). Clinicians will have to work at actively building trust among school personnel by developing relationships and showing understanding and respect for existing school culture before they can begin to introduce systematic change.

Stage 5: Ownership

In order for an externally developed program to be sustainable, it needs to become institutionalized within its implementation setting. Schools can be said to be “taking ownership” of an intervention or program when they embed it in their organizational context and routine by increasing the intervention’s extensiveness across the organization (Yin, 1979). This can be accomplished by schools’ putting their logo on program-related materials or sending relevant correspondence on school stationary, including clinicians in school meetings and
functions, and beginning to fund the program on their own budget cycles.

Related to this is the degree of intensiveness of the intervention’s integration within schools’ routines and procedures (Yin, 1979). For instance, does an intervention become part of the standard behavior support protocol? Are teachers promoting or hindering its optimal implementation? Is there regularly allocated time and space for the program (Hawe, 2009)?

**Scaling Up Phase**

*Stage 6: School Network-Building*

This stage marks the beginning of the scaling up portion of the SBCI process. After having dealt with individual schools in the last several stages, the remaining stages return to the community-level focus of the beginning steps by involving multiple sites, broader ecological levels, and cross-domain collaboration.

Once multiple schools have been established as intervention sites, they can be organized to form a new network around school and mental health-related issues. This will typically take the form of periodic administrators’ meetings facilitated by the planning team who guides participants in joint problem-solving regarding mental health and wellness and—with, perhaps some prodding—prevention-related issues. This collaboration increases interdependence between individual schools, allowing them to share information, ideas, social capital, and other resources with one another, and increasing schools’ abilities to develop
data and attract external funding. This network can also serve a socializing function for schools that join the program in future years by providing models of schools that have successfully implemented the program or intervention. This group will also form the basis for later cross-network problem solving.

It is important at this stage to be aware of underlying power differentials within the community that might be reflected within the groups. For example, in insular or resistant communities, the schools that are generally more open to outside innovation might have existing access to resources that the others do not. They might be early adopters of the planners’ program and might be subtly hostile to the involvement of more conservative groups. Planners must be mindful of not reinforcing existing divides or disempowerment.

**Stage 7: Cross-Level Problem-Solving**

The work at this stage is no longer focused on a particular level within the community system. Rather, it pertains to the essence of the dynamic community system: the interaction between the multiple components. The goal of this stage is to increase interdependence in the community between the school system, protective service sector settings, and organizations dedicated to children’s and families’ overall wellness. The work here also seeks to strengthen ties between community-based organizations and specialized expertise outside the community.

To support this cross-level interaction, planners bring together representatives from various sectors, at multiple levels
within the community, who address child and family wellness issues to problem-solve collaboratively regarding community issues. This cultural problem solving process (Forde et al., 2006) stimulates second-order change in the form of emerging organization, in which agents’ new interactions lead them to “reweave” their “webs of beliefs and habits of action” (Tsoukas & Chia, 2002, pg. 576). Planners facilitate this change by helping to make participants’ implicit local knowledge—both existing and emerging—explicit. They moderate process discussions about participants’ respective institutional standpoints and their current and potential roles in addressing relevant community issues, both as institutional representatives and as individuals.

Impact Phase

Stage 8: Readiness and Capacity

Once the SBCI has been fully implemented, its success is ultimately measured by the increase in readiness and capacity in the target community. Community capacity, writes Trickett, “is reflected in the creation or development of structures, processes, and networks of relationships that promote organized action with respect to community issues” (Trickett 2009b, pg 411). In SBCI, those and other forms of resource development can be seen on multiple ecological levels, across community sectors.

A successful SBCI creates new roles within schools and other community settings related to promoting wellness and mental health while elevating the prominence of mental health professionals and others already addressing those issues. It also
creates new settings for increased interdependence among individual schools and between schools and other community organizations, programs and service sectors dedicated to child and family wellness.

Through exposure to effective, culturally sensitive services and clinicians, a successful SBCI helps to reduce cultural and institutional resistance to change and to psychological services and innovations. By providing services and referrals in schools such an intervention also creates new pathways to the community’s social and preventive services, while strengthening existing pathways. It also enhances protective factors and reduces risk factors within school settings through improved school and classroom climate, organizational functioning, and teacher and administrator competency.

Successful SBCI’s also empower community agents to continue the processes of change. They activate parents and other competent citizens to participate in school-related activities and in broader community development, and they facilitate “community level learning” (Trickett & Espino, 2004) to help further develop collaborative relationships and select the best individuals for various roles in future interventions.
CHAPTER III

CASE STUDY

The following chapter describes an implementation of SBCI in the Orthodox Jewish community of Rockland County, New York. The intervention was planned and carried out by members of the School-Based Services (SBS) program of the Center for Applied Psychology (CAPs). Unless otherwise indicated, all data refer to the 2008-2009 school year and to the schools that were program participants at that time.

In this case presentation, broader descriptions of processes are highlighted by anecdotal accounts of individual events. This approach rests on the recognition of "the rich learning potential of any single encounter" that underlies all case-based, idiographic, and narrative research (Hess, 2005, p. 247). This format is particularly suited to multilevel interventions, because, as Trickett points out (2009), from an ecological perspective, they "involve far more than the specific development of activities and the assessment of their implementation and outcome. Rather, they involve a host of differing actions and interactions that, taken together, tell the story of the intervention in community context (p. 264)."
Also note that, while the setting descriptions that precede the intervention account were, in fact, borne largely from the ethnographic inquiry stage of the intervention, they are included here out of sequence, prior to the account of the ethnographic process in order to provide the reader with context and to avoid breaking up the intervention account.

Introduction

Organizational Setting

Bikur Cholim

Bikur Cholim of Rockland County-Partners in Health (Figure 1) is a social services organization serving the Orthodox Jewish community of greater Monsey, NY. Its original and primary mission is to address the needs of community members that require medical care. Such services include medical referrals, transportation,
medical equipment loans, and lodging and kosher food for relatives of hospital patients. In addition, Bikur Cholim includes two subdivisions, the Center for Applied Psychology (CAPs) a mental health clinic described below, and Yedei Chesed (which translates to “hands of kindness”), which services individuals with developmental disabilities from early childhood through adulthood.

**CAPs and the SBS Program**

CAPs is a division of Bikur Cholim. It is a community mental health organization based around its Department of Clinical Services (DCS), an outpatient mental health facility licensed by the NY State Office of Mental Health. DCS’ client population includes (but is not limited to) the full spectrum of Ultra-Orthodox and Hasidic Jews (UOHJ) of Monsey, New York and the surrounding area. In addition to DCS, CAPs’ Network for Applied Community Health and Services (NACHAS) department conducts a wide range of prevention, outreach and educational services, including the School-Based Services (SBS) program.

Through the SBS program—which is supported with federal funds by the East Ramapo Central School District—CAPs clinicians provide counseling, consultation, and other services to students at over a dozen local, non-public K-12 institutions. Participating schools have included Catholic and Conservative Jewish schools. Presently, however, all schools serviced by the SBS program are Orthodox Jewish.
Problem

The Ultra-Orthodox and Hassidic Jewish (UOHJ) population, both in Monsey and in its other enclaves, is underserved compared to the general population (Greenberg & Witzum, 2001). Despite displaying a degree of dysfunction and risk factors at or above other communities, the UOHJ community lags behind many communities in its level of prevention, identification, and treatment of mental health problems. This is due, in part, to the community’s significant resistance to outside influence and to forces of change associated with modern, secular society. Relatedly, many of the channels of resources and innovation found in other communities are weak or missing in the UOHJ community. Of particular relevance to the present study, the UOHJ educational system is largely unconnected to the greater education system of public schools, schools of education, and policy and support initiatives, including the systematic service of school psychologists, from which students throughout the nation benefit in some way.

