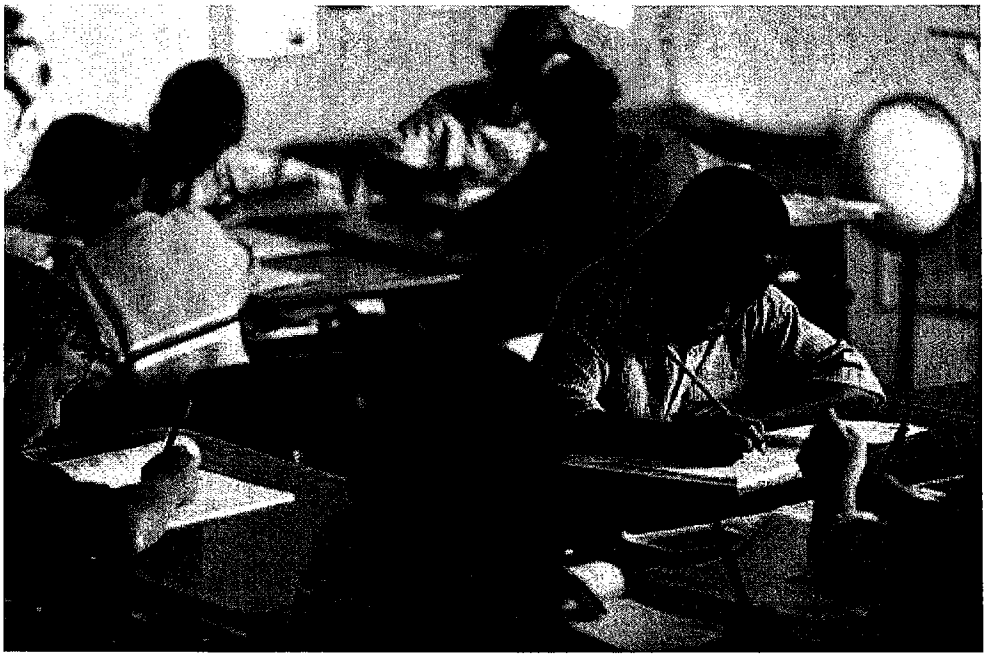
Working Together to Promote Academic Performance, Social and Emotional Learning, and Mental Health for All Children

A Position Paper of the School Mental Health Alliance



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Signatories

The organizations listed below endorse this position paper.

American Academy of Child and Adolescent Psychiatry (AACAP)

American School Counselor Association (ASCA)

American School Health Association (ASHA)

Association for Supervision and Curriculum Development (ASCD)

Bazelon Center for Mental Health

Center for the Advancement of Mental Health Practices in Schools

Center for Mental Health in Schools

Center for School-Based Mental Health Programs at Miami University

Center for School Mental Health Assistance

Center for Social and Emotional Education (CSEE)

Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD)

Collaborative for Academic, Social and Emotional Learning (CASEL)

Institute on Violence and Destructive Behavior

International Alliance for Child and Adolescent Mental Health and Schools

International Society for Adolescent Psychiatry and Psychology

Mental Health-Education Integration Consortium (MHEDIC)

The Midwest Symposium for Leadership in Behavior Disorders

National Alliance for the Mentally Ill (NAMI)

National Association of Pediatric Nurse Practitioners (NAPNAP)

National Association of School Psychologists (NASP)

National Association of Social Workers (NASW)

The IDEA Partnership at the National Association of State Directors of Special Education (NASDSE)

National Association of State Mental Health Program Directors (NASMHPD) Research Institute

National Center for Children in Poverty

National Mental Health Association (NMHA)

Ohio Mental Health Network for School Success

Policy Leadership Cadre for Mental Health in Schools

Task Force on Evidence-based Interventions in Schools, American Psychological Association

Executive Summary

In December 2003, a group of over fifty experts in school mental health research, policy, and advocacy gathered for a two-day summit focused on strengthening the link between mental health and schools, identifying obstacles to the implementation of evidence-based school mental health interventions, and reaching consensus on the most effective strategies for overcoming these obstacles. The group, which subsequently identified itself as the *School Mental Health Alliance (SMHA)*, defined mental health as necessarily encompassing the range of social, emotional, and behavioral functioning of children. As a consequence, ***school mental health services*** were defined to require a range of programs across the prevention and treatment spectrum that schools can implement in collaboration with students and their families to address the social, emotional, and behavioral needs of students.

The SMHA agreed that addressing students' mental health is fundamental for school success. Furthermore, the assembled experts and signatories to this document agreed that school-based programs that can contribute to students' mental health exist, but important educational issues must be addressed in order for schools to adopt and implement these programs. These issues include:

- *Mission Disparity Between Schools and School-Based Mental Health Interventions*
  Mental and behavioral health is not a high priority on the school-reform agenda (Taylor & Adelman, 2000). Proponents of school mental health must demonstrate to educators that the provision of quality school mental health interventions is directly linked to important educational outcomes for children.

- *Inadequate Mental Health Professional Development for School Staff*
  Teachers, administrators, mental health professionals, and other school staff all need additional professional development focusing on the mental health and social-emotional issues faced by children and how to address these issues within the context of a school setting.

- *Lack of Strong Advocacy Efforts for School-Based Mental Health*
  Advocacy for school mental health, particularly at the local level and with parent and youth involvement, is lacking. Such efforts are essential for advancing school mental health.

- *Lack of a Sustaining Fiscal Base to Support School-Based Mental Health Interventions*
  Few schools have the resources to implement a full range of school mental health interventions. Identifying sustainable and flexible funding sources for these programs is extremely important.

- *Lack of an Infrastructure to Support School-Based Mental Health Interventions*
  There is significant administrative fragmentation among the various agencies that have an interest in school mental health. This fragmentation is a barrier to sustained school mental health efforts.

- *School Mental Health Program Dissemination Challenges*
  While research-based models exist for promoting mental health in the schools and reducing emotional or behavioral problems, very little research has been conducted on how best to implement evidence-based practices in schools. The process of incorporating effective programs and sustaining them requires considerable effort, problem solving, and perseverance. But there is currently little research available to guide dissemination and implementation efforts.

To address these issues and help advance school-based mental health interventions, summit participants and signatories to this report made several recommendations in the areas of advocacy, training, research, policy, and local change. These recommendations are listed below. The SMHA has identified the recommendations in the areas of advocacy, local change, and training as its top priorities.

Advocacy

- ***Increase school mental health awareness*** among state education departments by developing ***a state-to-state school mental health promotional network.***

- Develop a ***consolidated Web clearinghouse and 800 number*** to provide information about evidence-based school mental health practices.

- Develop a ***school mental health report card*** that can be used to measure progress in school/mental health program integration.

Training

- ***Establish clear expectations*** that all schools will address the social-emotional, as well as academic development of students in a culturally sensitive fashion.

