School Mental Health Services for Adolescents

EDITED BY
JUDITH R. HARRISON
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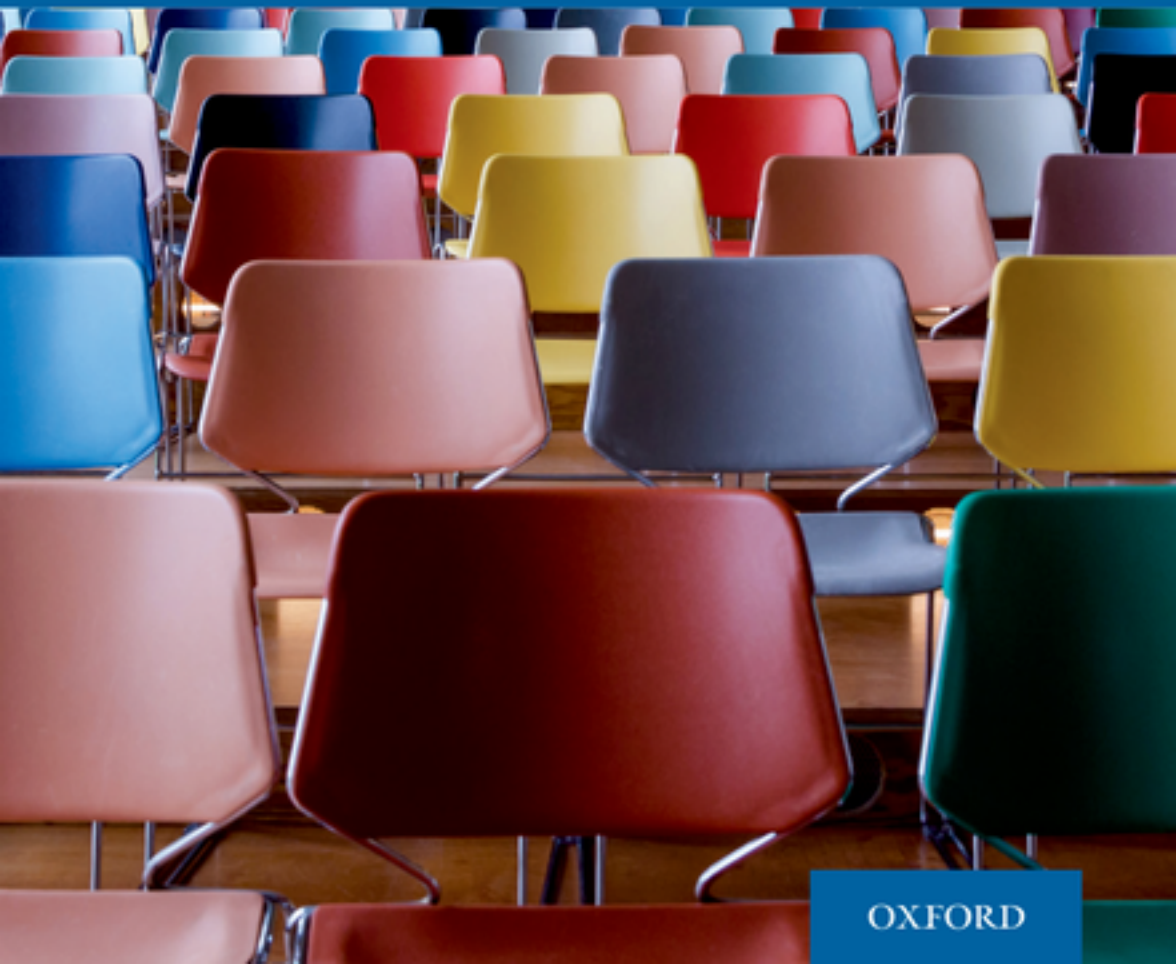

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INTRODUCTION

School Mental Health for Adolescents

Our intention when conceptualizing this book was to recruit a group of experts who could share their knowledge about school mental health and secondary schools with a broad group of readers, including practitioners, educators, and researchers. We believe that one effective method for improving the quality of care in school mental health is to educate people about best practices, and hopefully inspire them to develop tools that advance our ability to help adolescents with emotional and behavioral problems. With the publication of this volume, we will have certainly achieved part of this goal, as we were fortunate to have an outstanding group of authors agree to contribute chapters. The second part of our goal for this book involves the impact of the book on readers, and this will be determined over the coming years. Thus, we wish each and every one of you "happy reading" and encourage you to engage in high-quality practices that make a difference in the lives of adolescents with emotional and behavioral problems.

For almost two decades, experts have discussed a disheartening gap between the number of adolescents in need of mental health services and the number actually receiving services. In 1999, the U.S. Department of Health & Human Services estimated that 20% of children and adolescents demonstrated mental health needs. Similarly, Merikangas et al. (2010) found that 22.2% of adolescents experienced a mental health disorder associated with severe impairment or distress. However, in 2002, Kataoka, Zhang, and Wells reported that only 20% of children and adolescents in need of services actually received services. This continuing trend of need and lack of service is unfortunate, as evidence-based interventions to help youth with mental health disorders are available; however, service providers with the knowledge and skills to provide those services are lacking in both clinics and schools (Evans, Koch, Brady, Meszaros, & Sadler, 2013). Not surprisingly, one of the common reasons people do not pursue care is a belief that it cannot be helpful. Other obstacles to care include cost, transportation, and convenience. Integrating services into schools has been one way to address some of these barriers for children and adolescents, and educating those providers about evidence-based practices can increase the likelihood that these services will make a difference.

In the first chapter of this book, Mark Weist and colleagues describe this trend of integrating mental health services into schools and provide some history of school mental health. The authors identify and explore events and policies that have increased the development and utilization of school mental health to date. They conclude by describing opportunities for further growth and development of school-based services, including embedding programs within multi-tiered systems of support, improving training and workforce development, improving interdisciplinary and cross-system collaboration, enhancing high-quality and evidence-based practice, and developing effective systems of implementation support.

