"AND KEEP THE CHANGE…": A SCHOOL-BASED COMMUNITY

INTERVENTION MODEL

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

COMMUNITY

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY

OF

RUTGERS,

THE STATE UNIVERSITY OF NEW JERSEY

BY

BINYAMIN L. GOLDMAN

IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE

OF

DOCTOR OF PSYCHOLOGY

NEW BRUNSWICK, NEW JERSEY   OCTOBER, 2010

APPROVED: _____

MAURICE J. ELIAS, PHD

_____

LEWIS GANTWERK, PSYD

DEAN: _____

STANLEY MESSER, PHD

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.

ACKNOWLEDGEMENTS

"How can I help?" Like most people in this field, that was the objective that led me to psychology. I came to GSAPP to find the answer, but what I learned, instead, was how to ask the question. My training certainly equipped me with the skills to help in the ways that I had supposed it would. More than that, however, it taught me to think and see in new ways that opened up a wide range of "how"s that I had never imagined.

Maurice Elias was particularly instrumental in that process. In the classroom, through his work, and as a person, he has brought to life the concepts, values, and practical concerns of community psychology for me in a way that demands both thought and action. Maurice's deeply held Judaism is infused with an ethic of social justice and generosity of time and spirit that fuel his untiring work to most effectively improve the lives of other human beings throughout the world. The model that he sets compels those around him to make a difference, and it makes me proud to be a psychologist and a Jew. I consider Maurice my *rebbe* (teacher) for true commitment to the human community.

I owe tremendous gratitude to the staff, administration, and clients at the Center for Applied Psychology at Bikur Cholim of Rockland County for helping me to grow in so many ways as a professional and as a clinician. Dr. Isaac Schechter, the Center's director, has been an invaluable mentor to me as a clinician and administrator. The institution that he has built is

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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).

<div align="center">School-Based Community Interventions</div>

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 of
"second-order" (Watzlawick, Weakland, & Fiscch, 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. **E**thnography

2. **P**artnering

3. **I**ntervention Setup and service delivery

4. **C**ounselor integration

5. **O**wership

6. **S**cool network-building

7. **C**ross-network problem-solving, and

8. **R**eadiness

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.

<div align="center">Service Delivery Phase</div>

<div align="center">*Stage 3: Intervention Setup/Individual Service*</div>

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.

<center>*Stage 5: Ownership*</center>

     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)."
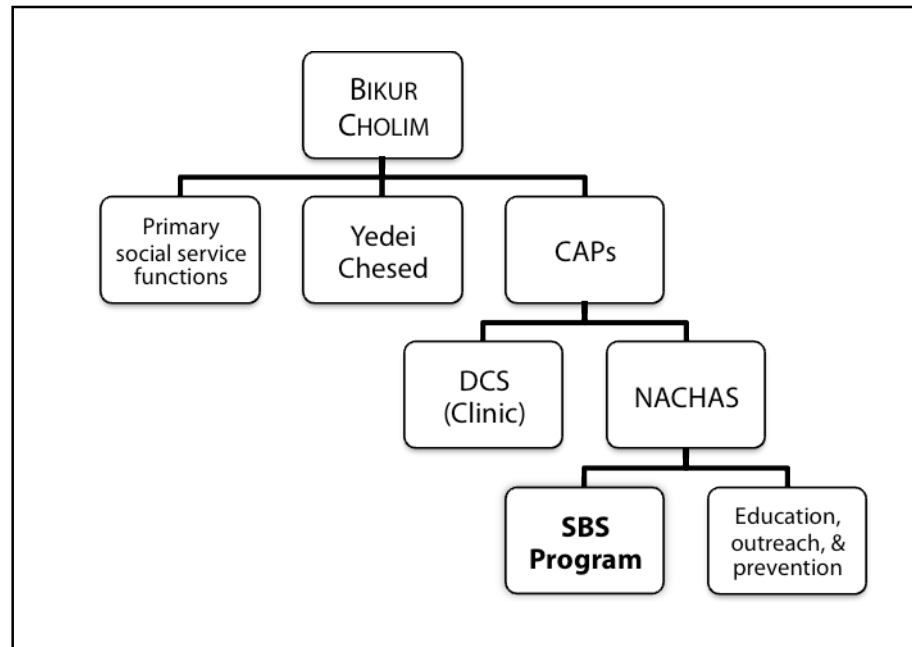
Figure 1. Bikur Cholim, School Based Services Program organizational chart.

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, 198 4, 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 UOHJ 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).

<center>Pre-Entry Phase</center>

<center>*Ethnography*</center>

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.

