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The School-Based Mental Health Collaboration (SBMHC): A Multi-Level University-School Partnership

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ABSTRACT

This article describes The School-Based Mental Health Collaboration (SBMHC), a novel school-based mental health partnership between Teachers College, Columbia University, and several high-poverty public grade schools in New York City. SBMHC is grounded in attachment and mentalization theory and practice. It applies nested mentalization to multi-level work with all school stakeholders, encouraging school leaders, faculty, staff, and parents to use mentalization with children, many of whom have experienced trauma. Graduate students serve as classroom consultants (CC), spending a half day per week in the classroom observing, doing push-in interventions, co-teaching a social-emotional learning curriculum, coaching the teacher, and making referrals for children. CCs follow up on referrals and coordinate among parents, teachers, and off-site providers. The CCs in turn receive weekly didactics and reflective clinical supervision. SBMHC works with school leaders to assess the school's social-emotional climate, identify unmet need for mental health services, and locate low-cost providers in the community. SBMHC is a promising model that aims to enhance social-emotional learning for all students while also identifying and referring symptomatic students. It thus combines universal and targeted approaches to serving high-risk students at low-resourced schools.

Our schoolchildren, especially those who are living in underserved communities, experience rampant unmet mental health needs (Cooper et al., 2008; Kataoka, Zhang, & Wells, 2002; Lanza, Rhoades, Nix, & Greenberg, 2010). The School-Based Mental Health Collaboration (SBMHC), a partnership between Teachers College, Columbia University, and selected New York City public grade schools, was developed to help meet those needs while providing a unique training opportunity for graduate students in psychology. SBMHC is informed by the rich history of psychoanalytic developmental thought, particularly recent developments in attachment and mentalization theories. Our premise is that all children can benefit from integrative social and emotional learning within the classroom, and that certain children will require mental health services beyond the classroom. To provide services both inside and outside the classroom, SBMHC collaborates closely with school stakeholders, parents, and community mental health providers.

This article is a description of our newly developed model. It discusses how we have adapted an integration of psychodynamic perspectives to our work with school stakeholders. Unlike school-based mental health models whose primary aim is to extinguish unwanted behaviors, SBMHC works

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toward making meaning of the child's behavior, attending to both unconscious and conscious processing. It is through the understanding of motivational factors underlying children's behavior that teachers are more likely to be more tolerant and empathic, use developmentally appropriate behavioral interventions with students, and feel more supported and competent. Our model, consistent with the earliest tenets of psychodynamic theory, is developmentally grounded. We begin by describing the theoretical underpinnings of our design and then go on to describe the program in greater detail.

Theoretical underpinnings of SBMHC

A developmental perspective

SBMHC approaches child behavior from a developmental perspective, as characterized by Levy-Warren (2018, p. 87):

> Thinking developmentally is thinking with a pluralistic/integrative model, with an awareness of temperament, individual experience, culture, class capacities for executive function/ego development, relational capacity and resources available from both constitutional and developmental perspectives… That is, trying to understand the individual from multiple standpoints and offer the richest version of their lives we can.

At SBMHC, we aim to adapt this approach to think developmentally not only about the students we serve but also about all stakeholders in the school, including principals, teachers, mental health staff, and parents. We apply these developmentally based psychodynamic principles as we carefully listen to, and closely observe, each of these individuals. We strive to stay aware of our biases and avoid making overt judgments due to our own distortions. We look beyond surface behaviors to explore their underlying etiologies, recognizing the same behavior takes on different meanings across different individuals.

This stance can model a relationship that allows for both security and exploration, regardless of whether the individual is a student, parent, or faculty member. Such a relationship is particularly salient for our student population, given the schools we target serve high-poverty populations. Children in poverty are more likely than other children to experience trauma, chronic stress, and erratic early relationships, all of which predict poorer socio-emotional adjustment and lower academic functioning (Bradley & Corwyn, 2002). Our model is informed, first, by attachment theory (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1980; Bretherton, 1992). Clinicians learn to consider how children's attachment styles manifest in a classroom context and how the match or mismatch of teacher-student attachment styles may impact the teacher's approach to that child. Our model is also informed by a mentalizing stance, which emphasizes the development of reflective functioning (Steele, Murphy, & Steele, 2015). SBMHC clinicians are taught to use a mentalizing stance for their work with teachers and children. It can be a daunting task for newly trained clinicians to be in the classroom with many children and teachers who have experienced deprivation, trauma, and stress. Newly trained clinicians deserve careful and thoughtful supervisory support, often termed reflective supervision, to avert burnout and poor clinical decision making (Remez, 2016). We now describe how each of these theories is harnessed in the service of delivering school-based care to underserved communities.

Attachment theory

Attachment theory posits that a secure child-parent attachment relationship provides a safe base for the infant to explore her or his environment with freedom and curiosity (Ainsworth et al., 1978; Bloch, 2014; Bowlby, 1969, 1980; Bretherton, 1992). Research demonstrates that parental nurturance, protection, and sensitivity to distress predict a secure attachment with child (De Wolff & van Ijzendoorn, 1997; McElwain & Booth-LaForce, 2006); by contrast, parental neglect, insensitivity, and harshness predict an insecure child-parent attachment. Insecure attachments are further

distinguished by whether the child demonstrates resistance or ambivalence toward their parent, avoidance and anxiety around their parent, or a disorganized response combining both resistance and avoidance (Main, Kaplan, & Cassidy, 1985; Main & Solomon, 1990).

