AN IMPERATIVE TO ADDRESS SCHOOL-BASED MENTAL HEALTH

PREFACE

ALL professionals who interact with children and youth can have a significant impact on their well being and potential lifelong success. Honoring this importance and recognizing the often isolated nature of professional practice, this paper serves as a call to action for these professionals to revise their roles and responsibilities - to do things differently - by investing themselves in an interdisciplinary, connected process of service provision. Professionals must work as equal partners to develop a coordinated approach in addressing the multifaceted mental health needs of children and youth.

Schools are concerned about the academic performance of students. Whatever a school does must support the mission of helping students reach their optimal academic performance. Increasingly, research supports that improved academic performance is a result of the provision of services to meet the mental health needs of students (Greenberg et al., 2003; Hussey & Guo, 2003; Zins et al., 2004). Consequently, for schools to be successful, we must seek to comprehensively address the mental health need of students.

This paper was developed by an interdisciplinary group to exemplify the foundation of school-based mental health (SBMH): a team of professionals from different disciplines engaged in a collaborative effort. Even in the writing of this paper, different disciplines struggled to develop a common language and move beyond priorities of individual professional approaches to a shared vision of school-based mental health. This necessary but challenging process is critical to the success of school-based mental health initiatives. Thus, this paper serves as a call to all school and community professionals who work with children and youth to “step out of the box”

and use their skills and abilities in a coordinated manner to enhance what a single professional can do.

BACKGROUND

To this end, the North Carolina School Psychology Association (NCSPA) and the School Mental Health Project of Eastern Area Health Education Center (EAHEC), with funding from The Duke Endowment, began an initiative to enhance the focus on school-based mental health and its benefits to students, schools and communities. Since no agency or organization has all the resources to meet the mental health needs of children, it is imperative that interdisciplinary coordination and collaboration occur. First, NCSPA recognizes that school psychologists cannot meet the mental health needs of all children in the school. Second, it recognizes that many other school professionals have the skills to meet some of the mental health needs. Third, it recognizes that community resources are needed. Finally, it recognizes that coordination and collaboration among school professionals and community resources are the only way that the mental health needs of students will be met.

To begin the initiative, the NCSPA and School Mental Health Project held an organization meeting of representatives from numerous professional and advocacy organizations in May 2008. A result of the meeting was the development of a statement about school-based mental health upon which all could agree. Thus, representatives from the NCSPA, the NC School Counselors' Association (NCSCA), the NC School Social Workers' Association (NCSSWA), East Carolina University Department of Psychology and Department of Counselor and Adult Education, and the EAHEC School Mental Health Project convened in August 2008 to formulate a position paper. To exemplify the need for collaboration across disciplines, the

representatives committed themselves to developing a statement that provides the guidance for that collaboration. The resulting paper will:

- Raise awareness of the connection between mental health and academic outcomes
- Provide a clear definition of school-based mental health
- Reconceptualize relationships between providers for more effective coordination of services for improved student outcomes
- Move stakeholders closer to being aware of the need for coordination of school-based mental health services
- Challenge school and community professionals to assure that the mental health needs of all children are met in one's community utilizing the points raised in this paper

INTRODUCTION

In 2003, the New Freedom Commission on Mental Health recommended in its report to the President of the United States that school-based mental health programs must be improved and expanded, stating emphatically, "schools should have the ability to play a larger role in mental health care for children". The impetus for this emphasis can be found in the statistics related to the mental health of children in grades K-12 and the access to services reported for this population. First, consider these prevalence rates:

- Approximately 20% of children have symptoms of a DSM-IV diagnosis during the school year (US Department of Health and Human Services, 1999).
- Approximately five percent of children have a disorder that affects their daily functioning in all environments (US Public Health Service, Office of the Surgeon General, 2001).

If one applies these statistics to a typical elementary school, the results are startling.

- In a class of 25 children, five children will have the symptoms of a disorder. One of those children will have a very difficult time participating in the classroom.
- In a school of 500, 100 of the students will have the symptoms of a disorder. Of those, 25 likely will have extreme difficulties functioning in the school setting.

In reality, the risk factors that predict childhood mental health problems are not equally distributed across our society. Some schools or districts will have significantly more students at risk for mental health problems than others due to lower socioeconomic status, more violent neighborhoods, or other social inequities.

Secondly, service rates are abysmal. Many studies indicate that more than 75% of children with mental health problems do not receive services (Goodman et al.,1997; Grunbaum et al., 2004; Marsh, 2004). That means only one or two of those children with identified disorders in the classroom described previously will receive services. Likewise, access to service is not evenly distributed across society. Unfortunately, many of the children with the greatest need for services are the ones with the least access, often due to financial constraints, lack of insurance coverage, inadequate transportation or unavailable services. When considering the mental health statistics and access of services by the K-12 population, the need for increased focus on mental health services in the school setting is readily understandable.

Current initiatives in North Carolina support the imperatives of the New Freedom Commission. Fundamental change has occurred in the state's mental health service system during the past six years. The responsibility of Area Mental Health Programs shifted from the delivery of direct services to that of managing the delivery of services through private providers. Unfortunately, many areas throughout the state experienced at least a temporary decrease in services, leaving fewer children receiving services than before system reform. This reinforces the

premise that schools, not community mental health providers, are the primary service providers for the children. Research indicates that about 70% of the children who receive services do so at school (Burns *et al*., 1995). For 48% of the children with serious emotional disturbances surveyed by Burns *et al*. who received services, the public school system was the sole provider. In a similar study, Costello *et al*. (1996) supported the findings of Burns *et al*., reporting that approximately 50% of children and adolescents who are present with serious emotional disturbances only receive mental health services through the school. After reviewing these findings and the findings from other studies, it was concluded that schools were the primary providers of mental health services for children (Hoagwood and Erwin, 1997).

