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Future Directions for Dissemination and Implementation Science: Aligning Ecological Theory and Public Health to Close the Research to Practice Gap

Marc S. Atkins, Ph.D.,

University of Illinois at Chicago, Institute for Juvenile Research (MC 747), 1747 W. Roosevelt Rd., Rm 155, Chicago, IL 60608, (312) 413-1048 atkins@uic.edu

Dana Rusch, Ph.D.,

University of Illinois at Chicago, Institute for Juvenile Research (MC 747), 1747 W. Roosevelt Rd, Rm. 155, Chicago, IL 60608, (312) 413-1708, drusch@psych.uic.edu

Tara G. Mehta, Ph.D., and

University of Illinois at Chicago, Institute for Juvenile Research (MC 747), 1747 W. Roosevelt Rd., Rm 155, Chicago, IL 60608, (312) 996-3910, tmehta@uic.edu

Davielle Lakind

University of Illinois at Chicago, Department of Psychology (MC 285), 1007 W. Harrison St., Chicago, IL 60607, (312) 413-1039, rlakin3@uic.edu

Abstract

Dissemination and implementation science (DI) has evolved as a major research model for children's mental health in response to a longstanding call to integrate science and practice and bridge the elusive research to practice gap. However, to address the complex and urgent needs of the most vulnerable children and families, future directions for DI require a new alignment of ecological theory and public health to provide effective, sustainable, and accessible mental health services. We present core principles of ecological theory to emphasize how contextual factors impact behavior and allow for the reciprocal impact individuals have on the settings they occupy, and an alignment of these principles with a public health model to ensure that services span the prevention to intervention continuum. We provide exemplars from our ongoing work in urban schools, and a new direction for research to address the mental health needs of immigrant Latino families. Through these examples we illustrate how DI can expand its reach by embedding within natural settings to build on local capacity and indigenous resources, incorporating the local knowledge necessary to more substantively address long-standing mental health disparities. This paradigm shift for DI, away from an over-emphasis on promoting program adoption, calls for fitting interventions within settings that matter most to children's healthy development, and utilizing and strengthening available community resources. In this way, we can meet the challenge of addressing our nation's mental health burden by supporting the needs and values of families and communities within their own unique social ecologies.

We were making little progress explaining to a classroom teacher why we were not seeing one of her students in our hospital's outpatient clinic. The child was 7 years old and referred to us because of his aggressive behavior at school. In addition to work with his parent, we proposed a behavior management plan for his school. But his teacher wanted none of it and now the school principal asked to meet with us. The principal listened carefully as we explained our reasoning – “There is little we can do in a clinic that will improve his behavior at school.” She nodded and said she understood. “You want to work with my teachers,” she said, more statement than question. “We have a lot of fighting at recess. Can you fix our playground?”

This incidental conversation more than 20 years ago launched a program of research that informs this commentary. Our response to this principal's question was a qualified yes. Yes we knew how to reduce aggression through improved supervision and engaging activities. But could we reduce aggression in this urban school relying only on the school's own resources? Though there was scant literature to guide that question, we were hardly alone in our interest to bridge the research-to-practice gap. Inspired by the ground-breaking studies of John Weisz and colleagues, who first reported the lack of clinical representation (i.e., sample, provider, setting) in research studies in clinical child psychology (Weisz, Jensen-Doss, & Hawley, 1995), we were challenged not only to show positive outcomes, but also to increase access and to sustain the services in these critically under-served communities (Atkins, Graczyk, Frazier, & Adil, 2003).

Subsumed under the rubric of dissemination and implementation science (DI; Schoenwald, McHugh, & Barlow, 2012), there is an emerging consensus for a more rapid integration of effective practices into usual care to close the research to practice gap and to reduce the nation's long-standing mental health burden (Glasgow & Chambers, 2012; Kazdin & Blase, 2011). To date, DI has relied heavily on social diffusion theory (to denote that people and their social networks matter) and organizational theory (to denote that settings matter); however, we argue that the over-focus on promoting packaged programs in the form of evidence-based programs (EBPs) does not successfully integrate the knowledge of settings and persons toward maximal impact. In this paper, we describe a process that aligns ecological theory with a public health model to address long-standing mental health disparities. We describe how this process evolved from our work in urban schools and we close with a description of a planned program of research to support Latino immigrant origin families. Our examples expand DI research from an emphasis on how to bring *this program to that setting* toward an ecologically-driven science that prioritizes the needs and resources of settings that matter most to youth and families.

