

Creating a Framework for School Based Mental Health Services in West Virginia

A Concept Paper

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Health, and especially mental health, is a fundamental cornerstone for ensuring that all youth have an equal opportunity to succeed in school and that no child is left behind. (Weist, Paternite, et al)

Overview

Recent national and state reports clearly document that our mental health system is in crisis. For youth, the prevalence of behavioral health (mental health and substance abuse) problems and the gap between needs and actual services are alarming.

Although the idea of developing a comprehensive continuum of mental health supports for children in public schools dates back to the early 20th century, it was late in the century that a national movement took hold. Recently, SBMH has been emphasized in several historic initiatives (No Child Left Behind Act, the Surgeon General's Report on Mental Health, the President's New Freedom Commission on Mental Health, NIMH's Blueprint for Change, 2001). However, mental health programs in schools, if they do exist, are characterized by fragmentation, lack of coordination, and a limited scope, often due to categorical funding requirements.

While schools should not be viewed as responsible for meeting all mental health needs of students, most educators would agree that schools should enhance social - emotional competence, character, health, and civic engagement (Greenberg et al 2003). Although the research supports the connection between mental health and academic success, recent school reform (i.e., No Child Left Behind) seems to ignore this, unfortunately.

In the last few years, recognition of and policy support for school based mental health programs and services has increased at the federal and state levels in the United States. Such programs make sense because they make services – both preventive and treatment – not only more accessible for youth, but also more comprehensive and coordinated, resulting in more efficient use of limited public resources. However, such programs require systems change and new ways of thinking. “School based mental health is a relatively new and tenuously supported field. There is a need for integrated action in policy, resource enhancement, research, practice and training.” (Weist, Paternite, et al 2005)

This report 1) summarizes the data regarding the need for behavioral health care among youth; 2) briefly reviews the literature regarding the school based mental health field, including national recommendations, data, research, and other states' efforts; 3) describes some of the issues and needs in WV; and 4) presents recommendations for a conceptual model or framework for school based mental health programs in our state.

Some comments about the report and the terminology: This report was prepared at the request of the WV Bureau for Behavioral Health, Children's Division. However, the recommendations encompass a broader view than just that which is the responsibility of that office. No single entity can or should be expected to address all of the behavioral health or educational needs of our youth. The issues and the solutions require systemic changes at local, state, and national levels, are multidisciplinary and involve many agencies and the private sector. This report is just a beginning – to assist in the dialogue about WV's future.

Note that throughout this report, the term “evidence based” is used. Researchers agree that in order for a treatment approach to be considered “evidence based” it must have

undergone several clinical trials in which the treatment was shown to be superior to either no treatment at all or another possible treatment; it should have been demonstrated effective using a research design including random assignment to treatment and control groups, and the treatments should be demonstrated as effective by more than the person who developed the treatment.

Further, it should be noted that not every problem has been linked to an evidence-based intervention. The complexities of problems often times make it difficult to decide on a particular intervention. In addition, even with evidence-based practices, the context in which they are implemented may change the results (program fidelity).

The term, “school based mental health programs (SBMH)” refers to programs provided in a school, either by school personnel or outside agencies. This report focuses on what community agencies other than the educational sector can and should do to address MH.

It should also be noted that although the literature uses the term school based mental health (SBMH), it is broadly defined to include all aspects of behavioral health such as substance abuse treatment and prevention and prevention of other risky behaviors common to youth.

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- Mark Weist, PhD, Director, Center for School Mental Health Assistance, U of Maryland
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Need/Prevalence

Several recent national reports have sounded the alarm – our nation’s mental health system is in crisis. The 1999 Surgeon General’s Report on Mental Health clearly documents that we have a crisis in youth mental health care. A subsequent report in 2000 proposed a national agenda for children’s mental health. In the foreword, Dr. Satcher states,

“When we think about a healthy start, we often limit our focus to physical health. But...mental health is fundamental to overall health and well-being...we must ensure that our health system responds as readily to the needs of children’s mental health as it

does to their physical well-being. Children and families are suffering because of missed opportunities ...fragmented services, and low priorities for resources.”

More recently, the President’s New Freedom Commission on Mental Health (2003), after a year-long study, concluded in their final report that “...the mental health delivery system is fragmented and in disarray...leading to unnecessary and costly disability, homelessness, school failure, and incarceration.” The report highlights gaps in care and lack of a national priority for mental health and suicide prevention. (www.mentalhealthcommission.gov).

These and other reports make several important points for understanding this crisis:

The number of youth in need of behavioral health services is much greater than the number being served. Most youth in need of mental health services are not accessing established sites for care, such as community mental health centers and private providers. Studies conservatively estimate that 20% - 38% of youth need active mental health intervention. Between 9-13% of youth ages 9-17 meet the federal definition of serious emotional disturbance (SED). (Goodman, 1997; Marsh, 2004) Prevalence figures for youth risk behaviors indicate that 28% of youth report episodic heavy drinking, 22% report marijuana use at least monthly; and 8% have made a suicide attempt within the past year. (U.S. Youth Risk Behavior Survey, 2003; Grunbaum, 2004). These figures do not include the many youth who are “at risk” and could benefit from intervention. A just-released study from SAMHSA reports that 9% (2.2 million) of adolescents 12 – 17 years experienced at least one major depressive episode in the past year. They were also more likely to have used illicit drugs in the past month than their peers who had not experienced a major depressive episode.

As few as one-sixth to one third of youth with diagnosable disorders receive any treatment. The number of youth in need of behavioral health services is much greater than the number being served. (Burns, et al 1995; Leaf et al, 1996)

Of those who do receive treatment, less than half receive adequate treatment. Moreover, even fewer of the youth “at risk” receive any help whatsoever. Further, there are important questions about the quality and efficacy of mental health services received by youth in all settings. (Weisz, 2004)

Half of all mental illness begins by age 14, three-fourths by age 24. While it is unknown whether early detection would prevent illnesses from worsening, there are studies that suggest that, left untreated; mild disorders often progress to become serious.

