Further Advancing the Field of School Mental Health

Mark D. Weist, Nancy A. Lever,
Catherine P. Bradshaw, and Julie Sarno Owens

We are pleased to bring to you this second edition of the *Handbook of School Mental Health*, with each of us involved in careers that emphasize bringing effective programs and services to promote students' positive behavior, health, mental health, and academic success in the most universal setting, "where they are," in schools. We have all been deeply involved in training, practice, research, and policy in the emerging and increasingly prominent school mental health (SMH) field, as well as in efforts to interconnect work occurring in each of these four realms of action.

School mental health is based on some simple yet cogent observations. First, the mental health system is broken, especially for children and adolescents (President's New Freedom Commission, 2003; United States [U.S.] Public Health Service, 2000). Families must navigate many obstacles to obtain care for their children in the "specialty mental health" service sector, with many of these obstacles (e.g., poor knowledge of mental health, stigma, long waiting lists, insurance problems, stress, and competing demands) seeming insurmountable. Indeed, some studies document that the modal number of specialty mental health visits for youth and families is only one visit (McKay, Lynn, & Bannon, 2005).

Second, while youth spend a large percentage of their time in school, and schools have been referred to as the "defacto" mental health system for children and adolescents (Burns et al., 1995), schools generally are very under-resourced to promote health wellness and address emotional/behavioral challenges in students (Weist, Paternite, Wheatley-Rowe, & Gall, 2010). For example, ratios of school-employed mental health professionals are not commensurate with what would be needed to provide quality comprehensive services, with far too many students per professional for the disciplines of school psychology, counseling, and social work. In fact, the ratio of students to professionals across all areas

M.D. Weist (✉)
Department of Psychology, University of South Carolina, 1512 Pendleton Street, Columbia, SC 29208, USA
e-mail: weist@mailbox.sc.edu

N.A. Lever
Department of Psychiatry, Center for School Mental Health, University of Maryland School of Medicine, 737 West Lombard Street, 4th Floor, Baltimore, MD 21201, USA
e-mail: nlever@psych.umaryland.edu

C.P. Bradshaw
Department of Mental Health, Bloomberg School of Public Health, Johns Hopkins University, Hampton House 839 624 N. Broadway, Baltimore, MD 21205, USA
e-mail: cbradsha@jhsph.edu

J.S. Owens
Department of Psychology, Center for Intervention Research in Schools, Ohio University, Athens, OH 45701, USA
e-mail: owensj@ohio.edu

M.D. Weist et al. (eds.), *Handbook of School Mental Health: Research, Training, Practice, and Policy*, Issues in Clinical Child Psychology, DOI 10.1007/978-1-4614-7624-5_1,

of school social work, psychology, and counseling is more than two to three times greater than the maximum ratios recommended by each single profession. Moreover, position constraints often get in the way of these staff being in roles of preventing and addressing emotional/behavioral challenges. While all three disciplines are usually trained in effective prevention and intervention, unfortunately school psychologists can be constrained into roles of "evaluators," school counselors as "academic advisors," and school social workers as "administrators and crisis responders" (see Flaherty et al., 1998; Waxman, Weist, & Benson, 1999).

Third, and based on recognition of these realities, there are considerable benefits to community mental health providers (e.g., clinical and counseling psychologists, clinical social workers, licensed professional counselors, child and adolescent psychiatrists) joining forces with schools, school-employed mental health staff, and educators to build multi-tiered programs and services to improve the school environment, promote student health and wellness, prevent and intervene early on emotional/behavioral problems, and provide intervention for students in need of more intensive services. These "expanded" SMH services involve community providers augmenting the work of school staff and ensuring access to the full continuum of programs for youth in both special and general education (Weist, 1997) and reflect a shared school, family, community-system agenda (Andis et al., 2002). Expanded SMH has been a core construct in our work, and the values of this approach are reflected throughout the first handbook (Weist, Evans, & Lever, 2003) and in the current one.

Brief History

While SMH is not in any way new, with mental health in schools discussed by John Dewey and others in the nineteenth century (see Flaherty & Osher, 2003), the approach reflected in the expanded SMH approach is relatively new, dating back to the development of school-based health centers (SBHCs) in the 1980s. SBHCs are typically served by a multidisciplinary health provider staff (e.g., nurses, physician/medical assistants, dentists, health educators, and mental health providers) who offer services including primary care for acute and chronic health conditions, substance abuse services, case management, dental health services, reproductive health care, nutrition education, health education, health promotion, and mental health services (National Assembly on School-Based Health Care [NASBHC], 2002; Strozer, Juszczak, & Ammerman, 2010). From their inception, mental health concerns have been a leading cause of student referrals to SBHCs, representing one-third to one-half of all visits (Center for Health and Health Care in Schools, 2001). Early in the development of SBHCs, for example, in seminal programs operating in Minneapolis and Dallas in the 1980s, this "flooding" of the centers with student mental health issues propelled more centers to include mental health services, as well as the growth of "stand-alone" expanded SMH programs which were much easier and less costly to develop (Flaherty et al., 1996).

Importantly, growth of awareness of student mental health needs and early examples of mental health services offered through SBHCs promoted significant involvement of the federal Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) in funding and guiding an initiative related to mental health in schools. In 1995, the *Mental Health of School-Age Children and Youth Initiative* was implemented by MCHB's Office of Adolescent Health. The Initiative prioritized the development of infrastructure, technical assistance, and resources to build capacity for school-based and school-linked mental health programs for students. Two national training and technical assistance centers were funded: the Center for School Mental Health (CSMH) at the University of Maryland School of Medicine and the Center for Mental Health in Schools at the University of California, Los Angeles. In addition, the grant funded five state infrastructure grants to Kentucky, Maine, Minnesota, New Mexico, and South Carolina in order to promote state support and advancement of school mental health services and programming. The MCHB investment proved foundational in raising awareness, building

infrastructure, conducting training, developing and sharing resources, and promoting collaboration to develop the field of SMH.