DI Research to Bridge the Research-to-Practice Gap

More than two decades ago, a series of national reports documented the slow pace of advances in mental health research and the need for a new paradigm to promote an integration of science and practice. Crystallized in the first-ever Surgeon General's report on mental health, a ground breaking review of the pervasive and unrelenting mental health burden facing our nation (U.S. Department of Health and Human Services, 1999), these issues were further articulated in two reports sponsored by the NIMH National Advisory

Mental Health Council to broaden the NIMH's research portfolio to promote public health (National Institutes of Health, 1999), and to align the differing cultures of science and practice (National Institutes of Health, 2000). Recent NIMH strategic plans also promote a public health approach to enhance the use of innovative prevention and intervention programs for those most in need and strengthen the public health impact of research (Insel, 2009; National Institute of Mental Health, 2015).

Bridging science and service, however, has proved more elusive than originally expected. Often referred to as a 17-year saga from "bench to bedside" (Wolff, 2008), the attempt to bridge science and practice has been described as a "valley of death" (Meslin, Blasimme, & Cambon-Thomsen, 2013), reflecting the few successful enduring outcomes. Green (2008) proposed a new set of priorities for research that incorporates practitioner perspectives throughout the research pipeline (Green, Ottoson, Garcia, & Hiatt, 2009); remarkably similar to a proposal to advance researcher-practitioner collaboration in clinical child psychology (Weisz, Chu, & Polo, 2004). More broadly, DI has become a prominent model in mental health research to examine potential mechanisms that can effectively and efficiently bridge the research-to-practice gap and lead to the integration of EBPs into routine mental health services. Multiple factors have been identified that impact the dissemination and implementation of effective services into community settings, including individual characteristics (e.g., provider attitude; Aarons, 2004), organizational characteristics (e.g., social context; Glisson, 2002), and public policy characteristics (e.g., financial resources; Massatti, Sweeney, Panzano, & Roth, 2008). Two research models have been especially influential in DI and are likely to remain prominent in future research: Social diffusion theory and organizational theory.

DI Research: The Influence of Persons and Settings

Diffusion of innovation theory (Rogers, 2003) and social network theory (Wasserman & Faust, 1994) describe the process by which new practices are adopted by an individual within a social setting. Empirically validated across diverse settings (e.g., agriculture, medicine, education), these theories have guided research demonstrating that information (or innovation) is adopted and spread among individuals in a predictable pattern, and is influenced by individuals in particular roles within a network of relationships (Burt, 1999). Social networks support the adoption and use of innovative practices by providing a context within which individuals make decisions regarding use of practices. These decisions are based in part on peer influences leading to a "tipping point" of use after which the former innovation becomes standard practice (Berwick, 2003; Green et al., 2009; Neal, Neal, Atkins, Henry, & Frazier, 2011).

Concurrent with research on diffusion theory and social network processes, organizational theory has emphasized the importance of setting characteristics for the uptake and implementation of innovative practices (see Aarons, Hurlbert, & Horwitz, 2011; Damschroder, Aron, Keith, Kirsh, Alexander, & Lowry, 2009). Glisson (2002) developed a widely used theory of organizational context that has been empirically validated in several contexts (e.g., children's social services, emergency rooms) and associated with more positive client outcomes, positive work environments, lower staff turnover, and higher

quality of services (e.g., Glisson & Green, 2011; Glisson, Hemmelgarn, Green, & Williams, 2013; Glisson et al., 2008). In a recent study, an organizational intervention derived from this work (ARC, Availability, Responsiveness, Continuity; Glisson & Schoenwald, 2005) was shown to enhance the effectiveness of Multisystemic Therapy for seriously conducted disordered youth (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009), in high poverty rural communities (Glisson et al., 2010). Specifically, therapist fidelity to MST was similar across conditions; however, youth in counties that implemented MST plus ARC improved at a faster rate in the first 6 months of treatment, and were significantly less likely to enter an out-of-home placement, than youth in counties that implemented only MST.