One impediment to the increasing trend to provide mental health services in schools is the contention that trained individuals with sufficient time to implement school-based services are not available in schools. Although many school mental health professionals may lack knowledge of evidence-based practices, the vast majority have training equivalent or superior to clinic-based practitioners. Unfortunately, in many schools these professionals are relied upon for administrative tasks such as scheduling, proctoring exams, and providing information about colleges. Rachel Kininger and colleagues describe these phenomena and explore the training and skill sets of professionals who could be at the forefront of school mental health, along with their actual roles in schools.

As school mental health continues to expand, the focus of research and practice in school mental health is on (a) efficient and timely identification of students with mental health needs in schools, (b) maximizing the effectiveness of school mental health services with the implementation of evidence-based interventions, and (c) developing feasible models of implementation. The authors of the chapters in Part II address these issues as they focus on various types of common emotional and behavioral problems experienced by adolescents. Problems with disruptive behavior, dysregulated emotions, disorganization, and drug abuse, and their associated school-based interventions, are described. Two chapters focus on strategies for addressing emotion regulation. Mychailyszyn and colleagues provide valuable information specific to assisting students struggling with internalizing disorders, and Bunford and Evans describe emotion regulation in the context of child development and attention-deficit/hyperactivity disorder. Sometimes, and far too frequently, these problems can be caused or exacerbated by experiencing traumatic events. Thus, evidence-based practices for addressing the needs of students who experienced trauma are described by Vona and colleagues. Students with the common problems described in Part II challenge teachers and school mental health professionals on a daily basis, and best practices for these problems are described in these chapters.

Although there is considerable literature on school-based interventions for elementary school–age children with autism, there is very little information available in relation to effective practices for adolescents with autism. Koegel and colleagues provide readers with an excellent update on how to continue to meet the needs of these students when they enter secondary school. Similarly,

services that can feasibly and effectively meet the emotional, behavioral, and health needs of adolescents with chronic health problems are also rarely available in the literature. Walcott and Kazmerski provide an outstanding description of the needs of adolescents with chronic health problems and how teachers and school mental professionals can meet those needs at school. These two chapters address problem areas that are insufficiently covered as they apply to adolescents. The chapters provide the latest approaches for practitioners and an excellent starting point for researchers looking to advance intervention development and evaluation research.

Finally, Reschly and colleagues focus on a critically important aspect of helping all of these students. Identifying those with problems and keeping them engaged and connected to school is a prerequisite to the provision of effective school mental health services. This is particularly true with adolescents with emotional and behavioral problems, as dropout, disengagement, and poor attendance are common, regardless of presenting problems. The approaches described in this chapter provide an outstanding alternative to practices in some schools that marginalize these students and push them further away, such as home schooling and computer-based instruction that are sometimes provided to adolescents with emotional and behavioral problems when their problems become difficult to address in the general education setting.

Part III explores the concept of implementing mental health services in secondary schools and in unique situations. Regardless of the problem area identified through assessment, students with mental health concerns will be taught in secondary schools. Kern and colleagues describe evidence-based interventions that can be implemented by secondary teachers within each tier of a three-tiered implementation framework, as well as means of overcoming barriers that might occur during implementation. Taking implementation one step further, Soares, George, and Vannest provide in-depth information regarding systems of progress monitoring to identify students' responses to evidence-based intervention. Simply selecting and implementing interventions is insufficient. As described by these authors, in order to achieve the most benefit for students, teachers, and school mental health professionals must collect data during implementation and adjust interventions as needed.

To translate research to practice and teach professionals to implement interventions in schools, procedures must be in place to provide quality training and feedback. The era of the two-day professional development should be in the past. School psychologists and special educators frequently find themselves in the role of consultant and collaborator, working with each other and with classroom teachers. Research informs the field that without quality consultation, training, and collaboration, school professionals are not likely to implement with fidelity and sustain the use of evidence-based practice.

In addition, one characteristic of mental health services provided in schools is the lack of supervision or mentoring provided to most school-based professionals. The approaches to training and consultation described by Coles and Massetti provide a valuable model for adopting an effective approach to

continuing education. Armed with this approach, many school mental health professionals may be able to enhance the practices of teachers and other professionals and thereby improve the outcomes for students with emotional and behavioral problems.

The final chapter of this volume provides an exceptional example of the role of culture in the provision of school mental health services to adolescents. Crooks and Dunlop provide a fascinating description of the unique culture of Aboriginal youth and how school mental health services may be effectively integrated into that context. In addition to learning about this unique culture, readers will be reminded about the importance of considering culture when attempting to provide effective teaching and school mental health practices in any community. Effective interventions are critically important tools, but effectively integrating them into the culture of the school and community is a necessary step before one can benefit the students with emotional and behavioral problems whose families and community shape the manner in which they can be provided.

CONCLUSION

In this book, the authors provide you with the knowledge and expertise of numerous leaders in the field. We address issues that practitioners face daily in schools working with the most challenging students. This task is not an easy one, as school mental health practitioners may be the only hope that many adolescents will have to receive evidence-based services in schools to help them be successful. We hope that we have provided a wealth of information and guidance that you will turn into practice and further research.

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PART I

Foundations

1

The History and Future of School Mental Health

MARK D. WEIST, LOIS FLAHERTY, NANCY LEVER, SHARON STEPHAN, KATHRYN VAN ECK, AND ABBY BODE ■

As documented in a number of books (e.g., Robinson, 2004; Weist, Evans, & Lever, 2003; Evans, Weist, & Serpell, 2007; Clauss-Ehlers, Serpell, & Weist, 2013; Weist, Lever, Bradshaw, & Owens, 2014), proliferating research and journal articles (see the newer journals *School Mental Health*, published by Springer, and *Advances in School Mental Health Promotion*, published by Routledge), and increasing federal support (President's New Freedom Commission, 2003; U.S. Public Health Service, 2000), the school mental health field is gaining momentum in the United States and around the world (Rowling & Weist, 2004; Weist & McDaniel, 2013). The field is based on several fundamental recognitions. First, in general, children, adolescents, and families have difficulty connecting to, and subsequently do not regularly attend, specialty mental health appointments (see Atkins et al., 1998; Catron, Harris, & Weiss, 1998). Second, although school represents a universal natural setting for youth, schools are under-resourced to meet the mental health needs of students (Nelson, 2003). Third, there are many advantages to augmenting existing school staff efforts to improve student mental health by partnering with community mental health programs to move toward an "expanded" school mental health approach (Weist, 1997). And, when done well, these collaborations demonstrate a range of positive outcomes for schools, students, and families (Weist et al., 2014).

