Supporting Teachers Through Consultation and Training in Mental Health

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Introduction

Teachers are likely to have multiple students in their classroom with social, emotional, or behavioral difficulties. For example, when just considering attention-deficit hyperactivity disorder (ADHD), approximately 5 % of children and adolescents are diagnosed with ADHD, which translates to an average of one or two students with ADHD in a typical classroom (National Research Council and Institute of Medicine, 2009). With the rate of all diagnosable mental health conditions currently estimated at 12 % to 22 % for children and adolescents, most classroom settings will be impacted by the serious and persistent symptoms of mental health disorders (National Research Council and Institute of Medicine). Research demonstrates that students with mental health difficulties often struggle in the classroom with regard to academic achievement and social-emotional and behavioral functioning (Frojd et al., 2008; Loe & Feldman, 2007; Mayes & Calhoun, 2007; Mychailyszyn, Mendez, & Kendall, 2010). As a result, teachers are accountable for supplementing traditional academic instruction with a variety of formal interventions and accommodations (e.g., Individualized Education Plan, 504 Plan) and informal supports for students with mental health difficulties.

In addition to supporting students with mental health difficulties, research suggests that teachers should integrate social-emotional learning (SEL) programs and positive behavioral interventions and supports (PBIS) into their classrooms in order to promote mental health and positive behavior for all students (Durlak & Weissberg, 2011; Sugai et al., 2010). Goldstein and Brooks (2007) assert that teachers must move from focusing solely on remediating problems to proactively promoting the positive outcomes they want to see. A recent meta-analysis indicates that SEL programs—which teach students valuable emotion identification and management strategies along with other skills beneficial for interpersonal relationships—promote positive social, emotional, and behavioral development; reduce symptoms of several common childhood mental health disorders; and are associated with impressive academic gains in the form of achievement tests and school grades, with an average 11 percentile points gain in academic achievement (Durlak & Weissberg, 2011). Likewise PBIS—which uses a systems approach to changing the school culture and implementing a tiered model of behavioral interventions —has been shown to decrease office referrals and suspensions, improve

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perceptions of school safety, and increase academic performance, particularly in reading (Bradshaw, Mitchell, & Leaf, 2010; Horner et al., 2009; Luiselli, Putnam, Handler, & Feinberg, 2005). These positive outcomes have led many schools to adopt SEL programs and PBIS and for more teachers to implement these positive approaches in their classrooms.

Clearly, the modern job description for teachers extends beyond providing traditional instruction and includes aspects of mental health care (Rothi, Leavey, & Best, 2008). This raises many questions: What training do teachers receive related to mental health promotion, prevention, and intervention? How do they feel about their role as mental health providers? Further, how can mental health professionals support teachers as they promote positive student mental health? The answers to these questions provide reason for both concern and optimism. This chapter begins by exploring teachers' training in student mental health, feelings of preparedness to support students with mental health problems, and desire for support from the mental health community. The remainder of the chapter provides an overview of school mental health consultation as a mechanism for equipping teachers with the skills to address student mental health.

Teacher Training in Student Mental Health

There is a discrepancy between the identified role of teachers in mental health care and their training related to mental health. The United States (US) Surgeon General identified teachers as "frontline" mental health workers, who should be trained to recognize and manage child and adolescent mental health difficulties (U.S. Department of Health and Human Services, 2000). Yet, there is no national mandate that teachers receive mental health training, and teacher candidates are not required to exhibit competency in areas related to mental health (Koller & Bertel, 2006). A few states have mandates related to training in certain mental health topics. For example, Connecticut requires that local boards of education provide teachers, administrators, and support staff with professional development on drug and alcohol abuse prevention, health and mental health risk reduction, the growth and development of children with special needs, and school violence prevention (Connecticut Board of Education, 2011). Similarly, Minnesota requires that teachers seeking to renew their license demonstrate that they have received professional development in the past 5 years related to the warning signs of early onset mental illness and how to respond when warning signs are observed (Minnesota Office of the Revisor of Statutes, 2009). In Ohio, all school personnel are required to obtain in-service training on the promotion of positive youth development and the prevention of substance abuse, child abuse, and violence. This training must also include attention to the board's policy on harassment, intimidation, and bullying (Ohio General Assembly, 2012). These states are the exception, with most states not specifying this professional development need.

