

# Policies and Practices to Support School Mental Health



Katie Eklund, Lauren Meyer, Joni Splett, and Mark Weist

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Providing mental health services to children and youth in schools has been found to be an effective and innovative approach to reaching at-risk or hard-to-reach youth (Sklarew, Twemlow, & Wilkinson, 2004; Zirkelback & Reese, 2010). A rich history of literature and research supports the use of mental health services in schools. School-based programs that support the mental well-being of children and youth not only promote wellness but have been linked to improved academic achievement and behavioral functioning among school-aged youth (Crespi & Howe, 2002; Owens & Murphy, 2004). The failure of the nation's child mental health system to fully address the mental health needs of children and adolescents has been well documented and highlights the urgency to reconsider current policy and practice (Burns et al., 1995; Kataoka et al., 2003; Simon, Pastor, Reuben, Huang, & Goldstrom, 2015). Furthermore, the need for school mental health services is detailed in special education regulations and national reports indicating that schools should provide services that target the mental health needs of youth (National Academies of Sciences, Engineering, & Medicine, 2018a, 2018b; President's New Freedom Commission on Mental Health, 2003; U.S. Department of Education, 2018).

Research indicates that of the small percentage of children and adolescents who receive mental health services, schools are the most common setting in which children access this care (Carta, Fiandra, Rampazzo, Contu, & Preti, 2015; Demissie,

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K. Eklund (✉)

School Psychology Program, University of Arizona, Tucson, AZ, USA

e-mail: [keklund@u.arizona.edu](mailto:keklund@u.arizona.edu)

L. Meyer

University of Arizona, Tucson, AZ, USA

J. Splett · M. Weist

University of South Carolina, Columbia, SC, USA

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Oarker, & Vernon-Smiley, 2013; Farmer, Burns, Phillips, Angold, & Costello, 2003; Office of the Surgeon General, 2000). Further, data indicate these services are indeed reaching youths, including students from ethnic minority groups and those with less obvious problems, such as depression and anxiety, who are unlikely to access services in specialty mental health settings (Foster & Connor, 2005; Kataoka et al., 2003; Ramos & Alegría, 2014).

School mental health (SMH) services provide youth increased access to services by reducing many of the barriers to seeking traditional services, such as transportation, cost, and stigma (Weist, Lever, Bradshaw, & Sarno Owens, 2013). Providing services within schools can provide a neutral environment whereby youth learn that seeking out help and support is commonplace and exists within a continuum of provided supports (e.g., academic supports, physical health services). Offering a broad range of universal, targeted, and intensive mental health support services to youth in schools has been supported by a public health framework that recognizes the diverse needs of children and families (Kleiver & Cash, 2005; Short, 2003).

Many states have implemented such multitiered systems of support so that children and youth quickly and effectively can access a diverse range of services, requiring individuals other than those solely at the highest level of risk receive attention (Doll & Cummings, 2008). By providing a range of services, schools are able to help address many of the barriers to learning that children and youth may experience at some point throughout their school trajectory.

Evidence indicates that more comprehensive SMH, involving community-based and school staff increasing the intensity and comprehensiveness of services, improves children's outcomes. It increases the likelihood of first appointment after referral (Catron, Harris, & Weiss, 2005), subsequent retention in services (Atkins et al., 2006), and more effective outreach to underserved communities (Anyon, Ong, & Whitaker, 2014; Armbruster & Lichtman, 1999; Atkins et al., 2015), particularly for those children presenting less observable "internalizing" disorders like depression and anxiety (Atkins et al., 2006; Weist, Myers, Hastings, Ghuman, & Han, 1999). There is also an evidence base for research-supported prevention and intervention programs in schools (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Elliott & Mihalic, 2004; Mihalic & Elliott, 2015). However, we must caution there needs to be solid empirical literature showing that mental health services delivered in schools are superior to those delivered in other settings.

## **Review of the Literature**

### ***Children's Mental Health Concerns***

Approximately 20% of children experience significant mental, emotional, or behavioral symptoms that would qualify them for a psychiatric diagnosis at both national and global levels (National Research Council & Institute of

Medicine, 2009). Not only does the prevalence of those conditions and indicators increase with age (Perou et al., 2013), behavioral disorders are the leading causes for years lived with a disability for children and adolescents (Baranne & Falissard, 2018; Mokdad et al., 2016).

