

# “Finalized Draft” Report on School Mental Health Workforce Issues

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(written on behalf of the Mental Health—Education Integration Consortium)

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## **Section I: Planning Process for the School Mental Health Content Area**

### ***History of the Mental Health—Education Integration Consortium***

The Mental Health—Education Integration Consortium (MHEDIC), a 20-member, multidisciplinary group, is serving as a *school mental health* expert panel for the Annapolis Coalition. MHEDIC emerged from a *critical issues* planning meeting, convened in May 2002 by the Center for School Mental Health Assistance (now the Center for School Mental Health Analysis and Action) at the University of Maryland (<http://csmha.umaryland.edu>). The one-day meeting focused on: 1) the realities of providing mental health supports in the educational system, and 2) the training needs of both school mental health providers and educators to more effectively address the unmet mental health needs of students (<http://csmha.umaryland.edu>). This meeting served as a springboard for the formation of MHEDIC (9 of the 20 current MHEDIC members were participants in the 2002 critical issues meeting). The work of MHEDIC evolved initially through a series of conference calls, e-mail exchanges, and face-to-face meetings at the CSMHA-sponsored annual school-based mental health national conferences (Philadelphia, 2002; Portland OR, 2003; Dallas, 2004), with membership expanding strategically since 2002.

Currently, the membership of MHEDIC represents the fields of clinical psychology, school psychology, social work, school health, public health, child psychiatry, teacher education, educational leadership, mental health administration, and educational administration (see Appendix A). The consortium is co-facilitated by three of its members: Carl E. Paternite (Center

for School-Based Mental Health Programs [CSBMHP] and Department of Psychology, Miami University), Robert Burke (Department of Teacher Education, Miami University), and Jennifer Axelrod (Collaborative for Academic, Social, and Emotional Learning [CASEL]). MHEDIC's mission is described below. Goals associated with this mission are detailed at the MHEDIC website (<http://www.units.muohio.edu/csbmhp/mhedic/index.html>).

***MHEDIC Mission:*** The mission of the Mental Health—Education Integration Consortium is to advance a systematic and emergent agenda that promotes the mental health professional preparation of educators and all other school personnel at all levels [pre-service, graduate, and in-service] as well as the professional preparation of mental health clinicians in understanding and working in educational environments. In addition, the mission includes effort towards promoting the integration of education and mental health systems as well as effective school-based mental health programs.

### ***Overview of MHEDIC Activities Addressing Workforce Issues***

MHEDIC members have collaboratively undertaken an extensive array of activities related to the consortium's emergent mission and goals (see Appendix B for MHEDIC's vita of representative recent presentations and publications). In addition, since 2002 MHEDIC has organized a training track that addresses mental health—education systems integration and workforce preparation issues, with these presentations being among the most widely attended at the annual CSMHA-sponsored school mental health conference.

In December 2003, six MHEDIC representatives participated in a summit facilitated by the Center for the Advancement of Children's Mental Health at Columbia University that brought together over 50 experts in school mental health research, policy, and advocacy. The goals of the summit included: 1) identifying obstacles to the implementation of evidence-based school mental health programs, and 2) reaching consensus about effective strategies to overcome these obstacles. As an outgrowth of that Summit, the participants formed the School Mental Health Alliance (SMHA) to help move the Summit recommendations forward. With funding

from the Lowenstein and Klingenstein Foundations, five SMHA workgroups were formed in 2004. MHEDIC co-facilitator Paternite is chairing the workgroup on Educator Training, and several other MHEDIC members are participating. One product of this workgroup will be a report on the mental health-related education and training needs of educators in schools, as well as recommendations regarding curricula, training, and credentialing. We believe the report produced by the Educator Training workgroup will be a valuable companion document to the current report for the Annapolis Coalition focusing on mental health provider training needs to work effectively in schools.

Coinciding with the SMHA collaboration, MHEDIC efforts to develop a workforce training agenda (training models, curricula, and processes) have been enhanced through a planning grant awarded by the Ohio Department of Mental Health, along with additional support provided by the IDEA Partnership. The IDEA Partnership, which is funded through the Research to Practice Division of the federal Office of Special Education Programs (OSEP), is dedicated to improving outcomes for students with disabilities, by joining federal and state agencies and stakeholders through shared, collaborative transformative learning and work. Most recently MHEDIC has agreed to work closely both with the newly funded Center for School Mental Health Analysis and Action (CSMHA) and with the IDEA Partnership, to build a mental health—education integration *Practice Group* and conduct and disseminate policy analyses on school mental health workforce issues and on the promotion of family, education and mental health systems integration. As a CSMHA-funded Practice Group, MHEDIC has made a commitment to develop and disseminate a minimum of one policy brief per year, with the first brief on *Enhancing Teacher Education, Training and Support to Foster Mental Health in Schools* disseminated by July 2006.

To facilitate the above noted work and other ongoing initiatives of MHEDIC, two 2-day work sessions have been convened at Miami University within the last 10 months (December 11-12, 2004 with 14 members; and July 15-16, 2005 with 13 members). Shortly before the July meeting, MHEDIC was asked to serve as a *school mental health* expert panel for the Annapolis Coalition. During the July meeting, and in subsequent e-mail and phone consultations, significant attention has been directed to the request from the Annapolis Coalition to specifically address recommendations regarding the professional training and preparation of the behavioral health workforce involved in schools. The content in this report is derived from themes and recommendations that have emerged over the past several years in the context of all of the collaborative activities described above.

A preliminary draft of MHEDIC's expert panel interim report was prepared for discussion at the Annapolis Coalition's senior advisors meeting on September 13-14, 2005; and at the same time the draft was distributed to the MHEDIC expert panel for additional review and comment. Two additional MHEDIC conference calls were convened in late September 2005 to work on revisions to the draft, and the expert panel officially endorses the finalized draft report.

## **Section II: Overview of School Mental Health Workforce Issues**

### ***Context: The School Mental Health Imperative***

The President's New Freedom Commission (2003) concluded that improvement and expansion of school mental health (SMH) programs are essential to transforming mental health care for children and youth in America—a conclusion that is echoed by other significant federal and national reports (e.g., American Academy of Pediatrics Committee on School Health, 2004; National Institute of Mental Health, 2001; U.S. Department of Health and Human Services, 1999, 2000). The New Freedom Commission noted that schools offer unparalleled access as

points of engagement with youth to address their interrelated academic *and* mental health needs (see [www.mentalhealthcommission.gov](http://www.mentalhealthcommission.gov); Huang et al., 2005). In addition to enhancing access to treatment for youth (Weist, Meyers, Hastings, Ghuman, & Ham, 1999), SMH programs and services also can:

- reduce the stigma of help seeking (Nabors & Reynolds, 2000);
- promote generalization and maintenance of treatment gains (Evans, 1999);
- enhance capacity for prevention and mental health promotion (Elias, Gager, & Leon, 1997; Weare, 2000);
- foster clinical efficiency and productivity (Flaherty & Weist, 1999); and
- promote a natural, ecologically grounded approach to helping children and families (Atkins, Adil, Jackson, McKay, & Bell, 2001).

Further, effective SMH practices offer significant potential to substantially address the mandates of the reauthorized 2002 Elementary and Secondary Education Act (No Child Left Behind, 2002) and the recently reauthorized Individuals with Disabilities Education Act (Individuals with Disabilities Education and Improvement Act) (Huang et al., 2005; School Mental Health Alliance, 2005; Weist et al., 2005; Weist & Paternite, in press). In this regard, there is compelling evidence not only that there are strong positive associations between mental health and academic success, but also that mental health problems are *significant* barriers to learning (e.g., Adelman & Taylor, 1999, 2000; Atkins, Frazier, Adil, & Talbott, 2003; Bishop et al., 2004; Catalano, Haggerty, Oesterle, Fleming, & Hawkins, 2004; Klern & Connell, 2004; Libbey, 2004; McNeely & Falci, 2004; Weist, 1997; and Wilson, 2004).

School mental health programs and services, *when done well*, are associated with strong satisfaction by diverse stakeholder groups, improvement in student emotional and behavioral

functioning, and improvements in school outcomes; for example, enhanced climate and student connectedness to school, improved attendance, fewer inappropriate referrals into special education, reduced bullying and violence, and reduced school suspensions (see Atkins, Graczyk, Frazier, & Abdul-Adil, 2003; Evans, Langberg, Raggi, Allen, & Buvinger, in press; Han, Catron, Weiss, & Marciel, in press; Masia-Warner, Klein, Dent, Fisher, Alvir, Albano, et al., in press; Owens, Richerson, Beilstein, Crane, Murphy, & Vancouver, in press; Stormshak, Dishion, Light, & Yasui, in press; Weist et al., 2005; Weist & Paternite, in press).

