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OVERVIEW

Facilitating School, Family, and Community Partnerships: Enhancing Student Mental Health: An Overview of the Special Series

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Abstract At least one in five school children in the United States have significant mental health problems, with only 60% of these children actually receiving services for their difficulties. Given the complexity and interconnectedness of the systems impacting children's mental health, key partnerships are needed to efficiently and effectively address the mental health needs of children and youth. Through multisystemic partnerships, school and pediatric psychologists collaborate with family and community partners to co-develop assessment and intervention procedures. The main purpose of this article was to describe extant models of partnership in order to provide a basis for conceptualizing an optimal process for delivering mental health services across a variety of contexts. Common elements across the various models were noted and linked to the contributions made by the articles contained within this special edition. The papers included in this series are also reviewed briefly.

Keywords School partnership · Partnership models · School mental health

In 2007, slightly more than 5% of parents reported their children had serious difficulties with emotions, concentration, behavior, or social relationships (Federal Interagency Forum on Child and Family Statistics, 2009). At least one in five school children in the United States have significant mental health problems, with only 60% of these children actually receiving services for their difficulties (Foster, Rollefson, Doksum, Noonan, Robinson, & Teich, 2005; US Department of Health and Human Services, 1999). Further, 25–30% of American children experience school adjustment problems, and school maladjustment is as high as 60% for some economically disadvantaged urban districts (Foster et al., 2005; National Research Council & Institute of Medicine, 2004). Children with chronic health difficulties and their families are at increased risk for mental health difficulties (Hysing, Elgen, Gillberg, & Lundervold, 2009; Kazak, Alderfer, Rourke, Simms, Streisand, & Grossman, 2004) and the immediate and long-term effects of mental health problems in children have been well documented (Broidy et al., 2003). Despite the need for mental health services and the deleterious outcomes these children may experience, only 20% of children with mental disorders are identified and receive mental health services in any given year (US Department of Health and Human Services, 1999).

Health disparities and unequal access to care highlight the need to address children's health across a variety of contexts (Kelleher, McInerny, Gardner, Childs, & Wasserman, 2000). Children living in low-income families are disproportionately represented among racial and minority groups, and they are especially susceptible to chronic illnesses (Clay Mordhorst, & Lehn, 2002) and mental health difficulties (Annie E. Casey Foundation, 2009; US Department of Health and Human Services, 2001). The inadequate provision of mental health services has been attributed to both economic and social-cultural factors, such as poverty, inadequate health insurance, social stigma, and limited access to culturally appropriate services (Clay et al., 2002; US Department of Health & Human Services, 1999). Given ongoing difficulties with

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equitable access to health care, including mental health services, schools have become a primary site for service delivery. In fact, approximately 20% of students are estimated to receive school-based mental health services (Foster et al., 2005).

The complexity and interconnectedness among family, school, and community systems impacting children's mental health make it essential to form partnerships to address the social, emotional, behavioral, and academic needs of all children (Christenson & Sheridan, 2001). Through multisystemic partnerships, school and pediatric psychologists share decision-making processes with family and community partners to co-develop assessment and intervention procedures according to specific contextual needs (Fantuzzo, McWayne, & Bulotsky, 2003; Nastasi, Moore, & Varjas, 2004; Nastasi, Varjas, Bernstein, & Jayasena, 2000; Nastasi, Varjas, Schensul, Silva, Schensul, & Ratnayake, 2000). Moreover, models of comprehensive partnerships are characterized by family and community empowerment through decision making and addressing culturally relevant priorities for change (Fantuzzo & Mohr, 2000; Sheridan & Kratochwill, 2007). This focus on mutual respect and accountability contributes to sustained supports for families, schools, and communities to promote children's well-being across systems (Power, DuPaul, Shapiro, & Kazak, 2003; Sugai & Horner, 2002). According to a growing body of evidence in the literature, research involving equitable partnerships among researchers and community stakeholders is recognized for addressing the distinct challenges of implementing evidenced-based interventions in at-risk communities (Fantuzzo et al., 2003; Fantuzzo & Mohr, 2000; Nastasi et al., 2004). If researchers in pediatric, school, and community psychology truly desire to promote the transition from research to practice, we believe that they must begin to proactively address partnership-based research.