Partnering

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 were, 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 organzation'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 thatn 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).
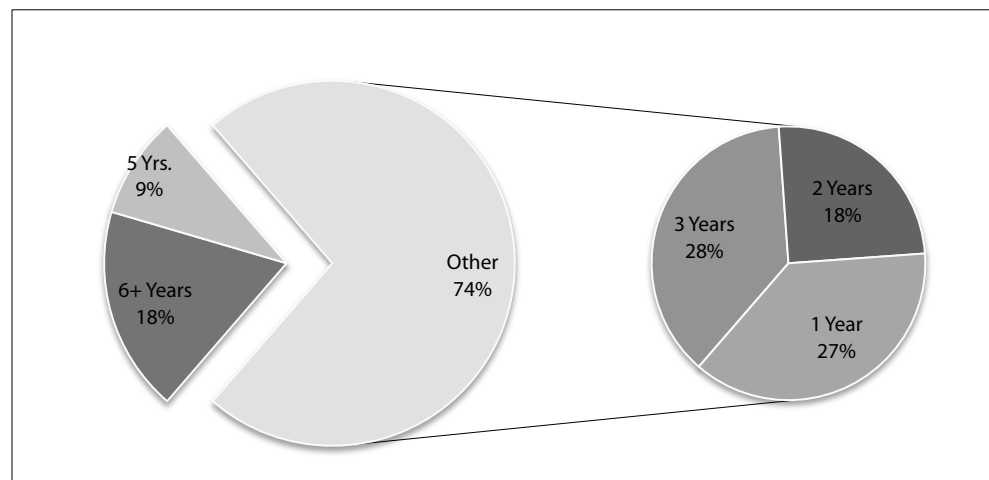
Figure 2. Percentage of schools served by mental health professional, by number of years.

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."

<div align="center">*Ownership*</div>

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.

<div align="center">Scaling Up Phase</div>

<div align="center">*School Network Building*</div>

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 be 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.

<div align="center">Impact Phase</div>

<div align="center">*Indicators of Change*</div>

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.
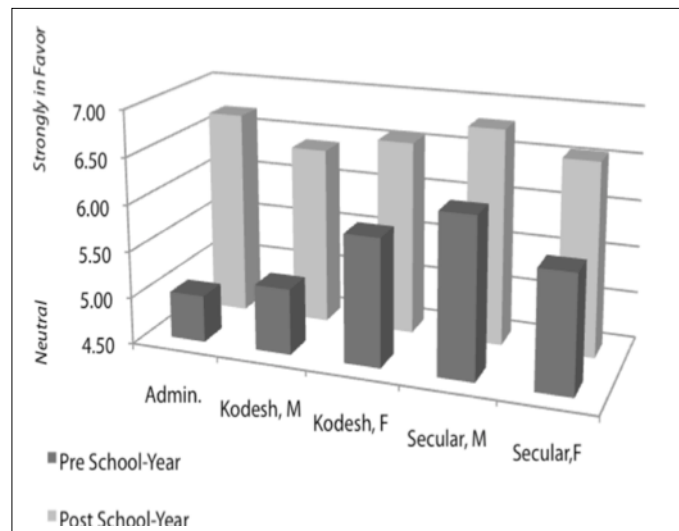
Figure 3. Attitudes toward counselor in school, before and after '08-'09

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.

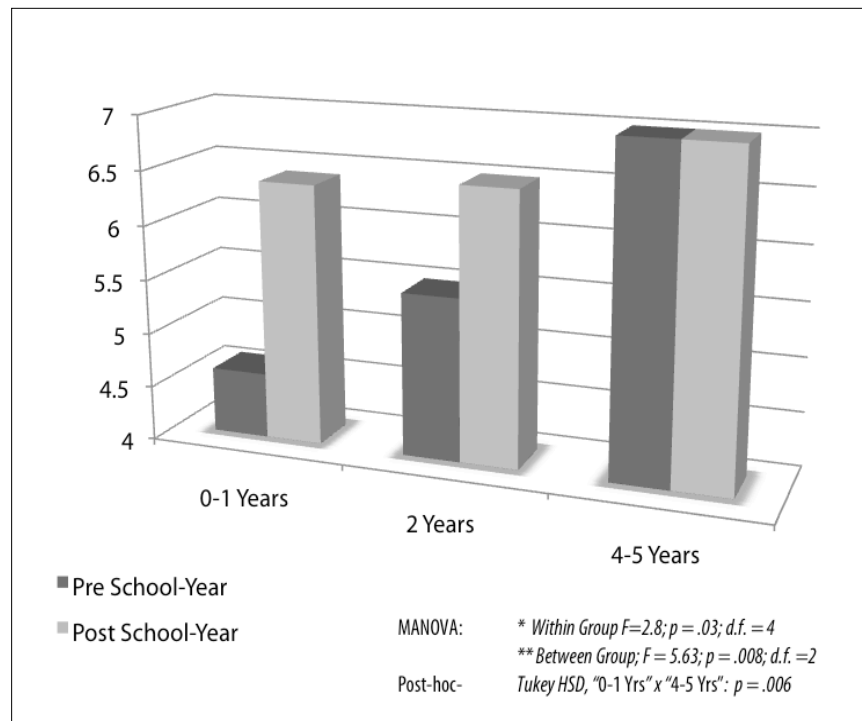   *The first years.* The events began in the summer of 2008, when CAPs received federal funding through the East Ramapo Central School District to conduct educational programming for parents in the community. CAPs administrators and clinicians developed a back-to-school program that was both relevant and 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 wit 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 "pearnting 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.