Research shows infants who are securely attached to their parent are more likely than insecurely attached infants to thrive academically and social-emotionally throughout early and middle childhood (Belsky & Fearon, 2002; Groh, Pasco Fearon, van IJzendoorn, Bakermans-Kranenburg, & Roisman, 2017; Sroufe, 1996; Veríssimo, Santos, Fernandes, Shin, & Vaughn, 2014). Conversely, insecurely attached infants, particularly those classified as disorganized, are at increased risk of disruptive and aggressive behavior (Greenberg, Speltz, DeKlyen, & Endriga, 1991; Lyons-Ruth, 1996; Matas, Arend, & Sroufe, 1978; Speltz, Greenberg, & Deklyen, 1990). Steele, Steele, Croft, and Fonagy (1999) argue when securely attached children experience distress, they are confident in the expectation they will be comforted by their parent, which enhances their ability to tolerate negative emotion. Consistent with this argument, several studies have shown securely attached children demonstrate higher levels of self-regulation of emotion and behavior than other children (Bloom-Feshbach, 2018; Oram, 2018; Viddal et al., 2015).

Despite the predictive power of early attachment style for later behavior, few school-based mental health programs draw on attachment theory. In part, this is because many school psychologists have not been trained to apply attachment theory to work with children in schools (Sapountzis, 2012). Those who have such training have found it difficult to apply these precepts to work with teachers (Kennedy & Kennedy, 2004).

Yet it is important to create school-based mental health services that draw from an understanding of the importance of attachment. It has been suggested that the teacher-child relationship is qualitatively similar to the parent-child relationship and may help offset the adverse effects of an insecure parent-child attachment (Pianta & Steinberg, 1992). It has been found that teachers who have been trained in attachment theory can forge safe and trusting relationships with children and serve as buffers against the impediments to learning posed by insecure attachment (Kennedy & Kennedy, 2004; Rass, 2018).

To this end, Geddes (2006) has delineated specific strategies to address the behavior of students with avoidant, ambivalent, or disorganized attachment styles in the classroom. For example, to address the needs of the avoidant child, who can provoke anger and frustration, the teacher must begin keeping the child's mind in mind and reflecting on why it is difficult for the child to engage with the task and/or the teacher. Geddes (2006) suggests the use of highly structured activities and consistent transitions for such a child, which may allay his or her anxiety over time. The teacher may also encourage the avoidant child to work with peers if adult interaction is difficult. The teacher should adopt a calm tone and cadence and be mindful of the need to model self-regulatory skills for the child. Thus, the teacher who tailors her approach to the attachment style of the child may minimize the adverse effects of this insecure attachment.

It may also be helpful for teachers to consider their own attachment style and how it interacts with the attachment styles of students whose behavior teachers find problematic. For example, an anxious and avoidant teacher may become especially dysregulated when working with a similarly anxious child (Kennedy & Kennedy, 2004). This can set up a negative pattern similar to the already insecure relationship the child has with her primary caregiver. A teacher who is able to gain insight into her own attachment style may be in a position to work more successfully with all children.

Mentalization theory

Mentalization theory (Fonagy, Gergely, Jurist, & Target, 2004; Jurist, Slade, & Bergner, 2008) posits that parents are poised to create a secure base for their child when they have achieved the capacity for reflective functioning. Reflective functioning is defined as the developmental capacity to understand one's own mental states as well as the ability to understand the mental states of others (Fonagy & Target, 1997; Steele et al., 2015). When the caregiver or therapist uses

a mentalizing stance, he or she becomes able to modulate seemingly unmanageable feelings for the baby or patient. This teaches the child to self-soothe and to make sense of strong feelings. Clinicians have developed specific strategies for using a mentalizing stance in clinical work with parents and children (Busch, 2008; Verheugt-Pleiter, Zevalkink, & Schmeets, 2008) that can be applied to a classroom setting. For example, Malberg (2015) lists eight essential components of a therapeutic mentalizing stance appropriate for a classroom context: (1) Keep a developmental focus, (2) pay attention to nonverbal cues, (3) lower arousal levels, (4) identify impasses, (5) stay in the here-and-now, (6) use authentic curiosity, (7) be honest about one's mistakes, and (8) use a stance of active wondering — not all-knowing.

Emphasizing other components of this process, Hagelquist's Security/Trauma Focused/Obtaining Skills/Resource/Mentalization (STORM) Model (2018) provides specific steps clinicians can take within a mentalization approach to providing mental health services for high-risk children. These steps include: (1) Establish security (trust) between adult and child; (2) focus on, and understand, trauma; (3) help the child to obtain specific skills enabling mentalization, such as mindfulness techniques and naming affects; and (4) draw on the child's resources, such as his or her own strengths and those of their support system. This model provides a useful roadmap to guide clinicians in school-based settings.