Even with mandates in place, the amount of professional development related to student mental health is limited; furthermore, these mandates do not affect preservice training. As Burke and Paternite (2007) poignantly describe, "Although teachers typically receive extensive preservice and in-service preparation in curriculum and instruction, they receive little or no education concerning the intra- and interpersonal dimensions of teaching and learning in classrooms. Teachers, ill-equipped to deal with mental health needs—either their students' or their own—are left to their own devices to cope" (pp. 21–22). There are three areas of psychology that are particularly relevant to teaching school-age students, including child and adolescent development, mental health problem identification and early intervention, and behavior management techniques, that will be briefly reviewed.

Child and Adolescent Development

Dr. James Comer (2005), a leader in prevention programming and education reform, argues that a greater focus on child development in teacher

training programs is the key to improving our nation's education system. The National Council for Accreditation of Teacher Education (NCATE, 2008) requires schools of education to demonstrate that their teacher candidates understand development in childhood and adolescence and the relationship of cognitive and affective development to learning. Indeed, an NCATE survey revealed that 90 % of teacher preparation programs required teacher candidates to take at least one course on child and adolescent development; yet, over half of the program representatives who responded to the survey stated that this requirement was insufficient to properly prepare teachers for effective practice (Pianta, Hitz, & West, 2009); thus, more preservice training is warranted.

Mental Health Problem Identification and Early Intervention

Generally, preservice teacher training programs pay very little attention to recognition of and early intervention for students' mental health needs (Koller & Bertel, 2006). While most preservice teachers are required to take a general psychology course, the content of the course does not typically focus on, or even cover, child and adolescent mental health issues. Furthermore, Langer (2009) reports that teachers may view courses in psychology as something to "get done" rather than an important component of training. Once in the field, teachers are often unaware of the mental health resources available in their school and surrounding community, as well as the evidence-based practices for supporting students with emotional and behavioral problems. In a study of five school districts (Stormont, Reinke, & Herman, 2011), most teachers were unaware of 9 out of 10 of the evidence-based practices for supporting students with emotional and behavioral problems and were unsure of the assessment and treatment services available within their school. More than half of the teachers did not know if their school provided functional assessment and intervention planning services (Stormont et al.).

Behavior Management

Research suggests that teachers are woefully unprepared in behavior management. A report from the American Psychological Association, Coalition for Psychology in Schools and Education (2006) revealed that 50 % of teachers reported receiving a lot of training, 37 % reported some training, 10 % reported little training, and 3 % reported no training in behavior management. Notably, those teachers who reported receiving a lot of training were more seasoned. For example, 59 % of teachers with 10 or more years of experience reported receiving a lot of training in behavior management compared to 19 % of first year teachers (Coalition for Psychology in Schools and Education). This suggests that much of the training in behavior management occurs on-the-job; however, professional development in this area is also lacking. Not surprisingly, first year teachers ranked behavior management as their highest professional development need, while experienced teachers ranked it as their second highest professional development need (Coalition for Psychology in Schools and Education). These findings indicate the need for increasing the quantity and improving the quality of preservice training, as well as on-the-job support related to effective behavior management.

Professional Development Procedures

Traditional models of professional development that are short term and disconnected from the actual daily challenges of the classroom have been criticized as ineffective in impacting teacher behavior or student outcomes (U.S. Department of Education, National Center for Education Statistics, 1999). Research suggests that professional development is most effective when it combines knowledge building with skill building and offers follow-up support (Blank, de las Alas, & Smith, 2008). Models that combine didactic training with ongoing consultation are ideal because they support teachers over an extended period of time and offer feedback and advice to address real-time problems in a

work-learn-work sequence. As discussed later, such models have proven more effective than didactic professional development alone.