REFERENCES

Adelman, H. S., & Adelman, L. (2000). Looking at school health and school reform policy through the lens of addressing barriers to learning. *Children's Services*, *3*(2), 117-132.

Adelman, H. S. (1993). School-linked mental health interventions: Toward mechanisms for service coordination and integration. *Journal of Community Psychology*, *21*(4). Retrieved from http://www3.interscience.wiley.com/journal/112408976/abstract

Adelman, H. S., & Taylor, L. (2006). Mapping a school's resources to improve their use in preventing and ameliorating problems. *The school services sourcebook: A guide for school-based professionals,* 977ñ990.

Albee, G. W. (1959). *Mental health manpower trends.* New York: Basic Books.

Albee, G. W. (1968). Conceptual models and manpower requirements in psychology. *American Psychologist*, *23*, 317-320.

Alvidrez, J. (2005). Ethnic variations in mental health attitudes and service use among low-income African American, Latina, and European American young women. *Community Ment Health Journal*, *35*(6), 515-530.

Anderson-Butcher, D., Lawson, H. A., Bean, J., Falspohler, P., Boone, B., & Kwiatkoski, A. (2008). Community collaboration to improve schools: Introducing a new model from Ohio. *Children & Schools*, *30*(3), 161-172.

Arum, R. (2000). Schools and communities: Ecological and institutional dimensions. *Annual Review of Sociology*, *26*, 395-418.

Baumel-Schwartz, J. T. (2009). Frum Surfing: Orthodox Jewish Womenís Internet Forums as a Historical and Cultural Phenomenon. *Journal of Jewish Identities*, *2*(1). Retrieved from http://muse.jhu.edu/journals/journal_of_jewish_identities/v002/2.1.baumel-schwartz.pdf

Beehr, T., & O'Driscoll, P. (2002). Organizationally targeted interventions aimed at reducing workplace stress. In J. Thomas & M. Hersen (Eds.), *Handbook of mental health in the workplace* (pp. 103-119). London: Sage.

Best, A., Stokols, D., Green, L. W., Leischow, S., Holmes, B., & Buchholz, K. (2003). An integrative framework for community partnering to translate theory into effective health

promotion strategy. *American Journal of Health Promotion*, *18*(2), 168–176.

Blumen, O. (2007). The performative landscape of going-to-work: on the edge of a Jewish ultraorthodox neighborhood. *ENVIRONMENT AND PLANNING D*, *25*(5), 803. doi:10.1068/d76j

Bowen, G. L. (2007). Social organization and schools: A general systems theory perspective. In P. Allen-Meares (Ed.), *Social work services in schools* (pp. 60-80). Boston: Pearson Allyn and Bacon.

Bowen, G. L., & Richman, J. M. (2002). Schools in the Context of Communities. *Children & Schools*, *24*(2), 67-71.

Braa, J., Monteiro, E., & Sahay, S. (2004). Networks of action: Sustainable health information systems across developing countries. *MIS Quarterly*, *28*(3), 337-362.

Branden-Muller, L.R., & Elias, M. J. (1991). Catalyzing the primary prevention revolution in the schools: The role of school psychologists. *Journal of Educational and Psychological Consultation*, *2*(1), 73–88.

Bronfenbrenner, U. (1989). Ecological systems theory. In R. Vasta (Ed.), *Annals of child development* (pp. 187-249). Greenwich, CT: JAI Press.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Bronstein, M. (2007). *Cultural and religious factors in the acceptance or resistance to mental health treatment in three subgroups of the Orthodox community.* PhD Union Institute & University, Cincinnati, OH.

Bryan, J. (2005). Fostering Educational Resilience and Achievement in Urban Schools through School-Family-Community Partnerships. *Professional School Counseling*, *8*(3), 9.

Buchbinder, J. T. (1991). Mental health services in the Charedi community in Jerusalem. *B'or Hatorah*, 7, 245-260.

Butler, J. (1993). *Bodies that Matter: On the Discursive Limits of `Sex'.* London: Routledge.

Butler, J. (1990). *Gender Trouble.* London: Routledge.

Campbell, H. (2007). What Hath God Wrought?: Considering How Religious Communities Culture (or Kosher) the Cell Phone. *Continuum*, *21*(2), 191-203. doi:10.1080/10304310701269040

Caplan, G. (Ed.). (1961). *Prevention of mental disorders in children.* New York: Basic Books.

Cappella, E., Frazier, S., Atkins, M., Schoenwald, S., & Glisson, C. (2008). Enhancing schools' capacity to support children in poverty: An ecological model of school-based mental health services. *Adm Policy Ment Health*, *35*(5), 395-409. doi:10.1007/s10488-008-0182-y

Costello, E. J., Copeland, W., Cowell, A., & Keeler, G. (2007). Service Costs of Caring for Adolescents With Mental Illness in a Rural Community, 1993-2000. *Am J Psychiatry*, *164*(1), 36-42. doi:10.1176/appi.ajp.164.1.36

Cowen, E. L. (1991). In pursuit of wellness. *American Psychologist*, *46*(4), 404-408. Retrieved from http://content.apa.org/psycinfo/1991-24195-001

Cowen, E. L. (1977). Baby-steps toward primary prevention. *American Journal of Community Psychology*, *5*(1), 1-22.