A search of the literature for published papers or book chapters on partnership-based models for interventions and service delivery was conducted in PychINFO using the keywords, "partnership model." The initial search yielded 40 articles, and the abstracts of these articles were further reviewed in order to identify unique models for developing and sustaining partnerships. Books, commentaries, and dissertations were excluded. The authors chose several models in order to illustrate both specific school mental health initiatives and community-based partnerships.

The main purpose of this article was to describe the extant models of partnership utilized across a variety of disciplines and the application of features of these models when addressing the mental health needs of children and youth. Common elements across the various models are noted and linked to the contributions made by the articles contained in this special edition. Despite the professed specificities of these models, the models in the literature were striking in their similarities rather than differences.

Brief Descriptions of Various Models of Partnership

Participatory Action Research Model

Lewin (1946) articulated a research approach that sought to address community-level problems in a manner that translated into social action. The Action Research approach to empirical inquiry proposed that research that fails to produce meaningful change is ill-conceived and detrimental to future research. Therefore, research should be targeted to specific needs within a community and that the resources inherent to that community are utilized to increase the reliability and applicability of the results. The approach consists of four elements: (a) identify community-level problems; (b) gather all available information; (c) develop and implement a research plan; and (d) evaluate outcomes with regard to whether research goals have been met. In the latter element, community-level participation in data collection and interpretation is particularly important. The values articulated by Action Research principles have had a profound impact on the development of more contemporary approaches to community partnership and collaborative research efforts such as Participatory Action Research (Greenwood, Whyte, Foote, & Harkavy, 1993).

Participatory Action Research models (Greenwood et al., 1993) extend the paradigm of Action Research (Lewin, 1946) to meaningfully address social and organizational difficulties occurring across the spectrum of the human enterprise. This model is predicated upon the notion that partnering with relevant stakeholders to address social problems results in better research designs and more meaningful outcomes (Fantuzzo et al., 2003; Hughes, 2003). There are a number of key elements employed in this approach to research: (a) collaborating with relevant stakeholders; (b) soliciting stakeholder's knowledge of the problem; (c) mobilizing theory, methods, and resources from a variety of sources; (d) allowing outcomes to drive the development of theory; (e) evaluating and strengthening partnership processes on a continual basis; and (f) creating real-world programming based upon study results.

Research conducted across community, educational, and business settings have demonstrated the benefit of using this model as well as highlighted the ongoing challenges of establishing and maintaining partnerships. Nastasi, Varjas, Bernstein et al. (2000) and Nastasi, Varjas, Schensul et al. (2000) describe a Participatory Intervention Model (PIM; Greenwood et al., 1993; Nastasi, Varjas, Bernstein et al., 2000) that seeks to enlist relevant stakeholders in the process of research formulation in order to maximize

outcomes and intervention acceptability. The PIM is an extension of the model that explicitly examines the role that culture plays in the implementation process, including the variation that occurs within cultural groups. Derived from the Participatory Action Research model, researchers seek to co-construct culturally meaningful research protocols with key stakeholders. Three key components are included in this model: (a) participatory generation wherein research is shared with partners and culturally relevant interventions are selected, (b) implementation and evaluation of research design with ongoing modification to meet the needs of participants, and (c) evaluation of effectiveness and overall acceptability of the program as it was implemented.

Community-Based Partnership

The development of community-based partnerships is another application of Action Research. Founded in the models of Development in Context Evaluation or DICE (Ostrom, Lerner, & Freel, 1995) and University-CBO Collaborative Partnership or UCCP (Harper & Salina, 2000), community-based participatory research (CBPR) emphasizes the importance of partnering with community agencies to co-develop culturally sensitive assessment and intervention strategies involving important problems facing low-resource urban communities (Connor, Rainer, Simcox, & Thomisee, 2007; Minkler & Wallerstein, 2003).