New Evidence on Teacher Preparation

A recent, online national survey of educators conducted by the Center for School Mental Health (CSMH; Gibson, Brandt, Stephan, & Lever, 2013), a federally funded national center for advancing mental health in schools, provided additional evidence that teacher training in mental health is limited in the US (Tables 1 and 2). On average, participants reported "some" preservice training in implementing SEL programs, identifying student mental health concerns, and supporting students with mental health concerns in their classroom. They reported slightly higher rates of preservice training in childhood development and classroom behavior management strategies and the least amount of preservice training in making a referral for mental health services. Participants reported having the most on-the-job training in classroom behavior management and the least on-the-job training in identifying mental health problems and making referrals. Teachers also reported variability in their ability to support students with specific mental health problems in the classroom and reported being the least prepared to work with students with depression or bipolar disorder, abuse or trauma, and substance abuse.

Table 1 Preservice training of educators in mental health topics

	None to very little (%)	Some (%)	A lot (%)
Child/adolescent development	8.7	41.2	50.0
Behavior management	11.5	45.9	42.6
Social emotional learning	22.7	47.9	29.3
Identifying problems	28.0	47.2	24.8
Supporting students	34.1	44.5	21.4
Making a referral	40.4	39.5	20.2

Table 2 On-the-job training of educators in mental health topics

	None to very little (%)	Some (%)	A lot (%)
Child/adolescent development	18.1	47.2	34.6
Behavior management	12.8	40.0	47.2
Social emotional learning	13.5	46.1	40.4
Identifying problems	27.0	42.0	31.0
Supporting students	21.6	43.2	35.2
Making a referral	27.0	45.2	27.8

A Call for Support

A lack of or limited training in student mental health likely contributes to teacher burnout and turnover. Up to 50 % of teachers leave the field within 5 years, and more than one third of those who stop teaching cite student behavior problems as a primary reason for their dissatisfaction with the field (Ingersoll & Smith, 2003). When teachers leave, students' may lose their sense of connection to their school and a positive adult who promotes educational attainment, as well as time and consistency in academic instruction (Burke & Paternite, 2007). Teachers who remain in education report high levels of stress (Kyriacou, 2001) that are associated with challenges in managing students' social, emotional, and behavioral difficulties (Chen & Miller, 1997). Indeed, research suggests a strong relationship between students' behavior and teacher burnout (Burke, Greenglass, & Schwarzer, 1996; Friedman, 2006; Kokkinos, 2007; McCormick & Barnett, 2010). In one study, teachers perceived students with mental health problems as impacting them in several ways, including increasing the need to use classroom management strategies, contributing to job stress, and negatively influencing their own mental health, all of which they believed hindered their ability to effectively teach (Rothi et al., 2008). With additional quality training that facilitates skill development, teachers may be less burdened by these difficulties.

Teachers have indicated that knowledge of the students' mental health needs is critically important for their success (Koller, Osterlind, Paris, & Weston, 2004). They feel a duty to help care for the mental health needs of their students but feel unprepared to recognize and intervene with students facing mental health challenges (Koller et al.; Rothi et al., 2008). Teachers report an interest in being trained in preventing mental health problems, recognizing the early signs of mental health problems, making referrals, and supporting students with mental health problems in the classroom through behavior management and other strategies (Doyle & Houtz, 2009; Rothi et al., 2008). Further, a multistate study found that the majority of teachers (62 %) and administrators (63 %) reported a desire for increased consultation from school mental health professionals (Gilman & Gabriel, 2004).

School mental health professionals are well positioned to respond to teachers' calls for assistance. Training and consulting with educators is a vital component of a comprehensive approach to school mental health and should be a priority for school mental health providers. Thus, providers should spend a substantial portion of their time and energy collaborating and consulting with educators (Burke & Paternite, 2007; Caplan, 1963; Paternite & Johnson, 2005). However, if school mental health providers are to work with educators additional questions must be answered. Most prominently, what are the most effective ways for school mental health providers to support teachers? To answer these questions, we turn to the literature on school mental health consultation.

