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ORIGINAL PAPER

The Need for School-Based Mental Health Services and Recommendations for Implementation

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Abstract Mental illness is a major public health concern with significant social cost. Symptoms of mental health problems generally emerge during the school-age years. Although effective interventions are available to decelerate or eliminate incipient concerns, they are rarely accessible to youth. Evidence suggests that school-based mental health services (SBMHS) have the highest likelihood of reaching youth in need. In this paper, the authors and the Council for Children with Behavior Disorders present a foundation for future policy recommendations relative to the need for SBMHS and recommendations for implementation.

Keywords School-based mental health services · Emotional and behavioral disorder · Emotional disturbance · Mental health

The prevalence, impact, and societal costs of mental illness have made emotional and behavioral disorders in children a major public health concern. With respect to prevalence, it has been estimated that 46.3% of school-aged youth between the ages of 13 and 18 have experienced a mental illness at some point in their lives and slightly more than 20% have been diagnosed with a seriously debilitating mental disorder (Forness, Kim, & Walker, 2012; Merikangas et al., 2010). These data align with global incidence, particularly in countries with similar pockets of social concern (e.g., living in poverty) that exacerbate mental health problems (e.g., Bullock, Zolkoski, & Estes, 2015). Further, in the last 10 years, the number of children and adolescents identified with mental health diagnoses has continually increased (Olfson, Blanco, Wang, Laje, & Correll, 2014).

Data indicate that few school-age children and youth receive services that could prevent or reduce the symptoms associated with the most prevalent disorders. For instance, although upwards of 5% of students may have a diagnosable disability that interferes with their educational achievement, only 1% receive a school-based diagnosis of Emotional and Behavioral Disorder (EBD) that renders them eligible for special education services (Kutash, Ducknowski, & Lynn, 2006). Also disconcerting is that an even greater number of students are not legally entitled to school-based services because they struggle with mental health-related problems that do not qualify as a diagnosable mental health disorder (NASP, 2015b).

Although mental health services may be available outside of the school setting, such services are rarely utilized. For example, several recent large-scale studies examining service utilization have consistently reported that as few as 20% of youth receive services for their mental health needs (Kauffman, 2001; Langer, Wood, Wood, Garland, Landsverk, & Hough, 2015; Merikangas et al., 2011). Furthermore, 40–60% of families who begin community mental health services prematurely end those services, with most attending only one or two sessions (Armbruster & Fallon, 1994; McKay, Pennington, Lynn, & McCadam, 2001).

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The consequences of insufficient mental health services have been chronicled for decades and can be seen in the form of poor educational attainment, juvenile delinquency, compromised physical health, substance abuse, underemployment, and ultimately premature mortality (Brooks, Harris, Thrall & Woods, 2002; Cicchetti & Rogosch, 2002; Halfon & Newacheck, 1999). Specifically, students who have been determined eligible for having an emotional or behavioral disorder perform in the lowest quartile academically on standardized tests, and high school dropout approaches 50% (Frey & George-Nichols, 2003; Osher, Morrison, & Baily, 2003). Substance abuse and criminality are widespread, with a 50% arrest rate among students with EBD within the first 5 years after graduation, with the rate increasing by at least 20% for those who do not finish high school (Quinn, Rutherford, Leone, Osher, & Poirier, 2005; Van Acker, 2004). Suicide is the tenth leading cause of death in the USA, yet it is the second leading cause of death for youth between the ages of 10 and 24 (CDC, 2015). Among those who die by suicide, more than 90% had at least one diagnosable mental health disorder (NAMI, 2013). Problems persist into adulthood with employment rates of adults with mental illness only two-thirds that of the general population (Mechanic, Bilder, & McAlpine, 2002). For example, using projected population estimates from a large and nationally representative sample, Merikangas et al. (2007) found that major depressive disorder accounted for an average of 27.5 disability days annually per individual. In all, youth mental illness has been estimated to cost society approximately $247 million dollars annually when factors such as healthcare, special education services, juvenile justice services, and decreased productivity are taken into account (CDC, 2013).