What does this mean for North Carolina students? The NC Department of Public Instruction (2007) identified 8,779 students as "Emotionally Handicapped," a small fraction (0.6%) of the 1,434,325 children enrolled in public and charter schools during 2006-07. If this represents the children with more severe problems who require special education services, then that leaves approximately 278,000 students who could benefit from mental health services but likely are not receiving them. These students are in danger of a host of academic and related concerns such as:

- Low academic performance (Weissman et al., 1999)
- School failure (Keys, Bemak & Lockhart, 1998)
- Teen pregnancy (Kessler, et al., 1997)
- Substance abuse (Cuellar, Markowitz & Libby, 2004)
- Gang participation (Corcoran, Washington and Meyers, 2005)

Consequently, up to 44% of students facing significant mental health concerns during high school will drop out before completing their diploma (Wagner, 2005).

ACADEMIC OUTCOMES AND GRADUATION RATES

If these students received appropriate mental health services and support, would it make a difference to the students and schools? In other words, would academic performance and behavior improve? Consider these examples from Baltimore City Schools.

- In 19 schools served by the Johns Hopkins-East Baltimore Mental Health Partnership, 80% of the students served demonstrated improved conduct grades (Glass-Siegel & Leslie, 1999).
- In one high school, fifty-one referrals were made during the school year. Of those fifty-one students, 24% had been suspended during the previous school year. During the school year in which they received support, only 3% were suspended.
- In one of the middle schools, 92% of the students receiving services had improved attendance. Ninety-four percent of the students had fewer suspensions and 90% had improved grades.

In a two year study of 35 elementary schools, Nelson, Martella and Marchand-Martella (2002) discovered a positive relationship between academic performance and social adjustment. Furthermore, Ialongo *et al*. (1999) found a significant positive relationship between academic outcomes and mental health concerns and behavior in a preventive program with first graders. Dallas Public Schools Youth and Family Centers found a 69% improvement in successful course completion for students served in school-based mental health clinics (Jennings, Pearson & Harris, 2000). Consequently, it is crucial to address mental health needs for students to be successful academically and for schools to function effectively (Flaherty, Weist & Warner, 1996).

Can school-based mental health programs improve graduation rates? Evidence indicates that the answer to that question is "Yes!"

- Wilson, Gottfredson, and Najaka (2001) conducted a meta-analysis of 165 studies of school-based prevention programs that taught self-control or social competency or employed cognitive-behavioral and behavioral instructional methods. They found these interventions were effective in reducing the number of students who drop out, have poor attendance, display conduct problems, and are involved in substance use.
- The National Center for Educational Statistics (U. S. Department of Education, 2002) cited the following top three reasons students reported for dropping out of school: (1) not getting along with teachers (35%), (2) not getting along with peers (21%), and (3) not feeling safe (12%). All three are social-emotional factors, not academic factors.
- A number of evidence-based Social and Emotional Learning (SEL) curricula and programs lead to prevention of substance abuse, interpersonal violence and promote positive mental health in youth development and achievement (Cartalan *et al.*, 2002; Durlak & Wells, 1997; Gottfredson & Wilson, 2003; Tobler *et al.*, 2002, Zins *et al.*, 2004). Positive outcomes associated with SEL prevention programs include:
    - higher achievement test scores
    - greater achievement in reading
    - improved math scores
    - more progress in phonological awareness
    - increased achievement over time
    - higher academic motivation
    - greater trust and respect for teachers

- fewer absences and suspensions
- reduction in aggression
- less drug, tobacco, and alcohol use

Are schools attempting to meet the mental health needs of their students? Yes, they often have a myriad of programs that address mental health needs, including the Character Education curriculum used in the classroom; health education; anti-bullying programs; adolescent pregnancy prevention programs; safe and drug-free school programs; counseling provided by school counselors, social workers, psychologists and nurses; classroom mentors; licensed therapists coming into the schools; Response to Intervention (RtI); Positive Behavioral Intervention Support (PBIS) – the list could go on. Are these effective and helpful interventions? Yes, in most situations. However, these programs and efforts are frequently viewed as "add ons" (Aldeman & Taylor, 2007) rather than as an integral part of the student's education since they are not "academic." There is seldom coordination between the support programs themselves and even less coordination between the academic components in the school and the support programs. Plus, they are often temporary, lasting one to three years because of funding, personnel changes or policy changes. One goal of this paper is to show the link between school-based mental health services and the academic outcomes of students.

What can schools do to better meet the needs of students? Resources to provide mental health services and supports are available to schools, both from within the schools and from community programs. Yet, they are probably not adequate to meet all students' needs. However, with coordination and collaboration, schools can increase service delivery for many more children. Thus, this paper seeks to provide an initial explanation of the structure and process of developing this coordination and collaboration.