Beginning in the early 2000s, the University of Maryland CSMH began collaborating with the IDEA Partnership, a federal investment of the Office of Special Education Programs (OSEP) of the US Department of Education to increase learning supports for students in schools and led by the National Association of State Directors of Special Education (NASDSE). The focus of the collaboration was on developing a National Community of Practice (CoP) on Collaborative School Behavioral Health[1], based on the recognition of SMH leaders at the time that systematic agendas (e.g., building high-quality evidence-based mental health promotion in schools) rested upon the foundation of relationships. In CoPs, groups of people who share concerns, problems, and/or interest in particular topics deepen their own knowledge base and effectiveness by interacting on a regular basis with others who have similar priorities (Wenger & Snyder, 2000) and focus on providing the support for effective convening and communication to move people from discussion to dialogue to collaboration and active policy change for the topic at hand (Cashman, Linehan, & Rosser, 2007).

The National CoP started formally in Dallas, Texas, in October of 2004 at a meeting sponsored jointly by the CSMH and the IDEA Partnership. A common theme was building a *shared agenda* for SMH, with local, state, and national efforts being genuinely guided by collaborative partnerships involving schools, families, and other youth serving community systems and agencies (Andis et al., 2002). The CoP unites federal partners, states, organizations, technical assistance, and resource centers with student and family consumers, frontline school-based staff, and policymakers to address intersecting education and mental health priorities to reduce barriers to learning and improve success for all students. There are currently 55 organizations, 12 practice groups (e.g., Quality and Evidence-Based Practice, Military Families, Families in Partnership with Schools and Communities), and 17 states within the CoP. An additional emphasis of the CoP is on promoting "multi-scale" learning among schools, districts, counties, states, national organizations, and federal agencies, in sharing information and providing mutual support to escalate the pace of positive change for the field.

A number of books and journals have greatly influenced and informed the field of school mental health. For example, the first edition of the *Handbook of School Mental Health: Advancing Practice and Research* (Weist et al., 2003; Springer, New York) captured the diverse and unique components of comprehensive mental health problems in schools within our nation. A number of the chapters in the book cite the term "expanded school mental health," referring to programs that represent partnerships between schools and community organization (Weist, 1997). All chapters reflect an integrated approach, wherein staff is coming together within schools in interdisciplinary efforts that prioritize health-promoting and preventive efforts, while connecting to other programs and services in the community. This book contains five sections. The first section, *Background, Policy, and Advocacy,* includes five chapters that review history and issues related to advancing policy, advocacy, research, and financing agendas. The second section, *Enhancing Collaborative Approaches,* includes chapters reflecting connections being made in SMH at the federal level, between various professional disciplines, between schools and communities, and with families and other stakeholders. The third section, *School Mental Health in Context,* presents the experiences of programs operating in distinctive settings and developing programs for students with distinctive needs. The fourth section, *Moving Toward Best Practice,* focuses on principles for best practice, developing training programs, initiating quality assessment and improvement, focusing on student strengths, and implementing evidence-based programs for specific problems faced by youth. The final

[1]Please note that some in the field prefer the term "school mental health" and others prefer "school behavioral health." Numerous discussions sponsored by CSMH have sought to reach consensus on the use of one term, and the clear conclusion is that this will not happen, hence acceptance of multiple terms used to describe the work.

section, *Cross-Cutting Issues*, discusses unique opportunities and challenges in the field in preventing and responding to crises, programming for generalization, focusing on cultural competence, and negotiating unique legal and ethical issues.

Another significant publication for the field was the first volume of *Advancing School Mental Health Services* (Robinson, 2004; Civic Research Institute, New York), which documented the extensive challenges that youth in our nation were facing as we were entering the new millennium, including drug use, domestic violence, gangs, and suicide, and provided a showcase of best practices that illustrated possible solutions to help children face these challenges. The book opens with a historical overview of the early development of SMH and a description of frameworks for funding, implementation, and managing ethical issues. The book also contains sections on family-engaged services, critical issues involved in program evaluation and outcome assessment unique to SMH programs, and model programs that demonstrate the above-described concepts in action.

A subsequent publication, entitled *Advancing School Mental Health Services, Volume 2* (Evans, Weist, & Serpell, 2007; Civic Research Institute, New York), aimed to present the latest literature by organizing chapters that reflect key themes in advancing SMH promotion and intervention. Chapters covered key realms in practical programming and intervention strategies including in-depth overview of the following: key components in successful school-based service delivery; evidence-based clinical services; funding sources and strategies; how to build effective, collaborative interagency relationships; solutions to the barriers of misunderstanding and stigma; and effective family interventions. The first section, *Strategies for Promoting Best Practices*, includes six chapters that review strategies for bridging the science and practice gap and emphasize quality and SMH. The second section, *Prevention and Mental Health Promotion*, focuses on school-wide frameworks and approaches to SMH as well as mental health consultation in schools. The third section, *Evidence-Based, Problem-Focused Treatment*, presents programs operating with students with distinctive mental health needs. The fourth section, *Key Issues in School-Based Mental Health*, discusses unique challenges to SMH including cultural competency, maintaining fidelity, international organizations, and teacher engagement. The fifth and final section, *Future Directions*, provides emphasis toward future work in SMH to meet the challenges and realize the potential for growth.