Children with chronic emotional behavioral and developmental problems are the least likely of all children with special health care needs to receive treatment or counseling. Thirteen percent of students are in special education programs. Youth with emotional, learning or multiple disabilities are at greater risk of binge drinking and marijuana use and those who reported ATOD use had more negative educational outcomes and earlier sexual activity. Their problems are more likely to affect their families and schools according to a survey of parents conducted by the CDC.

Children with chronic physical problems are much more likely to have emotional and behavioral health needs. Many studies document the much higher prevalence of emotional and behavioral health problems (eg depression) among children with chronic illnesses such as epilepsy, asthma and chronic obesity.

National Policy Recommendations

“One way to ensure that our health system meets children’s mental health needs is to move towards a community health system that balances health promotion, disease prevention, early detection and universal access to care.”

In the past ten years, school based health services have grown exponentially in the United States. Both the Surgeon General’s report on Mental Health (USDHHS, 1999) and the 2000 report on children’s mental health (U.S Public Health Service) highlight the importance of school based approaches. Further, the NIMH report, *“Blueprint for Change: Research on Child and Adolescent Health”*, states, “Scientifically proven interventions must be disseminated to clinics, schools, and other places where children, adolescents, and their parents can easily access them”.

The final report of the President’s New Freedom Commission on Mental Health (2003), *Achieving the Promise: Transforming Mental Health Care in America* recommends very specific and direct linkage to school based mental health services and programs through Goal 4: “Early Mental Health Screening, Assessment and Referral to Services Are Common Practice”:

4.1 Promote the mental health of young children

4.2 Improve and expand school mental health programs

4.3 Screen for co occurring mental and substance use disorders and link with integrated treatment strategies, and

4.4 Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports.

Many of the recommended action steps refer to expansion and improvement of school based services and programs:

- Encourage early identification of mental health needs in preschool, childcare, education, ...systems
- Promote cost effective, proactive systems of behavioral support at the school level;
- Co-locate mental health services with other key systems (e.g., education, primary care...)
- Strengthen resource capacity of schools to serve as...link to ...system of school and community - based identification, assessment, and treatment...
- Engage professional organizations in educating new frontline providers in various systems (e.g., teachers, physicians, ...) to better address children’s mental health needs

Mental Health in Schools: A Shared Agenda

It has long been acknowledged that psychosocial and mental health concerns must be addressed if schools are to function satisfactorily and students are to learn effectively.

The Carnegie Council Task Force on Education of Young Adolescents states, *School Systems are not responsible for meeting every need of their students. However, when the need directly affects learning, the school must meet the challenge.*

This reality is reflected in the aims of NCLB, and the IDEA. It is consistent with the President's New Freedom Commission on Mental Health, which recognizes that any effort to improve children's mental health must involve schools.

There are many advantages to school based mental health services and programs. Schools offer access to youth. In fact, for the small number of youth actually receiving mental health services, much of it is provided by and in the schools already. Combining students and staff, one fifth of the U.S. population can be reached in schools. (President's Freedom Commission Report) SBMH programs enhance the school's resources, expertise and ability to offer a range of preventive and therapeutic programs. Evidence suggests that SBMH:

- Increases access (Dial, et al, 2002; Weist, Myers, Hastings, Ghuman, and Han, 1999)
- Reduces stigmatization for seeking mental health support (Nabors & Reynolds, 2000);
- Presents more opportunities for mental health promotion and targeted prevention, (Elias, et al, 1997; Weare, 2000) ;
- Enhances clinical productivity (Flaherty & Weist , 1999)
- Contributes to academic achievement.
- Promotes maintenance of treatment gains (Evans)
- Broadened, more ecologically grounded roles for mental health clinicians (Atkins, Adil, Jackson, McKay, & Bell, 2001)

These advantages were supported in a recent policy statement on SBMH by the American Academy of Pediatrics which asserts that "school based programs offer the promise of improving access to diagnosis and treatment for the mental health problems of children and adolescents"; and that they improve opportunities for coordination of services with educational programs. (AAP Committee on School Health). The statement recommends 19 specific evidence-based actions to support the collaboration of primary health care professionals, mental health providers and educators.

SBMH in Other States

Strong policy and service delivery programs have been developed in a number of cities (Baltimore, Dallas, Los Angeles and Memphis) and states (Hawaii, Maryland, New Mexico, Ohio). Networks and training initiatives also have developed at state, national, and international levels. Leaders in this movement include:

- Center For School Mental Health Action and Analyses
- UCLA Center for School Mental Health
- Columbia University Teen Screen
- Center for School Mental Health Programs, Miami U, Ohio
- National Assembly on School Based Health Care (NASBHC)

Descriptions of New Mexico and Ohio’s programs are in the Appendix.

SBMH and Academic Success

Several studies document evidence of strong positive associations between school mental health services, access to care, and academic success. “School mental health services, when done well, are associated with strong satisfaction by diverse...groups (Nabors, Reynolds & Weist, 2000). Further, they are associated with improvement in student emotional and behavioral outcomes (e.g. symptom reduction, decreased disciplinary referrals, increased pro-social behavior, improved attendance, enhanced engagement), positive family outcomes...and school outcomes (school climate, reducing bullying, decreased special education referrals) Nabors, Reynolds & Weist, 2000)

Many of the recommended strategies for violence prevention and drop out prevention in schools have been delivered through SBMH programs. These programs include social skills development, parent engagement, mentoring, promotion of developmental assets, conflict resolution and training for students and staff (Weist & Warner).