In this chapter, we provide a brief history of the school mental health (SMH) movement, including key themes that have shaped the field's development, review federal investments with an emphasis on the work of the Center for School Mental Health and a connected National Community of Practice (CoP), and present key policy themes and ideas for future development.

HISTORY

Early History

The history of school mental health in the United States has been influenced by changes in society, in schools, in the development of professions, and in the expansion of the knowledge base within education and mental health (Flaherty & Osher, 2003). Just as in the late 19th century, schools in the 21st century are charged with fostering education while facing considerable challenges. In the late 19th and early 20th centuries, schools faced the problems of growing urban immigrant populations, competing work demands of increasing industrialization, and a school year that expanded to include an additional 38 days. The early 21st century presents some new and some old challenges to the school environment, including greater cultural diversity, exposure to trauma, and increased numbers of families living in poverty. Incorporating the wide range of cultural diversity typical of student populations into the learning environment can challenge school staff, particularly when individual schools represent dozens of different cultures and languages. Additionally, school staff must support student learning and well-being for students experiencing various kinds of psychosocial adversity, including poverty and intrafamilial and community violence (Flaherty & Osher, 2003; Truscott & Truscott, 2005).

School mental health services in the current era have been influenced by several factors. First is the knowledge of the high prevalence of psychosocial problems among youth, especially in disadvantaged communities. The extent to which these problems are untreated and undertreated influence the development of SMH services (Weisz, 2004). Second, the long-term implications of these problems in terms of morbidity and mortality have become clear (Aseltine, Gore, & Gordon, 2000; Flaherty, Weist, & Warner, 1996; McWhirter & Page, 1999). Third, the awareness that behavioral problems are often rooted in treatable psychiatric disorders, such as depression, post-traumatic conditions, and anxiety, has grown (Basson et al., 1991; Chiles, Miller, & Cox, 1980). Finally, there has been an "increasing awareness of the barriers posed to optimal development and learning by poverty, racism, gender discrimination, disability, and unsupportive schools," along with a "broadening vision of educational opportunity" (Flaherty & Osher, 2003, p. 20). All these factors have combined to support the development and expansion of SMH.

Current trends in school mental health have their origins in two parallel developments concerned with the well-being of children—the public health movement and the child guidance movement. Public health as a medical field is focused on the prevention of epidemics through screening for communicable diseases and the implementation of population-based approaches, such as ensuring the safety of food and water supplies. From its inception, child guidance has displayed an interdisciplinary orientation and focused on intervening to prevent mental illness and juvenile delinquency.

From School Nurses to School-Based Health Centers

In the early part of the 20th century, schools in urban areas were overwhelmed by large numbers of Eastern European immigrants who lacked access to basic healthcare. The placement of nurses in schools was both a response to these challenges and based on a public health model of detecting and treating illness. Nurses also provided instruction about proper nutrition and sanitation, and thus were engaged in health promotion. The origins of school nursing can be traced to the work of Lina Lavanche Rogers, who began working in the New York City schools in 1902. Soon other school nurses were hired to meet the needs of children whose health problems interfered with their schooling. The impact of these highly skilled and independently functioning professionals was profound—the number of children excluded from school went from 10,567 in September 1902 to 1,101 the following year (Hawkins, Hayes, & Corliss, 1994).

These pioneering efforts led to the establishment of health suites in schools staffed by nurses who oversaw vaccinations, were on hand to detect communicable diseases and treat minor illnesses and injuries, and, in some cases, provided teaching about prevention and health. Although emotional well-being was considered part of health, the field of child and adolescent psychiatry was in its infancy, and there was little recognition of the role that psychiatric disorders played in children's academic, social, and emotional functioning. In fact, depression was not even recognized as occurring in children, first appearing in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association, 1980).

School-Based Health Centers

The 1960s saw the establishment of the first school-based health centers (SBHCs), which provided primary healthcare to students who otherwise would have had difficulty accessing it. SBHCs grew out of the traditions of school nursing and public health clinics, and they began to proliferate in the 1980s to meet the need for primary healthcare for adolescents, the most underserved age group. With the recognition that many of the visits to SBHCs were related to mental health concerns (Lear et al., 1991), the centers expanded their scope to include mental health counseling. SBHCs increased from a total of 200 in 1990 to 1,380 in 2000 (Flaherty & Osher, 2003), and there were 1,909 in 45 states in 2010 (U.S. Government Accountability Office, 2010). Typically, these centers are staffed by a full- or part-time nurse practitioner or a physician's assistant, sometimes accompanied by an aide/receptionist, and a master's-level mental health clinician, such as a social worker. Originally located primarily in urban high schools, there was later an expansion of centers into suburban areas and elementary schools (Center for Health and Health Care in Schools, 2003; National Assembly on School-Based Health Care, 2002; U. S. Government Accountability Office, 2010).

From the Child Guidance Movement to Expanded School Mental Health

The guiding principle of the child guidance movement was that intervening in "maladjusted" children's environments could prevent mental illness and juvenile delinquency (Horn, 1989). The first child guidance clinic was established in Chicago in 1909 under William Healy, a neurologist. In 1922 the Commonwealth Fund gave impetus to the movement by funding the establishment of demonstration clinics in eight cities. The clinics were based in communities, not hospitals, and focused on psychological evaluation and therapy for children with behavioral and emotional problems in the context of their families and communities. This approach was based on a developmental perspective, arising from the psychoanalytic view that the origins of mental illness lay in childhood and parent-child relationships. From the beginning, these community-based clinics were an interdisciplinary effort, involving psychologists, social workers, and psychiatrists working together as child study teams (Witmer, 1940). The teams served as consultants providing guidance to teachers about how to better understand and teach children with emotional and behavioral problems. This model held sway into the 1950s.

