3 School Mental Health
Prevention at All Levels

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Jeremy, an 11-year-old, sixth-grade child at a large urban school district, is falling increasingly behind in reading and math. Jeremy’s behavior is troubling; sometimes he curses at the teacher, or threatens and hits his classmates. His attendance is less than the desired 80%, and he is reported to have no friends among his classmates. Jeremy is regularly suspended but serves “in-school suspension” to keep him in the building. The counselor and school social worker have had frequent contacts with Jeremy’s caregiver and grandmother, and while she is responsive to their recommendations, she is unable to monitor his out-of-home activities. She indicates that Jeremy’s mother has been in and out of drug rehabilitation, and that his father was murdered. Jeremy’s grandmother says that he cries himself to sleep more often than not, and says he “hates school.” Jeremy’s school has provided many interventions. He was referred and found eligible for special education services, and resources were provided for reading and behavior, including a referral to the city mental health clinic where Jeremy was placed on a “priority” waiting list. The school’s team has also provided incidence-driven consultation to the classroom teacher and “as needed” counseling when Jeremy disrupts his class. After several months and a series of interventions, the measured results have been minimal in changing Jeremy’s disruptive behaviors or improving his attendance or academics.

This is not an unusual scenario. Many schools which serve 400 or more predominantly poor children have at least 60 children with equally complex and intensive needs. Researchers also report that many of these schools have more than 20% of children entering each year with multiple risk factors for mental health and behavioral problems. These problems in early grades escalate year-to-year, having a dramatic negative impact on academic learning for these children and their peers (Walker & Sprague, 1999). In an effort to address the growing numbers of students with complex behavioral and academic challenges, schools and their caring staff can become overwhelmed. Moreover, school interventions frequently come too-little, too-late. As a result, most schools and communities fail to adequately address the very complex social-emotional needs of these children.

The “Domino Effect” of Academic and Behavioral Problems

Academic and behavioral problems like those experienced by Jeremy often place students on a road that is paved with school adjustment difficulties, gradual disengagement from school life, and inevitable school failure and dropout. Other research has shown that sixth-grade children who are academically deficient in reading or math, or who received poor marks for behavior, had only a 10% chance of graduating with their peers, and a 20% chance of graduating a year late (Balfanz & Herzog, 2006). Research has also revealed that as many as 80% of
youth found delinquent and incarcerated have a diagnosable mental health disorder (Cocozza & Skowyra, 2000). Other research suggests that more than half of students with a diagnosable mental illness drop out of high school (U.S. Department of Education, 2006). Jeremy is very likely to become one of these casualties.

In many schools, these youth consume a great deal of the school’s resources and attention; they constantly disrupt classroom instruction; consume the time and resources of disciplinarians, specialists and others; and lead frustrated school staff to reluctantly recommend a dead-end “alternative” placement. These are the youth who are at risk of delinquency (Shader, 2001).

Sadly, belief in the effectiveness of school mental health services suffers collateral damage from this scenario, as well. Since the school “provided mental health services” (i.e., social work involvement, family contact and/or clinic referral) and the child did not improve, school mental health services therefore must not work. Caring staff and well-intended special education and related services interventions are not enough to address the needs of students exhibiting a multitude of problems, who are attempting to cope with overwhelming trauma and loss, possible depression, or post-traumatic stress disorder. Fragmented services, delivered as a patchwork of disconnected interventions, will fail. Programs that provide little care management and lack intensive, individualized academic and behavioral intervention alignment (the combining and simultaneous delivery of academic and behavioral interventions) are all too common.

Jeremy is fragile, acting out, and coping with loss, social isolation, and the frustrations associated with academic delays. His multiple needs require an intensive, well-planned and monitored wraparound system of services: services that address behavioral, emotional, academic and social needs with multi-systemic elements and strong care-giver supports to give him—and his equally troubled peers—a fighting chance to succeed. Schools must provide the home for such programs. Moreover, intensive interventions are critical but by no means sufficient. The school climate must be mentally healthy. The climate must sustain and support mental health by building and maintaining peer and adult connections with all students, providing an atmosphere that promotes the prevention of problems, identifying students early who are placed at risk of problems, and supporting the positive behaviors and academic progress of recovering students.

Overview

This chapter will build the case in support of school-based prevention, discuss the state of mental health service delivery for children and youth in the United States, describe common childhood mental health challenges, and describe effective school mental health services, with an additional focus on successful prevention and mental health promotion. It will also explore solutions to the dilemma of how our resources are currently utilized, relative to what is needed to maximize student success. The reader will be provided with ideas and remedies to enable school and community mental health providers to partner with others, be progressive leaders in fostering mentally healthy schools, and ensure that children needing services receive effective, coordinated, proven interventions that produce positive results. Moreover, these challenges and solutions will be discussed within the broader policy and cultural context of school communities to shed light on the importance of the family, school and macro system ecologies in promoting positive student well-being at all levels.
Embracing the True Potential of Schools

School mental health services are critical to the academic mission of schools. Both the research literature and practice-based evidence clearly indicate that social-emotional skills and well-being are critical to academic learning; that safe and caring schools and classrooms enhance academic success; that reinforcing positive behaviors increases instructional time; and that supported, challenging instruction increases academic learning (see Osher, Dwyer & Jimerson, 2006). It is also no secret that the interaction between positive student development and safe and caring learning environments produces a synergistic effect, in which one enhances the other. Academically successful students are more likely to see their teachers as caring and less likely to have discipline problems and vice versa (Durlak, 1998). Conversely, students whose academic performance and behaviors are identified as problematic are more likely to experience more negative encounters with school staff and punishment within the classroom, producing an aversion to school and increasing their potential for dropout (National Center for Education, Disability and Juvenile Justice, n.d.). Integrating and aligning effective mental health and education services for children is vitally important to ensure academic learning and the development of life-long social-emotional skills. This integration is becoming increasingly self-evident to many stakeholders and has been acknowledged by leading federal, state and local policymakers, professional organizations and agencies (Weist & Paternite, 2006).

Schools provide the perfect milieu for improving the availability of quality services through the implementation of broad-based mental health promotion and prevention programming (Mills et al., 2006). The construct of mental health promotion refers broadly to the processes which serve to optimize the positive mental health and well-being of all individuals, regardless of history or risk for mental health problems (Canadian Mental Health Association, 1999; World Health Organization, 2002). Mental health promotion can include efforts to develop policies, procedures and environments that support positive mental health functioning, and initiatives that help individuals and communities to develop the skills and assets necessary to advocate on behalf of their own mental health needs, as well as to foster resilience against adversity that can increase risk for mental health problems. Within the context of schools, this can include curricula which target the development of social and emotional skills, school-wide initiatives to cultivate positive school climate, and the development of school-community partnerships that promote a sense of belonging, civic engagement and responsibility, to name but a few.

It is important to mention that mental health promotion is distinct from traditional “mental health treatment” in that the purpose is to maintain positive mental health outcomes for all (i.e., increase sense of efficacy, personal control, determination, and other protective factors), rather than treating symptoms of mental illness. Moreover, central to the mission of such initiatives is a commitment to utilize the natural support networks already existing within families and communities; to use a diverse range of culturally and linguistically responsive strategies that reflect the needs of the populations served; and to incorporate “...active citizen involvement in identifying mental health needs, setting priorities, controlling and implementing solutions, and evaluating progress towards goals” (Canadian Mental Health Association, 1999).

