The Benefits of School Mental Health

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In recent decades, student mental health services and supports have increasingly been integrated into education systems across the nation. In many districts, schools and communities have partnered in their efforts to both promote student wellness and social emotional competence and identify and address mental health problems as they arise. These school-community partnerships reflect a growing movement toward "comprehensive school mental health systems" (CSMHSs), or partnerships between school systems and community programs that provide a full array of evidence-based, tiered services (universal mental health promotion, selective prevention, and indicated early intervention). The integration of mental health into education offers the potential to enhance the wellness and reduce the mental illness of children across the United States, particularly in the most vulnerable communities with limited access to quality mental health care, including those in rural settings.

It has been established that there is a high incidence of children and adolescents with unmet mental health needs. According to data from the National Comorbidity Study—Adolescent Supplement (NCS-A), 46.3% of 13–18-year-olds currently or at some point in their life will have a mental health disorder (Merikangas et al., 2010). In younger children (ages 8–15 years), the National Health and Nutrition Examination Survey (NHANES) suggests that approximately 13% of children had a diagnosable mental disorder in the previous year (National Institutes of Health, n.d.). However, of those adolescents with a mental health disorder, approximately only 36% receive mental health treatment (Merikangas et al., 2011), and only 50% of 8–15-year-olds with a diagnosable mental health disorder received treatment in the past year (Grief Green et al., 2013). Other studies estimate that as many as 79% of 6–17-year-olds have unmet mental health needs (The National Survey of American Families; Kataoka, Zhang, & Wells, 2002). Furthermore, school principals indicate that mental health is one of the greatest unmet needs in their students (Iachini, Pitner, Morgan, & Rhodes, 2015).

Rural areas face unique mental health challenges, including more significant impairment among youth and difficulties providing adequate care to those in need. Even after controlling for socioeconomic factors, youth suicide mortality rates are significantly higher in rural areas as compared to urban areas, with this gap becoming larger in recent decades (Singh, Azuine, Siahpush, & Kogan, 2013). Further, access to care is difficult, with 1.9 million children in the United States experiencing mental health

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problems but living in rural areas with little to no mental health care resources. In rural areas, four out of five children who could benefit from mental health services live in a county without a community mental health center (Moore et al., 2005). Although children and families report receiving the majority of mental health care in school settings, rural schools indicate limited capacity to address the mental health needs of their students. In a survey of teachers, administrators, school psychologists, counselors, and social workers working in rural schools within the United States, participants reported that while learning, attention, conduct, and autism-related needs tend to be met in their schools, issues related to family, anxiety, depression, and trauma have higher rates of unmet need. Additionally, services for prevention, promotion, and mentorship were reported as lacking (Lee, Lohmeier, Niileksela, & Oeth, 2009).

In children and adolescents who do access care, rates of attrition are high. Approximately 40–60% of children, adolescents, and families who begin mental health treatment drop out prematurely (Kazdin, 1996; Kazdin, Holland, & Crowley, 1997). Moreover, more than half of families do not return by the fourth session (McKay, Lynn, & Bannon, 2005). Several factors predict treatment dropout, including family stressors, perception of lack of relevancy of treatment to child's needs, and poor therapist–client relationship. Even when these factors are minimized, families must navigate a multitude of obstacles in order to receive mental health services in traditional outpatient and specialty clinic settings including structural barriers (lack of availability of providers, uninsured, transportation difficulties, inconvenient appointment times, long wait lists) and concerns about the mental health system (limited trust of providers, privacy concerns, stigma; Owens et al., 2002; Weist, Lever, Bradshaw, & Sarno Owens, 2014). Many of these barriers are particularly pronounced in rural communities, where structural barriers are more prominent due to scarcity and geographic distance of specialty providers, as well as greater perceived threat to privacy and anonymity. The limitations of our traditional mental health system to adequately reach and serve children and families have led many communities to consider the potential of schools as a venue for providing a full continuum of student mental health supports.

