

COMMENTARY: BUILDING PARTNERSHIPS BETWEEN SCHOOLS AND ACADEMIC PARTNERS TO ACHIEVE A HEALTH-RELATED RESEARCH AGENDA

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INTRODUCTION

Schools in the United States represent one of the most enduring institutions in our country, and yet today, the school's ability to achieve its mission of providing quality education to all children is in doubt. In urban and rural communities, the "achievement gap" is a grim reality that prompted the formulation of *No Child Left Behind*, in hopes that all students, regardless of race, ethnicity, socioeconomic status, or other differences could demonstrate grade-level competence in reading and math.

Health and human services providers who want to work in schools must be able to fully comprehend the gravity of the public perception that schools are failing. School board members, superintendents, and educators are held accountable for two things: grades and test scores. For years, school mental health services have worked hard to garner widespread support in most of the 15,000 school districts and 100,000 schools in the United States. But in one area, school crisis intervention, mental health services have found a niche that meets a critical need and corresponds with the school's educational mission.

The tragic spate of school shootings expanded school crisis response and recovery services with the recognition that child trauma and fear disrupted learning. School mental-health crisis teams met the schools' need for support and demonstrated how mental-health services were vital to returning students to school, restoring the emotional safety of school environment, and supporting the resumption of teaching and learning.

Just as school crisis teams respond to the needs of schools and districts during a critical period of time, a similar understanding had to be achieved as the foundation of the academic community partnership. What matters to schools is attendance, academic performance, and grades. Academic achievement, not solely symptom reduction, is the foundation of any academic (health or mental health) community partnership.

Working with schools requires a different approach from traditional methods of academic research, which tends to be

very narrow in scope and of limited interest to school practitioners. Too often, academic researchers have approached schools with promises of assistance. Once the formal study is completed, they have left without much lasting benefit to the school program or the educational mission. Educators and other school personnel want researchers who understand the hierarchical relationships in a district and how business is conducted in schools and in the central office. They want research partners who are flexible in their approaches to provide results that are meaningful to all the stakeholders in the school and community.

This article tells the story of how an evidence-based intervention for children traumatized by violence exposure in the community was developed through a community-academic partnership. It explores the issues faced by district staff, how the challenges were addressed institutionally, and what challenges remain. The goal of the article is to heighten awareness of these challenges so that others may develop plans to consider and implement evidence-based programs or to know more of the pitfalls and options in doing so.

OVERVIEW OF LOS ANGELES UNIFIED SCHOOL DISTRICT (LAUSD) CRISIS COUNSELING AND INTERVENTION SERVICES

On a February afternoon in 1984, a mentally ill man who lived in a second floor apartment across the street from the 49th Street Elementary School opened fire on students as they were dismissed from their classes. He held the school under sniper fire for an hour and a half, killing a 9-year-old girl and wounding several other students and staff. He saved the last bullet for himself, ending the first armed siege on an elementary school in the United States. The shock and psychological trauma of that event prompted LAUSD to establish the first formal policy requiring all schools and the district at large to organize crisis intervention teams.

Since 1984, thousands of crisis team interventions have taken place. More than 80% of these have been in response to incidents in the community that have impinged on and disrupted the daily routine of the school. Now more than 250 district staff are trained annually to respond to school crises, and each of the 900 schools in our district has its own school site crisis team to respond to critical situations, with the objective of restoring the learning environment and supporting the mental health recovery of students and staff. Through our

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work on the crisis teams, we discovered that two very different cultures—education and mental health—have shared aims. The mission of schools is to educate. The mission of mental health services is to heal. Our common responsibility is to the child who will benefit from both. Our students' exposure to community violence brought home the reality that the mission of one cannot proceed without the success of the other.

In responding to thousands of crisis incidents during the past 20 years, we became aware that many of the students in our district have had previous experiences with violence in the community, especially in areas with high levels of poverty, crime, and gang activity. As we listened to children describe their experiences, we began to wonder how many children sitting in our classrooms had been exposed to violence and how many of them were not just traumatized but suffering from posttraumatic stress disorder and unable to fulfill their learning potential.

The opportunity to answer this important question began with my involvement with the clinical scholars program at the University of California–Los Angeles (UCLA), a program that trains health-services researchers. I made the decision to work with two of the clinical scholars because of their willingness to help me, as the head of a school community mental-health agency, to look objectively at issues of program accountability and efficacy. Initiated by our school district's mental-health services and crisis counseling unit, these academics brought important skills and knowledge about evidence-based practices, programs, and research design. For the clinical scholars, this project afforded them the opportunity to go beyond the published data on effectiveness to meet real-world challenges of program implementation, dissemination, evaluation, and institutional change through the development and uses of partnered research.

Multiple levels of school officials and staff were involved in considering the project, giving input into the design and tailoring the assessment and treatment models for use in schools. One of the requirements from the school mental-health program perspective was a need that the clinical scholars/researchers be able to provide data to the district to show the impact of crisis intervention and mental-health services. A second concern was that the clinical scholars/research partners demonstrate cultural sensitivity to the unique culture of education and the schools. Our experiences in the past involved researchers who had their own agenda, swooped into schools to conduct their studies, and left the school with no significant impact on constructive change or useful data.

