

DEVELOPING SCHOOL RELATIONSHIPS THROUGH ALTERNATIVE PROGRAM DEVELOPMENT

Presented by Bridget Bennett-Lewis, LISW

PROGRAM DEVELOPMENT IN SCHOOL SYSTEMS

Program development begins with recognizing the need, creating a shared vision and a willingness to tackle the problem. This presentation on the implementation of school programming by NRI Mental Health Center in the Woonsocket School District highlighted the process of program development and the critical elements that made it successful.

BEGINNING THE RELATIONSHIP

About 15 or 16 years ago the NRI Mental Health Center recognized that the schools were in trouble with treating severely emotionally disturbed kids. No one spoke about behavioral health or dual diagnosis even though those issues were there as well. The kids that were sent for treatment were the disruptive kids. “This kid’s got a mental health problem, can you take care of him? He’s so disruptive in class.” Intakes at the mental health center reflected this need, so the issue of how to meet the school’s needs rose to the attention of the mental health center. One of the initial questions was how to infiltrate the school system, which was perceived as a very closed system. An overture to a school department, the largest of the communities served by the mental health center, was made. Woonsocket, Rhode Island is a poor, post-industrial city. There is a lot of poverty and it is a very closed community. The mental health center said, “Let us come in and help you. Your kids are our kids. Let’s see if there’s something that we can possibly do.” The approach was soft, with an offer for some sort of consultation. Offering the free service caught the school’s attention and can be a tactic when there is no other way to engage the school. The cost of the worker was a sunk cost for the venture and the worker went in to hang out with the teachers, listen to their problems, validate them and help decrease their fear. The mental health worker knew the kids and knew how to work with them and how to work with their families. The process began with individual teacher consultations. The workers would come into the classroom and sit there and observe, then meet with the teacher afterward and say, “Yes, this kid is difficult, and we’ve thought about this and we can refer this family in.” The teachers were supported and the mental health center got a better sense of the school. This continued for about

a year and a half, until the people in the school started to see the center as not the enemy. In the second year, the school started saying, “Okay, maybe you’re not so bad and maybe we can contract for you to come into our classroom and offer some support in the classroom a couple hours a week.” The program grew from individual consultation to direct in-service in the classroom - usually the behavior disorder classroom.

ISSUES IN SCHOOL PARTNERSHIPS

Some of the issues faced when entering schools systems are unique to the school system. Union issues are significant. The mental health center is offering a service on someone else’s territory where they have union protected job that allegedly a school social worker or psychologist could be providing. However, these were children that nobody wanted to work with. They had the families that nobody wanted to deal with. So the union backed off. Later, when the union issues were still an issue, one of the things that was said to them was, “This kid is really tough to deal with. We really need to be working this family.” The social workers in that town did not want to do home visits and they did not want to work past their contracted hour time. The mental health center offered something nobody else was willing to provide, they said, “We can go in after 3 and we’ll do the home visits to the families and we’ll start to provide services to the families.” That gave the school union the permission to have the mental health centers services in the school as the center was providing something a little bit different than they were.

CREATING A SHARED VISION

By this point the school and the mental health center had started to “buddy up” and to talk about whether they had a shared vision and what was it. This process can occur faster if there already is a relationship with the school but it generally takes time to build. After a common vision is built problems can be addressed more directly. “This is how we see this problem and what is it that we can do for you that’s going to make your lives better.” The mental health center did that for 8 or 9 years and expanded their services to include more classrooms in more schools. At one point there was a decision to try something really different- a behavioral disordered classroom. It did not work but served to lead to another solution. The children were integrated into the mainstream and service providers became a mobile team. Ten children were

divided among 3 or 4 different schools and a mobile team with a therapist and a teacher's assistant who the mental health center hired were sent to support all of the 8 classrooms. That worked well for about 2 years until the school decided to offer the service themselves. However, the children were getting more complex and the school asked the mental health center back in. Then a new off site alternative was considered. A Day Treatment Center was opened, which is different than an adult day treatment. It was a 45-day assessment program where the school provided the money to purchase 10 or 12 slots for which they would pay \$17,000 a year. For that \$17,000 a year the school got to be the gatekeeper. It got to say who came in and out of the program. The children were taken out of the school because it appeared to be a very disruptive place for them to be. They came to the treatment center for 45 days, where they and their families received an assessment. During those 45 days the children were there, school personnel came to the center every 3 weeks for planning and partnering so that at the end of the 45 days there were no surprises. The school and the mental health center shared the vision that children belonged in their schools, in their communities. There was a 95% return rate to the school. However, part of the job was to recognize the children who needed more intensive help than the program could offer. Some children would go to the next level of alternative education or to residential programming although that was done very carefully. Decisions were made based on the therapeutic needs of the child.

This time-limited 45-day center has been running now for 5 years and it has been running fairly successfully. It was started with just high school aged children from 4 different communities. The classroom size was about 8 and it had a teacher, a teacher's assistant and a masters level clinician assigned to each classroom. Then a middle school program was created and, with the thought that intervention should be occurring sooner, an elementary program was the last to be created. The program now serves children from ages 5 to 18.

Last year the State Department of Education informed the center that a school license is required to continue to operate and gave the center a year to transition. Parents had complained about the academics and the behaviors in the program and the school passed those issues along to the program. The program therefore this year became a licensed educational facility and has hired a nurse, a gym teacher and other staff. The center has 3 years to fulfill the library

requirement. Costs have risen but the program is still significantly below the costs of other alternative schools in Rhode Island. The program now is looking for a new site as it has outgrown its space and is adapting to its new educational role. A physical education teacher was hired part-time who had not previously worked with children at risk. She has been able to adapt her curriculum, making it all hands on and it has become the core curriculum integrating the other subjects of science, math and language. Curriculum development is a huge focus. Substance abuse education is folded into the health curriculum. There are home visits. The environment is very rich. The program hires staff for their attitude and trains them for skill. The need for creative staff with vision and humor is very important. Likewise, stability in staffing is needed. Presently in the school there are clinicians assigned to the classroom and to the school. This is only sometimes effective. The effectiveness of staffing patterns and roles need to be continuously evaluated for their effectiveness. As the children change, their needs are different and the program must change.

SUMMARY

Relationships and collaborations with schools are formed in the same way relationships are formed with anybody. They are built on interactions, cooperation and trust. Initially providers may offer services that the school might not provide or might not want to provide and then once relations are built work creatively to help the school fund programs or utilize funding streams they might not have experience with. Recommendations from the service provider need to be aware of school limitations and partner with the school on treatment planning solutions. School relationships are continuing to develop and shared visions are created from those relationships and are the basis for developing a mutual plan. We all need to engage in the discussion of where we go from here.