Misguided Assumptions of DI in Mental Health Services Research

As exciting as these research findings are for efforts to bridge science and practice, there are several limitations in the application of these literatures to DI that compromise the public health impact of research. The first is the assumption that EBPs are the gold standard of intervention as indicated by the predominant emphasis on identifying and targeting factors influencing EBP program adoption. There are two problems with this assumption. First, it does not acknowledge that research on which these programs were based has largely failed to accommodate the realities of community practice (Weisz, Jensen-Doss, & Hawley, 2006). Thus, rather than attributing failure to adopt an evidence based practice to deficits in practice sites (e.g., low readiness for change; Weiner, Amick, & Lee, 2008), the most parsimonious explanation for poorer outcomes of EBP implementation in usual care is offered by Weisz and colleagues as a failure of research-derived practices to match the characteristics of usual care (Weisz, Ugueto, Herren, Cheron, & Herren, 2013). This is not to say that EBPs have no relevance to mental health practice. As Weisz and colleagues have shown, EBPs can be aligned with usual care when the values and expertise of providers are recognized and supported and the context of usual care settings are accommodated (Santucci, Thomassin, Petrovic, & Weisz, 2015; Weisz, Krumholz, Santucci, Thomassin, & Ng, 2015). However, context-specific services are the exception not the rule in DI research, which suggests the need for a large dose of humility to acknowledge that “what works for whom under which conditions” (Paul, 1967) has been a long-standing inspirational goal that is largely unaddressed by current research (Hoagwood, Atkins, & Ialongo, 2013; Weisz, Kuppens, Eckshtain, Ugueto, Hawley, & Jensen-Doss, 2013; Weisz, Ng, & Bearman, 2014).

Second, with over 200 interventions for children and adolescents currently listed in SAMHSA’s National Registry of Evidence-Based Programs and Practices (www.nrepp.samhsa.gov), it is unclear how community providers would select the most relevant intervention to meet the needs of their clients. Moreover, even if providers were able to implement multiple EBPs with perfect fidelity, there would be many children with problems that extant EBPs do not address. This was demonstrated powerfully by Chorpita, Bernstein, and Daleiden (2011) who showed that 86% of youth in a statewide clinical sample were not coverable when matched on presenting problem, age, gender, and ethnicity, as culled from 435 randomized clinical trials of EBPs. Over the past decade, Chorpita and colleagues have made considerable strides to broaden the reach of EBPs through a distillation of best practices for use by community practitioners (see Becker, Lee, Daleiden,

Lindsey, Brandt, & Chorpita, 2015; Chorpita & Daleiden, 2009). As we will illustrate, to complement this effort, an ecological framework could provide situational specificity to match best practices with setting-specific parameters.

A third misconception (to the extent that it is considered at all) is that wide-scale implementation of EBPs will effectively reduce the population prevalence of mental health issues. Dodge (2009) described the challenges of bringing interventions to scale; observing, for example, that the *Fast Track* preventive intervention (Conduct Problems Prevention Research Group, 2011) would potentially reduce the population prevalence of conduct disorder by just 2% in spite of its individual-level treatment record of reducing conduct disorder by 50%. This is due to challenges identifying at-risk children, serving non-treatment seekers and non-treatment completers, and family mobility. He also illustrated the unexpected consequences of scaling up interventions by describing a statewide push to reduce class sizes that resulted in a shortage of adequately credentialed teachers (Bohrnstedt & Stecher, 1999).

Given that our own work focuses on children and families in particularly vulnerable circumstances, we are especially aware of the limitations of DI for under-served populations. For example, selecting appropriate EBPs becomes more challenging in community mental health practice in high poverty communities where presenting problems are complex and comorbidity is the norm (Bradley & Corwyn, 2002; Xue, Leventhal, Brooks-Gunn, & Earl, 2005). Furthermore, while children and families in need of mental health services from all communities face significant barriers to seeking and receiving services in usual care settings (Kataoka, Zhang, & Wells, 2002), these barriers are more complicated and entrenched for children and families in poverty (Harrison, McKay, & Bannon, 2004). As currently conceptualized, the power and viability of DI will remain limited in its ability to address the public health needs of the majority of children and families, especially those who are already most vulnerable.

Ecological Theory: Embracing Persons and Settings

One way to overcome the limitations of DI research is to align interventions with settings important to children and families. This would lead ultimately to an understanding of setting-specific and person-specific factors associated with adoption and sustainability of practices across the broad array of settings and situations that influence children's mental health. Ecological theory describes the dynamic interrelations among personal and environmental influences -- the social ecology -- and the direct effects of persons and settings on children's health and mental health. The ecological framework we propose for DI draws on concepts from Bronfenbrenner (1977; 1979) and Kelly (1966; 2006), and from the biological study of sustainability (Dodson et al., 1998).