As these books were being developed and published, leaders in SMH also noted the lack of professional journals reflecting the interdisciplinary nature of the field, with all journals at that time focused on mental health in schools being discipline specific (e.g., for school psychology, counseling, or social work). This recognition created impetus for the development of *Advances in School Mental Health Promotion* (Editor, Mark Weist), an international journal sponsored by the Clifford Beers Foundation (focused on global mental health promotion) and the University of Maryland School of Medicine. *Advances* is presented as "essential reading for those with a clinical, professional, academic, or personal interest in promoting mental health in schools, and serves to emphasize the interconnectedness of research, policy, training, and practice, as well as opportunities to make progress in all of these areas through global dialogue, collaboration, and action" (from the journal cover, Clifford Beers Foundation, 2012). The inaugural issue of *Advances* was published in 2007. Since then, articles have been published quarterly and include contributions from more than 30 nations, reflecting research and developments in the field emphasizing promotion, prevention, and early intervention strategies. In 2012, Routledge of the Taylor and Francis Publishing Group (Abingdon, United Kingdom) began publishing the journal, assisting in raising its visibility and impact.

In March of 2009, Springer published the first volume of the peer-reviewed journal *School Mental Health* (Editor, Steve Evans), a multidisciplinary journal that publishes (Springer, New York) empirical studies, theoretical papers, and review articles related to prevention, education, and treatment practices that target the emotional and behavioral health of children in the education system. The articles that have been published in

the first three volumes of this journal reflect the current cutting edge issues in the field of SMH. For example, special issues have been organized on the themes of (a) family, school, and community partnerships, (b) new paradigms and tools for assessing intervention integrity in school-based interventions, and (c) developments in school-based interventions that address domain-specific impairments across the developmental continuum for youth with ADHD. In addition, readers of the journal will find articles that examine issues affecting implementation of interventions under typical school conditions (e.g., barriers, facilitators, acceptability, feasibility, teacher preparation) and outcomes documenting preliminary effectiveness of former clinic-based interventions that have been modified for school conditions by incorporating feedback from school-based stakeholders, families, and youth, as well as articles about the costs of childhood mental health problems and school mental health programs and impact of a host of issues on future policy development.

Our goal is for this second edition of the *Handbook of School Mental Health* to build from this literature to provide updates on progress in the field and to underscore key themes in advancing training, practice, research, and policy and to promote interconnections across these realms. A brief review of prominent key themes is presented below.

Cross Cutting Themes

Acknowledging there are many key themes in need of systematic attention for the field to advance, here we focus on eight that in our experience have been a significant focus of work and are foundational to progress: (1) multi-tiered systems of support, (2) training and workforce development, (3) interdisciplinary collaboration, (4) systematic quality assessment and improvement, (5) cultural competence, (6) family and youth engagement and empowerment, (7) evidence-based practices, and (8) implementation support and coaching. We orient the reader to each of these below and conclude with comments on further building policy support for the field.

1. Multi-tiered Systems of Support

A dominant framework in the field of SMH is multi-tiered systems of support, which draws heavily on public health and prevention science perspectives and concepts. The public health framework (Mrazek & Haggerty, 1994; O'Connell, Boat, & Warner, 2009) outlines three tiers of preventive supports which represent a continuum in terms of both target population and program intensity (Mrazek & Haggerty, 1994; O'Connell et al., 2009; Walker et al., 1996). Specifically, applying this tiered approach to schools, the Tier 1, or universal (primary) level of support, is aimed at all students, anticipating that some students (e.g., 20 %) may not be responsive to this level of prevention programming. These nonresponders may require more intensive supports and interventions, such as Tier 2 (i.e., selective), targeted systems of support, which address the needs of students at risk of developing behavior or mental health concerns. These types of prevention programs often take the form of group interventions and may be used in conjunction with screening processes to identify the students in need of these types of targeted preventive supports. It is likely that a relatively small group of students (e.g., 10–15 %) will require these types of supports, and these supports are typically provided in the general education context. The most intensive preventive supports are provided through Tier 3 interventions (i.e., indicated) and are aimed at students (i.e., 5 %) who are displaying early signs of behavioral and/or mental health problems. These more intensive interventions are typically individualized and may involve parent participation in the services. The one-tiered model often used in school settings is Response to Intervention (RtI), which has largely been used to address academic problems (Fuchs, Mock, Morgan, & Young, 2003), but has also been used to address behavior concerns (Hawken, Vincent, & Schumann, 2008),

Another multi-tiered system of support that is increasingly used in schools across the USA is Positive Behavioral Interventions and Supports (PBIS; Sugai & Horner, 2006; Walker et al., 1996). The universal elements of the tiered PBIS model are the most commonly implemented

aspect of the framework. Specifically, PBIS is a non-curricular prevention model which draws upon behavioral, social learning, and organizational principles (Sugai & Horner, 2006). The model aims to alter the entire school environment (i.e., classroom and nonclassroom contexts) by creating improved systems (e.g., discipline, reinforcement, and data management) and procedures (e.g., office referral, reinforcement, training, and leadership) that promote positive change in staff and student behaviors. The whole-school PBIS strategy aims to prevent disruptive behavior and enhance the school's organizational climate by implementing a three-tiered prevention model, where selective interventions complement the universal school-wide components of the model (Sugai & Horner, 2006, 2009, 2010; Walker et al., 1996).

There is a growing evidence base for the effectiveness of the universal element of PBIS (Horner, Sugai, & Anderson, 2010). Two recent randomized controlled trials of Tier 1 PBIS in elementary schools provided evidence of its effectiveness in reducing student office discipline referrals, suspensions, and behavior problems; increasing prosocial behavior and emotion regulation; and improving school climate (Bradshaw, Koth, Bevans, Ialongo, & Leaf, 2008; Bradshaw, Koth, Thornton, & Leaf, 2009; Bradshaw, Mitchell, O'Brennan, & Leaf, 2010; Bradshaw, Waasdorp, & Leaf, 2012; Horner et al., 2009; Waasdorp, Bradshaw, & Leaf, 2012). A recent randomized trial of PBIS at the Tier 2 level also suggested positive impacts for staff and students, including improved academic performance and reduced special education services (Bradshaw, Pas, Goldweber, Rosenberg, & Leaf, 2012).

