School Psychology Leadership in Behavioral and Mental Health Intervention and Consultation

Kristine Augustyniak

School psychologists are distinctively advantaged to serve as leaders in the implementation of prevention and intervention services for youth exhibiting mental and behavioral health concerns for several reasons. First, school psychologists are positioned in a natural ecological system where children spend considerable time. This allows for valid contextual assessment and progress monitoring and easy access for service delivery. Moreover, school psychologists are trained as advocates for coordinated, comprehensive, and culturally responsive school-based services. Their expertise in program delivery and resource allocation principles within a multitiered system can facilitate system-based policies and procedures to attend to the mental and behavioral health needs of all students. Given the substantial scope of training related to mental health evidenced in school psychology training programs, further integration of leadership theory with extant content related to mental health service delivery is a necessary next step in the advancement of school-based mental health services.

In a recent white paper, the National Association of School Psychologists (NASP, 2015) succinctly endorses:

> School psychologists who maintain competencies consistent with NASP standards are qualified providers of child and adolescent mental and behavioral health services. (p. 2)

NASP asserts that school psychologists are distinctively advantaged to facilitate prevention and intervention services for youth exhibiting mental and behavioral health concerns for several reasons. First, school psychologists are positioned in a natural ecological system where children spend considerable time. This allows for

K. Augustyniak (✉)
Niagara University, New York, NY, USA
e-mail: kma@niagara.edu

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valid contextual assessment and progress monitoring and easy access for service delivery. Moreover, school psychologists are trained as advocates for coordinated, comprehensive, and culturally responsive school-based services. Their expertise in program delivery and resource allocation principles within a multitiered system can facilitate system-based policies and procedures to attend to the mental and behavioral health needs of all students.

1 Prevalence and High-Need Mental Disorders

Reported prevalence estimates for mental health disorders are customarily reported as lifetime (the number of cases at any time in the lifetime of respondents, irrespective of whether the disorder is current), 12-month (the number of cases in the population during the past year), and point prevalence (the number of cases during a designated time period such as the time of the survey, within 3 months, within 6 months, etc.). The most common estimates of prevalence in children are either point or 1 year, because of the lack of reliability of lifetime estimates. In their meta-review from community surveys across the world, Merikangas et al. (2009) utilized median prevalence point rates and key prevalence point rates to estimate the magnitude of specific mental disorders in children and adolescents. Their findings echoed the results from the more recent CDC US study (Centers for Disease Control, 2013) finding that approximately one fourth of youth experience a mental disorder during the past year and about one third across their lifetimes. Moreover, about one out of every ten youths was estimated to meet the Substance Abuse and Mental Health Services Administration (SAMHSA) criteria for a Serious Emotional Disturbance (SED), defined as the presence of a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities (SAMHSA, 1993).

Perhaps the highest prevalence of mental health disorders among US youth is the rates of anxiety disorders. Merikangas et al. (2009) found the median prevalence rate of all anxiety disorders was 8% with an extremely wide range of estimates (e.g., 2–24%). Anxiety disorders are so commonly comorbid with all of the other major classes of disorders, including mood disorders, disruptive behaviors, eating disorders, and substance use disorders, that there is emerging theory that anxiety disorders may be part of the developmental sequence in which anxiety is expressed early in life followed by other mental health disorders as children age. Hence, suggesting anxiety disorders may be a particularly compelling group of disorders to target for treatment in schools. Reviews of previous studies show a median prevalence estimate of major depressive disorder (MDD) to be 4.0% with a range from 0.2% to 17% for major depression. Prevalence estimates of persistent depressive disorder (a.k.a. dysthymia) among adolescents and young adults were found to be typically

lower than those of major depression. In contrast, prevalence estimates of subthreshold depressive disorders and syndromes, including minor depression and unspecified depression (aka, other specified depressive disorder and unspecified depressive disorder), are generally higher than those of major depression across all age groups. Few community surveys included assessment of mania or hypomania, in part because of the widely held belief that these conditions are too rare in children. Current or 12-month prevalence rates of mania, hypomania, and bipolar disorder in population-based studies of youth range from 0% to 0.9% in children age 14–18. Lifetime prevalence rates for bipolar disorder among youth range from 0% to 2.1%, and the lifetime prevalence rate for hypomania ranges between 0% and 0.4%. Although the point prevalence rates of ADHD have varied from 1.7% to 17.8%, the median prevalence of ADHD in this meta-review was 3%. The median 12-month prevalence rate of disruptive behavior disorders (i.e., conduct disorder [CD] or oppositional defiant disorder [ODD]) is 6%, with a range from 5% to 14%. Community studies of youth have shown a high degree of association between all disruptive behavior disorders with mood and anxiety disorders.