The now classic image of Bronfenbrenner's concentric rings illustrates that individuals' behaviors are influenced by the settings in which they are embedded -- their families, schools, neighborhoods, nations -- and that we cannot fully understand these behaviors without accounting for the additive and interactive effects of these contextual factors. Kelly emphasizes the impact of settings' physical and socio-cultural characteristics on individuals,

as well as the reciprocal impact individuals have on the settings they occupy. Individuals adapt their behavior to align with setting goals and mores in these dynamic systems; their behavior, in turn, critically shapes the setting. Kelly also emphasizes that a fundamental feature of any given setting includes its positioning in the larger, dynamic constellation of settings. That is, settings are understood in context, as are individuals.

Kelly's ecological framework describes how settings or communities function internally, with four principles drawn from the natural sciences: adaptation, succession, cycling of resources, and interdependence (Kelly, 1966; Trickett, Kelly, & Vincent, 1985). These principles emphasize that settings are responsive and dynamic, and that they possess intrinsic strengths that can be enhanced or optimized. We also draw on the biological concepts of ecological balance and sustainability (Dodson et al., 1998); terms increasingly familiar in this time of great concern regarding climate change and limited natural resources. Biological systems that operate sustainably are able to remain diverse and productive without the need for outside resources. The analogy for DI is that a sustainable practice is one that can be maintained and modified to meet changing needs without depleting resources, thus conserving an ecological balance.

Ecological models have several advantages for DI. By redefining what has been called "resistance" as a lack of ecological fit (see Miller, Sorensen, Selzer, & Brigham, 2006), an ecological approach to DI works to fit interventions with diverse settings by capitalizing on the strengths of these settings, and promoting and supporting local norms. The focus of ecologically informed models on enhancing settings and using natural supports to augment local resources can facilitate program sustainability. Moreover, through an application of ecological theory, DI can play a more substantive role in reducing the nation's mental health burden by acknowledging the unequal geography and social ecology of opportunity in our nation that places ethnic minority poor youth and families at particular disadvantage (e.g., Acevedo-Garcia, Osypuk, McArdle, & Williams, 2008).

Repowering DI With An Ecological Public Health Framework

In addition to ecological theory, embedding DI within a public health model acknowledges the long-standing history of child mental health disparities (RAND Health, 2001) and associated unmet need of ethnic minority youth living in poverty (Bringewatt & Gershoff, 2010; Sturm, Ringel, & Andreyeva, 2003), including the growing numbers of children living in immigrant origin families (Flores et al., 2002; Pumariega & Rothe, 2010). DI has been slow to adopt a public health framework and we have suggested previously that continued efforts to improve usual care delivered through clinic-based services will have limited impact for most youth and families, particularly the most vulnerable who are the least likely to access services (Atkins & Frazier, 2011, Atkins & Lakind, 2013). The need for a broader public health approach for DI aligns with recent calls for a strategic shift in focus toward effective and sustainable implementation of comprehensive mental health services (Stiffman, Stelk, Evans, & Atkins, 2010), including attention to reallocation of resources (Kelleher, 2010) and workforce development (Schoenwald, Ringeisen, Hoagwood, Evans, & Akins, 2010), as well as consideration of mental health promotion goals across broad functioning domains and naturalistic settings (e.g., Atkins, Hoagwood, Kutash, & Seidman,

2010; Frazier, Cappella, & Atkins, 2007; Kuo & Taylor, 2004; Rotheram-Borus, Swenderman, & Chorpita, 2012).

Focusing on settings of importance to children and youth acknowledges a core ecological premise that the influences that matter most to children's development are those most readily available to them. We present the application of an ecological-public health model as a four-step process to promote accessible, effective and sustainable services:

1. Select an existing setting of high importance to children's development;
2. Identify core goals for that setting and consider the mental health benefit of those goals for children and youth;
3. Identify key opinion leaders to help identify and promote activities and intervention strategies to support those goals; and
4. Identify available resources to implement and sustain the service model.

To illustrate the application of this four-step process, we describe two programs of research: an ongoing school-based service model focused on the mental health needs of children and families in poverty, and a planned program of research to develop a mental health promotion model for Latino immigrant origin families.