In addition to findings noted above, compelling epidemiological data provides a strong basis for asserting this *School Mental Health Imperative* (cf. Adelsheim, Jennings & Weist, 2002; Weist, 1997; Weist, Paternite & Adelsheim, 2005). Namely,

- between 20% and 38% of youth in the United States (U.S.) have diagnosable mental health disorders, and 9-13% of youth have serious disturbances (Goodman et al., 1997; Grunbaum et al., 2004; Marsh, 2004). In addition, many more youth are at risk or could benefit from help;
- as few as one-sixth to one-third of youth with diagnosable disorders receive any treatment, and, of those who do, far less than half receive adequate treatment (Burns et al., 1995; Leaf et al., 1996; Weisz, 2004); and
- for the small percentage of youth who do receive services, most actually receive them within a school setting (Rones & Hoagwood, 2000; U.S. Department of Health and Human Services, 1999, 2001).

All of the above noted findings provide support for a *School Mental Health Imperative*, by raising questions about the insufficiency of the mental health field's commitment to the delivery of ecologically sensitive and effective services, and by reinforcing the importance of a

comprehensive community-based continuum of mental health promotion and intervention for all youth, with schools serving as a key setting for mental health programs and services.

The idea of developing a comprehensive continuum of mental health supports for children in U.S. public schools dates back to the early 20<sup>th</sup> century (see Flaherty & Osher, 2003). However, recent dramatic growth of SMH programs and services has been spurred by increasing recognition of the findings and reports summarized above.

School mental health services have been delivered in a variety of forms (Weist, Evans & Lever, 2003), and there is not an explicit “best practice” model. However, the term *expanded school mental health* (Weist, 1997; Weist et al., 2005) describes programs and services that incorporate key elements reflected in the recommendations of the New Freedom Commission (2003). These elements include:

- family-school-community agency partnerships;
- commitment to a continuum of mental health education, promotion, assessment, problem prevention, early intervention and treatment; and
- services for youth in general and special education.

*Expanded* conveys building on programs and services that exist in most schools, including the work of school-employed mental health staff (e.g., school psychologists, social workers, counselors, school nurses, and teachers with behavioral expertise). Further, expanded school mental health recognizes the importance of effective partnering among community agency-employed mental health professions and school staff, with agency professionals moving beyond a limited “co-location” approach to real interdisciplinary collaboration with school mental health staff, educators, education leaders, and youth and families, and to meaningful integration into the school. *Expanded school mental health* programs explicitly acknowledge that

family engagement is essential and that additional critical elements include empirically supported practice, ongoing quality assessment and improvement, and culturally competent services.

### *School Mental Health Workforce Issues*

Historically, SMH programs and staff (e.g., social workers, psychologists, counselors) often have been considered by educators to be “add ons” (Sedlak, 1997; Paternite, 2004; Paternite & Johnston, 2005; School Mental Health Alliance, 2005). The seeming incompatibility between the “nonacademic” interests of mental health providers and the “academic” interests of educators has resulted, at best, in uneasy cooperation (Staup, 1999). In order for mental health providers and educators to effectively serve students with emotional and behavioral needs and their families, to enable these students to succeed in school, and to successfully promote the interrelated mental health and school success for all students, they must collaborate in the provision of best practices in their fields. To collaborate meaningfully, however, will require re-design of the training and professional preparation of both educators and mental health providers. Maximizing the benefits of SMH programs and services will require professionals skilled in a specific set of competencies that include a strong cross-discipline knowledge, skill, and ability base to guide practice, as well as interdisciplinary communication, collaboration, and consultation skills uniquely demanded of professionals working in our nation’s schools. It is this set of competencies that MHEDIC, and other groups, are seeking to define, operationalize, and bring to the mental health and education workforce.

Integration of the fields of mental health and education, in the context of SMH programs and services, while making intuitive sense, has been problematic both at the training and practice levels. Barriers include limited pre-service and in-service training expectations and curricula,



different and at times confusing credentialing requirements, professional jargon and distinct disciplinary heritages, the continuing perception that mental health and education are distinctly different fields, and a wide range of logistic issues that make collaboration very difficult in everyday practice. In the following, we review two overarching themes most relevant to the improvement of workforce training for mental health providers working in schools. (As mentioned, workforce issues related to education staff are being developed in a complementary report by MHEDIC for the School Mental Health Alliance):

***Theme 1: Interdisciplinary Practice, Effective Collaboration, and Standards of Practice in School Mental Health***

**Interdisciplinary practice and effective collaboration.** Clinical and counseling psychologists, clinical social workers, child and adolescent psychiatrists, and alcohol/drug counselors are generally *not* trained to work effectively in schools or with education professionals. As a result, evidence indicates that this lack is associated with ineffective school-based practice (see Paternite & Johnston, 2005; Waxman, Weist & Benson, 1999), due to poor knowledge and appreciation of school culture and education laws and regulations (e.g., the Individuals with Disabilities Education and Improvement Act), and a failure to integrate mental health issues, needs, and services in school terms. Specifically, in schools terms, the provision of SMH services is best viewed as a means to an end, and not an end in itself. Such services should support the primary educational mission of the schools. That mission takes precedence to health and mental health issues in their own right. Mental health professionals must, but often fail to, recognize that it is the academic and functional implications of their services that are of primary interest to educational professionals. For instance, mental health providers collaborating with educators to develop integrated approaches to reduce both academic and nonacademic (mental

health) barriers to learning often are biased toward measurement of emotional/behavioral outcomes. As a result they seldom consider measuring educational outcomes of *most* interest to school administrators and families (e.g., school attendance, academic performance, school behavior) (see Collaborative for Academic, Social, and Emotional Learning [CASEL], 2003; Roncs & Hoagwood, 2000; Zins, Weissberg, Wang & Walberg, 2004; Weist & Paternite, in press).

An example of attending to the academic and functional implications of SMH services helps to clarify the issue raised above. Within the accountability structure and mandates of *No Child Left Behind*, schools are required to demonstrate adequate yearly progress (AYP) on measures of academic achievement administered to all students, including students receiving special education services. Failure to make AYP places a school in jeopardy of losing its autonomy and its students, who then take with them the state subsidy money when they transfer to a different school. AYP scores of students receiving special education services, as a group, must be presented in disaggregated form, they cannot be folded in with other students. Students with serious emotional disturbances typically qualify for special education services under the emotional disturbances (ED) category of IDEA. Mental health providers can offer "related services" to help these students succeed in school and make AYP. However, approximately 50% of students in the ED category drop out of school, the highest dropout rate of any disability group (U.S. Department of Education, 2001).

Part of the reason for dropout is that these students often require accommodations by classroom teachers who often have little training and/or preparation in how to meet their emotional/behavioral and learning needs, or how to structure appropriate academic environments so that they can learn in the least restrictive environment. Without regular and timely

consultation with appropriately trained mental health providers on *academic issues*, teachers often fail to facilitate meaningful learning for ED-designated students, the students often become behavior problems in the classroom, and the schools, fearful of their AYP standing, look for opportunities to remove these students from the school. Without adequate training in how to help teachers and other school staff accommodate to meet the *learning needs* of these students, SMH providers also will fail to meet the *emotional and behavioral needs* of students whom they are treating. Thus, for effective practice in schools mental health providers should be trained in developmentally appropriate and culturally sensitive learning strategies for students with emotional and behavioral needs.

School psychologists, school social workers and school counselors, should, for many reasons, be leaders in efforts to train other mental health providers on how to work effectively in schools. Their ability to fulfill this role, however, is hampered because of current job roles and responsibilities. For example, in many school districts school psychologists typically spend the majority of their time assessing students' eligibility for special education services rather than providing mental health services to students with emotional and behavioral needs, or implementing prevention and mental health promotion programs. Efforts of school psychology, as a field, to move beyond preparation of professionals for a role that primarily emphasizes assessment have been challenging. In a similar way, school counseling as a field has been struggling to move beyond role definition that emphasizes academic advisement (see Power, DuPaul, Shapiro, & Kazak, 2003; Rappaport, Osher, Garrison, Anderson-Ketchmark, & Dwyer, 2003, Weist, 2003). Thus, assuring that *all* mental health professionals who work in and with schools share a common knowledge base and an equal commitment to the provision of a full continuum of mental health services will require an integrated approach on multiple levels. It

also will require interdisciplinary training opportunities reflecting a shared vision in which the child serving systems and different disciplines work together, actively guided by families, youth and school and community leaders (see Lever et al., 2003).

