Many people face bullies during childhood. However, schools are increasingly facing issues that are more serious than stolen milk money and name-calling. April 20, 2009 marks the 10-year anniversary of the shooting at Columbine High School in Colorado that resulted in the death of 14 students and one teacher. Although this tragedy sparked a flurry of debate concerning gun control laws, school security policies, and teens' exposure to violence in the media, it also sparked interest in issues that can affect students' mental health—including harassment, teen suicide and trauma. While serious incidents of school violence are rare, the importance of mental health services in schools cannot be underestimated.

Many individuals experience depression and anxiety as they make the transition from childhood to adulthood. In an effort to distinguish between "normal" teenage angst and serious mental health disorders, schools are increasingly providing mental health services to students. Studies estimate that one in five children and adolescents has a diagnosable mental health disorder, two-thirds of whom are not receiving necessary treatment. When untreated, mental health disorders can lead to failure in school, conflicts with family members, substance abuse, violence and suicide. Children and adolescents can experience a multitude of mental health disorders, including mood disorders (e.g., depression, bipolar disorder), anxiety disorders, attention-deficit and disruptive behavior disorders, pervasive developmental disorders (e.g., autism spectrum disorders), learning disorders, eating disorders and substance-related disorders. Children who experience abuse or witness a traumatic event may have additional mental health needs.

Why Schools?
Insufficient or no insurance coverage for mental health, financial constraints and lack of transportation are examples of the major barriers to mental health services that children and adolescents face. As a result, 40 to 60 percent of families that access mental health services stop receiving treatment prematurely. When services are provided through an educational institution, however, many of these barriers can be avoided—schools can provide free screenings and can supply parents with information about insurance options for low-income children. Because many states and school districts already require their schools to provide students with physical health screenings and services, similar policies for mental health often can be established easily.

With more than 97 percent of 5- to 17-year olds enrolled in school, teachers and school administrative staff not only spend a significant portion of time with children but also are in a unique position to recognize symptoms—such as low attendance rates, struggling academic performance, and anti-social and problem behaviors—of a potentially larger problem. The mental health services provided by a school can include any number of benefits, including early identification, crisis intervention, prevention, treatment, and promotion of positive social and emotional development.

Most schools already offer some level of assistance. This can include teachers who identify and refer at-risk students to social services, in-class discussions about self-esteem, or individual consultations with child psychologist staff in the school. Unfortunately, no one best policy exists for implementing and financing mental health services in K-12 schools. However, studies consistently show that early identification and prevention of mental health disorders through either a school-based or school-linked program can enhance children's overall health, improve social confidence and academic success, and help them lead more productive lives. ⛪

Percentage of Children Reported to Have Emotional or Behavioral Difficulties by Age and Severity, 2006
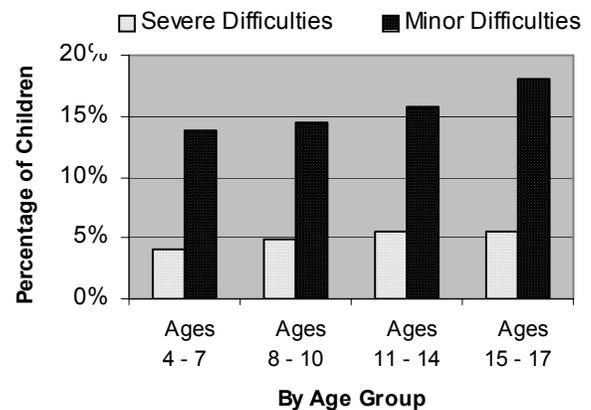
Source: The Federal Interagency Forum on Child and Family Statistics, *America's Children: Key National Indicators of Well-Being* (Washington, DC: U.S. Government Printing Office, July 2007).

SERVICE AVAILABILITY AND COORDINATION

STUDY AND RESULTS: The School Health Policies and Programs Study, which was conducted in 2000 and 2006, assessed mental health and social services from all 50 states, nationally representative samples of public school districts, and public and private elementary, middle and high schools. In six years, the percentage of states requiring schools to have a coordinator of mental health and social services decreased from 18.8 percent to 8.9 percent. The percentage of states that actually had such a coordinator increased from 52 to 79.2 percent. The study also found the number of states that require schools to offer student assistance programs increased by more than 21 percent.