THE DEVELOPMENT OF COGNITIVE BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOLS (CBITS)

My relationship with the clinical scholars began with doing several smaller collaborative projects together. At that time, I

was director of school mental health for the district and had built the program from 25 individuals to a staff of 250 clinical social workers and psychologists, child psychiatrists, and other support staff in four outpatient clinics and specialized, school-based programs.

We began our work by asking questions about quality of care in school mental-health services—the common referrals from school staff, the accuracy of diagnoses, the role of case management, the effectiveness of treatments, and the kinds of outcomes that educators desired. It was an intensive research tutorial for me as the community partner and an immersion in school culture for the clinical scholars.

A year after we began working together, I was presented with an opportunity to develop a crisis-counseling program for immigrant students. Teachers pointed out that these students had social and emotional problems that seemed to stem from traumatic experiences in their countries of origin, during the process of immigration, or in their current US neighborhoods of residence. Teachers observed that the traumatic experiences and memories were interfering with the students' ability to do well in school.

To create a program for the immigrant students from Mexico, Central America, Russia, Armenia, and Korea, district staff were interested in answering the following questions:

1. How many of these immigrant children had been exposed to violence at some point during their lives?
2. How many children exposed to violence had post-traumatic stress disorder, and how did the disorder disrupt learning?
3. Was evidence-based treatment and training available for school personnel to provide appropriate school mental-health services?
4. Could we merge the missions of education and child mental-health services through the implementation of an evidence-based intervention to improve outcomes that included symptom reduction, improved grades, and increased attendance?

Meeting District Deadlines

We were all under pressure in July 1998 to deliver a program by September 1998, with \$1 million in unspent, end-of-the-fiscal year dollars that would be lost unless a we collaborated on a proposal that met federal and district guidelines for "crisis counseling" services. Although needing to spend down funds at the end of a fiscal year was commonplace to me, collaborating with researchers whose time was measured by a different clock was a challenge. However, with this amount of district support and supplementary clinical scholars program (CSP) and the National Institute of Mental Health (NIMH) center funding support, our clinical scholars and research partners moved quickly to put a team of junior and senior researchers together and I, likewise, began recruiting

clinicians and supervisors to lead this effort on the district side. No other research partnership like this had ever been attempted before in our district.

We needed a dialogue between the research community and schools to come up with a program that was practical and meaningful to be done in schools and at the same time would produce sound data. The CBITS program¹ was based on prior research showing that cognitive behavioral therapy had promise in treating traumatized students. District clinicians worked with our research partners to ensure that the program was flexible enough that it would be appropriate for our multicultural, multilingual student body and could easily be delivered by our school staff.

The CBITS program was purposely designed as 10 brief sessions to accommodate the usual length of a class period and the practical problem of our limited resources in serving such a large district. In developing the evaluation plan, much discussion surrounded which questionnaires to use. For example, our research partners recommended one survey to detect violence exposure, but the school mental health staff felt strongly that this questionnaire did not translate well for our students, and the team agreed on an alternative survey. School staff also objected to students receiving outside community mental-health services if they got randomized to the comparison group since our experience was that families rarely followed up with outside services, so the partners developed a research design where some students were put on a wait list and got the program later in the school year.

Resolving differences became an integral part of the regular discussions in the development of the intervention and the evaluation process. Both the school mental-health professionals and our research partners had their commitment to this project tested on many occasions. My role as the administrator was to keep the focus on our shared mission, which was to evaluate whether CBITS was effective in treating traumatized children.

IMPACT OF THE CBITS RESEARCH PARTNERSHIP

In our initial work with almost 3000 students, we found that 85%–91% of middle-school students in 18 schools had been exposed to community violence. Twenty-seven percent of those exposed to significant violence (weapon-related violence or at least three exposures to physical violence or threat) had posttraumatic stress disorder, and 16% screened positively for depression. Most of these children had never been identified or treated for these problems. Our work pointed out that the literature on unmet needs must be expanded to the possibility that unidentified needs exist that have yet to be addressed

through screening and outreach to students and their families in our schools.

From the beginning of our community research partnership, our project depended upon funding sources that changed from year to year. The CSP and the NIMH center were truly a part of the effort to sustain support and to find more consistent funding for our program. Three years ago, through the collaborative efforts with our research partners, LAUSD received funding from the Substance Abuse and Mental Health Services Administration through the National Child Traumatic Stress Network to raise public awareness and improve access and quality of trauma informed services to the students of LAUSD. This funding has allowed us to begin developing longer term plans for dissemination of the CBITS program and tackling issues such as provider billing, expanded systems of care with the Los Angeles County Department of Mental Health, pursuit of new funding sources such as California's Proposition 63, and other initiatives to serve the unmet needs of our students.