- ***Build consensus*** regarding the knowledge and skills educators and other school staff need in order to promote students' social-emotional skills and development in a culturally sensitive way.

- ***Identify core mental health content*** for infusion into educator-preparation coursework.

- ***Consolidate*** existing educator-preparation curricula on mental health/social-emotional development.

- ***Partner with credentialing organizations*** to promote the inclusion of teacher competence, understanding, and knowledge about children's social-emotional development into standards for teacher training.

- ***Identify funding sources*** for teacher training initiatives and disseminate this information to key stakeholders.

Research

- ***Encourage research priority setting*** within the Office of Special Education Programs (OSEP), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other relevant agencies on implementation and dissemination of effective practices.

- ***Promote collaboration*** in school mental health research between NIH, the Department of Education, and SAMHSA.

- ***Involve investigators of color*** in school-based mental health research.

- ***Involve students' families*** in planning school-based mental health research.

Policy

- ***Work with family advocacy groups to develop policy initiatives*** for improving collaboration among agencies and advocacy groups that are responsible for supporting the social-emotional wellbeing of students.

Local Change

- ***Develop a toolkit,*** with input from students' families, for how to introduce mental health interventions to a school and work with students' families to provide consistent messages and continuity of care.

- ***Train key local school district change agents*** in the use of the toolkit.

- ***Engage local school boards*** in the process of introducing mental health interventions to schools.

Since the summit, the SMHA has been actively working towards putting these recommendations into action. A steering committee and five workgroups compose the SMHA. These workgroups are devoted to: 1) fostering research studies on replicating and disseminating evidence-based school mental health interventions; 2) developing a local educational authority (LEA) consultation manual and toolkit; 3) developing measures for assessing school/mental health integration; 4) preparing a guide of national resources available to assist school/mental health integration and providing technical assistance; and 5) developing curricula and standards for undergraduate and postgraduate educator training in mental health issues. Experts in each of these areas chair each workgroup and have recruited a representative group of individuals to work towards implementing the key recommendations outlined in this document.

To date, the steering committee and each workgroup have made significant progress towards implementing each of these recommendations, and further progress will be tracked and presented at a second national summit in 2005, comprised of national educational and key opinion leaders, federal and state program developers, and school mental health experts.

This document provides additional information about the critical school mental health concerns summarized above, offers specific recommendations for addressing these concerns, and details the progress made towards implementing these recommendations. The SMHA is dedicated to working collaboratively with students' and their families and other organizations and individuals committed to advancing school mental health (for a list of some of these organizations, see Appendix C). A consensus statement summarizing our views appears on the following page.

Consensus Statement

During the last three years, different professional associations and advocacy organizations have issued a set of important statements about social, emotional, and behavioral learning in schools and about the role of mental health in promoting educational aims.[1] The various statements convey an impressive consensus around a single message:

> *Health, and especially mental health, is a fundamental cornerstone for ensuring that all youth have an equal opportunity to succeed at school and that no child is left behind.*

The coalitions represented below fully support this message.

Both academic and nonacademic barriers to learning exist. Well-documented nonacademic barriers include a host of community, family, school, peer, and individual factors that contribute to behavior, emotional, and learning problems. A large body of research underscores the urgency of removing these nonacademic barriers to student learning. Moreover, an impressive science base supports school-based strategies for doing so.

The positive impact that promoting social, behavioral, and emotional development and addressing barriers to learning can have on children's futures is well known. Strategies exist for optimizing positive development so all children can succeed in school. *We know what to do and can make a difference.*

Failure to act has consequences. The burden of suffering caused by insufficient attention to students' social, behavioral, and emotional development has contributed to leaving too many children behind at the same time that federal legislation calls for just the opposite. Research on the links between education and health demonstrates that early identification and treatment of children's mental health problems can reduce the personal and social costs associated with these problems and can improve children's social, emotional, and academic outcomes.

To attain the promises of the No Child Left Behind Act, the legal mandates of the Individuals with Disabilities Education Act, and the goals and recommendations of the President's New Freedom Commission on Mental Health, it is imperative that schools and communities work together to improve education, promote social-emotional skills and mental health, and identify and treat mental health problems among youth. Integration of mental health interventions and services in every school will ensure that all students are assured equitable opportunities to achieve educational success.

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[1] Among these are the Learning First Alliance; the two National Technical Assistance and Training Centers focusing on mental health in schools (at the University of California–Los Angeles and at the University of Maryland); the National Mental Health Association (NMHA); CHADD; the American Psychiatric Association (APA); the professional organizations of the National Association of State Directors of Special Education (NASDSE), in partnership with the National Association of State Mental Health Program Directors (NASMHPD); the American School Health Association (ASHA); the Center for Social and Emotional Education (CSEE); the National Policy Leadership Cadre for Mental Health in Schools; the Collaborative for Academic, Social, and Emotional Learning (CASEL); National Association of Pediatric Nurse Practitioners (NAPNAP), the National Consortium for Child and Adolescent Mental Health Services member organizations, including the National Education Association Health Information Network; and the National Association of School Psychologists.

These organizations include most major education groups representing teachers, administrators, and school boards; major mental health associations; school mental health professional associations; and health and mental health advocacy groups.

Introduction

Of the various populations of students schools serve, those with significant social, emotional, and/or behavioral needs pose the greatest challenges for educators and other service providers. These young people, who represent two million of our nation's youth (Office of the Surgeon General, 1999), exhibit complex problems that manifest in most environments in which students function. Without effective interventions, these problems predispose students to long-term negative outcomes, including vocational and mental health problems as adults and incarceration (Office of the Surgeon General, 1999). These are often the young people who are shuffled from system to system without having their educational needs adequately assessed or addressed. School personnel frequently do not recognize the problems of these young people, and schools, as well as other caregivers often lack the resources to address children's behavioral and mental health needs. In some cases the consequences are fatal outcomes. For example, suicide, a concomitant of depression, is the third leading cause of death among adolescents—behind accidents and homicide (Office of the Surgeon General, 1999)—and is responsible for more deaths in this age group than all other illnesses combined.

Suicide ... the third leading cause of death among adolescents ... is responsible for more deaths in this age group than all other illnesses combined.

Many of these students present complex problems that require sustained and well-coordinated services from agencies of multiple disciplines, including schools, mental health, pediatrics, social services, and intensive case management with the active involvement of caregivers. Appropriate and well-planned educational curricula and special-education programs and services are among the essentials. The degree to which these services are available is directly correlated with both short- and long-term prognoses. Fewer services, provided in a haphazard fashion, translate to poor outcomes for these children, both immediate and distant (e.g., school failure, incarceration, substance abuse) (Office of the Surgeon General, 1999; MTA Cooperative Group, 1999).