To date, several school-based projects have successfully incorporated mentalization techniques. For example, the CAPSLE program, which is designed to improve school climate by reducing bullying and violence, teaches school stakeholders self-reflection and mentalization skills (Fonagy et al., 2009; Fonagy, Twemlow, Vernberg, Sacco, & Little, 2005). This approach has successfully decreased bullying and enhanced school social and emotional culture. As another example, the Primary Years Project places a consulting therapist in a preschool one day a week with the primary goal of increasing the mentalizing capabilities of school stakeholders (Malberg, Stafler, & Geater, 2012). Therapists work with identified children and families one-on-one outside the classroom. One disadvantage of this approach is the therapist does not observe and intervene with the child in real time in the context of interest, that is, the classroom. To appreciate the specific triggers for, and manifestations of, children's behavioral symptoms, it may be optimal for the therapist to be on-site (at least part of the time) with the child in class.

In-class observation may also give the therapist the opportunity to observe the teacher's and other students' behaviors to supply a fuller understanding of the child's behavior in context. That is, to fully apply a mentalization approach to children, it is necessary to apply a mentalization approach to the other actors in their environment. This comprehensive view of mentalization is embedded in the Building Blocks program (Cohen, 2016; Cohen et al., 2016), an intervention designed to increase the capacity for reflective functioning among parents and children in the foster care system. Building Blocks views the child as part of a system that includes not only the biological family but also the foster family and the child protective services agency. Accordingly, it applies the principle of "nested mentalization" (Jurist, 2005; Silber, 2015; Slade et al., 2017), in which therapists serving children are encouraged to keep their own, their patients, and all other actors' perspectives in mind simultaneously. Therapists receive reflective and supportive supervision, which helps them learn to tolerate the strong feelings that can be elicited while working with high-risk families.

SBMHC employs a similar approach to the provision of school-based mental health services. Schools are themselves systems containing multiple actors: students, teachers, parents, leaders, and mental health personnel. The dyadic and triadic relationships contained within this system go well beyond the clinician-student relationship. Therefore, SBMHC espouses nested mentalization as a guiding principle that encourages all stakeholders to keep each other's perspectives in mind. In addition, because SBMHC's model relies on classroom consultation, it adds yet another set of stakeholders — the classroom consultants themselves — to the system.

Accordingly, a key component of SBMHC is clinical supervision of all classroom consultants. Not only can the web of relationships be difficult to navigate, but also the stakes are high because the student body has experienced serious psychosocial risks, such as incarceration, addiction, and homelessness. The clinical supervisors, in turn, rely on nested mentalization to make sense of their supervisees' experiences and their own experiences with students and other school stakeholders.

SBMHC program description

SBMHC merges theory and research on attachment and mentalization into a novel model of school-based mental health services. We are currently piloting this program at three New York City (NYC) public schools serving grades K–5. SBMHC fulfills several mandates at once. First, as a classroom-based program, it takes an upstream approach to mental health (Adelman & Taylor, 2000). It serves all children, not just those who have been identified as needing behavioral intervention, thereby providing preventive and treatment services at once (Walker & Shinn, 2002). This approach is aimed at helping all children succeed, both socially and academically, and may have a particularly strong impact in low-income populations, which are typically in dire need of mental health services (Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008).

Second, SBMHC uses a consultative model, in which university-based clinicians advise school personnel, an increasingly popular approach to mental health services in schools (Cohen, 2014; Jacobs, 2012; Zins & Erchul, 2002). The university-based consultants may be perceived as neutral by parents and, hence, a more credible authority than teachers, who may be viewed as biased and judgmental. Moreover, our consultants offer services desperately needed by the schools with which we partner. City Department of Education psychologists, who are typically assigned to multiple schools, often struggle to complete their mandated psychoeducational assessments. There is a scarcity of school counselors and social workers, who often work part-time and are easily overwhelmed by the both the complexity and volume of cases. Therefore, most school mental health personnel welcome our presence. Consistent with our model, we work to form productive partnerships with school mental health personnel and collaborate in Child Study Meetings to meet the best interests of the children. To achieve these goals, open communication is essential and a clear delineation of responsibilities agreed upon between SBMHC and school mental health personnel.

Graduate students in psychology serve as a cost-effective pool of clinicians. Faculty provide essential training and supervision for graduate students, and students provide high-quality services in the schools while fulfilling externship and internship requirements. It is a school-community partnership mutually beneficial to both parties.

Third, SBMHC customizes its priorities in each school. Since every school community is unique, the program cannot be "one size fits all." SBMHC is designed to be structured and replicable yet flexible enough to meet the community it serves.

SMBHC is conceived as a multilevel intervention. That is, we intervene with multiple stakeholders along with schoolchildren themselves. As seen in Figure 1, we intervene with school leaders, teachers, students, and parents. In brief, we provide each classroom with a consultant who is present one half-day a week. The consultant serves as a coach and mental health guide for the teacher with respect to implementation of a social-emotional curriculum to promote prosocial and self-regulatory behaviors, classroom management strategies to decrease students' off-task and antisocial behaviors, and identification of students with pronounced mental health needs requiring on- or off-site intervention. For students identified as requiring intervention, the classroom consultant arranges a meeting with parents and teachers and sets a treatment plan in place, which is then monitored and evaluated. Each of these components is described below, beginning with the crucial step of fostering school change from the top down by focusing on school leadership.