***Standards of practice.*** Related to the above workforce preparation needs, school mental health staff from diverse disciplines often have different standards of practice. School psychologists and school social workers typically receive licensure or certification to practice in schools, whereas clinical and counseling psychologists and clinical social workers are licensed to practice in the community. In general, certification, licensure, and practice standards across these various professions are not well integrated. For example, community providers can practice in schools under their professional licenses, which do not assure adequate training to work in school settings (see Adelsheim, 2004; Rappaport et al., 2003; Waxman et al., 1999). These differing standards in many cases do not reflect the reality that the functions of various disciplines are blurring together. For example, school psychologists are practicing in community settings; clinical and counseling psychologists are working in schools; and all mental health providers working in schools are increasingly involved in case management and outreach in the community, traditionally the emphasis of social work (Weist, Ambrose, & Lewis, in press). Thus, there is a need for clear standards of practice, which specify common areas of competency and functioning for SMH providers of different disciplines, as well as areas of distinct competency and functioning. These standards then could logically inform and structure a meaningful certification process for mental health practice in the schools.

***Theme 2: Quality Assessment/Improvement and Evidence-Based School Mental Health Practices***

*Quality assessment and improvement in SMH programs and services.* Ongoing quality assessment and improvement (QAI) within SMH programs is essential in order to inform training and guide implementation of findings into school-based mental health service delivery. Unfortunately, training, research, and practice in QAI have been limited in the child and adolescent mental health field, and especially within SMH programs (see Leatherman & McCarthy, 2004; Weist, et al., 2002). In general, the literature describing QAI approaches tends to focus on bureaucratic processes (e.g., credentialing, adherence to paperwork requirements) and/or liability protection (e.g., procedures for handling crises) (Weist et al., 2002). In recent years the importance of QAI in SMH programs has received increased attention, and numerous dimensions of quality have been articulated, including: a) amount and quality of stakeholder input in program development, guidance, and evaluation, b) extent of collaborative relations among families, school staff and community providers, c) range of preventive and treatment services, d) productivity of staff, e) training and supervision of staff, f) coordination and avoidance of duplication of services, g) use of evidence-based interventions, h) use of appropriate evaluation strategies, i) use of evaluation findings to continuously improve programs and services, and j) use of evaluation findings to broaden awareness of and support for school mental health efforts (see Ambrose, Weist, Schaeffer, Nabors, & Hill, 2002; Evans, Sapia, Axelrod, & Glomb, 2002; Lever, et al., 2003; Nabors, Lehmkuhl, & Weist, 2003).

With support from the Agency for Healthcare Research and Quality, and the National Institute of Mental Health, Weist and colleagues have developed an expanded version of a school mental health report card—the School Mental Health, Quality Assessment Questionnaire (SMHQAQ, see Weist et al., 2005). The research-based SMHQAQ is being used in a randomized controlled study of QAI with SMH staff from programs in three states (Delaware,

Maryland, and Texas). Participants focus either on systematic QAI or enhancement of personal wellness. In the QAI intervention, clinicians working in small groups strive toward indicators of best practice. They share ideas, provide mutual support to each other, and receive ongoing training in cognitive behavioral skills during weekly team meetings guided by experienced clinicians. Many of the QAI indicators in the SMHQAQ focus on evidence-based practice, and the intent of the QAI intervention is to provide meaningful and manageable training and support to clinicians in their efforts to evaluate and improve the quality of services, with emphasis on empirically supported practices.

The pursuit of common principles and indicators for best practice helps to structure the independent variable of *school mental health* as a template for training and for effective practice. This has important implications for developing a *training—research—services—policy agenda* in SMH. This agenda contrasts with SMH research, reflected in much of the published literature, which focuses either on very specific interventions for highly select, narrowly defined problems (see Rones & Hoagwood, 2000) or very broad-scale preventive interventions (see Botvin, 2000; Durlak & Wells, 1997, 1998). The need to expand and improve training and research on everyday SMH services is supported by recent studies documenting the importance of program adherence to system of care principles in promoting improved behavioral outcomes for youth (Stephen, Holden, & Hernandez, 2004).

***Evidence-based SMH practices.*** Although there is a growing evidence base of what works in SMH, there is also evidence that SMH staff generally are not being trained in or implementing evidence-based practices (EBPs). Further, few receive training, ongoing pragmatic support, and user-friendly resources for adaptation strategies and processes that often are necessary to implement effective practices in school settings given the operating realities in those

settings (see Flaspohler, Anderson-Butcher, Paternite, Weist, & Wandersman, in press; Graczyk, Domitrovich, & Zins, 2003; Jensen, Hoagwood & Trickett, 1999; Rones & Hoagwood, 2000; Schoenwald & Hoagwood, 2001; Weist & Paternite, in press). A major factor contributing to this lack of preparation is that the credentialing processes for child and adolescent mental health professions, including psychology (school, clinical and counseling), social work, professional counseling, and child and adolescent psychiatry, do NOT require training in evidence-based practices and principles, nor do they require sufficient attention to the contexts (e.g., schools) in which mental health interventions are practiced. For example, Shernoff, Kratochwill, and Stoiber (2003) documented the inadequate attention to and training in evidence-based practices in school psychology graduate programs. This is a serious matter that is due, in part, to funding issues (i.e., accrediting bodies would lose substantial income if many training programs became ineligible). For these and other reasons, therefore, it is imperative that the public participates in the dialogue about mental health workforce training in general, and in discussions about mental health practice in schools, in particular. Clearly, there is a strong need for well linked connections between enhanced undergraduate education, graduate education, post graduate education, and on the job training in evidence-based practices as applied in schools. There also is a salient need for enhanced infrastructure to support SMH staff as they strive to implement effective practices in schools.

Importantly, the SMH workforce must have firm abilities with and commitment to services that are individualized in a manner that demonstrates support and respect for family and cultural values (Simpson et al., 2001). In addition, providers must be aware of how their own family and cultural values influence their beliefs about *normal* development and how families *should* raise children and adolescents. By forming a strong alliance with the child or adolescent's

family, the mental health provider can understand how families demonstrate warmth, sensitivity, and guidance in ways that might be different than the mainstream culture. Thus, significant attention to cultural competence is essential to adequately prepare mental health professionals who work in schools.

With reference to workforce preparation in culturally competent, best practice principles and processes, it is important to acknowledge that the SMH field has not done well in addressing transitions into and out of elementary and secondary schools. The need for early childhood mental health services and the importance of early intervention with this population are well supported in the literature (e.g., Bricker, Davis & Squires, 2004; Knitzer, 2000; Weatherston, 2005). While knowledge of the positive impacts of daycare and other preschool programs such as Head Start as effective venues for promoting mental health in very young children is growing (Knitzer, 2000; Kunesh & Farley, 1994; Melville & Blank, 1991; Svanberg, 1998; Simpson, Jivanjee, Koroloff, Doerfler & Garcia, 2001), there is limited literature and attention to the ways in which such knowledge should inform K-12<sup>th</sup> grade SMH programs and services. Similarly, although there are a few helpful programs in post secondary institutions that can help late adolescents transition from high school, in general, this is an area in need of substantial attention in SMH programs (Gallagher, 2002; Taylor, 2002).

From a workforce training perspective, greater emphasis is needed on helping school-based mental health professionals meet the mental health needs of pre-school and post high school youth in transition. It is incumbent upon SMH staff to apply best practice principles of early childhood mental health services. Commitment to and competence in the practice of these principles is essential to effective mental health promotion, problem prevention, early identification, and treatment in these critical early years (and through childhood and



adolescence). Such interventions must be family centered and characterized by a strong partnership between the provider and the family (Edelman, 2004; Simpson et al., 2001; Weatherston, 2001). The family should be an active and equal partner in identifying needs, setting goals and implementing interventions (e.g., Bricker et al., 2004). In addition, interventions delivered in natural environments (e.g., home, daycare, preschool, park, grocery store) are becoming the standard of care (Edelman, 2004).