Evolution of an Ecological Public Health Model: Schools as Context for Mental Health

The challenge to reduce aggression on a school playground that opened this paper provided a spark: there was both great need and great opportunity within schools to advance children's mental health. Figure 1 outlines the four-step process that evolved as we considered how to best leverage diminished mental health resources. Influenced by the Institute of Medicine tiered public health model that promoted a prevention-to-intervention continuum (Munoz, Mrazek, & Haggerty, 1996), we realized that we needed an alternative to the increasingly popular school-based clinic model that focused on intensive services delivered to individual children (see Weist, 1997). We needed a model to address universal and targeted strategies while accounting for the considerable resource constraints associated with urban poverty (Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008). With the ecological premise of aligning services with setting goals as our guide, we suggested a reversal of roles to our colleagues in school mental health: rather than promote mental health services as a core goal of schools, we suggested that if success in school was important to children's development then it followed that this should be a primary goal for mental health services (see Atkins et al., 2010).

Our first application of this process relied on children's peers, a natural and widely available resource, in two high poverty urban elementary schools (Atkins et al., 1998). In the first school, we responded to the concern for playground aggression by training all fourth graders in positive play and activity leadership during third grade recess. Play diaries completed by third and fourth graders were collected for two weeks on positive play and victimization during the mentored recess and during a standard recess occurring later that day. Results

indicated a significant reduction in victimization for the mentored recess relative to the standard recess. In the second school, recess was not available due to concerns for community violence. Instead, we were asked to respond to disruptive behavior in a first grade classroom during academic activities. We developed academic peer mentoring activities for all students in one sixth-grade class, including those rated highly aggressive by their teacher. The sixth graders were paired with the first graders on an activity led by the first grade teacher. Teacher and first graders' ratings of sixth graders' mentoring were uniformly positive, even for aggressive sixth graders, suggesting a normative school experience for both mentors and mentees.

This initial success encouraged us to consider a broader model for community mental health practice consistent with a mental health services research agenda (see Atkins, Frazier, & Cappella, 2006; Southam-Gerow, Ringeisen, & Sherrill, 2006). We knew that involving community mental health providers in urban classrooms would be met by skepticism of many urban teachers and parents towards outside influences (Fantuzzo & Atkins, 1992; McKay, Atkins, Hawkins, Brown, & Lynn, 2003). What we needed, we realized, was what Rogers (2003) referred to as a boundary spanner; someone with local credibility who can lend support to outside experts.

To reach parents we turned to the literature on family support programs that utilized ecological principles to empower parents and promote parental goals within schools (e.g., Comer & Haynes, 1991). We paired mental health providers with parents from the local school community and successfully engaged parents of children referred for mental health services in our school-based mental health model (Atkins et al., 2006). This was accomplished by providing multiple formats for reaching parents, including school events and home visits, as well as the knowledge offered by the parents on the mental health teams to infuse the model with local norms and values (Frazier, Abdul-Adil, Atkins, Gathright, & Jackson, 2007).

To reach teachers, we turned to the key opinion leader literature that was prominent in HIV prevention, medicine, and industry but as yet had not been utilized successfully in education (for a review see Flodgren et al., 2011). We examined the influence of peer-identified teacher key opinion leaders (KOLs) on classroom teachers' use of recommended educational practices for students with ADHD relative to the influence of mental health providers working alone (Atkins et al., 2008). As expected, we found that KOL influence, but not mental health provider influence, mediated higher rates of teacher report of their use of innovative practices.

Our next step was to incorporate teacher KOLs and parent advocates into a unified mental health service model to capitalize on their influence over their respective peers (Cappella et al., 2008). We named the service model *Links to Learning* (L2L) to emphasize that engagement in schooling was the primary goal, and identified empirical predictors of learning as specific goals for mental health services. As noted in Figure 2, universal and targeted services were specified to address these goals, along with referral for intensive services as needed, to explicitly involve mental health providers in the full spectrum of a public health model. The service model was implemented by teams comprised of a

community mental health provider and a parent advocate from social service agencies in high poverty urban communities, working in neighborhood schools adjacent to their agencies. All services were billed to Medicaid through the agencies to ensure that the model could be sustained within the existing funding mechanism. Most relevant to DI, the service model consisted of combinations of EBPs but none that we had developed, which meant that we had no incentive, personal or professional, for the selection of a specific packaged protocol.