Several cost–benefit analyses of mental health programs suggest that the monetary and societal benefits of effective mental health exceed the costs of such programs. According to Chisholm et al. (2016), for every dollar spent on treatment for depression and anxiety, the return on the investment could be fourfold or higher in terms of increased productivity and health. They make a global investment case for a scaled-up response to the massive public health issues related to depression and anxiety disorders based on a study that included 36 countries. The findings indicated that the expected returns to this investment would lead to 43 million extra years of healthy life over the scale-up 15-year period with a net economic value of $310 billion. Thus, in addition to intrinsic benefits associated with improved health, scaled-up treatment of common mental disorders also leads to large economic productivity gains.

In another analysis, the Michigan Association of Community Health retained Anderson Consulting Group to conduct a study on Michigan's mental health services (Sallee & Egemy, 2011). The findings indicated that the state was spending 20 times more money on severe mental health cases than on prevention. The study projected that investing in early intervention and moderate cases could save the state money by improving access to less costly services and preventing cases from reaching high severe status.

Another study, conducted in urban areas within Cincinnati, aimed to increase accessibility to healthcare services for African-Americans and low-income families through school-based health centers (Guo, Wade, Pan, & Keller, 2010). The findings suggested that school-based health can help reduce access barriers to care, such as transportation and parental difficulties getting time away from work to take a child to the health professional, which in turn help parents retain employment and employers increase worker productivity. The cost–benefit analysis showed a net social benefit of the program in the four Ohio school districts of about $1.35 million over 3 years. These findings indicate that SBMHS can reduce financial, familial, and cultural barriers by providing mental health care for children and adolescents in the neighborhood in which they live.

In fact, recent research indicates that school administrators are beginning to recognize mental health as a significant area of need that schools must address (Frabutt & Speech, 2012). For example, in a study conducted by Iachini, Pitner, Morgan, and Rhodes (2016), principals participating in an online survey and a follow-up phone interview were asked to identify and describe a range of both academic and non-academic needs faced by their students, teachers, and school staff. They identified mental health services as one of the greatest student, teacher, and school staff needs. This is not surprising since link between student mental health and academic performance is compelling, and researchers have long asserted that students' mental health must be addressed in order for students to learn effectively (Adelman & Taylor, 1998). This remains especially true today, particularly in an era with increased emphasis on academic outcomes and the extensive use of high stakes tests for important decisions, such as graduation, college entrance, and professional licensure (Kozik, Cooney, Vinciguerra, Gradel, & Black, 2009).

Together, the aforementioned research offers consistent and compelling evidence that the mental health needs of our population are not being met and that educators are increasingly recognizing the need for school-based mental health services (SBMHS). In response to the pervasive unmet need, The National Technical Assistance Center for Children's Mental Health released a call for a public health approach to mental health in a manner that optimizes the well-being of all children (Miles, Espiritu, Horen, Sebian, & Waetzig, 2010). This is aligned with other major reports concerning children's mental health (National Association of School Psychologists (NASP), 2015c; National Research

Council & Institute of Medicine, 2009; U.S. Department of Health and Human Services, 1999, 2006) that endorse broad expansion of services. Persuasive evidence exists that schools are best positioned to offer comprehensive services. Specifically, among the small number of youth who successfully access services, 70–80% receive those services at school (Langer et al., 2015). We support the provision of SBMHS as the most likely avenue for comprehensive programs with widespread delivery.

The provision of supports for students with emotional and behavioral challenges lies at the heart of the mission, vision, values, and strategic goals of the Council for Children with Behavior Disorders (CCBD). CCBD's vision and values include advocating for quality educational services, academic and behavioral strategies, and program alternatives for children and youth with emotional or behavioral disorders and a strategic goal is to inform policy and practice. To that end, the authors and CCBD present the following foundation for future policy recommendations relative to the need for SBMHS and recommendations for implementation.

The Importance of SBMHS

SBMHS is becoming a growing practice as it provides timely and convenient access to mental health services for a majority of children (Kutash et al., 2006). Schools are well positioned to provide a structured environment to facilitate early identification, prevention, and intervention to prevent escalation of mental health issues in a timely manner (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Practically, since children spend 6–8 h each day in school settings for at least 9 months a year, schools are a logical choice for SBMHS. Schools serve as an agency that can creatively provide supports for mental health while maintaining educational goals for students and collaboratively working with parents and community providers (Kutash, Duchnowski, & Green, 2011). Moreover, when provided effectively, SBMHS potentially reduce the issues of cost, transportation, and accessibility that commonly prevent access (Weist & Evans, 2005). In addition, to prevent deleterious trajectories, schools can provide support to students who do not meet the clinical criteria for mental health services but display early signs of mental health difficulties (Barrett & Turner, 2001).