In the 1960s, the community mental health (CMH) movement came to the fore with the passage of the Community Mental Health Act (CMHA) of 1963 (Public Law 88-164). This act specified that services to children and adolescents and consultation and education were essential services of community mental health centers (CMHCs). Although consultation and education were generally underfunded, CMHCs, such as the Walter P. Carter Center in Baltimore, Maryland, developed liaison relationships with the schools in their service areas by sending staff to meet weekly with school personnel and discuss children being seen at the centers' clinics. In the Baltimore case, these relationships later served as the foundation for the establishment of expanded school mental health (ESMH) programs in the schools in Baltimore City. Please note these close relationships between mental health systems and schools are foundational to ESMH (Weist, 1997) and to programs developed in locations throughout the U.S. (Weist, Lever, Bradshaw & Owens, 2014).

Individuals with Disabilities Education Act (IDEA): Public Law 94-142

Passed in 1975, the IDEA law mandated that schools serve all students, including those with learning or emotional disabilities that become barriers to learning. The law became an important facilitator in moving mental health professionals from outside consultants to integral members of the school staff. Since evaluations had to be performed to determine the degree of disability and necessary educational accommodations, schools added mental health professionals, such as school psychologists, to their staffs (Flaherty & Osher, 2003).

From Fixing Schools to Fixing Students

This shift in educational mandate was accompanied by a shift away from the school consultation model, rooted in the child guidance movement, which focused on helping teachers understand children's psychological needs and doing their work better. As pointed out by Flaherty and Osher (2003), the shift represented movement from fixing the schools to fixing the students. Instead of outside consultants from the various mental health disciplines coming to schools to offer their expertise to teachers and administrators, schools began hiring their own counselors, psychologists, and social workers to provide services directly to students.

Although mental health services were provided to some students who met disability criteria, this did not constitute an organized program of school-based mental health services. The development of SMH programming was driven in large part by youth with emotional and behavioral disorders who required support from many service providers, both in and outside of the school (Flaherty & Osher, 2003). Identified through IDEA as emotionally disturbed (ED), the focus on educational support through IDEA did not produce the improvement in outcomes for youth with ED that was seen among other youth receiving special education services. Furthermore, the unwieldy and costly intervention necessary for these youth taxed the services possible within this new system. As a result, the IDEA was amended in 1997 to expand the learning opportunities and support of students with emotional and/or behavioral disabilities, bringing into the schools an additional influx of mental health professionals. The 1997 amendments allowed for financial investment in collaboration with outside agencies to assist with implementing individualized educational plans (IEPs), as well as working toward broader goals such as promoting a positive school-wide climate and developing and administering prevention programming. Expansion of the goals in the amendments to address prevention in addition to intervention reflected the growing understanding that providing mental health services to students at risk for emotional and behavior disorders may be more effective than waiting to intervene until youth display symptoms severe enough to require a special educational placement. Thus, the 1997 IDEA amendment laid the groundwork for ESMH programs.

Expanded School Mental Health (ESMH) Programs

The concept of "expanded" SMH, which came to the fore in the 1990s, involved building upon programs already in schools by adding additional staff to go beyond the schools' existing focus on crisis management and the needs of students receiving special education services (Weist, 1997). The idea was to provide mental health services to youth in regular as well as special education. ESMH services included diagnostic assessment; individual, group, and family psychotherapy; crisis intervention; medication management; and case management. In addition, some programs implemented preventive services, including classroom consultation and

mental health education. Early ESMH successes in Baltimore, Maryland, provided an exemplar model for family-school-community partnerships to support student mental health, and laid the foundation for the receipt of significant federal investment to help advance school mental health programs and policies nationally.

FEDERAL INVESTMENTS

National Center for School Mental Health

Since 1995, the Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB), has pioneered efforts in the area of school health and mental health, funding national centers on school-based healthcare (National Assembly on School-Based Health Care, now rebranded as the School-Based Health Alliance), and two centers focused specifically on school mental health.

The School-Based Health Alliance (SBHA) is the national voice for school-based health centers (SBHCs). Its mission is to improve the health of children and adolescents by advancing and advocating for school-based healthcare. The SBHA is a national organization with 17 state affiliates that follow the mission, vision, and core values of the national SBHA. The national SBHA and the state affiliates assist each other in advancing a federal policy agenda that helps to promote and advance school-based and school-linked health services. The School-Based Health Alliance advocates for national policies, programs, and funding to expand and strengthen SBHCs, while also supporting SBHCs at the state and local levels with training and technical assistance.

Between 1995 and 2010, both the University of Maryland, Baltimore, and the University of California, Los Angeles (UCLA) were funded to provide training, technical assistance, and program and policy analysis in school mental health. During this 15 years of funding, school mental health was defined and frameworks for effective school mental health service provision were developed, with increasing emphasis on quality assessment and improvement. Funding decreased in 2010 to support only one center at the University of Maryland, the Center for School Mental Health (CSMH).

Built on the solid foundation of the Baltimore ESMH network, and on an established track record of research, the CSMH mission is to strengthen policies and programs in SMH to improve learning and promote success for America's youth. The CSMH has two overarching goals and several associated objectives, all directed toward facilitating the advancement of a shared family-school-community agenda for advancing three tiers of high-quality SMH programming and related policy to improve academic, behavioral, and socio-emotional outcomes for all students. The first goal of the CSMH is to enhance understanding of SMH policies and programs that are innovative, effective, and culturally and linguistically competent, across the development spectrum (from preschool through postsecondary), across three-tiers of mental health programming (promotion,

problem prevention, and intervention), and across levels of scale (international, national, state, and local). The second goal is to enhance implementation of innovative and effective SMH policies and programs through the dissemination and diffusion of analyses and instructive findings via a comprehensive, multifaceted, engaging, and creative communications framework that reaches the full array of invested stakeholders in SMH.