There is also substantial evidence that mental disorders generally identified in school-age children are quite prevalent in preschool children (Wichstrom et al., 2012). At least 8–10% of children younger than 5 years experience clinically significant and impairing mental health problems, which include emotional, behavioral, and social relationship problems There is also a high degree of comorbidity in young children with mental disorders; of those with one disorder, approximately 25% have a second disorder. The proportion of children with comorbidity increases about 1.6 times for each additional year from age 2 (18.2%) to 5 (49.7%) (Egger & Angold, 2006).

Efficacious identification and treatment of preschool, childhood, and adolescent psychopathology requires a developmentally sensitive approach that includes understanding of and ability to assess for both normative and atypical development, ability to synthesize biological, interpersonal, and other contextual risk factors, determination of the magnitude and consequences of present mental disorders, and the ability to deliver empirically supported treatments within collaborative contexts. Indisputably, these skills are inherent to sound school psychology practice.

2 Consequences

Because many mental health conditions onset before the age of 20, the mental and behavioral health of students is a necessary, appropriate, and critical focus of public education for individuals from birth to age 21. An extensive body of research supports an organic link between mental and behavioral wellness to educational outcomes. Students with mental health or behavioral difficulties who are left untreated or insufficiently treated are more likely to experience overall lower achievement,

more absenteeism, higher engagement in risky behaviors, disciplinary incidents, and substance abuse, poorer high school graduation rates, and a higher likelihood negative perception of school climate (Center for Health and Healthcare in Schools, 2014).

Moreover, because childhood mental and behavioral health problems tend to be stable and predictive of detrimental outcomes throughout individuals' developmental trajectory into adulthood. A prime illustration is that the lifetime prevalence rate for any mental disorder in adults (46.4%) is strikingly consistent with that in adolescents (46.3%) (Kessler et al., 2005; Merikangas et al., 2011). Regrettably, suicide has remained steady as the third leading cause of death in individuals ages 12–19 (Miniño, 2010). Detrimental outcomes are also predictable related to interpersonal relationships, employment, family income, physical health, continuing education, and enmeshment in the criminal justice, public assistance, disability systems. For example, alcohol use disorders and depression are the leading contributors to disability status in the United States (Murray et al., 2013). Because early intervention and prevention can be effective in improving these pathological progressions, schools are an opportune venue to improve health trajectories and prevent disability later in life; however, the barriers to mental health treatment in youth must be addressed.

3 Contextual Factors and Contemporary Practice

School psychologists must be cognizant that the provision of mental and behavioral health services is often affected by schools' organizational characteristics (e.g., administrative prioritization, approval and support, division of roles with other school-based mental health professionals, the need for additional professional development of staff to ensure competent practice, etc.). While it is ultimately an administrative responsibility of school districts to ensure that key organizational principles, such as distributed leadership, are in place so that school-employed professionals with specialized expertise can deliver comprehensive and integrated services to students, it is also the ethical responsibility of school psychologists and other mental health professionals to advocate for appropriate access to and the delivery of these vital services.

Along with being conversant of the position statements of their own professional organizations, (i.e., NASP), school psychologists should be versed in legislation that guide mental and behavioral health services in the context of education and healthcare reform. Congress has recently authorized and approved appropriations for various federal programs including the Patient Protection and Affordable Care Act (ACA; 2010) and the Medicaid School Supportive Health Program emphasizing the value of school-based mental health services in overall student learning and development. The ACA specifically recognizes school psychologists as qualified providers of child and adolescent mental and behavioral health services and authorizes several grant programs to increase school-based mental health services.

Unfortunately, the ACA left absent any clear definition of *school-based* services leading to competing viewpoints whether these services should be in-house (i.e., funding to expand the number and roles of school-based employees) or outside-in (i.e., funding to relocate or collocate community providers into schools). Proponents of in-house services identify several key advantages such as (1) ease of access for children, families, and providers; (2) preexisting expertise of specialized school staff (e.g., school psychologists, school social workers, school counselors, etc.); (3) reduced stigma of school building services; (4) the ability to observe problematic behaviors and utilize interventions in a child's natural setting, and (5) that school employees have a more authentic connection to the school community. For example, school mental health professionals are more likely to be adept at infusing their practices into school and classroom routines, whereas outside professionals are likely to have more difficulty promoting their agency's vision of service provision to hosting schools. However, in-house services can be complicated to structure and difficult to maintain over time. Several barriers have repeatedly been identified in the literature. For example, school-based mental services are characteristically predicated on universal access for all children. Hence, the client base is framed as quite large and, due to limited resources, services tend to be skewed to universal/primary prevention (i.e., Tier 1) services. In contrast, community agencies tend to specialize in treating children with the most significant needs (i.e., Tier 3). In addition, schools typically restrict hiring staff to those who hold a professional license or certification from their representative state education department, whereas community agencies recognize noncertified staff provided they are adequately trained and supervised by a credentialed professional, consequently providing more human resources at a lower cost (Doll et al., 2017).