Such programs “have cascading effects – creating conditions that promote academic achievement and school success.” For example, strong parent involvement is linked with high academic achievement, regardless of socio-economic status (SES), ethnic background, or parent education (e.g. Chavkin, 1989, Christenson, Rounds & Franklin, 1992; Dornbusch & Glasgow, 1996; Griffith, 1996; Simon, 2001)

Other studies have shown:

- increased student attendance and reduced drop out rates (Drake, 1995; Schargel & Smink, 2001;)
- enhanced motivation and sense of competence (Christenson, Rounds & Gorney, 1992; Grolnick & Slowiaczek, 1994)
- increased student connectedness to school which is associated with improvement in many areas including academic performance, decreased incidence of fighting, bullying, vandalism, absenteeism, substance use, early sexual engagement, disruptive behaviors, and absenteeism, and improved graduation rates and school attendance (Blum & Libbey, 2004; CDC’s Wingspread study, Declaration on School Connections, 2004)

“School based social development interventions that address specific risk factors, curb early manifestations of antisocial behavior and promote school bonding and social and emotional skills are likely to improve student academic achievement”

Strong positive associations between mental health and academic success abound. (Atkins, Frazier, Adil, & Talbott, 2003; Bishop et al, 2004; Catalano et al, 2004; Klern & Connell, 2004; Libbey, 2004; McNeely and Falci, 2004; and Wilson, 2004; Zins, Weissberg, Wang, and Walberg, 2004). Rones and Hoagwood (2000) in their review of SBMH services, suggested that schools' fulfillment of the mandate to educate all children necessitates attention to mental health issues. They documented that "children whose emotional, behavioral or social difficulties are not addressed have a diminished capacity to learn and benefit from the school environment. In addition, children who develop disruptive behavior patterns can have a negative influence on the social and academic environment for other children."

"Unfortunately, there is a disconnect between the findings which support the need for expansion of SBMH and contemporary school reform (i.e. No Child Left Behind Act). In general, reforms have not adequately incorporated a focus on addressing the non-cognitive barriers to development, learning and teaching ...except for some children in special education programs (Adelman & Taylor, 2000; Koller & Svoboda, 2002; Burke, 2002b). These non cognitive barriers include environmental/contextual factors eg poor nutrition, family stress, conflict, negative peer influences, exposure to violence, abuse, neglect, etc, as well as individual biological and psychological factors eg inattention, impulsivity, externalizing and internalizing mental health problems, trauma reactions, etc.. While school reformers acknowledge that academic success promotes well-being, they do not often acknowledge that, in turn, well-being promotes academic success (Leffert et al, 1998; Felner, 2000; Klern & Connell, 2004)

The School Mental Health Alliance recently developed a position statement on school mental health (www.kidsmentalhealth.org) which has been endorsed by over 50 national organizations. It presents a strong rationale for addressing the non-academic barriers to learning, describes the science base and connects SBMH to other national initiatives.

Challenges to Delivering Behavioral Health Services in Schools

While ESMH programs enhance access for youth, unique challenges and issues must be recognized. Weist et al list the following:

Family participation may be limited – studies document the importance of family involvement for successful therapy. The school setting may reduce that access. On the other hand, in a rural area, it may be much more convenient for parents to participate in therapy at their school than to drive a long distance to clinic.

Confidentiality and privacy concerns – mental health providers adhere to strict protections for informed consent and confidentiality. School based personnel are often used to sharing information about students and may not be aware of HIPAA guidelines. Adding to the complexity are different legal requirements for schools through FERPA. In addition, space in schools is often limited so finding private, comfortable space can be a challenge.

Ambiguities in record keeping and practices – SBMH programs often operate in a "regulatory gray zone". Mental health records are kept differently than school or primary

care records. If the program is sponsored by a community mental health center, it may be required to use certain assessment tools and follow procedures that do not fit the school setting;

Lost revenue – if a program is grant funded, it may not have the possibility of billing for services, therefore reducing its chances of sustaining beyond the grant period. On the other hand, billing might also influence the focus of the program toward treatment of individuals with established diagnoses and away from more preventive “non-billable” services. Related is the issue that community mental health centers for outpatient therapy are based on traditional treatment models; standards for more preventive and flexible services that should characterize the SBMH field have not been developed.

School environment – working with school systems and personnel is a challenge. Public schools are characterized by a crisis mentality and a reactive nature – school administrators do not have the luxury of time for planning. Shifting policies, pressures and scrutiny from various groups; federal and state mandates; turnover in staff; and a decentralized (site based) decision – making structure make it very difficult and labor intensive to establish a solid, trusting relationship within the school system. Community based agencies that want to work within the schools need to be flexible, tenacious, and good at communicating and relationship building. “Working agreements regarding roles, functions, and communication between mental health staff and school personnel typically need to be negotiated and maintained building by building.”

Marginalization of mental health in schools – As with health care in schools, mental health services of psychologists, counselors, social workers are sometimes viewed as add-ons – not essential to the schools’ mission. Legitimate concerns arise about the school’s capability and responsibility for care of students’ emotional problems, the possibility that services will be an entitlement under IDEA, stigma and lack of understanding about mental health issues. To address such resistance, Weist et al suggest a number of strategies:

- Ensure strong coordination among families, school leaders, and mental health program leaders during planning
- Ensure that school mental health providers are well trained, closely supervised, and socially skilled and understand the culture of schools and how to work collaboratively;
- Emphasize high quality and empirical support of SBMH services;
- Recognize that SBMH services are a means for reducing barriers to learning; and
- Document that services lead to valuable outcomes.