Mental health prevention refers to the myriad of interventions and strategies designed to decrease the known risk factors for mental health and academic issues, while simultaneously bolstering the protective factors that protect against the impact of said risk. School-based prevention science has consistently documented the utility and effectiveness of the public health
model of prevention—a model which includes a “three-tiered” approach for understanding and addressing the diverse levels of need among students and families within the school community. While numerous terms have been used to name these three levels of prevention, this approach typically includes the following dimensions:

- **Universal Prevention.** School-based universal prevention embodies mental health promotion in action. These systems, programs, and strategies can be implemented with the entire school community to develop the skills and assets that promote healthy social, emotional, and academic functioning in students, to protect against psychosocial difficulties, and create learning environments that will promote and sustain positive youth development and functioning (National Center for Education, Disability and Juvenile Justice, n.d.; JJ/SE Shared Agenda, 2007).

- **Early Intervention.** School-based early intervention strategies with students who possess specific individual and environmental risk factors for mental health and academic problems, and/or those students for whom universal prevention strategies have not worked and who are exhibiting initial signs of problems. Examples may include providing supports to students who have recently experienced trauma or personal loss, children who have experienced an unusual increase in school absences, or who have received one disciplinary referral rather than five (National Center for Education, Disability and Juvenile Justice, n.d., JJ/SE Shared Agenda, 2007). Early intervention is viewed as a means to intervene at the onset of psychosocial and school adjustment problems as a means of preventing unnecessary special education placement (Foster et al., 2005).

- **Intensive Intervention.** This form of intervention is necessary for about 1–3% of the student population (National Center for Education, Disability and Juvenile Justice, n.d., JJ/SE Shared Agenda, 2007). Students experiencing significant emotional and behavioral problems receive a full continuum of mental health and academic services and supports. The wraparound process has been lauded as an effective approach for structuring and delivering these services. This includes the coordination and planning of services across multiple systems to address the diverse ecologies of student and family life as well as home, community, and school-based case management and service provision and monitoring in the least restrictive placement. Extensive family involvement is central to the implementation of the process (National Center for Education, Disability and Juvenile Justice, n.d.; JJ/SE Shared Agenda, 2007).

In school communities serving students placed at risk by poverty’s adverse effects, these percentage distributions are remarkably different, requiring far greater intervention resources. Studies have shown that in communities burdened by poverty, at least 18% of the school student population have severe mental and behavioral problems, needing intensive-level interventions, and 40% are at risk with moderate behavioral and academic problems, needing planned early interventions, leaving only 42% having the foundation to respond to universal school-wide interventions and instruction (Baker, Kamphaus, Horne & Winsor, 2006).

There is a growing body of evidence supporting the use of the public health model for the design and implementation of comprehensive school-based mental health services. Research suggests that adopting the use of universal, early intervention, and intensive interventions can make a difference in the potential for dropout or graduation for a significant percentage of youth (See *School Psychology Review*, Volume 32 Number 3, 2003: “Emerging models for promoting children’s mental health: Linking systems for prevention and intervention”; Eggert,
Thompson, Herting, Nicholas, & Dickers, 1994; Felner, Brand, Adan, Mulhall, Flowers, Satrain, & DuBois, 1993; Hahn, Leavitt, & Aaron, 1994; Reyes & Jason, 1991). Implementation of mental health promotion interventions in the form of universal prevention curricula such as Lifeskills Training (Botvin, Eng, & Williams, 1980), Project ACHIEVE (Knoff & Batsche, 1995), and Responding in Peaceful and Positive Ways (RiPP) have resulted in a host of positive student outcomes, including significant reductions in substance use, violent behavior, discipline referrals, suspensions, special education referrals and placement, and grade retention (Botvin, Griffin, & Nichols, 2006; Spoth, Clair, Shin, & Redmond, 2006).

Another commonly cited advantage of school mental health, prevention and related services includes their potential to improve access to services for vulnerable and underserved populations by eliminating traditional barriers to mental health services and supports. Such services can reduce the stigma associated with mental health problems and treatment which often preclude help-seeking behaviors, by offering services in students' natural environments (Mills et al., 2006). School-based services can also improve access by providing unique opportunities to engage parents and families in the process of fostering their children’s positive development and well-being (Mills et al., 2006). One simple example includes increased opportunities for parents and mental health service providers to interact more frequently and informally, and to provide ongoing feedback and input regarding student needs and progress at common interface points within the school (i.e., report card pick-up days, parent-teacher conferences), as opposed to the once-per-week, “50-minute hour” which has typically characterized the structure of treatment within psychology and other mental health disciplines (Weist & Paternite, 2006; Weist, Evans, & Lever, 2003).

Both empirical and practice-based evidence tell us what works and what doesn’t when allocating and structuring our schools’ resources to better address the holistic needs of all students. Therefore, it would seem that such potential would be actualized in many if not most school communities. Unfortunately, reality is quite different; school mental health services are frequently marginalized or operate on a distinct and parallel plane to academic instruction (Adelman & Taylor, 1997). Schools have yet to see themselves as agents of social-emotional, behavioral and mental health skill development and well-being. Community, state and federal leaders demand that schools focus on academic standards, and these standards provide the criterion by which schools are compared and ranked for quality. Schools are rarely ranked on “caring” or their ability to help students “learn interpersonal problem-solving” and conflict resolution. Respect for teachers and students’ sense of responsibility for self are expected, required and often rewarded but rarely overtly taught.

In order for schools to move from talking about the critical link between academic and social-emotional skills to implementing effective, integrated practices, dramatic changes are required in the behavior of most stakeholders, particularly school staff and leadership. New methods will need to be learned to replace previously learned methods. Rules, regulations, procedures and resource allocations will require review and change. Learning a new behavior (i.e., reinforcing engaged time-on-task) to replace an old behavior (correcting a student for not working) requires a dramatic refocusing by teachers both in how they respond, and in which behaviors they respond to or reinforce (Doll, 2006).

A Status Report on Child and School Mental Health

While historically ignored, the importance of children’s mental health and recognition of childhood mental illness have grown considerably over the past half-century. Mental Health:
A Report of the Surgeon General (1999) dedicated a full, 97-page chapter to children. It reported study findings that, “21% of U.S. children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimal impairment . . .” (p. 123) and that 11% were found to be significantly functionally impaired and 5% extremely impaired, showing that mental illness is a significant public health problem. Of equal importance to these high percentages is the report’s finding that among all children the most common diagnosable disorders are anxiety and mood disorders (such as depression and bi-polar disorders) and not the behavior disorders that schools most often identify and associate with mental health problems.

That same Surgeon General’s report defined mental illness as:

. . . the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood or behavior (or some combination thereof) associated with distress and/or impaired functioning . . . Alterations in thinking, mood, or behavior contribute to a host of problems—patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom. (p. 5)

Intensity and duration delineate mental health disorders from what the report calls “mental health conditions,” the latter being either less intense or occurring for a short duration. Conversely, this same report defined mental health as:

. . . a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people and the ability to adapt to change and cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society . . . mental health is the springboard of thinking and communication skill, learning, emotional growth, resilience, and self-esteem. (p. 4)

School mental health has been defined broadly by national collaborative groups as encompassing mental wellness and the prevention, identification and treatment of mental disorders in children, families and staff. In 2001, the Policy Leadership Cadre for Mental Health in Schools defined school mental health to include “. . . 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” (Policy Leadership Cadre for Mental Health in Schools, 2001, pp. 5–6).