Dalton, J., Elias, M., J., & Wandersman, A. (2007). *Community psychology: Linking individuals and communities* (Second ed.). Belmont, CA: Thomson Wadsworth.

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J. P., et al. (2004). Prevalence, severity and unmet need for treatment of mental disorders in the World Health Organization World Mental Health (WMH) Surveys. *JAMA*, *291*, 2581-2590.

Deutsch, N. (2009). The Forbidden Fork, the Cell Phone Holocaust, and Other Haredi Encounters with Technology. *Contemporary Jewry*, *29*, 3-19. doi:10.1007/s12397-008-9002-7

Dohrenwend, B. P. (1990). Socioeconomic Status (SES) and Psychiatric Disorders. *Social Psychiatry & Psychiatric Epidemiology*, *25*, 41-47.

Douglas, M. (1966). *Purity and danger.* London: Routledge & Kegan Paul.

Ehrhardt-Padgett, G. N., Hatzichristou, C., Kitson, J., & Meyers, J. (2003). Awakening to a new dawn: Perspectives of the future of school psychology. *School Psychology Quarterly*, *18*(4), 483-496.

Eiraldi, R., Mazzuca, L., Clarke, A., & Power, T. (2006). Service utilization among ethnic minority children with adhd: A model of help-seeking behavior. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(5), 607-622. doi:10.1007/s10488-006-0063-1

Elias, M. J. (1987). Establishing enduring prevention programs: advancing the legacy of Swampscott. *American Journal of Community Psychology*, *15*, 539-553.

Elias, M. J., Patrikakou, E. N., & Weissberg, R. P. (2007). A Competence-Based Framework for Parent School Community Partnerships in Secondary Schools. *School Psychology International*, *28*(5), 540. doi:10.1177/0143034307085657

Erikson, E. (1984). "Identity and Uprootedness in Our Time," in *Insight and Responsibility.*. New York: Norton.

Goldberg, D., & Huxley, P. (1980). *Mental Illness in the Community: The Pathway to Psychiatric Care.* London: Travistock Publications.

Greenberg, D., & Witzum, E. (2001). *Sanity and sanctity: Mental health work among the ultra-orthodox in Jerusalem.* New Haven, CT: Yale University Press.

Greenberg, M., T. 1,2, Weissberg, R., P. 1,3,6, O'brien, M. U. 1,3, Zins, J., E. 1,4, Fredericks, L. 1,3, Resnik, H. 1,3 et al. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist*, *58*(6-7), 466-474.

Gresham, F. M. (2004). Current Status and Future Directions of School-Based Behavioral Interventions. *School Psychology Review*, *33*(3), 326-344. Retrieved from http://www.questia.com/PM.qst?a=o&se=gglsc&d=5007600468

Harrison, M. E., Mckay, M. M., & Bannon, W. M. (2004). Inner-city child mental health service use: The real question is why youth and families do not use services. *Community Mental Health Journal*, *40*(2), 119-131. doi:10.1023/B:COMH.0000022732.80714.8b

Hartog, K., & Gow, K. M. (2005). Religious attributions pertaining to the causes and cures of mental illness. *Mental Health, Religion & Culture*, *8*(4), 263-276. doi:10.1080/13674670412331304339

Hawe, P., Shiell, A., & Riley, T. (2009). Theorising interventions as events in systems. *American Journal of Community Psychology*, *43*, 267-276.

Heilman, S. (1992). *Defenders of the faith: Inside Ultra-Orthodox Jewry.* New York: Schocken.

Heilman, S. (2006). *Sliding to the right: The contest for the future of American Jewry.* Berkeley, CA: University of California Press.

Heilman, S. C., & Witztum, E. (1997). Value-sensitive therapy: Learning from Ultra-Orthodox patients. *American journal of psychotherapy*, *51*(4), 522-541.

Hoagwood, K., & Johnson, J. (2003). School psychology: A public health framework: I. From evidence-based practices to evidence-based policies. *Journal of School Psychology*, *41 1*, 3-21.

Holingshead, A., & Redlich, F. (1958). *Social class and mental illness: A community study.* New York: Wiley.

Ife, J. (2002). *Community development: Community-based alternatives in an age of globalisation.* Pearson Education Australia.

Jason, L. A., Keys, C. B., Suarez-Balcazar, Y., Taylor, R. R., Davis, M. I., Durlak, J. et al. (2004). *Participatory community research: Theories and methods in action.* Washington, DC: American Psychological Association.

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among US children: variation by ethnicity and insurance status. *American Journal of Psychiatry*, *159*(9), 1548–1555.

Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1999). Barriers to Treatment Participation Scale: Evaluation and Validation in the Context of Child Outpatient Treatment. *Year Book of Psychiatry & Applied Mental Health*, *1*, 66.

Kelly, J. G. (2006). *On Becoming ecological: An expedition into community psychology.* New York: Oxford University Press.

Kelly, J. G. (1968). Toward an ecological conception of preventive interventions. In J. J Carter (Ed.), *Research Contributions from Psychology to Community Mental Health* (pp. 77-99). New York: Behavioral Publications.

Kessler, R. C., & Merikangas, K. R. (2004). *The National Comorbidity Survey Replication (NCS-R): background and aims* (13).

Kessler, R. C., Zhao, S., Katz, S. J., Kouzis, A. C., Frank, R. G., Edlund, M., et al. (1999). Past year use of outpatient services for psychiatric problems in the National Comorbidity Survey. *American Journal of Psychiatry*, *156*, 115-123.

Krueger, J. P., & Parish, R. (1982). We're making the same mistakes: Myth and legend in school improvement. *Planning and Changing*, *13*(3), 131-140.

Le Compte, M. D., & Schensul, J. J. (1999). *Analyzing & interpreting ethnographic data (5th ed.).* Walnut Creek, CA: AltaMira Press.

Levitz, I. N. (1979). Orthodoxy and mental health : Suggested parameters for empirical studies. *Journal of Psychology and Judaism*, *4*(2), 87-99.

Linney, J. A. (1990). Community psychology into the 1990's: capitalizing opportunity and promoting innovation. *American Journal of Community Psychology*, *18*, 1-17.

Luke, D. A. (2005). Getting the big picture in community science: Methods that capture context. *American Journal of Community Psychology*, *35*(3), 185-200.

McLean, C, Campbell C, & F, C. (2003). African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re)productive of health inequalities. *Social Science & Medicine*, *56*, 657-669.

Meyers, A. B., & Swerdlik, M. E. (2003). School-based health centers: Opportunities and challenges for school psychologists. *Psychology in the Schools*, *40*(3). Retrieved from http://www3.interscience.wiley.com/journal/104086535/abstract

Meyers, J., Gaughan, E., & Pitt, N. (1990). Contributions of community psychology to school psychology. In T. B. Gutkin & C. R. Reynolds (Eds.), *The Handbook of School Psycholgy* (pp. 198-217). New York: John Wiley and Sons.

Miller, G. A. (1969). Psychology as a means of promoting human welfare. *American Psychologist*, *24*(12), 1063-1075.

Nastasi, B. K. (2000). School psychologists as health-care providers in the 21st century: Conceptual framework, professional identity, and professional practice. *School Psychology Review*, *29*(4), 540-554.

Nastasi, B. K., Varjas, K., Schensul, S. L., Silva, K. T., Schensul, J. J., & Ratnayake, P. (2000). The Participatory Intervention Model: A Framework for Conceptualizing and Promoting Intervention Acceptability. *School Psychology Quarterly*, *15*(2), 207-232.

Nastasi, B. K., & Hitchcock, J. (2009). Challenges of evaluating multilevel interventions. *American Journal of Community Psychology*, *43*(3), 360-376.

Nastasi, B., K., Varjas, K., Bernstein, R., & Pluymert, K.
    (1998). Mental Health Programming and the Role of School
    Psychologists. *School Psychology Review*, *27*(2), 217-232.

National Institute of Mental Health (1999). Mental Health: A
    Report of the Surgeon General.

Nelson, G., & Prilleltensky, I. (2004). *Community psychology: In
    pursuit of liberation and well-being.* New York: Palgrave
    Macmillan.

Newman, D. (1985). Integration and ethnic spatial concentration:
    the changing distribution of the Anglo-Jewish community.
    Transactions of the Institute of British Geographers, *10*,
    360-376.

O'Donnell, C. R., Tharp, R. G., & Wilson, K. (1993). Activity
    settings as the unit of analysis: A theoretical basis for
    community intervention and development. *American Journal of
    Community Psychology*, *21*(4), 501-520.

Osher, D., & Keenan, S. (2002). *Instituting school-based links
    with mental health and social service agencies* (6). Portland,
    OR: Northwest Regional Educational Laboratory.

Owens, p. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska,
    J. M., Kellam, S. et al. (2002). Barriers to children's
    mental health services. *Journal of the American Academy of
    Child and Adolescent Psychiatry*, *41*(6).

Ozechowski, T. J., & Waldron, H. B. (2008). Assertive Outreach
    Strategies for Narrowing the Adolescent Substance Abuse
    Treatment Gap: Implications for Research, Practice, and
    Policy.

Pavuluri, M. N., Luk, S. L., & McGee, R. (1996). Help-seeking for
    behavior problems by parents of preschool children: a
    community study. *Journal of Amer Academy of Child \&
    Adolescent Psychiatry*, *35*(2), 215.