The CSMH team is a committed and diverse stakeholder group with a wealth of experience and a commitment to reducing barriers to learning and promoting academic and social-emotional-behavioral success for *all* students (preschool to postsecondary). CSMH staff serves as clinicians and supervisors for the SMH programs, which provide mental health promotion and intervention to youth and families in schools in four jurisdictions in Maryland. The programs provide a direct connection to "front line" SMH and facilitate a strong research-practice-policy interface.

The CSMH is nationally recognized as a top-ranked training site for SMH professionals, recently receiving three honors: A Graduate Psychology Education Grant through HRSA to support the advancement of psychology training around school mental health, the 2010 American Psychological Association Award for Distinguished Contributions for the Education and Training of Child and Adolescent Psychologists, as well as the highest rated course in the University of Maryland's top-tier graduate social work program (developed by authors N. Lever and M. Weist, along with Michael Lindsay).

National Community of Practice (CoP) on Collaborative School Behavioral Health

A major milestone in the history of the CSMH and in the advancement of SMH nationally occurred in 2004 with the inception of a National Community of Practice (CoP) on Collaborative School Behavioral Health. Étienne Wenger, a pioneer of the CoP concept, defines CoPs as "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (Wenger, 2006). A CoP offers an innovative mechanism for doing work across a group of individuals who share similar concerns, problems, or interest in particular areas in an effort to deepen their own knowledge base and effectiveness (Cashman, Linehan, & Rosser, 2007). CoPs enable individuals to synergistically work together with a larger group to advance their knowledge, skills, and effectiveness (Wenger, McDermott, & Snyder, 2002). CoPs emphasize the value of each individual as an expert within his or her own context, while recognizing the importance of the larger group learning process over the individual contributions (Price-Mitchell, 2009).

The National Community of Practice on Collaborative School Behavioral Health is co-facilitated by the Individuals with Disabilities Education Act Partnership (IDEA Partnership) at the National Association of State Directors of Special Education (NASDSE) and CSMH. With the IDEA Partnership, the

CSMH has helped to build, and is committed to providing, ongoing support to advance the CoP. This community includes consumers, educators, practitioners, advocates, researchers, and decision-makers. The mission of the community is to bridge the differences across education and mental health to support youth. The CoP on School Behavioral Health began in 2004 with the convening of a diverse group of stakeholders at a pre-conference meeting to the Annual Conference on Advancing School Mental Health in Dallas, Texas. The group came together to discuss pivotal issues to further a shared mental health agenda involving families, schools, and communities, organized to advance statewide action in SMH. It was agreed that a CoP focused on SMH would be beneficial, and eight "practice groups" formed to pursue special topics at deeper levels. The National CoP currently has 12 Practice Groups, with 17 states, 23 national organizations, and 7 technical assistance centers working together on school mental health.

The National CoP facilitates SMH partnerships and provides practical examples of collaborative successes at the local, state, and national levels. It advances SMH knowledge, policy, and programming through widespread dissemination and diffusion and active, multi-scale communication. The CoP unites and offers collaborations with federal partners, states, and organizations; technical assistance and resource centers with student and family consumers; front-line school-based staff; and policymakers to address intersecting education and mental health priorities to reduce barriers to learning and improve success for all students. Convened annually at the CSMH Annual Conference on Advancing SMH, the CoP provides opportunities to stay connected throughout the year via web-based technology, teleconferences, and shared action (e.g., resource sharing, topical discussions, materials development, and translating knowledge to practice). The National CoP is poised to receive, respond to, and disseminate information through extensive networks.

The CoP has had tremendous impact on the field across the 12 practice groups, states, and organizations. An example of this impact can be highlighted through the Quality and Evidence-Based Practice Group. This group was originally formed during the Dallas landmark meeting of the CoP. From its inception, this practice group has been led by mental health and education professionals, including two authors of this article (M. Weist and S. Stephan), and it has been one of the most productive and impactful practice groups within the CoP. Its mission is to share information across individuals and groups interested in improving the quality of SMH programs and services, and to discuss, promote, and disseminate evidence-based practices in SMH. The practice group strives to bridge the research-practice and practice-research gaps in the field. In addition, the group seeks to understand and identify best student- and program-level evaluation strategies. The diverse stakeholders involved within the National CoP and Quality and Evidence-Based Practice Group collaborate to build a natural laboratory for investigating strategies and resources that could be used to advance evidence-based practices and programming in SMH. Through surveys, focused discussions, newsletters, and the sharing of ideas, resources, and skills through the National CoP, the authors

of this article have helped to define the feasibility of and implementation challenges related to the integration of evidence-based practices and programs within school settings. The CoP work has not only influenced the scientific integrity of the project, but also helped in the initial networking that brought some of the leaders of this project together. The CoP models effective communication and collaboration across agencies, systems, programs, universities, and stakeholder groups. Multichanneled communication—via teleconferences, e-mail, webinars, strategic planning meetings, dialogue guides, and wikis—and the appreciation of the expertise across stakeholder groups and systems are contributing to the success of the described studies.

Annual Conference on Advancing School Mental Health

Since 1996, the CSMH has organized an Annual Conference on Advancing SMH, which has drawn up to 1,000 participants each year from most states and several countries. The conference has become the nation's premier conference for advancing high-quality, interdisciplinary school mental health in collaboration with families, schools, and communities. Conference content addresses an array of SMH dimensions, and each conference has featured over 100 sessions, including renowned plenary speakers, intensive trainings, workshops, papers, Community of Practice training, and posters. The conference offers a comprehensive and rich array of training, networking, and partnership building. State, local, and federal officials have endorsed, sponsored, participated in, and used the conference as a platform to advance children's mental health and SMH efforts.

The Annual Conference on Advancing SMH is rapidly evolving via the Community of Practice framework, by allowing participants to stay connected throughout the year in this important shared work. Since 2004, the conference proceedings have been shaped by practice groups of the National CoP, with specialty tracks for each group: Building a Collaborative Culture in SMH; Connecting SMH and PBIS; Connecting SMH with Juvenile Justice and Dropout Prevention; Education: An Essential Component of Systems of Care; Family Partnerships in Mental Health; Improving SMH for Youth with Disabilities; Learning the Language: Promoting Effective Ways for Interdisciplinary Collaboration; Quality and EBP; SMH for Culturally Diverse Youth; Youth Involvement and Leadership; Psychiatry and Schools; and SMH for Military Families. The groups solicit, review, and select proposals for their track, and facilitators serve on the planning committee. EBPs, cultural and developmental sensitivity, and cross-stakeholder relevance are encouraged.