2. Training and Workforce Development

According to a report by the Annapolis Coalition on the Behavioral Health Workforce (2007), the mental health workforce in the United States is challenged by a lack of necessary training and implementation support related to mental health prevention and promotional activities, evidence-based practice, and interdisciplinary collaboration– all essential components within the delivery of school-based services. In addition, providers in schools, particularly providers from hospital, university, and community programs, may lack formal training in how to collaborate and deliver services effectively *in schools*. It is critical that the mental health workforce develops the skills needed to effectively integrate evidence-based interventions into school settings and learn how to effectively collaborate with school stakeholders to advance a shared family-school-community mental health agenda. While there are workforce issues at the preservice and in-service levels for mental health providers in schools (see chapters led by Lever and Michael in this handbook), there are also training and workforce issues for educators related to their often limited training in children's development, mental health, and behavioral strategies to address mental health concerns in students. Without adequate focus on educator and mental health provider training related to mental health needs of students and the effective delivery of services in schools, student outcomes, as well as clinician and teacher wellness, will be negatively impacted. Recognizing this need, the Mental Health Education Consortium was founded in 2002 and is seeking to broadly improve pre- and in-service training for educators on mental health, for mental health staff to work more effectively in schools, and for all disciplines working in schools to work more collaboratively and effectively together (Anderson-Butcher & Weist, 2011).

3. Interdisciplinary Collaboration

When working in schools, it is critical to be able to work across education and mental health systems to address barriers to learning and promote student success. As reviewed earlier, a key theme is having a *shared agenda* that is respectful of and recognizes the talents of all professionals within a school building (Andis et al., 2002). For example, it is important to recognize that educators are at the frontline of being able to identify student strengths and challenges in the classroom and are in a position to implement

behavioral strategies. While it is easy to set up a team, it is more challenging to set up a structure, process, and training for successful partnership across disciplines. According to the Carnegie Foundation for the Advancement of Teaching Conference Summary (2010, p. 5), "currently, teamwork is not a primary focus of most health professions education programs around the country. Regardless of the health profession – medicine, nursing, pharmacy, social work, dentistry, etc. – students are taught to function independently and usually learn in silos." Within a school setting, there are diverse professions represented including, among others, general and special education, school counseling, school psychology, school social work, nursing, and speech and occupational therapy. While schools reflect these multiple disciplines, working together and ideally being guided by youth, families, and school and community stakeholders, rarely are staff trained or coached to be effective in this interdisciplinary context (Mellin & Weist, 2011), another area of the field in critical need of further development (see Carnegie Foundation, 2010).

4. Systematic Quality Assessment and Improvement

In volume two of *Advancing School Mental Health Services* (Evans et al., 2007), the agenda around improving quality was presented to involve the following:

> Quality is a central or overarching construct to the advancement of SMH, including many concepts such as needs assessment, resource mapping and planning; inclusive and genuine stakeholder involvement; selecting, training, coaching and supporting staff; promoting the effectiveness of coordinating teams; delivering a full continuum of empirically supported services; evaluating the impact of these services; using evaluation findings toward continuous program improvement; and influencing policies and enhancing resources. An iterative and evolving process should occur so that this loop leads to the improvement and expansion of SMH initiatives; which in turn proceed through the above steps, and influence policies and resources on a broader scale. (Weist et al., 2007, p. 4:1)

A key theme in SMH quality is assuring that mental health staff is working effectively in schools. Ideally in the interdisciplinary SMH field, mental health staff employed by the school and those employed by other community agencies will be working closely together, and this requires relationship development, sharing of information, and purposeful efforts to reach out and collaborate (see Stephan, Davis, Callan Burke, & Weist, 2006). School-employed mental health staff often benefit from training in resources available in the community, and more intensive evidence-based intervention, and community-employed mental health staff often benefit from training in local school culture, federal laws regarding special education and sharing of information (e.g., Federal Education Rights Privacy Act [FERPA]), and particular district and school building level policies (see Paternite, Weist, Axelrod, Anderson-Butcher, & Weston, 2006; Rappaport, Osher, Garrison, Anderson-Ketchmark, & Dwyer, 2003). Further, staff without experience working in schools should be prepared for differences in this environment that can be stark as compared to traditional child and adolescent mental health settings. For example, the work in schools involves much less administrative support, greater pressure to be out of the office and in other settings (e.g., classrooms, hallways, school events), and involves more prevention and early intervention than more traditional community mental health settings (see Power et al., 2003; Weist et al., 2007). There are also many specific strategies associated with quality services, such as providing training to education staff, assuring referral processes are working effectively and rapidly, promoting meaningful family and student engagement in services, and sharing findings from focused evaluations with education staff.

Each of the above dimensions and strategies for effective work in SMH should ideally be monitored and trigger quality assessment and improvement (QAI) planning as indicated. Toward this end, we (MW, NL) have developed an expanded version of an SMH report card – the School Mental Health Quality Assessment Questionnaire (SMHQAQ; Weist et al., 2005;

Weist, Ambrose, & Lewis, 2006). The SMHQAQ is designed to be used by inclusive and well-functioning school teams (a major quality indicator) at regular junctures to monitor overall progress and to make adjustments to promote improvement for particular areas of functioning, based on 10 principles and 40 indicators of high-quality service. The SMHQAQ is a unique instrument in that it uses clinician self-report data to assess SMH quality and guides clinicians in directed improvement. Research on strategies to promote a consistent focus on QAI processes by SMH staff remains a priority in the SMH field.