Benefits of SMH

Integration of mental health into the education sector offers tremendous promise for addressing gaps in mental health care, as well as a mechanism for boosting student academic success. In addition to facilitating access to care, providing mental health services and supports directly in the school building offers a host of benefits including greater follow-through with initiated care, ability to see students in their natural environment (school) and generalize skills to that setting, ability to engage key socialization agents (teachers, parents), opportunities for screening and early identification of mental health concerns, and opportunities to offer mental health promotion activities as well as more intensive mental health intervention as needed. Each of these benefits is discussed below, with particular attention to their relevance in rural settings.

Access to Care

Schools offer a natural access point to students who need, but may not otherwise receive, mental health services. Children and adolescents spend a great deal of their time in the school setting (approximately 15,000 h), and in addition to parents, teachers and other school staff are often the first people to identify a potential mental health problem in children (Loades & Mastroyannopoulou, 2010). Indeed, current estimates suggest that over 70% of youths who receive mental health services do so in school and education settings (Rones & Hoagwood, 2000; Teich, Robinson, & Weist, 2008). As Weist (1997) explains, "By placing services in them [schools], we are reaching youth 'where they are,' eliminating many of the barriers that

exist for traditional child mental health services (e.g., as provided in community mental health centers and private offices)" (pp. 319–320). As compared to youth who receive services in community mental health settings, youth who receive services in schools are less likely to have received prior mental health counseling (Weist, Myers, Hastings, Ghuman, & Han, 1999). This is particularly true for students with internalizing issues such as depression and anxiety, and suggests that youth may be identified earlier in schools and/or that schools are reaching youth who may not otherwise receive care. For instance, in a rural high school with suicide attempts double the national average, the vast majority of the 42 students assessed for suicidal or homicidal threat (79%) had never received mental health services prior to the crisis. This on-site school mental health effort resulted in 23 of these students receiving formal mental health intervention support (14 in school, 9 in the community) and 19 being matched to an adult assigned to "check in" to monitor wellness and safety (Michael et al., 2015).

The presence of comprehensive school wellness centers is associated with much greater use of mental health care among students in both urban and rural settings, pointing to the value of placing mental health services on-site in schools (Gue, Wade, & Keller, 2008). Beyond initial access, students are also more likely to follow through with mental health services when they are offered in schools as compared to other community mental health settings, where high no-show rates are the norm (Catron et al., 1998). Although schools offer unmatched access to mental health care for youth, some findings suggest that students are more likely to access services when their schools are located in urban settings than in rural settings, suggesting that some of the other factors impeding care in rural settings (stigma, privacy concerns) may still be prominent in schools (Grief Green et al., 2013). That being said, given the relative lack of community mental health clinics and specialty psychiatric services in rural settings, schools are well positioned to narrow the access gap among rural youth with mental health problems.

Comfort/Stigma

Stigma around mental illness is one of the barriers to children and families accessing and remaining in mental health treatment. Stigma can impact the help-seeking behaviors and openness to mental health treatment of both the parent and the child directly. In a review of the literature on stigma and child mental health disorders, Mukolo, Heflinger, and Wallston (2010) concluded that stigma of children with mental illness may be as "unforgiving" as the public stigma that exists for adults. The general public tends to view mental health problems in children as related to propensity for violence and to support legally mandating that parents of children with mental illness place their children in treatment (Pescosolido, Fettes, Martin, Monahan, & McLeod, 2007). Furthermore, when adults were shown vignettes of children with emotions and behaviors that the adults viewed as dangerous or an indication of mental illness, they were more likely to respond punitively and negatively to the hypothetical situation and child (Pescosolido et al., 2007). Pescosolido et al. (2007) suggest that these attitudes reflect general societal stigma around child mental health problems and judgment of parents of children with mental health disorders. Similarly, children view individuals with mental illness less favorably than other groups (Wahl, 2002). Related to these perceptions of mental illness, adults and children alike may experience fear or embarrassment about help seeking for mental health problems.