The annual conference is moved throughout the country with strong state leadership and support from a state planning committee each year. Together, the CSMH and the IDEA Partnership have advanced the annual conference and National CoP, with meetings in Cleveland (2005); Baltimore (2006); Orlando (2007); Phoenix (2008); Minneapolis (2009); Albuquerque (2010); Charleston (2011); Salt Lake

City (2012); Crystal City, Virginia (2013); and Pittsburgh (2014), New Orleans (2015), and San Diego (2016).

In their role as facilitators, practice group facilitators lead conference calls for their groups, participate in National CoP calls, develop resources, host webinars, promote dialogue and knowledge exchange, share best practices and resources, and organize a track at the annual conference. Through regular dialogue with facilitators, there is an emphasis on youth and family presence and partnership at the annual meeting and within the overall CoP. The IDEA Partnership and the CSMH have together employed several strategies to ensure youth and family participation. Youth and family attendance and the annual conference and other events are supported through scholarships, grants, and significantly reduced rates. Each conference includes keynotes from youth and/or family. Each state that hosts the conference facilitates a regional youth day to advance understanding and advocacy related to SMH, which serves as a catalyst for helping to build a lasting youth SMH advocacy group in the state. Youth and family are strongly encouraged to participate in the annual conference as presenters. Youth and family participants appear on all state teams. Finally, it is a priority to connect youth and family voice to all practice groups and the larger CoP.

Since the inception of the National CoP, a Community Building Forum has been held each year on the day preceding the annual conference. Attendance has included representation from the state groups, national organizations, TA and resource centers, federal agencies, practice group facilitators, policymakers, and youth and family members. The forum offers an opportunity to review progress and allows participants to discuss strategies to move the community forward. A highlight of the forums has been the opportunity to share knowledge, resources, and best practices and to discuss SMH impacts of major education and mental health research and policy. As part of the Community Building Forums, state teams comprising key system leaders from each state (AZ, HI, MD, MN, MO, MT, NH, NC, NM, OH, PA, SC, VT, IL, SD, UT, and WV) have the opportunity to meet and develop SMH action plans and link shared agenda work to state accountability plans (e.g., state special education performance plans).

To assist the facilitators of each of the practice groups, the CSMH and the IDEA Partnership hold retreats and hosts webinars and phone calls. In addition, facilitators and participants use the IDEA Partnership website and wiki (www.sharedwork.org) for ongoing communication, resource development and sharing, and collaboration to build a *Shared Agenda* to advance SMH.

POLICY THEMES

As the CSMH has evolved, in alignment with guidance from federal funders, its focus has shifted from primarily technical assistance and training to the inclusion of program and policy analyses. Since about 2007, major policy foci of the CSMH have included the interplay of health and education reform and their relation to school mental health, application of a public health framework to school mental health, and creating sustainable funding for school mental health.

Mental Health and Education Policy

The CSMH has worked toward a truly integrated approach to the analysis and promotion of effective and impactful mental health and education policies, accounting for different parameters for these policies and programs across the educational spectrum from preschool to postsecondary education. In doing so, the CSMH has specifically considered three critical areas that often run counter to the establishment of integrated policy: marginalization, federalism, and school decision-making.

Marginalization. A critical challenge for the field is effectively addressing the question of why there should be mental health programs and services in schools. School leaders might purposefully resist an agenda to expand attention to mental health issues, based on the belief that schools are not in "the mental health business," or on concerns that schools will need to assume greater responsibility for students' emotional and behavioral problems. Further, stigma and poor understanding of mental health issues clearly interfere with the development of SMH programs and policies. SMH staff and programs may be viewed as "add-ons" that are not central to the academic mission of schools (School Mental Health Alliance, 2004). In addition, school reform efforts generally have not incorporated a focus on addressing noncognitive barriers to development, learning, and teaching (Burke, 2002; Koller & Svoboda, 2002). These noncognitive barriers include environmental and contextual factors (e.g., poor nutrition, family conflict, negative peer influences, exposure to violence, neglect) as well as individual biological and psychological factors (e.g., externalizing and internalizing mental health problems, trauma reactions). Although school reformers acknowledge that academic success promotes overall well-being, they do not often recognize that, in turn, social-emotional well-being is essential to academic success (Klern & Connell, 2004).

Federalism. Perhaps the most significant policy challenge to the SMH field relates to federalism (states' rights, local control), which contributes to tremendous variability in how child-serving systems (including education and mental health) function both across and within states (Weist, Paternite, Wheatley-Rowe, & Gall, 2009). When states and local communities have significant latitude in decisions about policy and practice, outcomes vary. For example, one community in a state may be demonstrating relatively advanced progress in SMH, while the adjacent community shows no progress, with no dialogue or collaboration between these communities. Federalism and the significant variability across child-serving systems contribute to inertia in local and state government in advancing system reform. An important strategy to address the constraints of federalism concerns the organization of state-level initiatives that reform and improve child-serving systems, with SMH at the nexus of such system transformation.

School decision-making. Compounding the challenges of federalism are three major characteristics of school systems in the United States. First, U.S. public schools are characterized by substantial organizational fluidity associated with high rates of mobility and turnover among administrators, teachers, and other

school personnel (Guarino, Santibañez, Daley, & Brewer, 2004). Second, school district and building policies and practices are highly reactive to shifting policy and programming realities associated with educational mandates at the local, state, and federal levels. Both necessitate repeated revisiting of agreements made between SMH programs and host schools, as well as ongoing advocacy to sustain services. Third, within most school districts, decentralized decision-making is the norm. In this site-based management approach, substantial decision-making authority is delegated from school boards and superintendents to individual school principals and personnel. Therefore, working agreements regarding roles, functions, and communication between mental health staff and schools typically need to be negotiated and maintained on a building-by-building basis. Policy analyses and dissemination activities of the CSMH will include examination of state and local decision-making processes and their interrelationships.

