

School Mental Health Services
for the 21st Century:
Lessons from the District of Columbia School
Mental Health Program

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District of Columbia School Mental
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EXECUTIVE SUMMARY

Overview

In January 2007, The Center for Health and Health Care in Schools at the George Washington University School of Public Health and Health Services was commissioned to assess operations of school mental health programs in Washington, D.C. and recommend future directions in practices, policies and systems development. While this guidance is directed primarily at the District of Columbia Department of Mental Health, the goal of this report is to offer guidance for all public and private organizations and individuals that share a commitment to effective mental health programs for children in the District of Columbia.

This report is based on a 16-month examination of school-connected mental health programs here in the District of Columbia and in cities, counties and states around the nation. In the course of the study, the authors conducted an in-depth examination of school mental health programs in DC, reviewed relevant literature, and interviewed 100 local and national experts in children's mental health and school mental health.

Policymakers, program directors, educators and mental health professionals increasingly view school-connected mental health as essential to effective schools and well-functioning mental health systems of care. Last year this perspective was evident in the District of Columbia when the Interagency Collaboration and Services Integration Commission (ICSIC) included school mental health as part of the District of Columbia Public Education Reform Amendment Act of 2007.

The overarching goal of this report is to document the critical components of effective school mental health programs utilizing the best current thinking and practice so that programs developed with this guidance in mind can withstand the political, economic, and social pressures that frequently erode best-practice models. To this end, the report recommends a number of roles, functions, and activities for the DC Department of Mental Health within five areas: organizational management, program development and evidence-based practices, training and professional development, financing, and program evaluation and outcomes research.

Key Findings

There is significant support for school mental health in the District of Columbia.

Over the course of this study, school system and mental health policymakers and program leaders have stated their belief that school-connected mental health programming is essential to effective schools and to effective child mental health systems of care. The depth of this support is evidenced by the establishment of the Interagency Collaboration and Services Integration Commission (ICSIC), within the District of Columbia Public Education Reform Amendment Act of 2007. Title V of this Act states that ICSIC will address the needs of at-risk children “through a comprehensive integrated service delivery system.” The Act then outlines a number of issues that the school-based strategies should address. The legislation indicates how important school-based professionals are in coordinating integrated mental health and social services within an educational setting.

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Despite growing support, school mental health services remain fragmented and need an overarching principle or framework to facilitate services integration and coordination.

The most significant observation emerging from this study is that District government agencies, public school officials, and state leaders have not articulated a unified conceptual framework to guide the establishment of an integrated approach to improving school performance and reducing health and mental health risk factors among District students. Although the ICSIC provides a sound organizational structure to examine programmatic, political, and fiscal issues related to providing services, there is no single model of care that guides this group. For example: A number of different, and sometimes competing, pressure points (e.g. No Child Left Behind legislation, the Blackman-Jones lawsuit, Dixon consent decree, and the new public school authority) have driven the implementation of multiple school health and mental health initiatives throughout the city. Although well intentioned and individually based on strong evidence, these initiatives are not coordinated and do not reflect a single vision for school-based health and mental health programs in the District of Columbia. Redundancy and fragmentation of services is evident.

Looking to the future, the mental health experts consulted recommend a public health model as the best framework for organizing school-connected programs, policies and practices.

The public health approach to mental health is characterized by concern for the health of an entire population, extending beyond diagnosis and treatment for individuals to including population-based approaches that promote well-being, facilitate access to treatment, ensure delivery of quality care, and identify individuals in need before treatment is necessary. DMH has drawn heavily from this model in the establishment of the School Mental Health Program (SMHP) but adoption of this framework has not reached the highest levels of District government. Having an umbrella framework that distinguishes multiple levels of care will yield a citywide plan with numerous programmatic activities that would be integrated, complimentary, and together create supportive school experiences for disadvantaged youth.

The “DC School Mental Health Model” should involve a continuum of services and programs delivered by a variety of school and community mental health professionals and educators.

Determining who is best able to help students calls for a critical assessment of services and programs to be provided, the skills needed, the capacities of school and community providers, and the identification of best practice models suitable to District of Columbia school students and their families. In the end, the organization and delivery of school mental health programs requires a high degree of interdependence between the education and mental health agencies. The degree to which prevention, early intervention, and treatment services are delivered will be a function of the skills, supports, and staff available from both education and mental health.

Expanding school-based mental health programs across the City will require investment in infrastructure development as well as program development.