Pescosolido, B., Perry, B., Martin, J., Mcleod, J., & Jensen, P.
    (2007). Stigmatizing attitudes and beliefs about treatment
    and psychiatric medications for children with mental illness.
    Psychiatric Services, *58*(5), 613.

Health, P. N. F. C. o. M. (2003). Achieving the Promise:
    Transforming Mental Health Care in America.

Power, T. J. (2003). Promoting children's mental health: Reform
    thorugh interdisciplinary and community partnerships. *School
    Psychology Review*, *31*(1), 3-16.

Power, T. J., Shapiro, E. S., & Dupaul, G. J. (2003). Preparing psychologists to link systems of care in managing and preventing children's health problems. *Journal of Pediatric Psychology*, *28*(2), 147-155.

Prilleltensky, I., & Prilleltensky, O. (2006). *Promoting well-being: linking personal, organizational, and community change.* New York: Wiley.

Prodente, C., Sander, M., & Weist, M. (2002). Furthering support for expanded school mental health programs. *Children??s Services*,. Retrieved from http://www.informaworld.com/index/787457416.pdf

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology*, *9*(1), 1-25.

Robins, L. N., & Regier, DA (Eds.). (1991). *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study.* New York: Free Press.

Rochlen, A. B., Whilde, M. R., & Hoyer, W. D. (2005). The Real Men. Real Depression Campaign: overview, theoretical implications, and research considerations. *Psychology of Men and Masculinity*, *6*(3), 186.

Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review*, *3*(4), 223-241.

Ross, M. R., Powell, S. R., & Elias, M. J. (2002). New roles for school psychologists: Addressing the social and emotional learning needs of students. *School Psychology Review*, *31*(1), 43-52.

Rost, K., Fortney, J., Fischer, E., & Smith, J. (2002). Use, quality, and outcomes of care for mental health: The rural perspective. *Medical Care Research and Review*, *59*(3), 231. doi:10.1177/1077558702059003001

Weiss, S. (1999). A Jewish Language in the Making: Review of Frumspeak: The First Dictionary of Yeshivish. *International Journal of the Sociology of Language*, *138*, 180-187.

Sarason, S. B. (1996). *Revisiting "The Culture of the School and the Problem of Change"*. New York: Teachers College Press.

Sarason, S. B., & Klaber, M. (1985). The school as a social situation. *Annual Review of Psychology*, *36*(1), 115-140.

Sartorius, N. (1998). Stigma: what can psychiatrists do about it? *Lancet(British edition)*, *352*(9133), 1058-1059.

Schensul, J. J. (2009). Community, culture and sustainability in multilevel dynamic systems intervention science. *Am J Community Psychol*, *43*(3-4), 241-256. doi:10.1007/s10464-009-9228-x

Schensul, J. J., Saggurti, N., Singh, R., Verma, R. K., Nastasi, B. K., & Mazumder, P. G. (2009). Multilevel perspectives on community intervention: example from an Indo-US HIV prevention project in Mumbai, India. *American Journal of Community Psychology*, *43*, 277-291.

Schensul, J. J., & Trickett, E. (2009). Introduction to multi-level community based culturally situated interventions. *Am J Community Psychol*, *43*(3-4), 232-240. doi:10.1007/s10464-009-9238-8

Schnall, E. (2006). Multicultural counseling and the Orthodox Jew. *Journal of Counseling & Development*, *84*(3), 276-282. Retrieved from http://aca.metapress.com/index/CLDG4WEL5C1RQ75F.pdf

Schnitzer, G., Loots, G., Escudero, V., & Schechter, Y. (in press). Negotiating the pathways into care in a globalizing world: Help-seeking behavior of Ultra-Orthodox Jewish parents. *International Journal of Social Psychiatry*,.

Scott, W. R. (1994). Institutions and organizations: Toward a theoretical synthesis. In W. R. Scott & J. W. Meyer (Eds.), *Institutional environments and organizations: structural complexity and individualism* (pp. 55-79). Thousand Oaks, CA: Sage Publications.

Seidman, E. (1988). Back to the future, community psychology: unfolding a theory of social intervention. *American Journal of Community Psychology*, *16*, 3-24.

Shaul, M. S. (2000). *At-risk youth: School-community collaborations focus on improving student outcomes (Report to the Honorable Charles B. Rangel, House of Representatives)*. Washington, DC: United States General Accounting Office.

Shinn, M., & Yoshikawa, H. (Eds.). (2008). *Toward Positive Youth Development: Transforming Schools and Community Programs*. New York: Oxford Univ. Press.

Sibley, D. (1981). *Outsiders in urban societies*. Oxford: Basil Blackwell.

Sibley, D. (1988). The purification of space Environment and
     Planning D: Society and Space. *6*, 409-421.

Smith, E. P., Connell, C. M., Wright, G., Sizer, M., & Norman, J.
     M. (1997). An ecological model of home, school, and community
     partnerships: Implications for research and practice. *Journal
     of Educational and Psychological Consultation*, *8*(4), 339-360.

Sofear, S. (2000). *Working together, moving ahead: A manual to
     support effective community-based coalitions.* New York: City
     University of New York, Baruch College.