A number of national reports have emphasized the critical importance of addressing the educational needs of these youth as a strategic approach to benefit all youth within our schools (Osher, 1994; Office of the Surgeon General, 1999; Chesapeake Institute/U.S. Department of Education, 1994). On an individualized program level, these youth require programs and services that are based on the following principles:

- Comprehensive early screening (with parental permission) of all students for emotional, behavioral, and learning difficulties.

- Appropriate and comprehensive assessment of the students who are the focus of our concerns, including general and special-education environments, as well as other environments in which they are being served.

- School-wide early intervention efforts that involve students' families and focus on prevention of more serious behavioral problems.

- Comprehensive interventions that are carefully matched to the needs of individual students and their families.

- Intervention strategies that are evidence-based and that are continually monitored for effectiveness.

- Educational programs in which students' families play an active and continuous role.

Most early and intensive interventions require school environments that are supportive and caring. School-wide primary prevention programs, including those that teach and reinforce problem solving, bullying prevention, positive behavioral supports, and stop-and-think, enhance individualized interventions (Osher, Dwyer, & Jackson, 2003).

Unfortunately, in many instances, school-based programs for children and youth who have significant behavioral needs are rarely fully implemented. These programs warrant priority consideration if we are to assure appropriate learning outcomes for these youth and the larger school environments in which all children must learn. A substantial research base has documented the effectiveness of early intervention, sustained and comprehensive treatment services, and high-quality educational services that emphasize prevention; thus, the long process of discovering effective treatments is well underway. Changes in policy and systematic efforts to "mainstream" the implementation of such programs are needed in order to take effective practices to scale.

School-based programs for children and youth who have significant behavioral needs are rarely fully implemented.

Some of the most recent advances in understanding students with emotional and behavioral problems relate to the role of instructional variables and recognize the reciprocal relationship between academic and behavioral problems. Academic failure increases risk for behavioral problems (Hallenbeck & Kauffman, 1995). Furthermore, teachers of students with emotional and behavioral disorders who emphasize high academic expectations, meaningful instruction, and high levels of academic engagement typically experience fewer behavioral problems than teachers who have low-level expectations for learning. However, students with emotional/behavioral problems have not fared well in terms of academic achievement historically. For example, data from the National Longitudinal Transition Study-2 (NLTS2) (Wager & Cameto, 2004) reported:

- 38 percent of youth in the primary disability category of emotional disturbance (ED) were held back a grade at least once in their school careers.

- 73 percent were suspended at least once.

- 40 percent had attended five or more schools since starting kindergarten.

Teaching students with emotional and behavioral needs is a challenging task under the best of circumstances, even for the most experienced teacher. Students with significant social, emotional, and/or behavioral needs, including those with early-onset mental illnesses, require high-quality academic instruction for two reasons. First, these students typically have significant learning problems, as well as behavioral problems (Kauffman, 1997), with learning characteristics similar to those of students with learning disabilities (Scruggs & Mastropieri, 1986). Second, behavior is inseparably linked to the educational environment. Instruction that inadequately responds to students' needs, or a curriculum that is irrelevant to students' interests often trigger inappropriate behaviors. Conversely, an environment that combines a rich curriculum with effective instruction reduces inappropriate behavior (Munk & Repp, 1994). Thus, perhaps the most effective behavior-management tool is high-quality instruction in relevant curricula. Research has delineated instructional methods that, when applied with fidelity, have a high probability of producing desired learning outcomes for students with emotional and behavioral challenges (Forness, 2001). When teachers rely on these methods to teach skill-appropriate and pertinent curricula, they often experience higher levels of student achievement and fewer behavioral problems.

It is essential for students with significant social, emotional, and/or behavioral needs to receive high-quality academic instruction.

To improve outcomes for such students, schools must assure that teachers with sufficient and appropriate professional preparation teach these students. Unfortunately, given the current shortages of qualified special-education teachers and the lack of undergraduate curricula and training requirements for general-education teachers, difficult-to-teach students are too often taught by under-prepared teachers. Even teachers who meet state standards for special-education certification might not possess the knowledge and skills needed to educate these students effectively.

What We Know About Current School-Based Programs and Services

Screening, Assessment, and Diagnosis

In the last decade, substantial advances have occurred in the ability to screen, identify, and assess children with significant learning, emotional, and/or behavioral needs. New tools have been developed and subjected to rigorous studies of their reliability and validity. Currently, a well-established diagnostic system, known as the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (1994), is used throughout the United States and most of the Western world. Every major learning, emotional, and behavior disorder that affects adults also affects children and adolescents. Such conditions include major depressive disorder, panic disorder, bipolar disorder, agoraphobia, obsessive-compulsive disorder, generalized anxiety disorder, and schizophrenia. Several conditions particularly affect children and, in fact, begin in childhood, such as attention-deficit/hyperactivity disorder (ADHD), learning disabilities, Tourette's syndrome, and autism. While physicians and scientists used to believe that such conditions were either milder or did not affect children at all, it is now known that when such conditions begin in childhood they are often more severe than the adult-onset counterparts of these disorders.

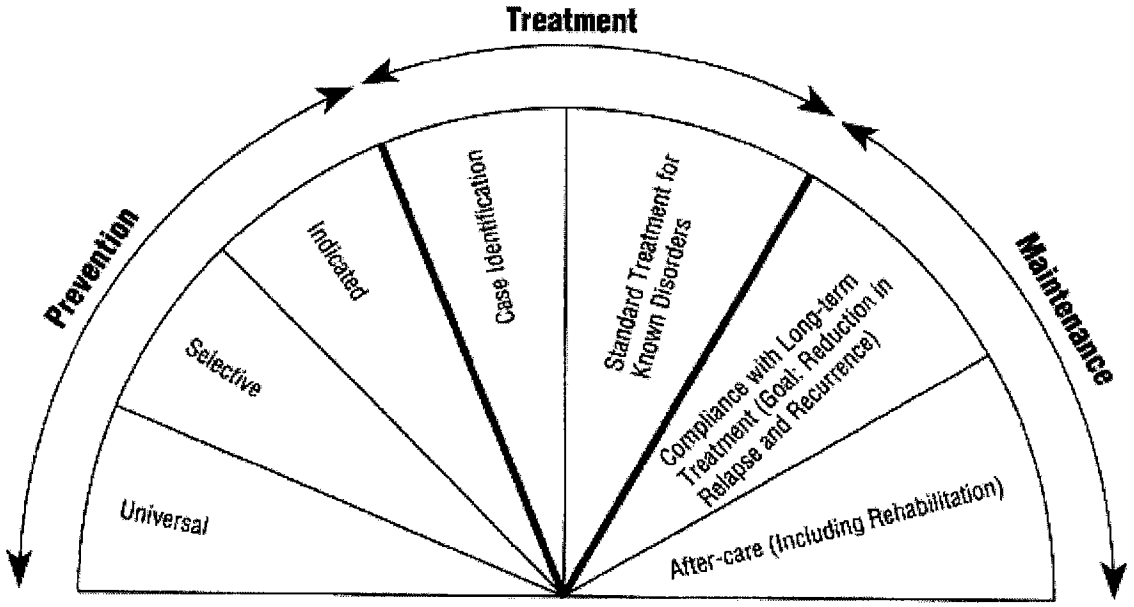
Every major learning, emotional, and behavior disorder that affects adults has been shown to affect children and adolescents.