### **Section III: Recommended Intervention for the National Strategic Plan**

Based on the themes discussed above, we offer the following workforce training recommendations for mental health providers who are likely to work in and/or with schools.

#### ***Recommendations***

The expert panel strongly suggests the development and implementation of a sequential and iterative School Mental Health (SMH) workforce training strategy that includes five specific recommendations:

- 1) Systematically identify and validate the core competencies for school mental health providers, and develop clear standards for SMH practice specifying common and distinct functioning for SMH providers of various disciplines;
- 2) Design training curricula, methods, and experiences for developing these critical competencies of SMH mental health providers;
- 3) Implement, strategically pilot test, and evaluate the curricula, methods, and experiences, within the context of model community—school partnerships that serve as *real world laboratories*;
- 4) Develop a common certification process and mechanism for *Mental Health Practice in Schools*, which requires mastery of the core competencies;

- 5) Use findings from the SMH training initiative to influence university-based mental health training programs and accreditation.

### ***Goal Addressed With these Recommendations***

The goal is to create and sustain a workforce that can facilitate *improvement and expansion of school mental health programs and services* (cf. President's New Freedom Commission, 2003), to effectively serve children and adolescents with mental health needs and their families, to enable these students to succeed in school, and to successfully promote the interrelated mental health and school success for all youth.

### ***Proposed Intervention***

**Recommendations 1 and 2.** The first two recommendations involve definition of the core competencies for effective mental health practice in the schools and development of the content and strategies for teaching the competencies. The competencies should be based on a clear understanding and articulation of standards of practice that delineate common and distinct areas of functioning for the variety of mental health providers who work in schools. At a minimum, the common core competencies for all SMH providers should include:

- ✓ well-developed cross-discipline knowledge, skills, and abilities to guide practice in schools;
- ✓ clear understanding of the background, training, professional identity, and professional standards (e.g., ethical, confidentiality, consent) of the other disciplines;
- ✓ strong interdisciplinary and jargon free communication, collaboration, and consultation skills and abilities uniquely demanded of professionals working in our nation's schools;

- ✓ firm understanding and appreciation of school culture and education laws and regulations, and related skills and abilities to integrate mental health issues, needs, and services in school terms;
- ✓ strong abilities to engage in and promote ongoing quality assessment/improvement and effective (best practice) school mental health services, that reflect and are responsive to the operating realities of schools; and
- ✓ well-developed skills, abilities, and commitment to demonstrate support and respect for family and cultural values in all SMH practices.

A more elaborated example of a preliminary set of common core competencies for mental health practice in schools has been compiled by MHEDIC colleagues working with four SMH research, training, and technical assistance Centers (see Appendix C).

Work undertaken by MHEDIC thus far (see Section II) suggests that there are substantial unmet training needs of most current SMH providers and educators. In this regard, there are many important questions that can be addressed once SMH competencies and teaching methods are defined. For example, it will be important to examine: a) the perceived value of these competencies by a variety of professional groups, parent advocacy organizations, and other community partners; b) the extent to which these competencies exist for SMH providers from various disciplines currently practicing; c) the degree to which, and ways in which, the competencies are addressed in university training programs and in continuing education; and d) costs and benefits to SMH programs that differ in the degree to which staff demonstrate the core competencies.

MHEDIC, through its connection to numerous state and national partners, is undertaking systematic study and development of training approaches addressing core competencies in SMH.

Work already undertaken by the Annapolis Coalition is highly relevant to this effort, and provides an invaluable foundation for targeted focus on the SMH workforce. For example, the Annapolis Coalition's cogently distilled summary of best practice principles in behavioral health workforce education and training is an invaluable resource (Hoge, Huey, & O'Connell, 2004).

**Recommendation 3.** The third recommendation involves implementation, pilot testing, and evaluation of SMH workforce training curricula, methods, and experiences. For this work model partnerships (e.g., community mental health center and a school building/district) should be established that include community and school mental health professionals who are being trained in the core competencies of SMH and working together with families and teachers for the benefit of children. These model partnership sites should be strategically selected to reflect diverse economic, racial, and ethnic contexts, and they should serve as *real world laboratories* for: a) development or enhancement of partnerships with local universities; b) comparison and refinement of training procedures to identify the most efficient and effective methods for SMH workforce training; c) examination of benefits to children and adolescents, of professionals having mastered core competencies; d) examination of new models of enhanced interdisciplinary mental health services; and e) documentation of challenges to and benefits of meaningful across-systems collaboration.

**Recommendations 4 and 5.** The fourth and fifth recommendations involve developing certification for *Mental Health Practice in Schools* and influencing university-based mental health training programs and accreditation. The lessons learned through field-testing in conjunction with recommendation 3 should provide a basis for developing a certification process and mechanism, in partnership with university training programs. University curricula should be modified to facilitate certification in specialty programs that are preparing mental health

professionals, to indicate completion of training in the school mental health competencies. In-service training programs for professionals already in the field should be developed or modified to ensure a coordinated set of educational experiences that take advantage of workshops, seminars, on-line courses, and on the job supervision and coaching. Expansion of “train the trainers” approaches also should be prioritized.

Ultimately, to promote the development of an effective SMH workforce through implementation of recommendations 1 through 5, and to promote improved and expanded SMH practices, there is a need for a substantial interconnected policy—training—practice—research agenda, with key elements described in Figure 1 (see Kratochwill, Albers, & Shernoff, 2004; Lever et al., 2003; Weist et al., 2005; Weist, in press; Weist & Paternite, in press). To achieve desired outcomes for students, effective mental health promotion through intervention services are needed. To ensure effective SMH practices, a critical quality assessment and improvement (QAI) agenda must be undertaken, which subsumes delivery of culturally competent evidence-based practices that are reflective of strong family and community engagement. Service delivery infrastructures that reflect effective communication, strong collaboration, and meaningful training underpin the successful development and implementation of such services. Policies to promote effective SMH practices must be based on a clear understanding of the current status and needs of the field and must inform strategic planning. Such policies and planning are needed to ensure adequate resources (new and reallocated) that are foundational to advancement of the field. Resources must be allocated judiciously to support well-coordinated, non-duplicative SMH services that reflect a common agenda for families and other stakeholders in child serving systems (education, mental health, health, child welfare and juvenile justice). These key elements reflect SMH as a cornerstone in the development of a *public mental health promotion* system in

the U.S., emphasizing more preventive services for children and youth “where they are” and consistent with positive experiences occurring in other nations (see Rowling & Weist, 2004; Weist, in press).

### ***Likely Impact on Consumers, Family Members, the Workforce, and Delivery Systems***

As noted previously in Section II, SMH programs and services, *when done well*, are associated with strong satisfaction by diverse stakeholder groups, improvement in student emotional and behavioral functioning, and improvements in school outcomes; for example, enhanced climate and student connectedness to school, improved attendance, fewer inappropriate referrals into special education, reduced bullying and violence, and reduced school suspensions (see Atkins et al, 2003; Evans et al., in press; Owens et al., in press; Weist et al., 2005; Weist & Paternite, in press).

### ***Obstacles and Change Strategies***

Many of the obstacles described in detail by the Annapolis Coalition to moving an evidence-based workforce strategic plan forward apply to these SMH workforce recommendations. A vital additional challenge for the SMH field in general, and for moving a workforce strategy forward, involves effectively answering the question “Why integrate mental health programs and services into schools?” For example, school leaders might resist an agenda to expand attention to mental health issues in schools, based on a conviction that schools are not in the *mental health business*. Relatedly, schools might be concerned about assuming excessive responsibility for students’ emotional and behavioral problems. This concern, which directly contributes to reticence to take on a mental health agenda can be related to a number of factors, including stigma and/or poor understanding of mental health issues, insufficient appreciation of the critical links between mental health and school success, the lack of precedent in a school for

focusing on the reduction of academic and non-academic barriers to learning, and the lack of a true shared agenda in which families, schools and other community agencies and programs work collaboratively and share resources in advancing SMH programs and services (see Weist & Paternite, in press). Change strategies for enhanced SMH workforce development, and for improvement and expansion of SMH programs and services, are emerging at all levels through the efforts of partners described below.