So the question remains: is the field of school mental health living up to its definition and its potential to improve access to and availability of an array of mental health services and supports to students and families in need? The empirical literature suggests that access to mental health services through the schools is far more universal than many would believe. Across all public schools, the access to school mental health services approaches 90%, such that students and families can seek assistance from school providers. However, it is important to note that access to services is by no means synonymous with direct, individualized or appropriately intensive, and sustained interventions.

The most extensive study of school mental health services, sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), included a sample of 83,000 public elementary, middle and high schools. Results of the study showed that 87% of schools reported that all of the students attending their schools were “eligible to receive mental health services.”
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Schools within the sample reported the use of a significant array of intensive mental health services (see Table 3.1), including: assessment; consultation; individual counseling; therapy, and family supports. Mental health services, categorized as counseling, psychological, social work and family supports services, were also listed as related services for children who were eligible for special education. While some form of universal prevention appeared to be implemented in most schools, the vast majority (78%) of programs noted in the study focused narrowly on the prevention of drug, tobacco and alcohol use. Universal prevention curricula designed to foster social and emotional skill development were implemented in 59% of schools, while early intervention strategies were provided in 63% of schools within the study. These results have been echoed by other national research on the implementation of comprehensive prevention initiatives (Carlson & Knesting, 2007). In sum, the authors concluded: “it is now well documented that, insofar as children receive any mental health services, schools are the major provider” (Chapter 1, p. 1).

The aforementioned figures suggest that schools appear to be making strides in bridging the gap between the need for school mental health services and access to these services. Nevertheless, there remains a significant level of unmet need for many groups of students and their families. Although most mental health services are provided in the schools, fewer than one in 17 children needing such services receive them and those that do, receive far less than needed. Even children receiving “psychological services” as a related service on an Individualized Education Program plan rarely have those services defined in a manner that can ensure they receive an appropriate evaluation for services.

Students from diverse ethnic and cultural backgrounds, including those who have recently immigrated to this country, continue to experience disparities in access to school-based services. It is well documented that students of color are placed at disproportionate risk of academic and eventual school failure. The non-graduation rates are particularly abysmal for males from ethnic minority backgrounds where, in some school systems, their non-graduation rates surpass 75%. Ethnic disparities in access and availability are due to a host of risk factors, including the dearth of sufficient school-based resources to provide quality education and mental health services (EDDJP). This disturbing reality is supported by findings from the SAMHSA study which revealed that eligibility for mental health services was supported less in

**Table 3.1 Percentage of Schools Providing Various Mental Health Services by School Level, 2002–2003**

<table>
<thead>
<tr>
<th>Mental Health Service</th>
<th>Elementary (%)</th>
<th>Middle (%)</th>
<th>High School (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>90</td>
<td>87</td>
<td>86</td>
</tr>
<tr>
<td>Behavior Management Consultation</td>
<td>89</td>
<td>86</td>
<td>82</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>87</td>
<td>86</td>
<td>82</td>
</tr>
<tr>
<td>Referral to Special Programs</td>
<td>85</td>
<td>83</td>
<td>81</td>
</tr>
<tr>
<td>Individual Counseling/Therapy</td>
<td>75</td>
<td>79</td>
<td>72</td>
</tr>
<tr>
<td>Case Management</td>
<td>74</td>
<td>70</td>
<td>68</td>
</tr>
<tr>
<td>Group Counseling/Therapy</td>
<td>70</td>
<td>67</td>
<td>61</td>
</tr>
<tr>
<td>Family Support Services</td>
<td>59</td>
<td>56</td>
<td>58</td>
</tr>
<tr>
<td>Substance Abuse Counseling</td>
<td>34</td>
<td>53</td>
<td>56</td>
</tr>
<tr>
<td>Medication/Medication Management</td>
<td>33</td>
<td>35</td>
<td>33</td>
</tr>
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schools across the country with high percentages of students of color, such that eligibility for services was more often restricted to students placed in special education (Foster et al., 2005). Access and availability for ethnic and cultural populations can also be undermined by cultural biases and stereotyping that can occur throughout the referral, assessment, diagnosis and intervention processes, and increase the likelihood of familial mistrust, resistance and dropout from treatment (Coutinho & Oswald, 2004; Hosp & Reschly, 2003; 2004; Skiba et al., 2008).

Despite mounting support for a continuum of school-based prevention services at all levels, schools also tend to demonstrate a bias in providing services to students with serious and pervasive problems alone, while prevention and early intervention strategies are less commonly utilized (Foster et al., 2005; Weist & Christodulu, 2000). Schools that provide intensive interventions for students with serious emotional problems may yield some positive results in helping those students; nevertheless, it is commonly seen that providing intensive services only for the most serious problems alone will not change a school.

It is valid on the face that “solving” the problems of disruptive students will effect change. However, the trap of addressing only the complex problems of youth with the highest levels of need, without addressing the multiple levels of intervention required for mentally healthy safe and supportive schools, is that the school itself may remain a toxic environment, continuing to produce more problems like the “dropout factories” noted previously. Specifically, if classrooms remain unorganized or behaviorally corrosive, new problems will surface for intensive service providers; children can learn to exhibit problem behaviors and schools will remain mentally unhealthy environments. The leadership and staff’s preoccupation with serious problems may reduce readiness for active participation in systemic, school-wide change and restructuring of how resources are allocated. Teachers may see the clinicians as the responsible agents to address mental and behavioral pathologies and staff may see their responsibility as primarily to help identify and refer other problem children and families to those clinicians. Consequently, this can overwhelm already overtaxed school mental health providers, further “siloing” their work and transforming their role into a “one-stop shop” for managing crises and putting out fires within their respective schools (Weist, 1997). Public mental health prevention and early intervention are just beginning to emerge, starting with a greater awareness of the interaction between environment and social-emotional well-being. (See: From Neurons to Neighborhood: The Science of Early Childhood Developments, 2000, Institute of Medicine, Washington DC: National Academy Press.)

In summary, both a public awareness of child mental health and an acknowledgement of the prevalence of child mental illness have recently gained national attention as a public health concern. School-based mental health services and supports are beginning to make headway in improving access and availability of services to students and families with varying levels of mental health support needs; upwards of 70–80% of children who receive mental health services appear to be receiving them in the school (Foster et al., 2005). Nevertheless, school-based services still struggle to catch up with the overwhelming proportion of unmet need within their school communities. Particular groups of students and families, including students of color, students without formal diagnoses, and students who are just beginning to exhibit problems, have more limited access, and may ultimately fall through systemic cracks. Some researchers have suggested that the lack of a unified child mental health policy agenda has brought the field to the point where we have accumulated a mound of evidence supporting the need for such services and so we possess the tools and technologies to intervene effectively, yet we are unable to reach the populations most in need of them (see Lourie & Hernandez, 2003). Within the realm of school mental health, our ability to align and integrate educational and
mental health policies, procedures and goals may be one of the single most critical determinants of our ability to engender the public will that is necessary to facilitate implementation of mental health and full-scale prevention services in schools, and ultimately improve service access to children, youth and families.