Overview of School Mental Health Consultation

A definition of school mental health consultation, offered by Judith Alpert (1976), describes "the process in which a mental health professional assists another, called the consultee, regarding clients for whom the latter has responsibility. In school, the clients are students, whereas the consultees are teachers, administrators, aides, or other school staff" (p. 620). The consultant and teacher engage in voluntary, collaborative, and solution-focused interactions (Rubin, 2008). The goal is for the consultant to enhance the teacher's knowledge, skills, confidence, or objectivity so that the teacher can address a current problem, as well as similar problems that may arise in the future (Alpert, 1976; Caplan, 1963; Gonzalez, Nelson, Gutkin, & Shwery, 2004). By working with a teacher, who then teaches and supports many students, the mental health provider is able to reach more students via the teacher than through individual interactions with students (Goldstein & Brooks, 2007).

Teacher consultation may be focused on treatment for a student, or promotion and prevention efforts, such as working with a teacher to improve classroom behavior management strategies or implement a SEL program (Alpert, 1976; Meyers, Meyers, & Grogg, 2004; Rubin, 2008). Alternatively, consultation may focus on whole school-level change (Meyers et al., 2004). For example, a consultant may work with a committee of teachers to assess bullying in their school and implement a school-wide bullying prevention program to address the needs of the entire student body. Thus, consultation can focus on one student, a small group of students, one or more classrooms, or the entire school.

Often there is a structured process by which consultation occurs. For example, behavioral consultation (a specific model for school consultation described later in the chapter) follows a four-stage process of problem identification, analysis, treatment implementation, and evaluation (Sanetti & Kratochwill, 2008). When necessary, consultation can also be an iterative process. If the evaluation suggests a lack of positive outcomes, the consultant and consultee(s) may revisit their analysis of the problem and select an additional or alternative solution to implement. This cycle can be repeated until the consultant and consultee are satisfied with the outcomes (Goldstein & Brooks, 2007; Gonzalez et al., 2004). At the program implementation level, consultation may begin with training, followed by a series of observations with feedback until the program is successful (Han & Weiss, 2005).

It is worth noting that mental health consultants can come from a wide array of mental health fields, including school psychology, school social work, clinical psychology, counseling psychology, or other mental health fields (e.g., psychiatry, nursing, occupational therapy). Some fields, such as school psychology and clinical psychology, include direct training in mental health consultation as a result of didactic requirements (American Psychological Association, Commission on Accreditation, 2009; Anton-La Hart & Rosenfield, 2004). The degree to which providers consult in a school is likely related to their training in the skill, as well as the constraints imposed by their particular role within the school. Some school mental health providers are more constrained by the role they have been asked to play in schools. In some settings, school psychologists report that they want to spend more time consulting, but are unable to do so due to their need to spend over two thirds of their time dedicated to special education eligibility assessments (Gonzalez et al., 2004; Stoiber & Vanderwood, 2008).

Models of Teacher Consultation

There are numerous models of mental health consultation, many of which have been used with educators. These models vary with regard to the focus of consultation, the number of participants engaged in the consultation process, and the degree to which the consultant takes a collaborative versus directive approach. One way to differentiate consultation models is to examine their focus: client-centered, consultee-centered, or system-centered (Meyers et al., 2004). The type of consultation used should depend on the focus of change efforts. Consultants should ask themselves: Who or what are we attempting to change? Client-centered models are appropriate when the aim is to help educators better support an individual student with an identified social, emotional, academic, or behavior problem. The focus of change for client-centered models is on changing some aspect of the student. In contrast, consultee-centered models focus on educators and attempt to change educators' feelings and behavior so that they can more effectively work with students. Finally, system-centered models of consultation focus on changes to the whole school, such as school climate, policies, and daily practices.