### ***Potential Partners and Available Materials, Resources, and Successful Models***

Building on the supportive and influential reports and recommendations noted in Section II (page 4), many partners are emerging. Recent federal investments in SMH provide opportunities for heightened commitment to a meaningful workforce training strategy. This support includes: a) two HRSA- and SAMSHA-funded national school mental health policy analysis centers at the University of Maryland (Center for School Mental Health Analysis and Action, [www.csmha.umaryland.edu](http://www.csmha.umaryland.edu)) and at UCLA (Center for Mental Health in Schools, [www.smhp.psych.ucla.edu](http://www.smhp.psych.ucla.edu)); b) the National Mental Health Promotion and Violence Prevention Center funded by SAMHSA; c) research and training centers for children's mental health at the University of South Florida, Georgetown University and Portland State University funded by SAMHSA, the Department of Education, and the Administration for Children and Families; d) special education resource and training centers addressing Positive Behavior Intervention and Support, Children with Disabilities, and Collaboration and Effective Practice, funded by OSEP; e) the Mental Health—Schools—Families Shared Agenda Initiative (2002) and the IDEA Partnership of the U.S. Department of Education, Office for special Education Programs; f) the Coordinated School Health Program of the CDC, and g) the Safe Schools/Healthy Students and Violence Prevention Initiatives involving a consortium of federal agencies, and coordinated by

SAMHSA (see Anglin, 2003). Additional federal investments in SMH have been made through: a) the Child and Adolescent Service System Program of SAMHSA; b) the Maternal and Child Health Block Grants of HRSA; c) the Mental Health Block Grants of SAMHSA (e.g., in Ohio block grant funds are partially supporting the work of the Ohio Mental Health Network for School Success); d) the Title IV Safe and Drug-Free Schools Programs; and e) research programs of these federal agencies and National Institute of Mental Health (NIMH), National Institute of Child and Human Development (NICHD) and the National Institute of Justice (any omission of federal support in this list is unintended).

Workforce issues are beginning to be prioritized within the context of SMH policy advocacy, service-delivery, and technical assistance that are emerging in some U.S. cities (e.g., Baltimore, Dallas, Los Angeles, Memphis) and states (e.g., Hawaii, Maryland, New York, New Mexico, Ohio, South Carolina). Collaborative SMH networks and training initiatives also have developed at state, national and international levels (e.g., Ohio Mental Health Network for School Success, [www.units.muohio.edu/csbnhp/network.html](http://www.units.muohio.edu/csbnhp/network.html); New Mexico School Mental Health Initiative, [www.nmsmhi.org](http://www.nmsmhi.org); Mental Health—Education Integration Consortium (<http://www.units.muohio.edu/csbnhp/mhedic/index.html>); Collaborative for Academic, Social and Emotional Learning, [www.casel.org](http://www.casel.org); IDEA Partnership, [www.ideapartnership.org](http://www.ideapartnership.org); School Mental Health Alliance, [www.kidsmentalhealth.org](http://www.kidsmentalhealth.org); and the International Alliance for Child and Adolescent Mental Health and Schools, [www.intercamhs.org](http://www.intercamhs.org)).

A growing collaboration between the IDEA Partnership and the Center for School Mental Health Analysis and Action (CSMHA) also is encouraging. In October, 2004 they co-sponsored a meeting of over 60 national organizations representing families, schools and other community systems to move through discussion and action toward the development of a national community



of practice in school mental health (Wenger, 1998; Wenger, McDermott, & Snyder, 2002). The group reached consensus on building this community, as well as plans for mobilizing Practice Groups—with one of the groups to focus explicitly on SMH workforce issues (MHEDIC is facilitating the workforce Practice Group). The national Community of Practice, and its specific Practice Groups, are envisioned as vehicles to enable active communication, the exchange of ideas, collaboration in grant seeking and programming, and the development of “multi-scale learning loops” between and among experiences occurring at national, state and local levels. The progress of the community is being tracked by the IDEA Partnership ([www.ideapartnership.org](http://www.ideapartnership.org)).

Finally, the recently awarded planning grants to states and local education systems from the U.S. Department of Education (Office of Safe and Drug Free Schools) to integrate schools and mental health systems is particularly noteworthy and encouraging. Such planning grants can provide important opportunities to carefully study and develop plans for workforce development and service delivery on both state and local levels.

### ***Resources Needed***

School mental health is an emerging field with challenges being confronted at many levels, and actions to advance a workforce development strategic plan are inextricably linked to many other actions. Adequate resources (new and reallocated) are foundational to developing and sustaining a competent workforce and to effective SMH practices (see Figure 1).

With specific reference to the SMH workforce training strategy proposed in this report, overarching funding support is needed to expand and sustain networking among individuals and organizations committed to enhance SMH workforce preparation. In addition, funding support is needed to implement and sustain **each** of the five recommendations. For example, with reference to recommendations 1 and 2 infrastructure and personnel investments will be necessary to

identify and validate core competencies and to develop and adapt training methods and experiences. Developing and sustaining model community-school partnerships (recommendation 3), which will serve as essential *real world laboratories* for workforce training, will require funding support to insure dedicated time investment of a broad range of stakeholders and to engage in ongoing quality assessment and improvement of the partnerships' workforce training efforts. In addition, achieving recommendations 4 and 5, focused on certification and changes in university-based training and accreditation, will require substantial resource investments in dissemination of findings to policy makers at all levels and in building and sustaining strong collaborative relationships with universities, professional organizations, and accrediting bodies.

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### ***Information About the Forum in Which Recommendations Were Developed***

The recommendations and the framework for this report were developed by MHEDIC, as described in Section 1 and Appendix A. The report was written primarily by Carl E. Paternite and Mark Weist. All MHEDIC members provided input for the earlier draft version and for this finalized draft report. In addition, MHEDIC members Steve Evans, Julie Owens, Ed Morris, and Marcia Rubin contributed substantially to the writing.

## Reference List

- Adelman, H. S., & Taylor, L. (1999). Mental health in schools and system restructuring. *Clinical Psychology Review, 19*, 137-163.
- Adelman, H. S., & Taylor, L. (2000). Promoting mental health in schools in the midst of school reform. *Journal of School Health, 70*, 171-178.
- Adelsheim, S. (2004). *Recommendations to improve child and adolescent and school mental health*. Unpublished manuscript.
- Adelsheim, S. Jennings, J., & Weist, M.D. (2002, September). *The school mental health imperative*. Presentation to the President's New Freedom Commission on Mental Health. Chicago.
- Ambrose, M. G., Weist, M. D., Schaeffer, C., Nabors, L. A., & Hill, S. (2002). Evaluation and quality improvement in school mental health. In H. Ghuman, M. D. Weist, & R. Sarles (Eds.), *Providing mental health services to youth where they are: School- and community-based approaches* (pp. 95 - 110). New York: Brunner-Routledge.
- Anglin, T. M. (2003). Mental health in schools: Programs of the federal government. In M. D. Weist, S. Evans, & N. Tashman (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 89-106). New York: Kluwer Academic/Plenum Publishers.
- Atkins, M., Adil, J., Jackson, M., McKay, M., & Bell, C. (2001). *An ecological model for school-based mental health services*. 13th Annual Conference Proceedings: A System of Care for Children's Mental Health: Expanding the Research Base. Tampa: University of South Florida.
- Atkins, M., S., Frazier, S. L., , Adil, J. A., & Talbott, E. (2003) School-based mental health services in urban communities. In M. Weist, S. Evans, & N. Tashman (Eds.), *School mental health handbook*. (pp. 165-178). New York: Kluwer Academic/Plenum Publishers.
- Atkins, M.S., Graczyk, P. A., Frazier, S. L., & Abdul-Adil, J. (2003). Toward a new model for promoting urban children's mental health: Accessible, effective, and sustainable school-based mental health services, *School Psychology Review, 32*, 503-514.
- Bishop, J. H., Bishop, M., Bishop, M., Gelbwasser, L., Green, S., Peterson, E., Rubinsztaj, A., & Zuckerman, A. (2004). Why we harass nerds and freaks: A formal theory of student culture and norms. *Journal of School Health, 74*, 235-251.
- Botvin, G. J. (2000). Preventing drug abuse in schools: Social and competence enhancement approaches targeting individual-level etiologic factors. *Addictive Behaviors, 25*(6), 887-897.
- Bricker, D., Davis, M. S., & Squires, J. (2004). Mental health screening in young children. *Infants & Young Children: An Interdisciplinary Journal of Special Care Practices, 17*(2), 129-144.
- Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E., et al. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*, 147-159.
- Catalano, R. F., Haggerty, K. P., Oesterle, S., Fleming, C. B. & Hawkins, J. D. (2004). The importance of bonding to school for health development: Findings from the Social Development Research Group. *Journal of School Health, 74*, 252-261.