The District's public mental health agency is ideally positioned to lead the formation of a unified master plan for school-based mental health services – services that can provide prevention, early intervention, and treatment care for all District students in need. For mental health programs to take root, DMH must also invest in an infrastructure that supports high quality care, transparent

EXECUTIVE SUMMARY: *continued*

and consistent communications inside and outside of the agency, sound decision-making about the allocation of resources, and professional capacity-building sufficient to sustain the programmatic growth envisioned.

The use of evidence-based practices and programs and data-driven decision-making is essential to establishing and maintaining a high quality, continually improving school mental health program.

Two of the most important decisions the DC School Mental Health Program can make to ensure quality services and effective delivery of care are: (1) to adopt evidence-based mental health practices (EBP), and (2) to commit to using data-driven decision-making. Concerning EBP, experts caution that, because the evidence base is always changing due to on-going research, a citywide school mental health program needs to adapt to the latest empirical evidence about effectiveness and efficacy. Experts also note that a citywide school mental health program model also needs to be able to adapt to changing demographics or environmental risk factors. Concerning data-driven decision-making, the city must invest in an information system that enables program and political leadership to monitor and evaluate school mental health programs and services across the city. The information system must have the capacity to collect mental health, substance use, violence-related, and academic data from the multiple agencies involved in each school-based program. Compatible and flexible information systems will significantly improve the program's potential to create and sustain fundamental change.

A unified DC School Mental Health Model will only be achieved with district-wide cooperation and community involvement.

While support for a public health approach to school mental health programs has grown within the education and mental health communities, clarity around who is responsible for the delivery, funding, training, and evaluation of interventions within each component of a school-based mental health approach remains to be determined. Decisions about what the "DC School Mental Health Model" looks like can only be made by those responsible for school-connected services. Mental health, education, health, parents, and elected officials all need to be at the table.

The future of mental health services provided in District of Columbia schools-will be decided by the city's political leadership, in consultation with community members, mental health and education professionals, and consistent with insights from research and informed by other state and community experiences.

To secure the desired end, decisions must be informed by what the research teaches about the structures and resources that must be in place to support whatever strategies are selected. The District of Columbia government and the public school systems have been remarkable in their support of school-based services and programs. Our hope is that decision-makers will recognize the many community, family, and university resources that exist and can be brought to bear to build upon the many successes already experienced.

SECTION I: INTRODUCTION

The Center for Health and Health Care in Schools was asked by the Student Support Center (formerly the Center for Student Support Services) to recommend a plan for sustaining and expanding school-based mental health services in Washington, D.C.

Early in this decade the city recognized that existing resources in the District of Columbia Public Schools (DCPS) were insufficient to meet the mental health needs of its young people. Building on an initial federal grant to the Center for Student Support Services (CSSS) to provide mental health assistance in a number of charter schools, the DC Department of Mental Health (DMH) committed to sustaining the original grant-supported school-based mental health services in charter schools and expanding the services into DCPS buildings. This expansion became known as the DC School Mental Health Program. Currently, the city has two principal school mental health providers: the Student Support Center (SSC; formerly known as CSSS) and the DC Department of Mental Health. In general, the expansion of school mental health services is supported by the schools and elected officials, particularly Council members David Catania and Tommy Wells who chair the Council's Health Committee and Human Services Committee respectively. Mayor Adrian Fenty also announced that expanding school-based mental health services in the District is one of his major goals for 2008 (Neibauer, January 26, 2008). In the schools, parents, family members, and community leaders have also welcomed the additional help for students – leading other schools to seek this service as well.

As interest in school mental health has grown, questions have been raised about how best to design and manage this promising new set of services. Among these questions are: What should be the role for the Department of Mental Health? Should it be a direct service provider as is now the case or should DMH primarily develop program standards, implement training, and provide oversight? What emphasis should be placed on prevention, early intervention, and treatment activities? What do we know about best practice in staffing requirements and training, and how have other cities and states organized mental health services in schools? What lessons do they have for us in terms of the implementation of evidence-based practice? And while program financing was not a primary

objective of this study, current funding arrangements that rely primarily on local dollars in the DC budget have created urgent concern about whether this is the best use of local dollars. This report addresses these questions with the intent of presenting the information essential to support decision-making about the continued expansion of the School Mental Health Program.