CAPs set out to utilize its SBS program to address this problem on multiple levels. First, it sought to make direct services available to children in the schools, where they are naturally found. Next, the SBS program was to address the forces of resistance that have hampered change efforts and service availability both within and outside of schools. Lastly, the program was intended to increase the capacity of the school system and the greater community to engage in problem-solving and
implement fundamental, sustainable change. Key elements of the process are described below.

**Context Description**

**Historicity**

Orthodoxy is a form of Judaism that most resembles the religion as it was traditionally practiced until around the 19th century. During the 1800’s, the Reform, and later the Conservative, movement began to make adaptations to Jewish practice and tenets that they felt necessary to maintain the religion’s relevance to new generations of Jews and its congruence with their contemporary culture and values. Orthodox Jews were, and remain, distinguished by their firm adherence to traditional Judaism, with its central emphasis on the faithful transmission of and adherence to a divinely given set of laws and traditions.

From the very inception of their nationality, the Jewish people have been defined—by themselves, their scripture, and their adversaries—in terms of their “otherness.” Even the name of the first Jew, “Abraham the Hebrew” ("Ha-Ivri") is derived, according to the Talmud, from the word “ever,” edge, (Yalkut, 73b) referring to that lone monotheist’s metaphorical position on a separate “edge of the Earth” from all of his contemporaries.

Jewish people self-consciously transmit and regularly reaffirm this narrative of separateness in both informal and ritualized ways that tend to emphasize the dual, perpetual threats of assimilation and persecution that Jews have
historically seen as necessitating their insularity. For example, observation of the Hannukah holiday is centered on demonstrative celebration of the Jews’ armed rebellion against Hellenistic assimilationism. Similarly, one climactic section of the Passover seder, includes the recitation of a passage reminding participants that, despite the historical, commemorative context of the night, “It is not just one man who has tried to annihilate us. Rather, in each and every generation people try to annihilate us; only our Divine Benefactor saves us from their hands” (Passover Haggadah).

This “cultural fixation on the matter of Jewish survival” (Heilman, 2006, p. 17) has been maintained and cultivated by the Jews’ tumultuous national experience. The history of the Jewish Diaspora has been marked by continual transmigrations (Erikson, 1984) and rapidly changing cultural and social contexts that have forced Jews to suddenly assume “new and often transitory identities” (Erikson, 1984, p. 86, in Heilman, 2006, p. 18) and have made it difficult for Jews to remain true to tradition.

This turbulence set the context for the beginnings of an Ultra-Orthodox movement during the years leading up to the Holocaust, when, together with the other major upheavals of the time, Orthodoxy was undergoing constant redefinition and was declining in popularity and representation. Responding to assimilation trends, many Orthodox leaders mandated that their loyalists protect tradition by avoiding even the smallest modifications, in the belief that any attempt to combine Jewish
identity with naturalization or acculturation was “cultural suicide.” As sociologist Samuel Heilman describes:

In the face of change, the only possible response was to embrace a more stringent insularity and parochialism that would enable one to avoid or perhaps deny the dislocations of change. Change had to be actively rejected and yesterday frozen in the imagination; no accommodation to local conditions was acceptable, lest it lead to drift... Moreover, even when they did do something new, the Orthodox had to persuade themselves that they were not really changing (2006, p. 18).

Socio-Cultural Makeup

The greater Monsey Orthodox Jewish community is comprised of three major divisions: Hassidic, Yeshivish, and Modern Orthodox. The first two groups are often referred to collectively as “Ultra-Orthodox” or “Haredi,” although those terms can also have more specific connotations, particularly in the context of Israeli Jewry. Each of these communities has its own leadership structure and institutions of education and worship. Nevertheless, their overwhelming cultural, historical, and theological similarities, together with their communities’ geographical contiguity and largely shared infrastructure, unite these distinct groups as one greater community.

A primary distinction among these groups is their respective stances toward modernity and the influence of the larger, outside society. As their name suggests, the Modern
Orthodox community embraces the outside world far more than their “Ultra-Orthodox” counterparts, encouraging secular education and consuming Western culture as long as it does not conflict with their ability to adhere to halacha, or Torah law. As this group differs from the surrounding society far less than the other Orthodox communities, many of this chapter’s descriptions of the socio-cultural distinctions and barriers within the broader Monsey community will apply less to them than to the Yeshivish and Hassidic communities.

The Yeshivish community values learning the Torah and adhering to its halakhic precepts above all and opposes advanced secular learning apart from that which is specifically necessary to prepare for a particular profession. This community takes a more restrictive approach to the surrounding culture, shunning such influences as movies, television, and the internet. To them, the term “modern” is a disparagement; individuals or groups to whom it is applied are thought to not measure up to the community’s socio-religious standards.

Most insulated among the Orthodox Jews are the Hassidim. Viewing change and outside influence as mortal threats to their community’s continued existence, they maintain the most extensive barriers to exposure and assimilation.

Means of Separation

Ultra-orthodox Jews separate themselves from the world around them by constructing various figurative and literal boundaries. This community has been noted for its tendency to
live in close proximity to one another (Newman, 1985; Waterman, 1989; Waterman & Kosmin, 1998). This is partly due to the practical need to live within walking range of key religious structures such as the synagogue and the mikvah (ritual purity bath) so that they can be accessed on the Sabbath, when driving is prohibited. However, this pattern of residential segregation also serves to maintain bounded notions of identity in which “insider” an outsider,” “pure” and “impure” (Douglas, 1966) are clearly, geographically delineated (Sibley, 1981, 1988; Valins, 2000a, 2000b).

Ultra-Orthodox Jews’ distinctive dress represents a routine, deliberately performative use of the individual body that serves to “represent and strengthen standards of [their] predisposed identity” (Butler, 1990, p. 136, 1993; Tulloch, 1999) by reinforcing modesty standards and declaring the “social Ultra-Orthodox body as Other wherever it appears” (Blumen, 2007, p. 825). Moreover, clothing styles, especially men’s, serve to distinguish between denominations within the community, as well, sometimes in subtle ways that are barely perceptible to uninitiated observers. For example, the Yeshivish community’s designation as “black hat” points to the discursive centrality of that group’s fedoras and its white, dress shirts and black, dress slacks and jackets. Hassidic garb is even more distinctive, styled after 19th-Century, Eastern European noblemen in order to reinforce their rootedness in the past (Heilman, 1992).
Language in this community is both a demonstration of difference from, and a powerful, practical barrier to, interaction with the outside world. Hassidic children typically learn Yiddish at home and only learn English when they enter school (Spolsky & Benor, 2006; Steinmetz, 1981; Weiser, 1995; Weiss, 1999). Girls—who are expected to earn a living and therefore need to interact more with the wider society—receive a somewhat extensive English and academic education, while boys—who are, ideally, to continue their Torah studies as adults, within the confines of the community—receive very limited English instruction.

Internal Power Networks

Within the UOHJ community, rabbis and rabbinic bodies overwhelmingly control the networks of power and influence. Those rabbis can be associated with congregations or with a particular Yeshiva (Torah school or academy), or can serve the community as a posek, an arbiter of halakhic decisions. One threat to the influence of individual school administrators is their need to maintain a reputation—among their school’s own parent body and within the community—as being religiously acceptable and competitive, which at times conflicts with the educational needs of the school or its students.

The Hassidic community has a much more centralized, hierarchical structure. The overall Hassidic community is actually divided into multiple subgroups that are each organized around a particular rebbe, or spiritual leader. These communities
trace their origins directly to individual Hassidic courts from as far back as nineteenth-century Eastern Europe; they are typically named after courts’ towns of origin in the alter heim (“old home,” referring to pre-War Europe), and their rebbes’ dynasties extend directly from the original leaders.