Dissemination efforts have been strengthened over the past five years with several journal articles on this collaboration and program published by Drs. Jaycox and Kataoka, culminating in the effectiveness study of CBITS published in *JAMA*.² This publication has led to national attention (*Time*, *LA Times* editorial, APA newsletter, etc)^{3–6} as well as renewed interest within our local district to expand CBITS to more schools.

Through the success of CBITS as an evidence-based program that addresses many implementation issues for schools, several other projects are now being developed in our district and in our communities. Research collaborations now exist in the area of improving our suicide-prevention program and mandated special education counseling services, both supported by NIMH research grants as well as a grant to adapt CBITS so that non-mental-health school staff can deliver some aspects of the trauma recovery program. The CBITS program is also being implemented and studied in the faith communities of Los Angeles and with our Los Angeles County Department of Mental Health clinicians.

The national exposure the program received from the *JAMA* article² prompted the district to decide to take an unprecedented step to screen all sixth-grade students for violence exposure. Based on our previous findings, the chief operating officer of LAUSD authorized surveys to be sent to each of the 32,000 sixth-grade students in 73 middle schools to determine their risk for posttraumatic stress disorder. More than 28,000 surveys were returned. Preliminary results show that the average rate of violence exposure is high, with higher risk associated with specific zip codes. Violence exposure before sixth grade was also associated with higher rates of suspension and expulsion and lower rates of attendance. As the chief operating officer of LAUSD has stated, the preliminary results from the sixth-grade survey suggest that the traumatic effects of

violence exposure appear to account for >50% of the “learning gap” experienced by the students in our district.⁷

From the inception of this project, our district has owned the data and has been able to rely on our original clinical scholars, now seasoned research partners, to answer salient program and policy questions, even questions not a part of the original research agenda. I have been able to take our data to the board of education, the chief operating officer, the superintendent, and to critical members of the superintendent’s executive staff, which has resulted in keeping this program alive despite massive district funding cuts that have totaled more than a billion dollars in the past two years.

From the academic perspective, papers are “co-written,” and I have participated in the analyses of data. Our academic partners assisted with presenting results to stakeholders in the local community. We have presented together and separately in national venues to research, policy, and school audiences. We have been privileged to respond to state and federal requests for information, briefing the US Congress and testifying for the Senate Subcommittee on Health and Education and California legislators. We continue to work together to seek co-funding for further research and program development, which is now seen as a joint responsibility.

From the educational perspective, our work has met the federal legislation mandates, such as *No Child Left Behind*, that require school programs to be held accountable for improved attendance and academic progress. Our district has seen firsthand how a mental-health program like CBITS can bring about not only positive mental-health outcomes for children but also improved school attendance and academic performance.

LESSONS LEARNED

- (1) In order to achieve the goals and objectives of both partners, the community partner and the research partner must share equally in the risks, the work, and the rewards of their project.
- (2) An active, ongoing partnership between a large school district and academic partners around a health-related research agenda is feasible and can be effective in developing research and useful programs, provided that that partnership blends rigorous science methods with programs that have relevance, utility, and cultural validity in the school. It proceeds on the shared belief that data will be provided on outcomes of greatest relevance to the school and the community and that this data can immediately in the near future be available for scientific publications.
- (3) Challenges exist on both sides of the partnership in developing the work.

- (a) Community liaisons must play an active role in translating the relevance of the science and the need for rigorous methods to stakeholders at all levels and have suitable academic partners for this task.
- (b) Academic researchers must not only assist with funding programs on the community side but also help with problems of developing relevant and timely evaluations and analyses for the community partner. In turn, the agency partners play a crucial role in being advocates and supporters of the research aspects of the program, facilitating data collection, and actively participating in the interpretation of data and preparing material for publication.

- (4) Trust and empathy are built over time. Partnership relationships benefit by taking on smaller projects to identify interests in common before initiating major projects.
- (5) Ups and downs will be encountered in support and program development for such research in a fluid system, such as the school system, which is subject to many other constraints, in particular, state budget variations and crises. Periods of project constraint, such as a period of reduction of the program to a few schools, can be balanced with periods of potential rapid growth and expansion, such as broadly screening of the district for violence exposure. Across these variations, the academic and community partners can work together to maintain a core focus on the quality and effectiveness of the program and strategies to disseminate and evaluate dissemination of effective programs.
- (6) Consistency benefits from having “champions” for the research and programs on both sides and at several levels on both sides. On the community side, the multiple levels of support are needed to stabilize support across variations in budget, while on the academic side, multiple levels of support are needed to create flexibility in resources as opportunities for research. In times of budget shortfalls and crises, the community program can look to the data of its research partners to provide a rationale for sustainability, rather than depend solely on anecdotal and advocacy approaches.
- (7) Finally, find clinical scholars and research partners with brain power, compassion, sensitivity, loyalty, commitment to children’s services and education, work ethic, and values, like Brad Stein, Sheryl Kataoka, Lisa Jaycox, Ken Wells, Naihua Duan, Arlene Fink, and Bob Brook, without whom none of this could happen.

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