Another advantage of SBMHS is that they can address a diverse population that is rapidly growing in the USA and is overrepresented among the EBD population (Skiba et al., 2008). That is, research suggests that SBMHS are effective for families and children from varied cultural backgrounds. For instance, a study was conducted to examine the effects of a school-based mental health prevention program that served 174 predominantly Latino at-risk students from two urban elementary schools during the 2008–2009 school year. Teacher pre- and post-reports, attendance rates, and academic scores were used to analyze the effects of the program (Montañez, Berger-Jenkins, Rodriguez, McCord, & Meyer, 2015). The findings indicated that SBMHS increased prosocial behavior, appropriate classroom behavior, and academic achievement of participating students. Attendance also improved for those who received services, compared with a control group of similar students not served by the program. These and other studies (e.g., Albrecht, Mathur, Jones, & Alazemi, 2015) offer a compelling rationale for SBMHS.

Features of Effective SBMHS

Although professionals and stakeholders share a common understanding of the term SBMHS, it is the actual implementation process that varies across professionals and requires clarity. Traditionally, the term referred to services that were non-hospital based and utilized community resources. Recently, SBMHS has taken a more focused view of mental health services delivered in a school setting and has provided guidance on the key features that are likely to contribute to their effectiveness. Rones and Hoagwood (2000) conducted a review of 47 studies published between 1985 and 1999 and identified main features of the implementation process that contributed to sustainability and maintenance: (a) consistency in program implementation; (b) inclusion of various stakeholders, such as parents, teachers, or peers; (c) use of various modalities; (d) integration of program content into general classroom curriculum; and (e) ensuring developmentally appropriate program components.

More recently, Barry, Clarke, Jenkins, and Patel (2013) presented the findings for interventions promoting the positive mental health and primary prevention of youth (age 6–18) in school and community-based settings. The study was commissioned by the World Health Organization (WHO). The authors identified 22 studies, 14 of which described interventions implemented in school settings in eight low-middle-income countries. Their review illustrated robust effects of mental health programs across five countries and emphasized the importance of integrating interventions that promote healthy development into education. In addition, the findings indicated that when multicomponent programs, such social skills training, emotional regulation, and cognitive behavior training were integrated within a whole-school approach, they had the potential to reach larger population groups with fewer resources. Structured universal interventions (e.g., school-based psychosocial structured activities, after school

activities, life skills and resilience training) had significant positive effects on students' emotional and behavioral well-being, including increased self-esteem and coping skills. Such programs can address common risk and protective factors and can be delivered within a supportive school environment in partnership with parents and the local community.

Education and mental health systems have a long history of providing services to students; however, different ways of delivering services have existed. Although services are sometimes delivered collaboratively between the two systems, they are more often provided in a parallel, rather than integrated, fashion (Adelman & Taylor, 2009). Professionals from both systems must work as equal partners to understand the connection between mental health and academic outcomes and to develop an integrated approach to providing mental health supports for children and youth in schools. Efforts to conceptualize SBMHS that are meaningful and relevant for school children and comprehensively addresses their diverse and sometimes intensive needs will be advanced by relying on a collaborative approach, integrating the role of each system (e.g., Garmy, Berg & Clausson, 2015).

Overcoming Barriers and Implementing SBMHS

In the previous section, we provided a rationale for SBMHS. Although SBMHS have grown, they have yet to be widespread in schools throughout the USA (Rones & Hoagwood, 2000; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). As schools continue to implement mental health interventions, we offer the recommendations below.

Programmatic Considerations

Administrative Support

In this section, we describe issues related to programming for SBMHS. First, however, we emphasize the need for administrative leadership and support in this effort. Administrative support is necessary to build the infrastructure to develop and sustain SBMHS. Administrative commitment will ensure the efficient allocation and use of resources, implementation with fidelity, and organizational management to achieve optimal outcomes.

Various requests and requirements cross administrators' desks for support for educational programming. These considerations compete with each other for recognition by administrators and priority practice. Mindful of the aforementioned statistics emphasizing the need for SBMHS, administrators are asked to recall mental health as a prime factor in the academic and the social/emotional well-being of students.