A DEFINITION OF SCHOOL-BASED MENTAL HEALTH

To say that the term "school-based mental health services" needs a clearer conceptual framework is an understatement. Similar terms are used interchangeably in the field and in literature: school mental health, school-based mental health, expanded school mental health and comprehensive school mental health. Other terms have entered into the discussion: social-emotional learning, psychological well-being, mental healthiness, psychological/crisis recovery. Add Positive Behavior Interventions and Supports (PBIS) and Response to Intervention (RtI), and the discussion becomes more convoluted.

In examining existent literature, it is easy to understand the difficulty in defining school-based mental health. The academicians and practitioners in the field discuss components of school-based mental health, the range of school-based mental health services from specific therapies to universal education programs, or school-based mental health according to who is delivering the service and where the service is delivered. Given the lack of a clear definition, how are we to talk about "school-based mental health" so that we have a common understanding?

Adelman and Taylor (2006) point out that part of the confusion and conflict in discussing mental health in schools is the variety of vested interests represented. Consider the disciplines within the school setting itself: psychology, counseling, social work, nursing, applied behavioral analysis and special education. Add into that mix professionals from the community, such as mental health therapists, community support professionals, psychiatrists and pediatricians. Each discipline brings to the table a potentially divergent agenda for policy, practice, research and training. Similarly, schools have been encouraged to adopt/enhance a range of programs and approaches for a) treating specific individuals, b) addressing specific types of problems in

targeted ways, c) addressing problems through school-wide, 'universal' interventions, and d) promoting healthy social and emotional development. And according to Kutash, Duchnowski and Lynn (2006), "perhaps the most prevailing source of divergence in school-based mental health comes from the differences in approach that exist between the education and mental health systems."

Adelman and Taylor further state that "any definition of mental health in schools must encompass considerations of the school's role related to both positive mental health (e.g., promotion of social and emotional development) and mental health problems (psychosocial concerns and mental disorders) of students, their families, and school staff" (p. 3). Any definition must also consider the different school-based and community-based disciplines that have a role in school-based mental health. Finally, and perhaps most importantly, a definition must consider the collaboration among disciplines, programs and services for school-based mental health to address the many needs of students.

Considering the previous factors, the Policy Paper Work Group proposes the following definition of school-based mental health: **Coordination of comprehensive, interdisciplinary, and evidence-based services and programs to address the mental health needs and wellbeing of all students in schools**. This definition is based on the following assumptions:

1. School-based mental health services and supports are crucial to the success of students – academic, social and emotional.
2. Both prevention and intervention programs are key components of school-based mental health.
3. School-based mental health is collaborative in nature, recognizing that each discipline brings its own expertise that can assist in meeting students' mental health needs.

4. School-based mental health programs will facilitate administrators and other school personnel in meeting their accountability standards.
5. School-based mental health is one component of a service integration approach, e.g., system of care, to comprehensively address student needs.
6. School-based mental health services and programs must be routinely monitored to evaluate their effectiveness and to encourage future adjustments as needed.

INTERDISCIPLINARY COLLABORATION: ROLES AND RESPONSIBILITIES

Interdisciplinary collaboration creates the fundamental facilitative conditions for implementing school-based mental health programs. Without a strong foundation of interdisciplinary collaboration, school-based mental health programs cannot be effective and will instead result in overlapping or conflicting service provision (Lopez, Torres, & Norwood, 1998). **Interdisciplinary collaboration must structure both the framework and coordination of services for school-based mental health services.**

To better understand interdisciplinary collaboration, consider a kaleidoscope. As one rotates a kaleidoscope, the shifting reflections of light bouncing off multiple mirrors create a vibrant, complex image (Kaleidoscope, 2008). Such is the process of interdisciplinary collaboration for school-based mental health professionals. As the roles of multiple, diverse professionals shift in response to environmental conditions and professional relationships, the complementary nature of their engagement produces a vibrant, fruitful partnership. By utilizing an effective system of interdisciplinary collaboration, school-based mental health teams can increase efficiency of service provision and improve student outcomes (Brabeck, Walsh, & Latta, 2003). Functional interdependency, requiring an awareness of the larger system and one's role within that system, (Heaney, 1975) allows professionals to produce outcomes not otherwise

achievable when working separately (Corrigan, 2000). Interdisciplinary collaboration must grow from a system of shared vision, goals, respect and trust (Muronago & Harada, 1999). School-based mental health teams in North Carolina must embody a strong commitment to interdisciplinary collaboration and a willingness to shirk territorial demarcations of professional responsibilities for a flexible, shifting process of leadership and professional engagement.

A powerful indicator of the importance of interdisciplinary collaboration for the school-based mental health process is the inclusion of statements mandating collaboration and participation in interdisciplinary teams by all of the major professional stakeholder organizations. The National Association of School Psychologists (NASP), in its statement on school psychology training and practice, include the domain of consultation and collaboration (NASP, 2000). The Standards for School Social Work Services developed by the National Association of Social Work asserts that school social workers must work as interdisciplinary team members and leaders (NASW, 2002). Competencies adopted by the American School Counselor Association (ASCA) include more than fifteen specific statements avowing the importance of collaboration and leadership (ASCA, 2008). Professional standards for school nurses also contain strong language supporting collaboration (NASN & ANA, 2005).