- Collaborative for Academic, Social, and Emotional Learning (2003). *Safe and Sound: An educational leader's guide to evidence-based social and emotional learning (SEL) programs*. Chicago, IL: Author.
- Committee on School Health (2004). School-based mental health services. *Pediatrics*, *113*, 1839-1845.
- Durlak, J.A., & Wells, A.M. (1997). Primary prevention mental health programs for children and adolescents. *American Journal of Community Psychology*, *25*, 115-152.
- Durlak, J.A., & Wells, A.M. (1998). Evaluation of indicated preventive interventions (secondary prevention) mental health programs for children and adolescents. *American Journal of Community Psychology*, *26*, 775-802.
- Edelman, L. (2004). Principles & strategies for family-centered home-based services. *Resources and Connections*, *3*(1), Retrieved August 1, 2005, from <http://www.cde.state.co.us/earlychildhoodconnections/Technical.htm>
- Elias, M. J., Gager, P., & Leon, S. (1997). Spreading a warm blanket of prevention over all children: Guidelines for selecting substance abuse and related prevention curricula for use in the schools. *Journal of Primary Prevention*, *18*, 41-69.
- Evans, S. W. (1999). Mental health services in schools: Utilization, effectiveness and consent. *Clinical Psychology Review*, *19*, 165-178.
- Evans, S. W., Sapia, J. L., Axelrod, J., & Glomb, N. K. (2002). Practical issues in school mental health: Referral procedures, negotiating special education, and confidentiality. In H. Ghuman, M. Weist, & R. Sarles (Eds.), *Providing mental health services to youth where they are* (pp. 75-94). New York: Brunner-Routledge.
- Evans, S. W., Langberg, J., Raggi, V., Allen, J., & Buvinger, E. (in press). Development of school-based treatment program for middle school youth with ADHD. *Journal of Attention Disorders*.
- Flaherty, L. T., & Osher, D. (2003). History of school-based mental health services. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 11-22). New York: Kluwer Academic/Plenum Publishers.
- Flaherty, L. T., & Weist, M. D. (1999). School-based mental health services: The Baltimore models. *Psychology in the Schools*, *36*, 379-389.
- Flaspohler, P., Anderson-Butcher, D. A., Paternite, C. E., Weist, M. D., & Wandersman, A. (in press). Community science and expanded school mental health: Bridging the research to practice gap to promote child well being and academic success. *Journal of Educational and Child Psychology*.
- Gallagher, R.P. (2002). *National Survey of Counseling Center Directors*. Alexandria, VA: International Association of Counseling Services.
- Goodman, S. H., Lahey, B. B., Fielding, B., Duncan, M., Narrow, W., & Rigor, D. (1997). Representatives of clinical samples of youths with mental disorders: A preliminary population-based study. *Journal of Abnormal Psychology*, *106*, 3-14.
- Graczyk, P. A., Domitrovich, C. E., & Zins, J. E. (2003). Facilitating the implementation of evidence-based prevention and mental health promotion efforts on schools. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health programs: Advancing practice and research*. (pp. 301-318). New York: Kluwer Academic/Plenum Publisher.

- Grunbaum, J. A., Kann, L., Kinchen, S., Ross, J., Hawkins, J., Lowry, R., et al. (2004). Youth risk behavior surveillance - United States, 2003. *Morbidity and Mortality Weekly Report*, 53, 1-95.
- Han, S. S., Catron, T., Weiss, B., & Marciel, K. K. (in press). A teacher-consultation approach to social skills training for pre-Kindergarten children: Treatment model and short-term outcome effects. *Journal of Abnormal Child Psychology*.
- Hoge, M.A., Huey, L.Y. & O'Connell, M.J. (2004). Best practices in behavioral health workforce education and training. *Administration and Policy in Mental Health*, 32, 91-106.
- Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S., et al. (2005). Transforming mental health care for children and their families. *American Psychologist*, 60, 615-627.
- Jensen, P. S., Hoagwood, K., & Trickett, E. J. (1999). Ivory towers or earthen trenches? Community collaboration to foster real-world research. *Applied Developmental Science*, 3, 206-212.
- Klern, A. M., & Connell, J. P. (2004). Relationships matter: Linking teacher support to student engagement and achievement. *Journal of School Health*, 74, 262-273.
- Knitzer, J. (2000). Early childhood mental health services: A policy and systems development perspective. *Handbook of early childhood intervention (2nd ed.)*. (pp. 416-438) Cambridge University Press, New York, NY, US.
- Kratochwill, T. R., Albers, C. A., & Shernoff, E. S. (2004). School-based interventions. *Child and Adolescent Psychiatric Clinics of North America*, 13, 885-903.
- Kunesh, L. G., & Farley, J. (1994). *Collaboration: The prerequisite for school readiness and success*. Champaign, IL: Clearinghouse on Elementary and Early Childhood Education, University of Illinois at Urbana-Champaign.
- Leaf, P. J., Alegria, M., Cohen, P., Goodman, S. H., Horwitz, S. M., Hoven, C. W., et al. (1996). Mental health services use in the community and schools: Results from the four-community MECA study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35, 889-897.
- Leatherman, S., & McCarthy, D. (2004). *Quality of healthcare for children and adolescents: A chartbook*. New York: The Commonwealth Fund ([www.cmwf.org](http://www.cmwf.org)).
- Lever, N. A., Adelsheim, S., Prodent, C., Christodulu, K. V., Ambrose, M. G., Schlitt, J., et al. (2003). System, agency and stakeholder collaboration to advance mental health programs in schools. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 149-162). New York: Kluwer Academic/Plenum Publishers.
- Libbey, H. P. (2004). Measuring student relationships to school: Attachment, bonding, connectedness, and engagement. *Journal of School Health*, 74, 274-283.
- Marsh, D. (2004). Serious emotional disturbance in children and adolescents: Opportunities and challenges for psychologists. *Professional Psychology: Research and Practice*, 35, 443-448.
- Masia-Warner, C., Klein, R. G., Dent, H. C., Fisher, P. H., Alvir, J., Albano, A. M., et al. (in press). School-based intervention for adolescents with social anxiety disorder. *Journal of Abnormal Child Psychology*.
- McNeely, C. & Falci, C. (2004). School connectedness and the transition into and out of health-risk behavior among adolescents: A comparison of social belonging and teacher support.

- Journal of School Health*, 74, 284-292.
- Melaville, A. I., & Blank, M. J. (1991). *What it takes: Structuring interagency partnerships to connect children and families to comprehensive services*. Washington, DC: Education and Human Services Consortium.
- Nabors, L. A., Lehmkuhl, H. D., & Weist, M. D. (2003). Continuous quality improvement and evaluation of expanded school mental health programs. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 275-284). New York: Kluwer Academic/Plenum Publishers.
- Nabors, L. A., & Reynolds, M. W. (2000). Program evaluation activities: Outcomes related to treatment for adolescents receiving school-based mental health services. *Children's Services: Social Policy, Research, and Practice*, 3, 175-189.
- Nabors, L. A., Reynolds, M. W., & Weist, M. D. (2000). Qualitative evaluation of a high school mental health program. *Journal of Youth and Adolescence*, 29, 1-14.
- National Institute of Mental Health (2001). *Blueprint for change: Research on child and adolescent mental health, a report of the National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health Intervention and Deployment*. Rockville, MD: Author.
- Owens, J. S., Richerson, L., Beilstein, E. A., Crane, A., Murphy, C. E., & Vancouver, J. B. (in press). School-Based Mental Health Programming for Children with Inattentive and Disruptive Behavior Problems: First Year Treatment Outcome. *Journal of Attention Disorders*.
- Paternite, C. E. (2004). Involving educators in school-based mental health programs. In K. E. Robinson (Ed.), *School-based mental health: Best practices and program models* (pp. 6-1 – 6-21). Kingston, NJ: Research Institute, Inc.
- Paternite, C. E., & Johnston, T. C. (2005). Rational and strategies for central involvement of educators in effective school-based mental health programs. *Journal of Youth and Adolescence*, 34, 41-49.
- Paternite, C. E., Weist, M. D., Burke, R., & Flaspohler, P. (2005). School-based mental health programs and services in the United States: Current status and future directions. Submitted for publication.
- Power, T. J., DuPaul, G. J., Shapiro, E. S., & Kazak, A. E. (2003). *Promoting children's health: Integrating school, family, and community*. New York: The Guilford Press.
- President's New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report for the President's New Freedom Commission on Mental Health (SMA Publication No. 03-3832)*. Rockville, MD: Author.
- Rappaport, N., Osher, D., Garrison, E. G., Anderson-Ketchmark, C., & Dwyer, K. (2003). Enhancing collaboration within and across disciplines to advance mental health programs in schools. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health programs: Advancing practice and research* (pp. 107-118). New York: Kluwer Academic/Plenum Publishers.
- Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review*, 3, 223-241.
- Rowling, L., & Weist, M. D. (2004). Promoting the growth, improvement and sustainability of school mental health programs worldwide. *International Journal of Mental Health Promotion*, 6(2), 3-11.