Furthermore, 9–13% of young people will experience a serious emotional disturbance with substantial functional impairment, while 5–9% will experience a serious emotional disturbance with extreme functional impairment (Friedman, Katz-Leavy, & Sondheimer, 1996). Unfortunately, only 15–30% of the children who demonstrate mental health concerns receive any type of help or support.

In order to address the gap in providing mental health services to children and youth, the President's New Freedom Commission on Mental Health (2003) called for a transformation in the delivery of mental health services in this country. School mental health services were suggested as one strategy in beginning to address many of the unmet mental health needs of children and youth (Atkins, Hoagwood, Kutash, & Seidman, 2010). As children currently receive more services through schools than through any other system, school- and community-employed clinicians are well positioned to provide mental health supports in schools (Larson, Spetz, Brindis, & Chapman, 2017).

### *History of School Mental Health*

The provision of school mental health services originates from four co-occurring initiatives. First was the placement of nurses in schools as a public health approach to detect and treat illness that evolved into the establishment of school-based health centers across the United States. Second was the creation of child guidance clinics that evolved into community mental health centers with the passage of the Community Mental Health Act of 1963 (Public Law 88-164). Third was the passage of Public Law 94-142 in 1975 and its reauthorization as the Individuals with Disabilities Education Act (IDEA) in 1997 that resulted in the hiring of school-employed mental health professionals. The final initiative was the emergence of the expanded school mental health movement which brought community-based mental health professionals into schools to not only consult with teachers but provide direct services to children and families.

### **School Nursing and School-Based Health Centers**

Employing nurses in the school setting largely resulted from the overwhelming number of eastern European immigrants moving to urban areas of the United States in the early part of the twentieth century without access to basic healthcare. In the early years, school nurses were effective at addressing health problems that interfered with student's learning. In fact, rates indicate that the percentage of students who missed school due to illness substantially declined from 10,567 in 1902–1101 in

1903 (Hawkins, Hayes, & Corliss, 1994). However, the school nurses' role was limited to physical health promotion and prevention of illness and injury. At that time, children's emotional well-being in relation to mental disorders was not recognized as affecting student's academic and social functioning.

By the 1960s, school-based health centers (SBHCs) started to emerge from what had previously been termed public health clinics and through the provision of services delivered via school nurses. SBHCs began to flourish in the 1980s, growing from 200 centers in 1990, to 1380 in 2001, and 1909 centers in 45 states by 2010 (U.S. Government Accountability Office, 2010). The SBHCs primarily employed nurse practitioners and/or physician's assistants. With the emerging recognition that many of the visits to the SBHC were related to mental health concerns (Lear, Gleicher, St. Germaine, & Porter, 1991), the SBHCs expanded their role to include mental health counseling provided by a master's level mental health clinician.

### **Child Guidance Clinics and Community Mental Health Centers**

Child guidance clinics began as community-based centers that provided psychological therapeutic and assessment services for children with mental health concerns and their families. Originating in Chicago in 1909, the clinics embraced an interdisciplinary approach to service provision by employing social workers, psychologists, and psychiatrists to best meet the needs of children with mental health concerns (Witmer, 1940). The implementation of the Community Mental Health Centers (sCMHC) Construction Act of 1963 (Pub. Law 88-164) initiated the delivery of mental health consultation and intervention services to children and adolescents via CMHCs. The Walter P. Carter Center in Baltimore, MD, served as a seminal provider of school mental health services by establishing relationships with local schools in the community. The Carter Center provided on-site consultation with educators and discussed children receiving services at the centers' four clinics. These clinics established a foundation for the later development of expanded school mental health (ESMH) programs.

### **Public Law 94-142 and the Individuals with Disabilities Education Act (IDEA)**

Originally passed as Public Law 94-142 in 1975, the IDEA mandates that schools serve all students, including those with learning or emotional disabilities. From its inception, IDEA facilitated the hiring of school mental health professionals, such as psychologists and social workers, to provide mental health supports to students. For example, schools hired school psychologists to conduct IDEA-required student evaluations to determine the degree of disability and necessary educational accommodations (Flaherty & Osher, 2003). The shift of mental health professionals from the community to employment as school staff members included providing services to students with emotional and behavioral challenges (Flaherty & Osher, 2003).

While early provisions of IDEA outlined service provisions to youth who met set criteria, it failed to address an organized and systemic approach to providing school mental health services. For example, students identified as emotionally disturbed (ED) had especially poor outcomes compared to students under other eligibility criteria, which may have been a primary driver in the development and expansion of SMH programming (Osher & Hanley, 1996).