WHAT'S IMPORTANT: Relatively few schools deliver mental health and social services through School-Based Health Centers, which provide a range of primary health care services within schools. Arrangements with providers located away from school property are more common. The authors determined that a lack of state and district policy that support broad school mental health and social services "may create unsystematic planning and implementation of services, as well as fragmented and piecemeal activities at the school level, an inefficient use of limited resources."

FIND IT: Nancy Brener et al., "Mental Health and Social Services: Results from the School Health Policies and Programs Study 2006," *Journal of School Health* (October 2007).

DISPROPORTIONALITY OF MINORITY STUDENTS

STUDY AND RESULTS: At the national level, African American students account for 33 percent of students identified as mentally retarded, but they represent only 17 percent of the school-aged population. African American students are the most overrepresented group in special education programs in nearly every state. American Indian and Alaska Native students have been particularly overrepresented in the category of learning disabilities. National data show that Hispanic students are underrepresented in overall special education services and in most disability categories.

WHAT'S IMPORTANT: To address this disparity, Congress passed the Individuals with Disabilities Act (IDEA) in 2004, requiring states to monitor the disproportionate representation of minority students in special education programs and establish policies and procedures to prevent overidentification. Despite laws, court cases and abundant research, however, disproportionality continues throughout the United States.

The study finds that racial and ethnic disparities in special education are not solely a special education problem but also are evident in sources of educational inequity in general education, including curriculum, teacher quality and resource availability. The authors recommend improving classroom management to prevent inappropriate referrals to special education classes, training teachers to be culturally-responsive, increasing parental involvement, and implementing an assessment model that emphasizes context for understanding students' academic or behavioral difficulties.

FIND IT: Ada B. Simmons et al., "Achieving Equity in Special Education: History, Status, and Current Challenges," *Exceptional Children* (March 22, 2008).

SCREENINGS EFFECTIVE IN MIDDLE SCHOOLS

STUDY AND RESULTS: Students with emotional and behavioral disorders (EBD) portray a pattern of socially inappropriate or undesirable behaviors that can be identified before preschool or as late as eighth grade. During this study, students in grades six through eight who attended rural and urban middle schools were compared using the Student Risk Screening Scale (SRSS), an evaluation completed by teachers for students who are identified as at-risk. Results indicated that when compared to other screening instruments such as the Strengths and Difficulties Questionnaire, SRSS yields reliable, valid scores in both rural and urban schools and can be more easily implemented.

WHAT'S IMPORTANT: Supporting students with EBD is both difficult and costly to schools. Because the rate of students diagnosed with these disorders varies from 2 percent to 20 percent of all school-aged children, improved methods of identifying these disorders are needed. The authors reported that systematic screenings in elementary schools generally are well-established, but "systematic screening tools are equally necessary at the middle school—a vulnerable time for many students."

FIND IT: Kathleen Lynne Lane et al., "Systematic Screening at the Middle School Level: Score Reliability and Validity of the Student Risk Screening Scale," *Journal of Emotional and Behavioral Disorders* (December 2007).

SCHOOL-BASED VIOLENCE PREVENTION PROGRAMS

STUDY AND RESULTS: Universal school-based programs targeted to reduce or prevent violent and aggressive behaviors are used to educate all children within a school or a school grade. Lessons are age-appropriate; for instance, elementary school students might focus on

mitigating disruptive and antisocial behavior, while older students learn about specific forms of violence such as fighting and dating violence. This study systematically reviewed rates of violence—which included acts of serious violent crimes (i.e., rape, aggravated assault), simple assault (i.e., attacks without a weapon), and physical and verbal aggression—in time periods that ranged from six months to six years after schools administered such universal programs. For all grades combined, the median effect was a 15 percent decline in violent behavior among students who completed the program—reductions of 32.4 percent in pre-kindergarteners and kindergarteners, 18 percent in elementary school students, 7.3 percent in middle-schoolers, and 29.2 percent in high school students.

WHAT'S IMPORTANT: Although topics covered and strategies pursued varied, all the school-based antiviolence programs examined during this study were associated with some reduction in violent behavior, regardless of grade level or socio-economic status. Costs to implement such programs also vary; however, the authors estimated a cost savings of $3.14 for every $1 invested, based on a projected decrease in involvement with the criminal justice system

Percentage of School Districts that Report Moderate or Major Funding Restrictions to the Delivery of Mental Health Services, 2002-2003

Source: Susan Foster, et al., *School Mental Health Services in the United States, 2002-2003* (Rockville, MD: SAMHSA, 2005).

and reduced personal property losses for crime victims. In addition to saving money, school-based violence prevention programs also can contribute to positive academic outcomes such as increased attendance and improved performance.