Sonn, C. C., & Fisher, A. T. (1998). Sense of community:
     Community resilient responses to oppression and change.
     Journal of Community Psychology, *26*(5), 457-472.

Spolsky, B., & Benor, S. B. (2006). Jewish Languages. In K. Brown
     (Ed.), *Encyclopedia of Language and Linguistics, 2nd ed.* (pp.
     120-124). Oxford, UK: Elsevier.

Stefl, M. E., & Prosperi, D. C. (1985). Barriers to mental health
     service utilization. *Community Mental Health Journal*, *21*,
     167-178.

Steinmetz, S. (1981). Jewish English in the United States.
     American Speech, *56*(1), 3-16.

Stith, S., Pruitt, L., Dees, J., Fronce, M., Green, N., Som, A.
     et al. (2006). Implementing community-based prevention
     programming: A review of the literature. *Journal of Primary
     Prevention*, *27*, 599-617.

Trickett, E. J., Kelly, J. G., & Todd, D. M. (1972). The social
     environment of the school: guidelines for individual change
     and organizational redevelopment. In S. Golan & C. Eisdorfer
     (Eds.), *Handbook of community mental health* (pp. 331-406).
     New York: Appleton-Century-Crofts.

Trickett, E. J. (1997). Ecology and primary prevention:
     Reflections on a meta-analysis. *American Journal of Community
     Psychology*, *25*(2), 197-205.

Trickett, E. J. (2005). Community interventions and HIV/AIDS:
     Affecting the community context. In E Trickett & W. Pequegnat
     (Eds.), *Community Interventions and AIDS* (pp. 3-27). New
     York: Oxford University Press.

Trickett, E. J., & Espino, S. L. R. (2004). Collaboration and
     social inquiry: Multiple meanings of a construct and its role
     in creating useful and valid knowledge. *American Journal of
     Community Psychology*, *34*(1), 1-69.

Trickett, E. J. (2009a). Community psychology: individuals and interventions in community context. *Annu Rev Psychol*, *60*, 395-419. doi:10.1146/annurev.psych.60.110707.163517

Trickett, E. J. (2009b). Multilevel community-based culturally situated interventions and community impact: an ecological perspective. *Am J Community Psychol*, *43*(3-4), 257-266. doi:10.1007/s10464-009-9227-y

Trickett, E. J., & Birman, D. (1989). Taking ecology seriously: A community development approach to individually based interventions. In L. A. Bond & B. E. Compa (Eds.), *Primary prevention and promotion in the schools (vol XII)*. Newbury Park, CA: Sage.

Tulloch, J. (1999). *Performing Culture: Stories of Expertise and the Everyday.* London: Sage.

Turner, E. A., & Liew, J. (2009). Children's Adjustment and Child Mental Health Service Use: The Role of Parents' Attitudes and Personal Service Use in an Upper Middle Class Sample. *Community Ment Health J*,. doi:10.1007/s10597-009-9221-8

U.S. Surgeon General. (2000). Mental health: A report of the Surgeon General. *Washington, DC*,.

United States Public Health Service. (2000). *Report of the surgeon general's conference on children's mental health: A national action agenda.* Washington, D.C.: Department of Health and Human Services.

Valins, O. (2000a). Institutionalised religion: sacred texts and Jewish spatial practice. *Geoforum*, *31*(4), 575-586.

Valins, O. (2000b). Institutionalised religion: Sacred texts and jewish spatial practice. *Geoforum*, *31*(4), 575-586.

Wandersman, A., Kloos, B., Linney, J. A., & Shinn, M. (2005). Science and community psychology: Enhancing the vitality of community research and action [Special issue]. *American Journal of Community Psychology*, *35*(3/4).

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-Month Use of Mental Health Services in the United States: Results From the National Comorbidity Survey Replication. *Arch Gen Psychiatry*, *62*(6), 629-640. doi:10.1001/archpsyc.62.6.629

Warren, R. L. (1967). The interorganizational field as a focus for investigation. *Administrative Science Quarterly*, *12*(3), 396-419.

Waterman, S. (1989). *Jews in an outer London borough.* London:
    Barnet University of London.

Waterman, S., & Kosmin, B. A. (1998). Residential patterns and
    processes: a study of Jews in three London boroughs.
    Transactions of the Institute of British Geographers, *13*, 75-
    91.

Watts, R., & Flanagan, C. (2007). Pushing the envelope on youth
    civic engagement: a developmental and liberation psychology
    perspective. *Journal of Community Psychology*, *35*(6), 779-792.

Watzlawick, P., Weakland, J., & Fiscch, R. (1974). *Change:
    principles of problem formation and problem resolution.* New
    York: Norton.

Waxman, R., Weist, M., & Benson, D. (1999). Toward collaboration
    in the growing education-mental health interface. *Clinical
    Psychology Review*, *19*(2), 239-253.

Weick, K., & Quinn, R. (1999). Organizational change and
    development. *Annual Review of Psychology*, *50*, 361-386.