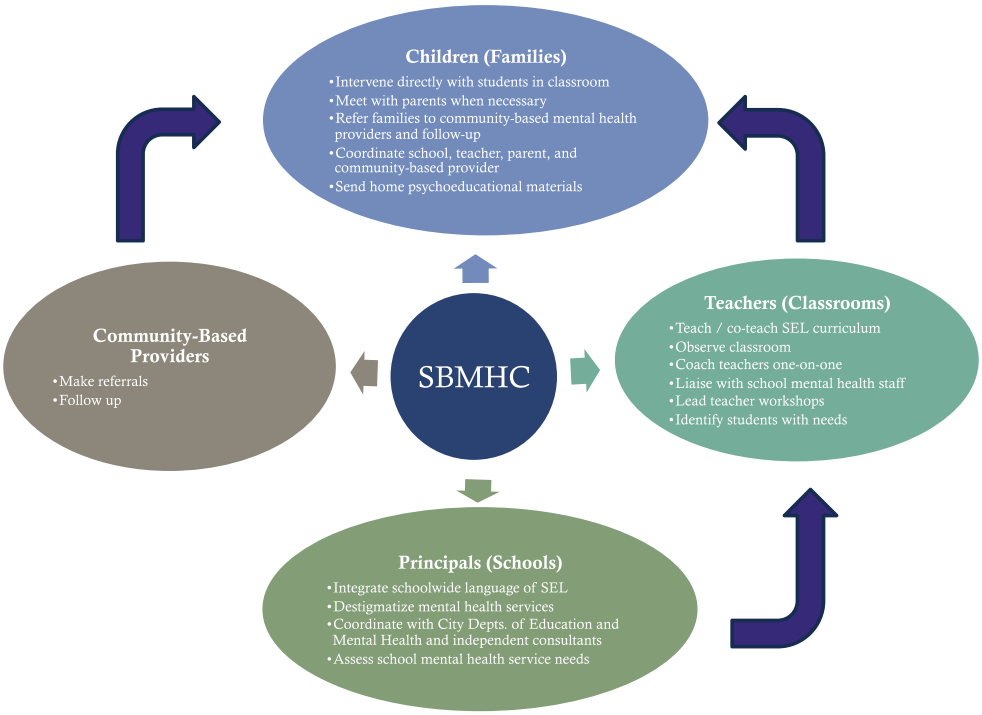

Figure 1. SBMHC model.

School leaders

Once a principal has agreed to partner with us, we begin by assessing the social-emotional climate of the school, the existence of social-emotional curricula, the availability of mental health services on-site (e.g., the presence of a social worker or psychologist), and the leaders' and teachers' perceptions of the degree to which students' social-emotional issues interfere with learning.

Based on observations of and communication with the principal and teachers, we learn about the strengths and weaknesses of the school's social and emotional culture. We ask about the communication style among and between staff and parents and then formulate hypotheses (to be refined over the year) about stakeholders' emotional styles. We clarify that we are not psychoanalyzing school leaders or teachers, nor are we evaluating their effectiveness. Rather, we are using our clinical skills to form hypotheses to inform efforts to improve the school's social and emotional culture and children's access to high-quality mental health services.

Because we target high-poverty public schools, their leaders typically feel chronically stressed by a lack of resources and support. Although leaders recognize an unmet need for student mental health services, they can be hesitant to take steps that are likely to meet with teacher resistance. It is key, then, that SBMHC leaders take a mentalizing stance when listening to the frustrations of school leaders. The SBMHC team observes each principal's leadership style and attends carefully to the underbelly — the meaning — of her words. For example, the principal may embrace change for the emotional and social fabric of the school, or she may be ambivalent about this process. We try to assess how the principal views the current emotional and social ethos in her community and what she perceives as strengths and weaknesses. At all times, we strive to convey a supportive and nonjudgmental stance to maintain a trusting relationship with the leader so that she views us as allies rather than critics. This approach, according to Sapountzis (2018, p. 188), can support the school leader to explore possible solutions to the sources of her frustration:

> The critical thing, according to Bion (1962), is what people do with the frustration they experience. Do they evade it or engage with it? The former, Bion points out, leaves people in the same place as before and more likely to remain entrenched in their initial views and existing perceptions. But the latter often becomes a source of growth that leads to new learning. The "capacity to tolerate frustration," Bion writes – and one can add doubts, uncertainty, fear, and so on – "… enables the psyche to develop thought by a means by which the frustration that is tolerated is itself made more tolerable" (p. 112). That is, the capacity to tolerate experiences that are frustrating, threatening, and even embarrassing instead of dismissing or blocking them from consciousness and then to be able to engage and try to make sense of them leads to new thoughts which, in turn, help make the initial experience more tolerable.

To illustrate the process of establishing a trusting relationship with a school leader, we describe the principal at one SBMHC school who had worked without a consistent or reliable mental health team prior to partnering with us, and who had to manage mental health issues from crisis to crisis. Here and elsewhere, fictional names are used to conceal participants' identity.

Case vignette: Ms. Ramirez, principal

Although Ms. Ramirez verbally welcomed SBMHC into her school, she was uncertain that our staff could handle acute mental health situations in accordance with the community's complex needs. Though Ms. Ramirez stated that she was chronically overwhelmed and needed additional mental health staffing, she also expressed that she had to oversee all facets of all situations herself to ensure they were handled properly. The SMBHC staff recognized that Ms. Ramirez had been repeatedly disappointed by the inconsistency of outside supportive services in the past, and she had developed this style to maintain the equilibrium of her school community. As Ms. Ramirez learned that SBMHC were reliable partners, she became more willing to revisit her reactions to crises and everyday issues.