In an effort to supplement funding sources for health services in schools, the Preschool/School Supportive Health Services Program (SSHSP, aka Medicaid in Education) permits, under specific stipulations, Medicaid coverage of certain services included in the Individualized Education Programs (IEPs) of students with disabilities. Eligible services include, among others, psychological assessment and psychological counseling. Though school psychologists already provide such services to children regardless of their Medicaid eligibility status, a potentially larger population of Medicaid-eligible children could subsequently result in a greater funding stream being returned to the school, enabling more comprehensive service delivery. Unfortunately, a significant number of schools are disqualified from receiving the full benefit of these provisions. Although federal legislative language has provided well-defined classifications of qualified service providers (e.g., school psychologists) and eligible services, states are not required to recognize federal definitions within state-specific Medicaid/education policies. As a result, state regulatory agencies diverge markedly in the interpretation and implementation of Medicaid policies. Currently, school psychologists are considered qualified providers of Medicaid services in only 34 states. Yet, seven out of ten students receiving mental health services receive these services at school. These restrictions on Medicaid further marginalize these critical services and leave students without access to care (NASP, 2017). Moreover, a range of exclusions and limiting factors

contributes to inconsistency even within these 34 states. For example, several states require an additional level of supervision for service providers based upon licensure and/or graduate preparation, while other states limit billable services to a single activity (e.g., assessment for special education decision-making) (National Register of Health Service Psychologists, 2015).

A more recent Labor, HHS and Education Appropriations bill for fiscal year 2021 includes an amendment that allows for the piloting of $10 million training program for school-based mental health. The primary objective of the amendment would create a program at the Department of Education to test and evaluate partnerships between universities and state and local education agencies to train school psychologists, school counselors, and other mental health professionals for positions in public school systems serving low-income communities. Funding will support school safety activities, including student mental health services, bullying prevention, and professional development for personnel in crisis management (House Committee on Appropriations, 2020).

Perhaps the legislative act most familiar to school psychologists is the Individuals with Disabilities Education Act (IDEA, 2004). If a child is suspected of having mental or behavioral disorder eligible for special education services, this law affords the child and family several provisions and protections. The first entitlement is a comprehensive evaluation to determine eligibility and, if applicable, prerogative for re-evaluation every at least every 3 years unless parents and the school agree that it is not necessary. When a child qualifies under the classification of severe emotional disturbance (SED) or any of the other 12 classifications, guaranteed among other provisions is a free appropriate public education (FAPE) and an Individualized Education Program (IEP). As an extension of FAPE, special protections for disciplinary procedures must also be followed if they are suspended or expelled for 10 days or more (i.e., a manifestation determination). The IEP is a written document that includes specific goals for the child based on the child's current level of performance. IDEA also asserts the use of functional behavioral assessment (FBA) and positive behavioral strategies, known as a behavioral intervention plan (BIP), for supporting children with disabilities. This must be part of the child's initial or subsequent evaluation when the suspected needs of the child include behavior. This helps to ensure that alternative reasons for the child's difficulty are considered and that pre-referral interventions and multiple sources of case data are adequately assessed.

4 Leadership and Advocacy Within a Multitiered Framework

Despite the barriers and controversies that have arisen in the aftermath of the aforementioned legislation, it is clear that high-quality school-based mental health services must be child centered, family focused, culturally informed, and diverse