Evidence-Based Practices

An important advance in education is an increased reliance on evidence-based practices. An evidence-based practice refers to an instructional or intervention approach supported by high quality research that offers empirical demonstration of effectiveness. Specifically, several organizations and authors have described specific quality indicators along with guidelines to evaluate the rigor of published research that use different methodologies (e.g., Council for Exceptional Children, 2014; Odom et al., 2005). These guidelines can be applied to a body of research evaluating an instructional or intervention approach to determine whether there is a sufficient number of studies that meet methodological criteria and result in desirable student outcomes (e.g., demonstrate meaningful effect sizes). Although guidelines for rigor differ, they share much common ground and move us toward closing the research-to-practice gap. To overcome barriers to the implementation of evidence-based practices, educators must allocate sufficient funding, assure adequate training, and commitment to implementing the program with fidelity (USDOE, IES, 2003).

We strongly support the continued requisite for evidence to support the effectiveness of SBMHS. Many interventions for the most common mental health concerns already have demonstrated effectiveness (e.g., cognitive behavior interventions for depression; Weist, Evans, & Level 2003) and these should be the first choice option. Promising interventions, or those with emerging evidence but not yet sufficient to be evidence-based, should be relied upon until evidence can be accumulated. Several organizations (e.g., National Center for Intensive Intervention, What Works Clearinghouse) routinely summarize the research evidence to support a variety of interventions, as do published literature reviews. These sources can be consulted for current information about evidence-based interventions.

Focus on Prevention

The purpose of preventive interventions is to avoid the initiation or worsening of children and adolescent mental health challenges. This approach contrasts with responsive interventions frequently used in schools, or those that delay initiation of mental health interventions until symptoms become so severe that they interfere with a student's healthy development and school functioning. Models of punishment-based consequences for inappropriate behavior are too often the first—and easiest—choice of response for administrators. A preventive approach relies on

instructional procedures that teach the skills needed for healthy development and positive social interactions. This is aligned with recent reforms in child and adolescent therapy that de-emphasize the idea of child or adolescent "psychopathology" and instead recognize the role of the environment on behavior (Weist, Lever, Bradshaw, & Owens, 2014). Specific strategies are consistent with a tiered approach to intervention described below. This approach is highly cost-effective because it reduces the need for intensive individualized interventions that are usually required for more severe mental health problems.

Tiered Intervention

There is much value to delivering mental health interventions within a tiered intervention approach (Kern, George, & Weist, 2016). This framework tailors prevention and intervention strategies in multiple tiers (typically three) with different levels of intensity matched to student need. As described above, this approach focuses on prevention, skill instruction, and consistent management procedures for all students at tier 1 to promote child and adolescent emotional and behavioral health and wellness. For example, anti-bullying programs teach students to recognize, address, and report instances of bullying. Similarly, School-Wide Positive Behavior Support clearly delineates expectations for behavior and teacher responses to appropriate and inappropriate behavior.

Tier 2 interventions offer more intensive support and are generally delivered in the form of small group instruction. For instance, structured small group social skills programs offer specific instruction for students having social interaction difficulties. Similarly, time-limited sessions to address loss and grief can help build successful coping strategies. Assigning students to small instructional groups requires administrators to make scheduling and personnel adjustments. Careful planning is required to weave a tiered services model into the daily school routine.

Tier 3 interventions are designed to address serious and ongoing emotional and behavioral problems, such as depression and anxiety. Interventions at this tier are individualized and designed by a team that includes mental health professionals. Because students at this tier exhibit intensive mental health needs, support may include collaboration with community agencies, ideally in the form of "inreach" into schools, although outreach to community agencies may be required.

Culturally Responsive Practices

Census population data report expansive changes in US demographics, predicting that nearly 40% of school-age children will belong to a racial/ethnic minority group by 2020. Racial and ethnic disproportionality in rates of eligibility for special education, particularly the category of "emotional disturbance," has been a persistent problem for the field of special education (Donovan & Cross, 2002; Dunn, 1968; Oswald, Coutinho, Best, & Singh, 1999; Skiba et al., 2008; Zhang & Katsiyannis, 2002). Further, research has documented disparities in the type and quality of mental health services across ethnic groups (Ghandour, Kogan, Blumberg, Jones, & Perrin, 2012; Merikangas et al., 2011). These data highlight the need for practice and policy changes, including resources and interventions to support culturally and linguistically diverse groups.