However, an essential difference exists regarding the mandate for collaboration by the professional organizations and the implementation of interdisciplinary collaboration posited here. The mandates given by professional organizations typically situate that particular profession as the "leader" of the collaborative effort. Interdisciplinary collaboration for school-based mental health programs requires flexibly shifting roles, including the rotation of leadership responsibilities. It requires that professionals shift from a disciplinary centrism in which any one profession is deemed to have the "correct" practical approach to an acceptance of

complementary roles (Arredondo *et al.*, 2004). The leader for any effort should be determined by particular school and community environmental characteristics, specific case requirements, and other factors unique to the situation and school-based mental health team. For effective interdisciplinary collaboration in expanded school-based mental health programs, all members of the team must be comfortable accepting the mantle of leadership and working collaboratively as contributors of equal worth and value. All professionals must have a working understanding of the roles and responsibilities of their collaborators and must seek to intentionally support their colleagues' professional efforts.

Beyond the obvious involvement of various support services disciplines, school administrators and teachers must also be stakeholders in this process. Although they may not be specifically trained in mental health service delivery, it is important to include them within integrative collaboration efforts for at least two reasons: 1) School administrators provide the framework in which the entire process occurs. Since they influence the behavioral climate of the school and dedicate resources (e.g., money, time) to programs, they must buy into the need for reform and support the efforts of certain programs for results to be significant; 2) Teachers are front line interventionists because they interact with students far more than any other support services personnel. Their response to students (or lack thereof) greatly affects academic and behavioral outcomes. Additionally, they will likely be called upon to deliver behavioral interventions and/or to monitor academic and behavioral progress in response to mental health interventions. As such, they are a crucial team member and their buy-in to school-based mental health programming is essential for success.

The key to sustainability of school-based mental health programs is effective interdisciplinary collaboration. The support that this process provides for practicing

professionals can lead to the prevention of professional burnout and improved clinical practice. The collective responsibility for student outcomes that results from effective interdisciplinary collaboration allows for the successes and challenges experienced by the team to be distributed across team members (Mostert, 1996), thereby reducing stress and maximizing possibilities for positive outcomes. Interdisciplinary collaboration is fundamental for the success of school-based mental health programs.

BENEFITS OF SCHOOL-BASED MENTAL HEALTH

School-based mental health programs offer a number of compelling benefits that have positive outcomes for children and adolescents (American Counseling Association, 2008). These benefits occur in three domains: students and their families, the local education agency (including school staff), and the community.

Benefits to Students and Their Families

When school-based mental health professionals are readily accessible, students feel less of a stigma in accessing and receiving mental health services, increasing the likelihood that these students seek help (Slade, 2002). Mental health professionals in the schools are also able to monitor the students' cognitive, social-emotional, behavioral and academic functioning over time. Additionally, staff and parents can utilize the mental health professional's expertise, which ultimately benefits the student.

Another benefit to students is the availability of school records such as cumulative files, exceptional children's files, and any pertinent testing, discipline and attendance data, for the school-based mental health team to review. These files assist the interdisciplinary team in determining the specific needs of the student and help the team develop a complete picture of the

child. Thus, the team can develop a comprehensive service plan which reduces redundancy of assessment or services.

Research has documented that children and adolescents receiving social-emotional support and preventive services demonstrate improved school achievement (Greenberg *et al.*, 2003; Welsh *et al.*, 2001; Zins *et al.*, 2004). A study revealed that students who have higher standardized test scores acquired the skills necessary to navigate the educational environment including connections to faculty and peers and skills to make better decisions (Fleming *et al.*, 2005). Conversely, students who received lower test scores and grades were identified as having limited positive connections to peers and aggressive and/or disruptive behaviors (Fleming et al., 2005). This bidirectional relationship between academic underachievement and behavioral problems has been documented repeatedly in the literature (Morgan, Farkas, Tufis, & Sperling, 2008).

Benefits to School and Staff

School-based mental health programs benefit not only students and their families, but also the school staff. One such benefit is collaboration among the various support personnel and teachers. The art of collaboration is a skill many student support personnel possess and is an absolute necessity when addressing the multiple needs of today's children and youth (Porter, Epp, & Bryan, 2000). From this collaboration in school-based mental health, benefits to school personnel include "shared decision-making and responsibility, peer supervision and a support network, enhancement of communication and negotiation skills, increased sensitivity to other providers, and broader awareness of clinical and ethical issues" (Flaherty *et al.*, 1998).

As each school professional is striving in his or her own way to positively impact the academic achievement of students, he/she often finds that the impact is greater when his or her

effort is in collaboration with other professionals . School-based mental health services provide a forum for melding the efforts of all school professionals into comprehensive, complementary service provision to students and families. This work must have at its core the goal of improving mental health, school performance and the overall quality of life for students served by these professionals. Flaherty, Garison, & Waxman (1998) strongly assert that these individual professional objectives must be met through comprehensive collaborative practice.

At the elementary level, expanded school-based mental health services have resulted in a reduction in referrals to special education and students sent to the office for disciplinary action. These services have also impacted the "school climate, grade retention and placement of at-risk students" (Burns *et al.*, 2004). For children experiencing "severe emotional and behavioral difficulties," mental health services offered at the elementary level have contributed to "reductions in conduct disordered behavior, attention deficit/hyperactivity, and depression" (Hussey & Guo, 2003). As expanded mental health "facilitates the early identification of students in need and the rapid delivery of appropriate services," it therefore assists in "improving the school climate" (Weist, Goldstein, Morris, & Bryant, 2003).