Approaches to MH in Schools

Although many findings support the benefits and impacts of SBMH services, the literature is relatively limited. The literature documenting research-based interventions in schools is actually stronger. In other words, to simply place traditional mental health therapies in schools...” characterized by passive, eclectic, reactive approaches...are of

negligible benefit” (Weisz, 2004; Weisz & Jensen, 2002; Weisz, Huey, & Weersing, 1998). (There is a need for a large interconnected research – practice agenda to ensure that SBMH services are well supported, quality focused and based on evidence of positive impact (Kratochwill, Albers & Shernoff, 2004)” (Weist, et al)

As the movement toward more comprehensive services in schools has progressed, the services are delivered in an increasing variety of forms (Weist, Evans & Lever, 2003). There are no explicit models for SBMH. Below is an attempt to highlight the various configurations and some of the more promising trends in SBMH services

Traditional (and Limited): Mental health services in schools are typically limited to assessment and consultation and minimal treatment only for those youth in special education or those with 504 accommodations .Unfortunately, federal funds do not support schools’ services under 504 (of the Rehabilitation Act of 1973). Depending upon the availability and training of guidance counselors, some additional students may receive limited counseling but usually the guidance counselors are too busy with other aspects of their jobs to dedicate enough time to individual counseling. Referrals to community settings usually do not occur or fail (Catron, Harris, & Weiss, 1998)

A number of issues arise in these programs: federal funds do not directly support schools’ efforts to implement Sec 504 even though it is mandated; students with IEPs may need related services but if these are written into their plan, the school system may become the payer of last resort and be obligated to provide them. Furthermore, what constitutes a disability under IDEA does not conform, necessarily, to what is a disability according to diagnostic criteria used in the health community (American Psychiatric Association, 1994). This leads to ambiguities, confusion and inconsistency in decision-making, diagnosis, coordination among agencies, and procedures. The complexity of these systems reinforces the need for school-community collaboration for successful SBMH.

Expanded SMH: The term “expanded school mental health” (ESMH) refers to programs that build on the core services typically provided by a school. ESMH also reflects the model recommended by the President’s New Freedom Commission. It describes programs that involve community mental health agencies; are committed to the full continuum of MH assessment, education, promotion, preventions, early intervention and treatment; and serve *all* students. Such programs augment services in schools through community partnerships that emphasize shared responsibility to fill in the gaps. A strong connection between schools and community agencies helps a community to move toward a true system of care (Leaf, et al) Expanded SMH should be viewed as a ***framework*** for programs and services upon which other elements may be added. (In WV, such “frameworks” exist in a number of communities; see appendices for examples.)

Positive Behavior Intervention and Support: “Complementing the framework of ESMH, Positive Behavior Intervention and Support (PBIS) offers a natural interface for collaboration between mental health providers and educators. PBIS is an empirically grounded conceptual model and set of practices for school based prevention and intervention that have been endorsed by 30 state departments of education (Horner,

Sugai, Todd & Lewis-Palmer, in press). PBIS involves a broad range of systemic and individualized school based strategies ...incorporating a continuum of integrated activities from health promotion through intensive intervention....School wide PBIS „enhances mentally healthy schools and students (Horner&Sugaik2000; Scott, 2001; Taylor-Greene & Kartub, 2000)and is also showing promise as a preventative strategy to decrease antisocial and other behavioral difficulties (Hoagwood,2000;McCurdy, Mannella,& Eldridge, 2003)....This function based approach is effective across a wide range of school populations and settings (Kincaid,Knoster,Harrower, Shannon & Bustamante, 2002, Horner et al, in press).” (Weist, Paternite, et al)

School Based Health Centers: School based health centers (SBHCs) provide primary health care to students in or near schools. They are usually sponsored by community health organizations (hospitals, community health centers) and emphasize prevention and health promotion along with provision of diagnostic, lab and treatment services. In recent years, the number of SBHCs in the U. S. has grown considerably. SBHCs offer a unique benefit for delivering MH care by reducing stigma. When students visit the SBHC, it could be for any health need. In addition, because students and parents may see the same provider many times for different health needs, they begin to develop a trust relationship, which alleviates fears about confidentiality and resistance to mental health counseling. Other advantages to offering MH services in SBHCs include:

- enhanced efficiency and productivity
- behavioral screening in the context of a primary care visit, which identifies risk and problems earlier, before they would typically be referred to a mental health provider;
- addressing MH needs that have a physical health component;
- providing a collaborative, coordinated approach;
- Providing the mental health provider with back up and team support.

Systems of Care: A major national initiative, the Child and Adolescent Service System Program, focused on developing local community infrastructures or supports for children with SED. These long-term projects have demonstrated improved access and less need for residential treatment. In WV, the Region 2 project demonstrated that with a community support system of care, youth were less likely to need out of state placement and were more successful in outcomes. Many of the principles of the system of care philosophy are consistent with the work of mental health in schools. The CASSPs are increasingly making connections to schools but in general, schools are not yet a focus of these initiatives.

Out of state placement for youth, needing residential treatment has been a serious and much debated topic in West Virginia. As the state moves forward in its efforts to bring youth home, it will be essential to have in place the necessary systems of support. For youth, school systems that are adequately prepared to meet their needs will be critical to success. This will require training, planning and preparation.

Enabling Approach: Adelman and Taylor (2000) advocate a SBMH model that incorporates school resource coordinating teams, which focus on improving student supports in six specific domains:

- 1) Crisis/emergency assistance and prevention
- 2) Support for transitions
- 3) Home involvement in schooling
- 4) Community outreach/volunteers
- 5) Student and family assistance, and
- 6) Classroom based approaches to enable learning

RECOMMENDATIONS FOR WEST VIRGINIA

There is clear research support for linkages between mental health and school success but the impact is often underestimated or not recognized by school policy makers and staff. The severity of mental health and substance abuse needs of youth is affecting the ability of educators to be effective in the classroom.

The need for more and better mental health services in West Virginia is as great as or greater than the rest of the nation. The WV BBHF estimates the prevalence of serious emotional disturbance (SED) among youth at 13% and that in any given year, only 28% of youth with serious emotional problems are receiving any care at all. This does not include youth with short term, acute problems or those at risk.