Healthcare Reform

Related to SMH funding challenges, there are significant considerations within healthcare reform that stand to positively impact SMH. A recent report by the U.S. Department of Health and Human Services (2010) indicated that a disproportionate number of children with mental health problems in the United States do not receive mental health services due to a lack of insurance. It is estimated that 4.7 million children are eligible for Medicaid or the Children's Health Insurance Program (CHIP), but are not currently enrolled in either (Kenney et al., 2010). Implementation of the Patient Protection and Affordable Care Act (ACA), Public Law 111-148 (2010), has had a significant impact on the way that healthcare services are delivered, since many youth who were previously uninsured or underinsured have gained access to services.

With the expansion of health insurance coverage, many of the most vulnerable populations, such as young children, youth aging out of foster care, and children living in poverty now have increased access to preventive services and mental health treatment (English, 2010). In addition, the authorization of funding for home visitation programs to promote improvements in areas such as child development, parenting, and school readiness provides opportunities for families who are in the greatest need. Having already contributed significantly to the national discussion on healthcare reform and implications for SMH, the CSMH continues to analyze healthcare reform policy, disseminate relevant findings to key stakeholder groups, and inform the evolving policy reform at state and national levels related to SMH.

School Mental Health and the Public Health Approach

Since around 2010, several journal articles and federal reports have recommended that the field of children's mental health adopt a public health approach

to conceptualizing children's mental health (see Blau, Huang, & Mallery, 2010; Miles, Espiritu, Horen, Sebian, & Waetzig, 2010; Stiffman et al., 2010; U.S. Department of Education, 2010). More specifically, the public health framework applies an ecological approach to conceptualizing children's mental health by recognizing that multiple systems influence children's difficulties and calls for an integration of mental health services across systems, including health, education, mental health, social services, child welfare, and juvenile justice (Blau et al., 2010; Stiffman et al., 2010).

This interdisciplinary and intersystems approach has characterized SMH (and the work of CSMH; see Weist, 2003; Weist, 2005) for years; thus, the SMH field can help to lead broader efforts to infuse a public mental health promotion strategy into services for children (Weist, 2001). This approach is strength-based and suggests a continuum of mental health services ranging from promotion activities that support and maintain positive mental health to prevention and treatment efforts (Blau et al., 2010). The field has not yet fully adopted this framework; only a few instances exist that demonstrate the successful application of the public health model to children's mental health (Miles et al., 2010).

Funding

Even with the significant progress and expansion of SMH programs over the past two decades, the funding for SMH services continues to be a struggle. A 2005 survey of SMH programs across the United States indicated that 70% of school districts reported an increase in need for services, but experienced the same level or decreases in their funding (Foster et al., 2005). It has become increasingly incumbent upon SMH programs to secure funding from multiple sources to sustain their service delivery (Evans et al., 2003; Weist et al., 2009).

While there are some potential funding sources that are underutilized (e.g., from Early and Periodic Screening, Diagnosis, and Treatment; Safe and Drug Free Schools; Title I), other sources of funding (e.g., Medicaid fee-for-service) are highly bureaucratic, unwieldy to obtain, and may not yield sufficient revenue (Center for Health and Health Care in Schools, 2003; Evans et al., 2003). Thus, the process of identifying and securing appropriate funding is difficult for programs. Further, funding provided by education systems is limited, leading to overcommitted and burdened school-employed mental health professionals (Lever, Stephan, Axelrod, & Weist, 2004). When community mental health mechanisms are used, they typically place a significant administrative burden on community providers who work in schools, who are also encumbered with multiple demands. In addition, these fee-for-service approaches have created concerns about overdiagnosis, limited time for prevention activities, and an inability to serve students without Medicaid (Lever et al., 2004; Mills et al., 2006). Exploring collaborative and unique funding arrangements that braid dollars from multiple sources to support shared goals, and to examine methods for assessing cost and cost-effectiveness of SMH, is recommended to help advance school mental health at local, state, and national levels.

FUTURE DIRECTIONS FOR THE FIELD AND CONCLUSION

This chapter highlights the extensive growth and development in the field of school mental health over the past century and a half. While the school mental health field has had tremendous success in increasing access to a broader array of services, there is room for improvement, with many opportunities for improving the quality and efficiency of mental health services that children receive in school. In the most recent edition of the *Handbook of School Mental Health*, Weist, Lever, Bradshaw, & Owens, et al. (2014) identified eight crosscutting themes in need of attention to escalate progress in the field. These themes summarize the primary challenges that face the field.

Building SMH in the Context of Multi-tiered Systems of Support

Significant attention has been given to the many advantages of integrating school mental health and Positive Behavioral Interventions and Supports (PBIS; see Barrett, Eber, & Weist, 2013). The compelling synergies unleashed recently in these two fields appear to be catalyzing them toward operating as one. Integrating SMH with a multi-tiered system is important for many reasons. First, youth function best in an environment that is consistent, stable, and positive. An important goal of SMH services is to collaborate with school staff to identify effective strategies for supporting optimal student behavior and well-being. When school and SMH staff work within the same multi-tiered system, they share similar goals and communicate with a common language, facilitating collaboration.

Second, multi-tiered systems provide a structured approach for identifying youth with specific mental health needs, which improves the clarity and efficiency of the referral process for SMH services. Third, using a multi-tiered system, such as PBIS, has a powerful prevention capacity with behavioral and emotional problems for children, allowing SMH services to reach youth with mental health concerns and those without current concerns but at risk for future problems. Thus, implementing SMH services within a multi-tiered system is an important next step for the field.