In 1997, IDEA amendments further expanded the educational opportunities and support for students with ED. These revisions provided a broader role for both school- and community-employed practitioners to assist with delivery of services to youth via individualized educational plans. These amendments represent the growing recognition of the need to provide prevention services to intervene when youth display at-risk behaviors rather than postponing intervention until students' symptoms require more intensive placement or supports. IDEA provided a solid foundation for not only expanded service delivery but also expanded school mental health (ESMH) programs.

### **Expanded School Mental Health Programs**

In the 1990s, the concept of “expanded” SMH emerged with early successes defined by the building of the child guidance clinic and CMHC models. This idea involved augmenting pre-existing school-based programs and roles that had been primarily focused on special education and crisis response services, toward a broad-based role of mental health supports (Weist, 1997). CSMH services included individual, family, and group psychotherapy, consultation with teachers and families, as well as mental health promotion and education. Several cities, including Baltimore, Maryland, demonstrated early success related to ESMH and brought about the receipt of significant federal funding in 1995 to establish the Center for School Mental Health (CSMH) at the University of Maryland as a national training and technical assistance center. The CSMH was funded by the Maternal and Child Health Bureau’s *Mental Health of School-Age Children and Youth Initiative*, which also provided funding to the University of California at Los Angeles’ Center for Mental Health in Schools, as well as five state infrastructure grants to Kentucky, Maine, Minnesota, New Mexico, and South Carolina.

Since 1995, the field of ESMH has grown significantly because of several efforts, including a national conference hosted by the CSMH, collaboration with the IDEA Partnership, and federal investment by the US Department of Education Office of Special Education Programs. These results have created a national Community of Practice on Collaborative School Behavioral Health, as well as 12 practice groups and 17 state groups, and a number of books and journals (Weist et al., 2013).

With this growth, the field came to represent more than just the original conceptualization of community-employed professionals providing mental health services in schools. As the emphases on public health frameworks, prevention science, and interdisciplinary collaboration emerged, the field of ESMH became known simply as school mental health (SMH). The change in acronyms better represented a

school- and community-wide approach inclusive of a team of school and community mental health professionals partnering with youth and families to provide a public health continuum of promotion, prevention, early intervention, and treatment services.

### ***Public Health Models that Support a Multitiered Framework***

Conversations regarding the provision of school mental health services have been prominent in educational policy dialogues in recent years. Legislative acts continue to address the need for a collaborative focus on mental health in schools, such as the School Safety and Mental Health Services Improvement Act (2018), with an emphasis on preventative measures that deter the seemingly increasing incidence of crisis events in educational settings (Birkland & Lawrence, 2009; Crepeau-Hobson, Sievering, Armstrong, & Stonis, 2012). However, conversations among SMH practitioners examining the importance of an integrated mental health model of service delivery predate contemporary comments by legislators on service implementation methods (Cowen & Lorion, 1976; Windle & Woy, 1983). These early discussions referenced the ineffective nature of traditional reactive methodologies, which are designed to provide services only when concerns arise, echoing a “wait-to-fail” model of service delivery (Albers, Glover, & Kratochwill, 2007). Consequently, students who do not manifest robust externalizing behaviors, for example, may not be identified with missed opportunities for early intervention.

This gap in service has resulted in research to address the short- and long-term deleterious effects (e.g., academic, social, emotional) that may emerge from unmet mental health concerns among children and youth (Perou et al., 2013). The 1999 Surgeon General’s Report on Mental Health first highlighted the need for preventative measures to effectively decrease the negative impact mental health concerns may have on youth (Office of the Surgeon General, 1999). Alternative models of service delivery are warranted, including those that reinforce the importance of collaboration between parents, educators, and mental health practitioners in schools and communities (Weist, Lowie, Flaherty, & Pruitt, 2001).

The public health approach incorporates an ecological framework in addressing children’s mental health by acknowledging the influence of multiple systems on children’s difficulties. This includes integrating systems of care for youth, including but not limited to child welfare, education, health, juvenile justice, mental health, and social services (Blau, Huang, & Mallery, 2010; Stiffman et al., 2010).

Although the public health model is holistic in nature, its goals do not oppose those in public education. The public health model goals are designed to supplement the current educational structure, build a bridge between school- and community-based services, promote partnerships between family systems and the school, and organize formative research that reflects the climate of the school so that the model can be tailored to students’ needs (Nastasi, 2004). This approach is strength-based and culturally and environmentally sensitive and prescribes a

continuum of mental health services ranging from activities that support and maintain positive mental health to prevention and treatment efforts (Blau et al., 2010; Office of the Surgeon General, 1999). Emerging research highlights a few examples, such as multitiered system of supports, that illustrate the effectiveness of the public health model in children's mental health services (Miles, Espiritu, Horen, Sebian, & Waetzig, 2010).