Many barriers to accessing care contribute to these statistics: the rural nature of the state, lack of providers in smaller communities, distance to access care, stigma associated with mental health, limited or no insurance coverage, complexities of the maneuvering through the “system”, especially for parents who are already overburdened; and meeting various eligibility criteria which often prevent early intervention (eg, many services require that youth be adjudicated or wards of the state in order to get treatment).

Schools cannot and should not do all of this work alone. In many cases, schools are already overburdened with demands that should be addressed in other community systems. It is incumbent upon health and social services providers in the communities to consider how they might shift resources to meet the needs of youth more effectively. The state’s role is to design and implement policies that support local communities to improve their coordination; provide incentives for such collaboration, provide technical assistance to communities for such efforts and guidance in identifying “evidence based” practices.

Even with the many limitations, however, examples of successful collaboration exist in many WV communities. **In fact, many of the essential elements for an expanded school mental health system of care are already in place in West Virginia. The challenge is to take these elements to “scale”.** WV can learn from these successful programs and build on them to reduce the barriers to learning for every child.

West Virginia has a number of different school - based programs that might fall under the rubric of “behavioral health”. In its broadest sense, this term would include most of the school programs that address developmental issues such as character-building, self-esteem, community service, prevention of drug, tobacco and alcohol use; and the entire scope of wellness programs. The other end of the continuum would include those programs geared to students with diagnosed conditions who need intensive, individualized, ongoing therapy. Not only is there a wide range in types of programs, there is a variety of types of providers, funding sources, etc. Some are operated by schools; others by community agencies; some are intermittent or short term projects; others are required curricula within the school systems; some are effective , evidence based, and of high quality; others are not; and funding may come from state, federal, local or private sources.

For purposes of this report, it is enough to recognize that a plethora of school based programs exist at the local level and that most evolved in response to various categorical funding opportunities. While many of them are effective and evidence based, it is safe to say that many barriers and gaps exist in the continuum of care; there is a dearth of qualified professionals in more rural parts of the state; and that existing services often are targeted to particular students such as those in special education, on probation, or in foster care.

While it would be easy (and accurate) to state that WV needs to put more funding into increasing mental health services for youth, that is not the entire solution. To keep doing what we are doing will only get us more of what we’ve got. State leaders must engage in a collaborative planning process that addresses infrastructure, capacity building, and quality. Essential participants in this process are service providers, policy makers and consumers from education, juvenile justice, substance abuse, mental health, primary health care and academia. Below are some recommended steps for such a process (not necessarily in order of priority or action).

➤ ***Define a Vision: (such as) to develop a comprehensive continuum of mental health supports for youth in schools to eliminate non-cognitive barriers to learning.***

➤ ***Adopt Principles and Values for School Based Mental Health***

Weist suggests the following “Ten Principles For Best Practice In School Mental Health”:

1. All youth and families are able to access appropriate care regardless of their ability to pay
2. Programs are implemented to address needs and strengthen assets for students, families, schools, and communities
3. Programs and services focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact
4. Students, families, teachers and other important groups are actively involved in the program’s development, oversight, evaluation, and continuous improvement

5. Quality assessment and improvement activities continually guide and provide feedback to the program
6. A continuum of care is provided, including school wide mental health promotion early intervention and treatment
7. Staff hold to high ethical standards, are committed to children, adolescents, and families, and display an energetic, flexible, responsive, and proactive style in delivering services
8. Staff are respectful of and competently address developmental, cultural, and personal differences among students, families, and staff
9. Staff build and maintain strong relationships with other mental health and health providers and educators in the school and a theme of interdisciplinary collaboration characterizes all efforts
10. Mental health programs in school are coordinated with related programs in other community settings.

➤ ***Define the State's Role***

“You can't have people in 100,000 different schools and 16, 0000 school districts out there, each trying to make collaborative arrangements with eight different agencies. There must be a strategy for defining the state role, and the role that local agencies will play in relating to all of the schools within their jurisdiction.”

– Thomas Payzant, superintendent, Boston Public Schools, and former assistant sec'y for elementary and secondary education USDOE (Wooley & Marx)

Unlike other countries, the United States educational system is decentralized. Most of the decision-making responsibility lies at the state and local levels. Indeed, the advent of site based management results in even greater authority and responsibility at the individual school level. To develop new, innovative and collaborative models at the local level, state agencies must redefine the way they do business with one another. A strong state level infrastructure is essential to success. Elements that need to be in place to establish and maintain a state level infrastructure include:

- Leadership and staff commitment from heads of all relevant state agencies (Education, Health, Medicaid, Social Services) including commitment of resources and support staff
- Interagency cooperation through written MOUs and regular meetings of agency staffs
- Ongoing monitoring and assessment
- Regulatory support
- Technical assistance
- Collaboration

- Marketing and communication
- Professional preparation

Policy making leadership of state departments of education, mental health, primary health care and family services should engage with other state and advocacy partners to generate a commitment to addressing the non-cognitive barriers to learning to support successful academic achievement for all children and youth in WV.

➤ ***State Level Action Steps to Facilitate Local Implementation***

The book, “Health Is Academic” (Marx and Wooley, eds) is a thorough review and how-to book for implementing the eight components of the CDC’s Healthy Schools Initiative. In it, the authors suggest that the role of state government should be to:

- Articulate a vision
- Develop a state level structure that supports collaborative, interagency, integrated approaches
- Provide financial support for program implementation
- Support or develop coalitions
- Strengthen professional preparation and ongoing development
- Support employment of professionally prepared and appropriately credentialed staff
- Involve local practitioners in state level planning and program development
- Develop materials, guidelines, and publications that support program implementation
- Provide data
- Demonstrate and evaluate program effectiveness
- Conduct advocacy and public awareness activities
- Provide technical assistance and training
- Develop supportive systems and technological approaches
- Regionalize technical assistance and training to facilitate access
- Integrate activities to address barriers to learning with instruction and school management reforms

➤ ***Establish an Interdepartmental School Behavioral Health Partnership for the various agencies in state gov’t related to education and mental health***