in-service options to meet individualized needs. Due to their skillset, school psychologists are in a unique position craft and market best-practice frameworks that optimize the benefit to children by merging in-house services with community pediatric mental health resources. In order to do so, school psychologists must possess, master, and employ complex set capacities to ensure that their daily practices foster effective personal strategies and organizational commitment to provide best-practice mental health services to students. According to NASP (2015), these services can be delivered in a multitiered structure and include psychoeducation for both students and parents, wellness promotion, assessment, early intervention, therapeutic supports for emerging problems and concerns, and more intensive therapeutic services for students with severe needs. Most school psychologists are familiar in working within a three-tiered framework of instruction and intervention (e.g., tier 1, core instruction; tier 2, smaller group interventions; tier 3, intensive interventions), the heart of which is a tailored needs assessment and trend analysis. Within this framework, the school psychologist customarily adopts a tripartite scientist-practitioner-advocate role. It is the intention of this text to advance a quaternary model of school psychology practice that expounds on advocacy roles and includes leadership roles, as these have been relatively neglected in school psychology literature. As stated in previous chapter, authentic leadership is rooted in multiple positions and titles throughout a school building and district. School psychologists might not be viewed, or view themselves, as leaders due the lack of positional leadership wherein persons in the roles of principal, superintendent, etc. have implicit leadership responsibilities. However, restricting leadership responsibilities for comprehensive mental and behavioral health services is likely to lead to ill-fated efforts due to the dissimilar skillsets between operating a school and developing/implementing a comprehensive behavioral health program for youth. Forman et al. (2017) recommend that a bipartite model of leadership that includes technical and adaptive leadership skills can provide straightforward guidance to school psychologists seeking to expand their roles to this end. This guiding framework is particularly fitting when considering the mental health needs of youth. Technical leadership is very congruent with and a natural extension of the practices most school psychologists are familiar such as screening, assessment, prevention, and intervention strategies. However, leadership in this realm would extend the role of the school psychologist to the role of trainer, coach, and even team manager with the goal of reaching large numbers of students. Adaptive leadership skills become necessary when the nature of problems or obstacles is unclear, solutions may be complex, and stakeholders aspire diverse or competing solutions. Hence, although both types of skills are needed at all levels, adaptive leadership skills such as trend analysis, synthesis of contextual/historical factors, and collaboration may become more vital to the success of tier 2 and 3 endeavors (Villarreal, 2018).

4.1 Tier 1: Increasing Mental Health Literacy and Reducing Mental Illness Stigma

Universal School-Based Mental Health Awareness Curriculum In light of the aforementioned prevalence rates of mental disorders in youth and the fact that many debilitating mental health disorders begin early in life, primary and secondary school-age is an opportune time to begin intervening on mental health concerns. A multitiered service approach requires that all students receive screening and prevention services (primary, universal services). Primary prevention services have strong potential to mitigate the need for more intensive treatments in the future. However, barriers to mental health treatment such as insufficient access, mental health literacy, and stigma must be addressed to improve health trajectories of American youth. Salerno (2016) conducted a meta-analysis examining the effectiveness of popular universal mental health awareness interventions in school-based settings, grades 5–12. The focus of these programs was general mental health awareness, suicide, and interpersonal violence. The effectiveness of three common desired outcomes was assessed: knowledge of mental health, attitudes toward mental health, and help-seeking behaviors. Knowledge of mental health was conceptualized in several ways, including knowledge of mental health/illness, violence spurred by mental health issues, depression and its risk factors, suicide and its risk factors/warning signs, suicide myths and facts, and mental health literacy. All studies suggested measurable improvement in knowledge of mental health with the overwhelming majority achieving statistical significance. Attitudes toward mental health were also measured in multiple ways. These included attitudes toward suicide, opinions about mental health, desire to learn about mental health issues, attitudes toward mental health professionals, opinions/attitudes toward mental illness, and mental illness stigma, among others. The most robust outcomes found, again, in a positive increase of knowledge, but only about half showing positive outcomes with regard to attitudes. Help-seeking was assessed by measuring intentions/likelihood/attitudes toward seeking help, knowledge of how to seek help, and actual help-seeking behavior. Results were mixed with some improvement noted in intentions/likelihood/attitudes toward seeking help.

Despite the fact that more research and implementation of these programs is needed, this analysis on universal mental health awareness programs in US schools overall supported improvements in mental health knowledge, attitudes, and help-seeking of students. These results suggest that school-based mental health awareness programs can be effective in positively influencing outcomes related to care seeking and social adversity among students with mental health concerns. Programs that have evidenced efficacy include SOS Signs of Suicide Prevention Program (SOS), Surviving the Teens/Suicide Prevention Program, and MasterMind: Empower Yourself with Mental Health (Salerno, 2016).

Peer-to-Peer Mental Health Awareness An increasing research base indicates that “greater degrees of social integration serve as protective factors against suicidal

thoughts and behaviors" (Centers for Disease Control and Prevention, n.d.). Helping students feel integrated into their school communities therefore can play an important role in health promotion and prevention efforts in schools. Because peers are often the first contact when individuals are emotionally troubled, peers can be a fundamental asset in this social integration and in mental health promotion in schools. These types of programs are increasingly being launched at the high school level, and students are attracted for a variety of reasons such as vocational interests, a personal or family history of mental illness, or a desire to advocate. The programs typically begin by educating small teams of high school students about common mental illnesses such as depression, anxiety, and psychological trauma and then supporting them in finding creative ways to convey this knowledge throughout their school. The aim is to reduce stigma, raise awareness, encourage help-seeking when needed, and ultimately help to promote the early detection of mental disorders (Walther et al., 2014). Some models include "Peer-to-Peer Depression Awareness Campaign" (Ann Arbor Public Schools), Mental Health America's (MHA) "Back to School Toolkit," and National Alliance on Mental Illness (NAMI) "Ending the Silence," "Bring Change to mind High School Program," and the "Adolescent Peer Support League," among many other resources.