Despite the recent availability of tools to aid in the assessment and diagnosis of such conditions, the Office of the Surgeon General (1999) estimates that only one in four children with a mental or emotional disorder is receiving any treatment (Burns et al., 1995; Leaf et al., 1996). Worse still, the under-recognition problem is especially pronounced in school settings. For example, despite national estimates of 5 percent of children meeting criteria for *severe* impairment due to mental illness (Office of the Surgeon General, 1999), state classification rates of children with behavioral and emotional disturbances under IDEA are a reported average of 1 percent and vary as much as 5-fold (Coker et al., 1998; Oswald & Coutinho, 1995), differences that appear to be principally explained by state-wide variations in school financial and training resources to identify and intervene with these children, rather than in actual differences in problem rates (Sturm et al., 2003). The accurate identification of medical-psychiatric conditions often determines the focus of special-education services that a school provides individual students (Forness & Kavale, 2001).

School-Based Interventions

According to Walker et al. (1996), approximately 80 percent of students in a typical school do not exhibit serious behavioral or emotional problems. A small percentage of students (about 15 percent) are at risk for problem behaviors, and an even smaller percentage (about 5 percent) actually has chronic problem behavior. In an inner-city middle school, however, Turnbull et al. (2002) found that only 31 percent of students had no serious problem behavior, 28 percent were at risk for problem behavior, 23

percent had chronic problem behavior, and 18 percent had extreme problem behavior. The figures reported by both Walker et al. (1996) and Turnbull et al. (2002) highlight the need for a range of school-based interventions that complement the efforts of students, families and community providers and that target students with different degrees of problem behaviors. The mental health intervention spectrum, developed by the Institute of Medicine (IOM) and depicted below, is a good model of the range of interventions needed in schools.



Mzarek & Haggerty (1994)

As the IOM model illustrates, in order to meet the mental health needs of all students, schools should implement prevention, treatment, and maintenance interventions. Within the prevention domain, schools can implement interventions at the universal, selective, or indicated level. Universal interventions are for all students in a school setting and help prevent students from developing serious problem behaviors. Selective interventions are for students at risk for developing problem behaviors. These interventions provide more intensive services than universal interventions, in an attempt to decrease the chances that a student at risk for the development of a serious problem behavior will actually develop the behavior. Lastly, indicated interventions are for the students in a school with intense problem behaviors. These interventions usually complement family and community-delivered interventions in order to stabilize and manage students in a way that is conducive to their academic success.

Even if schools implement the most effective preventive interventions, they would still have a need for school-based treatment interventions. As the IOM model illustrates,

treatment interventions include both identifying students in need of mental health treatment and working as part of a team to provide such treatment for diagnosed psychiatric disorders. Maintenance is the final component of the IOM mental health intervention spectrum. Within schools, maintenance refers to efforts that increase a student's compliance with treatment, as well as provide post-treatment services (i.e., after-care) to increase the likelihood that students will maintain the gains they made in treatment.

The IOM model is one example of the range of interventions for a school's mental health program. This model emphasizes the importance of prevention, but also recognizes the need for treatment. By implementing prevention, treatment, and maintenance interventions, schools can maximize their ability to meet the needs of students who display serious problem behaviors as well as create climates that prevent the development and exacerbation of these behaviors.

Existing school mental health interventions differ in the extent to which they address the multiple components of the IOM model. To provide a comprehensive and multifaceted framework for mental health in schools, the Policy Leadership Cadre for Mental Health in Schools (2001) developed the first-ever set of working guidelines. It incorporates the IOM model and provides the foundation for a unifying, systemic approach. The guidelines are available online at:

http://smhp.psych.ucla.edu/pdfdocs/policymakers/cadreguidelines.pdf

Hunter (2002) recently drew upon federal, state, and academic information sources to identify and review all programs addressing disruptive behavior disorders that had been evaluated for each of the three prevention categories (i.e., universal, selective, and indicated) described in the model. According to Hunter's review, multiple programs had substantial empirical support at each of these levels, but few programs were systematically implemented at any of the three levels. Wide spread implementation of effective programs will require increases in the level of school support and teacher training and implementation of these effective programs nationwide (Hunter, 2002; Office of the Surgeon General, 1999). Evaluation of the feasibility and effectiveness of comprehensive mental health interventions such as those suggested by the IOM model in schools is also needed.

Towards Greater Implementation of What We Know

To address the challenges presented here, experts in school mental health research, policy, program implementation, and advocacy gathered in New York City, December 3–4, 2003, for the *Approaches to School Mental Health Evidence-Based Partnerships: Key Obstacles and Strategic Opportunities Summit.* The summit, jointly sponsored by the Klingenstein Third Generation Foundation (KTGF), the Leon Lowenstein Foundation, the W. K. Kellogg Foundation, and the Center for the Advancement of Children's Mental Health at Columbia University, aimed to:

- Strengthen the link between mental health and schools.
- Identify obstacles to the implementation of evidence-based school mental health interventions across the prevention spectrum (i.e., universal, selective, and indicated).
- Reach consensus about effective strategies to overcome these obstacles.

A key premise of the summit was that evidence-based school mental health interventions exist, but that major barriers at local, state, and federal levels weaken efforts to implement and sustain these programs.

The summit occurred during a climate of heightened interest in children's mental health, evidence-based practice, and school mental health. Much of this interest was generated by the Surgeon General's National Action Agenda on Children's Mental Health, the President's New Freedom Commission on Mental Health Report, and the evidence-based practice movement within several federal agencies. The Surgeon General's National Action Agenda on Children's Mental Health (2000) recognized mental health as "a critical component of children's learning and general health" and recommended the promotion of mental health and the treatment of mental disorders as "major public health goals" (p. 3). The President's New Freedom Commission Report specifically called for efforts to "improve and expand school mental health programs" (p. 62). The report pointed to a link between school mental health interventions and educational outcomes and recommended that "Federal, State, and local child-serving agencies fully recognize and address the mental health needs of youth in the education system" (p. 62). Despite national recognition of the importance of addressing children's mental health needs within the education system, widespread efforts to do so are quite limited. The summit sought to identify the key obstacles to the implementation of school mental health interventions and formulate concrete solutions for overcoming these obstacles.

