Center for School Mental Health Analysis and Action
Committed to strengthening policies and programs in school mental health to improve learning and promote success for America's youth.

Enhancing Quality in Expanded School Mental Health: A Resource Guide*

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Enhancing Quality in Expanded School Mental Health: *A Resource Guide*

Center for School Mental Health Analysis and Action
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Principle 1: All youth and families are able to access appropriate care regardless of their ability to pay.

1) When indicated, do you provide case management assistance to students and families to assist them in obtaining health insurance or to facilitate enrollment in programs for which they are eligible?

Based on the data collected by the 2005 Current Population Survey (CPS) Annual Social and Economic Supplement by the U.S. Census Bureau, it is estimated that in 2004, 8.5 million or 11.2% of all children and adolescents in the United States were uninsured. Among children who were categorized as being in poverty, 18.9% were uninsured versus 11.7 % of all children (U.S. Census Bureau, 2005). Further, children ages 12-17 were more likely than their younger peers to be uninsured (12.5% vs. 10.5%). With regard to race, Hispanic children had the greatest rates of being uninsured (32.7%), followed by 19.7% for African-American children, 16.8% for Asian children, and 11.3% for non-Hispanic White Children (U.S. Census Bureau, 2005). These figures are alarming and highlight the large numbers of children who are not receiving necessary health care. Children without health insurance are less likely to access medical care, more likely to cite that there were times when they did not seek medical care when it was needed, and more likely to have unmet mental health needs (Brindis, Kapphahn, McCarter, & Wolfe, 1995; Kataoka, Zhang, & Wells, 2002; Newacheck & McManus, 1992). School mental health clinicians are positioned to be able to assist children and families with enrollment in programs for which they are eligible.

School-based staff and clinicians are often unaware of whether the children they serve are covered by any health insurance. Even when clinicians are aware that a child has insurance, they may not be aware of the adequacy of the insurance coverage. Students with inadequate or no health insurance may be eligible to participate in various programs that offer free or low cost health coverage. Students who do not have health insurance may be eligible to receive it through Medicaid or the State Children's Health Insurance Program (SCHIP). As part of the Balanced Budget Act (1997), SCHIP was created and approximately forty million dollars of federal funding was designated to provide insurance coverage to children and adolescents from low-income families. SCHIP is designed to provide insurance to children and adolescents who exceed financial eligibility requirements for Medicaid (Center for Mental Health Services, 2000). While states have different eligibility rules, typically children would be eligible for SCHIP if they are 18 or younger and have a family income (for a family of four) up to $34,100. To learn more about your state's insurance eligibility requirements, key websites to access include those developed by the U.S. Department of Health and Human Services (http://www.insurekidsnow.gov/states.htm) and the American Academy of Pediatrics (http://www.aap.org/advocacy/washing/elections/med_factsheet_pub.htm). While states have enrolled many children in SCHIP, an estimate based on 2001 U.S. Census data suggests that

there are more than 5.7 million children and adolescents meeting Medical Assistance or SCHIP financial eligibility requirements who are not insured (Morreale & English, 2003). In addition, while SCHIP can help meet the needs of many uninsured children, it remains unavailable to immigrants who were made ineligible by the 1996 Welfare Reform Law (Morreale & English, 2003). While clinicians cannot resolve all insurance coverage issues, they can assist families in enrolling in programs for which they are eligible and can become aware of agencies/programs that offer free care to individuals without health insurance.

The Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2000) reports that approximately 15% of children and adolescents eligible for SCHIP are in need of mental health or substance abuse services. ESMH clinicians, along with school-based health staff, can provide an important service to children and families by helping them to access health insurance. School-based clinicians need to be aware of available insurance within their state and should know how to access it. They should also be aware of requirements under Medical Assistance that ensure that children with this aid can receive necessary care. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a comprehensive preventive health care initiative created by Congress in 1967 and expanded in 1989 to respond to the needs of children covered by and eligible for Medicaid (Center for School Mental Health Analysis and Action, 2001). As part of the EPSDT program, children receive health screenings that include medical, vision, hearing, dental, mental health, and growth and development components. If a problem is identified through these screenings, appropriate assessment and treatment is required by law. Clinicians can use findings from these screenings to advocate for services for children on their caseloads. Often, the school nurse or staff in school-based health centers can assist students in determining their eligibility for public health insurance and can assist them in obtaining it. They can also assist families in making necessary phone calls to determine coverage for existing services. Forms for registering for SCHIP are often fairly brief and easy to complete. ESMH clinicians can easily give them to students and their families and can provide assistance in ensuring that they are completed and forwarded. They can assist families with how to contact SCHIP workers and can outreach to families through developing fliers for mailings, setting up information tables at parent events, and developing recruitment activities for children likely to meet criteria (e.g., eligible for free lunch) (Nabors & Mettrick, 2001). Whether or not clinicians are currently active in assisting students in obtaining health insurance, it is a good idea to coordinate with school health staff to ensure students' needs for adequate insurance are being met. School-based clinicians can assist with obtaining insurance by asking families about their insurance status and referring families to designated school health personnel or assisting them with necessary enrollment forms.

While insurance is a critical case management concern for families, clinicians should also be aware of other resource needs for families including recreation, shelter, employment, advocacy, free lunch, legal assistance, transportation, and child care. Research has found that regardless of programs put in place to help low-income children and families receive insurance, disparities in the access and utilization of services between lower income families and higher income families persist (Mayer et. al., 2004). These findings suggest the need for more research and resources to be devoted to understanding, developing, and disseminating effective program and strategies to bridge this utilization gap. It can be helpful for families if medical and mental health providers have a directory of programs/organizations/services at the community, city, state, and federal

level, readily available to share with them. The willingness of providers to inform families of resources and to help them to better access and coordinate care may help to enhance utilization of services. Several excellent directories for resources for children and families exist at the state and federal level and can easily be accessed by clinicians. In addition there are numerous advocacy and social service organizations that may have the capacity to handle some case management needs of the children and families. Clinicians will not have the time needed to provide full case management services but can assist in being a key referral agent to necessary resources.

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Resources for this Quality Indicator

- American Academy of Pediatrics (www.aap.org/advocacy/chis.htm; www.aap.org/advocacy/washing/elections/med_factsheet_pub.htm)
- U.S. Department of Health and Human Services (www.insurekidsnow.gov/; www.cms.hhs.gov/home/schip.asp)
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (www.mentalhealth.samhsa.gov/databases; (www.mentalhealth.samhsa.gov/publications/allpubs/KEN98-0050/default.asp)
- American Academy of Child and Adolescent Psychiatry (http://www.aacap.org/publications/factsfam/insuranc.htm)
- Early Periodic Screening Diagnosis and Treatment (EPSDT) (www.mchlibrary.info/KnowledgePaths/kp_EPSDT.html)

2) Are you engaged in activities that may bring resources or financial support into the school mental health program?

One of the greatest challenges in expanded school mental health is finding, securing, and maintaining funding (Evans, Glass-Siegel, Frank, Van Treuren, Lever, & Weist, 2003). While expanded school mental health programs are often collaboratives among universities, hospitals, health clinics, school systems, mental health agencies and organizations, social service organizations, and juvenile justice, no one component of the system can realistically fully cover the costs of financing an ESMH program. The funding strategies for each ESMH program are unique and often evolve over time (Evans et al., 2003). Funding sources for expanded school mental health typically include a blend of fee-for-service funding, federal and state funding, local funding, and private funding (Weist, Goldstein, Evans, et al., 2003). Often, the services that ESMH programs can provide are limited by the source of funding that is available. For example, dependence on fee-for-service revenue may limit services to children who meet criteria for clinical diagnoses and have insurance coverage (Leaf, Schultz, Kiser, & Pruitt, 2003). Dependence on this revenue may limit the extent to which the full continuum of mental health services from prevention to intervention can be delivered within the ESMH program (Leaf et al., 2003; Weist et al., 2003). In order to provide the full continuum of services it is critical for programs to link to the larger system of care within their communities. Within this larger system of care there are increased opportunities for blended funding and the potential for increased flexibility in the range of services that can be delivered by clinicians. Critical to securing funding and building a system of care are strong advocacy efforts and documentation of service impact (Hogenbruen, Clauss-Ehlers, Nelson, & Faenza, 2003; Leaf et al., 2003; Nabors & Mettrick, 2001). Documenting cost-savings, service utilization, satisfaction, and outcome for children and families of expanded school mental health programs may be a rallying point for the

program and may help drive money into ESMH programs (Evans et al., 2003; Leaf et al., 2003; Nabors & Mettrick, 2001).

Strong advocacy efforts are critical to ESMH funding and can aid in increasing funding at all levels of care. Key steps to school mental health advocacy include the following: 1) groundwork (consider what services and systems are already in place and note whether a mental health infrastructure exists), (2) obtaining initial buy-in (do an initial needs assessment and build relationships early on with key stakeholders within the school and community), 3) developing a community collaboration (identify key individuals and programs that are invested in children's mental health and develop effective partnerships that enhance resources) , 4) enhancing collaboration among school service providers (establish a collaborative planning process that considers turf issues and establishes clearly defined partnerships), and 5) increasing program resources (use necessary evaluation data and community collaborations to enhance program funding and support) (Hoganbruen, Clauss-Ehlers, Nelson, & Faenza, 2003). Clinicians play a key role in developing and maintaining relationships with school-based and community stakeholders. In addition to providing reimbursable services, clinicians can help increase financial support for their program through advocacy, grant writing, and helping to form and foster partnerships within their school and larger community. Clinicians can also assist programs with gaining funding by agreeing to participate and helping to collect data that documents the program's impact and effectiveness. Involvement in school mental health initiatives that focus on utilizing empirically supported interventions and treatment plans will increase resource availability by minimizing the use of funding on ineffective interventions and maximizing the use of underutilized resources (Weist, 2005).

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Resources for this Quality Indicator

- Centers for Disease Control and Prevention (http://www.cdc.gov./nccdphp/dash/funding.htm.)
- The Center for Health and Health Care in Schools (http://www.healthinschools.org)
- The Finance Project (http://www.financeproject.org)
- Financial Strategies to Aid in Addressing Barriers to Learning (Center for Mental Health in Schools) (http://smhp.psych.ucla)
- The Foundation Center (http://FdnCenter.org/)
- National Conference of State Legislatures (http://www.ncsl.org/programs/health/pp/strvsurv.htm)
- Office of Juvenile Justice and Delinquency Foundation (http://ojjdp.ncjrs.org)
- Safe and Drug Free Schools Program (http://www.ed.gov/offices/oese/sdfs/)
- Surfin' For Funds – guide to internet financing information (Center for Mental Health in Schools) (http://www.smhp.psych.ucla.edu/ [search *Quick Find*])
- Funding Tool Kit (http://nasbhc.org/Creating_Financing_TOC_pdf.pdf)

Private Foundations:

- The Abell Foundation, Inc. (http://www.abell.org/areasf.htm)
- Alcoa Foundation Grants (http://www.alcoa.com/know/foundation)

- The Annenberg Foundation (http://www.whannenberg.org/samples.htm)
- Annie E. Casey Foundation (http://www.aecf.org/grants.htm)
- AT&T Foundation (http://www.attt.com/foundation/)
- The Carnegie Corporation of New York (http://www.carnegie.org/)
- Freddie Mac Foundation (http://freddiemacfoundation.org/)
- The Gannett Foundation (http://gannettfoundation.org/)
- Hallmark Corporate Foundation Grants (http://ericweb.tc.columbia.edu/directories/anti-bias/hallmark.html)
- The Heinz Endowments: Children, Youth, and Families (http://www.heinz.org/)

Principle 2: Programs are implemented to address needs and strengthen assets for students, families, schools, and communities.

3) Have you conducted assessments on common risk and stress factors faced by students (e.g., exposure to crime, violence, substance abuse)?

Risk factors refer to aspects or characteristics in the child, family, or community environment that have been found to be associated with increased rates of negative psychosocial outcomes. There is a consensus among experts that both biological factors and adverse psychosocial experiences during childhood can influence a child's mental health (Department of Health and Human Services, 1999). An ecological framework can be very helpful in understanding how risk affects children and contributes to the development of problems (Brofenbrenner, 1993). This framework suggests that the individual functions within the increasing large contexts of family, school, community, and environment. Risk factors can occur on any level, and the risk factors on different levels interact with each other (Pellegrini, 1990). Child risk factors include low intelligence, medical conditions, grade failure, low self-esteem, temperament, developmental delays, teen pregnancy, and negative attitude about school. Family risk factors may include parental stress, family history of mental illness, inconsistent rules and structure, incarceration, domestic violence, family transitions, and unstable living arrangements. Community risk factors may include limited adult role models, limited community resources, community violence, substance usage and dealing, and media violence (Bendersky & Lewis, 1994; Fraser, Kirby, & Smokowski, 2004; Gutman, Sameroff, & Cole, 2003; Luthar, Burack, Cicihetti, & Weisz, 1997). Most often, however, there may be multiple risk factors on varying levels. Some research studies suggest that the presence of multiple risk factors has a multiplicative rather than additive effect (e.g., 3 individual risk factors and 3 family risk factors produces an overall risk level closer to 9 than to 6) (Rutter, Tizard & Yule, 1977). In a recent study, the risk factors evident in both externalizing and internalizing disorders in children were evaluated (Essex et. al., 2006). Clarifying the epidemiology of disorders may help to more accurately determine the risk factors most strongly associated with a specific disorder and ultimately help in identifying children at greatest risk (Essex et. al., 2006).

Understanding the particular risk factors that a community is contending with allows for the development of programs reflective of the issues facing the students. There are several key questions that should be addressed during this assessment of needs and stressors. Specifically, stakeholders should provide their perspectives on: 1) the most significant stressors encountered by youth in the community, 2) the most common emotional and behavioral problems presented by youth in the school, 3) the types, availability, and ease of access to social, health, mental health, and other programs (e.g., recreational), 4) how mental health services should be delivered in the school, and 5) other frequently accessed resources to support students (Acosta, Tashman, Prodente, & Proescher, 2002)

When assessing the risk factors impacting students, there are multiple sources of information. Depending on the age of the student, it may appropriate to host informal focus group discussions to learn what their perceptions are of the stressors. Informal interviews with staff, parents, and

community members will usually identify common issues (e.g., high levels of crime, violence, or substance abuse). When meeting with staff and community members, target a broad spectrum of individuals to ensure a fairly representative sample of information (Learning First Alliance, 2001). Of particular importance is to involve parents and family members. This data collection will help to familiarize family members with the services, provide them with opportunities to check out any misperceptions, and facilitate the implementation of the services as there may be less resistance if parents are actively involved in the planning (Acosta, Tashman, Prodente, & Proescher, 2002).

In addition to the qualitative information gathered through interviews, focus groups, and informal discussions, there are a number of sources of information that can be accessed to explore the stressors of the community. Socio-demographic data obtained from the school or school district can assist in identifying general stress and risk factors for students (e.g., truancy rates, percentage of students receiving free and reduced lunch, percentage of English Language Learners, and percentage of mobility). Other examples of the types of data that schools collect are achievement scores, grades, staff turnover and satisfaction reports, retention rates, number of special education students and patterns of special education reviews (Osher, Dwyer, & Jackson, 2003). At the community level, community mapping provides information about the broader context of the school. Data that might be collected includes the number of children in poverty, uninsured, on probation, and community crime statistics. These indices allow for an overview of the functioning of the school and community.

Surveying the school community is anther way to assess needs and protects the anonymity of the reporters (which may encourage some individuals to be more forthcoming about issues). Osher, Dwyer & Jackson (2003) suggest that when creating a survey to: 1) provide incentives for returning the questionnaire, 2) be brief, 3) clearly articulate why the data are being collected, 4) developed some questions that can be answered on a scale, and 5) inform participants of the approximate amount of time it will take to complete.

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Resources for this Quality Indicator

- National Center for Children Exposed to Violence (http://www.nccev.org/)
- Project Resilience (http://www.projectresilience.com/)
- Resiliency in Action (http://www.resiliency.com/)
- *Turning the corner from risk to resiliency: A compilation of articles from Western Center News* by Bonnie Benard, November 1993, available through the NWERL website (http://www.nwrel.org/index.html)
- *Early warning, timely response: A guide to safe schools*. Includes research-based practices designed to help school communities identify risk factors for violence and develop plans fro prevention (http://cecp.air.org/guide/guide.pdf)
- *Predictors of youth violence.* This document covers the results of 6 longitudinal studies of risk and protective factors for youth violence (www.ncjrs.org/pdffiles1/offdp/179065.pdf)
- National Youth Violence prevention Resource Center, *Risk and protective factors for youth violence* (http://www.safeyouth.org/scripts/facts/docs/risk.pdf)
- Surgeon General's report on Mental Health Risk and Prevention Factors (http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec2.html)
- Youth in a Difficult World (http://www.nimh.nih.gov/publicat/youthdif.cfm)
- Teens: Alcohol and Other Drugs (http://www.aacap.org/publications/factsfam/teendrug.htm)

- Getting the Facts About Adolescent Substance Abuse and Treatment http://www.athealth.com/Consumer/adolescentsufacts.html
- National School Boards Association – Education Leadership Toolkit, Assessment Tips http://www.nsba.org/sbot/toolkit/assesstps.htm

4) Have you held meetings with students, parents, and teaching staff to ask them about their needs and to ask them for their recommendations for actions by school mental health staff?

At times, clinicians in schools forget to regularly ask students about their needs and problems and to get their recommendations on improving mental health services. The National Assembly on School Based Health Care, in recognition of the importance of this issue, has called on school-based health programs to encourage "the students' active, age appropriate participation in decisions regarding health care and prevention activities" (National Assembly on School Based Health Care, 2002, para. 3). In order to accomplish this in the mental health field, feedback from students should be solicited early in the intake process and should continue regularly (at least once a month). Feedback solicited from students should provide meaningful information to inform program change; it should be action-oriented (e.g., What should we change? What can we do better?), include both positive and negative input about the school mental health services, and be solicited from students being served by the program and those not being served. Student feedback may be gathered via a number of avenues, including student involvement in program planning and development and student evaluation surveys. Student focus groups can also be helpful to learn about students' needs and obtain recommendations. Studies by Nabors, Reynolds, & Weist (2000) and Nabors, Weist, & Tashman (1999) obtained student feedback to identify clinician characteristics of importance to adolescents. Wagner, Tubman & Gil (2004) consider student focus groups and direct communication about the services provided crucial in developing and maintaining an effective intervention.

The literature has also documented that there is a disconnect between the services families believe they need and those that are actually offered. This contributes to families discontinuing services for their children (Massey, Kershaw, Falk, & Hannah, 2000). Families are essential partners in improving the mental health and well-being of children and need to be involved meaningfully in both treatment and program planning efforts (Lowie, Lever, Ambrose, Tager, & Hill, 2003; Bickham, Pizarro, Warner, Rosenthal, & Weist, 1998; Center for Mental Health in Schools, 1996; Comer & Haynes, 1991; Taylor & Adelman, 2000; U.S. Department of Health and Human Services, 1999). ESMH programs often struggle to keep families involved, both in collaborating to provide care for individual children receiving services and in providing general guidance to the program regarding how to improve mental health care. ESMH staff needs to include family involvement as part of best practice efforts and should strive to obtain parent views and develop strategies to incorporate related feedback into day-to-day functioning of the program (Lowie et al., 2003). One strategy for involving parents/guardians is to hold meetings with families to get feedback about their needs and concerns. Feedback from parents/ guardians can be obtained through focus groups, listening sessions and forums, and through facilitated discussions, interviews, and structured conversations (Ambrose, Weist, Schaeffer, Nabors, & Hill, 2002; Barnes, 2004; Nabors, Ramos, & Weist, 2001).

To be able to successfully engage parents in being willing to utilize and help improve mental health services, it is necessary to put effort into building healthy relationships with parents.

Critical to quality services in schools for parents are that staff are friendly and polite, respect parents, try to understand parent perspectives, listen to parents and recognize their expertise and strengths, and empower and assist families to achieve desired change (Anthum, 2000; Center for School Mental Health Analysis and Action, 2003). Assessing parent needs and recommendations should not be a one time activity but should be an ongoing process in insuring that programs are providing needed services in an effective manner. Beyond collecting data, programs have to develop strategies for incorporating suggestions, keeping open and active communication with families, and providing feedback to parents about how their ideas have been integrated into the daily functioning of the program (Nabors, Lehmkuhl, & Weist, 2003).

Meeting with educators and school staff is critical in identifying resources and gaps in service provision. This can be done through interviews, focus groups and more informal strategies. Focus groups as a method for gathering information from educators have become an increasingly popular method of data collection in schools (Williams & Katz, 2001). Using a forum for gathering information that is embedded within the concept of creating a team has been documented to have greater results in schools (NCREL, 1995). When accessing teachers and other related staff to share information and resources, it is important to be aware of time constraints as well as group dynamics. For the focus group to be effective, there should be a clear purpose, a small number of members, specific goals, and leadership (NCREL, 1995). Questions should be prepared ahead of time and include only open-ended questions. The members selected for participation (5-7 people) should be diverse and allow for all viewpoints of staff (Osher, Dwyer, & Jackson, 2003). Information gathered should focus on the needs of the school community, strengths, resources and on-going initiatives, and possible solutions to the needs. Furthermore, it is important to understand participants' impressions of the services (if they have been provided in previous years) and to ask about how other programs get implemented and sustained at the school to facilitate planning.

These opportunities for information gathering and sharing also address an issue that impacts the effectiveness of programming. Rappaport, Osher, Garrison, Anderson-Ketchmark, & Dwyer (2003) argue that professionals from different backgrounds and orientations may conceptualize student strengths and difficulties differently, have different professional "jargon", orientations, and responses to behavior that should be clarified early in the development of a relationship. They state that without clearly understanding other professionals' ways of being in the world and clearly establishing roles issues of turf and reluctance to engage in collaborative problem solving may occur. Furthermore, there may be difference expectations and priorities for students that will be only be made explicit through intensive discussions with teaching staff.

Upon completion of the focus groups, provide timely feedback to the administrator about the strengths and opportunities for programming and with the administrator develop an information dissemination plan. This plan should include an action plan which establishes the foundation for implementing programming in a comprehensive and coordinated manner (Osher, Dwyer, & Jackson, 2003).

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Resources for this Quality Indicator

- Annenberg Institute for School Reform, Tools for school improvement planning (www.annenberginstitute.org/tools/tools/index.htm)
- Center for Effective Collaboration and Practice, Resources on collaboration and comprehensive planning for services for children (www.air.org/cecp)
- Center for Mental Health in Schools, Parent and Home Involvement in Schooling; School-Family Partnerships (http://smhp.psych.ucla.edu)
- The Center for Health and Health Care in Schools – Children's Health Collaboration (www.healthinschools.org/collaboration.asp)
- Comer School Development Program (http://info.med.yale.edu/comer)
- Community Partnerships, Tools for needs assessments
- (www.communitypartnerships.health,gov.au/cpkpdfs/cpktbl.pdf)
- Community Toolbox, University of Kansas. Assessing Community Needs and Resources (http://ctb.ku.edu/tools/en/chapter_1003.htm)
- The Federation of Families for Children's Mental Health, Policy information (http://www.ffcmh.org/policy.html)
- Focus Groups (www2.edc.org/NTP/focusgroups)
- Institute for Responsive Education, Stakeholder involvement (www.responsiveeducation.org)
- National Assembly of School-Based Health Care (http://www.nasbhc.org/TAT/Principles_and_Goals.htm)
- National Education Association (www.nea.org/parents)
- National PTA. Developing a Parent/Family Involvement Policy (http://www.pta.org/)
- NCREL, Needs assessment for professional development (www.ncre.org/pd/needs.htm)
- Small School Project, Overview and guide for focus groups with sample tools and guidelines (www.smallschoolsproject.org/PDFS/focusgroups.PDF)
- Social Development Research Group, Research on effective practices and interventions that impact youth development (www.depts.washington,edu/srdg)
- *What Do Youth Want to Do? A Youth Needs-Assessment Process for Communities,* in Journal of Extension (http://www.joe.org/joe/1997february/tt1.html)

5) Do you have services in place to help students contend with common risk and stress factors?

Some common risk factors that have been documented in the literature include grade failure, medical conditions, teen pregnancy, familial substance use, inconsistent rules and structure, limited positive adult role models, high incidences of community violence and substance use, and limited community resources (Department of Health and Human Services, 1999). There are many potential stressors on students that could be the focus of purposeful programming by ESMH staff. These include high levels of violence, bullying and/or teasing, being in foster care, living with chronic illnesses, having family members who are sick, losing loved ones, coping with familial substance abuse, and recently entering the school, as a few examples. The realm of mental health services has experienced a paradigm shift; providers and programs are being encouraged to focus more on fostering resiliency and less on identifying pathology (Engle, Castle, & Menon, 1996). Resilient individuals are more likely to be able to withstand stress and

avoid negative outcomes. Some individual factors have been shown to act as protective factors for children and adolescents (Engle, Castle, & Menon, 1996; Rutter, 1987; Weist, 1997). These include being easy to get along with, having good social skills, feeling empathy, having a positive and optimistic outlook, taking responsibility for his/her actions, having a sense of personal identity, having a strong sense of what is right and wrong, having defined goals for the future, believing in one's self, asking for help, having good problem-solving skills, and being proactive.