Report goal

The goal of this report is to provide a set of recommendations about the most effective strategies for expanding school-based mental health services in Washington, DC that can withstand political, economic, and social changes. Although nationally there are a variety of school mental health program models and arrangements, this report focuses on strategies that can strengthen the relationship between community mental health organizations and schools/school districts in the delivery of school-based mental health care.

The report covers the following topics critical to the development and maintenance of school mental health services and programs:

- Organizational management
- Program development and evidence-based practices
- Training/professional development
- Financing
- Program evaluation and outcomes research

Methodology

The report and its recommendations are based on an analysis of local school-based services and programs, an environmental scan of best practices across the country, and assessment of peer-reviewed research in the five areas indicated above. The recommendations are meant to provide guidance to the Department of Mental Health, the DC Public School System and public charter schools, the State Superintendent of Education, community mental health providers, and the Mayor and city council members as the city proceeds to make decisions about program maintenance, sustainability, and expansion.

Multiple methods were used to gather information for this report. These include:

- Face-to-face interviews with 38 local key stakeholders, elected officials, and city administrators involved in

the provision of school-based services in Washington, D.C. These individuals represented the mental health, health, education, or social service sectors.

- Face-to-face or phone interviews with national experts in the fields of children’s mental health or school mental health. These interviews sought to learn about best practices in program development, administration, evaluation, and quality improvement. Twenty national experts were interviewed.
- Face-to-face or phone interviews with representatives from state or county mental health agencies outside the District of Columbia to discuss current policies, programs, management, and financing of school-based mental health care in their state or locality. Forty-two state/county representatives were interviewed.
- Focus groups with two groups of school-based clinicians, one from the DC DMH School Mental Health Program (8 participants) and the other from the Center for Student Support Services (15 participants).
- Participation in five national meetings addressing the critical issues emerging in the field of school mental health, including:
 - A System of Care for Children’s Mental Health conference hosted by the Research and Training Center for Children’s Mental Health (March, 2007)
 - National School-Based Health Care convention hosted by the National Assembly on School-Based Health Care (June, 2007 & June, 2008)
 - Advancing School Mental Health Annual Meeting sponsored by the Center for School Mental Health (October, 2007 & September, 2008)
- Documents reviewed included:
 - Descriptive materials about local initiatives in health and education, as well as city-wide strategies aimed at improving the well-being of the District’s children.

- Information about services provided by the DC Department of Mental Health School Mental Health Program and the Student Support Center, including evaluation studies, grant proposals, and annual reports. Materials included reports, protocols, regulations, and policies.
- Descriptive materials related to the organizational structure, evaluation, staffing, training, financing, and program and policy development of school-based mental health programs in other states, counties and cities around the United States.
- Research papers, scientific reports, and guidelines for best practices and evidence-based programs in school mental health.

Appendix A lists individuals interviewed for this report. Reports reviewed are listed in Appendix B. Research papers specifically cited within this report are included in the reference section.

SECTION II: BACKGROUND

Two hundred and thirty-four public schools and public charter schools serve 72, 378 D.C. school-age children. Of these children, 82% are African-American and about 11% are Hispanic (DC Public Schools Master Education Plan, 2006). The District of Columbia Public Schools (DCPS), the city’s largest local education agency (LEA), operates 162 schools in 151 different locations (more than one school may occupy a building). Public charter schools numbered 72 during the 2006-2007 school year and are operated by private non-profit boards under the jurisdiction of the Public Charter School Board. DCPS enrollment was 52,645 last school year (down 4.8% from the previous school year), while the public charter school student enrollment totaled 19,733 during the same period. Student mobility among D.C. students is high, with less than 90% of students remaining in the same school within a school year, and some moving several times before year’s end (The Brookings Institution, 2008).

All public schools (both DCPS and public charter schools) receive a Uniform Per Student Funding allocation — a resource that constitutes most of their operating budget.

The amount allocated to each local education agency (LEA) by the state agency is based on a formula that covers school-based instruction and pupil support as well as non-instructional services (such as facilities or security), administration and other overhead. According to the Master Education Plan for DC, the DCPS school system and charter schools received \$7,600 per student in Fiscal Year (FY) 2007 (D.C. Public Schools Master Education Plan, 2006).

Critical health statistics in the District of Columbia

The need for a robust school mental health program in the District of Columbia is evident in the data that characterize the physical and mental health issues affecting children and youth in the community. Children and families in urban areas are a generally underserved group (Atkins, et al., 2006), and unfortunately as indicated in Table 1, children in the District of Columbia are at even greater risk for poorer health and life outcomes than children in other parts of the United States (Annie E. Casey Foundation, 2008).