FIND IT: Robert Hahn et al., "The Effectiveness of Universal School-Based Programs for the Prevention of Violent and Aggressive Behavior: A Report on Recommendations of the Task Force on Community Preventive Services," *Morbidity and Mortality Weekly Report* (August 10, 2007).

ADDRESSING TRAUMA IN THE CLASSROOM

STUDY AND RESULTS: Following the attacks on the World Trade Center on Sept. 11, 2001, 63 children in Manhattan who were found to have symptoms of posttraumatic stress disorder (PTSD), generalized anxiety, and depression, received a 10-session, skill-based classroom intervention. These students in grades three through eight learned to talk about the experience and acquired tools to normalize their reactions and help them feel safe. After completing the in-class interventions, evaluations found that students experienced significant decreases in symptoms of depression and anger but not in general anxiety.

WHAT'S IMPORTANT: Although the study sample size was relatively small, it suggests a need to examine the feasibility of school-based trauma programs, particularly in low-income urban areas. The authors found that "school-based trauma programs provide a unique way to reach a large number of children in a setting that is familiar and comfortable to them."

FIND IT: Elissa J. Brown et al., "Matching Interventions to Children's Mental Health Needs: Feasibility and Acceptability of a Pilot School-Based Trauma Intervention Program," *Education & Treatment of Children* (May 2006).
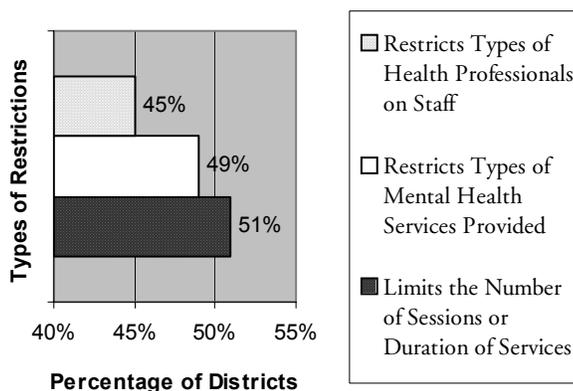
WHO KNOWS: AN INTERVIEW WITH AN EXPERT

Mark Weist is a professor in the Department of Psychiatry at the University of Maryland School of Medicine. He also is director of the Center for School Mental Health (http://csmh.umaryland.edu), academic editor for the international journal *Advances in School Mental Health Promotion* (www.schoolmentalhealth.co.uk), and co-founder of the International Alliance for Child and Adolescent Mental Health and Schools (www.intercamhs.org).

What are the most common mental health problems among kids in school?
It depends on their age and where they live. The common issues we see are disruptive behavioral disorders, including ADHD, depression, anxiety [and] trauma-related problems. For example, we have a large program in Baltimore city schools, and youth in most of the schools are contending with high levels of exposure to violence in their neighborhoods. There may be other trauma experienced through people that they know. They may

experience high levels of loss. They may be exposed to neglect. We also have growing initiatives for military families and we know of significant stressors that they're experiencing—including stress related to multiple deployments, separation from family, and family member exposure to combat-related trauma.

Do problems break down by age group?
For younger children, you see more of the disruptive behavioral problems. ADHD will surface usually in the elementary grades or sooner. You do see anxiety and attachment problems in young children. But in general as children get older, we see more anxiety, more depression. Beginning in the middle schools, we see issues with substances.

Can you talk in more detail about what you've experienced in Baltimore, and what lessons this might have for lawmakers who are attempting to expand mental health services in their own school systems?
The big issue is that we know that youth with mental health challenges tend not to receive services, the problem being that we have overly relied on sites away from children's natural environments—such as community mental health centers, private offices—and the literature indicates that the great majority of children do not get to these sites. Alternatively, within schools, the mental health agenda is often marginalized so that there are not enough services or people. What children can actually receive through schools is fairly limited.

So in Baltimore, we put these two rationales together to develop what we call *expanded* school mental health programs and services, which involve these school-family community partnerships to move towards a full array of mental promotion and intervention in the schools for youth in general and for special education. The advantage to the mental health system is that it's where the students are and it ends up becoming a much more efficient program reaching youth that otherwise wouldn't be reached. The advantage to schools is they receive very significant support. And in combination, we can do a much better job of reducing barriers to learning and promoting the kind of outcomes that all stakeholders care about. The legislators, the community leaders, the families, school leaders—all care about these outcomes that youth are coming to school on time, prepared to learn, listening, behaving, learning, graduating, and going on to become productive citizens. And there's evidence that these programs, when done the right way, help to promote these outcomes.