There are also some protective factors that lie outside of the student in his or her home, family, school, and community. Research demonstrates that there are three main characteristics in each of these environments that are important in fostering resiliency (Baldwin et al., 1993; Garmezy, 1991; Wandersman & Nation, 1998; Weist et al, 1995). These are caring relationships with adults who support the students and model healthy behavior, family cohesion, positive and high expectations that the student will succeed, and opportunities for meaningful participation in relevant, engaging activities.

Over the past few years, federal initiatives have facilitated the growth of school-based mental health programs (Paternite, 2005). The majority of students who receive mental health services obtain these services within the schools, therefore making schools a key setting for mental health prevention and intervention programs (Paternite, 2005). Schools can be an important place to offer protective factors and to reduce a youth's risk level (Rutter, 1987). General interventions to promote resiliency include starting after school programs, clubs and recreational opportunities, connecting children at risk with mentors, encouraging volunteer opportunities, and supporting positive relationships between the students and school staff. Specific programming to address these stress and risk factors includes: 1) focused interventions that can be provided by clinicians during individual meetings with students or their families, 2) structured group interventions, and 3) interactive presentations to larger groups of students (e.g., in classrooms) (Zimmerman & Arunkumar, 1994).

In addition to building students' assets and protective factors, there are strategies and interventions that have been developed to reduce the impact of risk on student outcomes. For example, there is extensive research in the realms of substance abuse, drug prevention, aggression reduction that teaching students problem solving strategies in a systematic and comprehensive manner has long-term benefits for student outcome (Greenberg, 2004). Meta-analyses of substance abuse, mental health, violence and antisocial behavior, and social and emotional learning (Durlak & Wells, 1997; Gottfredson & Wilson, 2003; Greenberg et al, 2001; Zins et al., 2004) have demonstrated the positive outcomes that universal and targeted intervention programs may have on reducing problem behaviors and symptoms while simultaneously improving children and youths coping strategies. The programs that have had the greatest success have been developmentally appropriate and have significant intensity and support to promote change over time. These programs frequently include a skill building component that can be taught in the classroom and school-wide with additional supports provided for children at-risk or currently experiencing mental health issues. Many of the programs that address one of these issues have significant positive impacts on the other risky behaviors due to the interrelatedness of risk in youth (Dryfoos, 1997).

Services that link universal and targeted interventions are still relatively rare in the schools. Fast Track (Greenberg, 2004) provides a unique model for the provision of services to at-risk students while promoting the health of all of the student population. This was accomplished through the establishment of a universal prevention program layered with supportive services (e.g., family outreach, small group support services, mentoring) to provide students with the skills and strategies to be successful. Another example of the types of services that could be developed is that of the Yale New Haven Primary Prevention Project that linked paraprofessionals with at-risk students, developed multidisciplinary teams, and coordinated services both within and outside the school to provide a continuum of care of students. Based on these models, programming at schools should include a significant skill building component and also address the school climate while providing individual students with opportunities to learn, practice, and model new skills to promote their success in school and in life.

Johns (2002) argues that there are multiple components that are critical for the success of programming that address students' risky behaviors in a school based context. Specifically, programming should incorporate knowledge of the school and community environments, identify political, social, or related environmental issues which may impact the success of the program, involves families/community members, intervenes at multiple levels, is coordinated, focused on teacher and parent training, and has an establish quality assurance and evaluation mechanisms with the data being used to improve practices. This argues for the ESMH clinician to develop collaborative relationships with stakeholders in the school to develop programming that reduces the impact of risky behavior on student outcomes and provides them with the skills to be more successful.

There are a number of programs that have been developed that address students' risky behaviors. These resources provide information about evidence-based programs that could be adopted by ESMH clinicians to address mental health concerns (e.g., depression, anxiety, school failure, exposure to violence). When developing and implementing programs, it is critical to assess the stressors and assets of the school, community, family and youth to ensure the implementation of effective programming.

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Resources for this Quality Indicator

- Turning the corner from risk to resiliency: A compilation of articles from Western Center News by Bonnie Benard, November 1993 (http://www.nwrel.org/index.html)

- Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA), *Model Programs for Substance Abuse Intervention* (http://www.samhsa.gov/centers/csap/modelprograms)
- Collaborative for Academic, Social, and Emotional Learning (CASEL), Reviews universal and selected prevention programs for social and emotional learning (http://www.casel.org)
- Institute of Medicine (IOM) report, *Reducing risks for mental disorders: Frontiers for preventive intervention research* (1994; edited by Patricia J. Mrazek & Robert J. Haggerty). Reviews effective preventive interventions across the lifespan. Executive summary of report available for free by writing: Institute of Medicine, Committee on Prevention of Mental Disorders, 2101 Constitution Ave. NW, Washington, DC 20418; full volume available for sale at National Academy Press, 2101 Constitution Ave. NW, Box 285, Washington, DC, 20055 or call (800) 624-6242. You can also read the report at the IOM website: http://www.iom.edu/ (click on "recent reports", then scroll down to 1994).
- Office for Juvenile Justice and Delinquency Prevention, *Blueprints for violence prevention* (1998). Sponsored in conjunction with the Center for the Study and Prevention of Violence (CSPV) at the University of Colorado (Director: Delbert Elliott, Ph.D.). Treatments and preventive interventions to address youth aggressive and violent behavior (www.colorado.edu/cspv/blueprints/)
- Handouts for students and parents on mental health problems
- (http://www.nimh.nih.gov/practitioners/patinfo.cfm)
- Bright Futures in Practice: Mental Health (2002), resources on mental health of children in a developmental context with information on early recognition and intervention (www.brightfutures.org/mentalhealth/index.html)

6) Are you matching your services to the presenting needs and strengths of students/families after initial assessment?

In matching services, clinicians should also consider when it is appropriate to end formal treatment or significantly reduce the frequency of sessions if goals have been met. A willingness to discharge patients from formal treatment is critical to be able to maintain capacity and can also reduce dependence on therapy. A discharge can be a positive and empowering event for children and families if used strategically.

Research conducted into the efficacy of mental health clinicians treating children in a non-research clinical setting found little or no evidence of change (Weisz et al., 1995), whereas several meta-analyses published between 1985 and 1995 demonstrated the efficacy of treatment of children in university sponsored research settings (Casey & Berman, 1985; Hazelrigg et al, 1987; Weisz et al., 1987; Kazdin et al., 1990; Baer & Nietzel, 1991; Grossman & Hughes, 1992; Shadish et al., 1993; Weisz & Weiss, 1993; Weisz et al., 1995). These findings suggest that interventions provided in a non-research setting were less effective than those provided through a research protocol. A variety of factors have been suggested to account for the gap, including less attention in real-world settings to careful matching of patients with treatments, less adherence to a treatment protocol, and less follow-up care (U.S. Department of Health and Human Services, 1999). Current best practices recommend a careful matching of an evidence-based treatment to the client's diagnosis, as this improves outcomes (McClellan & Werry, 2003; Weisz, Weiss & Donenberg, 1992; Remschmidt, 2003). Therefore, it is crucial that ESMH staff be

knowledgeable about which evidence-based practices are most likely to work for which types of problems, that they are familiar with developing evidence-based treatment plans, and that they are receiving quality supervision to ensure the most effective treatment plan possible. Indicator 13 provides a discussion of choosing an evidence-based treatment based on presenting problems and adapting it for use in your school. In a literature review that specifically evaluated research in school-based mental health, Rones and Hoagwood (2000) concluded that there were some strong school-based mental health programs that demonstrated evidence of impact across a range of emotional and behavioral problems. Critical features of implementation in these programs were consistent program implementation, inclusion of parents, teachers, or peers, use of multiple modalities, integration of program content into general classroom curriculum, developmentally appropriate program components.

Given that ESMH programs should provide a full continuum of services from prevention activities to intensive treatment, deciding what the best intensity is for a given student or family can be challenging. In general, staff should provide services that reflect the least intrusive strategy given presenting needs. Ideally, this means that therapy services should be reserved for youth who present with legitimate, more concerning mental health diagnoses, and/or are contending with significant stress. For these students with more serious mental health needs, research suggests that there is a dose-response relationship between the number of sessions and the amount of improvement, demonstrating that attending more than 8 sessions will be associated with better outcomes (Angold et al., 2000). Students with less intensive needs can be seen for one to three focused sessions, in which the focus is on problem-solving, providing encouragement and direction, and helping them connect with resources and appropriate programs. Similarly, students with less intensive needs may benefit from participation in a skills training or prevention group program (see indicator 4).

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Resources for this Quality Indicator

- Addressing Barriers to Learning, (Center for Mental Health in Schools, http://smhp.psych.ucla.edu)
  This book demonstrates how assessment results can be used in planning evidence-based interventions and monitoring the outcome of treatment.
- Bazelon Center for Mental Health Law - Principles for the Delivery of Children's Mental Health Services
  http://www.bazelon.org/issues/managedcare/jk/jkprinciples.html
- The Center for Health and Health Care in Schools - Organizing Mental Health Services for Children

http://www.healthinschools.org/mhs3.asp

- Center for Mental Health in Schools, Screening/Assessing Students: Indicators and Tools. http://smhp.psych.ucla.edu)
- *Treatment of Children with Mental Disorders* http://www.nimh.nih.gov/publicat/childqa.cfm
- The Evaluation Center at HSRI Publications and Materials
  "Objectives Based Treatment Plans" November 2001
  "Written Treatment Plans and Mental Health Outcomes" March - April 2000
  http://tecathsri.org/pubs.asp?search=tecscript#results

Principle 3: Programs and services focus on reducing barriers to development and learning, are student and family friendly, and whenever possible, are based on evidence of positive impact.

7) Do you receive ongoing training and supervision on effective diagnosis, treatment planning and implementation, and subsequent clinical decision-making?

ESMH programs should offer a full continuum of services from prevention, such as substance abuse and violence prevention programs, to intervention such as addressing clinical depression and anxiety through individual and group treatment. Although prevention occupies a significant presence in ESMH programs, staff should be well trained and educated in assessing and identifying issues that require indicated treatment. In order to provide effective treatment, it is important for staff to be well educated and trained on mental health diagnoses, recognizing both problems associated with diagnoses and appropriate uses (Acosta, Tashman, Prodente, & Proescher, 2002). It is important for clinicians to understand the necessary criteria behind each diagnosis. Once diagnoses have been assigned, the clinician can seek out best treatment strategies and protocols associated with that diagnosis. Best practice guidelines related to empirically supported interventions, specific diagnoses, and clinical practices have been developed and are readily accessible (e.g., American Academy of Child and Adolescent Psychiatry, n.d.; Center for School Mental Health Analysis and Action, 2003; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). While diagnoses can be helpful in determining effective treatment practices and in communicating with colleagues, diagnoses can be problematic if they are assigned primarily to meet fee-for-service demands. Programs that operate under a fee-for-service revenue structure often need to have a DSM-IV (American Psychiatric Association, 1994) Axis I diagnosis in order to receive reimbursement (Lever, Stephan, Axelrod, & Weist, 2004). It is under circumstances such as these that the danger of overdiagnosis becomes a greater issue. ESMH staff should examine protocols and procedures within their program to determine what checks are in place in order to ensure that a bias is not occurring and that all diagnoses are valid. Red flags of problems include: many youth receiving the same diagnosis, diagnoses being made based on interviewing with students alone (e.g., without talking to family members and school staff), "traitlike" conceptions of diagnosis, and limited efforts to assess environmental issues (e.g., in the home, school, neighborhood). Furthermore, significant thought needs to be given to initial treatment planning, and on an ongoing basis the clinician and the supervisor should be questioning: How is this student proceeding toward treatment goals? Is each of these goals still relevant? Are there other more important issues that need to be addressed? Is treatment proceeding systematically so that goals are progressively being resolved toward the appropriate closure of this case? Is therapy proactive or has it become reactive? (Beutler, 2000). Treatment planning and clinical decision-making are among the most important areas of clinical competence, and these should be a special focus of training. Training books and manuals can help clinicians develop effective treatment plans and can offer suggestions and strategies for implementing treatment (see Antony & Barlow, 2002; Jongsma et al., 2000; Jongsma, Peterson, & McInnis, 2000). Training should include review of biases and how they influence ongoing decision making, using evidenced-based strategies in care, effective diagnosis formulation and treatment planning, and ongoing monitoring and evaluation of student progress to ensure that services are matching presenting needs (Burns, 2003). This can be accomplished through training and supervision, which can

occur both formally and informally. Informal avenues for training and supervision include clinicians forming peer supervision and support groups, journal and book clubs, and co-leading groups with other professionals. More formal avenues include attending professional conferences and workshops, engaging in scholarly activities (research and grant writing), and through one-to-one supervision with a more experienced clinician (Spence, Wilson, Kavanagh, Strong, & Worrall, 2001).

Many clinicians believe that on-site one-on-one supervision is needed to improve their clinical skills, is the best form of professional development, and is the ideal way to provide meaningful evaluation and feedback. The process of supervision is designed to enhance skills in clinical practice and organizational functions with the overarching aim of providing optimal services to clients (Spence et al., 2001). Ongoing supervision and training is necessary for clinicians to maintain and enhance their skills and practices as the knowledge base is advanced (Barnett, Youngstrom, & Smook, 2001). As Evans & Weist (2004) state, sufficient supervision is necessary in order for school practitioners to continue utilizing empirically supported treatments and techniques that are documented as effective. With regard to ESMH practice, it is helpful if the supervisor is familiar with working in a school setting, can help the clinician with any gaps in training related to effectively working in schools, can provide advice on how to best collaborate within a system, particularly with incorporating treatment into the classroom, can understand the implications of diagnoses within the special education system, and can assist in developing realistic and effective treatment recommendations within a school setting (Stephan, Davis, Burke, & Weist, in press).

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Resources for this Quality Indicator

- American Academy of Child and Adolescent Psychiatry (http://www.aacap.org/clinical/parameters/index.htm)
- Center for School Mental Health Analysis and Action, Empirically Supported Interventions in School Mental Health (http://csmha.umaryland.edu/how/res_packets.html)
- Promising Practices Network, Proven and Promising Programs. (http://www.promisingpractices.net/programs_all.asp)
- U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Promising Practices in Early Childhood Mental Health (http://mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/practices.asp)
- U. S. Department of Health and Human Services, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda (http://www.surgeongeneral.gov/topics/cmh/childreport.htm)

8) Do you conduct screening and follow-up assessments to assist in the identification and appropriate diagnosis of mental health problems?

Mental health screening can occur at many levels, from school-wide implementation to individual implementation. Screening for mental health concerns can be a powerful means to identify students in need of services in schools. The importance of screening is recognized in the President's New Freedom Commission on Mental Health Report (2003) which specifically recommended increased screening for suicidality and mental illness. The commission specifically encouraged the development of screening programs that were voluntary and conducted with explicit parental consent. Within schools, there are long-standing policy controversies related to broad mental health screening, including questions about how appropriate large-scale screening is for mental health, a concern about the costs (financial and liability) of screening relative to the benefits, and questions as to whether schools are the most appropriate venue for screening efforts (Center for Mental Health in Schools, 2005). Arguments for screening in schools, include having the ability to access large number of students in a natural setting, to reach students who may not otherwise have been identified or referred, to provide services before symptoms worsen and become more costly to the system and have more negative impact on the student, and to inform the allocation of therapeutic resources which could help reach students most in need and help to improve the school environment by reducing barriers to learning and increasing student success (Center for Mental Health in Schools, 2005, Friedman, 2006, Weiss and Cunningham, 2006).

One example of a large scale school screening program is the Columbia University TeenScreen Program (see www.teenscreen.org). The goal of this program is to offer all parents the option to have their child participate in voluntary mental health check-up with the hope of improving early identification of mental health problems, including depression and suicidality. Once screened, parents of children found to be at risk would be notified and would be provided assistance with connecting with local mental health resources for further assessment and treatment. The New Freedom Commission Report (2003) recognizes TeenScreen as a model program.

Screening students early can help to identify those students who would benefit from services and prevent the development of more serious problems and difficulties. With this expectation that students will require less intensive interventions if early identification of problems and difficulties occurs, screening aims to improve cost effectiveness. Investing in effective prevention and mental health promotion will assist the school and community in achieving desired outcomes from students and as mentioned before, reduce future costs (indicator 25). Screening in schools promotes the concept that evaluating children's mental health is just as important as evaluating their academic abilities and physical health (Weiss & Cunningham, 2006).

Beyond large scale screening and assessment efforts, clinicians can use screening tools and assessment measures to evaluate students referred for counseling services. A thorough diagnostic assessment includes multiple methods of gathering information (i.e. clinical interview, observations, formalized assessments), multiple informants (i.e. client, parents, caregivers, teachers, primary care physician), and assesses functioning across multiple domains (school, home, social). Further, assessing risk factors, strengths, and the full spectrum of

symptomatology is important for ensuring a comprehensive evaluation (House, 2002; McConaughy, 2005). Research has found that some measures are more likely to incorrectly identify students as at risk, but less likely to miss at risk students and therefore, it is important to use appropriately standardized and relevant measures (Weiss & Cunningham, 2006). An accurate assessment is necessary to move treatment in the right direction, ensuring the most positive outcomes for students and their families. One concern with evaluation measures is the cost associated with purchasing measures. There are several excellent child mental health related assessment measures that are in the public domain and can be downloaded for no cost. A list of some free measures and how to access the information online is included in the Resource section.

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Resources for this Quality Indicator

- Center for Mental Health in Schools, Screening Mental Health Problems in Schools (http://www.smhp.psych.ucla.edu)
- Center for School Mental Health Analysis and Action, Suicide Prevention in the Schools, available free online, www.csmha.umaryland.edu
- Center for Epidemiological Studies Depression Scale for Children (CES-DC), free from http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf
- Child Dissociative Checklist (CDC) Version 3, free from http://www.energyhealing.net/pdf_files/cdc.pdf
- Columbia University Teen Screen Program, http://www.teenscreen.org/
- Impairment Narrative Description of Child (home and school versions), free from http://128.205.76.10/Impairment.pdf
- Parent/Teacher Disruptive Behavior Disorder Scale, free from http://128.205.76.10/DBD.pdf

- Spence Children's Anxiety Scale (self-report for children and adolescents), free from http://ww2.psy.uq.edu.au/~sues/scas/
- Strength and Difficulties Questionnaire (parent, teacher and self-report versions for youth ages 3-17 years), free from http://www.sdqinfo.com/ba2.html
- Vanderbilt Scales (ADHD Assessment)-free from http://www.nichq.org/resources/toolkit/

9) Do you continually assess whether ongoing services provided to students are appropriate and helping to address presenting problems?

When creating a treatment plan for a new student/family, the clinician must keep several important factors that determine treatment in mind. First, the clinician must complete an accurate assessment, and will want to use a combination of formal and informal assessment measures to determine presenting needs. In filling out these assessments, the clinician will need to not only involve the student, but also the parent and other important adults in the student's life. Second, from the assessment, the ESMH clinician will determine whether or not diagnosis is warranted for the student. If the student does have a diagnosable mental health problem, then the treatment plan should generally be driven by empirically supported practices and treatment for that particular diagnosis. If the student does not have a diagnosable mental health problem other supports (e.g., prevention groups, mentor groups, support groups) may be offered to this student and his/her family. Third, the ESMH clinician must then determine the appropriate frequency (once a week, once a month, etc.) and type (individual, group, family, etc.) of treatment. Finally, the treatment must be planned and implemented in a way that takes into account the student's and family's strengths, is culturally-appropriate, involves other relevant professionals and community resources, involves the family and is feasible. This treatment plan should be revisited throughout the treatment process to make sure the goals are being met.

Significant thought needs to be given to treatment planning, and on an ongoing basis the clinician should be questioning: How is this student proceeding toward treatment goals? Is each of these goals still relevant? Are there other more important issues that need to be addressed? Is treatment proceeding systematically so that goals are progressively being resolved toward the appropriate closure of this case? Is therapy proactive or has it become reactive?

It is widely recognized that in order to continually provide better service for mental health clients, there is a need to monitor and assess the quality of care of these services (U.S. Department of Health and Human Services, 2001). The 2001 Surgeon General's National Action Agenda on Children's Mental Health included the following action step: "Engage professional boards for mental health specialists to require training in: evidence-based prevention and treatment interventions; outcome-based quality assurance; competency-based assessment and diagnostic skills; and principles of culturally competent care. This step also calls for engaging youth and families as partners in assessment, intervention and outcome monitoring." (U.S. Department of Health and Human Services, 2001). The Committee on School Health (2004) recommends using quality assurance strategies to ensure appropriate services are received (i.e parent and student satisfaction surveys, evaluation of the school health program, etc.) Assessments of a program should be ongoing and occur at several different levels. Ongoing assessments create a continuous feedback loop in which services are delivered, evaluated, modified and redelivered. This process is called continuous quality improvement (CQI).

Elements of this process should include assessing and modifying relationships between providers and consumers. Data on these processes should be continually collected and analyzed. These same principles and procedures hold for assessing individual quality of care for each student in active treatment. Clinicians should be regularly evaluating students' progress toward treatment goals using standardized measures (e.g., CBCL, Conner's, Strengths and Difficulties Questionnaire) to document change in an objective manner.

Further, clinicians should also ask their clients and the client's families to evaluate the progress of treatment. When the Federation of Families for Children's Mental Health asked family-run organization leaders from around the country what outcomes of treatment families value, the responses can be characterized by one great desire that all of the families share: "Families want their children to get better." In the long run, families want their children with mental, emotional, or behavioral disorders "to be able to live at home, to go to school and get good grades, to enjoy friends and activities in the community, and become responsible adults living independently" (Osher, 1998). If clinicians use these goals as their own goals for treatment and standards for success, we can more heavily rely on the family's perception of change in determining treatment outcome. An analysis of the effectiveness research on school-based psychotherapy indicates that school-based clinicians seem to be most effective when they use group and behavioral therapy and interventions that target observed behaviors and problem-solving abilities (Prout & DeMartino, 1986). In other words, clinicians are more effective when their clients make changes that can be observed by others, including teachers and parents. More recently, Hoagwood and colleagues (1996) developed a more comprehensive model to look at outcomes of treatment for children and adolescents - the SFCES model. The SFCES model evaluates five domains: (1) symptoms, (2) functioning (adaptation to home, school, or neighborhood), (3) consumer perspectives (e.g., satisfaction with care, impact of family), (4) environments (stability of home, school, or neighborhood), and (5) systems (level of service, type of service, cost effectiveness). This model for evaluating outcomes for the students participating in ESMH programs is clearly superior to looking at symptoms alone, though it has seldom been used (Hoagwood & Erwin, 1997).

One problem that plagues all child mental health efforts, including ESMH programs, is the tendency to continue to work with clients who have resolved their presenting issue but yet continue to demonstrate a strong interest in continuing services. While this is not necessarily a problem for students under chronic severe stress, staff needs to ensure that they are fostering independence and encouraging the student's reliance on other sustainable school and community resources (friends, family, clubs, religious organizations, sports, etc.). Clinicians also must ensure that they have room in their caseloads for students with more serious needs. Another strategy is to continuously be evaluating whether services for this student at this point in time truly represent therapy, or represent mentoring or case management. If the conclusion is that it is mentoring or case management, then ideas to be considered include referring the student to a program in the school, decreasing the frequency and time of visits, or involving the student in a leadership activity that would enable regular time with the clinician. The overall goal is to support the client in achieving independence and to make sure that we are providing services in the least restrictive manner (Weist & Ghuman, 2002).

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Resources for this Quality Indicator

- Center for School Mental Health Analysis and Action, "Quality Assurance and School-Based Mental Health Services" and "Advancing the Quality Agenda in Expanded School Mental Health" (http://csmha.umaryland.edu)
- The Evaluation Center at HSRI Publications and Materials, Dealing with Therapist Resistance to Outcomes, September - October 1999
- (http://tecathsri.org/pubs.asp?search=tecscript#results)
- "Learning From Colleagues: Family/Professional Partnerships Moving Forward Together" A product of the peer Technical Assistance Network, this 48-page monograph presents research and commentary on the issues involved in utilizing a family/professional partnership systems approach in situations involving children who have developed or are at risk of developing serious emotional, behavioral, or mental health disturbances and their families. (http://www.ffcmh.org/publications_books.html)
- Center for Mental Health in Schools, Evaluation & Accountability: Getting Credit for All You Do (http://www.smhp.psych.ucla.edu)
- Mental Health Service Systems at Health Canada
- (www.hc-sc.gc.ca/hppb/mentalhealth/sevice_systems.htm)
- Center for Evaluation and Quality – NASBHC (http://www.nasbhc.org/EQ/EQImprovement.htm)

- Center for Mental Health in Schools, Assessing to Address Barriers to Learning (http://smhp.psych.ucla.edu)
- Fast Track Project – Mental Health Tools (www.fasttrackproject.org)
- Australian Centre on Quality of Life – instruments (http://acqol.deakin.edu.au)
- National School Boards Association - Education Leadership Toolkit (http://www.hsba.org/sbot/toolkit/inex.html)

10) Is there a clear and effective protocol to assist your clinical decision making and care for more serious situations (e.g., abuse and neglect reports, self-reporting of suicidal/homicidal ideation)?