- Schoenwald, S. K. & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? *Psychiatric Services*, 52, 1190-1197.
- School Mental Health Alliance (2005). *Working together to promote learning, social-emotional competence and mental health for all children*. New York: Author (Columbia University Center for the Advancement of Children's Mental Health, [www.kidsmentalhealth.org](http://www.kidsmentalhealth.org)). Accessed March 13, 2005.
- Sedlak, M. W. (1997). The uneasy alliance of mental health services and the school: An historical perspective. *American Journal of Orthopsychiatry*, 67, 349-362.
- Shernoff, E. S., Kratochwill, T. R., & Stoiber, K. C. (2003). Training in evidence-based interventions (EBIs): What are school psychology programs teaching? *Journal of School Psychology*, 41, 467-483.
- Simpson, J. S., Jivanjee, P., Koroloff, N., Doerfler, A., & Garcia, M. (2001). *Promising practices in early childhood mental health. Systems of care: Promising practices in children's mental health, 2001 series, volume III*. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.
- Staup, J. (1999, September). *The integration of mental health and education systems*. Workshop presented at the Fourth National Conference on Advancing School-Based Mental Health Programs. Denver, CO.
- Stephen, R.L., Holden, E.W. & Hernandez, M. (2004). System-of-care practice review scores as predictors of behavioral symptomatology and functional impairment. *Journal of Child and Family Studies*, 13, 179-191.
- Stormshak, E. A., Dishion, T. J., Light, J., & Yasui, M. (in press). Implementing family-centered interventions with the public middle school: Linking service delivery to change in student problem behavior. *Journal of Abnormal Child Psychology*.
- Svanberg, P. O. G. (1998). Attachment, resilience and prevention. *Journal of Mental Health (UK)*, 7(6), 543-578.
- Taylor, S.S. (September 2, 2002). Mental cases? *Community College Week*, 6-8.
- U.S. Department of Education, Office of Special Education Programs (2002). *Mental health, schools and families working together for all children and youth: Toward a shared agenda—A concept paper*. Washington, DC: Author. Available at: [www.nasdse.org/sharedagenda.pdf](http://www.nasdse.org/sharedagenda.pdf); [www.nasmhpd.org](http://www.nasmhpd.org). Accessed December 31, 2004.
- U.S. Department of Education, Office of Special Education Program (2001). *Twenty-third Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act: Results*. Washington, DC: Author.
- U.S. Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General- Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health.
- U.S. Department of Health and Human Services (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health.
- U.S. Department of Health and Human Services (2001). *Youth violence: A report of the Surgeon General*. Washington, DC: Author.



- Waxman, R. P., Weist, M. D., & Benson, D., M. (1999). Toward collaboration in the growing education-mental health interface. *Clinical Psychology Review, 19*, 239-253.
- Weare, K. (2000). *Promoting mental, emotional and social health: A whole school approach*. London: Routledge.
- Weatherston, D. J. (2005). Returning the treasure to babies: An introduction to infant mental health service and training. *The handbook of training and practice in infant and preschool mental health*. (pp. 3-30). Jossey-Bass, San Francisco, CA, US.
- Weatherston, D. J. (2001). Infant mental health: A review of relevant literature. *Psychoanalytic Social Work, 8*(1), 39-69.
- Weist, M. D. (1997). Expanded school mental health services: A national movement in progress. In T. Ollendick & R. J. Prinz (Eds.), *Advanced in Clinical Child Psychology* (Vol. 19, pp. 319-352). New York: Plenum Press.
- Weist, M.D. (2003). Promoting paradigmatic change in child and adolescent mental health and schools. *School Psychology Review, 32*, 336-341.
- Weist, M. D. (in press). Fulfilling the many promises of school-based mental health: Moving toward a public mental health promotion approach. *Journal of Abnormal Child Psychology*.
- Weist, M.D., Ambrose, M., & Lewis, C. (in press). Expanded school mental health: A collaborative community/school example. *Children & Schools*.
- Weist, M. D., Evans, S. W., & Lever, N. A. (Eds.). (2003). *Handbook of school mental health: Advancing practice and research*. New York: Kluwer Academic/Plenum Publishers.
- Weist, M. D., Myers, C. P., Hastings, E., Ghuman, H., & Han, Y. (1999). Psychosocial functioning of youth receiving mental health services in the schools vs. community mental health centers. *Community Mental Health Journal, 35*, 69-81.
- Weist, M.D. & Paternite, C.E. (in press). Building an interconnected policy-training-practice-research agenda to advance school mental health. *Education and Treatment of Children*.
- Weist, M.D., Paternite, C., & Adelsheim, S. (2005). *School based mental health services*. Report to the Institute of Medicine, Board on Health Care Services, Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders Committee.
- Weist, M. D., Sander, M. A., Lever, N. A., Link, B., Christodulu, K. V., Rosner, L. E., et al. (2002). Advancing the quality agenda in expanded school mental health. *Emotional & Behavioral Disorders in Youth, 2*, 59-70.
- Weist, M. D., Sander, M. A., Walrath, C., Link, B., Nabors, L., Adelsheim, S., et al. (2005). Developing principles for best practice in expanded school mental health. *Journal of Youth and Adolescence, 34*, 7-13.
- Weisz, J. (2004). *Psychotherapy for children and adolescents: Evidence-based treatments and case examples*. New York: Cambridge University Press.
- Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity*. New York: Cambridge University Press.
- Wenger, E., McDermott, R., & Snyder, W. M., (2002). *Cultivating communities of practice: A guide to managing knowledge*. Boston: Harvard Business School Press.
- Wilson, D. (2004). The interface of school climate and school connectedness and relationships with aggression and victimization. *Journal of School Health, 74*, 293-299.
- Zins, J. E., Weissberg, R. P., Wang, M. C., & Walberg, H. J. (Eds.). (2004). *Building academic success on social and emotional learning: What does the research say?* New York: Teachers College Press.

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## Appendix B

### MHEDIC Vita

#### Representative International Presentations

Axelrod, J., Burke, B., Cashman, J., Koller, J., Morris, E., Paternite, C., Rietz, K., & Weist, M.D. (2005, April) *Mental health-education integration in schools in the United States*. Poster presented at the Third World Conference on Mental Health Promotion, Dublin, Ireland.

Paternite, C., & Weist, M.D. (2005, April). *Strengthening partnerships for school mental health in the United States*. Paper presented at the Third World Conference on Mental Health Promotion, Dublin, Ireland.

#### Representative National Presentations

Koller, J. (2005, September). *Assisting Those in Need: Helping Qualified Candidates Secure GED Test Accommodations*. Invited keynote address at the 2005 Annual Arkansas State Department of Education, Little Rock, AK.

Paternite, C.E., & Weist, M.D. (2005, September). *School mental health workforce issues*. Presentation to the Annapolis Coalition on the Behavioral Health Workforce, Annapolis, MD.

Weist, M.D., Cashman, J., Paternite, C.E., Rietz, K., Gruttadaro, D., & Dodge, J. (2005, September). *Expanding partnerships in systems of care: Education, mental health and families working together*. National Technical Assistance Center for Children's Mental Health Conference Call Series, Washington, DC.

Weist, M.D. (2005, September). *Building Hawaii's position of leadership in the school mental health movement*. Plenary presentation at a statewide meeting convened by the IDEA Partnership and the Hawaii Department of Education, Honolulu, HI.

The National Conference of State Legislatures Annual Meeting, State Stories: "Value Added" through Communities of Practice. August, 2005

Paternite, C.E. (2005, August). *From awareness to public policy to local action in promoting a mental health—schools—families shared agenda: Ohio's experience*. Presentation at a Facilitated Strategic Planning Meeting for School-Based Mental Health Services in North Carolina. Raleigh.