Schools may be uniquely suited to addressing stigma as a barrier to treatment, in that they offer a more familiar and less threatening environment in which to seek care. Several studies have documented the positive therapeutic alliance between school-based providers and students and families (Lazicki, Vernberg, Roberts, & Benson, 2008; Nabors, Weist, Reynolds, Tashman, & Jackson, 1999). Students and caregivers also consistently report feelings of comfort and high satisfaction in school mental health services (Nabors and Reynods, 2000). Further, schools offer natural opportunities to provide training and education to teachers and parents on mental health literacy

and help seeking, in order to lower stigma and normalize mental illness and treatment. Despite the potential for reducing stigma and increasing comfort, some students might not feel comfortable seeking mental health care in the school setting. A recent qualitative study by Huggins et al. (2016) found that adolescents in high school often have a negative opinion of seeking mental health counseling at school, due to a fear of being embarrassed or negatively stereotyped. This may be particularly concerning for adolescents who are driven by peer approval and the need to "fit in," thereby suggesting the need for consideration of developmentally tailored strategies to reduce stigma and promote comfort among students seeking school mental health services.

Stigma may be particularly impactful on mental health help seeking in rural settings in part due to the perception of a lack of anonymity in small communities. Although research on stigma related to child mental illness in rural areas is limited, adults in rural areas view mental illness with more negativity than their urban counterparts, resulting in less help-seeking behavior (Rost, Smith, & Taylor, 1993). Polaha, Williams, Heflinger, and Studts (2015) found that in a sample of 347 caregivers of children with psychosocial concerns living in rural areas, higher perceptions of stigma around mental health services for children were related to lower rates of willingness to seek out services. Schools may offer a safe, familiar environment that parents and students already know and attend, possibly buffering the impact of stigma on mental health treatment use.

Early Identification and Intervention

Integrating mental health into schools offers the opportunity to identify and address mental and behavioral health problems early on. This is critical because mental health problems in children are often underidentified (Flett & Hewitt, 2013). In particular, young people with internalizing disorders (e.g., depression, anxiety) are less likely to be identified as having a mental health problem and receive treatment than those with externalizing disorders (e.g., conduct problems, hyperactivity); approximately 18–38% of youth meet the criteria for an anxiety or a mood disorder, but only 17–37% of those youth receive treatment, whereas approximately 15% of youth meet the criteria for a behavior disorder with 45–60% of those youths receiving treatment (Merikangas et al., 2010; Merikangas et al., 2011). A first step in the process of providing appropriate prevention and early intervention services to children is understanding and identifying the mental health needs of the population through systematic, evidence-based measurement. Schools are uniquely suited to early identification, as they have access to a large population of young people. Universal screening in schools, or the voluntary assessment of mental health needs and strengths across the entire student population (Dowdy et al., 2015), allows schools and community partners to identify areas of mental health need in their student population, identify students who may benefit from various prevention and intervention efforts, and monitor changes in these mental health needs over time. These data can be aggregated or disaggregated as needed, to inform resource utilization and programming prioritization (Dowdy, Ritchey, & Kamphaus, 2010); data are also useful measures for evaluating program effectiveness. As Dowdy and her colleagues (Dowdy et al., 2010) note: "By systematically engaging in periodic mental health screening of all children in schools (Hill et al., 2004), school-based mental health professionals can shift their focus away from solely providing indicated services to providing more population-based, ultimately preventive, services" (p. 169). Recent federal and state efforts to support teacher training in mental health have recognized the value of integrating teachers into the process of early identification of mental health problems. Teachers have the advantage of viewing a large sample of same-aged children (as compared to parents, for example), and therefore are well positioned to nominate those students who may be presenting in a manner that falls outside of the typical "curve" of development and behavior.

Early identification of mental and behavioral health problems is related to treatment engagement, as parents are more likely to seek out treatment once a mental health problem has

been documented (Cauce et al., 2002). Identifying mental health problems early also leads to better long-term outcomes, with the length of time a child's emotional and behavioral problems go unidentified being correlated with maladaptive trajectories over time (Gottlieb, 1991). Rather than waiting for children's problems to warrant the attention of specialty mental health providers, it may be possible to reduce the incidence of mental illness among children and adolescents by simply placing mental health services in more natural and accessible settings such as schools and primary care settings (Greenberg, Domitrovich, Graczyk, & Zins, 2005; O'Connell, Boat, & Warner, 2009). Given that youth mental illness alone costs the United States billions of dollars annually, efforts to reduce the incidence of mental illness through screening and early intervention could serve to not only improve quality of life for many children and families, but could also significantly reduce the fiscal burden of illness (Mrazek & Haggerty, 1994; O'Connell et al., 2009). A wealth of studies point to the effectiveness of early intervention programs, many implemented in the school setting, at improving child and adolescent social, emotional, and behavioral outcomes, with many early interventions being well suited to implementation in schools (Greenberg et al., 2001; Mytton, DiGuiseppi, Gough, Taylor, & Logan, 2006; O'Connell et al., 2009; Wilson & Lipsey, 2007).