Similar in design, a multitiered system of support (MTSS) framework aims to provide a continuum of care that combines the efforts of communities, families, and schools. The MTSS framework, however, is defined by the application of high-quality interventions and positive behavioral supports at various levels or "tiers." Extant literature describes response to intervention (RTI) and positive behavioral interventions and supports (PBIS) as MTSS approaches that target specific barriers to learning while amplifying the integration of evidence-based interventions and supports until the obstacles to learning are addressed (Batsche et al., 2005; Sulkowski, Wingfield, Jones, & Alan Coulter, 2011).

These systems underscore the role of prevention and wellness through the activation of multiple tiers (i.e., primary, secondary, tertiary) and progress monitoring. Organizing services in this way allows stakeholders to engage in a systematic data-based decision-making process that promotes the implementation of programming and services that meet the mutable needs of students.

However, despite the multitiered design of PBIS, a common concern in these systems is the insufficient development of Tier 2 and 3 systems and practices, resulting in unaddressed behavioral and emotional needs for students with more complex mental health concerns. In addition, PBIS Tier 1 systems, although showing success in social climate and discipline, do not typically address broader community data and mental health prevention (Barrett et al., 2017). Newer models, whose principles parallel those within the MTSS framework, aim to address these gaps.

The Interconnected Systems Framework (ISF), for example, borrows from the strengths of PBIS, implementation science, and RTI to create a healthy merger with school mental health (Eber, Weist, & Barret, 2014). At its core, ISF capitalizes on the use of (1) effective collaborations between community and mental health providers; (2) data-based decision-making; (3) formal evaluation and implementation of evidence-based practices (EBP); (4) early access via comprehensive screenings; (5) rigorous progress monitoring for both fidelity and effectiveness; and (6) ongoing training and coaching at system and practice levels. The benefits of this model are influential in both economic and social schemes: children and adolescents will gain earlier access to high-quality EBPs; professional roles will be clearly defined, particularly among school- and community-employed mental health staff; and cross-training will endorse common language, communication, and engagement among all parties: students, parents, community members, and school staff.

## School Mental Health Services in Multitiered Systems of Support

Within the public health framework of a multitiered system of support, such as the Interconnected Systems Framework, a collaborating team of education and mental health professionals provides a range of services across a continuum of assessment, intervention, and consultation services (Andis et al., 2002). This includes anything from accessing accommodations in the classroom (e.g., extended time, a quiet workspace, break cards) to more targeted and intensive services, such as the provision of individual and small group counseling services.

Universal strategies, often referred to as Tier 1 supports, traditionally provide a platform for promotion and prevention activities. They may also include social-emotional learning programs, welcoming and social support programs for new students and their families, staff development on positive behavior supports, violence prevention, coordination of a universal screening program, efficient referral mechanisms, and/or the development of crisis prevention and response procedures (Elliott & Tolan, 1998).

The second level of support often is referred to as targeted services, or Tier 2 interventions. This may include small group counseling for issues such as social skills, anger control, or depressive symptoms, psychoeducation and consultation with parents and families for issues related to bullying and peer conflicts, and/or daily behavior report cards to teach and reinforce positive replacement behaviors (National Association of School Psychologists, 2015).

The most intensive level of support services are offered at Tier 3 to selected individuals. Services commonly include psychological, psychoeducational, and/or functional behavioral assessments, individual and family counseling, a coordinated system of care, referrals to community service agencies, crisis intervention and response, and/or home-based programs (Andis et al., 2002; Splett, Fowler, Weist, McDaniel, & Dvorsky, 2013).

Across these tiers, SMH services include data-based decision-making, implementation support, and consultation and collaboration. Data-based decision-making includes using data to determine what services are needed and are working for an entire school (Tier 1), small group of students (Tier 2), and individual students (Tier 3). This includes formative and summative evaluation to monitor progress of prevention and intervention activities, as well as evaluate their overall efficacy and implementation fidelity.