ESMH clinicians will be called upon to intervene and participate in interventions for a myriad of serious clinical issues, and it is important that staff members are trained and prepared to address these issues in a professional manner. ESMH programs must have clear procedures in place to review clinical decision making and care in emergent and serious presenting concerns such as disclosure of abuse or neglect, or self-report of suicidal or homicidal ideation.

Having a policy and procedures manual available to all clinicians can ensure consistency within programs when attending to clinical decision making (Kerr, 2003). In addition to any policies and/or procedures that may have been developed by ESMH programs, clinicians should familiarize themselves with local policies and legislation regarding these issues, as well as school-specific policies. All 50 states and the District of Columbia have laws and regulations that define child physical abuse, sexual abuse, emotional harm and neglect, and have a mandated system response. Individual states' Departments of Human Resources and/or Departments of Social Services can be contacted for specific policies. They generally have regarding abuse and neglect and reporting procedures. ESMH clinicians are mandated to report child maltreatment (Peterson & Urquiza, 1993).

An important component of the National Strategy for Suicide Prevention, developed as a collaborative effort involving SAMHSA, CDC, NIH, HRSA, and HIS, addresses the importance of clinical training and development of procedures regarding suicidal ideation. Goals of the initiative discuss the importance of clinical training for mental health workers, especially regarding recognition of at-risk behaviors and delivery of effective treatment. Recognizing that clinical training can have direct benefit on clinical outcomes, the initiative states that, "By improving clinical practices in the assessment, management, and treatment for individuals at risk for suicide, the chances for preventing those individuals from acting on their despair and distress in self-destructive ways are greatly improved" (Department of Health and Human Services, 2001; Goal 7; see also National Strategy for Suicide Prevention, 2001). Therefore, ESMH programs should develop policies and procedures to assess and treat serious situations.

Regarding ESMH program capacity to assess clinical decisions regarding serious presentations, the U.S. Department of Health and Human Services (DHHS) recognizes the importance of careful emotional and cognitive processing with supervisors and other clinicians as an important aspect of quality control and also as a way to prevent burn-out (Gentry, 1994). Concerning the adoption of evidence based treatment plans and assurance of proper implementation of treatment protocol, researchers suggest that training clinicians, providing standardized intervention

protocols (e.g. suicidal and homicidal students), and administering on-going training and support reduces barriers that impede clinicians from using evidenced based protocols (Schaeffer et., al., 2005). ESMH procedures should support adequate time for supervision (DHHS, 1994; Peterson & Urquiza, 1993).

ESMH staff should proactively familiarize themselves with local policies and with resources that could be helpful in risk-assessment, treatment, and intervention (e.g., Kerr, 2003; Peterson & Urquiza, 1993). Gliatto and Rai (1999) suggest competent practice for screening suicide risk and determining whether to seek emergency psychiatric screening for suicidal clients. Common components of school crisis plans are: (1) prevention, (2) early intervention, (3) crisis intervention, (4) postvention or ongoing crisis response, (5) debriefing, and (6) evaluating the response and improving the plan (Kerr, 2003). Clinicians should seek experiences that will promote their comfort in conducting these activities or in making appropriate referrals. Clinicians' involvement in school-wide safety teams and planning committees can promote their visibility as an expert in times of crises and can ensure that they are part of a well-coordinated network.

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Resources for this Quality Indicator

Suicide

- American Academy of Child and Adolescent Psychiatry, Suicide Fact Sheet
- (http://www.aacap.org/publications/factsfam/chldabus.htm)
- Assessment of Suicidal Behaviors and Risk Among Children and Adolescents (http://www.nimh.nih.gov/suicideresearch/measures.pdf)
- A National Tragedy: Preventing Suicide in Troubled Children and Youth Tips for Parents and Schools, National Association of School Psychologists (http://www.nasponline.org/NEAT/syouth.html)
- National Strategy for Suicide Prevention (http://www.mentalhealth.org/suicideprevention/default.asp)
- American Association of Suicidology (http://www.suicidology.org/)

Child Abuse

- American Academy of Child and Adolescent Psychiatry, Child abuse and sexual abuse fact sheets (http://www.aacap.org/publications/factsfam/chldabus.htm)
- The American Professional Society on the Abuse of Children (APSAC) (http://www.apsac.org/)
- Safe Children – Strong Families (http://www.clinton-kids.com/Reporting%20abuse%20or%20neglect.htm)
- Child Abuse Prevention Network (http://child-abuse.com/)
- Prevent Child Abuse America (http://www.preventchildabuse.org/)
- Parents Anonymous (http://www.parentsanonymous.org/paIndex10.html), 800-421-0353
- Committee for Children (http://www.cfchildren.org/)
- National Center for Family Support (http://www.familysupport-hsri.org/)
- National Resource Center on Child Maltreatment (NRCCM) (http://nrccm.gocwi.org/)
- *Child Abuse and Neglect: The School's Response.* (2001). Connie Burrows Horton & Tracy K. Cruise. Guilford Publications (www.guilford.com) or 1-800-365-7006
- National Clearinghouse on Child Abuse and Neglect Information. The Clearinghouse is a national resource for professionals seeking information on the prevention, identification, and treatment of child abuse and neglect and related child welfare issues. (http://nccanch.acf.hhs.gov/index.cfm) State-specific reporting information: (http://nccanch.acf.hhs.gov/general/statespecific/index.cfm)

School Violence and Safety

- Center for the Prevention of School Violence. (http://www.ncdjjdp.org/cpsv/)

- ED/OESE Safe and Drug-Free Schools Program (http://www.ed.gov/about/offices/list/osdfs/index.html)
- National Association of School Psychologists (NASP), NASP safe school resources (http://www.naspcenter.org/safe_schools/safeschools.htm)
- National Child Traumatic Stress Network (http://www.nctsnet.org/nccts/nav.do?pid=hom_main)
- The National Resource Center for Safe Schools (http://www.safetyzone.org/index.html)
- Safe Schools Healthy Students Action Center (http://www.sshsac.org/index.asp)
- School Violence Prevention (http://www.mentalhealth.org/schoolviolence/default.asp)
- The U.S. Department of Education (http://www.ed.gov/admins/lead/safety/edpicks.jhtml?src=qc)
- School Crisis Prevention and Response Initiative. (http://info.med.yale.edu/chldstdy/CDCP/interventions/schoolcrisis.html)

11) Are you actively using the evidence-base (practices and programs) of what works in child and adolescent mental health to guide your preventive and clinical interventions?

There are many definitions of evidence-based practice; from strict research-based definitions involving the rigor of studies used to support a particular practice or intervention to those that emphasize at least some level of scientific support. We use the term *empirically supported* as a broader definition reflecting that all efforts are based on some scientific findings; within this broader context of using empirically supported approaches, we also use formally developed evidence-based interventions (e.g., manuals that have been shown to lead to positive impacts for students in schools through randomized controlled trials). Using this definition, two things are clear: 1) all ESMH staff should be using empirically supported approaches, and 2) with adequate training, support, ongoing technical assistance and supervision, ESMH staff should be striving to implement at least one evidence-based intervention each school year.

Through our experiences in research and practice in ESMH in Baltimore, we have developed an approach to empirically supported practice that involves four components: (1) reducing documented stress/risk factors in students' lives (e.g., exposure to violence, affiliation with acting out peers); (2) enhancing documented internal (e.g., reading for pleasure, helping others) and external (e.g., receiving support from positive adults, being involved in faith communities) protective factors in students' lives; (3) training youth and families in skills that have been shown to be associated with positive functioning in many studies (e.g., relaxation, problem solving, positive family management); and (4) using formally developed manualized approaches and modularized approaches to evidence-based practice with adequate training, supervision, support, and technical assistance as above.

In this work, we have found that areas 1-3 can be easily integrated into *all* assessment and intervention efforts. We have also learned that for 4 to occur, additional factors (beyond training, supervision, etc.) require attention. For example, the right manual-based intervention needs to be chosen. In general, this should be done through careful evaluation and decision making both by staff from the ESMH program and from school staff including the principal, other school leaders, school-employed mental health staff, and teachers. Once a manual is chosen, ongoing student and family input on the program and particular session content is

critical. To actually be able to implement the interventions, especially group interventions, ESMH will need considerable *pragmatic* support; for example, given adequate copies of materials (with copies regularly refreshed), offering assistance in recruiting students, and offering assistance in completing evaluations of the intervention (which are often required). One strategy that has proven helpful in our program in Baltimore is involving students in training (e.g., advanced undergraduates, graduate students) from disciplines including psychology, social work, and professional counseling.

The CSMHA has made a major commitment to promoting the use of evidenced-based practice in ESMH, and has organized a compendium on evidenced-based approaches that are appropriate for use in schools across the spectrum, from school-wide prevention to working with youth with established problems. Evidenced-based materials have been organized on specific topics such as preventing substance abuse onset, addressing disruptive behavior problems, and interventions for post-traumatic stress symptoms. Materials have been gathered based on several prominent literature reviews and dissemination initiatives (e.g., Center for the Advancement of Social and Emotional Learning, Institute of Medicine report, special issue of the Journal of Clinical Child Psychology) that are appropriate for use within schools/school mental health programs. The CSMHA has acquired treatment protocols, manuals, books, and other therapeutic resources from developers of the empirically supported interventions on this list. These materials have been summarized for quick reference by ESMH personnel and are available through the CSMHA's website (see http://csmha.umaryland.edu).

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Resources for this Quality Indicator

- Empirically-Supported Interventions in School Mental Health (Center for School Mental Health Analysis and Action, http://csmha.umaryland.edu)
- APA Empirically Supported Treatments (www.apa.org/divisions/div12/rev_est/index.html)

- Center For Substance Abuse Prevention, Model Programs (http://modelprograms.samhsa.gov/template.cfm)
- Center for Evidence-Based Practice, Young Children with Challenging Behavior (http://challengingbehavior.fmhi.usf.edu/resources/fixsen-etal-may03.html#9)
- Evidence-Based Practice in Child and Adolescent Mental Health Services Kimberly Hoagwood, Ph.D. (http://psychservices.psychiatryonline.org/cgi/reprint/52/9/1179)
- Georgetown University Center for Child and Human Development, Data Matters Newsletter (http://gucchd.georgetown.edu/datamatters6.pdf)

Principle 4: Students, families, educators, and other important groups are actively involved in the program's development, oversight, evaluation, and continuous improvement.

12) Have you helped your school develop an advisory board (including youth, families, administrators, educators, school health staff and community leaders) for its mental health programs?

In an article in *The American School Board Journal*, it was reported that in order "to strengthen public acceptance, health centers have found it useful to form community advisory boards that participate in policy and planning and give support and feedback" (Hurwitz & Hurwitz, 2000). Similar to school health centers, school mental health programs also benefit from community support and guidance and are dependent on stakeholder involvement and buy-in to be successful and accepted by the school and larger community. The term stakeholder refers to "individuals, agencies, and groups who have some stake or investment in the development, implementation, and evaluation of a given endeavor" (Lever, Adelsheim, Prodente, et al., 2003, page 150). Key stakeholder groups for ESMH include: youth, parents or guardians, teachers and school administrators, school and community mental health staff and administrators, local and state government officials, staff from other child-serving agencies, community leaders, faith leaders, business leaders, employees and leaders of civic organizations, funders, and child and family advocates (Acosta, Tashman, Prodente, & Proescher, 2002; Lever et al., 2003; Nabors, Weist, Tashman, & Myers, 1999; Waxman, Weist, & Benson, 1999). Including stakeholders outside of the education, health, and mental health fields highlights the need for the whole community to work together to help its children and families.

Paternite & Johnston (2005) conclude that engaging educators in collaborative partnerships to promote the mental and academic success of students is absolutely crucial in order to make certain that these efforts produce warranted results. The title "Educator" not only pertains to teachers, but also should include policy makers, administrators, and other supportive staff (Paternite & Johnston, 2005). Therefore, stakeholders involved should come from varying disciplines and professions. The importance of meaningful collaborations and worthwhile partnerships is discussed and supported in a variety of research (Paternite & Johnston, 2005, Hodges, Nesman, & Hernandez, 1999, p. 14, Acosta et al., 2002). Relevant stakeholder groups may not initially realize that they share a common interest with ESMH programs and that they too could benefit from the presence of such a program. In order for these partnerships to succeed, identification of common goals and interests is an important part of the process to foster stakeholder participation. One strategy to increase participation among stakeholders is to explicitly identify common goals and interests, thus bringing together a diverse group that shares a common goal. Successful collaborative relationships require different groups to come together to work as a team towards a common vision and a shared set of goals (Center for Mental Health in Schools, 2003; Friend & Cook, 1990).

Schools, families, and communities share goals related to improving education and the psychosocial functioning of youth. They must all collaborate with one another in order to maximize resources and results while minimizing problems and duplication of services (Taylor & Adelman, 2000). No one program or stakeholder group can realistically handle all of the mental health needs of a given community (Acosta et al., 2002). In the Executive Summary

describing promising interagency collaboration practices for grantees funded by the Federal Center for Mental Health Services as part of the Comprehensive Community Mental Health Services for Children and Their Families Program, one participant described it best by saying "Partnerships aren't a luxury, they're essential because the problems are too big and too complex" (Hodges, Nesman, & Hernandez, 1999, p. 11).

Combining the skills and knowledge of each of the stakeholder groups can enhance the understanding of available resources and can improve the overall system of care. While all stakeholder groups are important to the process, perhaps the most critical stakeholders to meaningfully include in program development and improvement processes are children and families. In fact, in the Executive Summary describing promising collaboration practices, it was stated that "the emergence of families as full partners in systems of care is the key to true and lasting collaboration" (Hodges, Nesman, & Hernandez, 1999, p. 14). Ideally, mental health programs involve school and community stakeholders in the original planning process. Meaningfully involving key stakeholders in the planning of an ESMH program may increase the level of commitment and support that the stakeholders will have towards the program once it is in place (Acosta et al., 2002). Key stakeholders in the planning process can be included in later advisory boards and can offer insight into the development of the program. School mental health advisory boards are supportive committees that typically do not control hiring/firing decisions or financial concerns, but instead are designed to "advise, inform, and make recommendations to the programs they serve" (Ambrose, Weist, Schaeffer, Nabors, & Hill, 2002, p. 104). School and community stakeholders can also continue to help ensure that the program addresses community needs (Nabors et al., 1999). Stakeholders are needed on a continual basis and can assist ESMH programs in ongoing assessment of community needs and available resources, helping to refine the ESMH vision and mission, helping to create special programs to address needs within schools and communities, developing quality assessment and improvement guidelines and protocols, making program improvement recommendations, and helping to secure additional funding (Acosta et al., 2002, Ambrose et al., 2002).

One way in which ESMH programs can monitor whether they are being responsive to the needs of the larger community is to receive guidance from an advisory board that is comprised of representatives from key stakeholder groups. ESMH programs that operate in multiple schools need to take steps to ensure that each school's EMSH services are tailored to meet the specific needs of the community it is serving. To help accomplish this personalizing of services for each school and community, it can be helpful to have representation from each community on the program-wide advisory board and to also consider having smaller school-wide steering committees/advisory boards that can report to the larger advisory board (Hogenbruen, Clauss-Ehlers, Nelson, & Faenza, 2003). The National Mental Health Association (2000) identified the following key aspects of successful involvement and participation by stakeholders: (1) broad representation of stakeholders: consumers, families, families of young children, advocacy groups, and the non-provider public; (2) cultural competency; (3) a fair and open selection process; (4) on-going training; (5) on-going logistical support and needed respite care; (6) adequate and timely information and staff support to allow for in-depth consideration of complex issues; (7) open meetings, on a regular schedule, and in a location and setting convenient and welcoming to stakeholders who desire to attend; (8) open meetings fostering meaningful and respectful dialogue among stakeholders and decision makers; (9) broad dissemination of minutes

and reports to affected stakeholders, and (10) staff follow-up to assure that stakeholders are informed of the results of meetings and that the results are effectively disseminated for maximum impact.

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Resources for this Quality Indicator

- Center for Mental Health in Schools, Working Collaboratively from School-Based Teams to School-Community-Higher Education Connections (www.smhp.psych.ucla.edu/ under Introductory Packets)
- Healthy People.Com (http://www.health.gov/healthypeople/state/toolkit/)
- Center for Effective Collaboration and Practice (http://www.air.org/cecp/promisingpractices/1998monographs/documents.htm#6)
- National Mental Health Association (http://www.nmha.org/position/ps3.cfm)
- Community Toolbox, University of Kansas, Involving Key Influentials in the Initiative (http://ctb.ku.edu/tools/en/section_1083.htm)

13) Do you collaborate closely with your school administrator and offer numerous opportunities for recommendations, feedback, and involvement in program development and implementation?

Principals are critical to the success of the ESMH program. They have the ability to expand the program and ensure that it becomes embedded in the daily functioning of the school or to decide that there are other ways that they want to allocate resources. Principals also provide leadership for forging partnerships and creating the vision of the school's response to students' social, emotional, and mental health needs. When ESMH clinicians have effective working relationships with the principal of the school, there is the opportunity for greater impact of the programming, as well as access to the principal's rich sources of knowledge about the school and student community (NCREL, 1995). Leadership in schools has been linked to student learning through promoting a vision and goals and ensuring that resources are in place so that teachers are able to teach well (Leithwood & Riehl, 2003). The level of involvement of the leader has repeatedly been linked to the success of the changes at the school, teacher satisfaction and retention and sustainability of programming (Elias et al., 2003; Jorissen, 2002; Kam, Greenberg, & Walls, 2003). Research has demonstrated that when administrators who are also providers,

were compared to administrators who are not providers, provider administrators were more likely to rate the statement, "Stakeholders are involved in the program's development, oversight, evaluation, and continuous improvement", as very important to advancing best practice in school mental health (Weist et. al., 2005). Perhaps, because of their involvement in the treatment process, they had a greater appreciation of the impact of effective collaborations on treatment process and outcomes (Weist et. al., 2005).

Involving school administrators in the day-to-day functioning of a program ideally begins before the program even enters into a school setting. Involving administrators from the inception of a program and including them in the planning process increases the likelihood that the program will address relevant concerns and will be well-received and supported by the planning team members and the larger community (Bickham, Pizarro, Warner, Rosenthal, & Weist, 1998; Nabors, Weist, Tashman & Myers, 1999). Opportunities for collaboration with administrators exist at all stages of ESMH programs (e.g., planning, program development and implementation, program evaluation) (Lever, Adelsheim, Prodente et al., 2003). Collaboration in the planning stage may include forming a planning team that will help to ensure that the unique school and community needs are understood and incorporated into the school mental health programming plans.

One of the primary goals of the planning team will be to develop mission and vision statements for the school mental health program and to define objectives for the initiative. These statements and objectives will need to be sensitive to diverse stakeholder groups and will need to fit into the ecology of the school and community (Prodente, Sander, & Weist, 2002). The creation of this mission statement and clear objectives to achieve the mission can have long-lasting impact on the day-to-day functioning of the program. The planning team will help provide some guidance in developing the overall structure of the program and can impact the policy and procedures of the program, including professional roles and responsibilities (Acosta, Tashman, Prodente, & Proescher, 2002).

Another way to involve administrators in the day-to-day operations of a program is to include them in the evaluation process. Administrators can assist in the development of a quality assessment and improvement (QAI) measure and can also serve on QAI teams for the school at large or for the school mental health program. The goals of a QAI team may include developing and implementing strategies for assessing service utilization and effectiveness (Lever et al., 2003). Finally, involving administrators in discussions of modifying and improving program services and training based on overall evaluation findings is another way to encourage involvement (Acosta et al, 2002).

Developing a supportive relationship with principals has been found to be enhanced through the development of clear expectations about the scope of services provided by the ESMH clinicians and establishment of clear policies and procedures that are in compliance with both education and mental health policies (Acosta, Tashman, Prodente, & Proescher, 2002). Negotiating these issues up front prior to any school crises will ensure that there is clear communication and planning in place to facilitate the needs of students. Relatedly, when making programming decisions, being open and communicative with the principal to ensure their support is necessary. Principals often are governed by mandates that the ESMH clinician needs to be aware of to

ensure that the services being provided in the classrooms and school-wide are reflective of these issues. These mandates may be used to bolster the programming of SMH clinicians as recent federal funding requires the implementation of evidence-based programs and the best practices (see www.ed.gov for Principles of Effectiveness which all schools with Department of Education funds must adopt).

Strategies for effective reform and change in schools have documented key factors that support innovation in schools (Osher, Dwyer, & Jackson, 2003). Specifically, change is most likely to be adopted if there is: 1) existing teams to create a common vision and adhere to the vision, 2) staff buy-in and support, 3) long-term planning and perspective-taking, 4) capacity building, 5) efficient use of resources, 5) a culture of support, and 6) supportive leaders. By building relationships with principals, ESMH clinicians are working to establish the long-term viability of the programming and ensuring the programming is responsive to the needs of the school and the broader community. Osher, Dwyer, & Jackson (2003) argue that efforts for reform will not be effective without the authority to act, which is granted from the principal. They state that "support comes from the school community and must be earned by the way your team acts and the way it involves the members of the school community" (p. 11). Building this relationship will occur over time with the establishment of clear expectations and understanding of the scope of the programming as well as a willingness of the ESMH clinicians to be appropriately responsive to identified needs that impact the social, emotional, and mental health of students.

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Resources for the Quality Indicator

- Association of Curriculum and Development, Educational leadership materials (www.ascd.org)
- Bazelon Center for Mental Health Law, Article on effective school-based interventions for children with mental or emotional disorders (www.bazelon.org/issues/children/publications/suspending/suspendingdisbelief.pdf)
- California Center for Effective Schools, Description of key components of effective schools (http://effectiveschools.education.ucsb.edu/correlates.html)
- Center for Mental Health in Schools (http://smhp.psych.ucla.edu, under Policy Issues and Research Base, Integrating School and Community)

- Comer School Development Program (http://info.med.yale.edu/comer; http://www.med.yale.edu/comer/about/parent.html)
- Edweek, Resource to be aware of initiatives impacting schools) (www.edweek.org)
- Institute for Educational Leadership (www.iel.org)
- Learning First Alliance, Materials on NCLB and resources to implement the legislation (www.learningfirst.org)
- National Association of Elementary School Principals, The ABCs of Children's Mental Health (www.nasponline.org/pdf/ABC_NAESP.pdf)
- National Association of Secondary School Principals, Materials on supporting teachers and creating nurturing mentoring relationships (www.nassp.org/publications)
- National Education Association (http://www.nea.org/parents/schoolinvolve.html)
- National Parent Information Network (NPIN) (http://ericps.ed.uiuc.edu/npin/npinhome.html)
- National PTA (http://www.pta.org/parentinvolvement/bsp/index.asp; http://www.pta.org/parentinvolvement/standards/index.asp)
- North Central Regional Educational Laboratory, Leadership learning (www.ncrel.org/cscd/)

14) Do you participate in methods or activities (e.g., meetings, focus groups, surveys) to obtain feedback on an ongoing basis from key stakeholders on how the program is functioning and how it can be improved?

As previously mentioned, the term stakeholder refers to individuals, agencies, and groups who have some stake or investment in the development, implementation, and evaluation of a given endeavor (Lever et al., 2003). Key stakeholder groups for ESMH programs include: youth, parents or guardians, teachers and school administrators, school and community mental health staff, school and community health staff, local and state government officials, staff from other child-serving agencies, community leaders, faith leaders, business leaders and workers, employees and administrators of civic organizations, funders, and advocates. A variety of avenues exist for exploring and obtaining feedback from stakeholders on how the program is functioning. This feedback is often obtained using peer review teams, focus groups/talking circles, questionnaires/ surveys, and key informant interviews (Acosta et al., 2002; Gilliam et al., 2002). Peer review teams can involve having clinician's review each other's work and evaluate therapy process and success. Using peers versus outside evaluators can be less intimidating to team members (Ambrose, Weist, Schaeffer, Nabors, & Hill, 2002). Focus groups/talking circles can be used to pull together key stakeholders to ask key questions related to their experiences and perceptions related to a given topic. With other stakeholders present, there are opportunities to interact and respond to each other's reactions (Nabors, Ramos, & Weist, 2001). Another way to gather the information is through developing questionnaires or surveys that ask respondents to self-report their feedback about the program. A popular means of obtaining feedback from stakeholders is to have them complete a satisfaction survey that assesses their satisfaction with services, processes, and/or program structure. This method can easy lend itself to data analysis and can be used with a large number of individuals in person, by mail, or by computer. Questionnaires may allow for increased anonymity when compared to the other strategies. Lastly, feedback can be obtained through structured or semi-structured interviews with stakeholders. Interviews can be developed to cover key topic areas and can be standardized in implementation (Nabors, Lehmkuhl, & Weist, 2003). Informal avenues include participating on

interdisciplinary teams in the school and the community, attending community meetings and forums, and directly asking stakeholders during appointments about their opinions of the program (e.g., How is it received in the community? Are services helping you? How can the program improve?) (Lever et al., 2003). Asking stakeholders for their input helps to build collaborative relationships and may result in improved relevance of the program's mission and goals and greater acceptance of and referrals to the program. Evaluation data related to how a program is functioning can be critical to the funding of a program. In this day and age of increasing accountability, being able to document impact is critical for securing and sustaining funding, informing and influencing policymakers, and successful advocacy (Acosta, Tashman, Prodente, & Proescher, 2002; Ambrose, Weist, Schaeffer, Nabors, & Hill, 2002; Lever et al., 2003).