Opportunities for a Full Continuum of Services

Not only do schools offer the opportunity to move "upstream" in order to identify and intervene before mental illness develops or worsens, but they also provide an unparalleled venue for providing a full continuum of mental health services and supports to students. The public health model focuses on preventing problems before they occur, by implementing policies and interventions that address risk factors for various health problems. Typically, public health frameworks provide primary, secondary, and tertiary interventions (Tomison & Poole, 2000). Primary interventions are those focused on entire populations or subpopulations, which aim to promote wellness and prevent problems before they occur. Secondary interventions focus on providing services to at-risk individuals, with the aim of reducing risk factors and preventing current difficulties from worsening. Tertiary interventions are more intensive interventions focused on addressing problems in the most severe cases. School systems are well suited to adopt this full continuum of service delivery (prevention through intensive intervention), often referred to as multitiered systems of support (MTSS), given their access to a large population of students, both those with and without current mental and behavioral health difficulties. In addition, schools already tend to operate from a preventive, multitiered framework with respect to academic performance; their use of universal screening and early identification and intervention to "catch problems early" and prevent academic decline align with MTSS for behavioral and emotional health.

Because most children are in schools for a significant portion of time, schools are arguably the most appropriate site for mental health promotion and prevention programs targeting all students in the school. These programs involve the promotion of social and emotional competence in all students, teaching of core positive behaviors and relationship skills, and mental health literacy. A wealth of literature demonstrates the positive impact of universal social emotional learning (SEL) efforts on both psychosocial (social, emotional, behavioral) and academic outcomes (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Similarly, frameworks such as Positive Behavioral Interventions and Supports (PBIS) provide an array of evidence-based strategies to support classroom management by all teachers and positive behaviors among all students in a school building (U.S. Office of Special Education Programs, U.S. Department of Education, 2015).

Given the scarcity of specialty mental health services in rural settings, it is of utmost importance to invest in mental health promotion

activities in schools. SMH programs can tap existing natural resources to promote mental health and prevent worsening of mental health problems when they arise. There is evidence that this investment in whole school approaches to mental health may lead to a reduction in referrals to specialty mental health and special education (Weist, Evans, & Lever, 2003). In addition, certain issues that impact the whole school, such as bullying, have been found to be more prevalent in rural than in urban communities (5–10% more prevalent; Eisler & Schissel, 2004; Nansel et al., 2001), pointing to the importance of universal approaches to social, emotional, and behavioral issues in rural schools as part of a full continuum of mental health supports.

Care Provided in the Natural Environment

Children's mental health care is most effective when it is provided in the child's natural environment (e.g., school, home, peer group). Bronfenbrenner's (1979) ecological model discusses the transactional relationship between an individual and the systems they are embedded within. From this perspective, intervention will be most effective when it targets not only the target individual's behavior and functioning, but also the behavior of the systems that individual exists within (e.g., teacher, parent). Indeed, an ecological approach to intervention that addresses emotional and behavioral issues in the settings where they occur is related to increased generalization and maintenance of treatment gains (Atkins, Adil, Jackson, McKay, & Bell, 2001; Evans, 1999).