Table 1. Child Health/Economic Statistics Comparing D.C. to the National Average

Health Indicator*		2001	2002	2003	2004	2005
Infant mortality rate (deaths per 1,000 live births)	DC	10.6	11.3	10.5	12.0	14.1
	US	6.8	7.0	6.9	6.8	6.9
Rate of teen death by accident, homicide, or suicide (ages 15-19) (deaths per 100,000)	DC	149	168	151	188	173
	US	67	68	66	66	65
Child death rate (ages 1-14) (deaths per 100,000)	DC	33	23	27	36	24
	US	22	21	21	20	20
		2002	2003	2004	2005	2006
Percent of children living with parents who do not have full time jobs	DC	49%	54%	52%	49%	46%
	US	33%	33%	33%	34%	33%
		2003	2004	2005	2006	2007
Percent of families with children headed by single parent	DC	63%	68%	65%	62%	60%
	US	31%	31%	32%	32%	32%
Percent of children in poverty	DC	36%	34%	32%	33%	23%
	US	18%	18%	19%	18%	18%
Percent of teens who drop out of HS (ages 16-19)	DC	6%	10%	8%	7%	8%
	US	8%	8%	7%	7%	7%

Source: Annie E. Casey Foundation, 2008

* The most recent published data differs by health indicator

Child poverty plays a critical role in poor child physical and mental health outcomes and the child poverty rate is higher in the District of Columbia than in most major cities (D.C. Fiscal Policy Institute, 2006). The consequences of severe poverty are tangible. The poorest of D.C. neighborhoods have a violent crime rate six times higher than in the least impoverished areas, and just under half of all confirmed cases of child abuse and neglect come from the poorest fifth of District neighborhoods (D.C. Action for Children, 2007).

As documented in a recent RAND report prepared for the Executive Office of the Mayor, the physical and mental health problems confronting children in the District of Columbia are extensive (Lurie, Gresenz, Blanchard, Ruder,

& Chandra, 2008). For example, based on 2003 data, District-wide, 36.3% of children between ages 6 and 12 were overweight, 11.9 % had asthma, 12.9% had a learning disability diagnosis, 10.5% had a behavioral health issue needing treatment, and nearly 8% had a serious emotional disturbance. The magnitude of these problems can vary substantially among the city’s eight wards as evidenced in Table 2.

Another window on the health care needs of District children is provided by DCPS. The school system reports that roughly 18% of students require special education services, with 46% of this population having learning disabilities, 18% emotional disabilities and 13% mental retardation (D.C. Public Schools Master Education Plan,

Table 2. Health Status Among Children in District of Columbia

Parental assessment of children’s health	DC	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
Poor/fair health (%)	4.1	6.3	9.1	0.6	1.9	4.4	3.1	4.4	4.5
Requires more medical care than other children (%)	12.1	12.4	11.7	8.2	12.9	15.2	9.6	14.1	11.3
Chronic conditions									
Current asthma (any severity) %	11.9	7.6	5.0	3.9	9.1	14.9	12.6	17.9	12.1
Moderate or severe asthma (%)	4.3	3.7	1.6	0.6	5.2	5.6	3.8	5.3	4.4
At risk of being overweight (%)	16.8	20.4	11.5	7.7	19.2	16.5	16.4	19.4	15.6
Overweight among 6 – 12 yrs (%)	36.3	35.4	25.5	10.8	30.4	36.5	49.7	36.4	44.2
Mental & cognitive health									
Behavioral health issue needing treatment (%)	10.5	10.6	8.0	8.0	7.1	14.7	11.7	12.0	7.9
Learning disability diagnosis (%)	12.9	12.1	12.0	11.1	10.1	13.6	15.6	13.3	13.5
Serious emotional disturbance (%) (2000)	7.9	8.1	7.6	6.4	7.5	7.9	8.1	8.1	8.4
Alcohol or illicit drug abuse or dependence among 12 – 17 (%)	6.0	6.1	--	8.5	5.6	5.5	5.9	5.4	5.7

Source: Lurie, Gresenz, Blanchard, Ruder, & Chandra, 2008 Working paper: Assessing Health and Health Care in the District of Columbia, RAND, p. 16.