There are several specific areas in which to intervene to address cultural issues. One is teacher preparation. Issues of cultural mismatch suggest that teachers may simply lack the knowledge and skills to successfully interact with students different from themselves (Ladson-Billings, 1995), highlighting the importance of teacher training in culturally responsive pedagogy (Klingner et al., 2005; Trent, Kea, & Oh, 2008).

A second area is improved behavior management. The most recent National Research Council panel identified inadequate classroom management as a factor increasing the risk of over-referral of minority students (Donovan & Cross, 2002). Culturally responsive behavioral supports have been identified as a promising method for addressing issues of classroom disruption and school discipline (Cartledge & Kourea, 2008; Klingner et al., 2005).

A primary prevention model, wherein universal supports are offered to all students and more specific supports, such as cultural brokering, are offered to students more at-risk appears to be a promising model for addressing disproportionality (Serna, Forness & Nielsen, 1998). In addition, family and community involvement is critical. To enable more active parent involvement, Artiles and Trent (1994) recommended that educators assess their own levels of cross-cultural competency. Parents and families should be involved in all aspects of mental health provision and the values of families and culture integrated into education decision-making processes (Harry, 2008; National Alliance of Black School Educators, 2002).

School-Wide Practices

Universal Screening

There is unquestionable evidence that emotional and behavioral problems among youth are under identified (Merikangas et al., 2011). Youth with mental health problems are generally detected because they amass high frequencies of office referrals or, less commonly, are referred by teachers (Lane, Menzies, Oakes, & Kalberg,

2012). These strategies tend to miss students with internalizing problems and delay identification as disciplinary procedures accumulate (McIntosh, Campbell, Russell, & Zumbo, 2009). On average, intervention is provided 8–10 years after symptoms of mental illness first appear (National Alliance on Mental Illness, 2016). Thus, an essential school-wide practice is regular and universal screening of *all* students to identify those with and at-risk of mental health challenges. Mental health screening allows school professionals to identify students with both emerging symptoms and those with serious mental illnesses and avoids unnecessary delay in service delivery.

There are a number of psychometrically validated screening instruments and questionnaires and most require only 10–15 min to complete and many are free of charge. It is important, however, to work through logistical issues that accompany school-wide screening. These include selecting an instrument that best suits a school's needs and adheres to state and district policies, scheduling screening during the school year when it is most likely to produce useful information, preparing for and administering the screening to assure procedural integrity and confidentiality, developing a process for scoring and interpretation (Oakes, Lane, Cox, & Messenger, 2014). Finally, it is critical that schools are prepared to respond to student needs that emerge, as discussed below.

Crisis Plans and Procedures

Perhaps all schools have experienced a crisis, or a dangerous situation that is highly likely to result in severe emotional responses by students and therefore requires immediate attention. Crises can occur at the school level (e.g., school shooting), small group level (e.g., death of a classmate where a small group of students are most affected), and the individual level (e.g., rape, assault). It is essential for schools to have a crisis intervention plan that reduces the adverse impact of the crisis by addressing resulting psychosocial problems students will experience, returning to routine procedures, and developing preventive procedures. We recommend clearly delineated school and district policies and procedures that (a) define events that are crises; (b) identify and train a crisis team with designated roles and responsibilities; (c) determine how to assess the trauma level; (d) delineate how to access needed resources and support; (e) specify how to report and respond to students, families, the community, and the media. In addition, the plan should include procedures for reviewing its effectiveness and making modifications and improvements. For specific guidelines and procedures see http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf.

Student Issues

Even though the awareness about mental health issues is increasing, students with mental health issues continue to face stereotypes, prejudices, social disapproval, or punitive actions from schools and communities (Corrigan, 2004). Sometimes, stigma is overt, in the case of issuing the negative or derogatory comment, "she is bipolar or schizophrenic." Other times, it is more subtle, such as assuming that all youth with mental health issues are aggressive or violent, make poor decisions, or can never be competent at work. Stigma directly affects the self-concept of people with mental illness, their beliefs about treatment effectiveness, and their support system, provider networks, and community resources (Corrigan, Druss, & Perlick, 2014). Furthermore, stigma serves as a barrier to youth and their families who are trying to engage in care seeking efforts, resulting in students with mental health issues facing feelings of isolation when parents, teachers, and peers around them deny the existence of mental health issues (Bowers, Manion, Papadopoulos & Gauvreau, 2013). Research also indicates that students with mental health issues often become targets of bullying (Ttofi, Farrington, Losel, & Loeber, 2011). There is a crucial need to creating school environments that understand, legitimatize, and importantly foster mental health supports for all students' well-being. In the context of effective SBMHS these barriers to students' positive mental health can be ameliorated.