Rank-and-file Hassidim defer heavily to their community’s socio-religious standards, which often extend far beyond the Halakhic code followed by their Yeshivish counterparts. These codes, based largely on precedent set by previous rebbes, extend to all manner of behavior and daily living and serve to preserve the Hassidic culture and social structure. The rebbe himself (only males can occupy this role) also sets policy, as do rabbinical bodies that he deputizes, such as committees to preserve public modesty and to oversee educational matters (va’adei ha-chinuch).

Information Networks

The UOHJ community works hard to keep information and innovation out of its confines. So when those things do enter the community, it is important to recognize the channels through which that occurs and the ways in which those cultural interfaces are perceived by those within the community. UOHJ communities ban television ownership and movie attendance and severely restrict internet use. Even web-enabled cell phones have raised rabbinic ire, prompting the powerful Israeli UOHJ community to pressure phone manufacturers to produce a “Kosher Phone” with no web, email, or SMS (text message) capabilities, and mandating its use
by adherents as a halakhic imperative (Deutsch, 2009). In practice, however, none of these regulations are universally followed.

Most community members receive their news from Jewish magazines and newspapers (for the Hassidim, mostly in Yiddish), which in recent decades have begun covering some world events to prevent readers from seeking reporting from outside sources. A common practice in the Yiddish-speaking (Hassidic) communities is to call in and listen over the phone to periodically updated news recordings. Even those within the community who use non-sanctioned media, generally use them in a “cultured” form, such as Haredi websites and discussion boards (Baumel-Schwartz, 2009; Campbell, 2007; Deutsch, 2009).

In the last 10 years, many of these periodicals, however have begun to also address issues that had previously been taboo, such as “kids at risk” and mental health (Schnitzer, Loots, Escudero, & Schechter, in press). In the U.S., this has had the effect of opening up discussion of these topics among the laity and allowing them and the professionals to pressure the leadership for policy changes. For communities in Europe and Israel, the impact of these American media exports have has been even more powerful, as their exposure to other forms of information is far more limited.

School System Networks

To the UOJH community, schooling is primarily a matter of connecting to an ancient event, the divine revelation of the
Torah at Sinai, through a chain of mesorah, or faithful transmissions, that has become subtly degraded with each generation’s increased distance from the source. Thus, innovation can often be seen, in theory, as antithetical to UOHJ education’s central mesorah imperative.

Practically, another barrier of information flow through the UOHJ school system is its relative lack of connection to outside networks. Typical school systems are parts of organizational fields that include other schools, teachers unions, teacher training programs, and government agencies, and that are rich sources of information and resources (Arum, 2000). UOHJ schools' organizational fields do not typically serve such a function.

Most Judaic studies teachers and administrators, especially men, are not formally trained educators. Most lack bachelors' degrees, and—with the noted exception of Chicago-area Judaic studies teachers—none are unionized. As private schools, these institutions are excluded from most state and federal educational policy initiatives and their associated funding. A bit more connected are general studies, or secular academics, teachers and administrators, and the various professionals, each in his or her area of expertise. Nonetheless, it is the Judaic studies faculty that wields the most power over school policy and culture, and the other voices tend to be drowned out. Further, in many Hassidic schools, the only faculty members with any form of
academic degree are part-time personnel employed by the district or another outside agency.

In some schools, this divide has important micro-political implications. In boys’ schools especially, it is common to find the upper administration and the staff of the Judaic studies programs, held in the morning to denote their importance, made up entirely of men who typically devalue non-Torah pursuits. Meanwhile, the general studies faculty, sometimes the lower grades' secular studies administrators, and the support staff, are mostly made up of women, many of whom have advanced degrees in education or in their subject area. In this male-dominant culture, this sets up a power struggle where the potential sources of innovation have already been marginalized and their input effectively discounted.

Support

The UOHJ community has traditionally looked to its own for support. Since Talmudic times, the community has maintained a complex array of volunteer support groups dedicated to the needs of the sick, the poor, the newly married, and the deceased. Large UOHJ communities like the one in Rockland County are often home to hundreds of small gemakh organizations (whose name forms an acronym for the Hebrew words meaning to bestow kindness) with single functions that range from interest free, need-based loans to lending medical equipment, tables and chairs, breast pumps, or wedding gowns. Most UOHJ communities have their own volunteer ambulance corps and many boast organizations called Khaveirim
("friends") whose members function as full-time, full-service good neighbors to help in situations such as getting locked out of the house or having a flat tire.

The community’s attitude toward outside support has been rather more ambivalent. A fitting analogue would be its approach to the cell phone, where community leaders said, in essence, give me the technology on my terms, and keep the schmutz to yourselves. So, too, with regard to accepting resources and services, the UOHJ community has been inclined to wield the political power that comes from its demographic concentration to attain funding or zoning variances for its institutions. However, making direct use of the services that government or other community outsiders have to offer has been too close for comfort. This is one area in which community members that can bridge the gap between the inside and outside are essential, as resources are available here but will remain largely irrelevant without changes in the attitudes of the community and the sensitivities of the providers.

Mental Health Barriers

Taken together, many of the social and structural elements described above translate into limited opportunities for increased wellness and mental health treatment for individuals and groups. As depicted, change can, in and of itself, be seen as contrary to communal ideals, especially on an organizational or system-wide level. Related to this, is the community’s resistance to reexamine community practices that foster non-ideal
development, such as lack of outlets for physical activity or creativity, or school policies that contribute to unsafe or unsupportive climates. In this climate, prevention efforts are particularly suspect, as they are seen as attempts to supplant the existing Torah wisdom regarding parenting and education.

Many barriers result as well from community members’ lack of information. For example, many behaviors that would trigger concern in other communities are tolerated in the UOHJ world (Buchbinder, 1991) simply because people are unaware that they might be associated with more severe pathology. Even if parents or teachers do become concerned about a particular symptom, they and those from whom they seek counsel might not know what to do or where to find treatment.

There is also significant stigma surrounding mental health treatment, often even more than for the pathology itself. Much of that stigma is related to the shiddukhim, or matchmaking, process (Bronstein, 2007; Heilman & Witztum, 1997; Schnall, 2006). In that system, where even minor deficiencies can discount a potential mate, prearrangement means families dig as deeply as they can for information about one another and close-knit communities mean that almost anything can become public knowledge. Even pronounced pathology can go untreated for fear that siblings will not get a shiddukh (Levitz, 1979).

Finally, many in the UOHJ community distrust psychology and mental health professionals. Many are suspicious of the therapists themselves, even if they are Orthodox Jews, because of
their advanced secular education and the possibility of their harboring secular attitudes (Schnall, 2006). Part of this sentiment is based on impressions—both accurate and inaccurate—about the nature of psychotherapy. Many see psychotherapy as promoting self-actualization and individualism in a way that conflicts with the collectivist nature of Judaism. Others believe psychology to be dominated—or at least based on—unacceptable ideas, such as Freudian psychosexual theories, or reductionist behaviorism that discounts the soul (Greenberg & Witzum, 2001).

Pre-Entry Phase

_Ethnography_

_Ethnographic Process_

The SBCI team was established in the context of CAPs administrators’ efforts to expand the scope of their services to include programmatic community endeavors. Discussions with the CAPs director, SBS coordinator, and other NACHAS staff identified the schools as a prime context for integrated community change efforts and the SBS program as an appropriate vehicle for implementing them. The SBCI that was subsequently form consisted of the CAPs director and SBS coordinator as program coordinators, with NACHAS staff in steering roles, and SBS clinicians responsible for most of the school-level implementation. All of the members of the SBCI team were themselves Orthodox Jews, representing various segments of the target community. However, many aspects of the community were unfamiliar to them, and the team lacked intimate up-close knowledge of the communal and
organizational dynamics necessary for such an intervention. As such, team members sought out ethnographic information, throughout the SBCI process, from a wide variety of sources, and shared it with one another as part of their weekly group supervision process.