2006). The data on academic outcomes for students in DC public and public charter schools is disheartening. A study of DC public school students found that 43% of students graduate from high school within five years, 29% enroll in postsecondary educational programs within 18 months of graduating from high school, and of this group, only 9% will earn a postsecondary degree within five years of enrolling in college. The statistics are even worse for youth living in Wards 7 and 8, and for male students in D.C. (Kernan-Schloss & Potapchuk, 2006).

Finally, results from the 2007 Youth Risk Behavior Survey (YRBS) conducted by the Centers for Disease Control and Prevention (CDC) also underscore the high level of risk affecting District youth (see Table 3). Several risk factors indicate youth in D.C. are at greater risk than a comparable sample of youth nationwide. Almost three times more students in D.C. reported they did not go to school because they felt unsafe and about twice as many D.C. high school students attempted suicide than was reported nationally. Furthermore, almost 60% of students said they had been or had a family member or friend shot or wounded. The consequences of witnessing violence are well documented and extensive (Schuler & Nair, 2001).

Findings from the 2007 YRBS indicate that gay, lesbian, bisexual, and transgendered and questioning youth (GLBTQ youth) in DC schools are especially vulnerable and in critical need for mental health programs and services. Specifically, 31% of gay, lesbian, bisexual (GLB) youth seriously considered attempting suicide in the past 12 months compared to 14% of heterosexual youth, while 33% of GLB youth actually attempted suicide at least once in the past 12 months compared to 9% of heterosexual youth (CDC, 2007; refer to http://www.k12.dc.us/offices/oss/hiv aids/pdfs/GLBT_fact_sheet.pdf for additional information).

Beginning in 2001, as described in the following sections of this report, the District of Columbia began to address the long-time gap between the need for children’s mental health care and available services. Led by a new non-profit entity, the Center for Student Support Services (CSSS), the city government – acting through the Department of Mental Health (DMH) – began to address the need for mental health services for children and youth. CSSS (now known as the Student Support Center- SCC), in partnership with DMH and the public charter schools, launched a school-based mental health 2007 initiative that inaugurated a new era in services for young people and

Table 3. Risk Behaviors Among D.C. Senior High School Students Compared to Students Nationwide

Health-Risk Behavior	2007	
	DC	US
Percent of students who did not go to school because they felt unsafe at school or on their way home from school on one or more of the past 30 days	DC US	14.4% 5.5%
Percent of students who have been threatened or injured with a weapon such as a gun, knife or club on school property one or more times during the past 12 months	DC US	11% 8%
Percent of students who were injured in a physical fight and had to be treated by a doctor or nurse one or more times in the past 12 months	DC US	10% 4%
Had sexual intercourse with four or more persons during their life	DC US	21.5% 14.9%
Percent of students who had seriously considered attempting suicide during 12 months preceding survey	DC US	14.9% 14.5%
Percent of students who actually attempted suicide one or more times in the past 12 months	DC US	12.2% 6.9%
Percent of students who had been or had a family member or friend shot/wounded (2003 data)	DC US	59.9% N/A

Source: CDC Youth Risk Behavior Survey, 2007

their families. The goal of these services was to reduce risk and improve outcomes for children in the District of Columbia.

Recent developments in school mental health

Over the past 15 years, the District of Columbia has established a record of providing school-based mental health services to children, youth, and families through a partnership between the public schools and the Commission on Mental Health Services, the predecessor organization to the Department of Mental Health (DMH). Building on its sponsorship of community mental health centers in the southeast, northeast, and northwest quadrants of the city, the Commission on Mental Health Services began providing a variety of school-based services (individual, family, group therapy, and consultation) on an ad-hoc basis to a small number of public schools across the city in the mid-1990s.

In 1999, a coalition of seventeen public charter schools was awarded a federally-funded Safe Schools/Healthy Students Initiative (SS/HS) grant whose purpose was to implement a comprehensive violence prevention initiative. The schools subcontracted with the Center for Student Support Services (CSSS) to manage this effort. The charter school coalition and CSSS then subcontracted with DMH to develop a school-based mental health promotion and intervention service in sixteen of the seventeen charter schools. With prevalence estimates suggesting that over 7% of youth in the District struggled with serious mental health problems but less than 1% of the population of children and youth were being served, community advocates complained that the public mental health system was ignoring children (Jones, 2001). As a result, this new School Mental Health Program (SMHP) quickly won support among community members and their elected leaders. Given the numerous environmental, social, and personal risk factors facing young residents -- poverty, crime, school failure, and high levels of individual depression and trauma -- expanding mental health support for children became a top priority for families, community leaders, and government agencies.