5. Cultural Competence

When defining culture, it is important to recognize that culture must be conceptualized broadly to include race, ethnicity, gender, age, socioeconomic status, location (e.g., urban, rural), community (e.g., military, school building), and professional discipline (e.g., special education, community mental health). Thus, to be culturally competent, SMH providers and researchers must be knowledgeable of and sensitive to these diverse cultures and contexts. However, it is important to remember that whenever a section of the population is being defined (e.g., based on race, location, or community), there are often as many within-group differences as between-group differences. Thus, to be culturally competent, providers and researchers must take responsibility for obtaining accurate information about the culture (beyond labels and stereotypes) and for exploring (rather than assuming) the extent to which the characteristics of that culture are relevant and meaningful to the client or group being served (Owens, Watabe, & Michael, 2013). Chapters within this handbook highlight the importance of cultural sensitivity in the context of (a) engaging youth and families in education and behavioral health programming for their child; (b) screening, assessing, and communicating about children's mental health problems; (c) adapting former clinic-based services to school-based approaches by incorporating feedback from school staff and families; and (d) implementing treatments with families of diverse backgrounds. In addition to the current handbook, readers are encouraged to utilize the *Handbook of Culturally Responsive School Mental Health: Advancing Research, Training, Practice, and Policy* (Clauss-Ehlers, Serpell, & Weist, 2013; Springer, New York) for more specific guidance on enhancing cultural competence in SMH.

6. Family and Youth Engagement and Empowerment

As has been acknowledged in the delineation of principles of best practice in SMH (Weist et al., 2005), family and youth partnership are fundamental to successful programs (Principle 4: *Students, families, teachers, and other important groups are actively involved in the program's development, oversight, evaluation, and continuous improvement*). With respect to SMH, the extent to which families are actively engaged in the development, implementation, and evaluation of programs and services predicts service quality and clinical outcome and is associated with better adjustment and improved academic outcomes for youth (Coalition for Psychology in the Schools and Education, 2006). School mental health programs are uniquely positioned to build partnerships with schools and families (Barrett, Eber, & Weist, 2012) while promoting a school-family-community partnership model, as opposed to a "walled model" that relies solely on the school to develop and implement all mental health-related activities. This handbook emphasizes the importance of family and youth partnerships in SMH, considers how to effectively partner with schools and communities around SMH, and offers insight into the power and potential of families when given a voice in their children's care.

7. Evidence-Based Practices

Evidence-based practice (EBP) has been defined as an approach to care provision in which the provider considers and synthesizes empirical evidence, clinical expertise, and patient values and preferences (Society for Clinical Child and

Adolescent Psychology). The publication of this handbook marks an extraordinary time in the history of evidence-based practice in the field of SMH. Namely, over the last 50 years, prevention and intervention programs and strategies for youth have been developed and tested under tightly controlled laboratory conditions (see Weisz, Sandler, Durlak, & Anton, 2005 for review). Further, the last decade has witnessed an increase in the transportation and examination of these programs and strategies when integrated into the school environment. The field is witnessing an increased emphasis on EBP across (a) the span of school-age development (preschool through high school), (b) a wide variety of providers (school-employed school counselors, social workers, and psychologists; school nurses and health providers; community-based mental health providers; educators), (c) a broad assortment of childhood problems (anxiety, depression/suicide, developmental disorders, aggression/behavioral disorders), and (d) the spectrum of service provision (promotion, prevention, assessment, selected and targeted individual and group-based treatments). Chapters in this handbook document the state of the science as the focus of research shifts from efficacy to effectiveness and dissemination. Although the science of effectiveness in SMH is in its infancy, the lessons learned that propel the next generation of research are articulated within many of the chapters. Themes that collectively emerge across chapters include issues related to feasibility of the services when implemented by school-employed or community practitioners; acceptability of the services for caregivers, students, and educators; the need for quality training and ongoing practice supports to maintain integrity of EBPs; and cost analyses. Other important themes include university-community partnerships that work collaboratively to narrow the science-to-practice gap, relevancy of the documented outcomes to educators, the importance of service marketing to obtain buy-in and adoption from school administrators, and iterative service development processes that incorporate feedback from key stakeholders into updated and modified versions of the services. These are exciting developments that breed ample opportunities for researchers, practitioners, families, and preservice graduate students to come together to address significant needs within the school community, while simultaneously advancing science that is grounded in the realities of the school setting.

8. Implementation Support and Coaching

There is increasing interest in the supports necessary to help implement EBPs in schools (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Domitrovich et al., 2008). While there has been a long history of providing implementation support to program implementers (e.g., teachers, clinicians), which often takes the form of coaching and consultation, only recently has there been a concerted effort to try to formalize the implementation support process. The field of implementation science more generally is concerned with identifying the supports necessary to promote successful and high-quality implementation of evidence-based program in "real-world" settings, such as schools (Fixsen et al., 2005). There is also an interest in trying to document which aspects of the support system are critical to high-quality implementation, such as training, technical assistance, and coaching, and, in turn, the association between implementation support and outcome for students and/or staff (Domitrovich et al., 2008). There has been a particular focus on coaching as a specific form of implementation support. As outlined in Pas, Bradshaw, & Cash (2013), there is a growing body of research aiming to document such an association; however, some of the empirical research to date has been mixed, with some studies reporting significant impacts on implementation quality and relatively few studies documenting the link with improved outcomes for students. While there is interest in coaching as a potentially promising conduit for the promotion of high-quality implementation of evidence-based practices in schools, be they programs implemented by teachers or clinicians, there is a need for more empirical research documenting the

critical features of coaching (Hershfeldt, Pell, Sechrest, Pas, & Bradshaw, 2012), identifying what types of coaching models are most effective for different types of programs or conditions of implementation (Denton & Hasbrouck, 2009) and what contextual factors influence the success of various coaching and other types of implementation supports (Domitrovich et al., 2008; Han & Weiss, 2005).