Benefits to the Community

The community benefits from having school-based mental health professionals. These benefits include improved safety and economic gains. School-based mental health professionals "bridge the discontinuity in mental health services between schools and community agencies" (Porter *et al.*, 2000).while partnering with "other social service institutions in keeping youth and communities safe" (Porter *et al.*, 2000).

Additionally, an analysis completed by the Institute of Medicine reported "the economic costs and benefits of early childhood interventions for low-income children have demonstrated

savings in public expenditures for special education, welfare assistance, and criminal justice" (Shonkoff & Phillips, 2000). By increasing the quality of our schools and investing more in education while lowering the dropout rate, "nearly $200 billion a year in economic losses could be recouped" (Teachers College, Columbia University, 2005).

ADDRESSING BARRIERS TO SCHOOL MENTAL HEALTH

Barriers to school-based mental health are numerous, ranging from systemic to the individual level. This paper will address a number of barriers at each level, not necessarily in order of importance. The first barrier to be discussed is attitude, which will be addressed from two perspectives. First, there is a common belief that providing mental health services will deprive the school of time and resources essential to the mission of educating students. With the increased focus on academic accountability via NCDPI's ABC plan and Average Yearly Progress (AYP) required by the "No Child Left Behind" federal mandate, the general attitude is that all resources (time, financial and human) must be placed on academic instruction. This results in the unfortunate reality that school-based mental health services are not even salient in some school systems.

To address this concern, Adelman & Taylor (2000) suggest changing the focus from specific mental health issues to "addressing barriers to learning," which is more in line with the perception that schools have of their mission. School personnel need to be educated about how mental health affects learning. As pointed out earlier in this paper, 1 in every 5 (20%) students has an identifiable mental health condition and would benefit from services and supports. Additionally, 1 out of every 10 (10%) students has impairments so severe that it is impossible for those children to function in a classroom without identified supports (Mental Health: A Report of the Surgeon General, 1999). In fact, it has been well established in the literature that less than

75% of students needing mental health services receive them (Burns et. al., 1995; Research Highlights, 2002). Weist reports that more than 25% of public school students could benefit from mental health services and less than one third of the students who need services receive them. Students who did receive services had often endured their symptoms for years. Those who did get services were more likely to get them at school. By addressing the mental health issues as barriers to learning, school personnel, parents, elected officials and community citizens can shift from viewing mental health services as "add ons" to seeing them as essential components of a student's academic success.

The second attitudinal barrier is stigma. In a survey of school systems about school-based mental health conducted by U.S. Department of Health and Human Services (USDHHS) for the school year 2002-03 (Foster, Rollefson, Doksum, Noonan, Robinson, 2005), 36% of the respondents listed stigma as a barrier to students accessing mental health services in the school. Samargia, Saewyc and Elliott (2006) found that adolescent girls from two-parent homes were not likely to seek mental health services because they thought they would either get over the problem without any help or because they did not want their parents to find out. One way to address stigma of seeking services is through the school-based health center (SBHC). Since the SBHC provides health services in general, seeking services from the SBHC likely will not carry the same stigma that is associated with going to an agency specifically designed to address mental health issues might. Mathias (2002) indicated that SBHC facilitated access by adolescent males experiencing mental health issues as well as adolescents from rural and socioeconomically deprived areas. A survey of adolescents in Australia found that the respondents wanted a focus on "wellness" rather than "illness" in health services (Sanci, Kang & Ferguson, 2005), another way that the SBHC can combat stigma. Outreach to the students themselves is an important

component of any successful school-based mental health initiative. Information about how to obtain services can facilitate access (Royal Children's Hospital Melborne, 2005). Students may need education about how seeking help can alleviate problems whereas waiting usually exacerbates them.

Finances are a second barrier in the availability of school-based mental health services. First, there is a lack of adequate finances. With limited money, school systems are forced to make the hiring of instructional staff a priority even if they believe that mental health services for children are essential to learning. North Carolina's funding formula for teachers is based on the Average Daily Membership (ADM), or the schools' populations. Thus, many rural LEAs, particularly those located in the coastal and far western parts of the state, often don't have enough instructional staff, let alone the student support personnel needed to address mental health needs.

In addition to state funding provided to school systems based upon the ADM, local county commissioners provide a major source of money available to fund positions and other resources needed in schools. Often, the only other source of revenue in a small school district is the local tax dollar money, which translates to fewer dollars available for student support personnel in the smaller more rural school systems.

A third source of funding comes from the federal government, such as Title I programs, exceptional children programs, and other related federal programs. In the USDHHS survey of school-based mental health (Foster, Rollefson, Doksum, Noonan, Robinson, 2005), 63% of the school systems reported using IDEA funds to provide school-based mental health services. However, these services were limited to those students who were identified as exceptional children and not available to the broader student population. Also, these federal funds often are

not sufficient to enable the school system to meet the required mandates. Yet they must do so with state or local funds, thus detracting from other programs, such as school-based mental health.

Advocacy is needed to help decision-makers understand that additional funds are needed to provide the necessary support students need to perform well academically. The focus must be on the local level (school board and county commissioners) as they determine the amount of local funds available and the priorities for those funds. Efforts must also come at the state level, educating lawmakers about the intricate relationship between the mental health of students and their academic performance. Finally, advocacy on the national level to provide adequate funding for federal mandates is essential.