The Great Systemic Divide between Education and Mental Health

The practitioner reader may ask: “Why doesn’t my school system get it? Why don’t the systems use the child-centered integrated developmental approach endorsed by most educational and mental health experts?” Although schools are the nation’s primary children’s mental health service provider, school leadership, local policymakers and stakeholders continue to perceive this as a role of public health, rather than public education. In fact, it has been asserted that schools are often actively resistant to taking on this critical role in fostering child development and mental health (Adelman & Taylor 2000). The primary mission of public education has traditionally been to ensure literacy in preparing the nation’s citizens and workforce. The fundamental cause of these barriers is rooted in these firmly entrenched traditional beliefs, and the resultant resource constraints, conflicting demands, inadequate knowledge about what works and availability of skilled professionals to implement interventions that target whole-student development and wellness.

As previously stated, traditions and governmental structures have polarized the governing and delivery of education and mental health. Schools are almost always separately managed and funded from general local or state government, which is responsible for health, safety, transportation and other services. Secondly, many community leaders see mental health as a treatment provided by a myriad of private and public clinicians and agencies, clearly separate from education. The education and public mental health governing processes and policies, as well as the necessary resource streams, are remarkably different. Access to free public education from kindergarten through high school is viewed as a right for all regardless of income, whereas access to publicly funded mental health services is limited to complex eligibility requirements. Public education is designed to prepare youth for employment and citizenship whereas public mental health has been designed to treat the most serious ill, economically disadvantaged children and adults. These differing traditional roles and beliefs, as well as the divide between the organizational supports that currently drive these systems, are significant barriers that must be addressed to ensure a full array of school mental health prevention and intervention services.

Student services continue to make their mark in improving education and the mental wellness of children and youth. Nevertheless, at the same time, student services professions are marginalized in addressing both children’s mental health and, some would say, the academic achievement of children (Adelman & Taylor, 1997). Some education leaders continue to see student services as a branch of special education, made up of eligibility assessors or IEP managers. National data suggests that this perception is reflected in the allocation of resources (including use of time) and such progressive ideals and roles are rare.

Public mental health prevention and early intervention are just beginning to emerge, starting with a greater awareness of the interaction between environment and social-emotional well-being, or “neurons to neighborhoods” (National Research Council & Institute of Medicine, 2000). In addition, elected officials from governors to local mayors and councils have begun to see the need to align, expand and integrate services in policy and others have initiated efforts to successfully address these barriers. Public policy also supports the inclusion of mental health and education. The nation’s principals’ and superintendents’ associations
Kevin Dwyer and Erika Van Buren acknowledge the need for mentally healthy development and recognize its connection to academic achievement. Yet the funders, families and practitioners in the local districts fail to see schools as responsible for teaching those required social and mental health skills or for providing mental health interventions. The skills are often perceived as the responsibility of the home, and agents of morality and treatment the responsibility of clinical agencies.

The percentage of schools that teach social skills, which the Collaborative for Academic, Social, and Emotional Learning (CASEL) has defined (Greenberg et al., 2003) to include a focus on building a caring school climate, positive discipline and the provision of an array of mental health supports, has slowly grown, but has not yet been recognized or adopted as a nationally funded priority. Weist and Paternite (2006) suggest that local and state-level autonomy in decision-making around mental health policy and practice have created significant variability in the types and quality of services offered, which has consequently contributed to inactivity in mobilizing reform within child-serving systems, including schools. The rate of progress in moving this agenda forward may likely depend on national and state leadership coordination and recognition of this priority. Likewise, recognition may well be dependent upon the ability of prevention researchers to bridge the divide between research and practice by proving the effectiveness of such preventive instruction and mental health service integration in schools, and disseminating this knowledge more effectively and efficiently to major stakeholder groups.

**Historical and Current Developments in School Mental Health Services: Translating Policies into Practice**

Although it is not possible to definitively conclude that the dramatic increase in numbers of school social workers and school psychologists since 1975 has been the result of federal special education and related services laws and regulations, it is hard to ignore that Public Law 94-142 and its regulations had a causal influence on this positive outcome. This law mandated that every school system create access to individuals who deliver eligibility assessment services and other related services to children to determine eligibility for special education. Numerous university programs were established with the law’s federal training grants (Ysseldyke, 1984). In addition, within the realm of school psychology, the first Blueprint for Training and Practice (Ysseldyke, 1984) was funded by special education funds. Progressive research has demonstrated that such practices funded under special education and related laws have led to significant advances in school mental health practice, including grants to train curriculum-based measurement and assessment, the precursor of “Response to Intervention,” instructional methods, classroom behavioral management and preventive school-wide discipline practices, cultural competence, functional behavioral assessment, alternative schools, problem-solving and coordinated services (Knoff & Batsche, 1995).

School mental health services for all students followed much later, enhanced by legislative initiatives outside the U.S. Department of Education through the “demonstration” grant processes of SAMHSA and the Child and Maternal Health Administration of the Department of Health and Human Services. Nevertheless, special education law remained the most significant driving force for granting children, families and educators access to school-provided direct and indirect mental health services. This was confirmed by the aforementioned document: *Mental Health: A Report of the Surgeon General* (2000) that indicated that children’s access to mental health services, although severely limited, was through the schools, provided by school’s psychologists, counselors, school nurses and other student service providers.
Funding of counseling, school social work and psychological services under Medicaid has been another boost to the provision of school mental health services to children and their families. This amendment to Title 19 of the Social Security Act in 1996 made Medicaid the payor of several related services including psychological services for eligible children. Most states allow Medicaid billing for school-provided related services to children who are eligible for that health insurance program.

The establishment of the Safe Schools, Healthy Students federal grants and the school mental health technical assistance centers (Adelman et al., 1999) have continued to support the critical roles that schools play in the continuum of mental health services. More recently, the President’s New Freedom Commission on Mental Health explicitly cited the improvement and expansion of comprehensive school mental health programs as a recommendation for effective mental health system reform (Mills et al., 2006).

The National Association of School Psychologists and other professional and mental health advocates consistently support legislation and regulations that enable access to effective school mental health services. State certification standards have improved and been adopted by many states that meet the agreed-upon standards for education and mental health. The national certification requirements are well respected and have become the standard for university training programs.

Numerous benefits have emerged from building the capacity of schools to support the social and emotional development and needs of children and youth. Many school-wide positive changes, including use of effective behavioral management strategies and school-wide efforts to transition from the use of ineffective suspension and expulsion to positive discipline, are linked to the efforts of student support personnel, including school counselors, psychologists and social workers. And, yes, evidence has begun to accumulate that these services have been critical in supporting best practices in academic instruction (Collaborative for Academic, Social, and Emotional Learning, 2008; Eber, Sugai, Smith, & Scott, 2002; Elias, 2006; Kutash, Duchnowski, & Lynn, 2006; Lewis, Hudson, Richter, & Johnson, 2004). However, it is still unfortunately rare that schools record the provision of recognized “best practice” services and match those to student mental health and academic achievement outcomes.