So in Baltimore we focused on, from 1989, progressively developing this expanded framework, increasing the number of schools, identifying methods to fund these programs and services—that's a big role for legislators—

utilizing mechanisms, maximizing their use such as fee-for-service. But we have challenges there. Medicaid in general has been an insurer that has traditionally supported school mental health. But many communities have struggled getting the other insurers on board with this agenda. We also know that it can't be all fee-for-service. There's a certain bureaucratic demand associated with fee-for-service that it makes it difficult to do the work, especially the more preventive work.

So we need the harder dollars, the harder resources. For example, on the education side there are resources through allocations such as Title I for impoverished children, through Safe and Drug Free Schools, through site-based management where principals having authority to spend in the way they see fit. So there are ways to fund these programs and that has been the experience in Baltimore where we're just trying to maximize all possible sources of support. We're trying to maximize the quality of services as we demonstrate valued outcomes. I've been in the city working on this since 1991—we've grown from four schools in 1989 to about 100 out of 180 in Baltimore city now, which is tremendous progress.

Have you seen similar programs or results from other states that have shown similar results or promise?
We have a national center for school mental health that I direct to help advance the school mental health agenda in the United States. A major focus of our center in recent years has been the creation of a national community of practice for school mental health, where we're really trying to learn what's out there and connect states together. We're trying to create multi-scale learning where all the connections are made. States, professional organizations, federal support, national support—all working together and moving to advance this school mental health agenda.

Part of what we're doing with a group—the IDEA Partnership, which includes over 30 organizations committed to this agenda—is to develop this national community of practice and within it to support particular states as they build systematic initiatives for school mental health. All of which again reflect the shared agenda—school, family, community partnerships. So on the website sharedwork.org, there's a review of this community. If you were to go on there, you would see 12 states listed that are systematically advancing this agenda, then you click on each one of those states and see what they're doing. So there's progress being made all across the country at the state and community levels. We're hopeful that in the new administration this is going to become even more of a priority.

Anything else you want legislators to know?
In all the work they that do, this is an agenda that should really rise up. Because it's about children, it's about

adolescents, it's about helping them learn, about helping them graduate. I know that legislators have many demands on them and many agendas. This is an integrative agenda that is very important for our nation that we're going to see grow and we would greatly appreciate the active involvement of legislators. We actually have four state legislators on our advisory board

for our national center and any legislator that's interested in this topic—we would be very interested in talking with them. We often go to communities and states to help support this agenda. We often have visitors to our national center and we welcome and appreciate the involvement of state legislators. ⛪

WHAT WORKS: PROGRAMS WITH PROMISE

Ohio's Partnerships for Success: State-Supported Local Planning

Administered by the Ohio Department of Youth Services, "Partnerships for Success" (PfS) is a community-based process that has helped local planning teams—known as Family and Children First Councils (FCF Councils)—since 2003. Comprised of a state-supported group coordinator and representatives from county agencies and community organizations, FCF Councils work to improve child well-being in a coordinated, cost-effective manner by identifying county priorities, evaluating existing programs, streamlining overlapping efforts, and developing evidence-based practices. Although participating FCF Councils adhere to fixed planning steps for capacity-building, PfS strategies are tailored to meet local needs.

In 2006, the state provided FCF Councils with $1.5 million, and an additional $17.3 million was raised through external funding to sustain and expand initiatives. Between 2005 and 2006 for every $1 invested in PfS, the program gained a return of $11.52. PfS helps counties maximize existing efforts by eliminating duplicative services so a program's success is not necessarily contingent upon the availability of funding.

The Allen County FCF Council, for example, implemented a successful PfS strategy to address student mental health in conjunction with delinquency, academic performance, substance abuse, teen pregnancy and

violence. To help with prevention, a questionnaire is administered periodically to screen all children who participate in Head Start and public pre-school programs for mental health problems. The program's mental health interventions, which include an array of evidence-based practices, help teachers and families effectively support children who are at risk of developing mental health issues.

The Allen County FCF Council also guided Freedom Elementary School to leverage funds for in-school and at-home mental health services and formed teams to create customized plans for students with poor academic performance. During the 2005-2006 school year, the PfS initiative helped propel Freedom Elementary from "Academic Emergency" to "Continuous Improvement" status.