Policy Support for the Field

Each of the above elements (i.e., using a multi-tiered framework, growing an effective and interdisciplinary workforce, that is guided by systematic QAI processes, emphasizing cultural competence, family and youth engagement and empowerment, and implementing evidence-based practices supported by the right forms and amounts of implementation support) together contribute to the achievement of valued school and student outcomes. In turn, the achievement of these outcomes will support federal, state, and local policy support and grassroots support (e.g., spread across schools as principals become "sold") for the field to gain momentum and capacity. An inherent paradox is that currently capacity for effective promotion, prevention, early intervention, or treatment in schools is often poor, resulting in implementation of random, superficial, and crisis-oriented services that typically do not contribute to positive outcomes. Hence, a critical need to improve and expand SMH (a specific goal of the President's New Freedom Commission on Mental Health, 2003) is to move toward more widespread implementation of local strategies inclusive of the eight themes reviewed above. These eight themes are found throughout this book.

Organization and Contents of This Handbook

The book opens with important commentaries from leaders in the field, Lucille Eber, Hill Walker, Kathy Short, Abe Wandersman, and Deborah Hamm, who amplify these eight themes while underscoring other critical directions for the advancement of SMH. There are then six sections that logically proceed in step with the multi-tiered framework, first reviewing foundational factors and moving up from more preventive strategies to interventions for specific problems.

Section 1: Foundations: Funding, Training, and Interdisciplinary Collaboration

This section includes six chapters, reviewing (a) an array of funding strategies, (b) competencies for interdisciplinary and cross-system collaboration, (c) specific recommendations and examples for preservice education, (d) strategies for effective teams, (e) a partnership model that integrates research and practice, and (f) strategies for assuring least restrictive environment for youth presenting challenging emotional/behavioral problems.

Section 2: Prevention and Mental Health Promotion

This section includes six chapters, on (a) integrating Positive Behavioral Interventions and Supports (PBIS) and Social and Emotional Learning (SEL), (b) developing early childhood programs for low-income youth, (c) primary and secondary prevention programs for at-risk youth, (d) preventing depression, (e) connecting after-school programs and SMH, and (f) preventing relational aggression.

Section 3: Youth and Family Engagement and Empowerment

This section includes five chapters reviewing (a) strategies for youth involvement including student recommendations, (b) strengthening components of family involvement, (c) methods for partnering with families, (d) increasing parental engagement, and (e) an ecological approach to family intervention.

Section 4: Coaching and Consultation

This section includes three chapters on (a) coaching classroom-based preventative interventions, (b) supporting teachers through consultation and training, and (c) models of psychiatric consultation to schools.

Section 5: Screening and Early Identification

This section includes three chapters reviewing: (a) early detection of problems through screening, (b) culturally competent screening for emotional and behavioral problems, and (c) early identification of students with psychosis.

Section 6: Intervention for Specific Problems/Challenges

This final section of the book includes eight chapters focused on (a) strategies to reduce bullying, (b) transportable treatments for anxiety, (c) treating depression in students, (d) organizational interventions for youth with ADHD, (e) integrating an evidence-based classroom intervention for youth with ADHD into a three-tiered system of behavioral supports, (f) a comprehensive, life-course model for treating emotional and behavioral problems in youth, (g) classroom intervention for youth pervasive developmental and autism spectrum disorders, and (h) supporting the mental health needs of military-connected students.

Conclusion

At the time of this writing, in the beginning of 2013, the aftereffects of the horrific school shooting in Newtown, Connecticut, in December 2012 are still cogently felt by the nation, and we hope that this book honors the victims, survivors, and heroes involved in this event. In response to the shooting, a group of nine leading scholars and researchers on effective schools, school violence, positive behavior support, and/or school mental health developed a widely circulated position statement endorsed by hundreds of organizations and leaders from these and other fields. While acknowledging the need for policy enhancement related to assault weapons access, the position statement emphasized the need for approaches characterized by four pillars: balance, communication, connectedness, and support (Interdisciplinary Group on Preventing School and Community Violence, 2012). Summarizing, avoiding reactionary and likely ineffective approaches (e.g., widespread use of metal detectors), increasing communication and relationships among students and school staff to increase the likelihood of identification and assistance to those at risk for committing school violence, and supporting and assisting students struggling with emotional and behavioral challenges, early on and effectively. Since the events and the publication of this position statement, there has been much local, state, and national discussion on the importance of SMH in assuring student and staff safety and in promoting the health and academic success of the nation's children and adolescents (see United States' White House, 2013). Indeed, it is our hope that this book spurs efforts to improve training, practice, research, and policy and promote interconnections across these realms in this critically needed and important field, helping to increase effective services in more schools, assisting more students and families, and enhancing the overall health of the nation.

References

Anderson-Butcher, D., & Weist, M.D. (2011). The Mental Health-Education Integration Consortium (MHEDIC): A community of practice working to advance school mental health. *The Community Psychologist, 3*, 23-26.

Annapolis Coalition. (2007). *An action plan for behavioral health workforce development: A framework for discussion*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse & Mental Health Services Administration, Department of Health & Human Services.

Andis, P., Cashman, J., Praschil, R., Oglesby, D., Adelman, H., Taylor, L., et al. (2002). A strategic and shared agenda to advance mental health in schools

through family and system partnerships. *International Journal of Mental Health Promotion, 4*, 28–35.

Barrett, S., Eber, L., & Weist, M. D. (2012). *Development of an interconnected systems framework for school mental health*. Office of Special Education Programs Center on Positive Behavioral Interventions & Supports, Eugene, Oregon; and University of Maryland Center for School Mental Health, Baltimore, Maryland.