Resource Allocation and Other Challenges in Implementing Primary School-Based Mental Health Programs It would behoove school psychologists embarking on the implementation of mental health programs to be prepared to address potential barriers by utilizing leadership/advocacy framework. Time and dedicated human resources are most often cited as barriers. However, historically, there have been a contingency of adult stakeholders such as parents, teachers, and administrators who fear that educating youth on mental health matters will have negative effects on students. Suicide and violence prevention programs are particularly provocative in this arena. Though research has demonstrated predominantly positive outcomes, parents, teachers, and administrators might not be particularly knowledgeable about this. Hence, school psychologists must put high importance on the value of communication of established knowledge and expectations to stakeholders in a manner that generates trust and optimism and advances the development of shared goals. Another barrier is that whether internally funded or grant-funded, financial and human resources in most school are stretched. Resources must be strategically allocated for any new curricular programs to be successful. Though school psychologists typically do not have the authority to dedicate such resources, they are frequently active participants on various school improvement teams and can be a compelling and instrumental voice in furthering school community values and goals that support mental health programming. Additionally, by virtue of their education in research models, assessment, and evidence-based programs, school psychologists can be invaluable resources in ensuring rigorous program/research designs that can more likely procure external funding and maintain fidelity to stated goals. Lastly, it is important to recognize that one common element to successful school-based mental health curricula is a multi-lesson format that would likely be delivered in the classroom. It is impractical to suggest that individual school

psychologist or other school-based mental health professionals can engage in sustainable push-in pedagogical work given their already overburdened schedules. For example, most school psychologists spend most of their time on Committee on Special Education (CSE) endeavors (e.g., assessment, meetings, etc.) and are able to allocate only about 9% of their time to individual mental health needs of students (i.e., tiers 2 and 3). Moreover, many school psychologists work far beyond the school psychologist-to-student ratio recommended by the National Association of School Psychologists (NASP) (Villarreal, 2018). If integration of mental health education into the general curriculum is a goal, it makes good sense that teachers are the most practical of school staff to deliver this education. It is probable that the prospect of this added teaching responsibility would be intimidating and unwelcome for some teachers. School psychologists are well prepared in instructional consultation and instructional leadership and must recognize that modeling behavior is an essential strategy to build human capacity. Hence, school psychologists can be impactful by modeling behaviors that align with expressed professional values and goals (i.e., highest standards of ethics, continuous learning, achievement motivation, strategic allocation of resources, etc.). Moreover, school psychologists can play an integral role in engendering collective expertise and responsibility and interdependence in goal attainment by engaging in collegial dialogue on matters of student outcomes and effective, informed professional practice.

A powerful strategy is to parallel the approach to mental health services to that of academic-based response to intervention (RtI) frameworks, with which teachers are already familiar. A potentially useful exercise is to inventory both existing academic and behavioral / mental health Tier 1, 2, & 3 programs with the description of services, intended goals, targeted population, desired outcomes, and assessments for measuring outcomes. This can be a perplexing and eye-opening experience for many school personnel when it is recognized that mental health goals for school-based programs tend to be far less structured than academic programs. Hence school psychologists can engage in technical leadership by delineating how RtI practices can uniformly be applied to behavioral/mental health preventions and interventions. This awareness can empower consulting teams to determine goals and objectives best suited for their unique school communities. As within an academic RtI framework, universal screening is the cornerstone of a needs assessment of the school. It is suggested that the in-house consulting group confers with other stakeholders such as parents, students, and community healthcare providers (i.e., focus groups) on screeners that best reflect the school's values to determine a screening procedure with the most fitting technical and construct validity. For example, a variety of screeners should be compared for their technical properties (e.g., normed on a comparable student population) and for a theoretical orientation congruent with the conceptualization of mental health and positive educational functioning of the focus group (i.e., social-emotional strengths vs. deficits, omnibus vs. targeted measures such as aggression/bullying/anxiety, etc.).