Flaspohler, P., Paternite, C.E., Evans, S., & Weist, M.D. (2005, August). *From policy to practice: Using community science to promote school-based mental health*. Symposium presented at the meeting of the American Psychological Association, Washington, DC.

- Price-Ellingstad, D., East, W., & Weist, M.D. (2005, August). *Implications of the IDEA reauthorization on mental health issues*. Workshop presentation at the national Safe and Drug Free Schools Conference, U.S. Department of Education, Washington, DC.
- Flaspohler, P., Paternite, C.E., Duvall, N., Anderson-Butcher, D., Maras, M., & Wandersman, A. (2005, June). *Aligning Community Science and school based mental health: Policy and practice*. Symposium presented at the 10<sup>th</sup> Biennial Conference of the Society for Community Research and Action. Champaign, IL.
- Weist, M.D. (2005, June). *Promoting mental health and school success for Mississippi youth*. Keynote presentation at the annual meeting of the Mississippi Association for School Health, Biloxi, MI.
- Anderson-Butcher, D., Stetler, G., & Paternite, C.E. (2005, March). *Promoting school success and student well-being through effective community collaboration*. Presentation at the Partnerships for Success 2005 Evidence-Based Practices Symposium. Columbus, OH.
- Koller, J. (2005, March). *Implications of Mental Health Issues in Individuals with Learning Disabilities*. Invited keynote address at the 2005 International Conference on Learning Disabilities, Reno, NV.
- Paternite, C., Weist, M.D., Flaspohler, P., & Adelsheim, S. (2005, March). *School mental health topical discussion*. Paper presented at the 18<sup>th</sup> Annual Conference, *A System of Care for Children's Mental Health: Expanding the Research Base*, Tampa, FL.
- Weist, M.D. (2005, March). *Advancing practice, training and education in school mental health*. Keynote presentation at the conference, *Inside the School House Door*, Southern Connecticut State University, New Haven, CT.
- Morris, E. (February, 2005). *Community of Practice to Promote a Shared Agenda Across Education, Mental Health, and Family Organizations - Missouri's Seed Grant*. Presented at The IDEA Partnership Winter Meeting.
- Weist, M.D. (2005, February). *Mental health screening in schools*. Presentation to the Illinois Children's Mental Health Partnership. Chicago, IL.
- Paternite, C.E. & Rietz, K. (2004, December). *Crucial links between mental health and school success*. Presentation to the Ohio Educator Standards Board. Columbus.
- Paternite, C.E., Leigh, D., Rietz, K., Garner, T., & Estrop, D. (2004, November). *Addressing noncognitive barriers to learning*. Presentation at the 2004 Capital Conference. Columbus.
- Armstrong, M., Duvall, N., Garner, T., Johnston, T., Maxwell, L., Paternite, C.E., Flaspohler, P., & Rietz, K. (2004, October). *From awareness to public policy to local action in promoting a mental health—schools—families shared agenda: Ohio's experience*.

Workshop presented at the 9<sup>th</sup> National Conference on Advancing School-based Mental Health, Dallas, TX.

Burke, R., & Axelrod, J. (2004, October). *Integrating Education and Mental Health*. Discussion session presented at the 9th Annual Conference on Advancing School-Based Mental Health Services, Dallas, TX.

Burke, R. & Paternite, C.E. (2004, October). *The essential role of classroom teachers in promoting academic success and social/emotional well being*. Paper presented at the 5<sup>th</sup> Annual Conference on Curriculum and Pedagogy, Miami University, Oxford, OH.

Burke, R., Koller, J., Weston, K., & Axelrod, J. (2004, October). *The Missing Person in the School Mental Health Movement: The PK-12 Classroom Teacher*. Intensive training session presented at the 9th Annual Conference on Advancing School-Based Mental Health Services, Dallas, TX.

Garner, T., Paternite, C.E. & Rietz, K. (2004, October). *Building state infrastructure—Real world lessons: Ohio's experience*. Preconference workshop presented at the 9<sup>th</sup> National Conference on Advancing School-based Mental Health, Dallas, TX.

Johnston, T.C. & Paternite, C.E. (2004, October). *Teachers as partners in effective school-based mental health programs*. Paper presented at the 9<sup>th</sup> National Conference on Advancing School-based Mental Health, Dallas, TX.

Koller, J. & Evans, S. (2004, October). *Quality assessment and improvement in school mental health*. Informal meeting moderated at the Ninth National Conference on Advancing School-Based Mental Health, Dallas TX.

Morris, E. (October, 2004). *Building State Infrastructure: Real World Lessons*. Presented at the Ninth Annual Conference on Advancing School-Based Mental Health Services, Dallas, TX.

Morris, E. (October, 2004). *Past and Current Mental Health Status among Juvenile Offenders: Implications for School-Based Mental Health Programs*. Paper presented at the 9th Annual Conference on Advancing School-Based Mental Health Services, Dallas, TX.

Owens, J.S., Paternite, C.E., Richerson, L., & Maras, M. (2004, October). *University involvement in mental health—education partnerships: Benefits for all*. Paper presented at the 9<sup>th</sup> National Conference on Advancing School-based Mental Health, Dallas, TX.

Weston, K. J. (2004, October). *Infusing a mental health curriculum into preservice teacher education*. Paper presented at the Ninth National Conference on Advancing School-Based Mental Health, Dallas TX.

Weston, K. & Axelrod, J. (2004, October). *Involving educators in school mental health*.

19. In all work, demonstrate an understanding of differences between a deficit and strengths-based model for mental health; and frame SMH programs and services in positive and proactive ways to advocate for mental wellness.
20. In all work, demonstrate an understanding of common childhood and adolescent stressors and effective coping strategies, common problems impacting development, and common mental health challenges faced by all stakeholders connected with schools (students, staff, families).
21. Conduct integrated academic and mental health assessments in a manner that is therapeutic for students and families.
22. Appropriately use paper and pencil assessments, behavioral observations, and other measures to enhance assessment for students being considered for or in early stages of services.
23. Actively share assessment findings with students and families (and when appropriate, school staff) and involve them as active and equal collaborators in decision-making.
24. Implement preventive and supportive interventions for youth presenting needs for assistance, including those without psychiatric diagnoses, using evidence-based strategies.
25. Implement treatment for youth meeting criteria for psychiatric diagnoses using evidence-based strategies.
26. Implement systematic quality assessment and improvement (QAI) strategies to monitor and continually improve the quality of all services.
27. Actively and on an ongoing basis use appropriate evaluation methods focusing on academic and behavioral outcomes that are valued by families and schools, and that are proximal to delivered interventions.
28. Share evaluation findings and outcome data with students, families, and school staff and integrate their feedback into QAI planning and action.
29. Assist the school in developing and implementing strategies to prevent and reduce all forms of violence, as well as assist students and staff who are exposed to violence.
30. Assist the school in developing and implementing effective plans to prevent and respond to crises.
31. Address high-risk student problems, including reports of abuse and neglect, and suicidal and homicidal ideation and behavior.
32. Enthusiastically participate in training, supervision and ongoing coaching and supportive actions to enhance school mental health promotion and intervention competencies of all stakeholders, in all instances utilizing evidence-based approaches.

\*Adapted from work underway by:

- 1) Center for School Mental Health Analysis and Action at the University of Maryland (grants: (a) #U45 MC00174-10-0, 2000-2005, *Achieving the Promise of Expanded School Mental Health*. MCHB, Health Resources and Services Administration; Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; and (b) #1R01MH71015-01A1, 2003-2006, *Enhancing Quality in Expanded School Mental Health*. National Institute of Mental Health, U.S. Department of Health and Human Services);
- 2) Center for School-Based Mental Health Programs at Miami University (grants: (a) #062984-6B-PB-04P05P/06, 2003-2006, *Mental Health for School Success*, Ohio Department of Education; and (b) #G01085, 2005-2006, *Enhanced Ohio Mental Health Network for School Success*, Ohio Department of Mental Health);
- 3) Center for the Advancement of Mental Health Practices in the Schools at the University of Missouri, Columbia (portfolio development project for Masters degree program in Mental Health Practices in Schools); and
- 4) Collaborative for Academic, Social, and Emotional Learning (key informant interview study completed by MHEDIC co-lead Jennifer Axelrod, July-August, 2005).



**Figure 1**