Bradshaw, C. P., Koth, C. W., Bevans, K. B., Ialongo, N. S., & Leaf, P. J. (2008). The impact of school-wide Positive Behavioral Interventions and Supports (PBIS) on the organizational health of elementary schools. *School Psychology Quarterly, 23*, 462–473.

Bradshaw, C. P., Koth, C. W., Thornton, L. A., & Leaf, P. J. (2009). Altering school climate through school-wide Positive Behavioral Interventions and Supports: Findings from a group-randomized effectiveness trial. *Prevention Science, 10*, 100–115. doi:10.1007/s11121-008-0114-9.

Bradshaw, C. P., Mitchell, M. M., & Leaf, P. J. (2010). Examining the effects of school-wide positive interventions and supports on student outcomes: Results from a randomized controlled effectiveness trial in elementary schools. *Journal of Positive Behavior Interventions, 12*, 133–148.

Bradshaw, C. P., Pas, E. T., Goldweber, A., Rosenberg, M., & Leaf, P. (2012). Integrating school-wide Positive Behavioral Interventions and Supports with tier 2 coaching to student support teams: The PBISplus model. *Advances in School Mental Health Promotion, 5*(3), 177–193.

Bradshaw, C. P., Waasdorp, T. E., & Leaf, P. J. (2012). Effects of School-Wide Positive Behavioral Interventions and Supports on child behavior problems. *Pediatrics, 130*(5), e1136–e1145.

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M., et al. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*(3), 147–159.

Carnegie Foundation for the Advancement of Teaching Conference Summary. (2010). *Educating nurses and physicians: Toward New Horizons*. Retrieved from http://www.macyfoundation.org/docs/macy_pubs/JMF_Carnegie_Summary_WebVersion_%283%29.pdf

Cashman, J., Linehan, P., & Rosser, M. (2007). *Communities of practice: A new approach to solving complex educational problems*. Alexandria, VA: National Association of State Directors of Special Education.

Center for Health and Health Care in Schools. (2001). *School-based health centers: Results from a 50 state survey: School year 1999–2000*. Washington, DC: George Washington University.

Clauss-Ehlers, C. S., Serpell, Z. N., & Weist, M. D. (2013). *Handbook of culturally responsive school mental health: Advancing research, training, practice, and policy*. New York: Springer.

Coalition for Psychology in Schools and Education. (2006). *Report on the teacher needs survey*. Washington, DC: American Psychological Association, Center for Psychology in Schools and Education.

Denton, C. A., & Hasbrouck, J. (2009). A description of instructional coaching and its relationship to consultation. *Journal of Educational & Psychological Consultation, 19*, 150–175. doi:10.1080/10474410802463296.

Domitrovich, C. E., Bradshaw, C. P., Poduska, J., Hoagwood, K., Buckley, J., Olin, S., et al. (2008). Maximizing the implementation quality of evidence-based preventive interventions in schools: A conceptual framework. *Advances in School Mental Health Promotion: Training and Practice, Research and Policy, 1*(3), 6–28.

Evans, S. W., Weist, M. D., & Serpell, Z. (2007). *Advances in school-based mental health interventions: Best practices and program models* (Vol. II). New York: Civic Research Institute.

Fixsen, D. L., Naoom, S. F., Blasé, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI Publication No. 231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Flaherty, L. T., Weist, M. D., & Warner, B. S. (1996). School-based mental health services in the United States: History, current models and needs. *Community Mental Health Journal, 32*(4), 341–352.

Flaherty, L. T., Garrison, E., Waxman, R., Uris, P., Keyes, S., Siegel, M. G., et al. (1998). Optimizing the roles of school mental health professionals. *Journal of School Health, 68*, 420–424.

Flaherty, L. T., & Osher, D. (2003). History of school-based mental health services in the United States. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 11–22). New York: Kluwer Academic/Plenum Publishers.

Fuchs, D., Mock, D., Morgan, P. L., & Young, C. L. (2003). Responsiveness-to-intervention: Definitions, evidence, and implications for the learning disabilities construct. *Learning Disabilities Research & Practice, 18*(3), 157–172.

Han, S. S., & Weiss, B. (2005). Sustainability of teacher implementation of school-based mental health programs. *Journal of Abnormal Child Psychology, 33*(6), 665–679. doi:10.1007/s10802-005-7646-2.

Hawken, L. S., Vincent, C. G., & Schumann, J. (2008). Response to Intervention for social behavior: Challenges and opportunities. *Journal of Emotional and Behavioral Disorders, 16*, 213–225.

Hershfeldt, P. A., Pell, K., Sechrest, R., Pas, E. T., & Bradshaw, C. P. (2012). Lessons learned coaching teachers in behavior management: The PBIS*plus* coaching model. *Journal of Psychological and Educational Consultation, 22*, 280–299.

Horner, R. H., Sugai, G., & Anderson, C. M. (2010). Examining the evidence base for school-wide positive behavior support. *Focus on Exceptional Children, 42*(8), 1–14.

Horner, R. H., Sugai, G., Smolkowski, K., Eber, L., Nakasato, J., Todd, A. W., et al. (2009). A randomized, wait-list controlled effectiveness trial assessing school-wide positive behavior support in elementary schools. *Journal of Positive Behavior Interventions, 11*, 133–144.

Interdisciplinary Group on Preventing School and Community Violence. (2012, December). *Connecticut school shooting position statement*. Charlottesville, VA: University of Virginia, Curry School of Education.

McKay, M. M., Lynn, C. J., & Bannon, W. M. (2005). Understanding inner city child mental health need and trauma exposure: Implications for preparing urban service providers. *American Journal of Orthopsychiatry, 75*(2), 201–210.

Mellin, E. A., & Weist, M. D. (2011). Exploring school mental health collaboration in an urban community: A social capitol perspective. *School Mental Health, 3*(2), 81–92.