Consistent with diffusion theory and our prior studies, the KOL teachers, in collaboration with community mental health providers, introduced and endorsed the classroom-based recommendations to their fellow teachers through co-facilitated professional development groups in their schools (Neal, Shernoff, Frazier, Stachowicz, Frangos, & Atkins, 2008). Similarly, the parent advocates in collaboration with the mental health providers co-delivered school-based and home-based services to parents. We examined the effectiveness of the service model in a three-year study in six schools with kindergarten-to-third grade children and results were promising. L2L, as compared to community-based mental health services as usual, produced significant positive effects on mental health service use, classroom observations of academic engagement, teacher report of academic competence and social skills, and parent report of social skills (Atkins et al., 2015). Though other goals, such as improved reading, were not realized, suggesting the need for further refinement of the service model, the study reinforced the value of coordination across schools and mental health agencies, and the feasibility of implementation of prevention-to-intervention strategies with goals common to both service sectors.

Mental Health of Latino Immigrant Origin Families

To further illustrate the ecological public health process we describe our planned work with a mental health promotion model for Latino immigrant origin families. This work is inspired by an urgent need to address immigrant mental health (Flores et al., 2002; Pumariega & Rothe, 2010), as this growing population has been particularly affected by research-practice-policy gaps (APA, Presidential Task Force on Immigration, 2012). In 2010, one in four youth under age 18 had at least one foreign-born parent, with 37% of the 40 million foreign-born from Latin America (Grieco et al., 2012). By 2050, Latino school-aged youth are projected to outnumber their non-Latino white peers (Fry & Gonzales, 2008). Nearly one-third of immigrant youth have an undocumented parent (Yoshikawa, Kholopseva, & Suárez-Orozoco, 2013) and immigrant origin families are over-represented in communities of concentrated poverty compared to native-born (19% vs. 15%) with the highest rates among Latinos (24%; see Van Hook, Brown, & Kwenda, 2004; Grieco et al., 2012).

Increased health care coverage and provision of preventative services under the Affordable Care Act will not decrease system barriers for immigrant origin families. Anti-immigration sentiment complicate and heighten barriers with ongoing changes in federal and state level policy, as reflected most recently by blocking Administrative Relief to expand Deferred Action for Childhood Arrivals (DACA) and to include Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) (see <http://www.nilc.org/dapa&daca.html> and <http://www.uscis.gov/immigrationaction>). For these reasons, in

addition to those described in previous sections, relying on usual care in community mental health agencies alone is neither sufficient nor feasible to combat long-standing disparities.

While attempting to understand the effects of immigration-imposed family separations on the mental health of Mexican origin families (Rusch & Reyes, 2013), we realized the prominent presence that non-specialty sector community-based organizations (CBOs) had in the lives of these families and that CBO staff were well-aware of the families' mental health needs. We had completed the first step of identifying a setting that immigrant families naturally access and that played a central role in the positive development of at-risk urban youth and families (e.g., Cordero-Guzmán, Martin, Quiroz-Becerra, & Theodore, 2008; McLaughlin, 2000; Roffman, Suárez-Orozco, & Rhodes, 2003). As we became more engaged in the Latino immigrant communities in Chicago, we envisioned this setting as one with untapped potential for mental health promotion (see Rusch, Frazier, & Atkins, 2015).

Similar to the anecdote that opened this paper ("Can you fix our playground?"), CBO program staff recognize the mental health needs of the families they serve and ask, "Can you tell us where to refer our families?" Unfortunately, the answer is often no. There are not nearly enough providers available to address the complex issues related to immigrant status, or who can deliver services in the language of the family, even in an urban metropolis like Chicago with a large immigrant population. In addition, even if there were enough clinics to refer families with providers that could competently serve them, traditional clinic-based services are under-utilized and arguably not designed to respond to the social context of these families (see APA, Presidential Task Force on Immigration, 2012). When services are available, system-level barriers such as insurance status, English language proficiency, and poor access to primary care referral sources (Huang, Stella, & Ledskey, 2006), as well as policy-level deterrents related to documentation status (e.g., Beniflah, Little, Simon, & Sturm, 2013; DeRose, Escarce, & Lurie, 2007) significantly limit the reach and the benefits derived from traditional clinic-based services.

CBOs are distinct from the mental health sector in terms of: (a) workforce training (certifications, advanced training, or health care qualifications may not be required); (b) organizational structure (no university or institutional governance); (c) funding sources and financial reimbursement (not-for-profit vs. fee-for-service or third party reimbursement); and (d) organizational mission informed by local context and a social justice perspective. Unlike many community mental health centers, CBOs have earned a non-stigmatizing visible and credible presence in the community (i.e., staff share cultural values, speak the language), thereby increasing comfort among families to enroll in programs and seek services. Furthermore, program enrollment is typically not contingent on insurance status, proof of legal documentation, or language proficiency, which increases access and encourages more consistent utilization.