Another difference between models of consultation is the number of consultees and consultants who are involved. The traditional model involves one consultant working with one consultee. However, there has been some support for a team approach in which multiple consultants, preferably from different disciplines, work together to assist one or more educators (Meyers et al., 2004). In addition, some authors have strongly argued for the benefit of group consultation, in which multiple educators meet together with one or more consultants. Cohen and Osterweil (1986) found that group consultation reduces educator's feelings of isolation, allows educators to offer emotional and practical support to each other, and reduces the educators' reliance on the consultant. This is also an economical and efficient way to provide consultation. Due to the time and money saved via group consultation, Meyers and colleagues (2004) believe that it is likely to become more widely used. Finally, Sheridan and colleagues have proposed a Conjoint Behavioral Consultation (CBC) that joins together parents and teachers with a mental health consultant in order to address behavioral, social, and academic needs for a child in both the home and school environments. Research has demonstrated that CBC leads to more lasting behavioral change than teacher-only consultation (Sheridan, 1993).

A final difference between consultation models is the degree to which the consultant takes a directive or nondirective approach. The majority of current models use a fairly nondirective and collaborative approach (Sheridan & Cowan, 2004). According to Alpert (1976), consultants who use a nondirective approach avoid giving advice. Instead, they help educators to come up with their own solutions. Rather than telling educators what they should do, consultants allow educators to discuss their feelings, engage in problem-solving discussions, and provide instruction, modeling, and encouragement as

needed (Alpert). Likewise, Sheridan and Cowan (2004) describe the need for equal say in decision-making. This model recognizes that both consultee and consultant bring expertise (in different areas) to the relationship. Nondirective consultation is clearly different from a hierarchical relationship in which the consultant tells the educator what to do without input or negotiation. For this approach, teachers are active participants in the consultation rather than passive recipients of information and instructions. A nondirective approach to consultation is well aligned with ideas from community psychology about empowerment and sustainable change.

There are three specific models of consultation that have been widely used in schools and vary in their focus, typical number of participants, and degree of directivity (Sheridan & Cowan, 2004). The three models, mental health consultation, behavioral consultation, and organizational development consultation, will be briefly reviewed.

Mental Health Consultation

The mental health consultation model aims to help the consultee understand how their feelings and actions contribute to a problem and assist them in developing perceptions, attitudes, and emotions that allow them to more effectively interact with clients (Caplan, 1963; Sheridan & Cowan, 2004). This model may be particularly useful when an educator believes that factors related to the child or family are to blame for the child's difficulties and that factors related to the teacher, classroom, and school environment do not matter (Soodak & Podell, 1994). In mental health consultation, the consultant uses questioning, processing, modeling, or teaching strategies to impact the consultee's thoughts and feelings about a client or situation. For example, a consultant may work with a teacher to better understand why a student is exhibiting off-task and disruptive classroom behavior and what the student's behavior elicits in the teacher. In this example, the consultant's goal is to increase the teacher's empathy for the student so that the teacher can act supportively towards the student rather than criticizing his or her behavior.

Behavioral Consultation

In contrast, behavioral consultation is more focused on changing the environment in order to improve clients' behavior. The consultant works with the consultee to identify aspects of the environment that reinforce client behavior and then removes those aspects that reinforce problematic behaviors while bolstering those aspects that reinforce positive ones. This is followed by evaluation of whether the intervention was effective (Sheridan & Cowan, 2004) and modification of the intervention as needed. Functional behavioral analysis is a specific technique often used in behavioral consultation. For example, a consultant may help a teacher to identify the triggers for a child's aggression and prevent those triggers. In addition, the consultant may help the teacher to create a system for rewarding the child when refraining from aggression and solving problems in an appropriate manner.

Organizational Development

Organizational development is quite different from both mental health and behavioral consultation. The focus is not on changing individuals, but on improving entire systems through assessment and intervention (Sheridan & Cowan, 2004). An organizational development consultant may work with an entire school to improve communication techniques, problem-solving approaches, or the relationship between school personnel.