*Utilizing Bikur Cholim.* An early and valuable source of information about the structure and culture of the community was the experience of the team, especially the CAPs director, of working within Bikur Cholim. Bikur Cholim serves a diverse clientele comprised of a wide array of community subgroups. One of the organization’s greatest successes has been its ability to cultivate the sense that it addresses the unique needs of the community on the community’s own unique terms. This has been particularly true of the insular Hassidic community, which is well represented among the staff, volunteers, and administration of the organization.

In establishing and operating CAPs, the director has needed to draw on Bikur Cholim’s expertise and cultural embeddedness in order to maintain the level of acceptance enjoyed by the larger organization, even as CAPs’ mission of mental health services represents a more radical service than Bikur Cholim’s. He, in turn, brought that insight to the SBCI by incorporating it into intervention planning, sharing it with SBS clinicians, and including SBS coordinators in relevant community meetings and functions.
Utilizing DCS. SBS counselors were also privileged to have unique access to expert local knowledge about the community’s mental health needs as a function of their positions as DCS clinicians. Most of the clinicians in the SBS program also functioned as staff therapists or pre-doctoral fellows in the Clinic, which serves sub-communities that largely overlap those served by the SBCI. This put them in uniquely intimate, extended contact with community members who were in fact dealing with the same phenomena, and often had to overcome the same cultural obstacles to care, that the SBCI sought to address. In addition, those SBS clinicians also participated in DCS team meetings in which they and other Clinic therapists shared and discussed their experiences, insights, and challenges related to the culture of the clients and their communities.

Continued inquiry. This process of ethnographic inquiry continued throughout the SBCI planning and intervention. As team members become more embedded within the schools and community structure, they routinely brought back their insights to the team to process them among themselves. In addition, having established connections with “local experts” at Bikur Cholim and within the community, team members were able to begin to check their observations and interpretations against those individuals’ cultural expertise. This process was particularly valuable in the context of the principal meetings that the SBCI team convened later in the intervention process. There, sharing ethnographic findings with school administrators not only allowed them to
critique team members’ assessment. It also made explicit many observations and assumptions that, until then, the principals held only implicitly, thus making that information available to both the schools and the clinicians to utilize for collaborative problem-solving.

Partnersing

External Agency - The School District

The easy part of the partnering phase was identifying the ideal external agency. The East Ramapo Central School District Office of Non-Funded Programs is dedicated to acquiring federal funds to which the local schools are entitled and to provide appropriate services to the schools accordingly. By offering services that meet the unique needs of the community’s schools, in a culturally sensitive way, this office has gained the trust of administrators and teachers and has managed to introduce direct services to the students as well as professional development opportunities for Judaic and general studies teachers that would not have otherwise been.

With regard to gaining the district’s trust, SBS had the dual advantage of bearing both the Bikur Cholim and the CAPs name. As a Bikur Cholim program, it was part of a long-standing agency that enjoyed name recognition in both the community and the district. CAPs, for its part, had earned the esteem of professionals and the public through its high level of service and unique cultural accommodations. It was, as they say in Rockland County, “a good shiddukh.”
School System and Community

Getting the schools to take part in SBS’ services was considerably more difficult. For the schools it was a simple offer: provide us a room, a child, and a time slot, and SBS will provide counseling and school support. Still, among all the Orthodox schools, only the single Modern Orthodox school would immediately participate in the program.

Over the next year or two, SBS worked to build rapport and trust upon which it could establish partnerships with more schools. Bikur Cholim administrators, where personally, members of various Hassidic groups engaged Hassidic lay leaders and educators as our ambassadors. Delegations of Bikur Cholim, CAPs, and SBS administrators visited Rabbis so that they could vouch for the personal character of the organization’s leaders. And—without SBS’ explicit intent—children, cousins, and friends of the declining school’s teachers, parents, and administrators were successfully treated in CAPs’ clinic (DCS).

As expected, once there was one mainstream Yeshivish school on board it was much easier to engage other Yeshivish schools. The same was true for Hassidish schools, which tended to join later than the Yeshivish ones. Nevertheless, each school has its own sense of where it stands on the hierarchy of socio-religiosity, and many still look at the schools that receive services and say, “That’s fine for a school like X, but until School Y does it, it’s not frum (ritually religious) enough for us.”
One figure that highlights the steady but gradual increase in school participation is from report delineating how many years schools had been serviced for by a mental health professional. For the 2008-2009 school year, 27 percent of schools were receiving mental health services for the first time; nearly 75 percent of schools had been receiving services for less than three years, including that year (Figure 2).

![Figure 2. Percentage of schools served by mental health professional, by number of years.](image)

**Service Delivery Phase**

**Intervention Setup**

As many of the schools were new to school-based mental health services, psychoeducation of administrators and faculty was crucial. One forum in which this was conducted was the principals’ orientation meeting at the start of the school year. There, the SBCI coordinators introduced themselves and the SBS
clinicians to principals of participating schools. Coordinators briefed the principals on the program and its goals, services, policies, and procedures, and distributed “Responsibilities & Expectations” forms delineating the respective roles of the schools and SBS (see Appendix A). A representative of the school district was present, as well, to answer questions about funding and to describe additional programs for which schools were eligible.

In addition to the collective meeting, clinicians met individually with their schools’ administration and designated program liaisons to coordinate in further detail and to review issues such as confidentiality that might require adaptation of school culture.

Service Modality

Modality Frequencies

SBS clinicians worked in each school between 2 and 16 hours each week, depending on school size and request. The modal number of hours was four. Intervention modalities in the individual school settings were largely dictated by school needs and preferences.

Individual counseling was the most frequently performed service in each of the participating schools. Parent and teacher consultation were also common in every school and were, respectively, the next frequent overall service modalities. In contrast, schools varied greatly in the degree to which they employed the counselor in areas of administration and school-wide
matters. In one school, the SBS clinician and the school principal jointly revamped the school’s disciplinary procedures, replacing them with a school-wide positive behavioral support program. In another school, the clinician had to repeatedly request and remind teachers and administrators to even inform her of major changes and decisions relating to her clients, let alone to consult with her. Schools also utilized SBS clinicians less frequently for other functions that, like administration, are hard to circumscribe and reach across school roles, such as crisis intervention and case management.

Interestingly, despite their frequency, most administrators reported receiving less counseling and consultation than they had expected. However, to the extent that they utilized those services, administrators also reported receiving more administrative support, crisis management, and case management services than they had expected.

Clinician Integration

The clinicians began preparing for the integration process even before the school year. Through sections of the policy and procedure handbook (see Appendix B) and discussions with veteran school clinicians, the group thought together about intergroup differences, anticipating being judged, and examining their own unspoken biases. In addition, each clinician was briefed on their assigned schools, their values, and the communities they represented. For schools previously served by SBS, past counselors described the school culture and micro-politics as
well as “lessons from the field.” As the school year started and progressed, clinicians utilized the group supervision to process their own personal experiences integrating, share ethnographic anecdotes, and explore issues of positionality.

One trend that emerged from clinicians’ reports related to the way schools from different sub-communities related to their newly arrived clinicians. Yeshivish schools, which were generally most similar to the clinicians’ own cultural identities, were likely to fully integrate their clinicians more quickly. However, they also tended to be more personally scrutinizing of the clinicians. In Hassidic schools, which were most different from the clinicians’ own backgrounds, clinicians generally did not experience themselves as full “insiders” until later, yet they felt more readily accepted from the start. One clinician described his experience, saying “At the Yeshivish schools, I was in the ballpark, so they had to place me on their “Jewish geography” maps to see if I learned in the right yeshiva and I was the cousin of the right brother-in-law. At the Hassidic schools, who’d we be kidding? They knew I wasn’t a Hassid, and I knew they took me anyway.”

Ownership

Program Extensiveness

One way that the SBCI team promoted the extensiveness of schools’ program ownership was through the schools’ communication with parents about the SBS services. For first-year-participant schools, CAPs provided two letters on its own stationary one
describing the services and the other requesting parental consent. Most schools chose to use both letters together, as printed, and to first inform parents of the presence of SBS services at the point of referral and consent request. In subsequent years, CAPs encouraged schools to make two changes to that process: to inform their entire parent bodies of the SBS services at the start of the school year, and to do so on school stationary.