Mrazek, P. J., & Haggerty, R. J. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy Press.

National Assembly on School-Based Health Care [NASBHC]. (2002). *School-Based Health Centers: A national definition*. Washington, DC: Position Statement of the National Assembly on School Based Health Care.

O'Connell, M. E., Boat, T., & Warner, K. E. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions; Institute of Medicine; National Research Council, The National Academies Press.

Owens, J. S., Watabe, Y., & Michael, K. D. (2013). Culturally responsive school mental health in rural communities. In C. Clauss-Ehlers, Z. Serpell, & M. D. Weist (Eds.), *Handbook of culturally responsive school mental health: Advancing research, training, practice, and policy* (pp. 31–42). New York: Springer.

Pas, E., Bradshaw, C. P., & Cash, A. (2013). Coaching classroom-based preventive interventions. In M. D. Weist, N. A. Lever, C. P. Bradshaw, & J. Owens (Eds.), *Handbook of school mental health: Advancing practice and research* (2nd ed.). New York: Springer 255–268.

Paternite, C. E., Weist, M. D., Axelrod, J., Anderson-Butcher, D., & Weston, K. (2006). School mental health workforce issues. In M. Hoge, J. Morris, A. Daniels, N. Adams, L. Huey, & G. Stuart (Eds.), *A thousand voices: The national action plan on behavioral health workforce development* (pp. 199–210). Rockville, MD: U.S. Substance Abuse and Mental Health Services Administration.

Power, T. J., DuPaul, G. J., Shapiro, E. S., & Kazak, A. E. (2003). *Promoting Children's Health: Integrating school, family and community*. London: The Guilford Press.

President's New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America. Final Report. (DHHS Publication No. SMA-03-3832). Rockville, MD: Author.

Rappaport, N., Osher, D., Greenberg Garrison, E., Anderson-Ketchmark, C., & Dwyer, K. (2003). Enhancing collaboration within and across disciplines to advance mental health programs in schools. In M. D. Weist, S. Evans, & N. Lever (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 107–118). New York: Kluwer Academic/ Plenum Publishers.

Robinson, K. E. (2004). *Advances in school-based mental health interventions: Best practices and program models*. New York: Civic Research Institute.

Stephan, S. H., Davis, E., Burke, P. C., & Weist, M. D. (2006). Supervision in school mental health. In T. K. Neill (Ed.), *Helping others help children: Clinical supervision of child psychotherapy* (pp. 209–222). Washington, DC: American Psychological Association.

Strozer, J., Juszczak, L., & Ammerman, A. (2010). *2007–2008 National School-Based Health Care Census*. Washington, DC: National Assembly on School-Based Health Care.

Sugai, G., & Horner, R. (2006). A promising approach for expanding and sustaining school-wide positive behavior support. *School Psychology Review, 35*, 245–259.

Sugai, G., & Horner, R. H. (2009). Responsiveness-to-intervention and school-wide positive behavior supports: Integration of multi-tiered approaches. *Exceptionality, 17*, 223–237.

Sugai, G., & Horner, R. (2010). School-wide positive behavior supports: Establishing a continuum of evidence-based practices. *Journal of Evidence-Based Practices for Schools, 11*(1), 62–83.

United States' White House. (2013). *Now is the time: The President's plan to protect our children and our communities by reducing gun violence.* Washington, DC: President of the United States. Retrieved from www.whitehouse.gov/now-is-the-time.

U.S. Public Health Service. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A national action agenda*. Washington, DC: Author.

Waasdorp, T. E., Bradshaw, C. P., & Leaf, P. J. (2012). The impact of School-wide Positive Behavioral Interventions and Supports (SWPBIS) on bullying and peer rejection: A randomized controlled effectiveness trial. *Archives of Pediatrics and Adolescent Medicine, 116*(2), 149–156.

Walker, H., Horner, R. H., Sugai, G., Bullis, M., Sprague, J., Bricker, D., et al. (1996). Integrated approaches to preventing antisocial behavior patterns among school-age children and youth. *Journal of Emotional and Behavioral Disorders, 4*, 194–209.

Waxman, R. P., Weist, M. D., & Benson, D. M. (1999). Toward collaboration in the growing education – Mental health interface. *Clinical Psychology Review, 19*, 239–253.

Weist, M. D. (1997). Expanded school mental health services: A national movement in progress. In T. H.

Ollendick & R. J. Prinz (Eds.), *Advances in clinical child psychology* (Vol. 19, pp. 319–352). New York: Plenum Press.

Weist, M. D., Ambrose, M., & Lewis, C. (2006). Expanded school mental health: A collaborative community/school example. *Children & Schools, 28*, 45–50.

Weist, M. D., Evans, S. W., & Lever, N. (2003). *Handbook of school mental health: Advancing practice and research*. New York: Kluwer Academic/Plenum.

Weist, M.D., Paternite, C., Wheatley-Rowe, D., & Gall, G. (2010). From thought to action in school mental health promotion. *International Journal of Mental Health Promotion*, *11*(3), 2009, 32–41.

Weist, M. D., Sander, M. A., Walrath, C., Link, B., Nabors, L., Adelsheim, S., et al. (2005). Developing principles for best practice in expanded school mental health. *Journal of Youth and Adolescence, 34*(1), 7–13.

Weist, M. D., Stephan, S., Lever, N., Moore, E., Flaspohler, P., Maras, M., et al. (2007). Quality and school mental health. In S. Evans, M. Weist, & Z. Serpell (Eds.), *Advances in school-based mental health interventions* (pp. 4:1–4:14). New York: Civic Research Institute.

Wenger, E., & Snyder, W. (2000). Communities of practice: Organizational Frontier. *Harvard Business Review, 78*, 139–145.