In one instance, during the second week of school, a student expressed the intention to self-harm, and Ms. Ramirez personally tried to manage all aspects of the emergency. Not only was Ms. Ramirez overwhelmed by the situation, but she also had to put her regular duties aside, causing additional stress not only for herself but for the teacher and students. The SBMHC clinicians knew that they had to be gentle partners who could model a calm and reflective stance. Without directly challenging Ms. Ramirez, the SBMHC classroom consultant and supervising psychologist clarified the school's legal obligation, accompanied the child to the hospital, contacted and comforted the parent, and supported the child as well as the teacher and other students who were visibly shaken by the crisis.

Following the event, SBMHC staff met with Ms. Ramirez to discuss and process the situation. They positioned themselves as allies rather than critics, a stance that facilitated her articulation of strong feelings of futility and frustration. Concurrently, they helped her to pause and take stock of the situation, which helped to lower her arousal level. In the days and weeks that followed, there was an observable change in Ms. Ramirez's attitude towards SBMHC. As the first semester progressed, Ms. Ramirez began to consider transferring some mental health responsibilities to SBMHC. For example, at a follow-up meeting, the SBMHC Director once again acknowledged the weight that Ms. Ramirez was carrying in all her roles and responsibilities, and praised her ability to stay calm during the event. Ms. Ramirez figuratively and literally heaved a sigh of relief, and expressed that having had SBMHC by her side during the incident helped solidify her trust in the program. This development was possible because SBMHC prioritized Ms. Ramirez's concerns, maintained a supportive rather than critical stance, and kept her mind in mind while formulating solutions. In the dialogues that followed, Ms. Ramirez recognized the need for a mental health coordinator, and SBMHC assisted in filling the position. By the end of the year, Ms. Ramirez could rely on SBMHC's support and collaboration.

Classroom consultation

The cornerstone of SBMHC is the classroom consultant (CC). Each classroom is assigned a CC who spends a half-day per week in that classroom. (Each CC is assigned to three classrooms.) Before the beginning of the academic year, CCs meet the teachers so they can learn about the teachers' preferred classroom procedures and clarify the roles they will play. At this time, parents also learn about the CC from announcements during parent meetings and in written information sent home.

Observation and intervention

The real work begins when the children arrive! The CC plays multiple concurrent roles. First, she carefully observes both the social and emotional climate in the classroom and the behavior of individual children. Adopting Malberg's (2015) principles of mentalization, the CC observes both teacher and students with a posture of gentle curiosity. She asks herself, what makes the children tick? What is the meaning and function of a given behavior? Is it an ongoing issue or an isolated incident? When a child chronically displays internalizing or externalizing symptoms, the CC observes the child's temperament, interactions with students and adults, and self-regulatory skills. Following the STORM model's fourth component (a resource focus; Hagelquist, 2018), the CC notes the particular situations in which a child demonstrates strengths so that they can be drawn on while working with the child. Per STORM's second component (a trauma focus; Hagelquist, 2018), the CC looks for indications of trauma and queries the teacher and school staff about problems at home that may be causing chronic stress. The CC's conceptualization requires much flexibility as she continually receives new information throughout the year, and generates and revises her hypotheses about the meaning of children's behavior.

Within several weeks, the CC begins making in-classroom interventions based on her observations. Interventions are adapted from STORM's third component (use specific skills to achieve mentalization; Hagelquist, 2018). CCs aim to help children improve self-regulation and mentalization by drawing from the following strategies: label emotions, validate emotions, practice mindfulness, redirect the child's attention, physically change the environment, and planfully ignore behavior (Eppler-Wolff, Homayoonfar, Jean-Pierre, & Semel, 2018). For example, the CC may speak privately to a child who is crying to validate her emotions and ask why she is distressed. The CC may arrange with a child to simply tap his shoulder when she notices his attention has wandered. The CC carefully monitors the child's verbal and nonverbal reactions to the intervention (i.e., acceptance, compliance or rejection) and adjusts course if necessary. Over time, the CC becomes a reliable, even-tempered, and authentic adult figure with whom the child has the freedom to express strong emotion without reproach.

SBMHC interventions vary with the stage and age of the child. Clinicians keep each child's mind in mind by assessing his or her position on the developmental trajectory toward effective mentalization (Fonagy et al., 2004). This assessment allows for realistic expectations and age-appropriate demands on the child. Of course, the child's cognitive, social, and psycho-sexual development are all considered when discussing issues such as anger or shame.

As an example of a CC's intervention, we describe a second-grade student who had a hard time sitting in his seat, and moved about the classroom interrupting other students' work.

Case vignette: Rafael, student. *The CC offered to take a walk with Rafael in the hallway, and he was more than eager. During their walk, the CC diligently continued to observe all aspects of Rafael's behavior and body language, and observed that Rafael was calmer and had better control of his body in the hallway than in the classroom. In casual conversation, using gentle curiosity and open-ended questions, the CC was able to build rapport with Rafael and learn more about him. Rafael revealed he was aware of his disruptive behavior in the classroom. He stated that he could not concentrate and keep his body still during group activities because the noise level in the room increased at those times.*

Rafael also conveyed his feelings of embarrassment and shame for failing to control his body. Recognizing the vulnerable position Rafael had just assumed, the CC expressed her appreciation of his honesty and trust, and assured him that relying on her as a partner in improving his learning was essential.