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Resources for this Quality Indicator

- Academic Development Institute, School Community Journal (http://www.adi.org/journal.htm under Recommendations for Research on the Effectiveness of School, Family, and Community Partnerships)
- Center on School, Family, and Community Partnerships (http://www.csos.jhu.edu/p2000/center.htm)
- Coalition for Community Schools, Community Schools Assessment Checklist (http://www.communityschools.org/pubs.coal.html under Strengthening Partnerships)
- Community Toolbox, University of Kansas, A Framework for Evaluation: A Gateway to Tools (http://ctb.ku.edu/tools/en/sub_section_main_1338.htm); Conducting a Focus Group (http://ctb.ku.edu/tools/en/sub_section_main_1018.htm)

15) Do you engage in efforts to ensure that stakeholder ideas and recommendations are actually implemented in a timely manner?

Quality assessment and improvement activities are recommended to be continuous and evolving in improving mental health care (Zarin, West, & Hart , 2001). Continuous quality improvement (CQI) involves the "systematic assessment and feedback of evaluation information about planning, implementation, and outcomes to improve programs" (Chinman, Imm, & Wandersman, 2004, p. 137). Effective CQI involves incorporating stakeholder feedback and suggestions in a timely manner into the program to improve ongoing implementation of the program. Giving stakeholders the opportunity to express their views can be valuable in and of itself; however, these groups may develop negative feelings if they believe their ideas are not being translated and integrated into the program. Stakeholders ideally are helping to "advise, inform, and make recommendations" to programs to ensure that program services are compatible with other services and accepted into the larger school/community system (Ambrose, Weist, Schaeffer, Nabors, & Hill, 2002). In her work to create new alliances between Philadelphia Public Schools and key constituencies (e.g. community organizations, faith-based institutions, families, and institutions of higher learning), Rochelle Nichols-Solomon, Senior Program Director of the Philadelphia Education Fund, pointed to the fact that many parents feel like meetings held with school officials serve only to blame and admonish them rather than to seek solutions and improve meaningful collaboration. This can lead to feelings of apathy and frustration on all sides and will likely reduce the willingness to collaborate with school-based activities and programs in the future (Nichols-Solomon, 2001). Parents are not the only stakeholders who become frustrated when their feedback and suggestions do not lead to any visible changes. ESMH programs need to be mindful of the need to maintain a positive and collaborative environment with stakeholders through meaningful discussions and incorporation of their ideas and recommendations (Center for School Mental Health Analysis and Action, 2002). One way to help encourage action is to develop at the start of an initiative "maintenance plans," for continued collaboration (e.g., who, how often, where, and for what purpose will meetings occur) (Berkowitz, 2003). It is also important to regularly monitor progress and how to maintain momentum (Center for Mental Health in Schools, 2001). The maintenance plan can include strategies such as the need to take clear notes and distribute minutes from each meeting that outline progress on how key ideas are being transformed into action. Setting up clear objectives, timelines, and action plans and reporting progress back to the stakeholders can

increase the likelihood that ideas will be translated into actual practice in a timely manner (Berkowitz, 2003). Including diverse stakeholders from a broad array of groups/organizations in all three stages of development (e.g., planning, implementation, and evaluation) can help ensure that community needs are always represented. Developing strategies for meaningful participation of stakeholders in program planning, development, and evaluation can increase a sense of ownership for and commitment to the program (Lever, Adelsheim, Prodente, et al., 2003). This enhanced involvement can help encourage individuals to push the team forwards towards action. Other strategies to enhance the likelihood of action include making a commitment to implementing at least one idea from every meeting and providing updates on the status of recommendations through mail, e-mail, and newsletters (Coalition for Community Schools, n.d.). Setting clear deadline goals for each goal to be implemented can also help programs remain on task. To maintain stakeholder investment, key strategies from stakeholders need to be acted on within a reasonable time period. If key ideas are not being implemented by clinicians and its administrators, a time analysis (e.g., how are clinicians and administrators across the program spending their time) can be completed. This exercise can highlight the problems of why the ideas are not being implemented and the team can work with stakeholders to improve the situation through potentially refining and then implementing an action plan (Fairchild & Seeley, 1995).

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Resources for this Quality Indicator

- Center for Mental Health in Schools, Organizational Facilitators: A Change Agent for Systemic School and Community Changes (http://smhp.psych.ucla.edu/dbsimple2.asp?primary=1401&number=9999)
- Center for School Mental Health Analysis and Action, Program Development Packet (http://.csmha.umaryland.edu);
- Coalition for Community Schools, Sustainability Planning Checklist (http://www.communityschools.org)
- Community Toolbox, University of Kansas (http://ctb.ku.edu/tools/en/sub_section_main_1058.htm)
- National Center for Family Support (http://www.familysupport-hsri.org/resources/index.html)
- W. K. Kellogg Foundation. Evaluation toolkit. http://www.wkkf.org/Programming/ResourceOverview.aspx?CID=281&ID=770

16) Are you providing training and educational activities for families, educators, and other stakeholder groups based on their recommendations and feedback?

In order for ESMH programs to be successful, it is important that training programs be provided for families, teachers, and other stakeholders on increasing awareness of mental health concerns and risk factors, and strategies for fostering resilience. Jivanjee & Friesen (1997) state that to promote successful interactions, mental health professionals when partnering with stakeholders should try to develop mutually agreed upon goals, shared responsibility, open and honest communication, and sharing of information. When developing trainings, it is an opportunity to share information, empower stakeholders, and develop more collaborative relationships. Involving families, teachers, and other stakeholders in planning trainings can ultimately increase the extent to which the training is meaningful and can help to promote positive outcomes in children (Lowie, Lever, Ambrose, Tager, & Hill, 2003).

The University of Washington, School of Nursing published a study that examined the effect that parent and teacher training programs have on student compliance. The study demonstrated that the provision of training programs for both parents and teachers were, in fact, successful in producing higher levels of compliant behavior in students. After one year of participation in the program, 80% of children identified as high-risk in the experimental group had moved to low-risk, while only 40% of those identified as high-risk in the control group moved to low-risk. Improvements were also noted in teacher and parent performance as recorded through observations for those who had taken part in the training (Webster-Stratton et al., 2001). This is but one example of the efficacy of involving parents and teachers in training programs in improving student outcomes.

When ESMH programs include training for parents, teachers, and other stakeholders, it is important to consider how to motivate participation. In a recent study regarding participation and drop-out rates among low-income urban families of color in a prevention intervention program, the researcher found that parents who remained in the program expressed that their own personal goals matched those of the program. In addition, 90% reported that the personality and trustworthiness of the program staff contributed highly to their continued participation (Gross, 2001). Thus, while training programs have been proven to be effective, ESMH staff need to bear in mind that training programs need to meet the expressed needs of the participating stakeholders. This can be accomplished by seeking input from these groups on their perceived needs and interests. The best way to make certain that the training programs meet the needs of the families and teachers is to have the stakeholder groups develop the schedule and topics of training programs, as well as participate in shaping the agendas of the meetings. You may want to access the families on your advisory board for guidance but be sure to target a broader audience. For example, you may want to conduct a needs assessment for the families and teachers, including both topics for trainings and convenient times. Each training may need to be offered more than once (e.g., once in the morning and once in the evening or over a weekend) to accommodate working families, and you will need to offer incentives to participation (e.g., food, child care, transportation, graduation, etc.; Kumpfer, Alvarado, Smith, & Bellamy, 2002). It is also essential to choose training programs with a proven track record of effectiveness which will help improve participation through parents seeing positive results from participating in the program. Kumpfer & Alvarado (2003) reviewed 35 programs with proven effectiveness and identified 13 basic principles that should be applied in implementing any family training.

Many ESMH clinicians find using multiple ways of reaching teachers and families to be the most effective, since there are many different adult learning styles, time constraints, and levels of need for each family or teacher being served (Webster-Stratton, 1994). If families identify, for example, sleep problems as an area for training, you may find it necessary to include articles on sleep problems in your newsletter that goes out to parents, send home brochures to parents who request further information, and offer a multi-media training session or two on getting your child or adolescent to sleep better. In one preschool/elementary school, the ESMH clinician hosted a morning coffee stand once a week where teachers and parents could stop by and enjoy free coffee, tea, and danishes (donated by a coffee shop), speak informally with the clinician, express needs, and get brochures or other information. This has been a great way to engage families and teachers in a non-threatening/non-judgmental way and to promote communication. Another school had difficulty with demoralization among the teachers. These teachers elected to have a

teacher roundtable once a month, which was led jointly by the ESMH clinician and the lead teachers. This roundtable served many functions: sometimes the teachers would request training on a topic of interest, sometimes the teachers would just provide support for each other during difficult times. Sometimes this teacher group was able to bring about system change. Teachers often do not receive adequate training in the mental health of children or in mental health in general. Opportunities for teachers to receive training and additional support around mental health can help enhance classroom management of children with mental health concerns and would greatly facilitate mental health promotion in the schools (Weist, 2005).

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Resources for this Quality Indicator

- Center for Mental Health in Schools (http://smhp.psych.ucla.edu)
- The Alliance National Center, technical assistance and training packages for parents, 1-888-248-0822, alliance@taalliance.org

- *Handbook of parent training: Parents as co-therapists for children's behavior problems, 2nd Edition* (1997) by James M. Briesmeister & Charles E. Schaefer (Editors) ISBN: 0-471-16343-0, Jossey-Bass, Wiley. (http://www.josseybass.com/WileyCDA/)
- *Defiant children, second edition: A clinician's manual for assessment and parent training* by Russell A. Barkley (1997). Guilford Publications, (http://www.guilford.com)or 800-365-7006
- University of South Florida Research and Training Center, Presentation on home, school, and community Partnerships (http://rtckids.fmhi.usf.edu/rtcpresents/al_krista_training/CCBD_2_14_Tampa_new_withtena.pdf)
- Research and Training Center on Family Support and Children's Mental Health Family involvement in mental health services (http://www.rtc.pdx.edu/pgProjParticipation.php)

Principle 5: Quality assessment and improvement activities continually guide and provide feedback to the program.

17) Are your efforts and activities being guided by an active and effective quality assessment and improvement plan that other school mental health clinicians and stakeholders (school staff, families, community) are aware of?

Programs should be developed strategically and should be guided by an active and effective quality assessment and improvement plan (Chinman, Imm, & Wandersman, 2004). Plans should specify who will do what, when, and where as well as how programs will be evaluated, how findings will be shared, and to what extent and in what manner feedback will be incorporated into the program. Ideally quality improvement activities should be ongoing and have a continuous feedback loop in which services are delivered, evaluated, modified, and redelivered in an ongoing cycle. This process is called continuous quality assessment and improvement (CQI) and it is increasingly gaining popularity and acceptance as a means of best practice in evaluation in the health and mental health fields (Chinman, Imm, & Wandersman, 2004; Dickey, 2001; Zarin, West, & Hart, 2001) and more specifically in expanded school mental health (Ambrose, Weist, Schaeffer, Nabors, & Hill, 2002; Nabors, Lehmukl, & Weist, 2003). Purposeful activities to enhance program quality will benefit the program in many ways, including increasing its acceptance in the school, increasing support from others in the school and community, improving services, facilitating the documentation of positive outcomes, and providing accountability data that can assist with funding, advocacy, and outreach efforts (Fairchild & Seeley, 1995; Nabors, Weist, Holden, & Tashman, 1999; Nabors Weist, Tashman, & Myers, 1999; Weist, Nabors, Myers, & Armbruster, 2000).

There is a continuum of quality assessment and improvement activities, including: (1) Addressing structural elements, such as ensuring that staff are well qualified, offices are adequate and enable private interactions, and school administrative staff support relationship development and referral processes. Structural evaluations also assess the extent to which the fundamental components behind a program including mission statements, vision, program objectives, and standards are being achieved. (2) Procedural elements of the clinician's work, such as how information is conveyed to school staff, how referrals are handled, how many students are referred and seen, how quickly students are seen, and feedback provided to referring staff. Procedural elements also include an evaluation of the process of therapy, supervision, and rapport and relationships between the clinician and key stakeholders. (3) Specific activities undertaken to better understand the needs of students, families, and the school, such as conducting satisfaction surveys, holding focus groups, hosting talking circles and discussion groups, and conducting structured interviews. (4) Focused quality improvement activities based on quality assessment findings, such as team analysis and problem-solving in developing new services, or enhancing linkages with community resources. (5) Systematic efforts to understand the impact or outcome of services, such as collecting measures of students academic and behavioral functioning before and after services. Outcome findings are often critical to funders and policy makers as a means of documenting impact. (6) Broadly and continuously seeking input from diverse stakeholders to increase support and progressively improve the program, such as provided through active advisory boards (Center for School Mental Health Analysis and Action, 2001; Nabors, Weist, Holden, & Tashman, 1999; Nabors Weist, Tashman, & Myers,

1999; Weist, Nabors, Myers, & Armbruster, 2000). ESMH programs need to develop and have readily accessible to staff and stakeholders a clear quality assessment and improvement plan. This plan should be consistent with the mission and vision statement of the program and should be responsive to ongoing feedback and guidance. It should also include clear objectives, timelines, and feedback mechanisms (Berkowitz, 2003).

Unfortunately, there is a tendency for quality assessment and improvement plans to be created and then left on a bookshelf in an administrator's office (Hernandez, Hodges, & Cascardi, 1998). Instead, best practice suggests that these plans should be highly visible and shared with key stakeholders who can regularly inform the program in a highly dynamic and interactive process about their perspectives on the plan and how to incorporate key feedback into practice (Organisation for Economic Co-Operation and Development, 2001). Involving key stakeholders in reading and improving quality assessment and improvement plans is a strategy for meaningfully involving stakeholders that may increase a sense of ownership of and commitment to the ESMH program and the services it provides (Lever, Adelsheim, Prodente, et al., 2003). In particular, ESMH programs and clinical staff should strive to make sure that school-hired mental health professionals, school administrators, and teachers are aware of the plan, able to access it, and have a clear mechanism available to provide feedback. Sharing the plan and discussing key aspects of service delivery and evaluation with these stakeholders can help to reduce confusion over roles and services, and can help enhance true collaborative efforts (Waxman, Benson, & Weist, 1998)

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Resources for this Quality Indicator

- Center for School Mental Health Analysis and Action; Program Development, Quality Assessment and Improvement (http://csmha.umaryland.edu/how/res_packets.html)

- Center for Mental Health in Schools, Evaluation and Accountability Related to Mental Health in Schools, A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning (http://smhp.psych.ucla.edu)
- Community Toolbox, University of Kansas. Using Evaluation to Understand and Improve the Initiative (http://ctb.ku.edu/tools/en/chapter_1047.htm)
- The Evaluation Center. Checklist and Tools for Use in School Evaluations. (http://evaluation.wmich.edu/resources/schooleval/)
- Rand Corporation. Getting to Outcomes (http://www.rand.org/publications/TR/TR101/)

18) Have you been well trained in paperwork requirements for the program and do your records clearly reflect delineated policies and procedures?

In this day and age of increased accountability, it is critical that programs have a clear and defined paperwork process that is consistent with clinical, legal, financial, institutional, and accrediting association regulations (American Psychological Association, 1993). Many school-based programs are affiliated with hospitals, universities, community mental health centers, and outpatient mental health centers and may need to abide by their documentation regulations (Lever, Stephan, Axelrod, & Weist, 2004). At times these regulations may be quite complex and may be contradictory. It is critical that directors of school mental health initiatives work to integrate the various requirements into a user-friendly document or manual that can be used to train clinicians in paperwork and be available to be referenced. Clinicians should not have to be burdened with trying to negotiate paperwork requirements and should be given clear and concise guidelines. Programs should strive to streamline paperwork in order to maximize service delivery and minimize burden on clinicians and patients (Lever et al., 2004). ESMH program should be engaging in quality assurance activities by appropriately documenting the services provided by the program. Programs should explicitly define documentation procedures during an orientation, as well as provide a policy and procedures manual for clinicians (Acosta, Tashman, Prodente, & Proescher, 2002; Center for School Mental Health Analysis and Action, 2003). Supervisors can monitor ongoing documentation in supervision and chart reviews, and peer-review processes can be used to help maintain and improve the quality of records (Ambrose, Weist, Schaeffer, Nabors, & Hill, 2002). At a minimum, documentation of clinical services should include date, reason, and source of referral; appropriate consent and release of information forms; session contact notes; intake and assessment forms; treatment plans, and record of discharge. It is also important for providers to document the total number of services provided in the school by the school mental health program (e.g. total number of referrals, number of students seen, individual, group and family contacts, collateral contacts, teacher consultations, team meetings, and school wide activities) (Center for School Mental Health Analysis and Action, 2003). Benefits of having a clear paperwork trail include: enhanced ability to document utilization and impact of services, a reference to use in treatment and in clinical supervision, improved preparedness to be accountable to funders and relevant auditing/oversite entities, and an increased focus on delivering clearly defined and goal oriented treatment (through treatment plan development and implementation) (Ambrose et al., 2002; American Psychological Association, 1993; Smith, 2003). Clear documentation procedures and policies that are compatible with best practice and professional ethical guidelines help to reduce liability concerns for clinicians when there are legal and ethical proceedings (American Psychological Association, 1993).

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Resources for this Quality Indicator

- American Psychological Association (http://www.apa.org/practice/recordkeeping.html)
- Center for School Mental Health Analysis and Action, Program Development Resource Guide (2003) (http://csmha.umaryland.edu/how/respackets/html)
- Center for Mental Health in Schools, Evaluation and Accountability Related to Mental Health in Schools (http://smhp.psych.ucla.edu)
- Center for Mental Health in Schools, Evaluation Accountability: Getting Credit for All You Do (http:///smhp.psych.ucla.edu)
- US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, (http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA01-537/chapter3.asp)

19) Are you ensuring that families are meaningfully involved in treatment planning and ongoing therapy efforts?

Family collaboration in educational and mental health service provision has emerged as a crucial factor in the success and treatment acceptability of interventions with youth (NASP, 1999). The Surgeon General's Report on Mental Health posits that "families have become essential partners in the delivery of mental health services for children and adolescents" (U.S. Department of Health and Human Services, 1999, p.18). Prior conceptualizations of children's mental health viewed family systems as causes and maintainers of problems. However, contemporary educational and ESMH initiatives ask that families be brought into the treatment process as change agents, as well as viewed as key collaborators in treatment by ESMH staff (Comer & Haynes, 1991; Cowen et al., 1996; Lowie, Lever, Ambrose, Tager, & Hill, 2003; Stoep, Williams, & Huffine, 2002).

From the onset of treatment, ESMH staff need to prioritize family involvement for all cases. It should be standard practice to involve families in assessment and in the development and implementation of treatment plans (Bickham, Pizarro, Warner, Rosenthal, & Weist, 1998; Lowie et al, 2003). Strategies for facilitating meaningful family involvement must be creative and flexible in order to address the multiple needs of students, family members, clinicians, school staff, and other stakeholders. Strategies that can facilitate family involvement include: 1) providers being flexible and creative; 2) programs taking time to assess the needs of the families it serves; 3) providing resources for families; 4) recruiting staff who are enthusiastic about working with families; 5) involving families early in the assessment process; 6) allocating resources necessary to promote family involvement; and 7) ensuring that methods of communication with families are active and take advantage of multiple methods (e.g., phone, home visits, school meeting; Bickham et al., 1998; Lowie et al., 2003). Additionally, clinicians need to appreciate the cultural differences among families in order to provide the most meaningful and acceptable treatment (Center for Mental Health in Schools, 1996).

It is also important for ESMH clinicians to understand and anticipate potential barriers to successfully involving families. Barriers can be practical or psychological and can reside in the perspectives of various stakeholders (Bickham et al., 1998; Lowie et al., 2003):

- Student Concerns
- Students, particularly adolescents, may not want family involvement in mental health treatment
- Students often desire to conceal certain mental health issues (e.g., substance use, sexuality)
- Volatile family relations (e.g., family violence, abuse, conflict)
- Family Concerns
- Some routines/responsibilities take precedence over mental health services (e.g. work)
- Unavailability of childcare or transportation
- Fear of being blamed for child's issues
- Concerns about being spoken to in a condescending manner (or with mental health "jargon")
- Concerns about confidentiality of information
- Stigma associated with seeking mental health care

- Clinician Concerns
- Fear that family involvement will slow down and/or complicate treatment process
- Concern that family involvement will negatively impact therapeutic relationship (particularly if family relations are strained)
- Clinician unaccustomed to sharing control with or recognizing expertise of family members
- Lack of clinician training to facilitate family involvement
- Clinician time demands hinder ability to engage families

Additional programmatic barriers to family involvement include lack of resources (e.g., funding, staffing) to provide evening/weekend appointments, child care, or transportation. Further, in poorly performing schools, there may be tension between families and schools. In such situations, schools may not be welcoming of families. Parents who had problems in school may avoid school visits and appointments due to negative memories (Bickham et al., 1998; Lowie et al., 2003).

Studies have demonstrated that actively engaging families in the treatment process from the beginning results in better attendance and follow-through with children's mental health services. Strategies to actively engage families can include reminders about missed appointments, intensive family-focused telephone engagement, establishing rapport, identifying and problem-solving potential obstacles to follow-through, and intensive first interview engagement (summarized by McKay, 2004). Family engagement is bolstered by clinicians' training and support (McKay, 2004).

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Resources for this Quality Indicator

- Federation of Families for Children's Mental Health (http://www.ffcmh.org)
- McKay presentation on Family Engagement (http://rtckids.fmhi.usf.edu/rtcconference/17thconference/17th_handouts/pdf/Session%2052/McKay-HoagSym.pdf)
- National Center for Family Support (http://www.familysupport-hsri.org/)
- Center for Mental Health in Schools, Parent and Home Involvement in Schools (http://smhp.psych.ucla.edu/pdfdocs/parenthome/parent.pdf)
- Research and Training Center on Family Support and Children's Mental Health (http://www.rtc.pdx.edu)
- NW Regional Educational Laboratory, School Improvement Research Series http://www.nwrel.org/scpd/sirs/3/cu6.html

20) Are peer review mechanisms in place for you to receive feedback from other staff on the way you handle cases and/or the way you implement preventive and clinician interventions?

ESMH clinicians have a clear responsibility to constantly improve and evaluate the quality of their services. In recognition of this fact, organizations such as the Royal College of Psychiatrists, a professional and educational body for psychiatrists in the United Kingdom, have developed what they call comprehensive systems of review against clinical governance

standards. These systems are careful to include both self-review processes as well as peer-review processes (Royal College of Psychiatrists, 1999). ESMH clinicians who hold professional licenses probably went through a peer review process to obtain those licenses, and most professional organizations and state licensing boards have peer review processes in place to handle ethical and professional concerns. A submission to a journal for publication undergoes a peer review process, as does a grant application to a federal agency (i.e., National Institutes of Health, Department of Education). If the mental health field puts peer review as the highest standard for academic activities and ethics violations, couldn't a peer review process be advantageous if used more proactively for professional development and quality improvement?

The roles that peer-review can play in clinicians' attempts to improve service are numerous. A peer review process can take the form of chart reviews, quality improvement reviews, or may act as a local ethics review board. A peer review process may also be implemented in the more proactive form of group supervision. The structured peer group format has unique advantages in terms of skill development, conceptual growth, participation, instructive feedback and self-monitoring (Borders, 1991). Such a group might take the form of didactic presentations, a journal club, case conceptualization, initial assessment reviews, reviews of video tapes or sessions, role-taking activities, or be more open-ended. Group supervision is unique in that growth is aided by the interactions occurring between group members. The opportunity of collaborative learning is a key benefit of group supervision, with the group members having opportunities to be exposed to a variety of cases, interventions, and approaches to problem-solving in the group. The group supervision format requires that the group leader be prepared to use their knowledge of group process. The integration of knowledge and experience is greatly enhanced by group supervision (Werstlein, 1994). The incorporation of a peer-review process of any form into clinical practice could be expected to help meet the multiple challenges of providing quality services in ESMH. Thus, it is imperative that ESMH staff seek out such professional interactions and that ESMH programs incorporate procedures for peer-review of cases as well as prevention/mental health promotion programs into their policies and procedures. Peer review mechanisms are an important component to a QAI program.

The University of Maryland School Mental Health Program tried a peer review mechanism that was largely designed by participants. A group of eight clinicians conducted intensive case reviews for 11 randomly selected cases. The review was a two hour meeting focusing on three activities: Case presentation by clinicians, mutual problem solving and the development of recommendations by clinicians and reviewers, and feedback to clinicians by reviewers. Clinicians reported that they felt that the meetings were a supportive way to intensely review cases, generate new ideas for approaching cases, and for receiving peer support. Negative aspects included the amount of time and energy the reviews took, and having difficulty following through on the numerous recommendations made by the reviewers (Nabors, Acosta, Tashman, Higgins, & Weist, 1999, as cited in Ambrose et al., 2002).