Schools in both the Yeshivish and Hassidic communities had concerns with these requests. However the schools’ distinct concerns revealed much about their own positions and the general hierarchy of power within their respective communities. Several Yeshivish schools were nervous about negative parent reaction to having mental health professionals in the building. One school, in an apparent effort to mitigate parent backlash, changed all of the letters’ references to a “psychologist” to “social worker.” Indeed, many parents in those schools refused consent even when treatment was quite obviously indicated. In contrast, at one Hassidic school, administrators objected because the parents’ enrollment of their children was viewed in that community as an absolute acquiescence to the educators’ judgment and expertise, and to explicitly ask parents for consent to a particular school action might confuse or worry them and possibly damage that implicit trust.
Program Intensiveness

Intensiveness of the SBCI was more difficult to establish and was closely related to the degree of the clinicians’ integration within the individual schools and to the schools’ internal micro-politics. In many of the schools, there was a tension between the Judaic and academic studies faculty – or, as they are called in the schools, limudei kodesh, sacred studies, and limudei khol, secular studies – where Judaic faculty saw themselves – in many ways, correctly – as more integral to the school mission. This was especially pronounced when the secular faculty members were not Jewish or religious, or when they were women. Compounding this divide, all Judaic classes are held in the morning and secular classes in the afternoon, and few, if any teachers work beyond their departmental shift. In many schools, depending on the group to which the therapist was perceived as being more aligned, this tension was significantly detrimental to intensive program integration.

Thus, for example, in one Yeshivish boys’ school the Judaic studies and older grades’ general studies teacher were all male, while the younger grades’ general studies teachers were all female. (Hassidic schools rarely employ teachers of one gender to teach students of the other.) The mental health liaison appointed by the principal was the general studies assistant principal for the lower grades. This placed the clinician in that school firmly within what one Judaic teacher jokingly called the school’s Beis Yaakov – a common name for Yeshivish girls’ schools – a discreet
sector of the faculty, clearly demarcated by department, gender, and schedule, and with significantly less influence over the culture and policy of the school. The clinician, despite being male, was effectively left to advocate on his own among unsympathetic rabbis to protect his assigned space and the interests of his clients.

For that clinician, increasing the program’s integration came after a long process of proving himself as friendly, helpful, and trustworthy. The turning point, however, came unexpectedly through a coded linguistic exchange. After many weeks of being interrupted during a particular time slot by the same rabbi opening the door during session and exposing the student inside, and many attempts at creative resolution, the clinician reflexively stepped out of his professional role and addressed the administrator casually, as a just fellow Jew. Making reference to the Talmudic dictum that embarrassing another person in public is tantamount to murder, the clinician remarked in a mixture of Yiddish and Hebrew, “It’s just that it’s a shtikele boosha berabim (a little bit of a public humiliation).” The rabbi nodded in understanding and concurrence, and became an important ally for the clinician from then on.

Scaling Up Phase

School Network Building

To encourage the development of cross-school networks, the SBCI team held principal meetings for all of the 13 participating schools. Many of the principals had attended district meetings,
but those had mainly been for professional development, or to
learn about grant funding and compliance. These meetings provided
principals with the opportunity to interact more informally with
one another and to be more actively engaged in the issues and
process. The meetings also allowed principals for whom mental
health was a new and foreign endeavor to literally see the faces
of the other schools that were participating and to be empowered
by the recognition that others like them were also involved. For
some principals, the meetings provided a safe forum to bring up
issues that they faced with students and families but that their
communities were not yet ready to discuss. For others, those
discussions helped to focus their attention on such issues and to
recognize, perhaps for the first time, how much the issues did,
in fact, affect them.

By gently moderating these discussions, SBCI coordinators
were able to guide the principals through a process of joint
problem-solving in which the group delineated several common, key
issues (e.g., increased divorce rates, bullying, etc.),
identified individual and joint resources, and explored various
means of addressing them. Administrators also provided valuable
feedback about the services that guided subsequent program
adjustments.

The greatest obstacle to effective school network building
was the difficulty of coordinating ongoing, regular communication
between the administrators. Being outside of a formal school
system, each school was on a different schedule, and finding a
time to meet in which all the schools were in session and administrators not preoccupied with other school functions was a challenge. In addition, because of the community’s restricted internet use, very few of the administrators were regular e-mail users, or even had e-mail access at all, ruling out other listservs or other forms of electronic discussion.

Cross-Sector Network Building

Having earned key school administrators’ trust and set in motion a process of empowered, joint problem solving, the SBCI team set out to gently urge them toward the final step of reaching across sectors and ecological levels. In some instances, this involved employing resources from beyond the community to address school-specific needs. In others, administrators joined with stakeholders from across the community and beyond to problem-solve toward true community-wide change.

Referrals to DCS

SBS clinicians took advantage of their position within an outside mental health agency to refer cases that required more intensive treatment than could be provided in a school setting, or where other family members required care. This created an important pathway that school personnel began to utilize outside of the context of SBS-referred cases. In addition, parents in SBCI schools, whose children had never been seen by SBS clinicians began to call the clinic requesting their schools’ clinicians by name, indicating that they had heard about that
individual through other parents in the school and were interested in services.

*Protective Services*

One important way in which the SBCI team helped to bridge between the UOHJ school system and external social services was by establishing a community liaison for Child Protective Services (CPS). This service drew on a relationship of mutual trust that was cultivated over several years between CAPs and CPS. Recognizing both the need for protective and preventative child services and the frequent distrust for CPS within the UOHJ community, CAPs administrators reached out to CPS administrators to help adjust the system to service them more effectively. As part of that participatory process, the two agencies held several joint sessions in which CPS staff voiced their frustrations over struggles in dealing with the UOHJ community while CAPs provided some cultural context for UOHJ fear of outside agencies as well as sensitivity trainings.

In the arrangement that ultimately emerged, CAPs and CPS work in tandem to address cases of suspected abuse and neglect in ways that are culturally compatible and effective with the community. CAPs educates community leaders and school faculty about the mandate to report and dispels many widely held rumors about the dangers of involving Protective Services. When cases arise, CAPs’ liaison walks families or organizations through the reporting process. When appropriate, cases can be referred to CAPs’ clinic to be addressed – within the community – through
therapy and other supports. When a case warrants more intensive action, the CAPs liaison consults with Protective Services to identify, to the extent possible, culturally appropriate solutions. This service has been instrumental to getting help for children in many situations where community members would otherwise have been afraid to come forward.

Several SBCI schools utilized the CPS liaison service, both in cases where the child was and was not being seen by the SBS clinician. Most of those schools had never reported suspected abuse or neglect (a legally mandated responsibility), yet all but one reported being very satisfied with the way in which the process was handled and the way in which it was resolved. Those schools reported becoming more empowered in looking after their students’ well being, and many have utilized the liaison since.

The most poignant illustration of schools’ changed attitude toward reaching out to CPS occurred at an end-of-year principals’ meeting in which the principal of the one dissatisfied school voiced her criticism that the SBS clinician and CAPs’ liaison had been too quick to report a suspected case of abuse. Before anyone from SBS had a chance to respond, four other principals, including two who had originally been strongly opposed to reporting of any kind, interjected with emotional declarations about the great mitzvah (commandment, good deed) of saving a life and the dangers of looking away.
Monsey Community Coalition for Health and Wellness

One exciting example of SBCI administrators taking on community-wide problem-solving endeavors is a project currently being implemented by CAPs’ NACHAS division. Funded by a grant from the National Association of Chronic Disease Directors at the Centers for Disease Control, and jointly coordinated by NACHAS and the Rockland County Board of Health, the its goal is to develop community policy and infrastructure for promoting physical and emotional health and wellbeing throughout the Monsey UOHJ community. The project’s initial achievement was to bring together representatives of diverse community sectors and levels to form the Monsey Community Coalition for Health and Wellness (MCCHW), a collaborative body that includes doctors, nurses, nutritionists, rabbis, politicians, psychologists, community organizers, grocers, restaurant owners, other business leaders, parents, members of the press and other diverse stakeholders in the community’s health.