Helping educators to see the interaction between behavior and academic instruction through the use of data-driven problem-solving and decision-making processes has positively changed some schools. While measurement based on curriculum and fidelity to proven instructional practices has been a persistent mantra of student service providers, it has also become clear that measurement of both social-emotional learning and academic achievement go hand-in-hand and inform schools as to what is working to improve learning (Collaborative for Academic, Social, and Emotional Learning, 2008). Measurement has become institutionalized through No Child Left Behind and “Response to Intervention” language in federal special education eligibility procedures. Most likely driven by quality review and accountability mandates at the local, state and/or federal levels, school improvement and problem-solving teams are beginning to identify measurable indicators of school climate and mental health as targets for change (i.e., student attendance rates), to collect and monitor this data to gauge the progress of their initiatives and modify them accordingly. Mental health professionals, particularly school psychologists, have served as practitioner cheerleaders for “best practices,” and as facilitators for collecting data and translating learning, behavioral and mental health research into practice.

More than at any time in the past, multiple examples of “best practice” interventions have been identified that can be functionally used in most public schools. We also know what is
unproven and what is unlikely to work. For example, school-wide teacher-taught character education can improve behavior and attendance (see the What Works Clearinghouse: http://ies.ed.gov/ncee/wwc/) while imported instruction such as Drug Abuse Resistance Education (DARE) has no measurable effect on reducing student drug use (Ennett, Tobler, Ringwalt, & Flewelling, 1994). Ineffective interventions are less than useless and may actually do harm by increasing cynicism towards school mental health practices and wasting valuable fiscal, human and material resources. Moreover, poorly applied, proven interventions can be equally as harmful. Large and small school districts have been observed using unproven practices (volunteers providing pull-out reading support) or ineffectively mastered proven practices (unmonitored Positive Behavioral Supports). These districts are often both disappointed and puzzled by the lack of desired behavioral and academic outcomes, and consequently teachers and administrators become reluctant to try innovative ideas and lose hope. Yet, carefully planned, resourced and monitored programs and interventions do work. Monitoring both the outputs (what you are doing) and the outcomes (results) of programs and interventions not only provides “proof,” but also informs you of your fidelity to the program (Walcott & Riley-Tillman, 2007).

A leader’s commitment to research-based instructional and mental health interventions has proven critical. Time and time again it has been cited in the chronicles of educators, practitioners, and researchers alike that a principal’s visible and proactive commitment to program implementation and evaluation is critical to its success. In one school system where ethnic disparities in reading achievement became evident over several years, a comprehensive research-based reading initiative was started under the direction of the superintendent. Each elementary school was resourced with a master reading specialist/coach and in-service training was provided to all primary grade teachers. Principals were evaluated as instructional leaders in literacy. Technology was provided (DIBELS) so that all children could be frequently monitored in their progress and individualized remedies were prescribed for those falling behind. Progress of ethnic and gender groups, by classroom and school, were all monitored and remedies provided when classroom or school-wide progress lagged. The success of the program was dramatic, in that third-grade reading scores for all students increased, including those of children identified as Hispanic and African American.

**Measuring Outcomes of School Mental Health Prevention and Intervention**

Proving that the three-tiered prevention-intervention construct works in schools requires a great deal of planning and management. Too frequently “programs” are initiated without a commitment to measurement of base rate data or the actual measurement of the inputs—the elements of the program itself. It is a difficult process, but there are some tips that many have applied with success, even when the interventions have been started before the pre-intervention measures have been gathered. For example, many have used general school-wide public data from the past three to five years, accounting for any significant changes in staffing, program and population. When looking at individual classrooms or students, some have used trend data over time and the interventions provided. The student is monitored twice a year for several years using individualized self-report, teacher and parent reports and discipline and report card data. The American Institutes for Research is using a model like this as one part of the New York City, United Way’s Safe Schools, Successful Students Initiative in six middle schools in the South Bronx (Osher, Dwyer, & Jackson, 2004). This program uses multiple quantitative and qualitative measures of program implementation and outcomes, including observations and interviews to assess school climate, student and school-reported
psychosocial functioning, family involvement, and staff satisfaction. To capture baseline school-level functioning, the evaluation conducts comparative analyses with archival indicators of school-level climate and culture that are reported annually through the district as part of their accountability reporting procedures.

Where difficulties come into play in the implementation of many three-tiered initiatives is in the lack of measures of the inputs, be they school-wide, targeted or intensive. For example, many schools report they are “using” Second Step (Frey, Hirschstein, & Guzzo, 2000) or Positive Behavioral Interventions and Supports (PBIS) but the quality may not be monitored and quality can vary from a “paper-only” program to one with significant fidelity. The first author of this chapter has had teachers report that they held one faculty meeting on Second Step, and no one was checking as to what they were doing in the classroom with that minimal exposure. He has walked through schools that report they use PBIS without seeing any posted signs reminding students of the positive behavioral expectations. So when the effect size is measured and the quality of the intervention is unknown, what do we know at the end of the day? The inputs have to be measured and ranked on a quality/fidelity scale much as we measure fidelity to the instructional methods for reading. The remedy for this challenge is to designate a well-trained, competent site-based professional to validate training needs, train and evaluate the fidelity of implementation and ensure measures of effects. The school’s principal should also be involved in this instructional leadership responsibility in supervising staff. Both the site-based coach and the principal’s monitoring are recordable inputs. Likert scales can be used to evaluate team functions and processes.

In addition to school-wide initiatives, intensive interventions must also be evaluated to monitor progress in reaching treatment goals and to make midcourse corrections where necessary. Again, what are the actual inputs? Are the interventions “deep” enough to address the complexity of student problems? Individual student self-report measures should go beyond symptom scales and look at other risk and protective factors, including the development of social skills, connectedness to school, and academic self-efficacy.

Components of Effective School-Based Mental Health Practices

An extensive monograph on school mental health programs involving school psychologists sought to analyze and classify the types of services being provided (Nastasi, Pluymert, Varjas, & Moore, 2002). The programs cited in the report were self-nominated, but were criterion-reviewed by a panel for inclusion. Programs were reviewed for their use of a four-level prevention-intervention service model, including (1) prevention, (2) risk-reduction, (3) early intervention, and (4) treatment services. Results of the review suggested that most programs delivered more than one level of service but few delivered all four levels (prevention, risk-reduction, early intervention, and treatment).

The report identified many common factors across programs. Nearly all programs used a team problem-solving approach in the development and implementation of interventions. In addition, the inclusion of stakeholders beyond the school staff was noted as critical to the design and implementation of these teams. Almost all of the programs staffed more than one school mental health professional, and most included interagency staffing models, including community mental health centers and other child-serving agencies. Most programs documented best practices based on sound theory. Required outcome measures were presented and almost all used multiple measures, including qualitative observations. Fidelity in program implementation was less regularly reported as were formal measures of longitudinal results.
The processes and strategies mentioned above are foundational pieces of any schoolwide mental health initiative, but do not magically unfold overnight, or over weeks or months for that matter. Establishing school-wide readiness, fostering organizational and leadership support for the initiative, building mutually beneficial partnerships and changing attitudes about mental health problems and interventions are part of an ongoing developmental process that must be accounted for on the front end of school reform and intervention planning, and that requires multiple strategies to address properly. Viewing effective comprehensive school-based prevention through a closer lens elucidates specific “active ingredients” or successful strategies that have consistently emerged from the pool of evidence-based and best practice models of successful and sustainable school-based prevention and intervention.