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Resources for this Quality Indicator

- Fostering Counselors' Development in Group Supervision.
  http://www.ericfacility.net/ericdigests/ed372351.html

- The Royal College of Psychiatrists, Feedback on the Clinical Governance Self- and Peer-reviews
  http://www.google.com/u/rcpsych?q=peer+review

- The Royal College of Psychiatrists, Clinical Governance Support Service
  http://www.rcpsych.ac.uk/cru/cgss.htm

- ClinicalSupervision.Com, Clinical Governance and Clinical Supervision: working together to ensure safe and accountable practice
  http://www.clinical-supervision.com

21) Are you actively using an evaluation plan that provides measurable results to and helps to improve your preventive and clinical intervention efforts?

Documenting the impacts of services is critical to the success of any ESMH program. Evaluation strategies and tools are necessary in determining the efficacy of an ESMH program (Weist & Evans, 2005). Documenting program impacts not only allows clinicians to understand and improve their preventive and clinical efforts, it provides funders and community stakeholders with valuable information about the effectiveness of the program (Horsch, 1998). Numerous

strategies can be used to document impact, including: 1) documenting service utilization and productivity (e.g., population served, number of students referred and seen, number of therapeutic contacts, etc.); 2) obtaining satisfaction surveys and informal evaluation data by stakeholders affected by the program (students, parents, teachers, administrators); 3) holding qualitative forums, such as focus groups with stakeholders to gather their ideas on program impacts and recommendations for improvement; 4) measuring changes in students' academic functioning throughout services in realms such as grades, attendance, and discipline problems; 5) measuring changes in psychosocial functioning throughout program services, (e.g., emotional/behavioral problems, risk and protective factors); and 6) assessing school-level or system changes (e.g., level of aggression in the school, referrals to special education, school climate). Such evaluation strategies can be enhanced by comparing outcomes of students or schools receiving services to those not receiving services (or receiving alternate services).

Programs should evaluate their size, resources and experience in making determinations about the most appropriate strategies for evaluation. All programs can document productivity and conduct satisfaction surveys, while only large, well-experienced, and well-resourced programs might attempt more comprehensive evaluations involving comparison groups or the assessment of school or system changes. In order to ensure successful implementation of program evaluation, programs must provide adequate resources (e.g., funding for measures) and support (e.g., the availability of research assistants), and allot clinician time to focus on evaluation and quality assurance activities.

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Weist, M., Paskewitz, D., Warner, B., & Flaherty, L. (1996). Treatment outcome of school-based mental health services for urban teenagers. *Community Mental Health, 32*, 149-157.

Resources for this Quality Indicator

- Center for Mental Health in Schools, Evaluation and Accountability Related to Mental Health in Schools (http://smhp.psych.ucla.edu)
- Center for Mental Health in Schools, A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning (http://smhp.psych.ucla.edu)
- Center for School Mental Health Analysis and Action, The Evaluation Initiative (http://www.georgetown.edu/research/gucdc/eval.html)
- Center for School Mental Health Analysis and Action, Quality Assurance Resource Packet (http://csmha.umaryland.edu/how/res_packets/html)
- Technical Assistance Center for the Evaluation of Children's Mental Health Systems (http://www.jbcc.harvard.edu/evaluation.htm)

22) Are you sharing positive and negative findings from the evaluation of your services with youth, families, school staff, and other stakeholders?

Once data related to evaluating a school mental health program has been collected and analyzed, it should be strategically disseminated to stakeholder groups in a user-friendly manner that is easy to understand, relevant, and interesting (Nabors, Lehmkuhl, & Weist, 2003). According to researchers at the Harvard Family Research Project, the process of publicly reporting evaluation findings is critical in demonstrating accountability to stakeholders (Schilder, 1997). Key stakeholder groups should be identified early in the evaluation process in order to ensure meaningful data collection and dissemination (Acosta, Tashman, Prodente, & Proescher, 2002; Schilder, 1997). For example, given that school administrators and educators are critical in the successful establishment and maintenance of an ESMH program, it is important to collect and disseminate information relevant to schools (e.g., student academic performance and attendance, school climate, etc.). One example of how to share expanded school mental health findings with stakeholders can be found in the work of Nabors, Leff, and Power (2004). In their quality improvement activity, they shared results from the Youth Satisfaction with Counseling Questionnaire with clinicians and school staff and then held discussions on how to improve services. Schilder (1997) recommends that when sharing evaluation findings with stakeholders, programs should include the evaluation planning framework (vision), goals and objectives of the program, benchmark and targets, as well as indicators (measures of progress).

For over 20 years, the Mental Health Statistics Improvement Program (MHSIP) Policy Group has been working to develop standards for mental health data. MHSIP is supported in part by the Center for Mental Health Services. The group developed a mental health report card (MMHRC), a consumer-oriented approach to monitoring the quality of mental health service delivery (Teague, Ganju, Hornik, Johnson, & McKinney, 1997). Several strategies regarding sharing evaluation findings with stakeholders are recommended. The developers of the MMHRC recommend involving stakeholders in every stage of the evaluation and reporting process, and suggest that stakeholder focus groups be held following the dissemination of findings in order to inform future evaluation and dissemination efforts. The MHSIP Policy Group emphasizes the importance of sharing *both* positive and negative findings in order to promote ongoing improvement of the program and services. The literature specific to quality improvement in expanded school mental health programs is consistent with this recommendation and emphasizes that meaningful stakeholder involvement requires sharing both the positive and negative outcomes and should allow for active feedback and suggestions for how to use these findings to improve the program (Lever et al., 2003; Nabors, Lehmkuhl, & Weist, 2003)

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Resources for this Quality Indicator

- Center for Mental Health in Schools, Evaluation and accountability related to mental health in schools (http://smhp.psych.ucla.edu)
- Center for Effective Collaboration and Practice, Using evaluation data to manage, improve, market, and sustain children's services (http://www.air-dc.org/cecp/promisingpractices/2000monographs/documents2000.htm#2)
- Center for School Mental Health Analysis and Action, Quality assessment and improvement resource packet (http://csmha.umaryland.edu/how/quality_assessment_2001.pdf)
- Harvard Family Research Project, Evaluating school-linked services: Considerations and best practices; Overview of results-based accountability: Components of RBA **(**www.gse.harvard.edu/hfrp/pubs/onlinepubs/school-linked.html**,** www.gse.harvard.edu/hfrp/pubs/onlinepubs/rrb/overview.html)
- Technical Assistance Center for the Evaluation of Children's Mental Health Systems (http://www.jbcc.harvard.edu/evaluation.htm)
- The Mental Health Statistics Improvement Program Consumer-Oriented Mental Health Report Card Toolkit & Consumer Survey (http://www.mhsip.org/toolkit/) (http://www.mhsip.org/documents/MHSIPConsumerSurvey.pdf)

Principle 6: A continuum of care is provided, including school-wide mental health promotion, early intervention, and treatment.

23) Do you offer activities promoting school-wide mental health?

Related to many factors including the Surgeon General's reports on mental health (1999) and children's mental health (2000), the recent report of President Bush's New Freedom Initiative (NFI) on Mental Health (2003; www.mentalhealthcommission.gov), and increasing international collaboration (see www.intercamhs.org), there are increasing efforts in the U.S. to build broad mental health promotion and prevention and early intervention efforts for youth. In these efforts, schools are prominent in that they are the most universal natural setting. In fact, in the report of the NFI, there is an explicit recommendation (4.2) to "improve and expand school mental health programs."

However, in spite of these efforts, primary prevention (whole-school, before problems have begun) and secondary prevention (targeting youth who are stressed, at risk, or showing early signs of problems) remain limited in most schools. This is largely due to the absence of a prevention focus or funding mechanisms in the U.S. It is clear that for ESMH staff to be significantly involved in prevention, specific funding to support prevention activities is usually required. Given that this funding is either very limited or does not exist, the needs for advocacy and policy enhancement are underscored. Given the success of advocacy efforts, resources and a school and community priority on prevention, it becomes critical for ESMH staff to collaboratively decide with school-employed mental health and education staff where the responsibility falls for various activities and services along the prevention continuum. The importance of this collaborative approach to decision making and the launching of prevention initiatives cannot be understated.

In this atmosphere of resources and collaboration to build prevention in the schools, there is much that can be done school-wide. This includes ensuring the school environment is safe, that adults are interacting warmly and positively with students, and that there are welcoming resources for students and families (see http://smhp.ucla.edu). Much can also be done to enhance secondary prevention, including providing targeted intervention to youth and families based on the best science (see indicator #13) for a few sessions; working collaboratively with teachers to improve student behavior and classrooms, and conducting a variety of skill training groups.

The Center for School Mental Health Analysis and Action, with the assistance of Dr. Cindy Schaeffer of the University of Maryland, Baltimore County, has organized a compendium of empirically supported interventions for the schools, including preventive interventions. The compendium describes various prevention programs and how they can be obtained, and is available through the CSMHA (http://csmha.umaryland.edu**).**

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Resources for this Quality Indicator

- Center for School Mental Health Analysis and Action, Compendium of empirically-supported approaches that can be adapted for use within school mental health programs (http://csmha.umaryland.edu)
- Empirically Supported Treatment Documents (http://www.apa.org/divisions/div12/rev%5Fest/)
- National Research and Development Centre for Welfare and Health, Promotion of mental health of children and young people (http://www.stakes.fi/mentalhealth/work3.htm)
- Suffolk Health Authority, A Mental Health Promotion Strategy for Suffolk 2002-2005
- (http://www.suffolkmentalhealth.org.uk/1960/MH%20Strategy%20Booklet%20.pdf)
- Prevention Research Center for the Promotion of Human Development College of Health and Human Development, Preventing Mental Disorders in School-age Children: A Review of the Effectiveness of Prevention Programs (http://www.prevention.psu.edu/pubs/CMHS.html)
- Promoting Children's Mental Health within Early Years an School Settings (http://www.des.gov.uk/mentalhealth/pdfs/ChildrensMentalHealth.pdf)
- Colorado Department of Education: A Guide to School Mental Health Services (http://www.cde.state.co.us/cdesped/download/pdf/SMHguide.pdf)

24) Are you actively involved in developing and implementing training and educational activities for educators on the identification, referral, and behavior management of social/emotional/behavioral problems in students?

Meeting the mental health needs of students is a critical issue in the classroom, one that requires the collaboration of ESMH staff as well as teachers and administrators. An interdisciplinary team, involving teachers, should engage in several activities including developing procedures for the identification and referral of students needing assistance and coordinating the provision of prevention and intervention programs (Weist, et. al., (2006). Unfortunately, many classroom teachers are not trained to address the myriad of mental health issues brought into the classroom by their students (Adelman & Taylor, 2002; Waxman, Weist, & Benson, 1999). A report published by the Mental Health Foundation of the United Kingdom recommends a greater proportion of initial teacher training should be dedicated to the study of child development and mental health needs (The Mental Health Foundation, 2002). In recognition of this need, the CSMHA held a critical issues meeting entitled *Bridging the Gap Between Mental Health and Education: Developing an Effective Framework for the Translation of Mental Health into pre-K through Grade Twelve Classrooms* (2002). The meeting, which was attended by school-based mental health professionals, educators, and pre-service educators, initiated interdisciplinary dialogue addressing how to improve the training of educators in the realm of mental health.

Experience has shown that in order to better equip teachers to be collaborators when it comes to student mental health, it is important that ESMH staff are actively involved in developing and implementing training programs for education staff (Waxman, Weist, & Benson, 1999). There is a diverse array of beneficial training programs that ESMH staff can provide to education and other staff in the school. These include training on: (1) emotional and behavioral problems in students, including signs and behaviors presented in the classroom suggesting the need for

referral; (2) more intensive training on particular emotional or behavioral problems such as depression or post-traumatic stress disorder; (3) stress factors such as abuse/neglect, exposure to violence, being bullied or teased, contending with domestic conflict and their impacts on youth; (4) resilience and protective factors that increase the likelihood that youth will show success in adverse circumstances; and (5) specific skill training programs in classroom behavior management or in teaching students anger- or self-control (Adelman & Taylor, 2002; Center for Mental Health in Schools, 2000).

While opportunities for staff training, support, and communication are vitally important for general education efficacy, these components are also vital for successful mental health program implementation. Trainings, supplemented by formal and informal networking opportunities, can facilitate school staff communication and increase morale related to meeting the needs of children with mental health concerns (Ringeisen, Henderson, & Hoagwood, 2003). Trainings can also generate appropriate referrals for mental health services. Training for educators can focus on the children, but can also consider staff wellness. ESMH staff have held interactive forums with education staff where the focus is on encouraging staff to talk about their stressors and to share advice on strategies for effectively handling them (Center for Mental Health in Schools, 2000). A healthy staff is better able to meet the needs of the children and families served within the school. Wellness of students and staff should be a priority within the school setting.

One research program demonstrated that variables such as external support, hours spent in in-service activities, degree of participation, the competence of the staff conducting the in-service training, implementation conditions, and school principal "buy-in" all contribute to the effectiveness of ESMH trainings (Kealey, Peterson, Gaul, & Dinh, 2000). These findings suggest that ESMH clinicians must be mindful of factors other than the material at hand when they develop and run a training program for teachers and school staff. It is particularly important to ensure that the topics or techniques being taught are relevant to and appropriate for the school environment and are supported by the principal. Additionally, teachers must be active participants in training activities in order to promote their ownership of acquired skills and knowledge. Scheduling brief training modules during all-staff activities may be a way to encourage attendance, as it does not ask teachers and administrators to add yet another meeting to their busy schedules.

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Resources for this Quality Indicator

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- Center for Mental Health in Schools, *Integrating mental health in schools: Schools, school-based counselors, and community programs working together* (http://smhp.psych.ucla.edu/pdfdocs/briefs/integratingbrief.pdf)
- Center for School Mental Health Analysis and Action, *Developing collaborative ESMH programs* (http://csmha.umaryland.edu/how/developing_collabor_2002.pdf)
- Doll, B., Zucker, S., & Brehm, K. (2004). *Resilient classrooms: Creating healthy environments for learning.* Guilford Publications (www.guilford.com) 1-800-365-7006.
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25) Do you offer group, classroom, and school-wide prevention activities?

Primary prevention (school-wide activities targeting all students or particular groups of students, such as all 8th graders) and secondary prevention (targeting youth who are stressed, at risk or showing early signs of problems) programs and services remain limited in most schools. This is largely due to the absence of a prevention focus, or funding mechanisms in the U.S. to fund large scale mental health promotion initiatives. For programs that rely on fee-for-service revenue, it can be disconcerting that many services offered by ESMH programs, including prevention activities, are not reimbursable (National Assembly on School-Based Health Care, 2000). This

ability to focus on prevention in the United States, contrasts with other countries such as Australia which has large-scale implementation and funding support for prevention through *Mind Matters* (see http://cms.curriculum.edu.au/mindmatters/), a mental health promotion program for secondary schools. It is clear, that for ESMH staff to be significantly involved in prevention, then specific funding is either very limited or does not exist, the needs for advocacy and policy enhancement are underscored (Evans, Glass-Siegel, Frank, Van Treuren, Lever, & Weist, 2003). Given the success of advocacy efforts, resources and a school and community priority on prevention, then it becomes critical for ESMH staff to collaboratively decide with school-employed mental health and education staff best use of time and resources as to who will do what along the prevention continuum.

Within Expanded School Mental Health Programs, the clinicians have three primary roles, two of which are associated with prevention activities, prevention specialist and change agent (Weist, 2001). As a prevention specialist, clinicians are expected to collaborate with educators to promote positive behavior in the classroom, conduct skill training groups, and see students and families to address targeted behaviors. As a change agent within the school, clinicians need to participate on school teams, bringing resources into the schools, and helping to support and implement school-wide programs.

It is suggested that conducting assessments of school based prevention activities and accepting feedback from school staff to develop new strategies to enhance this prevention focus, will assist in making prevention a priority within the schools. These efforts will help to prepare at risk students to appropriately deal with risks and stresses inside and outside of the school. Weist (2001) states that increasingly, research is demonstrating the effectiveness of school-based prevention programs to improve academic outcomes, improve the school environment and decrease risk taking behaviors in students. It is very difficult to implement school-wide activities without collaboration with schools, families, and the larger community. As we increasingly answer the call to improve the level of integration between treatment and prevention efforts and to focus on implementing evidence based practices and programs, it is critical to develop an understanding of which programs and/or practices will be most successful and what conditions are necessary for successful implementation (characteristics of the intervention, training and technical support, environmental conditions) (Tashman et al, 1999; Graczyk, Domitrovich, & Zin, 2003).

Examples of some school-wide prevention activities and programs are included in the resource section (Adolescent Transitions Project, I Can Problem Solve, Mind Matters, Olweus Bullying Program, Positive Behavioral Interventions and Support, Promoting Alternative THinking Strategies (PATHS), Responsive Classrooms). Please refer to the web resources that are available to learn more about these programs and to consider whether one of these programs would make the most sense within a given school.

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Resources for this Quality Indicator

- Adolescent Transitions Project, http://www.personal.psu.edu/dept/prevention/ATP.htm, http://www.dsgonline.com/mpg_non_flash/TitleV_MPG_Table_Ind_Rec.asp?ID=289
- Compendium of empirically-supported approaches that can be adapted for use within school mental health programs (Center for School Mental Health Analysis and Action, http://csmha.umaryland.edu/resources.html/resource_packets/download_files/empirically_supported_2002.pdf
- I Can Problem Solve, http://www.researchpress.com/product/item/4628/
- Mind Matters, http://cms.curriculum.edu.au/mindmatters/
- National Research and Development Centre for Welfare and Health- Promotion of mental health of children and young people, http://www.stakes.fi/english/index.html
- Olweus Bullying Program, http://www.clemson.edu/olweus/index.html
- Prevention Research Center for the Promotion of Human Development College of Health and Human Development- Preventing Mental Disorders in School-age Children: A Review of the Effectiveness of Prevention Programs http://www.prevention.psu.edu/pubs/CMHSxs.html
- Positive Behavioral Interventions and Supports, http://www.pbis.org/main.htm
- Promoting Alternative THinking Strategies (PATHS), http://www.colorado.edu/cspv/blueprints/model/programs/PATHS.html
- Promoting Children's Mental Health within Early Years and School Settings http://www.des.gov.uk/mentalhealth/pdfs/ChildrensMentalHealth.pdf
- Responsive Classrooms, http://www.responsiveclassroom.org/
- Skillstreaming, http://www.researchpress.com/product/item/5180/
- Sustainable Schoolwide Social and Emotional Learning: Implementation Guide and Toolkit (2006), http://www.casel.org/projects_products/toolkit.php

26) Do you offer intensive treatment services to youth and families including individual, group, and family therapy?

One of the primary roles of the ESMH clinician is to be a therapist (Weist, 2001). After a thorough assessment, treatment services should be provided to youth presenting with significant mental health concerns that are impacting functioning. If the student does have a significant mental health problem, then the treatment should generally be driven by empirically supported practices and programs for that particular diagnosis or problem area. In addition to determining intervention strategies, the ESMH clinician must also determine the appropriate frequency (once a week, once a month, etc.) and type (individual, group, family, etc.) of treatment. All services that are provided should be planned and implemented in a way that takes into account the student's and family's strengths, is culturally-appropriate, involves other relevant professionals and community resources, involves the family and is feasible (Acosta, Tashman, Prodente, & Proescher, 2002). ESMH services should be coordinated with school and community programs and resources in order to provide well-integrated and effective mental health care that promotes student success (Taylor and Adelman. 2000; Lever et al, 2003). Efforts to avoid duplication of services can help to ensure that ESMH providers are not duplicating services provided by school-employed staff or a community provider who may already be providing services to a child. With the well-documented mental health needs of students and gaps in the provision of services (New Freedom Commission on Mental Health, 2003), maximizing efficiency and coordination is critical in efforts to reduce the number of students in need of care who do not receive any services.

There is a national movement in the school mental health field, to promote evidence-based practice across the full continuum of treatment services. Clinical practice in schools can be guided not only by treatment manuals (CSMHA, 2002), but also by modularized training approaches (Chorpita, 2006) that recognize the importance of clinicians having competency training in core practice elements associated with positive outcomes for particular disorders in youth. Examples of practice elements for ADHD for example, include providing tangible rewards, parent praise, parent monitoring, time out, making commands and setting limits, parent psychoeducation, and response cost. An advantage of this approach is that it incorporates evidence-based practice, while still allowing for flexibility and individualization related to the complex cases that ESMH clinicians see in their everyday practice.

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Resources for this Quality Indicator

- Empirically Supported Treatment Interventions
  http://csmha.umaryland.edu/resources.html/resource_packets/download_files/empirically_supported_2002.pdf
- School Health Resources Center
  http://www.uchsc.edu/schoolhealth/res_pages/res_index.htm
- Civic Research Institute- Best Practices and Program Models
  http://www.civicresearchinstitute.com/ch10b_toc.html
- UCLA School Mental Health Project- Guiding Parents in Helping Children Learn
  http://smhp.psych.ucla.edu/pdfdocs/guiding/contents.pdf

27) Are you able to continue to have mentoring relationships with students who no longer present serious problems?

Positive relationships with adults in the school, family, and community are associated with enhanced resiliency in at-risk youth (Resnick, 1993; Rhodes, 1994). School mental health clinicians establish positive relationships with the children and families on their caseload and can continue some of these relationships beyond traditional counseling roles. Unlike services provided in traditional community mental health centers, contact with students does not have to end when the formal counseling relationship ends. Some clinicians are able to maintain relationships with students lasting throughout elementary, middle, or high school. In such long term relationships, at times clinicians are providing traditionally conceived therapy services (individual, group, family), but at other times (e.g. when there is less pervasive symptomatology), the therapist becomes less of a therapist and more of an informal mentor to the student (e.g. providing encouragement and practical support). Mentoring can be defined as a "one-to-one relationship between a caring adult and a student who needs support to achieve academic, career, social, or personal goals" (McPartland & Nettles, 1991). The adult mentor is a role model to the student and serves as an advisor and positive influence for the student (Kaufman Harrel, Milam, Woolverton, & Miller, 1986). Long lasting mentoring relationships, in which there is collaboration between the mentor and mentee, authenticity, empathy, and

companionship, are shown to have positive impacts on youth versus mentoring relationships which are terminated quickly lead to decreased self-worth and competence (Spencer, 2006). Mentoring is a powerful tool that enhances assets in youth and is associated with reduced absenteeism, improved attitude towards school, less drug and alcohol use, improved relationships with families, and more positive attitudes towards adults (Jekielek, Moore, Hair, & Scarupa, 2002). The strongest evidence in the literature is for using mentoring as a preventive intervention for youth at high risk due to environmental risk or disadvantage (DuBois, Holloway, Valentine, & Cooper, 2002). Mentoring relationships need not be officially assigned and part of a designated program, but can occur less formally in the natural environment (Rhodes & Roffman, 2003). Recent findings from research studies on resilience in youth have highlighted the value of youth feeling "connected" at home and in school (Weist, 1997). The ability of ESMH clinicians to continue to have some level of involvement with students who are no longer in need of intensive services can be a powerful way to ensure that youth feel connected in the school setting. Another advantage of the clinician remaining in contact with a student is that it can help prevent the development of more serious problems before they escalate. Clinicians can intervene with the child as situations arise to help deescalate problems and crises and promote healthy choices and development.

Perhaps one of the greatest challenges for clinicians in trying to maintain mentoring relationships with former clients is to figure out how to still manage the demands of their active caseload. Clinicians need to be creative in figuring out how to manage their time and services. Examples of activities that can assist the clinicians' ability to continue to work with students include clinician involvement in after-school and summer activities, brief monthly check-in visits, and developing new initiatives in the schools that include these students (e.g., peer mentoring groups, tutoring groups, career oriented and education related support groups). Clinicians should obtain necessary consent from families to continue to be involved with their children in prevention activities or less formal mentoring. If clinicians feel they do not have the time to continue in mentoring relationships, they can also help facilitate referrals to mentoring programs and/or can help create mentoring programs in the school. The National Mentoring Partnership has published a manual that describes how to mentor school-age children and defines and clarifies the steps needed to build healthy relationships in school and community based programs (Herrara, Sipe, McClanahan, Arbreton, & Pepper, 2000).

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Resources for this Quality Indicator

- Creating Safe and Drug-Free Schools Action Guide (http://www.ed.gov/offices/OSDFS/actguid/mentor.html)
- The Mentoring Group (http://www.mentoringgroup.com/)
- Mentoring USA (http://www.mentoringusa.org/; http://www.mentoringusa.org/index1.htm)
- National Mentoring Partnership (http://www.mentoring.org/resources/research/mentor_works.adp)
- The Search Institute (http://www.search-institute.org/archives/tdm.htm)
- Community ToolBox, University of Kansas (http://ctb.ku.edu/tools/en/chapter_1022.htm)

28) Are your referral procedures being well utilized by educators, other school mental health staff, health staff, administrators, parents and students?