The school is one of these critical environments where intervention can occur. As noted by Cowen et al. (1996), schools typically have the second greatest influence on shaping a child's development (after families) and are an ideal setting to provide treatment. Mental and behavioral health problems are a significant barrier to learning, so it also makes sense that intervention aimed at reducing these barriers are co-located in the learning environment as much as possible (Iachini, Levine Brown, Ball, Gibson, & Lize, 2015). There is evidence that the extent to which mental health supports are well integrated into the school setting and curriculum actually predicts positive implementation and intervention outcomes (Rones & Hoagwood, 2000). In fact, some of the evidence-based interventions with the most compelling evidence of effectiveness, particularly for externalizing problems such as ADHD and oppositional defiant disorder, are best implemented in the school environment. For example, daily report cards, contingency contracting, and teacher-implemented positive behavior programs (e.g., Good Behavior Game) have demonstrated positive short- and long-term impact on students' psychosocial and academic outcomes (Perkins & McLaughlin, 2015; Tingstrom, Sterling-Turner, & Wilczynski, 2006). Some of the benefits of providing mental health care in the school setting include the fact that (a) the mental health provider can work with children in the school and classroom environments where they are experiencing difficulties, including helping to manage behavioral interventions and contingencies; (b) providers can observe and monitor children's progress in school directly, rather than relying on someone else's report; and (c) teachers can be integrated into the treatment plan and help extend support throughout the full school day.

Providing services in the schools also allows the mental health system to better engage youths' key socialization agents, namely teachers, parents, and peers. Child mental health treatment is most effective when the adults who interact with that child modify their own behaviors and interactions with the child. School mental health providers are able to partner with educators to keep abreast of student functioning and to address teacher questions and concerns related to mental health. Further, teachers who receive training and coaching in student mental health demonstrate increased capacity to respond to students experiencing psychological distress, improved teacher-student rapport, and reduced peer victimization in their classroom (Cappella et al., 2012; Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010). Teachers are critical to rural systems of mental health care

for children, as systems "task shift" from mental health care provision by specialty providers towards non-specialty providers, including health care providers and educators (Fulton et al., 2011; Kakuma et al., 2011). Similarly, children's health outcomes are improved when parents are involved in their children's mental health care (McKay & Bannon, 2004). This is consistent with literature demonstrating that parent engagement in their children's education is associated with student success even through their senior year in high school (Kellaghan, Sloane, Alvarez, & Bloom, 1993; Trusty, 1999). Rural schools may be better positioned than traditional health care settings to engage families in their children's mental health related to the unique concerns about stigma and privacy in rural settings. There is evidence to suggest that help seeking differs between rural and urban areas such that rural parents are more likely to enter the mental health care system via informal supports such as schools and school counselors, while urban parents are more likely to rely on pediatricians and psychologists (Girio-Herrera, Sarno Owens, & Langberg, 2013). Finally, schools also offer the unique opportunity to engage prosocial and influential peers in supporting student mental health by engaging them as peer mentors, advocates, and therapy group members.

Outcomes

In addition to the benefits of integrating mental health into schools related to increasing access to a multitiered system of student mental health supports in natural environments that leverage opportunities to engage key socialization agents, school mental health has a positive impact on student psychosocial and academic outcomes (Greenberg et al., 2003; Hoagwood et al., 2007; Walter et al., 2011).

Psychosocial Outcomes

There is a growing body of evidence suggesting that comprehensive school mental health programs are effective in reducing mental health problems and improving student emotional and behavioral functioning. For example, one multitiered (universal, selected, indicated) school mental health program delivered in two schools resulted in significantly fewer mental health difficulties, improved behavior, less functional impairment, and greater mental health knowledge, attitudes, beliefs, and behavioral intentions in their students (Walter et al., 2011). Teachers in these schools also reported that they had greater proficiency managing mental health problems that arose in their classrooms. Hussey and Guo (2003) documented similar positive gains among the 201 students participating in a comprehensive school mental health program, with significant reductions in conduct behaviors, ADHD symptoms, and depressive symptoms after 1 year of program implementation. Similar positive impact has been demonstrated across a variety of school mental health efforts, as outlined in a meta-analysis by Hoagwood et al. (2007) in which 95% of the 40 identified published studies between 1990 and 2006 examining the impact of school mental health interventions on mental health outcomes demonstrated positive mental health outcomes for students.