Weiser, C. (1995). *Frumspeak: The First Dictionary of Yeshivish.*
    Northvale, NJ: Jason Aronson.

Weissberg, R. P., & O'Brien, M. U. (2004). What works in school-
    based social and emotional learning programs for positive
    youth development. *The Annals of the American Academy of
    Political and Social Science*, *591*(1), 86.

Weist, M. D. (1997). Expanded School Mental Health Services.
    Advances in clinical child psychology, 319.

Weist, M., Sander, M., Walrath, C., Link, B., Nabors, L.,
    Adelsheim, S. et al. (2005). Developing principles for best
    practice in expanded school mental health. *Journal of Youth
    and Adolescence*, *34*(1), 7-13. doi:10.1007/s10964-005-1331-1

World Psychiatric Association. (1996). Campaign to open doors.

Appdendix A

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

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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
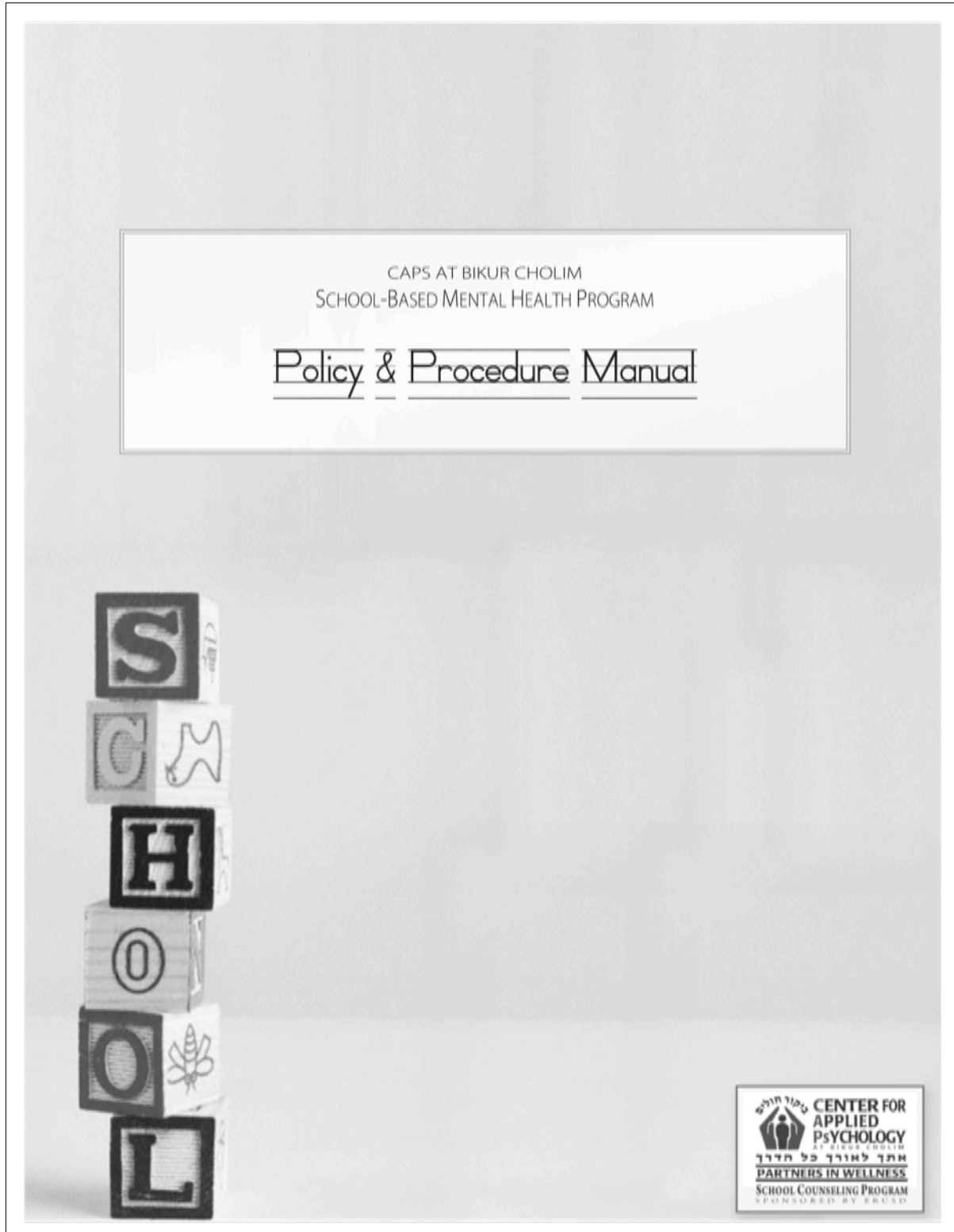
Starting the Year

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 *Yammim 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 (s)he is not the SBMH 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.

Although the clinicians' manual uses terms like "treatment" and "client," educators might be put off by overly clinical language. Try to stick to words like "counseling" and "students" that are more congruent with an educational setting.