Staff Training

One reason staff training is particularly important pertains to the under identification of youth with emotional and behavioral problems, particularly internalizing concerns (Forness, Freeman, Paparella, Kauffman & Walker, 2012). For example, Merikangas et al. (2011) reported that although 40% of youth with attention-deficit/hyperactivity disorder indicated not having received services for their difficulties, 80% of youth with anxiety disorders reported not receiving services. Administrators and school staff members who are trained to recognize symptoms of mental health challenges can provide a vital link between students experiencing challenges and evaluation and intervention.

Another reason for enhanced staff education in mental health relates to intervention delivery. SBMHS include a broad spectrum of prevention, referral, assessment, intervention, and counseling. To provide consistent and sustainable mental health services, school personnel need administrator supported professional development in evidenced-based practices and support systems to reduce variability in implementation quality (Han & Weiss, 2005). Schools also face several issues related to school-based

providers of mental health services; the needs, policies and budgets of the school; and involvement of families. The role of administrators cannot be more crucial in the development, resource support, and accountability of ongoing staff training in prevention and intervention strategies.

Provider Qualifications

Providers have a wide range of variation in qualifications depending on their post-secondary education level and their ability to consistently access and benefit from ongoing trainings and seminars. School districts often have inconsistent standards for the practice of mental health in schools and lack clarity about the roles of personnel providing mental health services. Different conceptual models exist for providing school-based mental health services that add to the complexity of the issue of variability and sometimes inconsistency. For example, some school districts view school or district staff as providers, while others use outside agencies to provide mental health services in the schools.

Models for personnel training also vary. Some schools consider a 1-day workshop sufficient for enhancing staff awareness about issues of mental health, while others are moving toward professional development models that include professional learning communities, coaching, mentoring, and follow-up supports for their staff. These contextual factors influence implementation of school-based mental health services and highlight the need for administrator supported, sustainable professional development opportunities for school staff and creating an infrastructure to better coordinate school-based mental health services (Greenberg, Domitrovich, & Bumbarger, 2001). More specifically, school personnel need to be well trained in (a) evidence-based practices and rationale behind them, (b) implementation of those practices with integrity, (c) structured evaluation of implementation integrity, and (d) continued support. Evidence-based practices in the school-based mental health literature have ranged from daily classroom management practices to more intense, individualized interventions. To provide consistent and continuous mental health services, the following recommendations are suggested for professional development.

Increase Awareness of Mental Health Issues School staff (preferably *all*) need to be trained in early warning signs indicative of stress, anxiety, trauma, abuse, depression, bullying, continuous peer conflict and rejection, and psychosocial adjustment problems (e.g., loneliness, social withdrawal), all of which can lead to school avoidance and reduced engagement in academic and social learning activities. Training should include how to approach students to discuss their concerns and encourage them to share how they feel when they are in school. Finally, school staff should increase their capacity to connect their students to the appropriate mental health supports. Also, at least some staff members need training in screening and assessment tools for identifying mental health issues of students.

Increase Awareness About School Connectedness and School Climate School staff can play a critical role in promoting student connectedness through positive relationships with students, which builds a positive school climate that is conducive to learning and a culture of well-being. School staff need to be trained in understanding how school climate influences students' academic achievement, positive peer interactions, social acceptance among students, and their overall emotional well-being. At the same time, school staff should be aware of the constraints within their schools that influence students' social and emotional environments, and understand why some students fail to develop positive friendships and affiliations and therefore begin to associate with peers who negatively influence their social growth. They may benefit from training in how to identify a student who is showing signs of disengagement and disconnectedness and how and when to refer that students for supports that will increase school connectedness.