The CC relayed what she had learned from Rafael to the teacher, and suggested accommodations such as noise-canceling headphones, moving Rafael's seat during group projects, and classroom noise reduction during group activities. The teacher made some of these accommodations and discussed them with Rafael's parents. Over time, and with repeated conversations with the CC, Rafael's shame about his difficulty waned, and he became increasingly comfortable speaking with his teacher when he found himself in problematic situations. He also continued to work with the CC on applying strategies to distance himself from the situation instead of acting out in class. The teacher and CC continued to discuss Rafael's progress in the classroom, and tweak accommodations as necessary.

Teacher coaching

Each week, the CC meets with the teacher one-on-one to discuss children's behaviors and the teacher's approach to them. These meetings are typically 20–30 minutes in length and take place during a teacher's preparation period, or before or after the school day. Flexibility and cooperation are key to the success of these meetings. At times, teachers ask for additional meeting time, and at others, these meetings may last only 10–15 minutes. This, like the CC's work with the children, is a work in progress throughout the school year.

At the beginning of the school year, while the CC-teacher alliance is growing, the CC shares useful psychoeducational information about topics such as the manifestations of trauma in children and understanding how attachment styles impact the teacher-child relationship. Just as the supervisory staff supports the CC (described below), so the CC supports the teacher.

Some teachers are eager to address social-emotional education and embrace their CC. Others can be defensive and resistant. We have witnessed gradual change in many of the latter teachers as they open their minds to alternative ways of framing student behaviors and their reactions. However, just as the STORM model necessitates a secure bond between adult and child (Hagelquist, 2018), it is also necessary to establish a secure bond between CC and teacher for meaningful change to occur. For example, with a teacher whose go-to disciplinary style is shouting at students, the CC knows that simply criticizing the teacher will damage their relationship and impede future collaboration. Instead, the CC encourages the teacher to take a stance of gentle curiosity using mentalizing language (e.g., "I wonder why Jaden responded that way"). As teachers become more skilled at thinking about their students' minds, CCs encourage them to become more aware of their own minds as well. For example, a CC can acknowledge how frustrated and helpless a student's behavior made *her* feel, thereby legitimizing the teacher's response to the child and strengthening the alliance between them. Within a supportive relationship with the CC, the teacher lowers her defenses about her behavior in the classroom and becomes more willing to critique herself and try new strategies.

A fruitful coaching relationship can improve a classroom even when the teacher already embraces social-emotional learning and mentalization. We describe a first-grade teacher who was extremely well-attuned to the emotional needs of her students.

Case vignette: Ms. Ferris, teacher. *At morning meetings, when children spoke about their joys and disappointments of the previous day, Ms. Ferris labeled and validated their emotions. She was notable among teachers for continuously supporting her students' developing emotional vocabulary. Ms. Ferris promoted a community of mutual respect in which students felt valued by her and by each other. Unfortunately, she had a significant loss in the middle of the year, and was absent for some time, during which the children experienced significant difficulty with the substitute teacher. When Ms. Ferris returned, although the children were ecstatic to see their teacher, the previous social-emotional climate of the classroom was not restored. Ms. Ferris had made the decision to keep her loss private and*

thus did not explain the reason for her absence to her students, despite schoolwide rumors that had reached some of them. While Ms. Ferris went through the motions of daily activities, the spark and joy within the room were clearly absent, and so was her usual emotional availability to the children's needs. Many of them exhibited regressive behavior, and the class became increasingly dependent on Ms. Ferris. Conflicts became more common, and children expressed somatization such as headaches, stomachaches, and even heartache!

During a coaching session with Ms. Ferris, the CC initiated a conversation about loss and its impact upon students. Ms. Ferris was not yet able to recognize the impact of her loss upon her students, and instead, expressed bewilderment at the change in her students' behaviors. Taking a gentle and supportive stance, the CC helped Ms. Ferris move toward recognizing how her sadness and anger were affecting her daily routine in the classroom. During coaching sessions over the next several weeks, Ms. Ferris gained more insight about how her own emotional experience caused confusion and sadness for her students. Ms. Ferris then taught a lesson about sadness and different kinds of loss. With support from the CC, she discussed loss in a developmentally appropriate manner. She briefly mentioned her own loss, and the students shared their feelings regarding her absence. This lesson not only provided an organic opportunity for social-emotional learning, but it also helped repair the bonds between Ms. Ferris and her students.

Referrals

When a CC and the teacher observe that a child needs mental health services beyond the classroom, they meet with the parent and an SBMHC supervisor. The CC provides referrals to no- or low-cost clinicians in the community who have agreements with SBMHC. Notably, the CC follows up with both the parent and community-based provider on the referral. If it is not successful, she will make a new referral. If the referral is successful, the CC follows the course of treatment and ensures the coordination of community services at school and at home.

This process is a key feature of SBMHC. For too many children, especially at schools with limited or no on-site mental health services, children and families must wait months for evaluations. Overworked school-based clinicians are often unavailable to give the family thorough and understandable feedback. When off-site mental health services are required, families often become discouraged due to long waits, a lack of understanding of the evaluation process, or mental health stigma. By holding out hope of expert services and then following through to ensure their successful delivery, SBMHC builds credibility and authority with both parents and teachers.