ESMH programs strive to be an integrated part of the school and community in which they provide services. Critical to this integration is the ability of key referral sources to the program (e.g., teachers, other school mental health staff, school health staff, school administrators, parents and students) to be able to make referrals without having to contend with excessive bureaucracy or paperwork. Excessive or complicated referral processes will only serve as a barrier to

accessing care and goes against the fundamental tenets of ESMH programs offering easy access to mental health care (Evans, 1999; Hunter, 2001; Weist, 1997). The referral process should be easy to access and follow through with and involve minimal paperwork (Center for Mental Health in Schools, 2003). Key information to obtain in an initial referral are name of the student, grade/homeroom, reason for referral, urgency of referral, source of the referral (and contact information for them), and date of referral. One way to explore whether all groups within the school (teachers, administrators, staff, school-hired mental health professionals, families) are utilizing the referral process is to track the referral sources for all referrals in the past school year or to track a given number of the most recent consecutive referrals. This would allow the program to monitor and analyze who is and is not utilizing the referral process. Increased outreach and education efforts could focus on those who are not making referrals to expanded school mental health services. It is critical to not only educate these individuals about the services and how to refer to them but to also discuss reasons why they may not be referring to the services. This knowledge could then be used to improve the referral process, the actual services, or the collaborative process. Findings from analyzing referral data could also inform the program about individuals or groups who are making inappropriate referrals for services. ESMH staff could then strategically outreach to these stakeholders and offer educational outreach and discussions on what constitutes an appropriate referral.

Given the turnover from year to year in staff and the regular entry of new students and families into the school, it is necessary to have a plan to regularly educate the school and community about mental health services and how to access them. This can be accomplished in a variety of ways including speaking at staff and student orientations, attending faculty meetings and PTA meetings, sending out letters and flyers, and arranging meetings with the various departments within the school (Acosta et al., 2002; Center for School Mental Health Analysis and Action, 2003; Waxman, Weist, & Benson, 1999). Teachers and other educational personnel should be trained to recognize early indicators of mental health problems and should have knowledge of basic mental health problems experienced by children and adolescents (U.S. Public Health Service, 2000; Weist, Nabors, Albus, & Bryant, in press). Educating personnel, families, and students about when to use counseling and how it works can help to reduce misconceptions and increase comfort with making referrals (Tashman, Waxman, Nabors, & Weist, 1998). Clinicians need to familiarize themselves with building specific and district policies regarding student referrals, as many building administrators have certain procedures in place which may be specific to their building. In some schools, referrals for mental health must be coordinated through a student support team or mental health team (Evans, Sapia, Loie, & Glomb, 2002). For such schools, membership and participation of the ESMH clinician on the team is critical. Having referrals coordinated through a team can also help to reduce duplication of services. A regular team meeting of mental health providers in the school would also help to dispel fears around “turf” issues and could help clarify how ESMH services can augment, but not replace, traditional services provided by school-hired staff (Acosta et al., 2002).

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Resources for this Quality Indicator

- Center for Health Care in Schools (http://www.healthinschools.org)
- National Mental Health Association, Standards for Consumer-Centric Managed Mental Heath and Substance Abuse Programs (Chapter 2) (www.nmha.org/pdfdocs/standcons.pdf)
- Center for Mental Health in Schools at UCLA. School-Based Client Consultation, Referral and Management of Care (http://smhp.psych.ucla.edu)
- U.S. Department of Health and Human Services, Surgeon General's Report on Children's Mental Health (http://www.surgeongeneral.gov/topics/cmh/default.htm)

29) Do you promptly screen/assess all students who have been referred for services?

Long waiting lists and lengthy intake procedures often characterize community mental health centers and are a barrier to the receipt of care (Weist, 1997). Part of the appeal of ESMH services is that services are conveniently located and can be rapidly accessed with little or no waiting period (Oppenheim & Evert, 2002). Service utilization, particularly in urban communities, is greatly enhanced in school-based mental health care and likely is related to the ability of ESMH programs to reduce barriers to care often found in traditional mental health outpatient settings (Catron, Harris, & Weiss, 1998). Responsiveness to requests for assistance is a characteristic of expanded school-based mental health services. The time from referral to action in trying to engage the student or family for services should be very brief, preferably less than a week and ideally on the same day or within forty-eight hours of receiving the referral. There should also be in place clear feedback mechanisms to the referral agent such that mental health referrals do not simply disappear and enter a "black hole" once they are turned over to the program (Center for Mental Health in Schools, 2003; Center for School Mental Health Analysis and Action, 2003; Conoley & Conoley, 1991; Weist, Nabors, Albus, & Bryant, in press). Referral feedback can be very general and can simply serve to acknowledge the referral and whether attempts to outreach to the student were successful. Referral feedback forms should be completed once the outcome of a referral is known. Such a form can be a quick and efficient strategy to provide feedback by checking off the appropriate statement (e.g., evaluation in progress, student attending sessions, family refused services) (Center for School Mental Health Analysis and Action, 2003). This shows a level of responsiveness that many teachers, educators, and health/mental health staff in schools appreciate. Interactions with and feedback to the referral source also affords opportunities to shape the appropriateness and timing of referrals (Acosta, Tashman, Prodente, & Proescher, 2002) For example, when a referral is made for a child who never attends school, it is unlikely that they will engage in school-based services. Such a case may be better referred for community-based or home-based services. Another example of referrals that may not be successful in school-based services includes referrals very late in the evolution of the problem. At times, children will be referred as a last attempt of

helping students before they are expelled from school. Often by the time these referrals occur, the administration has run out of patience and will not allow a child any opportunities to exhibit problem behaviors in the school. If a child has been acting out regularly, even with the best therapeutic practices, it is unlikely that this behavior will stop completely after a few sessions. (Hopefully it would decrease significantly in response to treatment, but there would need to be a time period for this change to occur). Referrals should be made to ESMH services when problems begin to occur to help reduce the extent of the problem before it escalates (U.S. Public Health Service, 2000). Sometimes individuals are reluctant to make referrals when problems do not seem very extensive. Also, it is important to give feedback to referring sources about the process of therapy and a reasonable time frame in which to expect changes. Referring sources need to be reminded that problems have developed and evolved over time and are unlikely to be resolved in a few sessions. Realistic expectations should be discussed to help reduce the likelihood that individuals will become disenchanted with ESMH programs and will cease to make referrals (Weist, Nabors, Albus, & Bryant, in press).

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Resources for this Quality Indicator

- Center for Mental Health in Schools at UCLA. School-Based Client Consultation, Referral and Management of Care (http://smhp.psych.ucla.edu)
- Center for School Mental Health Analysis and Action, Program Development Resource Packet (http://csmha.umaryland.edu/how/res_packets.html)
- National Mental Health Association, Standards for Consumer-Centric Managed Mental Heath and Substance Abuse Programs (Chapter 2) (www.nmha.org/pdfdocs/standcons.pdf)

Principle 7: Staff holds to high ethical standards, are committed to children, adolescents, and families, and display an energetic, flexible, responsive, and proactive style to delivery services.

30) Do you feel sufficiently trained, supported, and supervised to handle the unique demands of school-based practice in an ethical and effective manner?

While many school-based mental health clinicians (e.g., school psychologists, school social workers, and guidance counselors) have been explicitly trained in their graduate education and practicum experiences about how to work in an educational setting, many school-based mental health providers (e.g., clinical social workers, child psychiatrists, clinical and counseling psychologists, and professional counselors) have not received such formal training. Lack of knowledge and skills necessary to negotiate the complexities of service delivery in schools may lead to clinicians feeling overwhelmed and ineffective in trying to deliver care (Stephan, Davis, Burke, & Weist, in press). ESMH clinicians need supervisors with qualities and experience related to best practice in supervision in general as well as with specific qualities related to ESMH. Critical to the success and effectiveness of ESMH clinicians is the support of an experienced, knowledgeable, and supportive supervisor who can help bridge any gaps in training and education and can help serve as a mentor to the clinician (Barnett, Youngstrom, & Smook, 2001). Ideally supervision in counseling should help to facilitate the counselor's professional and personal development, promote competencies, and promote accountable counseling services and programs (Bradley & Kottler, 2001). Supervisors should be engaged in helping the clinician negotiate system issues, and define clear roles that are unique and are coordinated with other services in the school (Acosta, Tashman, Prodente, & Proescher, 2002). Ideally the supervisor has several years experience in providing services directly in the school community and has expertise in the primary age group being served by the clinician (e.g., elementary, middle, high school) (Acosta et al., 2002). Supervision of ESMH clinicians should take into account prior training and experience and should emphasize education and skill building related to the unique aspects of providing ESMH services. In a study by Turner, Marcantonio, & Stephan (2003), ESMH clinicians were asked to rank order characteristics of an ESMH supervisor in order of importance, and to both describe an ideal supervision arrangement and list unique aspects of supervision in ESMH. In a follow-up study, Stephan, Davis, & Callan (2004) led a facilitated discussion to collect data about the goals for and unique aspects of supervision in ESMH programs. In their chapter on ESMH supervision, Stephan et al. (in press) derived from these two studies and the larger ESMH and supervision literatures, the unique demands of working in ESMH programs that would need to be addressed in clinical supervision. Critical to providing services in schools is the provider's challenge to creatively and effectively integrate him or herself into the school community such that they become a valued and essential member of the school team. In order to be successful in this integration, the findings from the two studies suggest that supervisors need to work with clinicians to assist them in developing and refining the skills needed to accomplish the following tasks: (1) Conduct an assessment of the school's needs in order to ensure that the program is addressing relevant concerns and that services are coordinated within the school and community; (2) Inform school staff about the programs and services offered through ESMH; (3) Form positive rapport with school staff; (4) Participate in school teams and committees associated with improving academic, social, or behavioral functioning; (5) Create a service delivery strategy that is respectful of other school-based mental health programs, services, and staff and integrates well with them by filling in gaps in care; (6)

Understand the resources in a community and be able to refer appropriately to them; (7) Secure appropriate space and resources to provide quality services; (8) Understand education policy, regulations, and initiatives related to mental health in schools; (9) Understand the unique developmental and psychosocial needs of children across the age span and school levels (e.g., elementary, middle, high school); (10) Develop or enhance the skills needed to serve a diverse array of clients with varying presenting issues and severity of problems; (11) Meet billing and funding expectations and follow policy and procedures of the program; (12) Educate students, families, teachers, and other key stakeholders about the services ESMH programs can provide, promote mental health in the school environment, and help to reduce stigma related to mental health.

Beyond the initial orientation and regular supervision, training is a critical and continuous aspect of quality service provision (Acosta et al., 2002; Tashman, Waxman, Nabors, & Weist, 1998). Ongoing training can be most beneficial if it reflects the professional development needs of the clinicians in the program. Seeking recommendations for training can help insure the relevancy of the training and can also help the staff address solutions to problems that may be occurring at multiple sites. Other opportunities for training in ESMH include peer supervision, case presentations, group supervision, and attending conferences and seminars. There is a need for interdisciplinary training for both clinicians and educators to improve their ability to function effectively in the school community (Weist & Paternite, 2006).

Another critical role of the supervisors is support. Supervisors should take their roles seriously, be reliable, be available between meetings to help provide advice and support during crises, serve as a mentor and help to advance the supervisee's professional path, and should strive to be role-models exemplifying ethical and effective practice (Barnett, Youngstrom, & Smook, 2001; Center for School Mental Health Analysis and Action, 2003). It is beneficial for clinicians to have the opportunity to voice their concerns and to feel that supervisors and administrative staff hear them and will consider seeking action to address important concerns. To help clinicians feel supported, managerial staff can work to establish fair productivity standards, work to streamline paperwork demands, protect time for paperwork days, enhance training and professional development, dedicate time to wellness activities, and strive to enhance the quality of and commitment to supervision (Lever, Stephan, Axelrod, & Weist, 2004). Supervisors can also show support for the clinician by providing on-site supervision and by being reliable, invested, and prepared (Stephen, Davis, & Burke, 2004). On-site supervision respects the value of the clinicians' time and recognizes the importance of experiencing a school setting in person. Providing comprehensive professional development and training, offering ESMH related clinical supervision, and helping to enhance the work environment by making sure clinicians feel valued and not overburdened by administrative demands are key aspects of this needed support (Stephan, Davis, Burke, & Weist, in press). ESMH work can be very isolating. Clinicians may feel like an outsider in the school system and may feel disconnected from their colleagues who are offering similar services in other schools. Although such feelings of isolation can be tempered by collaborating with other professionals in the school, administrators of ESMH programs should take great care in providing clinicians supportive supervisors and other management staff who can create policies and procedures and general environments that encourage positive work experiences. According to a study done by Vinokur-Kaplan (1995), workers who feel that their supervisors are willing to listen to work-related problems and can be

relied on during stressful times at work, reported greater job satisfaction, and were more likely to remain on the job. In addition, Vanderberghe (1999) notes that individuals who experience a conflict between professional values and those of the organization are more likely to quit, while those who find a good fit between their needs and values and the organizational structure tend to stay longer. This is especially important in the mental health field as high turnover and burnout rates can disrupt continuity and quality of care (Braddock & Mitchell, 1992).

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Resources for this Quality Indicator

- Center for Effective Instructional Support, Clinical Teaching Checklists (http://www.uchsc.edu/CIS/ClinSupChkList.html)
- Eric Digest. Administrative Skills in Counseling Supervision (http://www.ericdigests.org/1995-1/skills.htm)
- Eric Digest. Models of Clinical Supervision (http://www.ericfacility.net/databases/ERIC_Digests/ed372340.html)
- National Association of School Psychologists, Position Statement on Supervision in School Psychology (http://www.nasponline.org/information/pp_supervision.html)
- National Association of Social Workers (http://www.socialworkers.org/practice/standards/clinical_sw.asp)

31) Are the services you provide characterized by a flexible, proactive approach that enables youth and families in need to be served as rapidly as possible?

ESMH programs have been developed with a purposeful strategy to overcome barriers that characterize traditional models of mental health service delivery (Weist, 1997; Weist & Ghuman, 2002). One of the biggest barriers in traditional mental health programs is excessive bureaucracy, often associated with fee-for-service paperwork, long wait times, and rigid procedures. Usually when a program seeks fee-for-service revenue for outpatient mental health care, this necessitates (appropriately so) following state laws that regulate such care. This usually means a fair amount of paperwork and procedural safeguards. However, the paperwork and procedural safeguards have been developed to ensure appropriate care and minimize liability in the treatment of youth with more serious problems. A problem has been that the bureaucratic requirements to provide care to these youth have been inappropriately generalized to providing any mental health care for youth, including more preventive services. What are needed in most ESMH programs are clear guidelines and separate procedures for providing more intensive fee-for-service care versus more preventive or focused care for youth with less serious problems. In the latter category, efforts should be made to streamline paperwork and procedures to ensure that they are responsive to students' and families' presenting needs, while at the same time providing appropriate safeguards. It is important to provide policies and procedures to ESMH staff on making this transition back and forth between the role of providing intensive services (and negotiating all bureaucratic requirements) and the role of providing more preventive services, while simultaneously maintaining a high level of responsiveness. An ESMH program that is

able to be flexible and proactive and provide a tailored response to the students' and families' needs will be more effective (Weist, 1997; Weist & Ghuman, 2002).

In more traditional service settings, a meta analysis of 125 studies of psychotherapy dropout concluded that the overall dropout rate was 47%, but this rate was greatly increased for clients that were minority, less-educated, and from lower income groups (Wierzbicki & Pekarik, 1993). In a report submitted to the Agency for Healthcare Administration, Massey, Kershaw, Falk & Hannah (2000) documented that families have difficulty accessing and receiving mental health services, and that waiting time and convenience of appointments strongly influenced families' decision to discontinue services. In this report, the parents report that top two reasons for children's drop out of treatment were based on the early interactions the parent had with staff: "had to wait too long in between appointments" and "had to wait too long before attending the first appointment." Parents also decided to discontinue services if they felt that the appointments conflicted with their child's schooling and if they thought they were going to see a doctor but saw some other agency staff instead. This report also suggests that these children had mostly externalizing disorders and were in very high need of mental health services. These findings underscore the importance of delivering proactive and responsive services and suggest that initial contacts with families, including intake calls, will determine the course of treatment for a large percentage of families.

ESMH clinicians are at a definite advantage in terms of access for the students, but they may need to work harder to engage families. Research studies aimed at reducing no-show rates for initial appointments have demonstrated that relatively simple techniques can improve show rates and increase family engagement in seeking care. Easy to implement practices such as a reminder appointment letter to families (Swenson & Pekarik, 1988), an information packet telling the family about the program and/or what to expect, followed up by a reminder call the day before the appointment (Hardy, O'Brien, & Furlong, 2001), and a 30 minute talk on the phone with the family about presenting problems, ways therapy might help, and initial steps that the family can take even before the appointment (McKay, Stoewe, McCadam, & Gonzales, 1998).

The Mental Health Statistical Improvement Program (1996) defines access to care as one of the four core areas of service to families. In an effective and responsive program, they would expect families to agree that: (1) The location of services was convenient. (2) Staff was willing to see me as often as I felt it was necessary. (3) Staff returned my calls within 24 hours. (4) Services were available at times that were good for me. (5) I will be able to get the services I wanted even though I couldn't pay for them. (6) I was able to see a psychiatrist when I wanted to. Would the families in your school agree with these items?

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Wierzbicki, M. & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology Research & Practice, 24,* 190-195.

Resources for this Quality Indicator

- American Psychological Association, A Mental Health Patient's Bill of Rights (http://www.apa.org/pubinfo/rights/rights.html)

- Center for Mental Health in Schools, School-Based Client Consultation, Referral, and Management of Care (Tech. Aid Packet, updated 1/03) (http://smhp.psych.ucla.edu)
- Evaluation & Accountability: Getting Credit for All You Do (http://www.smhp.psych.ucla.edu)
- National Association of Social Workers Standards for the Practice of Clinical Social Work (http://www.naswdc.org/practice/standards/clinical_sw.asp#5)
- The Mental Health Statistics Improvement Program (MHSIP) (http://mhsip.org/toolkit)
- Mental Health Service System at Health Canada (www.hc-sc.gc.ca/hppb/mentalhealth/service_systems.htm.)
- Center for Evaluation and Quality – NASBHC (http://www.hasbhc.org/EQ/EQImprovement.htm)

Principle 8: Staff is respectful of and competently addresses developmental, cultural, and personal differences among students, families, and staff.

32) Are you receiving regular training on effectively providing care for students and families who present diverse developmental, cultural, ethnic, and personal backgrounds?

2000 Census data shows an increase in our nation's racial/ethnic diversity (Clauss-Ehlers, 2003; United States Census Bureau, 2001; Wehrly, Kenney, & Kenney, 1999). These data estimate that 67% of the population identifies as White, 13% as African American, 13% as Latino, 4.5% as Asian or Pacific Islander, 1.5% as American Indian or Alaskan Native, and 7% as another race. Census data also show that ethnic minority children and adolescents are the fastest growing group in the United States (Clauss-Ehlers, 2003; Porter, 2000). Brewer and Suchan (2001) found that diversity has increased for all states with some yielding up to 34% increases. Brewer and Suchan summarized Census 2000 data to determine which states were more diverse than others. They found that high diversity states (i.e., 60–77% racial/ethnic minority groups) included California, Texas, Arizona, New Mexico, and Virginia. Medium–high diversity states (i.e., 49%–59% racial/ethnic minority groups) included Maryland, New York, Illinois, Washington, Nevada, Colorado, Montana, Alaska, North Dakota, South Dakota, Minnesota, Wisconsin, Michigan, Arkansas, Louisiana, Alabama, and North and South Carolina (APA, 2003).

In the year 2000, ethnic minority youth comprised approximately 30% of the entire population. In addition, the 2000 Census was the first time that respondents could indicate having two or more races. 2.4% of the population checked off two races, and of those, 42% were under 18 years of age, a percentage that speaks to the increase of biracial youth in the United States. These data highlight that ours is an increasingly diverse nation, and underscore the reality that school-based mental health practitioners need to be culturally responsive in their respective schools and communities.

School-based staff may not be aware of how cultural competence applies to the school setting. In fact, cultural competence is applicable to all educational systems that are invested in the growth and learning of their students (Clauss-Ehlers, Weist, et al, in progress). Historically, the nation's public schools were seen as a point of entry for immigrant children and a place where they were thought to be "Americanized". At that time in America's history, youth were to learn English and taught to view themselves as Americans rather than other racial/ethnic groups (Olneck, 1989). After the Great Depression and World War II, school districts began to challenge this initial assumption and implement programs in "intercultural education". This movement was furthered with the 1954 Supreme Court ruling in Brown vs. Board of Education when the Supreme Court opposed the "separate but equal" doctrine, and ten years later, the Civil Rights Act. These events have set the stage for the current need for culturally competent school-based providers in America's schools.

Much of the challenge of cultural competence concerns how to go about defining the term. Thus, Sue (1998) talks about the "search for cultural competence." Sue's phrase captures the inconsistency, debate, and lack of agreement with regard to those factors that make up cultural competency. Sue defines cultural competence as "the belief that people should not only appreciate and recognize other cultural groups but also be able to effectively work with them" (p. 440). This definition acknowledges that cultural competence refers not only to knowledge and awareness, but also to skill and application. Kagawa-Singer and Chung (1994) state that culturally competent care is achieved when the "therapist can effectively use the knowledge of

his or her own culture and the client's to negotiate mutually acceptable goals of therapy with the client/family" (p. 200). The authors further state that culturally based and competent care involves work "in a manner which is culturally comprehensible and acceptable to the individuals and their families" (Kagawa-Singer & Chung, 1994, p. 200). Increasingly it has been recognized that cultural competence is an ongoing process that one should strive for versus an end-state that can be achieved (Reich and Reich, 2006). Culturally competence practices should be an ongoing goal that one should value and continue to pursue in clinical practice.

Pachter (1994) says the following of a culturally competent system, a definition that is applicable to the interactive system of a school or school district:
A culturally sensitive health care system is one that is not only accessible, but also respects the beliefs, attitudes, and cultural lifestyles of its patients. It is a system that is flexible – one that acknowledges that health and illness are in large part molded by variables such as ethnic values, cultural orientation, religious beliefs, and linguistic considerations. It is a system that acknowledges that in addition to the physiological aspects of disease, the culturally constructed meaning of illness is a valid concern of clinical care. And finally, it is a system that is sensitive to intragroup variations in beliefs and behaviors, and avoids labeling and stereotyping (Pachter, 1994).

Given that the U.S. Census Bureau projects there will be more ethnic and racial minorities than Whites by the year 2045 (U.S. Census Bureau, 2001), it is important to consider how culturally competent care may be provided to strengthen the experience of children of color in our nation's schools. Flores (2000) presented a five-point model that can be applied to cultural competence in school mental health and highlights why regular training in cross-cultural competence is urgent. These five components have been adapted from Flores' (2000) original model to pertain to school situations. The five components include:

(1) Normative cultural values – The school-based mental health provided needs to be familiar with the cultural values of his/her students because these values may affect the health of the student. Familiarity with the culture can be accomplished through literature concerning the ethnic group and consultations with members of the community.
(2) Language issues – Interpreters are essential when students are not fluent in English and the provider/staff is not fluent in the student's language.
(3) Folk illnesses – Learn about common folk practices/illnesses of different cultures; however, do not assume that the student adheres to these beliefs. Communication is important so it is vital to ask the student about beliefs he/she may have and about any current treatments the/she may be receiving.
(4) Student/ parent beliefs – Identify student beliefs and recommend alternatives to any treatments that may be harmful. Integration of harmless remedies associated with a person's culture/belief should be considered.
(5) School-based mental health provider practices – Providers need to take note of any ethnic disparities that may arise in clinical procedures and health outcomes. Regular monitoring is essential.
Regular, ongoing training in cultural competence is essential to address both external and internal barriers that arise in this area. The Center for School Mental Health Analysis and Action

Critical Issues meeting on culturally competent practice in ESMH (2003) identified some of these barriers to be addressed by ongoing commitment and training. They include the following:

Self-awareness is a key component to cultural competence. For many people, the kind of critical self-reflection needed to incorporate cultural competence can be threatening. Commitment to knowledge of self is reflected in the 2003 APA Guidelines that state, "Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves" (APA, 2003, p. 382).

Many efforts to foster cultural competence attempt to place individuals into various cultural or sub-cultural groups based on perceived common characteristics. This can lead clinicians to place individuals into certain categories which may or may not be accurate and proceed to interact with the individual based on assumptions made regarding the supposed characteristics of that cultural group. Thus, the group cautioned against using a "cookbook" approach where people are described as being all the same in one particular way. Rather, the group talked about the importance of acknowledging *within-group differences* as well as *between-group differences*.

Much of the mental health model in this country is based upon a pathology perspective rather than a strengths perspective. A focus on weaknesses rather than strengths can lead clinicians to interact with clients based on the perceived weaknesses of their cultural group rather than the strengths of the group and, more importantly, of that particular client. In this vein, Clauss-Ehlers and Weist (2004) talk about the importance of taking a strengths-based perspective that focuses on the resilience building aspects of diverse cultures in which youth from all racial/ethnic backgrounds develop.

External barriers

Many standards, rules, laws, and regulations exist regarding cultural competence, but there is little in the way of supervision or monitoring to ensure that culturally competent practice is indeed being practiced.

Many clinicians are not aware of the policies and regulations that have been implemented by their own agencies

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Mental health services in schools have often been associated with remediation of problem behaviors rather than with mental health promotion, prevention activities, and intervention. This has historically resulted in a limitation of the opportunities for proactive efforts and collaboration with education staff.