Implementing evidence-based programs and practices as intended is an essential, yet often ignored, aspect of delivering an effective continuum of mental health services in schools. Research indicates the need for access to implementation supports such as coaching, training, and technical assistance to promote high-quality implementation of evidence-based programs in “real-world” settings (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

Thus, a conduit for providing effective mental health services in schools is certainly access to a strong infrastructure of implementation supports. Similarly, consultation and collaboration with parents, youth, teachers, school administrators, other mental health professionals, and key community stakeholders are critical to

effective SMH services (Weist et al., 2005). Consultation and collaboration promote engagement and service quality across the continuum of services.

## **Critical Issues in School Mental Health**

### ***Providing School Mental Health Services***

A critical challenge in the field is effectively addressing the question of why mental health services should be provided in schools. Often times, schools may view mental health services as “add-ons” that are not central to the academic mission of schools (School Mental Health Alliance, 2004), and traditional school reform efforts focus on student learning, teaching strategies, and non-cognitive barriers to development (Burke, 2002; Koller & Svoboda, 2002). While educators may be willing to address barriers to student learning, they often do not recognize that social-emotional well-being is essential to academic success (Klem & Connell, 2004). National efforts, such as the No Child Left Behind Act (NCLB, 2001), the President’s Commission on Excellence in Special Education (2002), and the Every Student Succeeds Act (ESSA, 2015), place priority on academic goals and may minimize attention to the social-emotional or mental health needs of students. There are provisions in national legislation that focus on health promotion and risk reduction (e.g., safe and drug-free schools in the NCLB Act and reducing risk for serious emotional disturbance in the New Freedom Commission on Mental Health report, 2003). However, policy reform still is needed at the local, state, and federal levels to include a focus on how behavioral and academic outcomes can be highly correlated (Nastasi, 2004).

Providing school mental health services within a public health model differs from traditional service delivery models as the explicit focus is on a community or society as opposed to any one individual. Theoretically, this perspective is well aligned with ecological systems perspectives, as proposed by Bronfenbrenner (1979), in which individuals and systems are mutually influential. Within an ecological framework, each student is at the center of a series of concentric circles, which represent increasingly expanding, mutually influential systems. For lasting impact to occur, change must occur at a broader level than just within an individual.

If the focus of school mental health services is to provide prevention, intervention, and response services to children and youth, the educational context by which services are delivered must also be a core consideration. Namely, teachers spend countless hours with students each day and often become intimately familiar with children’s behavior, routines, and abilities. As many disorders often arise for the first time in adolescents or young adults, early recognition and treatment increases the chances of better long-term outcomes. However, identification and help-seeking behaviors can only occur if young people and their support systems (e.g., families, teachers, friends) know about early changes produced by mental disorders and how to access help.

## Universal Screening

Universal screening is a proactive approach of using brief and efficient measures to identify students at risk for future difficulties (Eklund & Dowdy, 2014; Jenkins, Hudson, & Johnson, 2007). A primary purpose of universal screening pertains to the identification of individual students who have not responded to universal prevention efforts and are likely in need of targeted or intensive supports (Eklund & Tanner, 2014; Levitt, Saka, Romanelli, & Hoagwood, 2007).

Research suggests schools provide an ideal setting for identifying at-risk students due to the large number of youth in school and the ability to provide follow-up care within schools (Glover & Albers, 2007; Levitt et al., 2007). For example, providing behavioral supports in schools allows for the modification of environmental contingencies toward the disruption of problem behavior development. On the basis of research that shows positive outcomes may be achieved through early identification and intervention, recent educational policy and legislation place an increasing focus on data-based decision-making and universal assessment in schools (IDEA, 2004; Lane, Robertson Kalberg, Lambert, Crnobori, & Bruhn, 2010; Reschly, 2008). Indeed, children with childhood behavioral difficulties who are identified early and receive intervention are likely to make significant gains in positive emotional and behavioral functioning (Brophy-Herb, Lee, Nievar, & Stollak, 2007; Eklund & Dowdy, 2014).

Despite this research and screening's status as an essential component of MTSS service delivery, many schools have not begun to adopt universal screening (Bruhn, Woods-Groves, & Huddle, 2014; Romer & McIntosh, 2017). Although reasons for such limited implementation of universal screening abound (Chafouleas, Kilgus, & Wallach, 2010), more understanding of how screening is implemented and whether or not they achieve intended outcomes is needed. While initial research demonstrates that screening identifies a group of at-risk students previously unknown to school staff and/or not receiving services (Eklund & Dowdy, 2014), additional research on treatment utility is needed to demonstrate students are receiving improved access to care and ultimately, positive response to early intervention services.