Social-emotional learning curriculum

Finally, the CC coaches the teacher on the delivery of a social-emotional learning (SEL) curriculum of the school's choice. To date, all schools have adopted the Second Step curriculum (Committee for Children, 2003a, 2003b, 2003c). Each week, teachers deliver a grade-specific lesson on topics within four major units: Skills for Learning, Empathy, Emotion Management, and Problem Solving. Each lesson is taught according to the provided order using specific lesson cards. CCs typically help prepare upcoming lessons on a weekly basis, but teachers vary in the degree to which they request help leading the lessons. The Second Step curriculum provides a weekly take-home sheet for parents as well as a specific daily follow-up plan for teachers to help them integrate the lesson into their daily lessons and activities.

The CC may enhance the packaged curriculum by devising developmentally appropriate activities. For example, one CC used SEL concepts as answers in a "Family Feud"-style game she created with the students. This activity not only further encoded the concepts but also provided the students with an opportunity for teamwork and comradery. On another occasion, a CC showed her class optical illusions to demonstrate the concept of understanding different perspectives. Some CCs have assisted teachers in designating and creating a "mindfulness corner" within the classroom. Often CCs and teachers use this area to implement emotional regulation interventions.

The CC is mindful of specific issues that may arise during the course of the year. For example, one CC helped students navigate sexual harassment, anxiety regarding entering middle school, and misunderstandings and curiosity regarding sexual development. The goal is to integrate the language and lessons from the SEL curriculum into discussions that arise on a daily basis, as illustrated by the following vignette:

Case vignette: Evan and Jamal, students. *In one classroom, two young boys, Evan and Jamal, displayed an unhealthy competitive relationship that caused frequent verbal arguments and occasional physical fights. At the start of the year, the CC worked individually with each boy to lower his arousal level. As time passed and a trusting relationship was established with each boy, the CC used gentle curiosity in speaking with each one about his internal responses to the other and how those responses manifested in their verbal and body language. Each child used words to describe the physical reactions they felt before verbal and physical altercations (e.g., rise in heart rate, clenching of fists) and, with time, became more aware of those reactions as they occurred. The CC linked these physical reactions to the emotional vocabulary from the ongoing SEL lessons. For example, she reminded the boys about the SEL lessons on Emotional Management, when they had discussed strategies to calm strong feelings such as anger. Those lessons had also covered ways to plan and problem-solve when faced with differences in experience and perspective. She also referred back to the lesson on Empathy. She reminded them how "to step in each other's shoes" and feel compassion for one another. Over time, Evan and Jamal improved their ability to control their reactions to upsetting feelings. They became better able to recognize their emotional and physical states and to use language to express themselves. In fact, on one occasion, the CC overheard Evan say to Jamal, "I really feel like hitting you, but instead I am going to use my words. I am really angry at you." With that, Evan walked away. The CC used this incident as an opportunity to praise and reinforce the behavioral choices made by the two students.*

Recruitment and training

SBMHC CCs are selected graduate students in psychology from Teachers College and other accredited universities in NYC. All participate in an eight-hour training with the SBMHC Director on the application of attachment and mentalization theories to work with children in schools. They also attend a full-day workshop on the rudiments of SBMHC consultation and receive an SBMHC Classroom Consultant Guidebook (Eppler-Wolff et al., 2018). Both the trainings and guidebook strive for consistency of procedures across CCs but also acknowledge the need for flexibility in resource-strapped schools and the primacy of clinical acumen on a case-by-case basis.

Supervision

CCs receive on-site and off-site supervision (two hours per week) from the SBMHC Director and Clinical Coordinator. Both are experienced, licensed psychologists, and the first is on faculty at Teachers College. They interweave didactics with weekly reflective supervision. In supervision, CCs focus on their own mind-mindedness, their responses to teachers and students, their self-regulation in the classroom, and how all of this affects their relationships with school stakeholders. Reflective supervision helps CCs manage and normalize strong affect that could interfere with their work with teachers. An environment of exploration, support, and safety is created for the CCs, as exemplified by the following vignette:

Case vignette: Margo, CC. *Margo spoke honestly about her strong feelings during the initial group meet-and-greet at the school, attended by six teachers, two CCs, the SBMHC Director, and the SBMHC Clinical Coordinator. As SBMHC staff and classroom teachers met for the first time, most of the teachers were highly engaged and participated in meaningful group discussion. One of the teachers walked in late, sat far from the table where everyone else was sitting, and spent much of the meeting on*

her phone. Later, when the teacher and Margo, her designated CC, engaged in their first one-on-one conversation, the teacher seemed both disinterested and critical. She said, for example, "I can only give you 20 minutes."

During group supervision, Margo shared how the teacher's behavior triggered anxiety related to some of her own early experiences with feelings of dismissal and a lack of acceptance by others. She wondered how she would be able to work effectively with a teacher whose style brought back a flood of unpleasant memories. The supervisors and the other CCs supported her honesty and acknowledged the risk she took in revealing her personal history. Group members normalized Margo's reaction by describing their own reactions to this teacher's behavior. They also discussed possible reasons behind the teacher's behavior. The supervisors promoted a mentalizing approach by encouraging the CCs to try to take on the perspective of the teacher while remaining aware of their own reactions to her. Through such discussion, Margo and the other CCs were better able to recognize feelings of vulnerability and fear of judgment, and fear of evaluation in the teachers. The group was then able to discuss strategies Margo could take to work productively with the teacher in light of this inauspicious start.