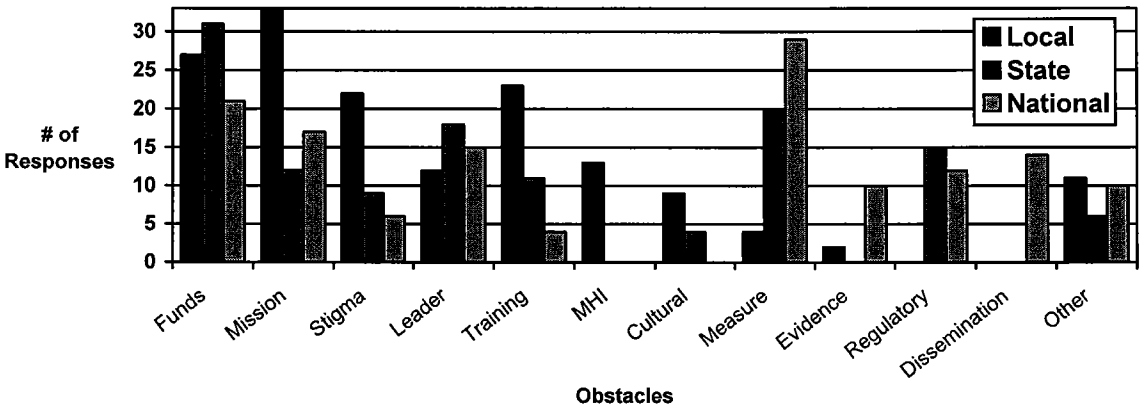
Planning for the summit was an eight-month collaborative effort between representatives from the Klingenstein Third Generation Foundation, the Lowenstein Foundation, the Ittleson Foundation, Columbia University's Center for the Advancement of Children's Mental Health, the New York State Office of Mental Health, the University of Maryland, and Drake University (see Appendix A for a list of summit planning committee members).

The planning committee deliberately decided that the summit should not revisit issues around definitions of evidence-based practices, but begin from the premise that, there exists a corpus of programs that schools can implement and whose effectiveness in ameliorating behavior problems in schools has been demonstrated. The challenge for the summit was to identify obstacles to adopting new service programs.

Prior to the summit, participants completed a brief survey about their perceptions of the key obstacles (at the local, state, and national levels, respectively) to implementing evidence-based mental health interventions across the prevention spectrum in schools. Forty-four surveys were distributed and thirty-two returned, for a response rate of 73 percent. Identified obstacles included:

- Lack of funding and resources (Funds)
- Mission disparity between schools and school-based mental health interventions (Mission)
- Mental health stigma and a lack of mental health awareness and education (Stigma)
- Lack of leadership and support for school mental health efforts (Leader)
- Insufficient training (Training)
- Mental health school integration problems (MHI)
- Cultural Barriers (Cultural)
- Lack of evidence-based school mental health interventions (Evidence)
- Measurement, services, and individualized planning issues (Measure)
- Regulatory issues and barriers (Regulatory)
- Lack of dissemination models and strategies (Dissemination)
- Other

The graph below illustrates the local, state, and national obstacles identified and the number of responses that fell into each category.



As the graph above illustrates, similar obstacles were identified at the local, state and national levels. Mission disparity between schools and school-based mental health interventions, a lack of funding to support school mental health, and limited mental health training for school staff were among the most frequently cited obstacles. The next section of this paper summarizes the critical concerns about school-based mental health interventions raised during the summit.

Critical School Mental Health Concerns

Mission Disparity Between Schools and School-Based Mental Health Interventions
Summit participants overwhelmingly agreed that the mission of schools is vastly different from the mission of school mental health interventions. As stated by Adelman and Taylor (2000), "... schools are not in the health or social service business. Their mandate is to educate" (p. 171). This disparity between the mission of schools and that of school mental health is a significant barrier to the successful implementation and sustainability of these school mental health interventions. Despite its existence, this disparity is untenable, since schools and school mental health interventions both share a common mission to prepare students for success in life.

> *Schools are not in the health or social service business. Their mandate is to educate.*
>
> *Adelman & Taylor, 2000, p. 171*

Approximately one fifth of young people in the United States between the ages of nine and seventeen have a diagnosable mental health disorder (Shaffer et al., 1996). Many of these young people never receive mental health interventions. "Of those fortunate few who do receive some type of mental health care, the overwhelming majority—70–80 percent—receive them within the school setting" (Hoagwood & Johnson, 2003, p. 4). Thus, although the public's position is that schools are not in the mental health business, they are "children's 'de facto' mental health system, providing the bulk of mental health care to children" (Burns et al., 1995, as cited by Hoagwood & Johnson, 2003, p. 4).

Given the central role schools play in delivering mental health interventions to students, bringing the mission of schools and school mental health interventions into closer alignment is a vital task. "Despite widespread acknowledgement of problems facing youth in school, interventions related to mental and social health are not a high priority on the school reform agenda" (Taylor & Adelman, 2000, p. 210). Mental health will never be a priority for schools unless school mental health providers can demonstrate to the general public and educators that the provision of quality school mental health interventions is directly linked to important academic outcomes. Currently, most research on school mental health interventions does not include any evaluation of academic outcomes. If evaluations of these interventions continue to exclude academic outcomes, schools will continue to view school mental health interventions "as additional burdens to education systems" (Ringeisen et al., 2003, p. 155).

Inadequate Mental Health Professional Development for School Staff
Since schools do not view mental health as part of their mission, teachers do not receive much professional development on the topic. Generally speaking, teachers and school administrators enter their jobs with a limited understanding of the mental health and social-emotional issues faced by young people. Consequently, they are inadequately equipped to handle the behaviors displayed by children suffering from mental health problems, or to promote healthy social-emotional skills. In large part, teachers and

school administrators do not know how to address students' mental health needs because they have never been taught how to do so.

Current teacher-preparation programs are very much in line with the mission of schools - academics. Most of these programs "equip pre-service teachers with the curricular knowledge and instructional skills needed 'to deliver the goods'"(Burke, 2003, p. 3). As such, they do not focus on how to address the mental health and social-emotional issues that present as barriers to learning.

Two professional organizations—the Interstate New Teachers Assessment and Support Consortium (INTASC) and the Mental Health and Education Integration Consortium (MHEDIC)—have been working on improving the quality of teacher-preparation programs. INTASC, a program of the Council of Chief State School Officers (CCSSO), currently has members from thirty-four states and territories in the United States. Participating members "work with the state education agencies responsible for teacher licensing, professional development, and program approval to promote standards-based reform of the licensing process" (CCSSO, 2002, p.1). INTASC believes that teachers "must be able to create learning experiences that are responsive to students' social, emotional, physical, and cognitive development, their cultural and community experiences, and their interests, talents, and learning styles" (INTASC, 1995, p. 1). The inclusion of emotional development in this list of things teachers must be able to do highlights the importance of providing teachers with mental health training.