Adelman and Taylor (2009) suggest that school mental health must be addressed with the notion that additional funds will not be available. How can this be done? The basic premise is a reallocation of existing funds to meet identified needs. They recommend a framework in which decisions about the use of finances are based the needs of a range of learners with emphasis on prevention of and early intervention in learning problems. Such a focus will reduce the need for intensive interventions and treatments which are usually more costly.

Another financial barrier is payment for services. Fifty eight percent of the school districts in the USDHHS survey by (Foster, Rollefson, Doksum, Noonan, Robinson. 2005) reported that financial constraints of the families were major barriers to services. Many school districts (38%) reported that they use Medicaid to help pay for school mental health services. Yet, many families, especially in rural areas with migrant workers and immigrants, are not eligible for Medicaid, do not have insurance and cannot afford to pay. Also, it is not unusual that the cost of billing Medicaid and private insurance exceeds the reimbursement rate, particularly as

it relates to the number of treatment sessions eligible for billing. Unfortunately, many school districts in the survey indicated a lack of administrative capacity to bill third-party payers, which limited service delivery. One way to address this issue is the combining of finances of several school districts in designating a lead district to carry out the billing or to contract with an independent agency to do so. Another innovative approach to dealing with lack of funding and resources is to establish a team specifically designed to focus on seeking and coordinating resources (National Center for Mental Health Promotion and Youth Violence Prevention , 2007). The team would reach out to community agencies and other schools to identify and access existing resources as well as seek appropriate funding sources. Such a team would not focus on direct services and meeting individual needs, but instead focus on systemic changes.

The third barrier to be discussed focuses on personnel. The number of school-based mental health providers is limited. Forty-nine percent of the schools in the USDHHS school mental health survey (Foster, Rollefson, Doksum, Noonan, Robinson, 2005) indicated inadequate resources as a major barrier. School personnel who provide mental health services, such as school counselors, school psychologists, school social workers, and school nurses, are technically defined as student support personnel by the North Carolina Department of Public Instruction. In many school systems, not only in North Carolina but also nationally, the current priority is the hiring of instructional staff, as opposed to student support personnel. Currently, there is no funding formula for hiring student support personnel, nor are there any mandates that LEAs must hire specific numbers of such personnel based on a recommended ratio. Even if the state does recommend such ratios, they are only recommendations without any real mandate or consequences for the LEA.

Another personnel factor deals with the competing duties of the support personnel. In the USDHHS school mental health survey (Foster, Rollefson, Doksum, Noonan, Robinson, 2005), 46% of the schools reported this as a barrier. Even though school psychologists, school counselors and school social workers are qualified to provide mental health services and supports needed by students, their time is diverted to other responsibilities. All too frequently, their roles are redefined by the school principal or the central office administration. For example, school psychologists are usually the official "testers" of exceptional children and often given little responsibility beyond testing; school counselors are often the testing coordinators for End-of-Grade and End-of-Course testing, divesting much of their time from counseling; school social workers often are seen as focusing on truancy and not given the opportunity to use their counseling skills. It's not surprising that, according to Sanders (2001), insufficient time and difficulty in securing participation by school staff and community members are the two most frequently cited barriers to providing comprehensive school-based mental health services. Reallocating those responsibilities is a necessary step to allow these professionals to address the mental health needs of students. For example, some school systems have reassigned testing coordination to assistant principals or hired personnel as testing coordinators. Another example is the training of special education teachers to administer some of the tests of exceptional children, thus reducing some of the testing responsibility of school psychologists.

Data from Repie (2005), based on a survey of special education teachers, general education teachers, school counselors, and school psychologists in urban, suburban and rural schools, indicate that another barrier to school-based mental health services may be educators themselves. They found that teachers generally underestimate students' need for mental health services. The authors speculate that teachers are trained to value the educational mission of

school, while school counselors and school psychologists are trained for, and thus value more, clinical services outside of the classroom. The authors conclude that poor knowledge of mental health services was reported to be a greater barrier in rural and urban settings than in suburban ones. Ongoing in-service training (face-to-face and online) and a resource bank (on location and online) can be ways to educate school personnel about the need for and benefits of school mental health services.

A fourth barrier involving personnel and a key focus of this paper is that school service personnel, from a variety of disciplines, often place student academic needs at the forefront and fail to view their roles as team players in dealing with students' social and health needs (Bucci & Reitzammer, 1992). One possible approach to overcoming this barrier is for institutions of higher learning to provide future professionals with interdisciplinary training in which they can learn to collaborate with professionals from other disciplines (Bearinger & Gephart, 1993; Krist, 1990; Robinson & Masty, 1989; The Health/Education Correction, 1990).

When professionals fail to work as a team, the lack of coordinated services, the tendency to duplicate services and fragmented delivery of services often result (Krist, 1990). These issues can be overcome by sharing governance, collaborating in the planning and funding process, assigning ownership to the school, providing new roles for faculty in the schools, providing for the position of case managers, phasing in program components in a gradual fashion, and providing for extensive training of staff (Center for Research, 1992; Weist, 2006). One such example is the inter-professional training project at Ohio State University-Columbus in which they include training on human services and health issues in their education programs for teachers (Snider, 1992). The expectation that personnel must work together in an integrated and

collaborative manner must be built into their job descriptions, reflected in their evaluations and supported by time and resource allocation (Brilhart & Galanes, 1995; Rees, 1993).