Since the MCCHW coordinator presented the program at a SBCI principals’ meeting, several principals have become active members of the coalition and currently sit on its subcommittees. An indication of the promise shown by the partnership between the schools and the wider cross-sector coalition is MCCHW’s first initiative, to develop a standardized set of wellness policies to be established across Monsey UOHJ schools. SBCI schools have been well represented in this process, including principals who sit on several policy development subcommittees, and numerous SBCI
schools who have been among the first to commit to the anticipated policies' implementation.

Impact Phase

Indicators of Change

Attitude Changes

The changes in the attitudes of school faculty and administrators after being exposed to counseling and other services over the course of the SBCI were drastic. For 27% of the participating schools, 2008-2009 school year was their first year receiving services and 73% had had a counselor in their schools for 2 years or less. Based on survey data, among school faculty, male administrators and teachers, especially limudei kodesh, Judaic studies, teachers, had more negative attitudes toward having a mental health professional in the school than did female faculty (Figure 3). At the end of the school year, faculty attitudes had drastically improved, and the inter-gender attitude differences were insignificant.

Figure 3. Attitudes toward counselor in school, before and after ’08-’09 school year, by faculty role.
The attitude change stimulated by exposure to SBS services was found to continue for the first two years of counseling exposure, after which, the pre-school-year attitudes are already so high that little change is possible over the year. Faculty in schools that had 0-1 year of prior services had neutral attitudes before the school year, which became strongly in favor by the end of that year. For schools with 2 years of prior services, pre-school year attitudes were higher, in favor of services, but improved even further during the year. By the 4th and 5th years of service, teachers and administrators entered the year strongly in favor of services (Figure 4).

Figure 4. Attitudes toward counselor in school, by number of previous years served.
Parenting Program

The scope and scale of the changes and the incredible resistant that the SBCI faced is most powerfully encapsulated by the story of the CAPs parenting programs.

The first years. The events began in the summer of 2008, when CAPs received federal funding through the East Ramapo Central School District to conduct educational programming for parents in the community. CAPs administrators and clinicians developed a back-to-school program that was both relevant and as clinically neutral as was possible (e.g., "Tips for Homework Time," "Strengthening Your Relationship with Your Adolescent").

Before publicizing the event, CAPs administrators formed a delegation together with the Hassidic administrators of the greater Bikur Cholim organization to present the program to several Hassidic rabbinical leaders and to secure their “kosher certification.” However, the leaders did not agree to sanction the event, and only after some urging and negotiation did they offer verbal commitments to allow it to take place.

As soon as the event was publicized, though, those tenuous consents became irrelevant. Community activists opposed to the program flooded the community with leaflets in the traditional pashkevil format decrying the event as an attempt by outside forces to hijack “our holy flock [of pure children] and shepherd them to iniquity.” The centerpiece of the leaflets was a 1972 declaration by a group of since-deceased rabbis and relating to a different set of circumstances but whose tone fit perfectly the
alarmism at hand. Next to that venerated declaration was printed an updated outcry against CAPs’ parenting program that bore the names of around a dozen Hassidic rabbis, including—without their knowledge or permission—those who had met with the CAPs delegation.

To an observer, this program might not seem the biggest threat, compared to other forms of potential, insidious cultural infiltration. The program was indeed being presented from the perspective of professionals who, despite being Orthodox themselves, were educated in the outside, academic world. However, the sessions were addressing an issue that was central to the community’s value system, and that could not rightly be considered secular. Yet it was precisely that centrality that made the Hassidim view the program as such a danger.

The other reason that the Hassidic community took this program so seriously also had to do with its being “close to home” for them. As mentioned earlier, Bikur Cholim has invested considerable effort into creating an organization that feels to all segments of the Orthodox community like it is “theirs.” For the Hassidic community, this has included providing Yiddish materials and publications and staffing Hassidic volunteers, among many other policies. For the Hassidim, therefore, this was not just any Orthodox organization breaking their sense of Hassidic standards. It was one of their own, and that made them subject to the collective, internal forces of communal jurisdiction and coercion.
The CAPs staff was determined to continue with the event, if only for the Yeshivish parents who would still attend. However, the activists were not content in preventing members of their own sub-community from attending; they wanted the event suspended entirely. The day before the event had been scheduled for, activists sent out notices on forged Bikur Cholim stationary announcing, falsely, that the event had been canceled. Rather than fan communal tensions, CAPs and Bikur Cholim chose to stay silent and not challenge the public impression that they had mysteriously cancelled the event themselves.

The following year, the program was not publicized within the Hassidic community. Despite widespread publicity, the event drew far fewer people than had been projected for the previous year’s event. Many individuals and organization cited the abrupt cancelation of the previous year as the reason for their lack of interest in participating.

2009 Program. For the third parenting event, CAPs chose to integrate the event into the SBCI as an opportunity for building school ownership and involvement. Rather than having CAPs host the event and invite the community, the schools would jointly present it as event “co-sponsors.” Practically, this would mean simply that the schools would allow their names to be printed on the promotional materials and that they would send out the event flier to their parents with letter on school stationary.

This, of course, proved more difficult in execution than in concept. Despite the once-again neutral topic of social-emotional
development, many schools were reluctant to participate. Not wanting to repeat the mistakes of previous years, CAPs billed the event as “an educational event for parents,” instead of a “parenting event.” Nonetheless, some Hassidic administrators explained privately that they were interested, but that their *vaad hachinuch* educational boards would not allow it. Other schools insisted that social-emotional development was not “a problem” that they faced (although one such administrator still eagerly requested any recordings that might be available of the presentations). One school declined because they did not want their parents exposed to the likes of parents from another of the schools. That school imagined itself and its families to be far more religious than the others’, despite there being considerable overlap between the two schools’ parent bodies.

Another issue related to the female keynote speaker, a well-regarded researcher on bullying and social skills and the Orthodox community. Many of the Hassidic schools requested that the audience be seated by gender and separated by a *mechitza*—a room divider, typically used to separate the genders for prayer—and that she speak while standing on the women’s side, out of the view of the men. The more stringent condition came, surprisingly, from a Yeshivish school, that demanded that CAPs change the event to be for mothers only.

All of the negotiations and accommodations paid off, though, and the event was a success by all accounts. Seven schools signed on that had likely never done anything together
before and hundreds of women attended. Throughout the evening, one could hear women looking across the room at the wide array of head coverings, each indicating membership in a different communal sub-group, and marveling at the rarity the sight (see Appendix C).

Following the success of the women’s event, several administrators, including some who resisted the original women’s event, have taken the initiative to push forward with a similar event for men.

Readiness

The CAPs SBS SBCI process has created many changes throughout the Monsey community and school system. At the microlevel, individuals and families have received services and become empowered to seek help; at the mesolevel, new roles, settings, and networks have been created within schools and across schools; at the exolevel, community leaders have been engaged and partnerships created with outside agencies networks; and at the macrolevel, changes are being made to policies and culture in the wider community. However, the ultimate impact of this SBCI is far more profound than just the sum of these impressive parts.

Working in concert, these developments, at the various levels at which they were strategically facilitated, have functioned synergistically to radically change the way in which the community and the school system approach the issues of wellness and mental health. As a result of SBCI-generated
changes, schools and parents have a language for identifying and speaking about emotional and behavioral issues as well as settings for addressing them with the schools. Families have clear pathways for seeking more intensive help and schools have increased capacity for future problem solving regarding mental health issues. These are complemented by changes to the community’s culture and attitude toward mental health and help seeking, in which parents and patients feel less stigmatized seeking help and leaders feel more emboldened taking on important issues with each other and the public. All of these changes are sustained and amplified by enduring and ambitious policy initiatives. The collaboration of previously unconnected elements of the community ecology that the SBCI facilitated represents a fundamental evolution of the system’s dynamic, the way in which system components interact with one another.