School-based prevention programs have achieved similar positive results. A meta-analysis conducted by Wilson and Lipsey (2007) examined the specific impact of school-based psychosocial prevention programs on aggressive and disruptive behaviors. Analysis of 249 experimental and quasi-experimental studies found average effect sizes of 0.21 (universal programs) and 0.29 (selected/indicated programs). This suggests the small, but significant, impact of prevention programs in schools on reducing aggressive and disruptive behaviors in children. In a review of 40 studies of the Good Behavior Game, a classroom-wide behavioral intervention for preschool and elementary school children, impressive reductions in disruptive, aggressive, and inattentive behaviors in the classroom were reported (Tingstrom et al., 2006). Another prevention program focused on social-emotional learning (Promoting Alternative Thinking Strategies, PATHS) is related to increases in emotional understanding and prosocial behavior

(Gibson, Werner, & Sweeney, 2015). Taken together, findings suggest that SMH programs, including school-based interventions implemented at different tiers of the continuum, are contributing to positive psychosocial outcomes for students.

The positive impact of SMH programs and interventions on students' psychosocial outcomes extends to programs in rural areas. For example, in a study of a rural school mental health program using non-manualized cognitive behavioral therapy, Michael et al. (2013) found that adolescent (ages 14–18 years) program participation was related to positive mental health outcomes over the course of treatment (average of 14.88 sessions). Similarly, a rural SMH program using CBT-based treatment with high school students through the Assessment, Support, and Counseling (ASC) Center found that 63% of the participants in the program showed improvement or recovery based on their reliable change index (RCI) on the Youth Outcome Questionnaire. The majority of the participants showed symptom reduction after participation in the school-based treatment (Albright et al., 2013). A rural school mental health program that integrated a suicide prevention intervention (Yellow Ribbon Ask 4 Help) into its model led to increased student knowledge about suicidal ideation, help seeking, and the Ask 4 Help program they learned about. Over a 4-year period after implementing the program, 21 students sought help for suicidal ideation using the method taught to students (Yellow Ribbon Card; Schmidt, Iachini, George, Koller, & Weist, 2014).

Academic Outcomes

The impact of school mental health services on academic outcomes, such as grades, attendance, and discipline experiences, has also been explored in the research literature. Unlike the impact of school mental health on psychosocial and behavioral outcomes, the relation between mental health care and academic outcomes is more complicated and research findings are mixed.

Our understanding of the impact of mental health care on academic outcomes is partly limited by the fact that studies in the child mental health research literature rarely measure educational outcomes (only approximately 15% of studies; Becker, Brandt, Stephan, & Chorpita, 2013). Those academic outcomes that are studied can be divided into two general types of outcomes: proximal and distal (Suldo, Gormley, DuPaul, & Anderson-Butcher, 2014). Proximal academic outcomes reflect performance over a typically short period of time or attitudes of current abilities. For example, proximal outcomes may include curriculum-based measurement (multiplication fact speed, reading fluency, reading comprehension), on-task behavior directly observed in class, or student perceptions of academic self-efficacy or school motivation. Distal outcomes, on the other hand, reflect skills over a longer period of time and are generally global performance measures. Distal measures of academics may include course grades, GPA, school attendance, office discipline referrals and suspensions, and perceptions of school climate or school satisfaction. Overall, research suggests that proximal academic outcomes are rarely studied and distal academic outcomes show inconsistency in their relation to school mental health services.

However, there is some compelling evidence for the positive impact of SMH on academics (Becker et al., 2013). Overall, school mental health interventions lead to improved academic performance (Greenberg et al., 2003; Welsh, Parke, Widaman, & O'Neil, 2001; Zins, Bloodworth, Weissberg, & Walberg, 2004), fewer special education referrals and lower need for restrictive placements (Bruns, Walwrath, Glass-Siegel, & Weist, 2004), decreased disciplinary actions (Jennings, Pearson, & Harris, 2000), greater engagement and feeling of connectedness to school (Greenberg et al., 2005), and higher graduation rates (Lehr, Johnson, Bremer, Cosio, & Thompson, 2004). One component of comprehensive school mental health that has been linked more consistently to academic outcomes is social emotional learning (SEL) programs (e.g., Catalano et al., 2003). For example, students in SEL programs, on average, rank 10 or more percentile points above their average peer not in an SEL