Once screeners are selected, school psychologists can apply their technical expertise in data collection and analysis to provide insight into the needs of the

students and identifying which students are in need of support beyond universal programming (i.e., tiers 2 and 3). Concomitantly, at this initial stage, sustainability of all planned programming must be addressed as assembling workable, maintainable, and effective programs are the ultimate goal of school-based mental health programming. However, this is a monumental task wrought with potential pitfalls that cannot be accomplished by school-based mental health professionals alone. An adaptive leadership paradigm is most fitting to spearhead stakeholders in troubleshooting program implementation. Questions that are likely to surface include goal development, selection of curriculum, evaluation measures, use of in-house resources, professional development, teacher and/or peer mentoring, and the possible use of external partnerships. Engaging and authentic collaboration with a diverse range of school staff and community stakeholders in these endeavors will likely promote their insight and commitment to comprehensive school-based services (Doll et al., 2017).

4.2 Tiers 2 and 3: Best-Practice Programming and Special Challenges

Multitiered Systems of Support Of the many Multitiered Systems of Support (MTSS) for improving student emotional/behavioral (EB) functioning that are being utilized across the country, (school-wide) positive behavioral interventions and supports (SWPBIS or PBIS) remains the most ubiquitous multitiered system that focuses on designing positive environments to prevent and reduce problem behaviors in school settings. The essential components of PBIS are that it is a proactive, interconnected, multitiered system of Tier 1 (universal prevention for all children), Tier 2 (targeted intervention for children at risk or showing early signs of problems), and Tier 3 services (intensive, individualized interventions for children and youth with more significant problems). A mounting evidence base supports PBIS as a foundation for increasing the efficacy of academic instruction decreasing student discipline referrals, reducing suspension rates, and improving various factors of school organizational functioning (e.g., staff turnover, self-efficacy among teachers, student-reported improved quality of life, etc.) (www.pbis.org). PBIS entails execution in seven domains: implementation in the organization; teaming; collaborative planning and training; family and youth engagement; intervention selection, implementation, and progress; and school-wide data-based decision-making. Like the RtI Model, the PBIS model assumes that 80–90% of students will respond successfully to proactive universal strategies that provide systematic reinforcement and training of expected social behavior (tier 1). A second group of students, about 5–10%, will not respond to universal school-wide interventions and will continue to engage in problem behaviors beyond acceptable levels. This group of students will require somewhat simple, efficient smaller group interventions that provide increased structure and support. Approximately 1–5% of students will

exhibit significant behavioral problems and/or skill deficits that do not respond to universal or more focused group interventions. These students will require more intensive, individualized interventions. This continuum of tiered support composed of three different levels of intervention creates systematic and durable model for schools in planning, implementing, and evaluation of programs but promotes lasting change in the outcomes of many students at risk for the development of persistent problem behavior patterns.

Despite its promise, the success of PBIS and similar programs, especially at tier 2 and 3 levels, can be jeopardized by a variety of systemic factors that undermine the aspiration of delivering a full continuum of holistic, school-based, mental health services. Perhaps the most vexing problem to mental professionals is the cultural forces that steadily marginalize the school mental health (SMH) agenda. Although enhanced approaches to academic goals are increasingly embraced by schools and their communities, the SMH agenda is often marginalized due to forces such as intense achievement pressures on school professionals and students, limited financial and human resources for mental health, and "gray zone" status, wherein SMH programming may not be viewed as fully under the purview of the school versus mental health system (Weist et al., 2012).

The logistics alone make interdisciplinary teamwork a demanding endeavor in schools. However, when it comes to SMH, this teaming can be especially challenging due to the divergent nature of the typical professional groupings. Different professionals are likely to have distinct philosophies, goals, and approaches to programming, varying responsibilities, and/or concerns about their roles/job security which may lead to territorial attitudes and behavior. Training for mental health professionals who work in schools is also undoubtedly widely divergent with some receiving significant training on evidence-based practices (EBPs), and others not; some having a good understanding of educational law and school dynamics, and others not; some having good understanding of mental health ethics and diagnostics systems, and others not. Additionally, mental health professionals employed by schools must follow a different set of rules and regulations related to privacy and student records than those who work in schools or solely in mental health agencies. Because school staff are covered under the Family Educational Rights and Privacy Act (FERPA; which states that student records may be accessed by family and relevant school staff), they are used to have open access to student records. Community mental health professionals, on the other hand, are bound by the Health Insurance Portability and Accountability Act (HIPAA), which requires a child's parent or guardian to sign a release before a mental health professional share mental health records. For example, FERPA can limit community mental health professionals' ability to participate in meetings focused on a child's IEP. Alternatively, HIPAA constrains what community mental health staff can share with school staff seeking critical information about individual students. Hence, both FERPA and HIPAA can encumber interdisciplinary collaboration when mental health services are provided to students (Weist et al., 2012, 2018). The type and quality of services that school psychologists are able to provide are ultimately affected by the practitioner's

available time. School psychologists are charged with many time-consuming responsibilities and often itinerant assignments to multiple school buildings. Nevertheless, the prevailing experiences of school psychologists is that they spend the majority of their time involved in assessment activities, especially as they relate to special education eligibility determinations even if this is not identified as the most valuable activity or the area where professional development is most desired. Although assessment and special education procedures are necessary roles, their continued dominance has prevented school psychologists from taking on a broader continuum of SMH services (Splett et al., 2013).