As with our work in schools, we have no interest in reforming the mission of CBOs. Rather, we see the aforementioned distinctions as leverage points for innovation and seek another opportunity to promote mental health through alignment with the core goals of CBO-sponsored services and initiatives. In comparison to the mental health sector, CBOs provide a broad range of social services, such as adult learning programs (ESL, computer skills, job

training), youth after-school programs, immigrant rights/advocacy, legal aid, community leadership and civic engagement activities, and various forms of health education and literacy. This range of family-centered services allows for unparalleled access to immigrant families and presents more sustainable ways to activate meaningful change in the lives of children.

Unlike traditional mental health clinics, the historical stance of CBOs has been to provide culturally responsive services by identifying specific needs and unique concerns of the community. Programmatic goals include an over-arching focus on capacity-building and empowering at-risk communities (Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001; Hardina, 2006), in addition to facilitation of community involvement in problem identification and innovation (e.g., Poole, Ferguson, DiNitto, & Schwab, 2002). ESL teachers, legal support staff, family advocates, and youth organizers are influential with families and youth and therefore are potentially well positioned to serve as key opinion leaders and strong advocates for mental health promotion efforts. Advocacy and empowerment play an integral role in mental health service delivery for Latino immigrant adults (Alegria et al., 2008) and children (Olin et al., 2010a; 2014), and we plan to build upon existing family advocacy models that have worked within the specialty mental health sector (Olin et al., 2010a, 2010b; Rodriguez et al., 2011).

We see exciting opportunities within adult ESL instruction to identify innovative ways to engage parents in strategies that support children's learning at home (e.g., reading activities with your child, creating homework routines) and positive parent-teacher-school interactions (e.g., facilitating attendance at school events, advocating for additional educational services). Building on a program of research in after-school settings (Frazier, Atkins, Mehta, Hur, & Rusch, 2013; Frazier, Mathies, Rusch, Boustani, Mehta, & Reitz, in press), we propose to enhance opportunities for CBO staff to incorporate skill building during after-school time (Rusch, 2013). Relatedly, CBO goals around community organizing can support the positive integration of immigrant youth and families into school and community activities. CBOs develop partnerships with local schools (Hong, 2011), health-related service learning programs (Cashman & Seifer, 2008), and federally-funded coalitions (Gittel & Wilder, 1999), highlighting the opportunity to expand the reach and impact of mental health services and to sustain services through ongoing collaborations.

CBOs can play a critical role in the prevention to intervention continuum by leveraging their engagement with Latino immigrant families. Aligning with a CBO presents a unique opportunity for community mental health providers (i.e., those with skills to address more intensive needs) to work alongside CBO staff at the universal and targeted levels of intervention. This allows for the knowledge and expertise of CBO staff to become part of the mental health supports available to immigrant families, and fosters the integration of practices that are informed by local norms and values. This could include, for example, a consultative supervision model, wherein the role of community mental health clinicians becomes integrated into CBO programs. By acknowledging the goals and expected outcomes that CBO envision for their programs, mental health services are better positioned to reach immigrant families and enhance the mental health of youth and families.

Summary and Conclusions

DI is contributing significantly toward moving science into practice, but enhancing its relevance and impact for the mental health of all children and youth will require an intentional paradigm shift toward an ecological public health model to respond to the needs of the most vulnerable families. We draw upon ecological theory to emphasize how contextual factors impact behavior and the reciprocal impact individuals have on the settings they occupy, and on a public health model to ensure that service models span the prevention to intervention continuum. Through our exemplars we illustrate how the mental health needs of urban children and of Latino immigrant families can be addressed by aligning services with the goals of settings that matter, building on local capacity, and incorporating the local knowledge necessary to more substantively address long-standing mental health disparities. Intentionally aligning ecological theory and a public health model can enhance access to services for traditionally underserved and vulnerable youth and families, and support or complement the existing community mental health workforce within our nation's increasingly diverse communities.

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Figure 1.

Four-step process to promote accessible, effective and sustainable service models with examples noted in italics.

Figure 2.

Links to Learning: Application of an ecological public health framework to support children's learning and school engagement.