Mental health professionals and education professionals have a perceived difference in philosophy and "jargon" that creates difficulty regarding efforts to engage in dialogue and collaboration. Related to this issue concerns the use of professional vocabulary that can place a communication barrier between parents and the school mental health professional. For instance, a professional using a diagnostic category to describe a child's behavior may lose the parent's

trust if she does not understand what the diagnosis actually means and feels her child is being labeled.

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Resources for this Quality Indicator

- Center for School Mental Health Analysis and Action, Cultural Competency Resource Packet. (http://csmha.umaryland.edu/)
- Division of Social and Transcultural Psychiatry, McGill University (www.mcgill.ca/tcpsych/publications/report/final/training-intercultural/)
- National Multicultural Institute, Training and Consulting (http://www.nmci.org/otc/training.htm)
- National Clearinghouse for English Language Acquisition & Language Instruction Educational Programs, Resources about Language and Culture (http://www.ncela.gwu.edu/resabout/culture/)
- Native American Research and Training Center, Publications (http://www.fcm.arizona.edu/research/nartc/publications/index.htm)
- -National Mental Health Association, Position Statement on Cultural Competency in Mental Health Systems (http://www.nmha.org/position/ps060198a.cfm)
- Center for Effective Collaboration and Practice, Cultural Competence Resources
- (http://cecp.air.org/cultural/resources.htm)

33) Does your caseload reflect the diversity of the school population?

The Surgeon General's supplement to the 1999 Mental Health Report, Report on Mental Health: Culture, Race, and Ethnicity (Department of Health and Human Services, 1999b), documents that minorities have less access to mental health services and are less likely to receive mental health services. The services that they do receive tend to be of lesser quality. Barriers that deter minorities from accessing treatment include cost, lack of availability of services, language, mistrust and fear of treatment, stigma, discrimination, and religious beliefs. The ESMH movement, to a large extent, was borne of the need to rectify the need-receipt discrepancy in children's mental health (Flaherty & Osher, 2003). However, despite mental health services being offered at no cost in schools where kids are, problems of access, mistrust, and stigma still may compromise the ability of clinicians to engage children and families of ethnic minority or low socioeconomic status (Bickham, Pizarro, Warner, Rosenthal, & Weist, 1998; Lowie, Lever, Ambrose, Tager, & Hill, 2003). ESMH providers must be conscientious of their school's demographic makeup and must make significant efforts to outreach to all groups within their school community. Clinicians should regularly compare their service recipients on their caseloads to the larger school population. If there is a large discrepancy, clinicians should consider with their supervisors and ESMH team how to better outreach to that group and put a plan into action.

The cultures of racial and ethnic minorities influence many aspects of mental illness, including how patients from a given culture communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. Likewise, the cultures of the clinician and the service system influence diagnosis, treatment, and service delivery. Cultural and social influences are not the only determinants of mental illness and patterns of service use, but they do play important roles (Department of Health and Human Services, 1999b). Many mental health workers are not fully aware of the impact of culture on mental health, mental illness, and mental health services (Cross, Bazron, Dennis, & Issacs, 1989; Roizner, 1996). The Surgeon General has recommended that all mental health professionals develop an understanding of the roles of age, gender, race, ethnicity, and culture in research and treatment (Department of Health and Human Services, 1999a). This increased awareness, in turn, will permit ESMH clinicians to shift their practice patterns and methods of engagement. It may follow that minority consumers will be more satisfied with treatment and will be less likely to terminate prematurely. This, coupled with increased likelihood of consumer referrals, may help ESMH clinicians' caseloads approximate the demographics of the school. Demographic information is typically available from the school district headquarters or via district websites.

Some research suggests that staffing patterns that mimic community characteristics produce better engagement and retention (Resources for Cross Cultural Health Care, 2002). For instance, potential clients from different multicultural groups may prefer to seek care from providers of their own race, ethnicity, or language group. Such cultural concordance can have a positive impact on appropriate service utilization, treatment participation, and receipt of some services. However, it is not always possible to hire a diverse staff. In such a case, the following information may be useful for ESMH clinicians.

Some examples of ways that ESMH clinicians may conceive barriers to working with children and adolescents of diverse cultures are offered by Roysircar & Gard (in press). For instance, they suggest that cultural responsiveness/sensitivity results from shared attitudes between the therapist and client is a better predictor of client ratings of satisfaction, empathy, unconditional regard, and therapist credibility than race. When conceptualizing barriers associated with minorities' religiosity, clinicians should keep in mind that the degree of a client's religious commitment is more important than specific beliefs with regard to client coping and attitudes. When conceptualizing and thinking of ways to deflect minority client mistrust, these authors identify seven therapist responses that have been identified as potentially creating an atmosphere of mistrust: (1) an abrupt shift in topic; (2) purposeful inaccurate paraphrasing; (3) mood and interest change; (4) a break in confidentiality; (5) exposure of a hidden agenda; (6) a stereotyping statement; and (7) a broken promise.

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Resources for this Quality Indicator

- Center for Mental Health in Schools, Cultural Concerns in Addressing Barriers to Learning (http://www.smhp.psych.ucla.edu/pdfdocs/cultural/culture.pdf)
- Multicultural Mental Health Evaluation (MCMHEVAL), a listserv regarding evaluation of mental health services for diverse cultural, racial, and ethnic populations. Also provides

technical assistance and material development. (http://tecathsri.org/lists.asp#multi) (http://tecathsri.org/multicultural.asp)
- Multicultural Center for Research and Practice (http://www.multiculturalcenter.org)
- National Center for Cultural Competence (http://gucdc.georgetown.edu/nccc/index.html)
- National Information Center for Children and Youth with Disabilities (http://www.nichcy.org/)
- Surgeon General's *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the Surgeon General [electronic version]*. Fact sheets related to mental health for each of 4 major ethnic groups in America. (http://www.mentalhealth.org/cre/factsheet.asp)
- U.S. Census Bureau website's link to demographic information. (http://factfinder.census.gov/servlet/SAFFPeople?_sse=on)

34) Are you making efforts to ensure that your school mental health program and services are welcoming and respectful to the students and families you serve?

In order to best facilitate a collaborative relationship with students and families served by ESMH programs, clinicians need to make every effort to ensure that the environment of the program is welcoming and respectful. Many times, reluctant clients have already formed opinions of the therapeutic setting before they have ever seen a clinician (Bronheim, 2004). Negative opinions may result from perceived insult or patronization, or from insurmountable language barriers. Although creating a child and family-friendly environment is the responsibility of all school staff, ESMH clinicians will often be called upon to use their clinical skill and cultural sensitivity to model and guide a welcoming and respectful stance. The National Association of School Psychologists (NASP) has advised its members to be mindful that the school must send consistent messages to families that their contributions to forming effective partnerships are valued. Further, NASP states that efforts should be made to work collaboratively with all families, including those whose primary language is not English and those with limited literacy skills (NASP, 1999).

Cultural awareness regarding ethnicity, disability, gender, sexual orientation, and socioeconomic status is crucial in fostering a welcoming environment for students and families (Bickham, Pizarro, Warner, Rosenthal, & Weist, 1998; Center for Mental Health in Schools, 1996). Creating a welcoming physical environment, as well as interacting in a warm and respectful manner, are ways in which ESMH staff can ensure that they are providing sensitive treatment to the students and families they serve (see Rubenstein, 1998). Awareness that traditional mental health service provision are not often culturally sensitive (see Center for Mental Health in Schools, 1996) can invite the clinician to assess the treatment setting and look for aspects that suggest disregard or disrespect for diverse cultures (e.g., lack of images or cultural icons relating to diverse groups, confidential materials in full view).

In terms of administrative and programmatic support, ESMH clinicians can self-assess their situation (Bronheim, 2004). For instance, does the administrative staff mirror the clinician's tone of sensitivity, respect, and protection of confidential information? Can staff communicate with bilingual clients, clients with limited English proficiency, or hearing-impaired clients? Are translators available? Does the clinician have organizational support (e.g., training, materials,

resources) related to ensuring respect for diverse clients? Clinicians may request translation services or other accommodations for children and family members with physical disabilities. However, their parent organization may be more or less able to accommodate requests. Teaching and modeling confidentiality and respect for diversity are activities that are much more within school-based clinicians' command.

Conceptual developments in educational and ESMH principles endorse expanding the notion of families as collaborators in their children's education and mental health treatment (Bickham et al., 1998; Comer & Haynes, 1991, Lowie, Lever, Ambrose, Tager, & Hill, 2003). A "shared-learner" perspective is the cornerstone of creating a respectful environment for families of children with whom ESMH staff work. It suggests that parents and providers: (a) both share knowledge and insight, (b) develop treatment goals together and agree on these goals, (c) share responsibilities in planning and decision-making, (d) respect each other as equals, and (e) engage in open and honest reciprocal communication (Lowie et al., 2003). Clinicians may not have sufficient background or comfort in working with families, or may have been trained in paradigms that run counter to the shared-learner perspective (Bickham et al., 1998; Lowie et al, 2003). Fortunately some evidence indicates that training which promotes clinicians' *mindfulness* (e.g., ability to create new categories, openness to new information, awareness of multiple perspectives, non-judgmental stance, patience, "beginner's mind," trust, nonstriving, acceptance) can produce demonstrable increases in the family friendliness of mental health interventions (Singh et al, 2002). Interestingly, such training demonstrated the best effect on the development of Service Plans (i.e., treatment team including family members determines what interventions are needed and who will be responsible for carrying them out and/or supporting them).

Ways that ESMH clinicians can respectfully engage family members include the following:

- Engage families from the onset of treatment. Avoid simply sending the consent form home with the child for a caregiver's signature.
- Convey mutuality—operate from the perspective of a collaborator versus an expert. Ask questions.
- Ask how you can be helpful.
- Discuss confidentiality parameters.
- Avoid labeling and jargon when discussing children's presentations.
- Assess for and discuss perceived stigma.
- Maintain flexible appointment times to accommodate caregivers outside of school hours.
- Provide decision-making opportunities for families in assessment, intervention, and program planning.

Adapted from Bickham et al., 1998; Lowie et al., 2003; NASP, 2002.

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- Center for Mental Health in Schools, Welcoming and Involving New Students and Families (http://smhp.psych.ucla.edu/pdfdocs/welcome/welcome.pdf)
- Center for School Mental Health Analysis and Action (http://csmha.umaryland.edu/)
- Center for Mental Health in Schools, Cultural Concerns in Addressing Barriers to Learning. Good information regarding bilingual and non-English-speaking children and families. (http://www.smhp.psych.ucla.edu/pdfdocs/cultural/culture.pdf)
- Multicultural Mental Health Evaluation (MCMHEVAL), a listserv regarding evaluation of mental health services for diverse cultural, racial, and ethnic populations. Also provides technical assistance and material development (http://tecathsri.org/lists.asp#multi) (http://tecathsri.org/multicultural.asp)
- National Information Center for Children and Youth with Disabilities (http://www.nichcy.org/)

- Parents, Families, and Friends of Lesbians and Gays (http://www.pflag.org/education/schools.html)
- University of Maryland, Sexual Orientation Specific Resources (http://www.inform.umd.edu/EdRes/Topic/Diversity/Specific/Sexual_Orientation/)

35) Are key stakeholders who provide ongoing guidance to your school mental health program diverse in terms of gender, race/ethnicity, and personal/cultural background?

Having a diverse set of advisors for the ESMH can help ensure that the services provided are culturally sensitive and responsive to the needs of the community which it serves. This becomes increasing important as the population of the United States is continuously growing with increasing diversity. When thinking about diversity it is important to think about all areas of diversity: linguistic, physical disabilities, gender, ethnicity, cultural, social economic, background, sexual orientation (NYS, 2003). By outreaching to key stakeholders with different backgrounds and life experiences and who understanding the school and surrounding community, programming for staff, families and students can be improved to be reflective of the populations that are served. To work effectively with children and families from diverse populations, it is important for both ESMH staff and those providing ongoing guidance to ESMH staff to have an appreciation for cultural diversity. Clinicians should utilize the knowledge of those stakeholders to help enhance their understanding of the types of problems facing children and families from diverse populations, including those related to the immigration experience and language struggles between home and school. In addition, appropriate attitudes, knowledge, and skills to work effectively with diverse youth and their families are necessary, which can be acquired through professional preparation, experience, and a willingness to ask questions to learn about the experiences of individuals.

Having an understanding of cultural differences also may have a significant impact on the types of services and understanding of the problem behaviors of youth. For example, Baker (2003) states that "how adults view child behavior may be heavily influenced by ethnicity, and more specifically, by culture. Cultures may differ markedly in terms of the specific problems for which children tend to be referred to mental health specialists"(p.6-7). Having stakeholders share information about typical cultural behavioral variations will help the clinician understand the child in context. As stated by Cook and Kilmer (2004), an integral component of systems of care is culturally competency and diversity. In order to ensure that children and families receive the individualized help they need, it is necessary to understand their perspectives, values and their culture. Involving diverse stakeholders in ESMH will facilitate the development of services that will best help all children and families.

Having diverse representation of stakeholders guiding the clinicians also helps to ensure that families are able to access the services. For example, forms may need to read in the language of the guardian, or alternative methods developed for individuals who are blind or deaf. Kalyanpur (2003) states that professionals need to recognize that not all families will access services through formal approaches, and alternative more informal approaches need to be developed. She goes on to state that there is a perception in the field that families should be able to access the services without assistance, she argues that many families may not even know what are the questions to ask or what they need to figure out. By having diverse stakeholders providing

guidance to the program, innovative outreach methods can be developed as issues such as the one just mentioned are made explicit.

In addition to addressing cultural practices in the therapeutic environment, partnering with stakeholders to address the issue of diversity in the broader school environment is also important. For example, efforts can be made to infuse multicultural programming and activities throughout the school and to encourage an inclusive school culture through increasing accessibility and creating a welcoming environment (Mock, 2003). All of these strategies and those employed by the clinician in the clinical setting are critical to enhancing the impact of the mental heath services.

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Resources for this Quality Indicator

- American Association for People with Disabilities (http://www.aapd-dc.org/)
- Center for School Mental Health Analysis and Action (http://csmha.umaryland.edu)
- Cultural Concerns in Addressing Barriers to Learning (available through the Center for Mental Health in Schools, http://www.smhp.psych.ucla.edu)
- Diversity in Mental Health Project (http://www.wmpmh.org.uk/wmpmembers/diversity/)
- Multicultural Mental Health Evaluation (MCMHEVAL), a listserv regarding evaluation of mental health services for diverse cultural, racial, and ethnic populations. (http://tecathsri.org/lists.asp#multi)
- Multicultural Center for Research and Practice (http://www.multiculturalcenter.org)
- National Center for Cultural Competence (http://gucdc.georgetown.edu/nccc/index.html)
- Office of Minority Health Resource Center (800-444-6472)
- Quality Education for Minorities Network (http://qemnetwork.qem.org/)
- NYS Psychology-Psychology practice in a pluralistic society (www.op.nysed.gov/psychpluralguide.htm)

Principle 9: Staff builds and maintains strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes all efforts.

36) Are you helping to coordinate mental health efforts in the school to ensure that youth who need services receive them while avoiding service duplication?

ESMH programs are collaborative endeavors in which key stakeholders, social workers, psychologists, nurses, psychiatrists, parents, students, teachers, and school administrators work together to address the emotional and behavioral difficulties that interfere with learning in order to optimize overall student health and well-being (Acosta, Tashman, Prodente, & Proescher, 2002). Collaboration can result in the expansion of resources available through cooperative programming and service provision and can enhance staff skills by sharing information and organizing joint training (Comer & Woodruff, 1998). ESMH services are designed to augment mental health services that already exist within the school and community setting (Weist, 1997). The identification and coordination of all mental health services in a school is necessary to provide a full continuum of services to all students and to avoid service duplication (Weist, Proescher, Prodente, Ambrose & Waxman, 2001). Without careful coordination, the same students may be referred to multiple service providers within the school. Much time and energy can be conserved and greater numbers of students can receive services if the system for determining who (e.g., what agency or provider) provides services is well coordinated and efficient.

Historically, school personnel have tended to work in isolation – teachers in their classrooms, counselors in their offices, and nurses in their clinics. Developing a coordinated school mental health program requires a *team approach* – one that capitalizes on the skills and contributions of staff from different disciplines (Flaherty et al., 1998; Hodges, Neeman, & Hernandez, 1999). In order to capitalize on the skills of different disciplines (e.g., psychology, social work, education, nursing), it is important to understand the core competencies, education, and training of each discipline (Acosta et al., 2002; Rappaport, Osher, Garrison, Anderson-Ketchmark, & Dwyer, 2003). Service providers often have different educational backgrounds, use dissimilar jargon, and look to their own professions for recognition, respect, and promotion. Agencies working collaboratively must develop a shared method of communication early in the process so that differing backgrounds and terminologies do not interfere with recognizing common goals. One way to achieve this level of collaboration is by forming interdisciplinary teams, such as a mental health team or student support team (Weist et al., 2001). An emphasis on collaboration between school staff, community agencies, stakeholders and all involved in maintaining the welfare of a child, is an important aspect of Expanded School Mental Health programs; building from established mental health programs and services, additional involvement strengthens the programs (Paternite, 2005). When functioning well, mental health teams can take on the role of agents for systematic change in the school and can help coordinate the distribution of referrals. These teams may initiate school-wide interventions such as developing and implementing crisis intervention plans, bringing relevant curricula into the school to promote the development of psychosocial competencies, conducting mental health education programs for children in

classrooms, and developing and directing peer counseling programs (Hodges et al., 1999). Another example of a collaborative team is a resource coordinating team (Center for Mental Health in Schools, 2000). The focus of a resource coordinating team is to clarify available resources and their best use. A resource coordinating team can be charged with identifying, analyzing, and improving existing efforts to prevent and alleviate barriers to learning; enhancing systems for intervention, case management, and quality assurance; guaranteeing appropriate procedures for effective management of programs and communications; and exploring ways to redeploy and enhance resources. In addition to mapping and analyzing psychosocial programs, resource mapping is useful for assessing all major programs and services supporting education instruction (Center for Mental Health in Schools, 2000).

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Resources for this Quality Indicator

- Center for Mental Health in Schools, Resource mapping and management to address barriers to learning: An intervention for systemic change (http://smhp.psych.ucla.edu)
- Center for Mental Health in Schools, A resource aid packet on addressing barriers to learning: A set of surveys to map what a school has and what it needs. (http://smhp.psych.ucla.edu)
- Community Tool Box, University of Kansas (http://ctb.ku.edu)

37) Are you using or helping to develop communication mechanisms to ensure that information is appropriately shared and that student and family confidentiality is protected?

It is a fundamental right of individuals to have their personally identifiable information protected (Center for Health and Healthcare in Schools, 2002). This right includes the expectation that confidential information shared with mental health professionals working in schools will not be disclosed to third parties without explicit permission. Students and their families have a right to expect that student health information, except in a few special cases (see below), will be kept confidential and that only information necessary to provide appropriate health and educational services will be shared (Prodente, Sander, Grabill, Rubin & Schwab, 2003). However, professionals working in schools often are required to balance the requests for information from parents, teachers, administrators, and other individuals with students' rights to privacy. In an effort to provide coordinated care within the school setting, it is often helpful to obtain explicit consent from the onset to share needed information with those providing services to the child (educators, school mental health staff, health staff, community agencies) (Taylor & Adelman, 1998). This implies that the clinician could share relevant information but not feel obligated to share all personal information for a given child. Thus only information that is relevant to and would assist another's involvement with a child or family should be released.

To better understand legal and ethical issues related to confidentiality, it is important for clinicians to be familiar with the definitions of both confidential information and consent. Confidential information may include, but is not restricted to, any identifiable information about a student and his or her family, disclosures of physical, mental or emotional status, family problems, substance abuse, criminal behavior, sexual activity, or usage of medication (Prodente et al., 2003). Professional organizations such as the National Association of School Psychologists, National Association of Social Workers, American Psychological Association, and School Social Workers Association of America have standards of practice for their members that specifically address privacy and confidentiality. However, federal and state statutes prevail over standards of professional organizations (Prodente et al., 2003).

Two federal laws provide students and parents access to their own individually identifiable health information or education records and help to protect patient confidentiality. The first of these laws is the Family and Educational Rights and Privacy Act (FERPA). Enacted in 1974, Congress has amended this legislation nine times, most recently in the No Child Left Behind Act. FERPA is a federal law that applies to all public or private schools that receive federal funds from the U.S. Department of Education (Center for Health and Healthcare in Schools, 2003). The Health Insurance Portability and Accountability Act (HIPAA), which went into effect April 14, 2003, is the second of these two laws. HIPAA is a complex law that, among other things, mandates confidentiality requirements for the individually identifiable information of patients (Center for Health and Healthcare in Schools, 2002).

FERPA. Within schools, confidentiality is protected largely under The Family Educational Rights and Privacy Act (FERPA; 20 U.S.C. 1232g; Regulations at 34 CFR 99). FERPA is a federal law that allows for the internal sharing of information between school personnel without parental permission given that the information shared is of "legitimate educational interest" (Center for Health and Healthcare in Schools, 2003). This law implies that school psychologists, social workers, and other school personnel can share confidential student information with teachers, administrators, and other school employees who provide educational services to the child (Prodente et al., 2003). Clearly the information shared should be relevant to the individual's involvement with the student (e.g., sharing information with a teacher about how to help improve the academic functioning of a student, making recommendations to an administrator regarding how to handle a student's emotional outbursts that are interfering with school functioning). FERPA requires schools that receive federal funding to keep a student's education record confidential. As school employees, school psychologists, school social workers, and guidance counselors are required to comply with FERPA, which makes no distinction between academic, health, and mental health records. Under FERPA, school professionals may share information internally if it of "legitimate educational interest," parents have access to all of their child's school records, and parents have the right to challenge the accuracy of the records through a hearing.

While adherence to FERPA is required for school-hired employees, mental health professionals from other organizations and agencies affiliated with a school but not hired by them have other regulations to follow (Prodente et al., 2003). In addition to contending with their professional organizations, community clinicians working in a school need to abide by HIPAA rules. These rules are more restrictive than FERPA. Professionals providing expanded school mental health services are required to adhere to differing statutes regarding student/client records and confidentiality. According to the Center for Health and Healthcare in Schools (CHHCS, 2003), when services are made available to students on school property but are provided by a non-school institution or agency, health records of students who use the facility are retained by the health care providers and are subject to the privacy requirements of HIPAA. This means that the records of these providers cannot be released to school personnel or other third parties without parental permission. Special permission is needed to allow student records to be released to the school. Once records are released to the school, they could potentially become a part of the "educational record". Under HIPAA regulations, parents are the representatives of their children and can access and control information about their minor children. However, under certain state and other laws, minors can authorize services without parental consent. In such cases, it is the

minor, not the parent, who may exercise privacy rights. Privacy rights extend to all forms of communication (oral, written, or electronic).

Exceptions to Confidentiality. There are several notable exceptions to confidentiality. Providers may disclose confidential information under the following circumstances:

- With consent of the person in treatment (for minor children this right typically rests with the parent or legal guardian)
- Disclosure to payers (this information is limited to diagnosis, legal status, reason for continuing services, and assessment of current level of functioning and progress)
- Disclosure to parents or legal guardians of minor children until the child attains age of majority
- Disclosure to protect safety
- Danger to self
- Danger to others (Tarasoff vs. Regents, 1976)
- Suspected abuse and neglect

Confidentiality as a Barrier to Collaboration. Interdisciplinary collaboration is a hallmark of expanded school mental health programs (Weist , Lowie, Sander, & Christodulu, 2002). However, the desire to protect students' confidential information can sometimes act as a barrier to effective interdisciplinary collaboration (Taylor & Adelman, 1996). Refusing to share information with appropriate colleagues not only creates an impediment to collaboration, but undermines the goals of having mental health services provided in schools (Center for School Mental Health Analysis and Action, 1998). School-based providers cannot properly and effectively serve students in isolation or without some level of reliance on other professionals. Clinicians need to work with families and obtain appropriate consent for release of information in order to effectively coordinate care.

Providers must learn to delicately balance the school's and the parent's right to know with the student's right to privacy. School mental health personnel should be trained on ways to share information with school personnel in a practical way that does not necessarily violate students' confidence. For example, clinicians could provide information that empowers the teachers to work in a way that helps the student achieve his/her academic potential. This does not mean that clinicians need to share specific information. It does mean that clinicians may need to re-think their definition of "confidentiality." Maintaining confidentiality may not mean "say nothing." Clinicians may be able to make general recommendations or observations that do not reveal any private information. Some professionals recommend the sharing of process information as opposed to actual content with those individuals in the school who are trying to assist specific students (e.g., tell an administrator, "I think she might respond better if you let her tell her side of the story by asking her questions first, rather than first accusing her or delivering the punishment" (Center for School Mental Health Analysis and Action, 1998).