➤ ***Develop school behavioral health programs across the continuum from training to prevention to screenings, early intervention and treatment with joint funding.***

➤ ***Establish Regional School Mental Health advocates to link schools with mental health supports and technical assistance***

- ***Increase supports, training, and TA to develop a systematic quality assessment and improvement agenda***
- ***Emphasize empirically supported practices***
- ***Incorporate program evaluation that feeds into CQI agendas***
- ***Build Infrastructure/Relationships***

Convene a consortium of educators and mental health providers to advance a systematic agenda for promotion of integration of the educational and mental health systems, including school based MH programs. Such a consortium in Ohio identified the following priorities to address:¹

- Cross training of education personnel and community based providers of mental health
- Increasing awareness of the critical role of all school personnel as promoters of mental health;
- Increasing awareness of the role of BH providers in facilitating student educational success
- Awareness of the association between BH and school success
- Development of pre graduate courses that better equip teachers and school administrators to promote student mental health; and that prepare mental health clinicians to be effective partners in educational systems.
- Identify and address barriers to integration of MH and education
- Promote funding streams the support above efforts
- ***Define a model***

School reform has neglected to address the many psychosocial and environmental barriers to learning. The concept of an “enabling component” (Adelman & Taylor) weaves together relevant school, community, and home resources through policy reform and system restructuring. It results in the type of integrated health and social services coined by Dryfoos as the “full service school model. By focusing on the barriers to learning, the efforts focus on six goals:

- Enhancing classroom based efforts
 - Providing student and family assistance
 - Responding to and preventing crises
-

- Supporting transitions
- Increasing home involvement in schooling
- Reaching out to develop greater community involvement and support

A conceptual framework for linking prevention strategies with mental health treatment for children and families is needed. Such a framework should address the continuum from prevention to treatment for serious emotional disorders. Weisz, et al proposes the following terminology and components of a continuum of care that fits well with systems of care values. Specifically, the model is child and family centered, community based, encourages cultural competency and emphasizes evidence-based practices. The child, family, community and culture comprise the core of such a model. Interventions include:

- Health promotion/positive development: addresses entire populations; general positive health and risk reduction through various avenues, such as positive youth development programs and academic enhancement
- Universal prevention: addresses risk factors among groups (such as certain grades, groups) without attempting to identify which particular children are at risk
- Selective prevention: addresses groups at risk of mental health problems, such as children exposed to traumatic events does not identify which children, specifically
- Indicated prevention: targets those who have mental health problems but do not necessarily meet criteria for a diagnosis ; may intersect with time-limited therapy
- Time limited therapy: provides treatment for a single episode of care i.e., a limited number of sessions, for those diagnosed with a mental health problem; treatments are often “manualized”; i.e., have a protocol
- Enhanced therapy: provides treatment for an extended period of care (beyond a single episode) for those diagnosed with a mh problem; includes booster sessions
- Continuing care: provides an array of services over extended period to support effective living in students with persistent long-term conditions.

The first four interventions seek to prevent mental health problems; the last three provide services to those with problems

One strategy recommended for coordinating resources at a school site is the resource coordinating team. It differs from a team created to review individuals; rather it is focused on managing and enhancing systems to coordinate, integrate and strengthen interventions. It weaves together all programs for addressing barriers to learning. This team addresses not only mental health issues but also all aspects of learning and healthy development.

➤ ***The Essential Elements of a SBMH program***

- Risk Screening
- Coordination/consultation with school personnel

- A School Based Resource Coordinating Team
- Standards
- Systematic screening for depression and suicide – e.g., Columbia Teen Screen or other depression screening tool and to have in place the necessary capacity to respond to positive findings from such screenings.
- Strong family involvement
- Linkages for referral
- Substance abuse screening and follow up
- Positive Behavior and Intervention Supports Program
- Require all funded programs to bill third party and Medicaid for services.
- ***Develop a strategic plan for school based mental health services that will move toward equitable distribution of resources, uniformity and sustainability in SBMH***
- Require CMHCs to partner with schools and SBHCs and “critical infrastructure” partners
- Integrate with other school health programs to create a continuum of programs and services in schools. At the state level, this process would be aided by the creation of an interagency council on school health. Such a committee would be charged with coordinating state policies and funding streams and ensuring that systemic barriers are removed for effective school based programs. This activity has begun informally, through the School Health Partnership, which includes representatives from several of the agencies involved with children’s health issues.

➤ ***Build Resources***

Incentives and Collaborative Funding : A commitment to healthy children often involves blending of funding. The state should identify and work across agencies to combine funding for pilot school based comprehensive programs. In New Mexico, for example, the departments of health and education worked with other state agencies to design a policy that uses maternal and child health funds, adolescent health funds to support school based health centers, teen pregnancy prevention programs and comprehensive school health education. Local districts were encouraged to design models that combined these resources.

➤ ***Deliberate, Planned Strategy for Expansion and Sustainability***

- Require third party billing where possible.
- Define appropriate roles for various professional levels
- Determine a strategic plan
- Define what services and in what mix
- Identify criteria for setting priorities for expansion

- Emphasize “evidence based” programs
- Build on current programs
- Include SBMH programs into the statewide behavioral health structure

➤ ***Integrate mental health with SBHCs***

Integrate with school-based health centers where they exist. Encourage/require SBMH programs to collaborate more closely with primary care providers in their community, including a requirement of a written MOU.