Build School-Wide Capacity All school staff need to serve as mental health promoters led by the school administrator. For SBMHS to work effectively, school professionals need to be empowered to provide evidenced-based practices. Some practices require minimal training. For example, teachers can reinforce anti-bullying interventions in their classrooms, prompt the use of relaxation strategies for a student working on anxiety management, and provide regular feedback to mental health professionals regarding the academic and behavioral progress of students with mental health needs in their classroom. At other times, they may have to expand their role in providing mental health support by seeking additional training from other mental health professionals when students present more intensive needs. They need to learn and be proficient in teaching the problem solving and coping skills that can benefit all students. Opportunities for learning can be created via components of group consultation (Webster-Stratton, Reinke, Herman, & Newcomer, 2011), professional learning communities (Shernoff, Lora, Frazier, Jakobsons, & Atkins, 2011), and collaborative learning and coaching models (Nadeem, Jaycox, Kataoka, Langley, & Stein, 2011). Administrators are responsible for assuring training needs are not only affordable with respect to both time and money, but also accessible.

Fidelity of Implementation Fidelity refers to the coordination and execution of practices as they are intended to be delivered. It has been demonstrated that the fidelity with which a program is implemented will directly affect the success of an evidence-based program (Kratochwill, Volpiansky, Clements, & Ball, 2007). Only by understanding and measuring whether SBMHS have been implemented with fidelity can researchers and practitioners gain an understanding of whether or not they work and the extent to which they can improve student outcomes. High implementation fidelity requires training, opportunities to practice, and coaching as needed in selected services. When good fidelity is achieved, it guides reflection, further refinement, and subsequent action. Ultimately, accountability measures should be reviewed between administrators and staff members on a regular schedule.

Parent Collaboration

Active school and family collaboration is an essential component in the provision and utilization of services. Education should be viewed as a shared responsibility and a positive parent–school partnership can be fostered through increased communication, coordination of goals, and joint decision-making (NASP, 2012). Parents who are concerned about their child's mental health should initiate communication with school personnel and inquire about available school-based services such as behavior plans, small group instruction, or classroom accommodations. If tier 1 or tier 2 interventions offered within the general education environment are ineffective, a special education evaluation may be necessary (NASP, 2010). The evaluation should be conducted by a team of licensed professionals to determine if the student qualifies for specific disability accommodations under the *Individuals with Disabilities Education Act* (IDEA, 2004).

School mental health professionals need to keep several things in mind when working with parents to secure mental health services for their child or family. First and foremost is that parents know their child the best. School personnel need to be collaborative and avoid appearing to be the expert based on school observations and evaluation data. Further, school personnel should not lead parents to feel like they have done something wrong or are the reason for their child's mental health problems. Rather, they need to focus on providing child centered supports by respecting *children who have mental health needs*, *empowering their families*, structuring the surrounding environment to optimize support, and increasing their awareness about therapeutic services that are well integrated and well organized within the school system and outside the school community.

In addition, there is unfortunately still a stigma about obtaining mental health services and some cultures are particularly resistant to the idea of mental health treatment. School professionals and parents need to be a collaborative team and parents need to be empowered about where and how to seek mental health interventions for their child that are effective, yet align with their values.

Resource Allocation

The National Association of School Psychologists (NASP, 2003) advocates for increased school-based mental health funding from the federal, state, local, and private sectors. This funding is necessary to promote psychological resiliency as well as educational attainment, achievement, and success. Recent budget cuts have drastically reduced the ability of schools to provide students with necessary mental health and special education services. These budget cuts have continued, despite the fact that research has demonstrated that such services can be implemented in a cost-effective manner, which, in turn, can reduce the long-term costs to society (NASP, 2015b).

Particular concerns arise when the needs of students and their families exceed the abilities of any one agency. When partnerships are collaborative, programs are equitable and comprehensive, and sufficient resources are provided, accessibility to mental health services for all school-aged youth can become a financially sustainable reality. Systems of care and wraparound approaches (Burchard & Clarke, 1990) in which education, mental health, juvenile justice and other community youth-serving agencies collaborate to develop integrated services, offer promise as a way of providing additional resources to schools to address the most serious and challenging behaviors. This approach is most effective when providers value the philosophy of a "shared agenda" (Kern et al., 2016).

Coordination of services for students with mental health concerns has grown out of the *systems of care* approach to service delivery. First developed as part of the National Institutes of Mental Health Children and Adolescent Service System Program (CASSP) in 1984 (Stroul, 2002), the systems of care approach focuses on coordinating mental health, education, welfare, and other social services into a network to meet the individual needs of children with emotional and behavioral disorders in their home communities and supporting family members as allies in the treatment process. Simultaneously, providers need to adopt a shared agenda model.