## Parent and Community Partnerships

One of the greatest strengths of school mental health models is the emphasis on building an alliance between those who have a shared responsibility for the child, particularly models that invite and encourage parent, school, and community involvement. However, efforts to develop links between stakeholders have illuminated the inadequacy of services and holes in delivery, which subsequently produce a lack of enthusiasm for participation in dialogues on SMH. One qualitative study (Ouellette, Briscoe, & Tyson, 2004) reported that while parents would like to participate in community events and services, the absence of public and private transportation made following through with these commitments difficult. Furthermore,

parents reported that too few organizations offer the services they need to build partnerships with the community. The limited availability of after-school programming and tutor services may contribute to this resistance.

Service provider's concerns echoed those of parents, citing the importance of transportation services. An increase in public transportation availability may help address these concerns.

Communication was another noted weakness, as the discourse used by human service workers may fail to convey useful information and strategies for interventions adequately (Ouellette et al., 2004). Faith-based organizations contributed to the conversation as well, expressing concerns for safe home environments and resources for crisis situations (e.g., clothing, employment, food, shelter).

Ecological models designed to facilitate conversation between parents, teachers, and community members are gaining recognition. The Positive Attitudes for Learning in School (PALS) model, for example, encourages clinicians and community members to work collaboratively on school-based teams to address concerns unique to the community, in addition to issues arising in academic achievement, behavior management, and social support for parents, teachers, and children (Frazier, Abdul-Adil, Atkins, Gathright, & Jackson, 2007).

Variations in geographic landscapes may also inform the development of mental health services. The limited availability of services and their proximity to individuals in need, for example, may act as barriers to those in rural communities. Reinforced by restrictions in transportation and the less than desirable fiscal obligations, families residing in these small rural communities may feel less inclined to pursue services, even if needs are demonstrated (Girio-Herrera, Owens, & Langberg, 2013).

Alternatively, researchers examining the bridge between mental health and education in urban communities identified socioeconomic status and disconnects between community resources and school supports as major challenges in the implementation of effective services (Cappella, Jackson, Bilal, Hamre, & Soulé, 2011).

Mobilization of SMH services requires a network of practitioners and researchers who are willing to share jurisdiction over the development, implementation, and evaluation of interventions. Programs like Bridging Education and Mental Health in Urban Schools (BRIDGE) are an example of such a partnership (Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008). This particular program capitalized on teacher consultation to increase pro-social interactions between students with behavioral difficulties and their classmates. It was designed to connect mental health practitioners with educators so that students receive the most effective form of service delivery possible. Individualized support and teacher observations were at the core of this framework.

School mental health practitioners are in a unique position to connect parents with community services. School psychologists and school counselors, for example, may lead the task of identifying culturally and environmentally sensitive resources that bridge the two contexts for the child (Nastasi, 2004; Nastasi, Varjas, & Moore, 2010). Additionally, SMH providers may find it appropriate to implement

training programs for parents, teachers, and community members that prioritize learning goals and address concerns voiced by all parties while empowering each group to contribute to the implementation and monitoring of interventions (Cappella et al., 2008; Nastasi, 2004).

### **Evidence-Based, Culturally Sensitive Interventions**

Building partnerships across settings is critical to balancing evidence-based services with cultural sensitivity. While research has demonstrated positive outcomes when evidence-based interventions are tailored to meet culturally diverse needs (Harachi, Catalano, & Hawkins, 1997; Wang-Schweig, Kviz, Altfeld, Miller, & Miller, 2014), other findings indicate the outcomes can be weakened or reduced when unexpected or ill-advised changes occur (Kumpfer, Alvarado, Tait, & Turner, 2002; Milburn & Lightfoot, 2016).

Evidence-based interventions in SMH that allow for cultural adaptation through partnerships with local communities during the dissemination, planning, and implementation stages have shown positive outcomes and greater buy-in (Ngo et al., 2008). For example, exposure to violence is a significant national concern and particularly prevalent among minority and ethnically diverse youth (Carothers, Arizaga, Carter, Taylor, & Grant, 2016; Weist & Cooley-Quille, 2001). In recognition of this concern, violence prevention and trauma response have been prioritized by national initiatives and federal funding associated with President Obama's Now is the Time Initiative (The White House, 2013, January 16).