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Resources for this Quality Indicator

- Advocates for Youth, Legal issues and school-based and school-linked health centers: Commonly asked questions (http://www.advocatesforyouth.org/publications/iag/sbhcslhc.htm)
- American Psychological Association, Ethical Principles of Psychologists and Code of Conduct 2002 (http://www.apa.org/ethics/code2002.html)
- American School Health Association, National Task Force on Confidential Student Health Information: *Guidelines for Protecting Confidential Student Health Information.* ASHA 7263 State Route 43/PO Box 708 Kent, OH 44240
- The Center for Health and Health Care in Schools (http://www.gwis.circ.gwu.edu/`mtg)

- Center for School Mental Health Analysis and Action, Legal and ethical issues in the practice of school mental health (http://csmha.umaryland.edu/cim.html)
- National Assembly of School-Based Health Care, HIPAA, FERPA, IDEA AND SBHCs: The Alphabet Soup of Health Information and Privacy Protection (http://www.nasbhc.org/TAT/About_HIPAA.htm)
- School Social Worker Association of America, School Social Workers and Confidentiality. If you are a member: http://sswaa.org/about/publications.html
- Center for Mental Health in Schools, Introductory packet on confidentiality and informed consent (http://www.smhp.psych.ucla.edu/qf/confid.htm)
- US Department of Education, Family Educational Rights and Privacy Act (FERPA) (http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.htm)
- U.S. Department of Health and Human Services, Fact sheet - Administrative simplification under HIPPA: National standards for transactions, privacy, and security (http://www.os.dhhs.gov/news/press/2002pres/hipaa.html)

38) Do you actively collaborate with other professionals in your school (other health/mental health providers, educators, administrators)?

Effective practice in school mental health requires the ability to collaboratively work across disciplines and with school-hired health and mental health staff (Center for Mental Health in Schools, 2000). This collaborative work requires clinicians to move past tensions to determine how to form true partnerships with their school-based colleagues (Flaherty, Garrison, Waxman, et al., 1998; Waxman, Weist, & Benson, 1998). Tensions related to forming these collaborative relationships are often related to "turf" issues, concern about job stability (e.g., if they are here, is there still a role for me?), misunderstandings about each other's roles, portraying clinical superiority, an unwillingness or disinterest in learning each other systems and culture, and an unwillingness to collaborate with one another (Flook, 1997). In view of the tremendous mental health needs of children and adolescents in today's society, school and community resources are both needed to meet the mental health needs of children (Center for Mental Health in Schools, 2001). Mental health staff must move past difficulties inherent in forming true collaborative partnerships and keep their main focus on doing what it takes to improve the health and well-being of the students served. Collaborations with other mental health providers help to increase the breadth and depth of available services, and increases capacity to serve students' mental health needs (Acosta, Tashman, Prodente, & Proescher, 2002). The services across school-hired and ESMH staff should be coordinated so that services are not duplicated and that clear gaps in services are being addressed. Within each ESMH school, a plan for mental health services should be developed that capitalizes on resources and is respectful of, responsive, and personalized to meet the specific needs of the school and the community (Hogenbruen, Clauss-Ehlers, Nelson, & Faenza, 2003). Ground rules must be set to avoid "turf" issues. Weist, Ambrose, and Lewis (2006) suggest three ground rules, which can keep "turf" issues from occurring. First, collaborators must exhibit mutual desire and respect to learn about each others disciplines. Second, a provider from one system should not be displaced in order to allow a provider from another system to work in a school. Third, mental health staff hired by the school should serve as leaders in mental health expansion efforts because they are in the best position to understand the dynamics of the school and its staff, students and families.

ESMH staff must also form true collaborative partnerships with school-based health staff. The imperative to integrate mental health and health services is consistent with the recommendations of the National Center for Chronic Disease Prevention and Health Promotion's "Coordinated School Health Model" (2001). A Coordinated School Health Program consists of the following eight components: Health Education, Physical Education, Health Services, Nutrition Services, Counseling, Psychological and Social Services, Healthy School Environment, Healthy Promotion for Staff, and Family/Community Involvement. The model recognizes the need for schools to provide comprehensive and integrated services that consider issues beyond just the education realm. Use of this coordinated model within schools can ultimately help to reduce barriers to learning and improve individual child well-being and overall school climate. Lloyd Kolbe, Director of the CDC's Division of Adolescent and School Health, highlights the tremendous value of the model in his statement that "Coordinated school health not only improves children's health, it improves the learning capacity of children" (National Center for Chronic Disease Prevention and Health Promotion, 2001, p. 6). Through the use of this model, schools strive to develop healthy school environments that promote positive behaviors and learning environments. The growth of school-based health centers (SBHC's) has underscored the unmet mental health needs of youth. In many SBHC's mental health concerns are the first or second most frequently stated issues for referral to the clinic (Anglin, 1996). An optimal approach is for ESMH programs to operate out of SBHC's . This partnership promotes a coordinated approach to student health and mental health issues. There is evidence which suggests that health outcomes are improved when mental health and medical services are integrated (Kibby, Tye, & Mulhern, 1998). As reviewed by Weist, Goldstein, Morris & Bryant (2003), additional advantages of such coordinated care include an enhanced referral base, promotion of a team approach, increased ability to screen for psychosocial concerns, enhanced confidentiality and privacy, reduced stigma, and decreased need for more intensive care.

Effective partnerships and collaborations with school staff are critical to the success of school mental health programming and are a defining characteristic that separates school mental health from community support services for children and youth. Adelman & Taylor (1996) suggest that there are three areas to focus on when linking with teachers to improve students' outcomes including: 1) prevention and health promotion in the classroom, 2) teaming to address children who need additional mental health supports, and 3) collaborative problem-solving to create comprehensive, coordinated programming. There are both formal and informal relationships that ESMH clinicians should engage in at schools. For example, student problem solving (prereferral teams) and/or other teams that address the social and emotional concerns provide opportunities to link with educators as well as other mental health service providers to impact interventions for students. These teams also can function as a mechanism for referrals to the ESMH program and provide clinicians with knowledge about the supports and services available at the school. In a more informal role, ESMH clinicians should participate in staff meetings and on planning teams (where appropriate). These meetings provide information about the status of the school, upcoming events/initiatives, and an opportunity for the ESMH clinicians to network and become part of the broader school community.

Working effectively with teachers and school personnel also should occur through collaborative prevention programming. There have been a number of interventions and program initiatives developed that emphasize the critical role of school staff on promoting the health and well being

of students (e.g., wraparound services, positive behavior interventions and supports, FAST Track). One of the defining factors of the success of these programs is the partnership of school, community, and support services personnel as linkages between prevention and intervention are explicit and planful (Dwyer, 2002; Ouellette, Briscoe & Tyson, 2004). Furthermore, teachers are the frontline providers for the mental health services for children, and the impact of the strategies they use and classroom climate on student's success has been clearly demonstrated in the literature (Bazelon Center, 2003; CASEL, 2003; Lynn, McKay, & Atkins, 2003; Paternite, 2004). Additional research supports the display of prosocial behavior by children is facilitate through teacher support and the establishment of clear rules, routines, and consistent consequences (Zins, Weissberg, Wang, & Walbeg, 2004). Rones & Hoagwood (2003) argue that "children whose emotional, behavioral, and social difficulties are not addressed have a diminished capacity to learn and benefit from the school environment. In addition, children who develop disruptive behavior patterns can have a negative influence on the social and academic environment for other children." Schools with effective classroom management, appropriate negative consequences for inappropriate behavior, consistent problem solving, and that utilize team approaches have students that are more socially and academically successful (Atkins, Frazier, Adil, & Talbott, 2003; Dwyer, 2002; Stuhlman & Pianta, 2001).

Through information dissemination and consultation, ESMH clinicians have significant supportive roles in helping teachers and administrators create positive learning environments to promote student success (Rappaport, Osher, Garrison, Anderson-Ketchmark & Dwyer, 2003). For example, providing teachers with effective stress management techniques and strategies for coping with problematic behaviors in the classroom not only empowers teachers to be more successful but provides them with evidence-based tools to utilize in the classroom (Paternite, 2003). Partnering with the school staff to create a shared vision for children and being an active participant in the working with the school to create a comprehensive system of caring will ultimately reduce the number of children in need of intensive mental health services. Collaborating with educators to promote children's health and well-being has been challenging as scheduling, resources, language, and frameworks for mental health professionals and educators do not always overlap neatly. Being aware of the issues and concerns facing schools and available resources to promote developing/sustaining programming are useful for effective discussions. Recognizing the stressors on and expectations for school staff will assist ESMH clinicians in the development of prevention and intervention strategies that incorporate best practices for students while also being reflective of the expectations for staff. These close working relationships will diminish duplication of services and create an atmosphere where educators are more likely to seek out the ESMH clinician to address needs of students. These relationships take time as individuals learn to trust and to ensure that there is common understanding and purpose between ESMH clinicians and school staff (NCREL, 1995).

It is important to remember that when addressing the needs of particular students in schools that the confidentiality mandates are different for educators and mental health professionals (Evans, Sapia, Axelrod Lowie, & Glomb, 2002). Confidentiality issues should be addressed up front with school staff so as to diminish areas of confusion, and confidentiality of private information should be maintained.

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Resources for this Quality Indicator

- American School Health Association, National Task Force on Confidential Student Health Information: Guidelines for Protecting Confidential Student Health Information (www.ashaweb.org)
- Bureau of Primary Health Care's Healthy Schools, Healthy Communities (http://www.bphc.hrsa.gov/center/students.htm)
- Center for Effective Collaboration and Practice (http://cecp.air.org) (www.casel.org/projects_products/safeandsound.php)
- The Center for Health and Health Care in Schools (http://www.healthinschools.org/sbhcs/papers/pictureofhealth.asp)
- Center for Mental Health in Schools, Resources on collaborative teams (http://smhp.psych.ucla.edu/topicslist.hmll#IB)
- Center for School Mental Health Analysis and Action, Critical issues document focusing on the integration of mental health and education (http://csmha.umaryland.edu/cim.html)
- Center for School-Based Mental Health Programs, Presentations on teacher involvement in mental health programming (www.units.muohio.edu/csbmhp/research.html)
- Collaborative for Academic, Social and Emotional Learning, Safe and Sound – provides an overview of social and emotional learning and the impact on student outcomes and school climate
- Community Toolbox, University of Kansas, (http://ctb.ku.edu/tools/coalitions/expand/index.jsp)
- National Assembly on School-based Health Care (http://www.nasbhc.org/nasbhc_resources.htm, under Principles for school-based health care)
- National Center for Drug Prevention and School Safety Program Coordinators, Resources for collaboration and integration of support services throughout the school day (http://www.k12coordinator.org/resources_detail.cfm?id=40)

- National Association of School Psychology, National Mental Health and Education Center, Excellent handout for parents, teachers, and principals (www.naspcenter.org)
- Resource Oriented Teams: Key Infrastructure Mechanisms for Enhancing Education Supports (available through Center for Mental Health in Schools, http://smhp.psych.ucla.edu)
- Positive Behavior Intervention and Supports (www.pbis.org)

Principle 10: Mental health programs in the school are coordinated with related programs in other community settings.

39) Are you knowledgeable about existing mental health and related resources for students in the school and community and is this information readily available in a directory that can be broadly shared within the school?

Expanded school mental health programs should exist as one component of a broader continuum of mental health care in the school and community (Leaf, Schultz, Kiser, & Pruitt, 2003; Weist, Lowie, Flaherty, & Pruitt, 2001). Unfortunately, the continuum of care is often limited due to either a dearth of resources or to system fragmentation and isolation of programs (Zetlin & Boyd, 1995). A system of care that is striving to promote the educational and psychosocial functioning of children should integrate mental health and educational activities with other services that can assist children and families (e.g., health, recreation, social services, etc.) (Leaf et al., 2003). In order to improve the quality of ESMH services, it is critical that school mental health providers understand the existing resources for students in the school community, not only to establish collaborative partnerships and a referral base, but also to avoid service duplication and to provide needed and meaningful services. The challenge to school mental health programs is to fill in gaps in the services continuum at all levels toward the development of a true system of mental health promotion, early intervention, and treatment (Weist et al., 2001). For ESMH staff to address this challenge, they need to learn about particular needs and strengths in the community at each level of care. For example, if too few students are able to access care in community outpatient settings for individual and family therapy, clinicians might consider whether these services can be augmented in the ESMH program. Conversely, if there are strong outpatient individual and family services, enhancing linkages to these programs would probably be the most viable strategy. Essentially, school mental health programs should seek to understand the community's needs, tailor services to best fill in gaps, and enhance linkages to strong community programs (Weist, 1997).

Resource mapping and analysis within the school and in the broader community can assist school mental health programs in this process of identifying and assessing the existing mental health services available to youth (Acosta, Tashman, Prodente, & Proescher, 2002). Resources would include school-wide and community-wide efforts that seek to prevent mental health problems, identify and intervene in emerging problems, and treat existing mental health problems (Weist et al., 2001). Both clinicians and stakeholders can contribute to identifying school and community resources, the services they provide, and the types of students that are typically seen (Center for Mental Health in Schools, 2000). A compilation of existing resources can be distributed among students, school staff, and parents, and can be used by the clinician as a reference for referrals and needed support for families. It is important to include only those resources and services that are relevant and assessable to the students and their families. Another way to help to make sure that services are well understood and coordinated within a school setting is to create a resource coordinating team (Center for Mental Health in Schools, 2000). A resource coordinating team helps to clarify available resources in the school and community and how they can best be accessed and utilized. The team could be comprised of key stakeholders including school administrators, mental health staff, guidance staff, teachers, students, families, and outside agency representatives.

In order to provide the kind of comprehensive mental health services that ESMH programs strive to offer, it is important that programs integrate themselves into schools in ways that mesh with related services, rather than supplant them. ESMH clinicians also need to ensure that they have knowledge of and access to all of the resources that could help the students and families in their school. In order to accomplish this, there should be an integration, maintenance, and development of resources both within the community and within the school itself (Rosenblum, et al., 1995). The development of a "resource coordinating team," is one way in which resources can be made more accessible. According to the model described by Rosenblum et al., the resource coordinating team can facilitate cohesion and coordination of school support programs for students and families. Some roles which can be taken by the resource coordination team include: identifying and preparing a list of available resources at the school, in the district, and in the community; clarifying how school staff and families can gain access to resources; ensuring maintenance of needed resources; and exploring ways to improve and augment existing resources. In order for the team to be effective, it should consist of members from various stakeholder groups including ESMH staff, school staff, community agencies, and parents. Others may be invited to join as new sources of support are identified. It is crucial that the team be interdisciplinary in order for the resources identified to be as comprehensive as possible. The team should meet as needed. Typically, the team will meet more frequently in the beginning. However, the team should be an ongoing effort, occasionally reassessing service needs and constantly seeking out new resources to be included and disseminated.

An important activity for the resource coordinating team is to obtain or develop a manual of relevant supportive community, health and mental health resources, and programs currently available to youth in the school and in the surrounding community. Such a directory should include both local and national organizations that can provide direct services to families or staff, or provide materials to support or educate families or staff. The more specific the information, the more helpful it is. In particular, including program requirements or referral processes and relevant phone numbers can save a lot of leg work and going down blind alleys when the time comes for someone to access the resource. Any referral forms, brochures, or copies of parent handouts that can be included will also save time. The team may want to organize the resource by topic with an index in the front to make them more accessible (sometimes when looking for a resource, the clinician won't know the name of an organization, but may know that they are looking for help with housing, for example). Finally, once the directory is finished, make sure it is accessible to everyone who might need it, and make sure there is more than one copy of all of the materials.

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Resources for this Quality Indicator

- Afterschool Gov State by state Community Page (http://www.afterschool.gov/cgi-bin4/states.pl)
- Big Brothers/Big Sisters of America, 230 North 13th Street, Philadelphia, PA 19107; (215) 567-7000, (215) 567-0394 (FAX); national@bbbsa.org (http://www.bbbsa.org)
- Boys and Girls Clubs of America, National Headquarters, 1230 West Peachtree Street, NW, Atlanta, GA 30309; (404) 487-5700; CRathburn@bgca.org
- Boy Scouts of America, National Council, PO Box 152079, Irving, TX 75015-2079 (http://www.bgca.org)
- Building More Effective Community Schools: A Guide to Key Ideas, Effective Approaches, and Technical Assistance Resources for Making Connections Cities and Site Teams (Annie

E. Casey Foundation)
(http://www.aecf.org/publications/pdfs/tarcguides/schools.pdf)
This Casey Foundation resource guide provides information, best practices, and technical assistance resources for its Making Connections communities as they seek to improve their community schools.

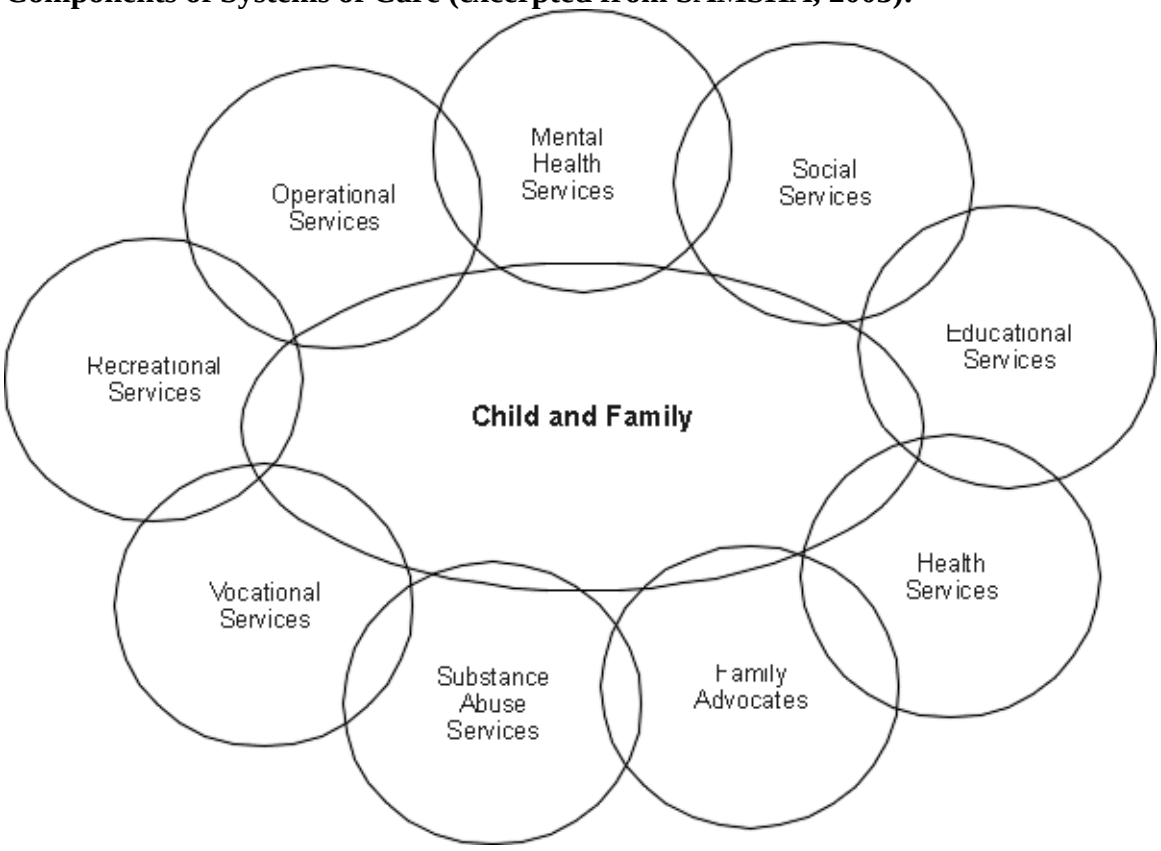
- Bureau for At-Risk Youth (http://www.at-risk.com)
- Camp Fire Boys and Girls, 4601 Madison Avenue, Kansas City, MO 64112-1278; (816) 756-1950, (816) 756 0258 (FAX); info@campfireusa.org (http://www.campfire.org
- Center for Mental Health in Schools, Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What a School Needs, School Mental Health Project (http://smhp.psych.ucla.edu)
- Center for Mental Health in Schools, School-Community Partnerships: A Guide, School Mental Health Project (http://smhp.psych.ucla.edu)
- Center for School Mental Health Analysis and Action, ESMH Program Development Resource (http://csmha.umaryland.edu/how/program_development_2002.pdf)
- Coalition for Community Schools (http://www.communityschools.org/)
- State Affiliates Listing for the Coalition for Community Schools (http://www.communityschools.org/stateaffiliates.html)
- Community Problem-Solving (http://www.community-problem-solving.net/)
- Communities in Schools (http://www.cisnet.org/)
- Girl Scouts of the U.S.A., 420 Fifth Avenue, New York, NY 10018-2702; (800) 478-7248 OR (212) 852-8000 (http://www.girlscouts.org)
- National Association of Partners in Education (http://napehq.org/)
- National Community Education Association (http://www.ncea.com/)
- National Dissemination Center for Children with Disabilities (in English and Spanish) NICHCY compiles disability-related resources in each state (http://www.nichcy.org/states.html)
- National Network of Partnership Schools (http://scov.csos.jhu.edu/p2000/p2000.html)
- National Mentoring Partnership (http://www.mentoring.org/)
- National PTA, 330 N. Wabash Avenue, Suite 2100, Chicago, IL 60611-3690; (800) 307-4PTA OR (312) 670-6782, (312) 670-6783 (FAX) (http://www.pta.org)
- National PTA Washington DC Office, 1090 Vermont Ave. NW, Suite 1200, Washington, D.C. 20005-4905; (202) 289-6790, (202) 289-6791 (FAX), Hotline: (888) 425-5537; info@pta.org
- United Way of America, 701 N. Fairfax Street, Alexandria, VA 22314; (703) 836-7112, (703) 683-7840 (FAX) (http://www.unitedway.org)
- YMCA of the USA, 101 North Wacker Drive, Chicago, IL 60606; (312) 977-0031; 350 Fifth Avenue, 3rd Floor, New York, NY 10118; (212) 273-7800 (http://www.ymca.net)

40) Are you working closely with other community health and mental health providers and programs to improve cross-referrals, enhance linkages, and coordinate and expand resources?

More and more attention is being paid to concerns regarding the fragmented way in which community health and human services have historically been planned and implemented

(Adelman & Taylor, 1997). In fact, there is emerging evidence that coordinated systems of care for children and adolescents contribute to improved functioning for youth with emotional disturbances. According to Stroul (2002), a system of care incorporates a broad array of services and supports that are organized into a coordinated network. Such a network integrates care planning and management across multiple levels. The Substance Abuse and Mental Health Services Administration (SAMSHA) describes how a system of care collaborates to help children or adolescents get the services they need in or near their home and community: "In systems of care, local public and private organizations work in teams to plan and implement a tailored set of services for each individual child's physical, emotional, social, educational, and family needs. Teams include family advocates and may be comprised of representatives from mental health, health, education, child welfare, juvenile justice, vocational counseling, recreation, substance abuse, or other organizations (see following graphic on "Components of Systems of Care"). Teams find and build upon the strengths of a child and his or her family, rather than focusing solely on their problems. Teams work with individual families, including the children, and with other caregivers as partners when developing a plan for the child and when making decisions that affect the child's care."

Components of Systems of Care (excerpted from SAMSHA, 2003):



One crucial component to coordination and collaboration efforts across multiple levels is the formation of an interagency steering committee (England & Cole, 1992). The steering committee should include a number of individuals from the participating agencies who are "close enough to the level of service provision to quickly resolve issues of interagency cooperation and access to services" (England & Cole, 1992: 631). Some strategies that have been found to be

helpful are: streamlining paperwork, emphasizing universal forms wherever possible; implementing a management information system that ties together agencies; localizing service planning and management. When working with a youth or family that is involved in multiple organizations, one person should be identified as the youth's case manager. This person will be responsible for coordinating services, making sure that each service provider's role is clearly defined, and make sure that goals stay strength based and feasible (SAMSHA, 2003).

Even if the ESMH clinician does not have access to an already established system of care, s/he can form new collaborations around specific needs or specific students. Communication between agencies is essential in ensuring that the student receives the best care and the appropriate action is taken (Rapport & Salmon, 2005). Making even one contact with an outside provider or community organization around a single student can form the cornerstone for building a new collaborative relationship and may lead to new, exciting opportunities. Alternatively, a clinician may choose a specific need or project in the school and build collaborations around that issue.

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Resources for this Quality Indicator

- Bureau of Primary Health Care's Healthy Schools, Healthy Communities (http://www.bphc.hrsa.gov/HSHC/)
- CASSP (http://pacassp.hbg.psu.edu/start.cfm)
- CDC, Division of Adolescent and School Health (http://www.cdc.gov/nccdphp/dash/cshpdef.htm)
- Center for School Mental Health Analysis and Action (http://csmha.umaryland.edu)
- Center for Mental Health in Schools , Integrating mental health in schools: Schools, school-based counselors, and community programs working together.
- (http://smhp.psych.ucla.edu/)
- The Center for Health and Health Care in Schools (http://www.healthinschools.org/links/)
- Family Guide to Systems of Care for Children with Mental Health Needs (in English and Spanish) (http://www.mentalhealth.org/publications/allpubs/Ca-0029/default.asp)
- National Assembly of National Voluntary Health and Social Welfare Organizations, The Community Collaboration Manual - provides step by step guidelines for the initial formation of collaboration and discusses how collaborations may maintain momentum and involve youth and businesses. The manual also identifies the role of the median contemporary collaborations. 1991/76pp $13.95

- National Assembly on School-based Health Care (http://www.nasbhc.org/)
- State Children's Health Insurance Program (SCHIP) (http://www.ncsl.org/programs/health/chiphome.htm)