The Ohio Department of Youth Services cites several benchmarks that demonstrate PfS's success. The 53 counties currently participating in PfS generate more collaboration between agencies than the 35 counties that are not involved. FCF Councils also use more than 50 evidence-based programs that prove to reduce problem behaviors. For more information, visit www.pfsacademy.org.

Statewide Wraparound: Scaling Up in Oregon

Oregon's Statewide Wraparound Initiative exemplifies how states can advance successful local initiatives. Wraparound initiatives integrate the work of businesses, government agencies, and nonprofit and community health organizations in supporting children who are at risk for or have developed complex mental health or substance abuse problems. Based in Multnomah County, Oregon's two pilot projects began serving children up to age 18 in 2005.

One wraparound approach connects school-based mental health programs with Positive Behavior Intervention and Supports (PBIS), an initiative that improves safety and efficiency in the classroom by reducing disruptive behavior and recovering administrative and teaching time and resources. PBIS targets all students at the most basic level and provides higher levels of services to those in need. Several Oregon counties are incorporating PBIS into existing mental health services to better identify students

States Impacted by National Wraparound Initiative (NWI), 2009
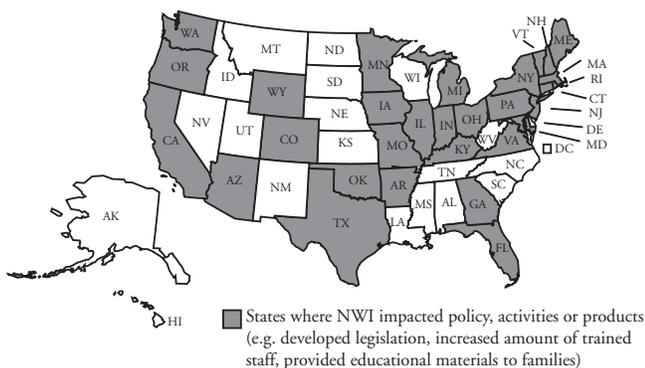
Source: Eric J. Bruns, et al., *Impact of the National Wraparound Initiative: Results of a Survey of NWI Advisors* (Portland, OR: National Wraparound Initiative, 2009).

with mental health needs and connect them with a wraparound team—consisting of mental health professionals, such as counselors and social workers—who can operate within or outside the school.

Oregon also integrated mental health services with expansion of School-Based Health Centers (SBHCs) where students can receive both preventive care and treatment services, regardless of insurance coverage. The Oregon legislature and Department of Human Services funded the start-up and operation of new SBHCs across the state. As a result, the proportion of certified SBHCs with a mental health care provider on site rose from 44 percent in 2006 to 67 percent in 2007. A recent report on SBHC expansion in Oregon found that, when employed onsite, mental health providers were more likely to properly diagnose students' mental health disorders and provide ongoing treatment. Eleventh grade recipients of SBHC care also reported fewer unmet mental health needs, when compared with other students in the state.

In a follow-up to the success of local wraparound initiatives, Governor Ted Kulongoski appointed a steering committee to determine how the state might better serve youth who have complex mental health needs. Among the committee's final recommendations were combining state and local funding for programs and using information technology to support coordinated efforts. In 2008, the state legislature approved funding to assess necessary infrastructural changes for comprehensive reform of delivery of children's mental health services. Refer to www.wraparoundoregon.org for additional details. ⌂

ON THE HORIZON: EMERGING PROGRAMS

TeenScreen: Linking Youths with Mental Health Checkups
The concept is simple: Increasing the availability of mental health screenings for young people should increase the likelihood that those in need of mental health services will have access to them. The school is a sensible option for providing such services because of its accessibility and familiarity to children and parents and because most are already equipped for other screenings such as hearing and vision. To promote this concept, the TeenScreen National Center for Mental Health Checkups at Columbia University offers its TeenScreen Schools and Communities program.

The program, which is voluntary, free of charge, and requires active parental consent, provides middle schools and high schools with the necessary resources to start a mental health screening program. Screenings, also known as mental health checkups, identify potential mental health problems such as depression with the intent to reduce disability associated with mental health disorders and prevent suicide. Parents of youth found to be at risk are notified and helped to identify and connect to local services where they can obtain a complete evaluation by a qualified professional. The process is not geared toward diagnosis or treatment, but rather to identify children who might need help and connecting them with appropriate mental health professionals.