**Successful Initiatives Are Facilitated by Site-Based “Coaches/Facilitators/Implementers”**

Although there is scant research available, school/agency-based coaches or facilitators have been observed to be most effective in making sure that initiatives are implemented with fidelity and that data requirements are followed. We do know that staff training is most effective when trained staff have the opportunity to see skills modeled and have the support of a trusted coach providing immediate feedback regarding their implementation (Garet et al., 2001). The authors of this chapter have observed the coaching model used in several grants, and throughout the process, survey data has shown staff feeling more confident in using new skills when supported by frequent coaching. Some systems have used in-house coaches and others have used an itinerate support model (two to three schools for each coach). Although initially expensive, the in-house model seems the most effective method of ensuring fidelity. Other models such as having the monitoring and support come from existing staff or an administrator may also be effective.

Coaches must be highly skilled in the interventions they are training and supporting. They must also have effective interpersonal skills and be proficient in adult learning styles. Teachers and staff must have trust in the coach and be able to access coaching support in a timely manner. Adults, much like older students, are frequently reluctant to ask for help when they need it, particularly if they believe that they are “expected to know” the skill. Therefore, it is critical that coaches regularly monitor and support staff. Many coaches have used grade-level monitoring, focusing on common proficiencies and then focusing on “skills that are more difficult to maintain,” seeking suggestions and support from peers.

Coaches also have the potential to serve in the role of cultural liaisons or brokers between the lead and community partners, and the host schools for prevention initiatives. Knowledge of the student and family communities, the complex cultures and competing demands of schools, as well as mastery of intervention model are invaluable in facilitating collaboration, translating diverse interdisciplinary argot, values and norms, and managing the interorganizational dynamics of difference that can emerge when multiple stakeholders come to the table.

**Successful Initiatives Are Supported by Stakeholders Who Believe They Can Implement the Desired Interventions**

When asking systems to change, and requiring members to learn new skills and refocus their approaches to tasks, there is a general principle that 80% of the implementers need to “buy into” the desired skills, responsibilities and vision of the program. It is not enough to have coaches and the support of the principal or agency head if the classroom teachers, counselor
and clinical social workers are not on board in believing that the required changes will enable them to be more successful (and lower their stress). Frequently the first step to “buy-in” is demonstrating that learning the new skill will reduce frustration, including from classroom disruptions that consume energy and precious instructional time. For example, the research staff for Project ACHIEVE (Knoff & Batsche, 1995) observed classes and recorded amounts of lost time caused by disruptions to instruction. When staff saw that engaged instructional time could be increased by giving students training in social skills and reflective thinking, “buy-in” was sustained. Moreover, providing opportunities for systematic decision-making input and needs assessment from staff can be automatically engaging and promote support for the initiative. For example, as part of its preplanning processes, the PBIS model has a prerequisite of written support from at least 80% of staff before intervention planning can move forward.

Teacher buy-in can be enhanced by focusing on “learning behaviors” (McDermott, 1999) that have been shown to support academic success. Schaefer (2004) and others have demonstrated that teachers are excellent in identifying keystone behaviors that they can then teach and reinforce. Likewise, teachers recognize that faulty learning behaviors are relatively common in classrooms and therefore conducive to classroom and school-wide interventions. The focus on academic behaviors rather than on “social skills” and discipline may help gain teacher and administrative support for prevention programs.

Successful Initiatives Include Measurement of Vital Stakeholder-Identified Outcome

One way to increase staff support is to establish agreed-upon measurable outcomes that are meaningful to those front-line workers who interact directly with students. Measuring school-level reductions in office referrals may mean little to a teacher who is temporarily relieved of the disruptions by the referred student. Temporary stress reduction is a strong reinforcer. Seeing the cumulative loss to the student, the class and the teacher over time may assist the team in defining a more meaningful outcome for such teachers.

Having staff identify outcome measures, using existing school measures (report cards, attendance, formative and summative assessments) as the base, has been demonstrated to increase compliance in data collection. New cumbersome measures are less likely to be supported or used. Measures such as instructional time and individual students’ time-on-task will require both observations and more school resources. Individualized behavioral and academic measures are time-intensive and thus less consistently applied. Overcoming this resistance through direct paraprofessional support or incentives can be critical to securing the necessary data to determine the student’s response to interventions.

Questionnaires on school climate and staff (student and parent) satisfaction surveys are usually acceptable measures. Partners, school mental health and clinical providers are most commonly expected to connect their services to measurable outcomes and for students whose IEP contains such services a connection to school progress is required.

Successful Initiatives Generate Clearly Identified and Required Interventions and Outputs That Can Be Replicated

One of the more serious problems found among school-collected measures are the actual staff and leadership behaviors that are being maintained that produce positive outcomes. Outputs are the things we do that result in the desired outcomes we achieve. Running teacher support teams (TST) that provide little timely and effective ideas, versus teams that respond with immediacy, follow-up, evaluate if needed, and modify supports, are examples of different
outputs, although on the surface they may look generically the same (both have regular
properly staffed TST meetings). Frequency, intensity and actual descriptions of the interven-
tions are critical. This is more common in academic instruction than in behavioral instruction
and management. For instance, manualized cognitive behavioral therapies are effective in
documenting evidence of the connection between outputs and outcomes. Individualized
Education Programs (IEPs) have been designed to connect interventions to academic
and behavioral goals. However, they are too commonly less informative than they could be
in helping a new teacher or other staff know clearly what outputs are required to sustain
progress.

Furthermore, using outputs to inform us as to what elements of prevention programming
should be sustained is also very important. Measuring what is required to learn and maintain
a school-wide social skills program is critical to its replication in going to scale within a school
system. The Collaborative for Academic, Social and Emotional Learning (CASEL) is one
organization that has identified criteria for implementing such school-wide programs (Elias,
Zins, Gracyzk, & Weisberg, 2003).

Successful Initiatives Use Structured Team Problem-Solving Processes

Structured team problem-solving has been shown to be an effective tool for schools and agen-
cies to ensure meaningful intervention planning and resource allocation that will appropri-
ately address agreed-upon goals and visions (Osher, Dwyer & Jackson, 2004; Dwyer & Osher,
2000). In fact, the three-tiered prevention-intervention construct requires team problem-
solving and can be the most critical element in any program’s implementation. However,
there are a number of essential factors and cautions when setting out to establish problem-
solving teams. Lessons from the field tell us there are a number of clear right and wrong meth-
ods for establishing and implementing these processes, which can have clear implications first
for staff buy-in and support of the initiative, and ultimately for program success.

It is important to note that team problem-solving has been seen by teachers as time con-
suming and ineffective because the necessary staff support to make the recommendations
effective is not available, and suggestions are frequently not backed up by training. When staff
members are untrained in team problem-solving, the process becomes mechanical and mean-
ingless, lacking the depth of inquiry and generation of effective, targeted interventions that are
monitored for fidelity and measured for results. Without training, “early intervention” strate-
gies generated by teams are almost always shallow and have little effect. The team deteriorates
and begins to become a “reactive” and crisis-driven dumping ground, moving students to spe-
cial or alternative programs. In schools where training in problem-solving is intensive, and
where training is evaluated, the results can be significant.