MHEDIC, a fairly new group, focuses on integrating mental health content knowledge and skill acquisition into undergraduate and graduate teacher-education programs. The group has a variety of projects underway, all aimed at infusing mental health content into teacher-education programs. Some of these projects include a book addressing the mental health knowledge needed by teachers in pre-kindergarten through high-school general education classes, a web site, and a leadership cadre for pre-teachers.

INTASC and MHEDIC are making progress in the effort to provide teachers with the mental health training they need to address the social-emotional needs of students. Clearly, accomplishing this goal will require the continued collaboration and coordination of organizations like INTASC and MHEDIC, as well as many others.

In addition to providing school personnel with mental health, social-emotional, and behavioral training, schools need to provide school-based mental health professionals providing services in schools with training in school-related learning problems, the connection between learning and behavioral difficulties, and ways to assist and work with schools to improve services and outcomes for students.

Lack of Strong Advocacy Efforts for School-Based Mental Health

A lack of strong advocacy efforts for school mental health is another barrier to the more widespread adoption of mental health interventions in schools. Advocacy, especially at the local level and with parent and youth involvement, can be a powerful tool for advancing school mental health. In order to be successful, however, school mental

> *School mental health advocacy efforts "must be presented as an integral part of the school and the community, fully compatible with the educational mission."*
>
> *Hoganbruen et al., 2003, p. 48*

health advocacy efforts "must be presented as an integral part of the school and the community, fully compatible with the educational mission" (Hoganbruen et al., 2003, p. 48). The families of affected students need to see advocacy efforts as supportive and not blaming or superseding parental rights.

Collaboration between different professional and grassroots associations is essential for successful advocacy efforts at the national or federal level. Generally speaking, organizations with a stake in school mental health advocate for their own special interests. This individualistic approach to advocacy is understandable, given that these associations exist to promote the interests of their members. Such an approach, however, leads to fragmented advocacy efforts. By joining forces, associations interested in promoting school mental health can advocate more strongly and effectively. The strongest advocacy efforts "are the product of communitywide coalitions and careful collaboration between multiple constituencies" (Hoganbruen et al., 2003, p. 48). Collaborative advocacy efforts between mental health and educational associations could go a long way in advancing school mental health interventions, particularly at the local level.

Lack of a Sustaining Fiscal Base to Support School-Based Mental Health Interventions

Even if schools come to embrace school-based mental health interventions and value their contribution to educational outcomes, the school mental health movement will not progress without the establishment of a strong fiscal base. "Few schools have sufficient resources to provide a comprehensive range of programs to promote mental health, minimize psychosocial problems, and provide treatment to students with severe problems" (Taylor & Adelman, 2000, p. 210).

> *Administrative demands make it "difficult for the revenue that is received to even match the costs associated with providing services and negotiating fee-for-service bureaucracies."*
>
> *Weist et al., 2003, p.72*

Financing school-based mental health interventions is difficult, and programs are often short lived as a result. Current funding options fall into four general categories: fee-for-service, federal/state funding, local funding, and private funding (Weist et al., 2003).

All of the current funding sources for school-based mental health interventions have their own unique limitations. Fee-for-service options like private insurance, Medicaid, and the State Children's Health Insurance Program primarily support assessment and treatment services in schools for children with established mental health problems. IDEA allows some flexibility in using Medicaid as the payer of first resort for related mental health interventions to Medicaid-eligible children who receive special education. Fee-for-service funding options typically do not cover many of the unique

services such as classroom observations and interventions that school-based mental health providers can offer. Furthermore, the administrative demands associated with these options make it "difficult for the revenue that is received to even match the costs associated with providing services and negotiating fee-for-service bureaucracies" (Weist et al., 2003, p.72).

A variety of federal and state funding streams could support school-based mental health efforts (for a complete review, see Evans et al., 2003), with the largest amount of support coming from the ***Safe Schools-Healthy Students Initiative.*** This initiative, a collaborative effort between the United States Departments of Education, Health and Human Services, and Justice, provides grants on a competitive basis to support violence prevention, healthy childhood development, and resilience. To date, this initiative has invested $600 million in funding for ninety-seven communities (Weist et al., 2003). The ***Healthy Schools, Healthy Communities*** program, established by the Bureau of Primary Health Care in 1994, supports the development of school-based health centers, a significant provider of mental health interventions in schools. In 2001, the program provided $17 million in support to school-based health centers (Weist et al., 2003). In addition to the Safe School-Healthy Students Initiative and the Healthy Schools, Healthy Communities program, states could use federal block grants to fund school-based mental health interventions (Weist et al., 2003).

Mental health interventions are not new to schools. Since 1975, almost all school systems are required to have minimal mental health service supports as part of the Individuals with Disabilities Education Act. These supports include psychological services and social work services, as well as counseling. However, more than 50 percent of this resource is used for eligibility diagnosis, rather than needed consultation, teacher training, or direct services to children and families (Curtis, Hunley, Walker, & Baker, 1999). At the local level, some schools and districts also allocate funds to support school-based mental health interventions. For example, the Baltimore City Public School System provides $1.6 million per year in contracts to community providers of school-based mental health interventions (Weist et al., 2003). Private foundations are another source of funding for school-based mental health interventions. Several foundations (i.e., Annenberg, Robert Wood Johnson, and W. K. Kellogg) have a specific interest in supporting school-based mental health efforts. Unfortunately, support from private foundations is typically time-limited and cannot maintain a project indefinitely.

Although a range of funding options exists to finance school mental health efforts, none of these options fully meet the long-term fiscal needs of school mental health interventions. Identifying sustainable and flexible funding sources for these programs is extremely important and will most likely require major reform to the health care financing system.

Lack of an Infrastructure to Support School-Based Mental Health Interventions
In addition to the lack of a strong fiscal base to support school mental health efforts, an infrastructure to support these efforts at the federal, state, and local levels is lacking. Currently, significant administrative fragmentation exists among the various agencies that have an interest in school-based mental health interventions. This fragmentation is a significant barrier to sustained school mental health efforts.

There is significant administrative fragmentation among the various agencies that have an interest in school mental health.

In a concept paper, *Mental Health, Schools, and Families Working Together for all Children and Youth: Toward a Shared Agenda,* the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Directors of Special Education (NASDSE) identify the lack of an infrastructure as a major obstacle to creating a shared agenda for children's mental health. Specifically, NASMHPD and NASDSE list fragmented efforts at the state and local level, turnover of key players and stakeholders, and policy that does not support interagency collaboration as some of the barriers.