When the federal Safe Schools/Healthy Students grant ended in 2002, DMH agreed to allocate some of its appropriated dollars to support the ten public charter

schools that continued to offer mental health services. (Six charter schools dropped out of the program either due to school closure or a decision not to sustain their mental health services.) DMH then spread services to 16 more D.C. public schools. These 16, referred to as the Spingarn Cluster (schools in geographic proximity to each other and that feed into Spingarn High School), became the first step in a progressive expansion of the program. Since 2002, DMH has added thirty more schools to the School Mental Health Program by allocating increased funds from the agency's budget. (Refer to pg. 35 Table 8 for details.)

In the 2005-2006 school year, another federal SS/HS grant was awarded to 18 new D.C. public charter schools and again the CSSS was subcontracted by the charters to manage the prevention and early intervention services provided through that grant. Taken together, during the 2007- 2008 school year, 63 public schools in D.C. had supplemental emotional and behavioral support services on-site and managed by one of two outside mental health organizations (DMH or CSSS). See Appendix C for a listing of D.C. Public Schools and D.C. Public Charter Schools with School Mental Health Program staff offering services on-site.

The DMH school mental health conceptual model

"This model is the best thing in terms of accessibility for kids, obtaining information on relevant mental health issues quickly from multiple sources and for reducing stigma, and it is a major test of clinical expertise and skills for clinicians in terms of how well they can address children's mental health issues." Jacquelyn Duval-Harvey, Director, East Baltimore Mental Health Partnership, personal communication, January 11, 2008.

The conceptual model for the DMH School Mental Health Program is based on an understanding that by fostering resilience and reducing emotional and behavioral barriers to learning for all students, the Program will maximize students' potential to become successful learners and responsible citizens. The Program's pathway to this goal is implementing a program that prevents mental illness and promotes emotional, behavioral, and social health among students and their families.

The DMH School Mental Health Program (SMHP) is modeled after the expanded school mental health framework that aims to supplement mental health services traditionally offered in schools (Weist, 1997). The SMHP employs licensed or license-eligible social workers, psychologists, or mental health specialists to provide prevention and intervention services to students with the aim of preventing the negative outcomes likely to result from exposure to multiple risk factors. Early intervention and treatment services are available to all students assessed as needing them. These services, however, are not intended to meet the service requirements of students with Individualized Education Programs (IEPs). The focus of the SMHP has been on prevention and early intervention and on preventing unnecessary entry into the special education system by addressing emotional and behavioral problems before they significantly impact learning.

Former school district administrators voiced their preference for school employees to provide the required services for students with special needs in order to maintain greater control over the delivery of those services. Legal concerns and an absence of practice guidelines for DC school-based providers underscored the need to maintain school-hired mental health professionals as the main providers of care to students with IEPs. DMH program administrators, therefore, decided that until clarity was achieved around education and mental health regulations (i.e., HIPAA, FERPA, and the Mental Health Information Act), and public financing for school-based services was achieved, it was inadvisable for school mental health professionals to be the main providers of care for special needs students.

Until recently, one full-time school mental health professional was assigned to one school to provide an array of services and supports to the students and the school community. Beginning in the fall of 2008, the DMH SMHP assigned 10 clinicians to two schools each in order to address pressures to expand and to reach more students and their families.

Based on lessons from successful programs in other regions, the DMH SMHP designed a set of services consisting of three levels of care; primary, secondary, and tertiary prevention services.

Primary Prevention

(also known as Universal Prevention Services)

Prevention services available to the entire student body, the school staff, or parents/guardians (depending on the target audience for a particular intervention) are delivered to prevent the development of serious mental health problems and to promote positive development among children and youth. Program examples included staff professional development, mental health educational workshops for parents/guardians, school staff, or students, and evidence-based or promising school-wide or classroom-based substance abuse and violence prevention programs.

Secondary Prevention

(also known as Selective Prevention Services)

Students identified at elevated risk for developing a mental health problem are offered one of a number of early intervention services. These interventions could include involvement in support groups, focused skills training groups, dropout prevention programs, and training or consultation for families and teachers who work with identified children.