Teachers, student support staff and administrators are frequently required to participate on
a myriad of school teams. The decision to create problem-solving teams, or to integrate effec-
tive problem-solving processes and training into already existing team structures, including
school improvement teams and quality review teams, should ideally be informed by a more
comprehensive resource-mapping process (Adelman & Taylor, 2006) This process helps to
identify and reduce redundant or duplicated efforts and helps with the reallocation and more
efficient distribution of time and human resources. Collaboration with other school-based
groups and teams can also help to facilitate task completion, reduce fragmentation and foster
a sense of shared accountability and support for the implementation of school-wide strategies.
The school leadership is critical for shaping the vision and mission of such teams, and provid-
ing ongoing guidance and support as needed.
Successful Initiatives Are Coordinated by School, Community Agency, Non-Governmental Services, Students and their Families

Agencies and schools are more successful when they coordinate their family-friendly interventions to ensure that interventions are carried out as designed and supported by all providers. Schools and agencies that blend resources, co-train staff, align services and actively involve families seem to be more effective than services that are merely housed in the same building, implementing parallel or duplicative services. Exemplary mental health programs build in assistance to schools and systems to integrate and coordinate mental health, health, social service and educational programs to maximize efficiency and effectiveness of service delivery. They also provide support for interagency and community programs that safeguard children’s mental health and safety.

Successful Initiatives Are Responsive to the Cultural and Linguistic Values, Norms and Preferences of the Students and Families Served

Too often we hear of well-supported mental health prevention and intervention programs and strategies that flop because they simply do not translate to the communities in which they are implemented. The selection criteria for prevention and intervention programming and strategies must include a successful track record of use with the cultural and linguistic populations served. Have evidence-based interventions been implemented, and protocols standardized using a meaningful percentage of students and families within the cultural and socioeconomic populations of focus? Are there mechanisms for adapting protocols to incorporate the values, traditions, norms and needs of families? And, just as importantly, are there feedback loops in place to ensure that family members provide ongoing feedback and input throughout the process of implementation?

Developing culturally and linguistically responsive mental health services is a developmental process that should be infused in all aspects of program development and implementation (Cross, Bazron, Dennis, & Isaacs, 1989). Successful program models, such as federally funded systems of care communities (Eber, 1998; Stroul, 1996), are based on a set of guiding principles which include a youth-guided, family-driven and culturally and linguistically competent approach to service design and provision. School-based systems of care communities are growing in frequency throughout the country, and have developed innovative strategies for recruiting and retaining representative, community-based staff to work within the cultural frameworks and in the preferred languages of students and families they serve. Such services promote organizational infrastructure development that will support and sustain culturally and linguistically appropriate practice, and prioritize meaningful and respectful collaboration with youth, families and community members in meaningful and respectful ways. For instance, one school-based system of care community has made tremendous progress in outreach and engagement to the Latino community within its cachement area, and specifically with the Latino families and caregivers it serves. Youth and families are represented among their staff and major decision-making bodies. This system of care conducts ongoing dialogues and focus groups with families with the primary goal of engaging them in the development and implementation of service delivery, instilling family empowerment and leadership.

Successful Initiatives Measure the Effectiveness of Training and Coaching

Most trainings are evaluated immediately after the presentation, using participants’ desired outcomes rather than ongoing surveys of actual use and usefulness. Training research suggests
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that needs-based training that involves engaged instruction followed by modeling, coaching, observations and evaluation is effective, whereas most didactic training is minimally effective in changing the behavior of the participants. Didactic workshops may be effective in increasing the participants’ awareness of what can be tried or modified to improve instruction or classroom behavior and increase interest in finding out more, but it is not professional development which implies developing, demonstrating and using new and effective skills.

High-quality professional development is a science that has been evaluated (Garet, Porter, Desimone, Birman, & Suk Yoon, 2001), showing that adequate training time, active participation, the attainment of new knowledge and support of study groups, same-school peer support and mentoring increases skill development and implementation.

Successful Initiatives Align Best Practices Across Academic, Social-Emotional, Safety and Other Critical Areas

Some schools use math and science vocabulary in their basic reading programs to enhance and reinforce meaning. Some high schools connect literature to history, and math to chemistry. Almost all schools use some standard sequential curriculum to teach reading and the foundations of math and written language. The language of social skills can also be part of the language of reading and writing. Some middle schools have developed creative writing skills using the theme of bullying, writing plays to dramatize the issue. The vocabulary used by staff in the cafeteria to remind students of respect and social responsibility should be the same as the language of the classroom and hallways. The therapist helping a student with impulse control strategies may be most effective using the social skills curriculum’s structure enabling the teacher to naturally reinforce that student’s therapy. Security personnel and hall monitors in a school that use the “Stop-and-Think” program must be trained in that model to ensure they reinforce that approach to behavior. Staff that yell (louder, longer and more frequently) at misbehaving students should be assisted in learning and replacing behavioral language to maximize the positive behavioral support effects.

As managers of school-wide social skill promotion, instructional leaders (i.e., principals) should plan for this kind of alignment of academic, social skills, safety and mental health interventions on levels that support applied learning opportunities. Alignment across content areas as well as alignment among service intensities can make the classroom therapeutic and the therapy instructional. Family caregivers have reported that they too can participate in this process when given the tools and support to function as partners in learning.

Successful Initiatives Are Planned, and Given the Time and Resources to Demonstrate Results

Change takes time. Change, resulting in measurable results, takes even more time than its agents expect. Although this construct is acknowledged by policymakers, leaders and stakeholders, it is rarely concretely noted and accounted for in planning. Patience with “disrespectful, irresponsible children” is rare. Schools want children who are “ready to learn” or change agents who can quickly remedy problems that make teaching difficult. Most teachers are more patient with struggling students trying to phonetically de-code a new word than students struggling with learning appropriate classroom behaviors. Patience is almost always lost when students yell out vulgarities, hit or defy an authority’s command. Classroom control is lost, instruction is disrupted, unwanted feelings of anxiety, anger, even impotence surface and threats may be expressed, too frequently escalating the student’s negative behaviors.
A structured, highly individualized intervention plan that requires positive comments when appropriate behaviors are observed, predicting outbursts and modifying or acknowledging the warning signs to help stimulate taught/learned replacement behaviors, as well as maintaining firm consistent consequences for serious infractions, will not immediately extinguish the inappropriate behavior, but should reduce its frequency. It takes time to teach new skills and, frequently, more time to extinguish previously learned and reinforced inappropriate behaviors. Likewise, school-wide prevention and mental health promotion plans and interventions will take time to implement and have measurable results. In fact, most school-wide interventions take more than three years to demonstrate significant measurable outcomes.

**Successful Initiatives Are Cost-Effective, and Use Multiple Funding Sources**

As noted earlier, public schools and mental health agencies are commonly managed and funded under different governmental systems. Even at the federal level, the funding streams come through different agencies as directed by various laws. Few laws, such as the Safe Schools Healthy Students grants, require interagency controls that can better ensure coordinated resource allocation. The Safe Schools Healthy Students demonstration grants make the school system the grantee but require interagency collaboration and are federally managed by the Departments of Education, Justice and Health and Human Services.