Emerging Models

More recently, research has focused on alternative and hybrid models of consultation in school. For example, Tysinger and colleagues (2009) advocate for a collaborative-directive model of consultation that enables the consultant to engage in shared decision-making with the consultee

when possible but also to be prescriptive when more direct advice is warranted. This model recognizes the right of the consultee to reject suggestions made by the consultant, as well as their ability to develop their own solutions and contribute to the consultant relationship, while also acknowledging that sometimes a more directive role is appropriate.

A second new model, based on social diffusion theory, trains teachers to act as consultants to their peers. Diffusion theory states that certain people, known as key opinion leaders (KOL), are able to persuade others in their social network to adopt new interventions. Atkins and colleagues (2008) recruited peer-identified KOL teachers and asked them to provide consultation to other teachers in their school regarding the use of classroom practices for children with ADHD. Compared to teachers who received standard mental health consultation alone, the teachers who also received consultation from KOL teachers were more likely to report using the classroom practices. These findings indicate that in order to increase the likelihood of teachers implementing recommended interventions, consultants may want to focus their efforts on training and working with a select group of KOL teachers, who would then work with their peers. This approach recognizes natural leaders within the school environment and may be especially useful in school environments where there is a distrust of outside providers or pessimism about mental health interventions (Atkins et al.).

Empirical Research on Consultation

Mental health consultation, behavior consultation, and organizational development have been well researched and found to be effective (see meta-analysis by Medway & Updyke, 1985). However, in schools, behavioral consultation has received the most empirical and clinical attention, while organizational development consultation has received the least attention (Sheridan & Cowan, 2004). Substantial research demonstrates that behavior consultation is effective in providing teachers with strategies to improve current and future student behavior and is highly accepted by teachers (Kratochwill, Elloitt, & Busse, 1995; Sheridan, Welch, & Orme, 1996). While each of these models is an appropriate option for teacher consultation, behavioral consultation has the most robust research support.

Decades of research has revealed effective strategies that teachers can use to support the mental health of their students, but all too often these strategies are unknown, unused, or misused by educators (Sawka, McCurdy, & Mannella, 2002). Community science is a framework for reducing the gap between research on effective interventions and the implementation of these interventions in the real world (Flaspohler, Anderson-Butcher, Paternite, Weist, & Wandersman, 2006). This framework proposes that mental health professionals can close the gap between research and the real world by working with stakeholders (i.e., educators) to tailor research-based interventions to fit their needs and building the stakeholders' capacity to implement and evaluate these interventions. The role of a consultant is to provide training followed by technical assistance. While training is a time-limited and directive interaction, in which the consultant provides information and teaches skills, technical assistance involves ongoing support for implementation (Flaspohler et al.). This twofold approach to supporting teachers provides teachers with an intensive early learning opportunity and continuing assistance.

Teachers report that they appreciate didactic training as a means of receiving support from mental health professionals (Gibson et al., 2013). However, research indicates that this model of support has little effectiveness when used in isolation and is much more effective when followed by ongoing consultation and performance feedback (Jones, Wickstrom, & Friman, 1997; Joyce & Showers, 2002; Witt, Noell, LaFleur, & Mortenson, 1997). Joyce and Showers (2002) found that when teachers receive training alone, there is virtually no transfer of information into the classroom; however, when training is followed by ongoing coaching in the classroom, 95 % of teachers will use the new skills in the classroom. Similarly, the Strengthening Emotional Support

Service (SESS) model, which combines training and ongoing consultation, has demonstrated promising outcomes. The SESS model combines 4 days of active training (i.e., modeling, practice of new skills) in ecological behavior management, academic assessment, academic intervention, and behavior intervention with weekly consultation. The consultation is comprised of observation, modeling, feedback, and additional instruction, as requested by the teachers. The percentage of teachers who could effectively model the skills from the training increased from 43 % to 87 % after ongoing consultation (Sawka, McCurdy, & Mannella, 2002). Together, these studies suggest that a combination of training followed by ongoing consultation may be particularly well suited to schools.