Training and Workforce Development

Extensive developments have occurred in providing training for providers to support the use of evidence-based treatments and in cultivating the skills needed to work in interdisciplinary and collaborative service contexts. A major objective of current training with educators involves increasing knowledge and awareness of childhood development, mental health, and behavioral issues. An example

of these development efforts is represented by the Mental Health Education Consortium, which focuses on increased training for preservice and current providers. Training topics include collaborating on interdisciplinary efforts within the school setting, providing empirically supported treatment, and integrating services within the school context (Anderson-Butcher & Weist, 2011).

Interdisciplinary Collaboration

Working within schools requires establishing a shared agenda with other school personnel (Andis et al., 2002), so there is a need to develop training and practice approaches to establish effective teams that emphasize the talents of diverse members coming together to promote youth well-being. Discipline-specific issues can challenge interdisciplinary work, such as language, conceptual frameworks, therapeutic orientation, training models, and other issues. Familiarity with the range of viewpoints across disciplines on these issues can support professionals from different disciplines to engage in effective communication and find ways to strengthen SMH services through the diversity of viewpoints.

Systematic Quality Assessment and Improvement

Given the nature of working in the school context, school-employed mental health staff may benefit from receiving trainings in available resources as well as in school culture, since providing mental health services within schools requires more flexibility in roles than do more traditional service provision. Further, the development of the School Mental Health Quality Assessment Questionnaire (SMHQAQ; Weist et al., 2005; Weist, Ambrose, & Lewis, 2006), a SMH report card that assesses overall progress of SMH work, represents a move to increase efforts surrounding the need to increase quality practices in SMH.

Cultural Competence

A critical future goal of the SMH field is finding effective ways to increase training and practice efforts that foster cultural sensitivity in mental health practices. In terms of mental health treatment within the school environment, cultural considerations, such as identity and labels are important skills to emphasize within the cultural context of the school. Further, cultural beliefs and practices can enhance or conflict with treatment, and the perception that a clinician understands and accepts one's cultural context improves clinical rapport, which is an important component for change in therapy. Thus, finding ways to incorporate cultural competence in training endeavors and cultural sensitivity into SMH services are essential areas of development for the school mental health field.

Family and Youth Engagement and Empowerment

Schools are in a position to readily access youth and families, and so the motivation to change and interest in engaging in SMH services may display greater diversity than is found in clinic-based services. Because the extent to which families are engaged in mental health treatment impacts the quality and clinical outcome of services, identifying effective strategies for supporting family engagement in the SMH context is critical. Furthermore, SMH services have the unique capacity to include youth and families in the development of programs. This point of collaboration is a powerful tool for improving not only the quality of services, but also family engagement by empowering youth and their families to share their voice (Barrett, Eber, & Weist, 2013; Coalition for Psychology in the Schools and Education, 2006).

Evidence-Based Practices

Further research on the effectiveness of evidence-based practices (EBPs) is needed. More research is necessary regarding outcomes when EBPs are implemented in diverse settings rather than traditional laboratory settings. Although EBPs may demonstrate efficacy within the highly controlled context characteristic of many quality research designs, the degree to which these effects translate to the context of the diverse settings that schools can present is often unclear. Additional research is needed to identify the effectiveness of EBPs across developmental stages, across provider and discipline training levels, across various cultural characteristics, and across presenting problems and service provisions.

Implementation Support and Coaching

There is growing emphasis on the need to increase implementation supports for promoting the use of EBPs in schools (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). SMH professionals need support beyond training to implement EBPs effectively with children and staff in schools. Thus far, the literature equivocally demonstrates that student outcomes improve with the provision of coaching and implementation supports. More development and investigation in this area is needed to improve SMH services to youth.

INTERNATIONAL EFFORTS

Although much of this chapter focused on the historical context and current practices of SMH on a national level, SMH efforts are gaining momentum on an international level as well. For instance, the growth of the field internationally is evidenced by the development of leadership networks designed with the goal of

bringing together like-minded SMH researchers, policymakers, and practitioners from around the world with the common goal of promoting youth mental health within the school context. The International Alliance for Child and Adolescent Mental Health and Schools (INTERCAMHS) was an active network from 2003 to 2010, emphasizing international collaboration in order to bridge efforts from key leaders and policies to guide the development of the field. From the platform of relationships built by INTERCAMHS, and ongoing participation in world conferences on mental health promotion (see below), new international networks focused on SMH are developing, such as the School Mental Health International Leadership Exchange (SMHILE), which is bringing together leaders from regions and countries across the world to share knowledge; co-create dissemination and leadership strategies; and signal best research, policy, and practice directions for the field (Short, Weist, & McDaniel, 2014).

In addition to interagency and international collaboration efforts to enhance the quality of practices in SMH and youth mental health promotion, countries around the world are making strides in developing broad, evidence-based school mental health promotion programs. Of note is the MindMatters program (Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000), a national mental health promotion program implemented in Australian schools. MindMatters is a multi-tiered whole-school approach to mental health promotion that emphasizes a community of health promotion, focusing on addressing the knowledge and awareness of mental health among students and teachers within the school, and on targeted interventions to provide in-house supports to those students who require more focused efforts to address mental health concerns. Similarly, the Resilient Families Program (Shortt, Toumbourou, Chapman, & Power, 2006) is a school-based prevention program implemented within Australian schools that emphasizes linking efforts across the home and school community with the aim of creating environments that reinforce consistent and positive strategies. The Resilient Families Program utilizes the school context and teacher-parent relationships to help increase positive communication and problem-solving approaches to promote mental well-being (Shortt et al., 2006).

In addition to specific school-based interventions gaining support internationally, conferences aimed at bringing like-minded professionals together to share research and knowledge regarding the promotion of mental health are growing in popularity. For instance, the World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders was held for the eighth time in London in September 2014. This conference had a number of plenary presentations and a stream of more than 20 presentations on SMH as a prioritized theme in the global mental health promotion movement (see Weist & McDaniel, 2013). Benefitting from the leadership of SMHILE, global networking and collaboration in the advancement of practice, research, and policy in SMH has continued in subsequent world conferences, including a meeting held in Columbia, South Carolina (September 2015). In all of this work, the United States is a clear leader, consistent with progressive and increasing federal policy support for the field (see Anglin, 2003; Cashman, Rosser, & Linehan, 2013).

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