Both the DICE and UCCP models involve: (a) establishing reciprocal partnerships between research institutions and community organizations, (b) co-designing evaluation programs, (c) collecting and analyzing data deemed meaningful by community members, and (d) using findings to promote systems-level community change. Similarly, modern CBPR begins with research topics identified by community members and focuses Action Research on promoting meaningful and sustainable social change to improve community health and eliminate health disparities (Brosnan, Upchurch, Meininger, Hester, Johnson, & Eissa, 2005; Harper & Salina, 2000; Rapkin, Massie, Jansky, Lounsbury, Murphy, & Powell, 2006). Through building the capacity of stakeholders, CBPR builds the strengths of multiple systems to promote effective and efficient public health research as well as to identify, study, and address health issues of importance to the community. Key examples of these capacity-building activities unique to CBPR include: (a) collaboration between researchers and program/community partners to develop the local research focus, questions, and design, (b) community-focused recruitment of study participants under the leadership of community-based program staff, (c) employment of community residents as research staff and use of a team approach in research decision making and practice, (d) joint program-research oversight, and (e) shared preliminary findings with program/community partners often engaging them in interpretation of findings and implications for program practice.

Family Partnership Model

The Family Partnership Model (Davis, 2009) focuses largely on the importance of process in building partnerships between families and professionals who work with children and families. The European Early Promotion Project is a prevention services model based on the following principles: (a) theory based, (b) clear aims and goals, (c) family centered, (d) partnership with parents, (e) community based, (f) developmental focus but address multiple needs, (g) uses evidence-based strategies, (h) involves universal early identification, (i) effective monitoring and evaluation, and (j) well-trained staff support by skilled managers. Specifically, the project aims to prevent the development of psychosocial problems in children through the promotion of the well being of infants and families. The objectives include the use of explicit, holistic, and family-centered practices in order to develop an effective relationship with families. These objectives are achieved through the process of helping, including the development of a working relationship, which is determined through skills the "helper" and the parent bring to the interaction. For example, a working relationship is built through attentive and active listening, prompting parents to talk and explore, and responding empathically and negotiating. Additionally, the "helper" should demonstrate internal qualities, such as respect and genuineness, and an understanding of the processes of helping that facilitate parent engagement in the intervention. The service and community context and a constructionist viewpoint are also important parts of the model. Although future research must focus on implementation and evaluation outcomes of prevention services based on the family partnership model, the framework for developing relationships within the partnership process is helpful.

Relationship-Based Partnership Model

Getting Ready is a model of early childhood intervention that emphasizes the transactional nature of development and the important role parents play in the preschool readiness process (Sheridan, Marvin, Knoche, & Edwards, 2008). The model relies on collaborative partnerships between parents and professionals to promote parental competence and confidence in providing natural learning opportunities to improve school success. Further, the

Getting Ready approach includes integrated, ecological, and strengths-based approaches to working with families of young children. Getting Ready is an integration of triadic intervention and collaborative consultation models in a unique, ecologically and strengths-based intervention that promotes skills and outcomes in children and their families via enhanced relationships. In particular, the family partnership model is collaborative, intentional, developmentally responsive, and strengths based. Within each stage of consultation (i.e., needs identification, needs analysis, and plan implementation), there are both behavioral (e.g., identify strengths of child, family, teacher, and systems) and relationship goals (e.g., establish/improve working relationships between parents and teacher and between the consultant and consultee). Empirical evaluations are currently being conducted as part of a large-scale longitudinal study (Sheridan et al., 2008).

PROSPER

Spoth, Clair, Greenberg, Redmond, and Shin (2007), Spoth and Greenberg (2005), and Spoth, Greenberg, Bierman, and Redmond (2004) developed a multitiered partnership model called Promoting School-Community-University Partnerships to Enhance Resilience (PROSPER) that consists of a three-component structure including local community teams, a state-level university research team, and a coordination/liaison team. The model is primarily based on Rogers' diffusion of innovation theory (Rogers, 1995) and relies on the "land grant idea" that the central mission of universities should be working to benefit and improve the larger society's social status (Bonnen, 1998). The purpose of the model is to improve the supportive infrastructures of evidence-based family and youth-competence building interventions to sustain quality improvement and build capacity.

Linking capacity agents provides the framework for meeting the goals of the model. Specifically, the model relies on external resources agents from community agencies outside of public schools and the state public education system, internal capacity agents in public school, and linking agents from the State University Extension system. Partnerships operate at three levels within the state: (a) school community-level strategic teams of local, internal, and linking agents, (b) intermediate level coordinating teams of linking agents and regional technical assistants, and (c) state-level teams of external resource agents. Spoth et al. (2007) utilized the model to implement a family-based intervention designed to reduce youth substance use and improve parenting skills and youth social skills and peer resistance skills. Results indicated that even after controlling contextual variables at the community and school district levels, the functioning of the community team and technical assistance variables were related to higher recruitment rates. The PROSPER model is unique in that it emerges from the basis of Land Grant Universities and Cooperative Extension Services, involves direct partnerships between university scientists and community experts, and focuses narrowly on educational infrastructures and intervention delivery systems (Spoth & Greenberg, 2005).