School psychologists' training and competence in SMH services is another area that can inhibit, as well as facilitate, the provision of SMH services. For example, research has suggested that surveyed school psychologists reported feeling less competent in providing prevention/intervention activities than assessment and consultation/collaboration activities. Similarly, a minority of school psychologists express confidence in the NASP (NASP, n.d.) Practice Domain 4: "Mental and Behavioral Health Services and Interventions." School psychologists may feel they are not experts in providing SMH services due to a perceived lack of content knowledge and applied experiences. Many contemporary school psychologists describe feeling they had too little exposure to important SMH topics in their training, such as treatment planning and group counseling during pre- and in-service training, likely leading to a lack of confidence in their ability to competently provide these services. Large majorities of school psychologists participating in studies in the state of current practice have noted a substantive discrepancy between actual and desired preparation, competency, and professional engagement with a wide array of critical SMH practices such as trauma-informed care, crisis intervention and prevention, and suicide assessment, prevention, intervention, and postvention (Adamson and Peacock, 2007; Erps et al., 2020; O'Neill et al., 2020; Splett et al., 2013). Even everyday encounters in collaborations with colleagues from mental health-related disciplines can be demanding and test the confidence level of even the most competent parties on both sides due to knowledge of different systems practices and professional lexicon. For example, although school psychologists must master a firm grasp on the complexities of federal and state educational laws, it may feel daunting when confronted with some diagnostic terms from which are bound to be novel unless they had been availed of specific training considering the Diagnostic and Statistical Manual of Mental Disorders (DSM–5; American Psychiatric Association, 2013). Consider that the DSM-5 has some 265 diagnoses, not including specifiers (versus 12 IDEA classifications). Moreover, though school psychologists are familiar with many resources and databases related to evidenced-based academic practices in the school, they may be less familiar with mental health service, especially for students with more intensive needs, such as the Substance Abuse and Mental Health Services Administration Evidence-Based Practices Resource Center (https://www.samhsa.gov/ebp-resource-center), the American Psychological Association various help centers (e.g., https://www.apa.org/education/k12), and practice parameters from the American Academy of Child and Adolescent Psychiatry AACAP (https://www.aacap.org/AACAP/Resources_for_Primary_Care/

Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx), all of which can serve as valuable resources for school personnel, as well as students and families. In addition, school psychologists may benefit from specific knowledge about how to synthesize student mental health within PBIS service delivery. Since 2007, leaders in school mental health and PBIS have been working to develop the defined interconnected systems framework (ISF) resulting in an initial white paper and subsequent monograph (Barrett et al., 2013). The ISF model provides guidance on the systematic interconnection of school mental health and PBIS, emphasizing mental health clinicians (from the mental health system) joining PBIS teams (in the education system) and coordinating work together across the continuum of promotion and prevention (tier 1), early identification and targeted small group intervention (tier 2), and more intensive individualized intervention (tier 3).

Limitations in Special Education Programming Although IDEA provides necessary safeguards for students classified as having a serious emotional disturbance that affects their ability to benefit from general education, there are a number of plausible shortcomings that can diminish the intended positive impact of its provisions. Potentially problematic is the inexplicit language used surrounding the definition, purpose, and implementation of the FBA and BIP provisions. Despite the fact that there was an effort to incorporate more explicit language in subsequent versions of the legislation, an examination and comparison of IDEA 2004, IDEA 1997, and final implementing regulations reveal no definition of functional behavioral assessment exists in past or present versions of IDEA or its implementing regulations. Hence, schools continue to be provided with only basic contextual guidance respecting their duty to provide the assessment, and school administrators continue to have pronounced flexibility with respect to the essential elements of the functional behavioral assessment such as components of the evaluation, interpretation, and implementation, which might result in lower-quality standards. In the absence of clear guidance, professional judgment remains essential for deciding how to conduct functional behavioral assessments on an individual basis. Because of their specialized training in this area, the crafting of best-practice FBAs and BIPs and the policies that guide their development consequently fall under the expertise and ethical responsibility of the school psychologist. Moreover, it is arguable that the intended protections of FBAs and BIPs would be most frequently employed in cases where students are classified as having an "emotional disturbance" (ED).