A study of the program found that TeenScreen identified 15 times the number of high school students in need of mental health services as compared to preexisting in-school mental health services. Another study demonstrated that TeenScreen accurately identified 63 percent of students with significant mental health problems, while school professionals accurately identified only 37 percent. The same study also showed that TeenScreen identified 100 percent of teens at highest risk for suicide—those with suicidal ideation or a prior suicide attempt and a current mood, anxiety or substance use disorder.

More than 500 school- and community-based screening programs currently are operating in 43 states. Iowa and Ohio have partnered with TeenScreen to pilot statewide screening programs. Iowa alone has 56 TeenScreen sites, most of which are school-based. The Ohio Department of Mental Health and the Ohio Suicide Prevention Foundation established 93 screening sites in 16 counties and is planning to open 18 new sites in the next three years.

TeenScreen, recognized by the President's New Freedom Commission on Mental Health as a model program, is included in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices. For further details, visit www.teenscreen.org. ⌂

The **Center for Mental Health in Schools** (http://smhp.psych.ucla.edu) pursues theory, research, practice and training related to addressing mental health and psychosocial concerns through school-based interventions.

The **Center for School-Based Mental Health Programs** (www.units.muohio.edu/csbmhp) promotes the development and implementation of effective programs to enhance healthy psychological development of school-age students and reduce mental health barriers to learning.

The **Center for School Mental Health** (http://csmh.umaryland.edu) is committed to strengthening policies and programs in school mental health to improve learning and promote success for America's youth.

The **Research and Training Center for Children's Mental Health** (http://rtckids.fmhi.usf.edu) works to improve services for children with serious mental health disorders.

The **Center for the Advancement of Mental Health Practices in Schools** (http://education.missouri.edu/orgs/camhps) develops evidence-based training to serve as a connection between school systems and community mental health agencies that work with children.

The **National Assembly on School-Based Health Care** (www.nasbhc.org) helps state departments of education, in collaboration with partner agencies, to participate in a pilot technical assistance and training initiative. The NASBHS website provides resources for mental health planning and feedback from students.

The **Center for Health and Health Care in Schools** (www.healthinschools.org) provides background information, papers on financing policies, and examples of existing programs.

IDEA Partnership facilitates interaction and shared work in order to improving outcomes for students. The mental health page (http://www.ideapartnership.org/report.cfm?reportid=97) provides an extensive list of web-based periodicals.
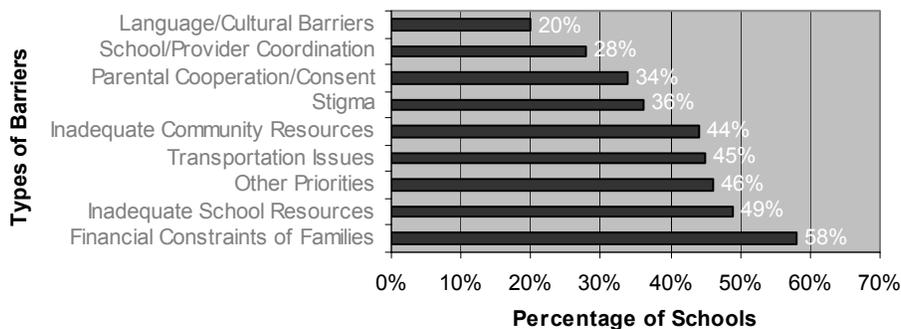
SchoolMentalHealth.org provides practical, user-friendly resources and tools related to advancing mental health identification, referral and best practices in schools.

The **National Community of Practice on Collaborative School Behavioral Health** (http://www.sharedwork.org) is a national community including consumers, practitioners, researchers, and decision-makers with the mission to bridge the differences across education and mental health to support youth.

The **National Center for Children in Poverty** has a children's mental health webpage (www.nccp.org/topics/mentalhealth.htm) that provides publications on public policy issues concerning the mental health of youth.

For more information on the **Coordinated State Leadership for Better Mental Health**, NCSL's mental health project funded by the John D. and Catherine T. MacArthur Foundation, go to www.ncsl.org. ⌂

Percentage of Schools Reporting Barriers to Providing Mental Health Services, 2002-2003

Types of Barriers	Percentage of Schools
Language/Cultural Barriers	20%
School/Provider Coordination	28%
Parental Cooperation/Consent	34%
Stigma	36%
Inadequate Community Resources	44%
Transportation Issues	45%
Other Priorities	46%
Inadequate School Resources	49%
Financial Constraints of Families	58%

Source: Susan Foster, et al., *School Mental Health Services in the United States, 2002-2003* (Rockville, MD: SAMHSA, 2005).