One evidence-based intervention focused on treating youth exposed to violence from a culturally sensitive framework is *Cognitive Behavioral Intervention for Trauma in Schools* (CBITS; Jaycox et al., 2007). CBITS prioritizes partnerships with local schools and communities, including stakeholders from parents, clinicians, community organizations, and faith-based groups throughout all stages of the program. It was developed for and with diverse children and families in mind and has shown positive outcomes in randomized control studies and dissemination evaluations with Mexican and Central American youth, urban African American students, Native American children, and children in rural communities (Kataoka et al., 2003).

CBITS includes formal and informal feedback mechanisms, as well as multi-stakeholder planning committees, during local program development and implementation planning to ensure the consultation, outreach, training/supervision, evaluation, and service delivery models meet the cultural context while keeping the core cognitive behavioral therapy components intact (Ngo et al., 2008). Tailoring implementation to be culturally sensitive and respectful of the local community is supported by collaboration with cultural liaisons, who have both knowledge of the cultural context and clinical intervention (Ngo et al., 2008). SMH practitioners implementing CBITS or any other evidence-based practice should (1) develop partnerships across stakeholder groups; (2) familiarize themselves with the local cultural context and any individual issues that may arise; (3) stay vigilant in their attention to

the unique needs of their students; and (4) work with others who have cultural knowledge and clinical expertise for collaboration, training, and supervision.

From a research perspective, more efforts are needed to invite open dialogues and use the cultural experiences of youth to inform the development and delivery of culturally sensitive and specific interventions. Dialogue among a wide range of culturally diverse stakeholders in SMH is needed to improve the service delivery, consultation, and evaluation models currently employed in the field. Given issues of disparity and collaboration with parents and families, more dialogues around methods to break through these barriers are needed. Additionally, in developing culturally specific interventions and/or tailoring existing evidence-based interventions to be more culturally sensitive, ethnographic research is needed to better understand the cultural experience of youth (Anyon et al., 2014).

Similar to CBITS, other interventions have been developed because of ethnographic research, which aimed to expand the literature on students' cultural experiences and in what ways these experiences affect behavioral and academic functioning. In one particular study, four culture-specific themes emerged—adult-sanctioned behaviors and practices, adolescents' perspectives about the present, adolescents' aspirations for the future, and societal factors (Varjas, Nastasi, Moore, & Jayasena, 2005). The authors argue these factors should guide the development and implementation of culture-specific interventions and conclude that these factors will intersect in different domains of the ecological framework, including school, family, peer, and community contexts.

### **Mental Health Literacy**

Mental health literacy has been recognized as one strategy in facilitating early intervention for mental health concerns. In this approach, young people and their support systems are taught how to provide appropriate mental health first aid and how to support help-seeking behaviors upon first recognition of a mental health concerns. These interventions can include community campaigns aimed at both youth and adults; school-based interventions that teach help-seeking behavior, mental health literacy, or resilience; and programs training individuals on how to intervene in a mental health encounter or crisis (Kelly, Jorm, & Wright, 2007).

While there is no standardization of mental health education in schools, initial research suggests mental health literacy can be improved with planned interventions. Key components may include campaigns tailored to the specific needs and preferences of the intended community that will appeal to different groups (e.g., youth, teachers, parents); ensuring the availability of trusted and established help-seeking pathways among youth; and providing education and accurate information on what to expect when seeking help and obtaining professional support (Kelly et al., 2007; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Gatekeepers, such as teachers, parents, and other important adults, play an important role in offering help to those who need it most.

## Financing for School Mental Health Services

It is estimated that childhood emotional and behavioral disorders cost the public \$247 billion annually (National Research Council & Institute of Medicine, 2009). Other estimates suggest that in 2012, \$13.9 billion was spent for the treatment of mental disorders in children, which was the highest of any children's healthcare expenditures exceeding asthma, trauma-related disorders, acute bronchitis, and infectious disease (Soni, 2015, April). As an estimated 20% of children have a diagnosable mental, emotional, or behavioral disorder, treatment remains one of the most prevalent and costly of all chronic illness in youth.

Historically, as many as one in seven adolescents have been without health insurance and therefore have been unable to receive third-party reimbursable mental health services in the private sector (Crespi & Howe, 2002). Reports by the US Department of Health and Human Services indicated that a disproportionate number of children with mental health problems in the United States do not receive mental health services due to a lack of insurance (Maternal and Child Health Bureau, 2010, 2018, October). An estimated 2.8 million children are eligible for Medicaid or the Children's Health Insurance Program but are not enrolled currently in either (Kenney, Jennifer, Pan, Lynch, & Buettgens, 2016, May). Sole reliance on providers outside the school environment has placed considerable burden on families without such insurance.