A school-based mental health team should include not only school personnel but also members of the local community who can help provide a link with community resources. The National Center for Mental Health Promotion and Youth Violence Protection (NCMHPYVP, 2007) provides the example of the Mid-Valley Providers Consortium (MVPC) which sought to integrate services for migrant workers and immigrants by bringing together representatives from law enforcement, juvenile justice and mental health. Other community resources include the Department of Social Services, Local Health Department, Boys and Girls Clubs, other after school programs, and county and city recreational programs, just to mention a few.

For school-based mental health teams to be effective, core members should be designated to carry out specific functions and auxiliary members can serve in an advisory role (Center for Mental Health in Schools, 1998). Teams also need a leader or facilitator who keeps the team focused on the mission and task-oriented, and a recorder who keeps track of decisions, plans and outcomes. Computer technology should be used to facilitate effective and efficient team functioning. Finally, the organization (e.g., school system, school-based center) should work to ensure that team members are competent and committed. Potential harmful group dynamics can be dealt with effectively. For example, hidden agendas can be kept in check by allowing for an individual's brief presentation of a point and then moving the group on through redirection. The need to be validated can be covered by writing a point on a board or putting it into an "agenda bin" for later consideration. Reaching an impasse can be overcome by brainstorming or interjecting a new perspective. Personal conflicts may be the hardest barrier to overcome. If

conflict resolution strategies are ineffective, it may be necessary to restructure the make-up of the group.

Family involvement (34% of the school systems) and language and cultural barriers (20% of the school systems) were also identified barriers in the USDHHS school-based mental health survey (Foster, Rollefson, Doksum, Noonan, Robinson, 2005). The Center for School Mental Health Assistance (2002) identified many factors that can interfere with effective engagement and partnering with families:

- Stigma related to receiving mental health services
- Concerns about confidentiality
- Transportation (lack of, unreliable modes, distance, cost)
- Scheduling (conflicting work schedules)
- Concerns about maintaining a sense of control over other family members
- Resistance on the part of the child to involve the family
- Time constraints on the part of the clinician (large caseload, lengthy paperwork, etc.)
- Lack of resources within a program to encourage family involvement
- Preexisting tensions between schools and community members
- Lack of training on the part of the clinician

Families of students attending public schools do not always trust that the schools have their needs and interests at heart. To address this barrier, school personnel can provide outreach and education to families in response to their needs (e.g., parent training, transportation, child care.).

One outreach approach was to have service providers from the school make a preliminary home visit with someone who is already connected to the family (NCMHPYVP,

2007). These service providers must have proficiency in the specific language and culture of the family as well as expertise in meeting the needs of children and adolescents. However, providers must take caution in not over emphasizing cultures at the expense of individuals. For example, a Korean student who was assigned an Asian counselor stopped coming for counseling because he was disappointed he wasn't assigned to the 'blue-eyed" counselor his friend talked about (Center for Mental Health in Schools, 2007). Mason, Benjamin and Lewis (1996) suggest "The Cultural Competence Model" which focuses on diversity as a value in students and staff, that encourages self-evaluation of cultural "blind spots" and differences, stresses cultural education as a continuing process, recognizes the impact of culture on interaction styles, and makes accommodations for culture in direct interventions as well as in organizational policies and procedures.

Confidentiality is often mentioned as a barrier to school-based mental health services, but only 8% of the schools in the USDHHS school-based mental health survey (Foster, Rollefson, Doksum, Noonan, Robinson, 2005) identified it as such. Still, that issue must be addressed. Confidentiality requirements from federal and state governments as well as professional regulatory agencies may prohibit service providers in different agencies from sharing information (Ooms & Owen, 1991). Overcoming this barrier is a matter of establishing trust with students, families and other professionals. The team-based approach greatly facilitates obtaining permission to share information in order to better serve the students.

Another barrier that can be addressed by a school-based mental health team is variation of how school-based mental health is defined. Thus, it is important for school psychologists, school social workers, school counselors, school nurses, all working with their community partners, to collaboratively operationalize what school-based mental health means for their local

community and how it translates into comprehensive mental health services for children. This paper provides a base for that discussion and assistance in determining the needed array of services.

The final barrier to be discussed is the philosophy of the delivery of school-based mental health services. In the medical model, the focus is on the mental health disorder of the individual, the underlying assumption being "something is wrong with the child." The Family and Youth Services Bureau of the U.S. Department of Health and Human Services (1994) suggests a move away from the "medical model" toward examining the environment of the child (e.g. the classroom, the school, the home and the community) to identify the barriers to learning experienced by the child. Thus, a better way to serve the mental health needs of students is to provide services along a continuum from preschool to high school and in the community as well as inside the school buildings (Meyers & Swerdlik, 2003). Adelman and Taylor (2009) provide a learning support framework to develop that continuum through six components:

- Enhancing regular classroom strategies to enable learning (i.e., improving instruction for students who have become disengaged from learning at school and for those with mild-moderate learning and behavior problems
- Supporting transitions (i.e., assisting students and families as they negotiate school and grade changes and many other transitions
- Increasing home and school connections
- Providing assistance, with support of community services, to students and families,
- Responding to, and where feasible, preventing crises
- Increasing community involvement and support (outreach to develop greater community involvement and support, including enhanced use of volunteers

Shifting from the “medical model” mindset to a comprehensive approach requires gaining people’s trust through needs assessment (surveys, questionnaires, focus groups, etc.) and ongoing program evaluation (Weist *et al*., 2000). Equally significant is educating the major stakeholders (teachers, parents, administrators, school board members, community leaders, etc). (Meyers & Swerdlik, 2003) about the impact of a comprehensive approach to school-based mental health on academic performance and overall well-being of the child.