To support some of the ideas put forth in the "shared agenda" concept paper, NASMHPD/NASDSE developed a state planning grant program. Six states (Missouri, Ohio, Oregon, South Carolina, Texas, and Vermont) received funding to continue the policy and infrastructure work necessary to build partnerships for school mental health. These states are using strategies such as identifying common values across agencies associated with children's mental health, systematically integrating policies across these agencies, pursuing shared accountability, and promoting interagency flexibility in an effort to develop the infrastructure necessary to pursue a shared agenda for children's mental health.

Although not a recipient of one of the NASMHPD/NASDSE state planning grants, New Mexico is an example of a state that has had some success building an infrastructure for school mental health. Steve Adelsheim, M.D., director of the School Mental Health Program for the New Mexico Department of Health, spoke during the summit about his state's experience with developing an infrastructure for school-based mental health intervention. Like many states, mental health funding for children and youth in New Mexico is spread across multiple state agencies (i.e., the Public Education Department, the Human Services Department, the Department of Health, and the Children, Youth, and Families Department). Infrastructure-development grants have allowed the state to develop an Office of School Health. This office has a strong mental health component partially staffed by school mental health advocates who work around the state linking schools with mental health providers. So far, centralizing the state's school-based mental health efforts through the Office of School Health has proved promising. New Mexico and the states receiving the NASMHPD/NASDE planning grants are good examples of how focusing on infrastructure development can facilitate the implementation of school mental health interventions.

School Mental Health Program Dissemination Challenges

While an infrastructure that supports school mental health is essential, its impact will be limited without more work on disseminating mental health interventions in schools. The process of implementing school mental health interventions requires a fair amount of effort, problem solving, and perseverance. Gil Botvin, Ph.D., the founder of the Life Skills Training program, spoke during the summit about some of the challenges associated with disseminating research-validated mental health interventions in schools.

Botvin identified dissemination challenges associated with fidelity, infrastructure, and adaptation. Maintaining the fidelity of an evidence-based program is essential for replicating successful outcomes (e.g., Dane & Schneider, 1998; Domitrovich & Greenberg, 2000; Durlak, 1998). Without fidelity, a program is unlikely to produce the same outcomes achieved during a research trial. Ensuring fidelity requires proper training and monitoring of the delivery of program components. Both of these activities take time and effort.

For students to succeed in school, organizational systems change is needed.

Schools do not have even minimal amounts of time to devote to implementing mental health interventions: "Usually, assistance and resources to apply the evidence base in schools are lacking" (Tashman et al., 2000, as cited by Weist et al., 2002). Thus, developers of such programs must have staff available to provide training, handle administrative tasks, monitor implementation, and support school staff in their implementation efforts.

In addition to establishing an infrastructure for dissemination and maintaining program fidelity, tailoring a given mental health program to the unique needs of an individual school is essential for successful dissemination. Striking a balance between tailoring a program for a particular school and maintaining program fidelity is one of the challenges associated with this work. Adaptations made to address cultural or ethnic issues usually do not change the framework that makes an intervention "work", but program developers must be careful not to sacrifice effectiveness for the sake of adaptation.

Unfortunately, there is limited research to guide the dissemination and implementation efforts of school mental health program developers. Although a fair amount of research exists supporting a link between school-based interventions and positive outcomes for children (Weist et al., 2002), we do not know much about how best to implement these interventions in schools. There is a gap "between research-based practices for youth with mental health problems and their application in school settings" (Hoagwood & Johnson, 2003, p. 5). To address this gap, "new models of programmatic research are needed that will address the important questions about how to implement, disseminate, and encourage organizational systems change to sustain high quality mental health and educational practices within schools" (Hoagwood & Johnson, 2003, p. 5).

Recommendations

An integral part of the summit was developing recommendations that address some of the obstacles to advancing evidence-based school mental health practices. Recommendations fell into five general categories: advocacy, training, research, policy, and local change. These recommendations are presented below. Recommendations in the areas of advocacy, local change, and training are currently the SMHA's top priorities.

Advocacy Recommendations

Advancing evidence-based school mental health practices requires close collaboration with mental health and family advocacy groups and ongoing advocacy and promotional efforts. The case for school mental health interventions can be more compelling using evidence showing that such interventions can improve academic achievement (and thus school test scores). Summit participants recommended:

- ***Increasing awareness*** of the value of school mental health to state education departments and other agencies by developing ***a state-to-state network*** that promotes school-based mental health interventions.

- Developing a ***consolidated Web clearinghouse and 800 number*** that provides information about evidence-based school mental health practices.

- Developing ***a report card*** of the ten key indicators of best practice in the area of school-based mental health interventions that both educators and family members can use.

Training Recommendations

Principals, teachers, other school staff and families of affected students need training on mental health issues and social-emotional skills. Summit participants recommended:

- ***Establishing clear expectations*** that all schools will address the social-emotional, as well as the academic skills of students in a culturally sensitive fashion.

- ***Building consensus*** regarding the knowledge and skills educators and other school staff need in order to promote students' social-emotional skills in children in culturally sensitive ways.

- ***Identifying*** core mental health content for infusion into educator-preparation coursework.

- ***Consolidating*** existing educator preparation curricula on mental health/social-emotional development.

- ***Partnering with credentialing organizations*** to promote the inclusion of teacher competence, understanding, and knowledge about children's social-emotional development in standards for teacher training.

- ***Exploring funding sources*** for teacher training initiatives.

Research Recommendations

Research on the dissemination of effective school-based mental health practices is lacking. Summit participants stressed the need for:

- ***Encouraging*** OSEP, SAMHSA, and other relevant agencies to support research on the implementation and dissemination of effective practices. In the absence of a strong research base to guide implementation efforts, the field is left in the awkward position of applying non-evidence-based implementation strategies to the delivery of evidence-based practices.

- ***Promoting collaboration*** in school-based mental health research between NIH, the Department of Education, and SAMHSA.

- ***Involving investigators of color*** in school-based mental health research.

Policy Recommendations

Advancing school-based mental health efforts requires policy level changes. Summit participants recommended:

- ***Developing policy initiatives*** that improve communication, collaboration, cooperation, and coalition forming among local, state, and federal agencies and advocacy groups that are responsible for supporting the social-emotional wellbeing of school-aged children and youth.

Local-Change Recommendations

Sustained change in school mental health requires localization. Summit participants recommended:

- ***Developing a toolkit*** for introducing mental health interventions to a school.

- ***Training key local school district change agents, including family advocates*** in the use of the toolkit.

Moving from Recommendations to Action: The School Mental Health Alliance

Putting the advocacy, training, research, policy, and local change recommendations mentioned above into action will require coordination and collaboration among organizations and individuals committed to advancing school-based mental health interventions. To facilitate this process, summit participants formed the ***School Mental Health Alliance*** **(SMHA)**. The primary goals of the SMHA include:

- Developing an infrastructure that supports furthering the work of the summit.
- Forming a steering committee as well as research, educator-consultation and toolkit-development, standards/measurement, resource-mapping, and educator-training workgroups to implement the summit recommendations.
- Developing specific products related to the summit recommendations in areas of communication, collaboration, research/practice integration, and advocacy/policy.
- Maintaining ongoing communication with individuals and organizations committed to advancing school-based mental health initiatives to inform them about the work and progress of the SMHA.