Youth/Adult Partnership: Seven Circles Coalition

Wunrow and Einspruch (2001) describe a youth/adult partnership model that is focused on the planning, implementation, and evaluation of agency and community programs and initiatives. This partnership model involves youth development (i.e., increasing the bond between youth and society will help to prevent delinquent behavior) and youth empowerment (i.e., youth are given opportunities to learn skills, assume responsibilities, and participate in public affairs) in the context of a drug abuse and delinquency prevention program (e.g., Seven Circles Coalition). Five structural components are described to achieve youth development and empowerment: (a) formation of a youth/adult task force with defined roles and responsibilities, (b) initial training of youth/adult leaders in core skill areas, (c) training of youth members in core skill areas, (d) providing specialized skills training for a youth-launched project, and (e) implementing a specific project or program. Anecdotal data are provided attesting to the success of this model in promoting youth empowerment across a wide region in southeastern Alaska. Although this model has not been used in school settings, these components could be applied to design and implement prevention programs, particularly at the secondary level.

Asset-Based Community Partnership Model

In contrast to many models of partnership aimed at improving communities that address the deficits of the community environment, the Asset-Based Community Development model (Kretzman & McKnight, 1993) focuses on identifying and using the strengths of multiple partners within a community in reaching a common goal. Primarily focused on community economic development, five key elements compose the model including (a) mapping the individual and community assets, (b) building relationships, (c) mobilizing for economic development and information sharing, (d) convening the community to develop a vision and plan, and (e) leveraging outside resources to support locally driven development. Price, Zavotka, and Teaford (2004) applied the model in establishing a partnership among university, community, and retail agencies to facilitate the development of knowledge

about universal housing design for aging adults. Universal housing design was defined as homes that have at least one no-step entry, first floor access to a bathroom (with walk in shower) and bedroom, easy-grip controls, accessible appliances, and wider doorways. The general public, residential builders, home building suppliers, remodelers, and health care professionals have limited exposure to concepts of universal design in building. The purpose of the partnership was specifically to address the lack of community knowledge about value of universal design.

Based on Kretzman and McKnight's (1993) model, Price et al. (2004) identified university faculty specializing in interior design, gerontology, and occupational therapy, professionals from the Ohio Department of Aging, local area agency on aging, local AARP chapter, county extension agents, students majoring in interior design and occupational therapy and managers and employees from the Lowe's Home Improvement Warehouse as key members of the partnership. Starting with the identification of partner strengths and shared learning, a set of mutual goals were established. Specific educational program resources were developed and delivered through workshops and then implemented through in-store and in-community events, in-home assessments, and a design of a web page devoted to universal design. The successful implementation of the partnership illustrated the importance of identifying the key assets that each partner brought to the problem, and the capacity to develop a unique solution that impacted all partners equally.

Summary of Partnership Models

Each of the partnership models includes key characteristics that foster collaboration across home, school, and community systems. These characteristics include an emphasis on strengths and assets (rather than problems or deficits), a focus on building trusting, long-term relationships, an emphasis on shared ownership across systems, an attempt to build capacity for sustainability over time, and use of participatory Action Research methods for model evaluation. The models are dominated by their similarities rather than their differences. At the same time, although each model is conceptually appealing, these models are lacking empirical support for the most part. A few models have been examined within a case-study framework, but large-scale systematic evaluation of model process and outcomes has rarely taken place. Thus, the articles presented in this series are meant to provide data-based examples of partnership models in action. These models include many of the key characteristics enumerated previously, while also demonstrating empirical support for process and/or outcomes.