Tertiary Prevention (also known as Indicated Prevention Services)

Students with more intense or chronic problems who need more targeted support are offered a number of brief treatment services. The aim is to minimize the impact of the problem and help restore the child or adolescent to a higher level of functioning. Examples of these clinical services included individual and family counseling, and therapeutic groups (i.e., grief and loss groups). Students who need more intensive services may be referred for community-based services outside the school depending on their need for more specialized care.

The SSC school mental health conceptual framework

While the Student Support Center (SSC), formerly known as the Center for Student Support Services, and the DMH have been closely linked partners in the development of the School Mental Health Program, SSC school mental health services have evolved in a slightly different direction. The emphasis of the SSC overall program is on enhancing the school's capacity to successfully implement school-wide behavioral health promotion strategies through

manualized interventions and to support discipline policy improvement, to identify all students in need of more targeted mental health support, and to provide students and their families with school based short-term treatment services (up to 21 weeks). Referrals are limited to those students who need extensive services not available at school.

Primary Prevention:

The SSC model expects and supports the school staff to take primary responsibility for implementation of universal evidence-based prevention curriculum to create a “healthy” school culture. SSC’s team of educators/coaches provide hands-on expert coaching on the implementation of Positive Behavioral Support (PBS), and trains all teachers from pre-school through middle school to conduct school-wide trainings in a violence prevention curriculum called Second Step. Early childhood programs are supported to provide universal screening and to use findings for the development of individualized plans.

Early Intervention:

A team of three Prevention Educators conduct manualized universal and targeted evidence-based prevention programs augmenting the clinicians and school support staff in delivering evidence based prevention curriculum in the schools for students and parents. They facilitate the implementation of parent education

workshops (i.e., Guiding Good Choices) and conduct pre and post tests.

Early Intervention and Treatment:

Mental health clinicians, a multi-disciplinary team of doctoral and masters-level clinicians, are placed full time in the larger schools and half time in small charter schools. They provide clinical services, both early intervention and treatment, to children and families referred through the Student Support Teams. Ongoing training and support is provided with Cognitive Behavioral Therapy (CBT) as the major mode of support for older children. The organization also has a specialty practice with pre-school children using child centered play therapy as the predominant therapy employed. Clinicians receive monthly supervision. A web-based case recording system provides supervisors with the ability to monitor clinical work, case plans and any pre-post data that is collected.

SSC’s emphasis on treatment is partially driven by its concern about sustainability. Its funding is predominantly through federal grants, with a 20% subsidy from participating schools (see “Financing” section for more information). The organization has sought to sustain services through Medicaid. However, current DC Medicaid reimbursement policies have been complex and costly for school-based practitioners and administrators to utilize. SSC, although certified as a Core Service Agency as required by city

Table 4. Continuum of School Mental Health Services by Location

Location	Universal Prevention	Selective Prevention	Indicated Prevention	Treatment ¹	Other ²
Washington, DC (DMH SMHP)	25%	25%	30%		20%
Baltimore, MD ⁱ	7%	20%	40%	33%	
Long Island, NY ⁱⁱ	40%	40%		20%	
South Carolina ⁱⁱⁱ	30%			70%	
Charlotte, NC ^{iv}	35%			55%	
Montgomery County, MD ^v	70%			30%	
Arkansas ^{vi}	30%			70%	

Note: In many cases, programs did not differentiate levels of prevention programming offered through their SMHP.

¹Treatment services are defined as services that are eligible for reimbursement by insurance plans (Medicaid or other private insurer) and where a diagnosis is provided.

² Other refers to quality improvement activities, school meetings, and training of mental health staff.

Source:

ⁱ Baltimore Mental Health Systems, Inc. FY08 Appendix “A” Contract Deliverables & Provider Progress Report, pg 5

ⁱⁱ Rose Starr, Director of Planning, Alliance for School Mental Health, North Shore-Long Island Jewish Health System, Interview (October 9, 2007).

ⁱⁱⁱ South Carolina Department of Mental Health School Based Mental Health Programs Annual Report Summary FY 2004-2005, page 1

^{iv} Joanne Sobolewski, Manager of SBMH Program, Carolina’s Health Care, Interview (December 18, 2007)

^v Monica Martin, Manager/DHHS Representative, Linkages to Learning, Interview (December 19, 2007)

^{vi} Arkansas Department of Education, Special Education Unit. (2005). School-Based Mental Health Network: Policy and Procedures Manual, page 7-8 and 29.