Since the summit, the steering committee and the five workgroups of the SMHA have been actively working towards accomplishing these goals. The steering committee, under the leadership of Peter S. Jensen, M.D., and Kimberly Hoagwood, Ph.D., prepared the consensus statement printed in the beginning of this paper. Most major education groups representing teachers, administrators, and school boards; major mental health associations; school mental health professionals; and health and mental health advocacy groups have endorsed this statement.

Furthermore, through each of the five workgroups, the SMHA is actively working towards putting the previously noted recommendations into action, with the following products in development: 1) strategic planning efforts with the Department of Education to foster research studies on replicating and disseminating evidence-based school mental health interventions; 2) development of a local educational authority (LEA) consultation manual and toolkit; 3) development of measures for assessing school/mental health integration; 4) a guide of national resources for assistance with integration of mental health interventions with physical health and educational interventions and systems; and 5) development of curricula and standards for undergraduate and postgraduate educator training in school-based mental health issues. Additional details about the current work of the SMHA workgroups follows. Most of this work is accomplished through regular conference calls with workgroup members and face-to-face meetings on an as-needed basis.

Research Workgroup
The **research workgroup** is working on developing recommendations for the Office of Special Education Programs (OSEP), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other relevant agencies regarding funding research that investigates variables related to sustained implementation of effective practices. Rob Horner, Ph.D., from the University of Oregon, chairs this workgroup.

Educator-Consultation and Toolkit-Development Workgroup
Under the leadership of Steve Evans, Ph.D., from James Madison University, the **educator-consultation and toolkit-development workgroup** is designing a strategic-consultation approach and an associated toolkit focused on helping local educational authorities (LEAs) maximize opportunities for integrating evidence-based mental health interventions within school systems. Given the great challenges schools face to appropriately address the needs of students with disruptive behavior disorders, the toolkit/consultation manual will cover issues that LEAs must consider if they are to plan for optimal school/mental health integration. The workgroup is in the process of developing a set of procedures that schools can use to initiate or advance their efforts to help youth with disruptive behavior disorders. The materials will encompass a range of services, from universal interventions (e.g., schoolwide behavioral systems) to very targeted services, and include providing education to teachers, as well as establishing mechanisms to coordinate with physicians. A model for youth with disruptive behavior disorders will create a template that might apply to a wide range of other problems. In addition, the focus on a specific set of problems will allow for the successful development of procedures that include sufficient detail.

The model will help educators and community members understand the nature of disruptive behavior disorder, current costs associated with helping these youth, and methods for improving the effectiveness and efficiency of interventions aimed at addressing this problem. Specific steps and resources for improving care will be outlined, as well as methods for obtaining technical assistance. The final product will be a toolkit that, with additional funding support, might be implemented within schools and communities to address this critical area of mental health need.

Standards/Measurement Workgroup
The **standards/measurement workgroup** is focused on assessing the quality of school/mental health integration and developing measures of how well schools address mental health across the continuum of support. Under the leadership of David Osher, Ph.D., from the Center for Effective Collaboration and Practice, and with the input of leaders from the Collaboration for Academic and Social-Emotional Learning (CASEL) (Roger Weissberg, Ph.D.), this group is working with the Learning First Alliance and other groups to develop a school mental health report card for assessing school/mental health integration and to foster forward movement in this area nationally.

Resource-Mapping Workgroup
Mark Weist, Ph.D., from the University of Maryland's Center for School Mental Health Assistance, and Carl Smith, Ph.D., from Iowa State University, chair the **resource-**

mapping workgroup. This workgroup is developing a comprehensive "map" of existing efforts that support mental health in terms of:

- National and state level health and mental health coalitions that address school-based interventions.

- Services in place within the portfolios of various federal and state agencies, including national and regional technical assistance centers that can aid LEAs in the process of integrating school-based mental health interventions into other school initiatives and systems.

- Existing school reform efforts.

- Existing materials, toolkits, communication strategies, training, etc., available from government, professional associations, community organizing groups, and family advocacy organizations.

Educator-Training Workgroup

The work of the **educator-training workgroup**, chaired by Carl E. Paternite, Ph.D., from Miami University, interfaces nicely with efforts of the preexisting Mental Health-Education Integration Consortium (MHEDIC). This workgroup also works closely with the Center for Social-Emotional Education that has begun several teacher-training initiatives. Through a variety of initiatives, MHEDIC addresses pre-service and in-service education and training issues—for both educators *and* mental health professionals working in schools. In addition, MHEDIC has promoted much-needed cross-disciplinary education and training. A cross-disciplinary practice group of MHEDIC members is serving as the SMHA educator-training workgroup. This workgroup is developing:

- A report detailing not only the education and training needs of educators and mental health providers working in or with schools, but also conceptually and empirically informed strategies for moving the training agenda forward. This report will address each of the training recommendations developed at the December 2003 summit.

- A proposed model for development of cross-disciplinary teaching and learning communities of practice for the school-based mental health field (Wenger, 1998; Wenger, Snyder, & McDermott, 2002). The models consider including both trained professionals and interested family and community advocates. This work also will include recommendations for teaching and learning methods that enhance research-to-practice integration and ongoing practice-based learning.

- Sample core curricula that are theoretically and empirically sound and ecologically grounded in the realities confronted in schools and classrooms.

- A proposed template for grant- and contract-funding requests in the education and training arena.

- A proposed strategy for advocacy and partnering with credentialing organizations, legislative entities, and funders that promotes explicit attention to the social-emotional skills of students.

All of these products will be vetted through mental health and education focus groups of university faculty, practitioners, pre-service students and family organization representatives. In addition, product drafts will be shared with the full MHEDIC membership, and revisions will be incorporated.

To date, the steering committee and each workgroup have made significant progress towards developing the products described above, and further progress will be tracked and presented at a second national summit in 2005, comprised of national educational leaders and key opinion leaders, federal and state program developers, and school mental health experts.

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APPENDIX C
Groups and Organizations with School Mental Health Interests

Center for Health and Health Care in Schools
www.healthinschools.org

Center for Mental Health in Schools
http://smhp.psych.ucla.edu

Center for the Advancement of Mental Health Practices in Schools
www.schoolmentalhealth.missouri.edu

Center for School Mental Health Assistance
http://csmha.umaryland.edu

Collaborative for Academic, Social, and Emotional Learning
www.casel.org

Center for Social and Emotional Education
www.csee.net

Task Force for Evidence-Based Interventions in School Psychology