Even beyond these changes to specific units within the system, SBCI has produced essential changes to the system itself. Participatory action together with the SBCI team has made explicit previously tacit knowledge of cultural capital within the community in ways that can now be utilized by participants in their own activities. Newly formed networks have increased social capital and the flow of resources and innovation, creating enhanced capacity for future problem solving.
CHAPTER IV

DISCUSSION

The CAPs case study illustrated one successful implementation of the SBCI model with an UOHJ community that is highly insular and resistant to change. Clinicians from a local community mental health center developed a program of school-based mental health services and structured the program and its planning and implementation in a manner that created new roles, enhanced network capacity and problem-solving readiness, and reduced many barriers to emotional wellness and treatment.

However, the larger significance of the study lies in its approach. This study represents a radical reconceptualization of the function of school-based mental health programs within communities. Most interventions involving schools are unmistakably “school-based” in the sense that they are shaped by the student-centered educational traditions of their school settings. Even when they incorporate community involvement, these interventions are conceived of and developed from the schoolhouse looking out, engaging the community primarily as a means toward achieving individual student-level outcome goals. SBCI allows intervention developers (as well as researchers-evaluators) to step outside of the schoolhouse and assume a new, unbounded vantage point that sees beyond the schools as individual systems and recognizes their integral and ecologically nested position
within the system of their communities. This perspective holds great potential for creating new forms of community-school interventions whose impact extends well beyond the individual student.

Using the SBCI model in the context of the case study was useful at various stages of the intervention. At the development stage, the SBCI framework compelled the team to truly root their intervention in their formative research and guided that formative research process. This resulted in a program that was well accepted relative to the settings’ high resistance and that was disseminated based on a nuanced understanding of community networks. The SBCI structure also helped during service delivery to help keep the interveners mindful of the larger context and goals of their activities. This led them to be far more attentive to the dynamics of the settings and to develop relationships with individuals within the school with whom they might not have connected if they were focused only on individual services.

One way in which the model was not as helpful was that, while the it calls for action to be participatory, it lacks guidance for how to foster the participation of stakeholders, especially parents. Other shortcomings pertained largely to the model’s ability to guide evaluation of processes and outcomes. The CAPs SBCI team encountered this at the Cross-Level Problem-Solving stage, where the model guided the process of establishing network connections, but, unlike, for example, in the Ownership stage, did not address how to recognize whether and how
effectively the expected effects of that process were taking place. Similarly, the Readiness stage addressed many areas of expected change, but offered few guidelines regarding formal assessment.

Limitations and Suggestions for Future Research

The ecological approach that informs this model recognizes that the effects of multilevel interventions in dynamic community systems will always be non-linear and unpredictable. Thus, this study’s utility is, by design, limited in that it cannot be used as an implementation-ready model to be easily applied to individual settings. Although the SBCI model is presented here in the context of non-public schools, it is equally suited for use with the public schools. Moreover, public school systems have the advantage, relative to non-publics, of existing, unifying district networks and formal links to outside bodies and resources that bolster their social capital and can benefit SBCI implementation and impact.

Barriers to Implementation

Bridging various community levels and sectors is one of the SBCI model’s strengths, but it also increases resistance. The encapsulated culture of school systems often means that individuals within them are reluctant to collaborate with outside groups. Additional resistance can arise from the notion that the community-level network building is more directly related to goals that are outside the school and might not be viewed by the schools or school boards as a worthy investment of resources.
Practically, involving multiple organizations and agencies also complicates implementation by making it more difficult to coordinate schedules, priorities, and resource cycles. Another practical barrier is the heavy focus on formative research, which delays the implementation and might lead to loss of participation or resources from stakeholders or funding sources that do not understand that process as necessary to the process.

**Empirical Validation**

This case study was limited in that it lacked more systematic and varied assessments. Most of the evaluation was conducted using only a few methods of qualitative analysis such as participant observation and surveys of administrators. This weakness made it difficult to clearly identify and separate the most important forces behind intervention outcomes. More systematically including reports from parents, teachers, and community stakeholders would have elicited additional, valuable data regarding social validity and perceived success at multiple levels.

An important step toward advancing the SBCI model would be to establish its empirical validation. The methodological challenges to that process have been documented by multilevel intervention researchers (Schensul, 2009; Hawe et al., 2009; Nastasi and Hitchcock, 2009). Traditional methods for research design and analysis, such as randomized control studies and regression, are not suited for the multitude of contextual
variables and explanatory variations in outcome across settings (Schensul, 2009; Nastasi and Hitchcock, 2009).

Instead, evaluation of this model requires a mixed-methods design that incorporates both qualitative and quantitative evaluation techniques in order to capture the full range of intervention actions and across community levels outcomes and the contextual forces that contributed to the success or failure of the model’s implementation. Nastasi and Hitchcocks (2009) Comprehensive Mixed-Methods Participatory Evaluation (CMMPE) model, for example, offers a useful framework for evaluating multiple aspects of interventions, (e.g., acceptability, ownership, and outcome) at multiple community levels.

Qualitative methods such as in-depth interviews, ethnographic surveys, participant observation, and key informant interviews are particularly important for identifying the various components that led to intervention outcomes, including aspects of the setting that would support or hinder implementation in other contexts. These methods can also help to identify essential and nonessential components of the intervention outcomes to shape future implementations and integrity efforts.

Quantitative assessments include measures of individual-level intervention outcomes, of effects on within-setting variables such as social climate, and of changes in knowledge and beliefs. Several statistical methods are also useful for understanding the changes in the intervention context. Social network analysis, for example, offers the ability to measure
outcomes related to increased network capacity by measuring changes in the density of social networks due to the creation of new settings and the introduction of new technology (Hawe et al., 2009). In addition, geographic information systems (Luke, 2005) facilitates the measurement of changes to community resources.

From a pragmatic point of view, this will be accomplished with a massive randomized control trial, but rather will hearken back to the recommendations of Emory Cowen (1977). Cowen believed that knowledge would be advanced in school-based mental health research primarily through the accumulation of contextually-sensitive case studies. Anticipating current ecological-contextual methods of the kind used in this study, Cowen understood that it would be virtually impossible to create an experimental design that would adequately control for the myriad of variables operating on comprehensive systems in context. While it might be possible to write up such studies for the purpose of publication as if adequate experimental controls existed, Cowen believed that this would be a disservice to both science and practice. Thus, future research on the SBCI is most likely to advance through a series of case studies of the kind represented in this document, with the methodological improvements of the kind noted above.

Changing Schools’ Perspectives and Roles

Nevertheless, this study has important potential implications for those who work in schools, and particularly school psychologists, with regard to how they understand and
interact with their community settings. School personnel must expand their understanding of communities to recognize the complex, reciprocal relationships that exist between schools and community systems. They must also expand their conception of their school’s responsibility and position relative to their community to include active, ongoing, collaborative community engagement to maintain local ecological knowledge, and trust-based partnerships. This implies a necessary redefinition of roles and allocation of resources within the schools. Administrators or professionals whose positions currently include participating in school and district meetings might need, in addition to attend functions and meetings within the community that have little or no direct relevance to school issues, but that provide the context for developing “local knowledge” and establish rapport with important community leaders.