It is projected that implementation of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 (June 2010), will have a significant impact on the way that healthcare services are delivered, as many youth who were previously uninsured or underinsured will gain access to services. With the expansion of health insurance coverage, many of the most vulnerable populations, such as young children, youth aging out of foster care, and children living in poverty, will have increased access to preventive services, as well as mental health treatment (English, 2010). In addition, the authorization of funding for home visitation programs to promote improvements in areas such as child development, parenting, and school readiness will provide opportunities for families who are in the greatest need. The provision of the PPACA to authorize funding to establish and expand school-based health centers has the potential to significantly increase and enhance mental health education, prevention, and early intervention efforts within schools.

While school mental health programs have grown over the past two decades, identifying and securing sustainable funding sources continues to be a concern. Recent studies suggest 70% of school districts reported an increase in need for services but saw funding remain stagnant or decreased (Foster & Connor, 2005). As education systems provide limited funding for SMH services, schools traditionally look to grants or other fee for service programs (e.g., Medicaid). However, sole reliance on these mechanisms may not provide sufficient revenue and can be highly bureaucratic and difficult to obtain (Center for Health and Health Care in Schools, 2003; Evans et al., 2013; Freeman, 2011). In addition, fee-for-service approaches have created concerns about overdiagnosis, limited time for prevention activities, and an inability

to serve students without Medicaid (Lever, Stephan, Axelrod, & Weist, 2004; Mills et al., 2006). As a result, schools are called upon to explore collaborative and unique funding arrangements to sustain SMH services and programs.

Sustainable funding is needed to support SMH services. Although there are some potential funding sources that are underutilized (e.g., from Early and Periodic Screening, Diagnosis, and Treatment, Safe and Drug-Free Schools, Title I), access to such funds and continued sustainability continue to be a concern for many schools. In order to address these barriers, many programs and services have blended or “braided” funding, by deriving funding from multiple sources, including grants, contracts, and private agencies (Lever et al., 2004). Fee-for-service revenue has served as a primary source of funding for many mental health services provided in schools. Third-party payers (e.g., Medicaid, State Children’s Health Insurance Programs, private insurance) provide reimbursement for mental health services provided to children. However, reimbursement is typically limited to those students who have a clinical diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013) for traditional mental health services (e.g., individual and group counseling, family counseling) versus broader SMH services (e.g., teacher consultation, parent consultation, prevention services, case management).

Sole or primary reliance on fee-for-service models provides a number of barriers to school districts and agencies, including significant paperwork, administrative duties, and managerial responsibilities. Although larger school districts and agencies may have mechanisms in place to be able to hire and train staff to manage Medicaid billing and services, rural communities and smaller agencies may be at a disadvantage. Many of these same barriers are placed upon clinicians, who face substantial paperwork that can become burdensome when the primary focus should be on providing direct clinical services and preventative care.

## Implications for Behavioral Health

The SMH field has grown significantly since its beginning days in child guidance clinics and primary focus on expanded models inclusive only of community providers. The opportunity to provide mental and behavioral health services within the school setting has been an ongoing goal for many mental health professionals (e.g., social workers, psychologists, counselors) who desire to improve access to care by providing evidence-based interventions to a greater number of children and families.

Service delivery models that emphasize teaming and collaboration across school, community, and family stakeholders within the system of a multitiered public health continuum of promotion, prevention, early intervention, and treatment are increasingly showing positive outcomes for children in need. This includes the aforementioned Interconnected Systems Framework that combines implementation science, school-based response to intervention models, and PBIS to streamline services for children, families, and educators. This framework provides concrete examples of

interdisciplinary collaboration among school- and community-based mental health providers as being essential to delivering high-quality evidence-based mental and behavioral health services in schools.

Furthermore, schools continue to utilize public health models that emphasize prevention through screening and early intervention practices that can eliminate or reduce the severity of behavioral and emotional symptoms when combined with early intervention. However, more work is needed, and critical issues remain.

The field must continue to emphasize the critical role of mental health in the academic mission of schools and should consider how to intertwine behavioral and academic standards for student success. For example, Illinois Learning Standards now include three social/emotional development standards that students should know and be able to do to varying degrees in grades K-12 (Illinois State Board of Education, 2018). This includes the development of self-awareness and self-management skills, as well as the use of social-awareness and interpersonal skills to establish and maintain positive relationships. These types of educational policies can be instrumental in continuing to advance mental health promotion in the school setting.

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