In summary, each of the above models offers an appropriate, research-based option when consulting with teachers. Which model is selected should depend on the goals of consultation and preferences of the individuals engaged in consultation.

Stages of the Consultation Relationship

As with any relationship, consultation evolves over time. Often consultation is first sought by a school when there is a "crisis point" wherein a student, teacher, or the entire school is experiencing distress related to an acute problem. As the consultant assists with particular cases, trust builds, and the consultant may be invited to join in problem-solving at the program or organizational level (Abec, 1987). During this time the primary goal of the consultant is to integrate into the school culture, build relationships with the school's staff, and have a formal conversation about roles and responsibilities (Alpert, 1976; Sheridan & Cowan, 2004). Early conversations must clearly explain objectives and methods of the consultation relationship (Brown, Pryzwansky, & Schulte, 1995). A verbal or written contract may be beneficial, or even necessary, in order to clarify important details such as fees, specific responsibilities, time, and resources. To gain acceptance and trust during this stage, the consultant must demonstrate respect for educators by being a good listener, responding nonjudgmentally, and acknowledging educators as experts about their school and students (Sheridan & Cowan, 2004). It is also important to acknowledge that the teacher may be afraid of being observed by the consultant, and the consultant should provide reassurance that his or her job is to provide support, not to evaluate. This point should also be made clear to administrators so that data from observations and consultation sessions do not become part of the teacher's job performance evaluation process (Alpert, 1976; Goldstein & Brooks, 2007). One way to begin the discussion of any fears the teacher may have is to ask them about their expectations for the consultation relationship and process. In addition to opening the door to discussion of fears, this prompt allows the consultant to explain his or her theory of change and adapt an approach to better fit with the teacher's needs and desires (Tysinger, Tysinger, & Diamanduros, 2009).

Most consultation models include some form of a problem-solving stage that follows the entry phase. This may include working with the teacher(s) to collect data, identify the problem, develop a plan to address the problem, implement the planned intervention, and evaluate the outcome of the intervention. In behavioral consultation this process encompasses all fours stages: problem identification, problem analysis, intervention, and evaluation (Sanetti & Kratochwill, 2008). A systematic approach to the problem-solving stage, such as the one taken in behavioral consultation, is associated with consultation effectiveness, whereas failure to systematically engage in the above steps may lead to ineffective consultation (Meyers et al., 2004). During the problem-solving phase the consultant's focus will vary depending on the identified problem (Alpert, 1976). Gathering the data necessary to identify the primary problem is an essential step that should not be minimized.

An effective consultant will eventually work themselves out of a job. In other words, the job of a mental health consultant in schools is to help educators solve the problem that led to seeking

consultation and, more generally, to successfully teach students with a wide array of psychological strengths and weaknesses. When the consultant and consultee agree that the problem is adequately addressed and the consultee feels comfortable moving forward independently, consultation has reached the termination phase. During this phase, there may be uncomfortable feelings that should be discussed, such as doubt about being ready to end or fear of future problems (Alpert, 1976). As in therapy, the mental health provider should instill confidence where it is due while assuring the teacher that future support is available if needed.

Effectively Working in Schools

Schools are very different from other settings in which consultation may occur, such as hospitals and community-based clinics. The primary purpose of schools is to educate, not treat mental health problems, and as a result teachers and other school staff need ways to support students that will not detract from the educational process. In addition, each school has a unique culture, with differences in the climate, staff interactions, formal procedures, and unwritten rules. During the entry phase of the consultation relationship, consultants must come to understand the nuances of the school so that they can effectively adapt their approach to meet the needs of the students and staff (Gonzalez et al., 2004). In order to understand what supports are needed, the consultant must know what internal and external resources are already available (Abec, 1987). In addition, it is important to understand how change happens at that particular school (Alpert, 1976). Are decisions made top-down or more democratically? Who are the staff members that others look to for advice and who has the most influence on their peers? Most schools have a hierarchical power structure, with the administrators making decisions that are passed along to the teachers. Therefore, it is usually important to form positive relationships with administrators and gain their support for the consultation work (Goldstein & Brooks, 2007). However, administrators vary in how much information they want to know about the consultation and how frequently they want to be updated on progress. Early on, it may be useful to ask the principal and other administrators how much information about the consultation they would like and to schedule meetings accordingly. The more the consultant can tailor work to the characteristics of the school and its staff, the more likely they are to provide a service that is truly helpful.