program on achievement tests (Payton et al., 2008); they also show better attendance, more positive classroom behavior, and better grades, and are less likely to be disciplined (Payton et al., 2008). In Australia, students receiving a well-implemented SEL program (Australian Kids Matter) demonstrated significantly better academic gains as compared to students in low-implementation-quality schools, even after controlling for socioeconomic factors. They were 2.6 months ahead by year 3 of the program and 6.2 months ahead by year 7 (Dix, Slee, Lawson, & Keeves, 2012). Furthermore, in a study of 2790 2nd–4th-grade students in six schools, they found that students in the three schools using the Responsive Classroom Approach (RCA) had statistically significant gains in standardized math and reading test scores when compared to students in the three non-RCA schools (Rimm-Kaufman, Fan, Chiu, & You, 2007).

Nonetheless, there are also several comprehensive studies that suggest that the link between school mental health and academics may not be definitive. Daly et al. (2014) compared the academic outcomes of 89 students who received community-partnered school mental health services to a matched comparison group of students who did not. Both behavioral academic outcomes (attendance and out-of-school suspensions) and standardized reading and math test scores were examined over a 3-year period. Results of the study suggested that there was not a statistically significant effect of receipt of school mental health services on any of these academic outcomes. Iachini, Levine Brown et al. (2015) conducted a meta-analysis of early school mental health intervention and its relation to academic outcomes for at-risk high school students. They defined early intervention as programs and services provided for a child who is identified as having a need for support but not to the degree of needing intensive individual interventions (i.e., tier 2 or prevention-focused services). The researchers found seven studies that met the criteria for their study, suggesting that the amount of research being conducted on this topic is quite limited. Results of the meta-analysis showed that there was not a significant effect of early intervention participation on academic outcomes, including GPA, attendance, and discipline. This mixed evidence suggests that more rigorous research on this topic is needed. Michael et al. (2013) argue that a more nuanced approach to examining the impact of school mental health on academic outcomes is needed; for example, maintenance of grades may be a successful academic outcome in the context of studying students who are already at risk of declining grades related to emotional and behavioral health challenges. In particular, it will be important to differentiate between outcomes for students whose mental health concerns are affecting their academic performance at intake versus students for whom they are not, examine outcomes longitudinally to understand long-term effects, and incorporate more proximal measures of academic progress into evaluation.

Very little research has been conducted examining the impact of rural school mental health programs on student academic outcomes. One study found that a rural SMH program in which clinicians used CBT showed some positive impact on academic outcomes. A large portion of the sample showed improvement or stability in grades, attendance, and discipline. Over half the students had higher GPAs after SMH treatment as compared to pretreatment. Nonetheless, none of these findings were statistically significant when comparing pre- and post-academic outcomes for the whole sample (58 high school students; Michael et al., 2013). More research on the impact of SMH on both psychosocial and academic outcomes for rural youth is needed.

Conclusion

Integration of mental health into the education system has the potential to offer our nation's youth a comprehensive array of mental health supports and to remedy many of the shortcomings of our traditional approaches to youth mental health. Federal, state, and local investments in school mental health reflect an acknowledgement of this potential, with MTSS becoming a regular part of the dialogue among educators. A systematic and streamlined partnership between schools and

communities to support a full continuum of mental health supports in schools can lead to better mental health for all students and increased access, earlier identification and intervention, and ultimately better outcome for those students with mental health challenges. This vision reflects a great reliance on the natural supports for students, including families and educators, and less reliance on an already scarce specialty mental health system. In rural communities, where specialty mental health is even more limited and traditional mental health care has achieved less success in serving children and families, this multitiered, public health approach is critical.

In an effort to support states, districts, and schools in advancing the quality of their comprehensive school mental health systems, the national Center for School Mental Health developed an empirically based set of national performance standards for school mental health quality and sustainability. Several federal partners from the education and mental health sectors have supported the adoption of these standards, and districts and schools have been encouraged to utilize a free, online mechanism to engage in quality improvement grounded in the performance measures, the School Health Assessment and Performance Evaluation System, (SHAPE, www.theshapesystem.com). These standards reflect best practices in all areas of quality school mental health, and districts and schools now have the opportunity to engage in a systematic quality improvement process to advance their comprehensive school mental health systems.

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