The initial paper by Power, Hughes, Helwig, Nissley-Tsiopinis, Mautone, and Jones (2010) describes a model of multisystemic care for children identified as having Attention Deficit Hyperactivity Disorder (ADHD). Effective delivery of services for children with ADHD requires a natural link between medical, family, and school systems of care. Power et al. (2003) look at the processes impacting the engagement in treatment of families from urban, high-poverty areas. Within a model entitled, Partnering to Achieve School Success (PASS) that links primary health care and schools, the paper examines the process and challenges in getting families to engage in enrollment within the PASS program. In particular, the paper examines how pre-treatment telephone contact with families functions as a key variable in getting family engagement in the treatment process. An important component of the PASS model is the use of the clinician who will be implementing the intervention as the individual who also pursues phone contacts.

In the next paper, Weems et al. (2010) describe a partnership between a school district and university related to providing a program of prevention and support for students with test anxiety. As Weems et al. (2010) note, internalizing emotional difficulties such as anxiety are often not a noticeable concern among school personnel despite the important relationship between such disorders and many other aspects of the student's mental health. In addition, although test anxiety is the focal point of treatment and a logical entry point in schools for intervention, the empirical links between test anxiety and other more generalized anxiety problems provide excellent opportunities for broad impact on many types of internalizing problems.

In the third paper, Stormshak, Fosco, and Dishion (2010) describe an analysis of data from their ongoing Family Check Up model. Their model is conceptualized as a parent training program designed to impact a wide variety of youth and families that could be implemented in school settings. The model has a long and successful history and is simple in its design. Based largely on the impact of motivational interviewing (Miller & Rollnick, 2002), the Family Check Up model was evaluated in two longitudinal studies where the first study showed students receiving intervention attained higher GPAs and demonstrated better school attendance than matched control students. Their second study, which is still ongoing, emphasized home-to-school linkages using a self-regulation framework, and tested the impact of the self-regulation strategy on psychological adjustment and school engagement. Specifically, they hypothesized that their model would impact depressive symptomology and school-related academic skills. Their paper reports the outcomes of this analysis using an intent-to-treat design. Such designs lead to conservative estimates of overall intervention effects. Results

of their study showed that significant and sustainable reductions in depressive symptoms and increases in school engagement were found 4 years after the brief intervention.

The study provided increased evidence of the potential of a family-centered intervention focused on self-regulation. Outcomes offer continued evidence of the importance of the family partnership in impacting school mental health for youth. In particular, the study examined the transition to high school as a critical time when youth experience potential high rates of mental health concerns. Stormshack et al. (2010) raise some excellent questions about the capacity of such a model to be implemented in schools without the key structure that grant-supported research brings. Their efforts are currently focused on building the model into a program that can be implemented within the support structure already present in school settings. Alderfer and Hodges (2010) examine a very interesting perspective on partnership between schools and health care providers for children who have cancer. Although many have examined the importance, value, and outcomes on families of partnerships for the child who is under treatment, few have examined the impact on the siblings of these children.

In the fourth paper, Alderfer and Hodges (2010) extend the partnership to the siblings of the child. Considering the stress that having a child with cancer places on an entire family unit, the paper focuses on the emotional and behavioral needs and forms of social support needed by siblings of children with cancer. Following a group of very young children diagnosed with cancer, Alderfer and Hodges (2010) obtained multiple rating scales assessing the behavioral/emotional status of the siblings of these children as well as their perceived level of emotional support. Their findings showed that while siblings of children with cancer reports of behavioral/emotional symptomology remain within normal ranges, the need for and presence of perceived social support from the school environment plays a critical role in addressing the emotional/behavioral needs of these siblings. Indeed, school-based social support is considered a potential protective factor for the mental health of the siblings of children with cancer. Alderfer and Hodges (2010) imply that the critical elements of school/family partnership around the key emotional issues for these siblings may offer substantial opportunities to facilitate the support so necessary to sustain these families through the difficult process of treatment for childhood cancer.

Finally, a set of comments on these papers are provided by two nationally recognized experts in the area of school mental health, Laurel Leslie and Hill Walker. The commentaries offer perspectives from two experts in the field, one (Leslie) focused more on the medical side of partnership and the other (Walker) on the school side of the partnership. Together, the papers in this series offer a broad perspective on the importance, nature, and evaluation of partnership models. The empirical nature of the investigations provides a strong indication of the ongoing efforts to evaluate the impact of partnership models as well as to fully understand the variables that may be underlying the effectiveness of outcomes.

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