Integrating mental health services with primary medical care in SBHCs should be encouraged. The advantages of a collaborative relationship are obvious:

- Improved identification, risk screening, and case finding
- Increased productivity
- Efficient use of resources
- More Opportunities for prevention/early intervention
- Reduced stigma
- Better Coordination
- Opportunities to build a support network

➤ ***Improve quality***

There is a need to develop standards and benchmarks to create/enhance a system of accountability about quality mental health interventions

- Establish standards for SBMH programs (see example)
- Licensing, credentialing, certification
- Training
- Standards
- Programs should be developed along dimensions of best practices and adhere to a set of standards
- Assessment and Evaluation
- Evidence based practices essential to quality SBMH
- Assets building approaches rather than a focus on pathology

➤ ***Define Criteria for expansion priority***

- Schools on probation/under state control/not meeting NCLB
- Those that demonstrate a plan to integrate BH with SBHCs
- Schools with high percentage of at risk, low income, students
- Alternative schools

- One per county
- Those counties without a SBBH program
- Schools that are large enough to ensure productivity, i.e., cost effective
- Capacity to effectively implement
- Community support/involvement
- Build on current programs – where limited but successful programs already exist, build on those by providing resources to expand and develop the other aspects of a system of care.

➤ ***Address issues of professional preparation, qualifications and provider shortages***

- Address issues of shortages of trained qualified, mental health providers, especially psychiatrists; strengthen recruitment efforts
- Implement telepsychiatry to link psychiatric consultations with students in rural communities. This is being done and has successfully increased access and productivity of clinical specialists.

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Appendix 1: Examples of Two States with Well-Developed Coalitions for SBMH

Ohio's Experience

Recently Ohio has been recognized nationally as a leader in building and expanding collaboration across education, mental health and family-serving organizations in developing a shared agenda for children's mental health and school success. As noted above, this work has been funded in part by a planning grant awarded in October 2002 from PMP/NASDSE (now the IDEA Partnership) and NASMHPD. In Ohio, the policy-making leadership of education, mental health and family serving organizations is engaging with state and local partners to generate a commitment to addressing non-cognitive barriers to learning to support successful academic achievement for all children and youth.

Prior to award of the planning grant, momentum was developing in Ohio. In 2001, the Ohio Department of Mental Health (ODMH), in partnership with The Ohio State University Center for Learning Excellence (CLEX), and with participation of the Governor's office and the Ohio Department of Education (ODE) convened a hearing that served as a "call to action" for Ohioans to improve mental health and school success for all children. The Hearing Summary and Resource Guide, and a more recent follow-up publication, have been disseminated widely throughout the state (Ohio Department of Mental Health, 2001, 2003). Concurrent with the 2001 hearing, the Ohio Mental Health Network for School Success was formed, consisting of action networks spearheaded by affiliate organizations in six regions of the state. Each affiliate has in turn created an action network with their region. Initiation of the Network was made possible, in part, by an infrastructure grant from SAMSHA to ODMH. Currently the Network is funded by ODMH and ODE and is co-led by CLEX and the Center for School-Based Mental Health Programs (CSBMHP) at Miami University. The Network vision is that every child in Ohio, including students with disabilities and non-identified students, will have the opportunity, and support needed, to be successful in school. The mission of the Network is to help Ohio's school districts, community-based agencies and families work together to achieve improved educational and developmental outcomes for all children—especially those at emotional or behavioral risk and those with mental health problems.

To accomplish this mission the Network works through a multifaceted action agenda to:

- 1) Promote awareness of the mental health and emotional and behavioral needs of pupils attending school in Ohio;
- 2) Help to build capacity within mental health agencies to promote and directly support the improvement and expansion of school-based mental health services in their communities;
- 3) Provide and promote direct training (pre-service and in-service) and technical assistance to designated audiences within the regional action networks who will in turn work toward the improvement and expansion of school-based mental health services at the local level; and
- 4) seek in each case both to reduce barriers to learning and to support the positive efforts of children and families as they work to achieve success in school (<http://www.units.muohio.edu/csbmhp/network.html>; <http://altdmh.osu.edu/omhn.htm>).

Ohio's Shared Agenda Initiative is being implemented within the collaborative infrastructure of the Network. Thus far four phases of Ohio's shared agenda initiative have included a statewide forum for leaders of mental health, education and family policymaking entities in March 2003, Six regional forums held for policy implementers and consumer stakeholders in April and May 2003, an historic, first of its kind, legislative forum/hearing involving key leadership of relevant house and senate committees on October 9, 2003, and ongoing policy/funding advocacy and technical assistance to develop and promote an action plan for implementation of the recommendations derived from the seven forums, with coordination by a steering committee.

Across the seven forums preceding the legislative event, various features included cross-stakeholder panel discussions, youth and parent testimony, displaying of promising work and facilitated discussion structured to promote collaboration and explore implementation issues. Recommendations derived from the facilitated discussion of the first seven forums provided the framework for the October 9, 2003 Legislative Forum. During the legislative forum adult and student, panelists shared personal testimony, findings and recommendations from the previous seven forums. Presentations were made by Michael Hogan, Director of the Ohio Department of Mental Health and Chair of the President's New Freedom Commission on Mental Health, and by Jane Wiechel, Associate Superintendent of the Ohio Department of Education. The legislative panel heard compelling testimony and exchanged ideas with students, parents, educators, mental health professionals and other interested parties from across the state.

On immediate outgrowth of the legislative forum was successful advocacy for inclusion of an amendment in an "educator standards" Senate bill, which became law on June 9, 2004. The law establishes a new Educator Standard Board in Ohio to establish and monitor implementation of training requirements for recertification of teachers. Included in the law is the stipulation that requirement "shall include standards that address the crucial link between academic achievement and mental health issues" (2004 Ohio Revised Code, Section 3319.61).

The current and ongoing phase of the shared agenda initiative in Ohio involves development and implementation of a comprehensive action plan. The guiding principles for this plan, consistent with the principles alluded to previously in this paper, are that *mental health is crucial to school success* and that *there are shared opportunities for mental health, schools and families to work together more effectively*. The plan, which was released officially and jointly by ODMH and ODE in August, 2004) details 5 goals and 23 objectives, that incorporate attention to awareness raising; identification, expansion, and implementation of evidence-based practices, advocacy of realigned State budget allocations, and expansion of capacity to support mental health in schools thorough pre-service an in-service education, training, and professional development (Ohio Mental Health Network for School Success, 2004).