Funding at the local level is best managed when it enables the blending and braiding of funds to address the complex barriers to learning, as well as support the prevention of problems. Blending funds requires school system and agencies to pool funds to address a specific agreed-upon set of interventions or service. Unlike braided funding there is no tracking of each organization’s dollars. Braiding enables the pool of funds to be followed to specific components of service and is frequently favored over mere blending.

Local management boards (such as a Child and Family Collaboration Council) that include representation from schools and agencies, using local, state and federal funds as well as charitable non-governmental organization funds, are becoming more common. The next step at the federal level will be for legislation to give incentives (or mandates) for merging demonstration grants, such as, for example, those that address serious mental illness in children from the Substance Abuse and Mental Health Services Administration with those that support social-emotional education through the U.S. Department of Education’s Leave No Child Behind and Medicaid.

**Successful Initiatives Are Shown to Quickly Relieve Some Elements of “Crisis”**

The state-of-the-art model for designing the comprehensive mental health promotion, prevention, early and intensive intervention approach for schools has been to plan for, train and implement the whole model, simultaneously. This construct enables services at different levels of intensity to support each other, to engage all staff in connecting with agreed-upon goals, to ensure interventions are aligned, and to enhance easy inclusion and transitions for youth.

Many Safe Schools, Healthy Students federal grant recipients have followed this design, relying on the federal funds to accomplish this multi-year implementation effort. Another approach is to relieve some elements of a crisis. For example, a school that has identified several behaviorally troubling youth who are consuming significant resources and producing a contagion of disruption may find that the first step to change is to address the “fires” by...
providing wraparound services to the youth and families with the most serious problems. Nevertheless, in this case, the establishment of an effective, school and home-based agency-driven mental health program may be the first step to enable the school to devote its energies to designing the prevention and early intervention components of the model. Regardless, even the intensive intervention component cannot stand alone for long. When youth have their complex social-emotional and behavioral needs addressed, the school’s climate improves best when it mirrors those supports. So the successful treatment reduces the crisis and enables the schools to develop supportive strategies to prevent other youth from following that trajectory. Furthermore, those elements that are shown to promote learning and prevent problems can then be made available to support all youth, including those who have serious, complex problems. Making the determination about where to start may be driven by the level of crisis in which the school finds itself. There is a noted danger in starting with intensive services and that is that those services, like special education, can become a separate entity consuming all the school’s mental health resources. Prevention and effective early intervention services are thus never resourced or implemented.

In sum, it is critical that regardless of where one starts, each school establish its plan for a comprehensive prevention, intervention school mental health program and provide assurance that the full program will be implemented. Addressing the crises first can enable the school to begin building a mentally healthy climate and system of prevention and intervention.

Successful Initiatives Combine a Spectrum of Comprehensive Prevention, Early and Intensive Interventions and Services

Our identification of successful elements of school-based initiatives would not be complete without discussion of the evidence supporting implementation of the full continuum of prevention, early and intensive services, and the successful characteristics of these services. Earlier discussion within this chapter highlighted the general proclivity of US schools to rely on the provision of intensive services, and the negative implications associated with this pattern. The most effective programs appear to provide an excellent universal instructional method. When all students are carefully monitored in their responses to that curriculum and instruction, those who are falling behind are quickly identified and proven remedies are expeditiously applied. For youngsters who do not respond to such interventions, teams examine the “why” and prescribe appropriate intensive interventions, again monitoring results and modifying or maintaining effective interventions that improve the student’s reading. Everything is connected to the general curriculum and instructional measures; in essence, instruction is aligned. The same is necessary for social, emotional development. Behavioral remedies must be connected to the language of the classroom and the reinforcements of teachers, staff and peers. For example, in one school the agency-assigned clinical social worker learned the social skills language used across all the primary grades, and incorporated it into the “language of therapy.” This enabled both the therapist and the parent to shape replacement behaviors that the teacher and staff could naturally support and reinforce.

Conclusion and Summary

Children who are mentally healthy, who have proven coping and problem-solving skills, and who have these skills promoted within schools, are far more likely to learn and achieve. Nevertheless, the school mental health promotion and prevention programs which promote
the development of these important life skills cannot stand alone, nor can intensive intervention services enable children to maximize their learning in schools with corrosive classroom climates. This chapter has summarized the collective knowledge from both research and experience in the field to help practitioners and policymakers put the prevention and intervention pyramid in place. If a school can improve attendance, achievement and graduation rates, decrease suspensions and expulsions, as well as disproportionate special education placements, its initiatives will be seen as winners by most stakeholders. The mental health promotion and prevention-intervention paradigm is believed to be the most efficient and effective model schools can implement to ensure these positive educational outcomes communities seek. Demonstrating a connection between interventions and desired outcomes is the critical issue.

What can we conclude about “what works” in schools? We can paint a relatively clear picture using what we know. First, effective programs have been supported by sound theory, including a clear understanding of the research-supported mechanisms for change (Fullen, 1991). We know that interventions that work are well resourced, sustained and celebrated by critical leadership as well as by teachers, students and families. They are connected to the academic mission of schools and their leadership, which provides the cornerstone of “mutual interest” that will sustain principal buy-in and support for the initiative. They are put in place with equal zeal and resources as that of academics. Leadership, policies and procedures related to such programmatic efforts must be system-wide and sustained, independent of personal initiatives or discretionary “soft money.” Programs that succeed are well coordinated, understood by staff, students and community. Like academics, they are evaluated for impact on individuals, classrooms, schools and system-wide. Identified best practices are used with fidelity and the staff is well trained, including such ancillary staff as cafeteria workers, school security personnel, mentors and other community partners. The school principal’s role as instructional leader includes mental health “instruction.” The numbers of student services personnel such as counselors, school psychologists and social workers are commensurate with the needs and such personnel support or provide coaching, consultation, monitoring and individualized services to ensure complete promotion, prevention and intervention services. They work in interdisciplinary and interagency teams that use effective planning and problem-solving techniques to maximize effectiveness and efficiency, always partnering with families. Schools look for incremental success, understanding that persistence of sustained effort and measured outputs will produce results.

Although the breadth and depth of our understanding regarding how schools should function continues to grow, the educational system struggles to adopt this vision. Nevertheless, successful state and local initiatives are beginning to emerge which represent a shift from a “two-component policy framework,” which typically includes an agenda for improvements in instruction and school governance, to a three-component framework which addresses barriers to learning and uses language such as “an Enabling Component, a Learning Supports Component, and a Comprehensive Student Support System” (Adelman & Taylor, 2005; this volume). This third element combats marginalization of school mental health services, and supports a commitment to change. Although change is inconvenient, maintaining ineffective educational systems and interventions is more than dangerous to some. Schools can no longer afford to neglect paradigms of teaching and learning that embrace the richness and potential of the “whole child”; a richness that every child possesses, and that need only be cultivated and nurtured within the social worlds in which they live, learn and play. To truly educate is to draw out that richness and to ultimately promote the positive development of mentally healthy children and youth, which will serve to sustain them throughout their education and beyond.
References