The challenges facing those who are invested in providing school-based mental health services can seem overwhelming. A spirit of collaboration combined with keen problem solving skills can provide the impetus for overcoming the barriers to providing those services.

IMPLICATIONS AND DIRECTION

A common framework of multi-level support has emerged when considering integrating initiatives like Positive Behavior Support (PBIS) and Responsiveness to Instruction (RtI). Primary, secondary, and tertiary interventions bring about the concept that multiple levels of support along a number of domains must be considered, including academic, behavioral, social and emotional supports. These frameworks are further elaborated on in Osher *et al* (2008) and Doll and Cummings (2008).

At the individual school level, it is important to advocate for frameworks and approaches that meet the needs of the student population. School counselors, school social workers, school nurses, and school psychologists can collaborate and create a school-based mental health team or a student support team. This team can function as a consultant to educators in meeting the needs of these students in the individual classroom and on a larger scale through building programs at schools that allow these students to get consistent services. These programs could include setting up the groundwork for a school-based health clinic and/or setting up a partnership with a local

mental health service provider to assist in providing services to needy students. On a universal level, this team could collect data on staff knowledge of mental health/substance abuse and increase awareness through presentations at faculty meetings and grade level meetings. This team could also conduct a survey on the school climate and coordinate programs that target identified needs, such as a bullying prevention program.

In addition, members of this team could be involved with other school staff on the school improvement team. To assist the school improvement team in analyzing learning supports and making data based decisions, Adelman and Taylor (Center for Mental Health in Schools, 2002) have developed a highly useful resource: *Mapping & Analyzing Learning Supports* (found at http://smhp.psych.ucla.edu/summit2002/tool%20mapping%20current%20status.pdf). As a member of the school improvement team, one could help the school to expand its mission to build comprehensive learning supports, as discussed by Adelman and Taylor (Center for Mental Health in Schools, 2007). In "New Directions for Student Support: Current State of the Art," Adelman and Taylor (2006) report that the current problem is that student supports are marginalized and fragmented. Many of the current approaches to school improvement are not broad enough, focusing typically on improving instruction and management. As Adelman and Taylor state, "the straight forward psychometric reality is that in schools where a large proportion of students encounter major barriers to learning, the often reported initial increase in test score averages tend to plateau after a few years." In addition, "[a]ll districts focus to some degree on the need for safe and drug free schools, parent and community involvement, discipline problems, and compensatory and special education. Few are developing a system to comprehensively address the many factors interfering with students having an equal opportunity

to succeed at school." If schools are truly going to address the many reasons that students are not succeeding in school, it is time to reassess how to achieve that mission.

Adelman and Taylor (2006) suggest the following recommendations for individual schools and school systems:

1. "revisiting school improvement policies to expand them in ways that will end the marginalization of student supports"
2. "adopting unifying intervention frameworks that encompass a comprehensive and multifaceted continuum of interventions with the intent of guiding development of a cohesive enabling or learning supports component at every school"
3. "reframe[ing] the infrastructure at school and district levels to ensure effective leadership, redefine[ing] roles and functions, and establish[ing] resource oriented mechanisms;"
4. " learn[ing] how to plan and implement strategic approaches essential to enabling effective systemic change and scale up"

Two examples of a comprehensive approach to student learning supports are "Iowa's System of Learning Supports, a state department education initiative," (Iowa Department of Education., 2004) and "Hawaii's Comprehensive Student Support System, a statewide initiative." (Hawaii Department of Education)

THE FUTURE OF SCHOOL-BASED MENTAL HEALTH IN NORTH CAROLINA

One area that will most certainly affect the future of school-based mental health is securing and bolstering funding sources within the school system and/or the school health center. According to research conducted by the W. K. Kellogg Foundation, two-thirds of the voters surveyed nationwide were in support of schools providing health care. Obtaining the support of political and community leaders for this initiative is an important step for future success of

school-based mental health. An initial step in rallying that support is helping school personnel, community mental health providers, families and advocates to become aware of the crucial connection between mental health and educational achievement through an educational campaign. School-based mental health needs some serious marketing and advertising!

A second major focus for the future directions would be to increase the availability of mental health services in schools. When services are provided at school, transportation problems become less of a factor. Also, a school-based provider who is known by the student or family may be more likely to establish a trusting, caring relationship, which is paramount for services to be effective. Furthermore, the stigma of mental health services may be reduced by allowing students to seek help and visit on their own terms in familiar territory.

At the present time, the mental health services in North Carolina public schools are largely ineffective in meeting the mental health needs of students. The unmet needs and resulting problems contribute to high dropout rates and account for substantial proportions of child morbidity (Werthamer-Larsson, 1994). Thus, students may be forced to seek their own methods to meet their needs, including aggression, substance abuse, defiance, social isolation, withdrawal, self-mutilation, and gang involvement. It is time for all stakeholders in North Caroline to assure that all students in need of school-based mental health services have access to well trained, competent school-based providers. As this paper confirms, the research showing the relationship between students' mental health and their academic and behavioral performance is compelling. Also confirmed by this paper is the notion that school-based mental health can become a reality through professional collaboration and stakeholder resolve to address the barriers to learning.

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