An outgrowth of these efforts, wraparound is a process for building constructive relationships and support networks among youth with emotional/behavioral challenges, their families, teachers, and other caregivers. In wraparound, a team works to (a) identify the underlying needs, interests and limitations of families and service providers, and (b) develop a plan that addresses these interests using natural, community supports wherever possible (Bruns & Burchard, 2000; Eber, Nelson, & Miles, 1997). Thee process also is used to inventory, coordinate and, if necessary, create supports, services and interventions to address agreed upon needs of the youth and primary care givers (i.e., families, teachers) across home, school, and community. School-based wraparound efforts have been recommended as a method for implementing tier 3 services within a multi-tiered model (Eber, Sugai, Smith, & Scott, 2002).

Careful implementation of the wraparound process has been shown to lead to some promising outcomes for children, including decreases in out-of-home placements, decreased placement in restrictive school settings, and some improvements behavioral, academic, social, and post-school adjustment indicators (Eber et al., 1997; Malloy, Cheney, & Cormier, 1998). Meta-analysis of the wraparound process (Suter & Bruns, 2009) also has shown some initially promising results in terms of improved mental health outcomes and decreased residential placement; however, the effectiveness of the approach appears to depend on a high level of fidelity to the outcomes- and community-based elements of wraparound (Effland, Walton, & McIntyre, 2011). Nonetheless, processes such as wraparound can streamline services and reduce redundancy as well as enhance communication.

At this time, however, school resources are simply finite. In this case, a "resource mapping" approach is useful to identify how the time of potential school-based providers is allocated. Often, time is spent using reactive procedures, rather than preventive. Allocating resources to implement evidence-based approaches (e.g., cognitive behavioral therapy) can reduce crises, counselor drop, and disciplinary actions that often consume great amounts of time. In addition, the presence of youth-serving agencies in the community can be assessed as a potential source for providing additional services in schools (Castrechini, Gardner, & Ardoin, 2011). It is helpful to concurrently develop a network of long-term relationships with local child-serving agencies in order to increase the mental health services available to schools on an ongoing basis. Finally, the availability of local wraparound teams should be explored. In the absence of a local team, a school-based coordination team can be developed as part of tier 3 services in a tiered system of support.

Conclusion and Recommendations

While school administrators may recognize mental health as a significant area of need to assure students' academic success and emotional well-being, few students receive services that could prevent or reduce the symptoms associated with the most prevalent disorders. Too often intervention is implemented after a crisis has occurred rather than as a preventative measure. Prevalence rates for school-aged children mandate attention to policies and practices that should be implemented in all schools if students in emotional distress are to be afforded opportunities for educational success and personal well-being. We strongly encourage the adoption of the following SBMHS applications as administrative guidelines for school policies and practices.

1. Acknowledge that students with emotional concerns need comprehensive SBMHS.
2. Build infrastructure within schools for the systematic and systemic teaching of prosocial skills.
3. Adopt programs and practices that reduce racial and ethnic bias.
4. Evaluate behavior management strategies from individual student, classroom, and school-wide perspectives, moving from punishment-based strategies to prosocial instructional approaches that promote social, emotional, and behavioral development.
5. Train school staff to recognize early signs of emotional distress and to intervene early with evidence-based preventive practices that are implemented with integrity.
6. Monitor school climate by periodically examining relationships among students and staff members to assure climate is positive and all at-risk students are connected with or mentored by school staff.
7. Assure connectedness with families in communication, coordination of goals, and joint decision-making.
8. Establish systems of care with community mental health service providers, revenue sources, juvenile justice, and others to create networks of support.

We acknowledge barriers to the implementation of SBMHS and have offered suggestions for overcoming those barriers. Administrators have many decisions to consider when allocating personnel, time, materials, space, and other limited resources and may be reluctant to prioritize student mental health as a critical component of the educational curriculum and philosophy. At the same time, the high prevalence of emotional and behavioral challenges, their link to student academic performance, the long-term implications of neglecting student mental health, and clear evidence of cost–benefit make SBMHS

imperative. Additional guidance on improving school mental health practices can be found on the national technical assistance Web site (http://www.pbis.org) and the national Center for School Mental Health Assistance web site (http://csmh.umaryland.edu; also see Weist et al., 2014; Kern et al., 2016).

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical standards Human subjects were not used in the current paper; therefore, informed consent was not needed. We assure that the contents of this paper are original and are not currently under review elsewhere.

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