The Ohio Mental Health Mental for School Success is playing a pivotal role in implementation of the shared agenda goals and recommendations, which have been incorporated into the Network's preexisting action agenda. One of the recent productive partnerships has involved Network collaboration with ODE in its efforts to expand

Positive Behavior Support in Ohio's schools. In addition, the Network is partnering with Ohio schools to participate in a SAMHSA-funded 3-year Elimination of Barriers Initiative (EBI) to identify effective approaches in addressing stigma and discrimination associated with mental illness. Ohio, which is one of eight states selected to participate with SAMHSA, has chosen to focus its efforts on the school age population and on the piloting of school resource materials as well as a youth speaker panel/bureau.

New Mexico's Experience

In New Mexico, school mental health programs have received increased attention as a critical component of the state behavioral health infrastructure. The focus on school mental health in New Mexico largely developed from the receipt of a federal Maternal and Child Health state School Mental Health Infrastructure grant in 1995-2000, which led to the creation of the New Mexico School Mental Health Initiative (SMHI) in the Department of Health. This Initiative was housed in the Office of School Health, in the Public Health Division in the Department of Health, as an integrated component of a similar state grant from the CDC to develop school health infrastructure. Through the Initiative, the Interdepartmental School Behavioral Health Partnership was created between the multiple agencies in state government that housed component programs related to both schools and mental health supports. Through the collaborative efforts of the Interdepartmental Initiative, school behavioral health programs across the continuum from training to prevention to screening, early intervention and treatment were developed and implemented with joint funding. Throughout this development, the Office of School Health collaborated with the University of New Mexico Department of Psychiatry to share both staff and resources to expand this effort.

As increasing recognition of the need for expanded school mental health grew, additional infrastructure staff positions were developed for the Initiative. A Behavioral Educational Consultant position was created to develop statewide training models for school staff and school health professionals in behavioral health issues of students. In addition, regional School Mental Health Advocate positions were developed in Health Department district offices throughout the state, to link schools with mental health supports and technical assistance. These advocates were partnered with school health advocates at the same offices, who had a similar role in supporting school nurses as well as overall school health efforts. Over the past several years, additional staff has been added to support critical efforts in dropout prevention, screening models for behavioral health supports in schools and the development and evaluation of protocols for behavioral health treatment in school-based health centers (SBHCs).

While the initial program training and support from the SMHI initially focused on educational and prevention models, the more recent training requests from school districts have focused on direct services education and treatment models. Over the past several years, the most attended programs at the Office of School Health's annual "Head to Toe Conference on School Health" have been the mental health workshops, often taking 150-200 of the 600-700 attendees. The School Behavioral Health Training Institute, a train-the-trainers model for school staff and school health professional moved from requested trainings in classroom behavioral management to the neurobiological

impacts of trauma on the developing brain and the impact of poverty on classroom behavior.

School Mental Health Initiative efforts have supported screening, early identification and treatment services in both SBHCs and stand alone school mental health programs. A grant from the Center for Health Care Strategies to the New Mexico Human Services Department led to the development of effective models for Medicaid reimbursement for SBHCs and protocols for the recognition and treatment of depression in SBHCs. Additional support from the Depression and Primary Care Programs of the Robert Wood Johnson Foundation led to the evaluation of the effectiveness of these protocols in rural SBHCs.

Through a partnership with the Columbia University TeenScreen program, New Mexico has been able to educate schools about the value and models of early screening for behavioral health problems. An additional partnership with the New York University Child Study Center led to the anti-stigma campaign “Childhood Revealed New Mexico”. This awareness-building effort brought together artwork of children with mental health issues from throughout the country and New Mexico to inform the communities of Albuquerque, Santa Fe and Roswell about how mental illness affects our children and their families. Follow-up efforts have been developed to help youth and their families recognize the signs and symptoms of depression as well as to break down stigma surrounding the acknowledgement of the impact of mental health problems on our families and the importance of getting help.

Over the past several years, New Mexico has also expanded its focus on linking school health and behavioral health programs to Native American communities throughout the state. In 2001, the Northwest Areas School Health Champions group was established by SBHC providers who work in Native American communities. Through partnerships tied to this effort state Medicaid policy was changed in 2003 to allow for off-facility Medicaid billing by the Indian Health Service, thereby allowing for critical reimbursement for SBHC services. The Acoma-Laguna and To’hajiilee Teen Centers, a partnership between the University of New Mexico Health Sciences Center and Indian Health Service, has received several grants through the Robert Wood Johnson Foundation, state foundation partners, and other state agencies to increase school mental health services at their rural school sites. Most recently, New Mexico Voices for Children, a statewide children’s advocacy organization, received a grant from the Kellogg Foundation in partnership with the New Mexico Chapter of the National Assembly for School Based Health Care to expand advocacy and policy development toward increasing the number and quality of SBHCs in Native American schools throughout the state.

Several recent state initiatives are underway to bring school mental health programs solidly into the state behavioral health infrastructure. In the summer of 2004 the state administration called for the development of the Interagency Council on School Health, a consortium of all state agencies involved in school health activities, to link programs, staff and funding for school health programs, including school mental health. Recent priorities developed by the Council include behavioral health, teen suicide prevention, SBHCs, obesity and dropout prevention. In addition, New Mexico is making

school behavioral health services a critical component of the state's behavioral health restructuring model. Under the new system, community behavioral health programs, including school behavioral health, will be prioritized, requiring providers to collaborate with schools as critical infrastructure partners. In addition, a recent request of the Governor as part of his efforts to decrease the teen suicide rate in New Mexico calls for the doubling of SBHCs in New Mexico within one year. Because of all of these efforts, New Mexico plans to be a state with a strong school mental health infrastructure that provides a continuum of school mental health supports for years to come.