Perhaps no element is more important to consultation than effective communication. Consultation cannot work without the ability of the consultant and consultee to speak in a "common language" (Gonzalez et al., 2004). To work with educators, consultants must understand the language of education. Many of the terms and acronyms used by educators are foreign to mental health providers, even those who regularly work with children. Consultants should take the responsibility for learning the language of the school system. For example, it is important to understand terms such as *Individual Education Plan* (IEP) and *504 Plan* and to ask the educator to clarify unfamiliar terms or acronyms. Similarly, consultants should keep in mind that teachers may not have the same understanding of mental health constructs and terms and should monitor their own use of language and modify accordingly. Even when teacher and mental health consultants use the same term, that term may not have the same meaning. For example, the consultant's understanding of "anxiety" may be different than a teacher's, and therefore, consultants should use language that is clear, be careful not to assume they understand what a teacher means, and ask for clarification when needed.

Consultants may wonder how much time they should spend at school and, more specifically, meeting with their consultees. The consultant's presence in the school demonstrates availability and commitment; thus, it is a good idea to allow time outside of scheduled meetings to visit with staff and observe how the school operates. Research demonstrates that the more hours a mental health consultant is at school, the more likely teachers are to consult with him or her (Gonzalez et al., 2004). Furthermore, the more

time that is spent in direct consultation, the more satisfied teachers are with the consultation and the more they perceive students as improved; yet, teachers are no more likely to implement recommendations of the consultant when given intensive rather than limited consultation (Tyler & Fine, 1974). Thus, consultants should recognize that extra time may lead to increased utilization and appreciation, but not necessarily changes in teachers' behavior.

When time is limited, consultants may want to focus their energy on working with KOL teachers and new teachers. As previously discussed, KOL teachers may be more successful than consultants in encouraging their peers to implement and adapt new interventions, and thus, consultants may consider training and supporting KOL teachers, who in turn support their peers (Atkins et al., 2008). Unlike experienced KOL teacher, new teachers are facing a classroom for the first time and may be struggling to find techniques that work for them. This may be why teachers with less years of experience are more likely to engage in consultation than teachers with many years of experience (Stenger, Tollefson, & Fine, 1992). New teachers report that their biggest concern is their inability to deal with student problem behaviors and that their most pressing need for support is in classroom management, with this need being particularly strong at the beginning of their first year on the job (Meister & Jenks, 2000; Stroot et al., 1999). Thus, working with new teachers on issues related to classroom management is likely to be particularly useful and appreciated.

Future Directions for Mental Health Consultation with Teachers

Mental health professionals have the knowledge and skills necessary to help teachers more effectively work with students with mental health problems and to promote mental health for all of their students. However, to improve their ability to assist teachers, it is essential that mental health professionals receive preservice training (e.g., didactic and hands-on experience) in working in schools and in consultation. Furthermore, mental health professionals would benefit from a set of resources developed specifically for use when consulting with teachers. Such a resource could include quick reference guides for the entry, problem-solving, and termination phases of consultation, and tools consultants could share with teachers. The Center for School Mental Health has been charged with developing guides for school mental health providers to use when conducting teacher consultation. Moreover, effective strategies for consultation should continue to be documented and shared. As has occurred for therapeutic interventions, as research accumulates, the field will be able to develop, test, and disseminate evidence-based models for mental health consultation with teachers.

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