Teacher professional development

Psychoeducation for teachers is another component of SBMHC. Regular professional development workshops are held during the school year and are both experiential and didactic in nature. These workshops introduce concepts such as positive disciplinary strategies, how trauma affects brain functioning, and how to create an integrative SEL classroom culture. Teachers learn through role play with the SBMHC supervisors, CCs, and each other. They also have input into the topics they would like covered.

Services for parents

It is important that parents not only learn the same social-emotional language as children, faculty, and administrators but that they also feel supported and understood. Toward this end, SBMHC CCs are present at parent-teacher conferences. SBMHC also distributes weekly materials (backpacked home with children) based on the SEL curriculum that discuss that week's lesson topic, such as improving empathy or listening skills. We also provide tri-annual newsletters to parents about the program.

Current programmatic limitations

We have made many strides in the three years since we launched SBMHC, but we still struggle with programmatic obstacles. In our inaugural year, consistent with our view of parents as key stakeholders within the school as a system, we held bi-weekly groups for parents. They combined psychoeducational didactics on mentalization and self-regulation with a supportive environment in which parents could safely explore child-rearing issues. Unfortunately, few parents attended these groups and so they were disbanded. We recognize that participation in these groups may be impractical for, or perceived as irrelevant to, low-income parents struggling with challenges to daily living. Yet we also acknowledge that the concepts and skills taught at school are more likely to take hold if they are reinforced at home by parents.

The use of graduate students as CCs is advantageous not only because of cost savings, but also because they expect and appreciate clinical supervision. However, a drawback is the turnover in CCs from year to year, given that most will not want a second year of placement in the same position. This necessitates that teachers must rebuild the relationship with their CC anew each year. The first few months of the academic year typically require that CCs spend more effort on establishing a trusting working relationship with the teacher, and less effort meeting the needs of students.

Simultaneously, a high rate of teacher and school leader turnover has impeded progress from year to year. In one case, SBMHC staff chose to leave a school after two years due to a second change in school leadership.

Future directions

An evaluation of the program is currently in its second year of data collection. The study is designed to assess the change in attitudes and practices among teachers, and in behaviors among students, caused by participation in SBMHC over one school year. Each of our three participating schools has two classrooms in each grade: one was assigned to the treatment group and received a CC and the other was designated a control classroom. In all classrooms, data on teachers and students are collected at the start and end of the school year. Teachers self-report on their attitudes toward and practice of social-emotional education and well as on individual students' prosocial and antisocial behaviors. This year, we added classroom observations of both teachers and students to provide observational as well as teacher-reported data. Change in teachers and students over the school year will be compared across treatment and control classrooms. Results will indicate whether the intervention affects teachers' attitudes, practices, or both, and students' prosocial behaviors, anti-social behaviors, or both. Also, at the end of the school year, in treatment group classrooms, we collect feedback from teachers on their CC. We also elicit feedback from parents who meet with the CC during the year. This information and the results from the evaluation will inform future program improvements.

Ultimately, we would like our collaborating schools to become more self-reliant in terms of both promoting social-emotional learning and intervening with student behavior issues. The former can be achieved by the school's consistent integration of social-emotional learning among all school stakeholders, making concepts such as "empathy" and "respect" part of the intrinsic fabric of the school culture. The latter can be achieved, albeit slowly over time, by two mechanisms. First, it is our hope that school leaders and teachers will increasingly recognize the importance of understanding the meaning of their students' behavioral issues, expand their repertoire of strategies for dealing with those behaviors, and continue to prioritize ongoing communication with parents about these issues. We hope that with several years of exposure to CCs, teachers will become increasingly independent when managing normative social and emotional issues in the classroom. Second, we hope to establish procedures within each school that teachers and leaders will routinely follow when a student is recognized as needing services beyond the classroom. We try to help schools secure on-site mental health services through arrangements with the City's Department of Education or through private funding, and we help establish referral agreements and coordination with nearby community-based agencies. We foresee that in some schools the transition to independence could take three to four years. Other schools may never achieve this independence, but it is worth striving for this goal. Third, we hope that SBMHC interventions will achieve long-lasting change for all stakeholders. Preliminary anecdotal evidence suggests we are on the right track. For example, one teacher said, "Since Charlotte [her CC] and I worked together, the way I think about my students' (and my own children's) behavior has changed forever!"

We are currently operating in three public schools. The potential for expansion to other schools is necessarily delimited by our small staff. The SBMHC Director personally works with the principal to increase access to mental health services on- or off-site, participates in group and individual supervision with the CCs, conducts teacher trainings, and meets with parents when necessary. Her time and energy are finite. However, the project could be replicated by another university-based clinical psychologist in collaboration with her local public school system. As with the current program model, the director of this extension of the program would need to customize her approach to each school given its strengths and weaknesses. A great deal of determination and initiative would be required, but the rewards would be great for both graduate students and school stakeholders alike.

Disclosure statement

No potential conflict of interest was reported by the authors.

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