When comparing the rather general classification criteria for emotional disturbance under IDEA with the much more explicit criteria of DSM-5 (American Psychiatric Association, 2013), it is readily apparent that classification in the education arena of ED does not correspond well with known psychiatric disorders. Arguably, this misalignment may be a significant factor for delayed or incorrect educational classifications, leading to erroneous placement in ambiguous special education categories where treatment is not aligned with actual needs (Kataoka et al., 2009). Moreover, students meeting the criteria for SED and a DSM-5 diagnosis are among those in need of effective collaborative processes to meet their individual needs. Leadership in helping school-based and external professionals develop

a mutual understanding of the lexicons and system processes and capitalize on the provisions of both educational and clinical systems can be indispensable for students with the highest needs.

Perhaps one of the most significant safeguards of IDEA is the call for a continuum of educational environments to ensure the most appropriate and least restrictive educational setting for students with disabilities. Also, the placement of a student into the appropriate educational environment is one of the most complicated and contentious issues in special education. Findings of a 2014 study conducted by Hoge, Liaupsin, Umbreit, and Ferro suggest that placement decisions made for students classified as having an emotional disturbance have some alarming inconsistencies. These findings included a limited transitioning of students with ED back to less restrictive settings once placed in alternative schools, a greater number of factors considered during exit decisions from alternative schools than entry, and students' return to a less restrictive setting not contingent on those factors considered when placing the student into the school. For example, aggression was the most frequently identified reason for moving students with an ED classification out of general education placement, but in less than half of those same cases was aggressive behavior mentioned in rationale in maintaining these students in restrictive placements. Alternatively, failure to meet the requirements of a school-wide level system was the most common reason students were denied transition. It is important to be mindful that behavioral programming is the foundation of level systems utilized in many alternative educational placements for students with ED. Unfortunately, the development of many of these systems is highly susceptible to subjectivity based on staff collaboration marked by the opinions and perspectives of staff and administration rather than scientific-based principles. Hence, system procedures and practices may be sorely lacking in necessary components that would enable a student's successful transition back to less restrictive settings.

Barriers to students receiving special education services for ED have also been identified in the general education environment with regard to instructional practices. McKenna et al. (2018) state that although the majority of students with ED spend and receive a significant amount of instruction in general education settings, there is a severe dearth of research to guide school practice or teacher preparation programs in effective instructional practices with this population. As such, these authors assert there is a substantial disconnect between intervention research and the operationalization of LRE mandates, the academic demands in general education classrooms, and the rights and responsibilities associated with FAPE for students with ED. Hence, students classified as ED or at risk of classification present a notable need for advocacy and expert knowledge in mental health, behavioral, and academic intervention.

5 Conclusions

School mental health (SMH) programs have great potential to improve learning and life outcomes for children and youths with a range of mental health difficulties. School psychologists possess the knowledge and skills to advance these efforts through a variety of leadership endeavors. Though the needs, opportunities, and challenges will vary across school milieus, some principles are quite generalizable. First, successful relationships with key stakeholders must be cultivated. Strong support from administrators, teachers, and parents is essential from the beginning to collaboratively find practical ways to meet these challenges. Assessing and expanding mental health literacy among all stakeholders is a foundation to launching and sustaining effective programming in order to increase affiliation with program goals and increase willingness to devote resources and time to interventions. Mental health literacy has several components including (1) the ability to recognize mental health needs and related problems, (2) knowledge and beliefs about causes and risk factors, (3) understanding of potential short- and long-term outcomes, and (4) understanding and facilitation appropriate for help-seeking strategies. Among all the school-based professions, school psychologists are likely to have the broadest training in holistic understanding of the comprehensive, complex needs of students with mental health issues including academic, cognitive, behavioral, emotional, social, and ecological needs.

Leadership endeavors for school psychologists may also be indicated in targeted advocacy efforts such as destigmatizing mental health diagnoses, identifying mental health services that could be delivered by specific school staff, collaborating on the provision of professional development, evaluating the effectiveness of different models of providing resources for mental health interventions by seeking ways to diminish conflict over scarce resources, and exploring differentiated approaches that promote both learning and social-emotional development.

An overarching leadership tenet for leadership in high-quality SMH programming is addressing marginalization of SMH, as part of a broader array of school services and target outcome goal, as opposed to be viewed as a peripheral agenda in schools. School psychologists who may feel uncertain about their roles in SMH leadership can find edification through the vast research and professional organization guidance on EBPs for instruction in general education classrooms, supplemental programs, and interventions for students with mental health needs.

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