Schools would do well to establish district-wide interdisciplinary committees that include teachers, administrators, support professionals (e.g., school psychologists, school counselors, speech therapists) and that can interface with the community to examine community-level issues and coordinate school-based components of interventions and initiatives. This type of community partnership would ideally involve a broad community consortium with a diverse membership that represents multiple community sectors, various professional perspectives and methods of inquiry, and the community’s full cultural, linguistic, and socio-economic diversity.
School psychologists, in many ways, are logically suited to function as coordinators of such partnerships, either on the community level or within the school or district, as many of the demands of such a position overlap with their existing skill set. Nastasi (2000), in her “model for school psychology in the 21st century” cites school psychologists’ broad expertise in calling upon them to assume a central role in coordinating expanded services and multi-disciplinary collaboration. She identifies several aspects of the traditional school psychologist role that are consistent with collaborative, ecologically based action research methods. For instance, the recursive action research cycle is in line with the notion of the school psychologist as a reflective practitioner (Nastasi et al., 1998) who defines and refines the referral problem and intervention based on ongoing evaluation. The process of engaging stakeholders to partner in designing and implementing the intervention draws on the same skills as collaborative, participatory consultation (Nastasi et al., 2000), and ethnographic qualitative evaluation is similar to classroom observation and self-report data collection methods.

Nonetheless, school psychologists’ ability to effectively work on the community level ultimately demands changes to their typical training to include foundations in ecological perspectives, community research methods, and a greater focus on interdisciplinary collaboration (Power, 2003; Power et al., 2003).
The model can be particularly useful in communities that are very diverse or in which there are significant inter-group disparities of power. Such an application might be developed by an SBCI team composed of representatives of the various groups, that can conduct formative research to understand the individual networks and dynamics of each subgroup and the community dynamics from multiple perspectives. Schools would be particularly valuable to such an effort because they they their organizational culture and structure unites their diverse members, and their school climate and policy generally contribute to more equitable distribution of opportunities than in the surrounding society. Within this type of SBCI, school-focused programs can be developed in collaboration with diverse community groups that might have been less likely to partner in the context of their usual operations.

This and other applications of SBCI can also draw upon a particularly striking finding from the CAPs intervention regarding the ability of SBCI's to powerfully influence beliefs and attitudes of school personnel. School surveys from the CAPs intervention indicate powerful, consistent resistance from administrators and male Judaics teachers to having mental health workers in UOHJ schools. This resistance dropped significantly after just one year of receiving mental health services in their schools. Pre-school year resistance to mental health services also differed significantly among groups based on the number of years they had received services until there was no longer
significant resistance left among them. This points to the potential of using schools to roll out and disseminate social change initiatives, such as reducing bias and changing health attitudes, by involving parents and community groups in developing and implementing school-based programs that focus on those issues.
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Appendix A

Orientation form distributed to SBCI principals at the start of the school year

School Expectations & Responsibilities

EXPECTATIONS: What you can expect from CAPs

COMMITMENT

Dedication on the part of CAPs and of each and every counselor to the growth, wellness, and success of the students that we service and their teachers, schools and families

PROFESSIONALISM

Counselors who:

- Are capable, experienced and well-trained clinicians
- Provide services in a thorough, conscientious manner
- Demonstrate understanding and sensitivity for school’s and families’ mission, culture and hashkafa

SUPPORT

Counselors who are available:

- To parents for consultation, questions and follow-up
- To teachers and administrators for regular monitoring of student progress and for consultation on individual, classroom- and school-wide issues

CAPs staff & administrators who are available:

- To schools for additional support on emergent clinical issues, administrative matters, interfacing with outside agencies, and crisis management

RESPONSIBILITIES: What CAPs will expect from you

COMMITMENT

Dedication to work alongside CAPs to promote the growth and wellness of each student referred.

PROFESSIONALISM

Schools will:

- Clearly delineate and abide by the counselors’ roles within the school
- Respect the counselors’ time by consolidating their sessions in order to minimize the time spent at the school in between or outside of sessions or consultations
- Consult or inform counselors about major changes or developments regarding the progress or program of students that they see
- Respect counselors’ professional and ethical needs for maintaining confidentiality

SUPPORT

Schools will:

- Provide counselors with a private space that is available from week to week during their set session times
- Obtain written parental consent prior to the commencement of counseling services
- Communicate with faculty members, as needed, regarding the need for pull-out and observation during their class times and making themselves available for consultation outside of class
Appendix B

Excerpt from policy and procedure manual given to SBS clinicians

CAPS AT BIKUR CHOLIM
SCHOOL-BASED MENTAL HEALTH PROGRAM

Policy & Procedure Manual
I. Initial Contact

After receiving your school assignments, you will need to contact the principal at each of your schools to introduce yourself and set up a setup meeting.

Many of the schools' contact people for the CAPs School-Based Services Program (SBS) are not the principals, but other administrators, such as assistant principals. Those will be the people with whom you will be interacting most during the course of the year. During your phone conversation, find out who that person will be and arrange for them to be present at the meeting.

In some instances—most likely schools that are new to the program—the school will not yet have designated a specific individual to coordinate the counseling from the its end. Alternatively, the principal or another administrator might have a vague notion that he or she will be in charge or "take care of" the counseling arrangements, but will not have a clear idea of how that is to be done. If you believe that this is the case with your school, don't worry; you will have the chance to address the issue during your meeting.

Principals tend to be busy at the start of the school year and leading up to the Yamim Tovim, so you might need to be persistent to make sure you reach them. But keep trying: the sooner you set this up, the sooner you can get into the schools and work with the kids.

II. Setup Meeting

There are three purposes for this meeting: (1) introductions, (2) policy review, and (3) arrangements.

1. INTRODUCTIONS

This is a chance to meet and be met. You will get your first glimpse of the school and how it works, and establish an important connection with the principal who, if she is not the SBM contact, might not seek out very much interaction with you on his or her own later in the year.

GETTING "CHECKED OUT"

Depending on the yeshiva/cheider/Beis Yaakov that you are in, the faculty might be concerned about your "fit" with their school. You might be asked some questions that are more personal than you would get in a clinical, patient-therapist exchange, such as inquiries about "Jewish geography," where a male therapist (or female therapist’s husband) "learned," and his or her marriage/parenthood status.
Administrator feedback from past years indicates that in nearly every case, CAPs therapists were seen to have understood and fit the school’s mission very well, even when there was a very wide gap between the therapist’s background and the community that the school represented. Nevertheless, just like with transference/countertransference experiences, it is important to be aware of the reactions that this type of exchange might elicit.

GAINING CONTEXT

It is very helpful to understand why the individual schools wish to have mental health professionals working in their building and the role that they expect you to play toward that end. One school might be most interested in helping to manage students who disrupt their classrooms while others might be most concerned with children who have social difficulties, who fight during recess, or who have internalizing emotional problems that faculty recognize are beyond their expertise as educators. They also might be interested in “all of the above.”

Find out how long the school has had counselors working there. Schools who have had clinicians from CAPs or other organizations (e.g., Ohel) might have very clear ideas of what they want, while other schools might not.

Keep in mind that while the principal’s perspective provides valuable context about the school and your overall role, those expectations might not be shared by all of the school personnel, and it might not be the principal’s goals that most impact your regular activities. The types of issues that get sent to you and the expectations regarding what you will do to address them are, in practice, largely determined by the referral system that the school (implicitly or explicitly) sets up. See the section entitled “The Referral System” later for a more extensive discussion.

2. POLICIES

One of the keys to a smooth working experience in the schools is to clarify at the outset what is to be expected from you and from the school. Each school will receive a memo from CAPs-SBMH that outlines the basic policies that relate to them. However, it is important to discuss them directly with the administrators, as well. You should discuss the following:

A. CONSENT

As clinicians, we are legally and ethically required to obtain parental consent for any ongoing treatment (see “clipboard”) that we provide, with the exception of: (1) classroom observations and (2) one-time crisis interventions. Signed consent forms should be received by the clinician before the first session. In the event that obtaining written consent will present a logistical impediment to timely treatment, clinicians are permitted to provide one session based on verbal consent, after which any further sessions must wait until completion of the form.