Table 5. Number of Clinicians and Schools by School Mental Health Program (SY 2007-2008)

Location	Program	Number of Mental Health Staff*	Number of Schools with Mental Health Staff
Washington, DC	DMH/SMHP	48	48
Washington, DC	SSC	16	21 (this represents school campuses not LEAs)
Baltimore, MD	UMD/SMHP	20	25
Baltimore, MD	JHU/SMHP	14	18
Rockville, MD	Linkages to Learning	28	35
Charlotte, NC	Behavioral Randolph SMHP	28	42
New York City ^{vii}	SBMHP	--	135
South Carolina ^{viii}	SC Dept of Mental Health	282	457

* We could not confirm whether all mental health staff in this column were clinical providers or if this number included other staff (supervisors, managers, etc.). In addition, information provided indicated number of staff and not total FTEs, which would differ if clinicians did not work full time.

Source: ^{vii} New York City School-Based Mental Health Program, New York City Department of Education, viewed 02/01/2008 at: <http://schools.nyc.gov/Offices/DYD/Health/SBHC/MentalHealth.htm>

^{viii} South Carolina Department of Mental Health School Based Mental Health Programs Outcome Report FY 2006-2007, page 1

regulations, reports that it has found the cost of billing for Medicaid insured services financially prohibitive.

A comparison of mental health services offered in schools located in several cities and counties in the US show great variability (Table 4). However, all programs maintain some level of preventive intervention and provide some reimbursable treatment services. Table 5 reports the number of community-hired mental health staff employed and the number of schools involved in the programs. Appendix D offers an additional comparison of the DC school mental health programs and other cities as it relates to staffing requirements, cost per clinician, and productivity requirements.

What the researchers and experts say about children’s mental health needs and schools

The rising tide of unmet children’s mental health needs, documented extensively by the Surgeon General’s Mental Health report in 1999, has continued to draw the attention of researchers and policymakers (Atkins, et al., 2006; Cooper, 2008; Foster, et al., 2005; Kutash, Duchnowski, & Lynn, 2006; Tableman, 2004; Weist & Paternite, 2006). Authors of the CDC School Health Policies and Programs Study (SHPPS) 2006 argue that stronger collaboration between school-hired mental health professionals and community mental health providers could begin to address the insufficient number

of mental health and social service providers employed by schools to meet students’ emotional and behavioral needs (Brenner, et al., 2007). Over 40% of state children’s mental health authorities report a variety of mental health initiatives in their schools (Cooper, 2008). The CDC surveyed all 50 states and the District of Columbia about policies and practices at the state, school district and local school levels and the authors found that 98% of state education agencies, 76% of school districts, and 72% of local schools collaborated with a corresponding mental health agency in their community, but the nature, extent, and length of these associations remain uninvestigated. Although Brenner and her colleagues call for greater efforts to build ‘systematic state agendas,’ there are few examples available to help define the essential components of a solid partnership between education and mental health systems. (See Appendix E for a list of state child mental health laws that address a mental health continuum and the role of schools).

The New Freedom Commission, established by President Bush, also encouraged the expansion of school mental health programs nationwide as a key strategy to increase access to mental health care for children (President’s New Freedom Commission Report, 2003). According to the Commission, school-based programs should provide on-site preventive interventions, screening and other early detection methods, early intervention supports, assessment, and treatment, with links to community-based services. A

SAMHSA study of a sample drawn from 83,000 public schools and their associated school districts, reported that almost half the school districts sampled had formal arrangements with community mental health providers, 60% of districts reported an increase in referrals to these providers over the last year, and one-third stated that the availability of outside providers had decreased (Foster, et al., 2005). Furthermore, two-thirds of the school districts indicated that the need for mental health services had increased among their students, but one third had to contend with a decrease in funding for mental health services provided in schools. The discrepancy between need and available funding requires that public agencies and communities consider alternative models of care, creative partnership approaches, and the careful allocation of limited resources.

Experts in the school mental health field caution that a nationally-accepted definition of school mental health does not yet exist (Cooper, 2008), and that it is too early to deem one model as 'best practice'. Yet, many respected experts agree on using a public health model as an organizing framework for school-based mental health interventions (M. Weist, K. Hoagwood, C. Paternite, K. Kutash, A. Duchnowski, L. Eber, & M. Atkins, personal communication, varying dates; SAMHSA, 2007).

The public health approach to mental health extends beyond diagnosis and treatment for those who need care, to include systematic population-based approaches to facilitating access to treatment, ensuring the delivery of quality care, identifying individuals in need before treatment is necessary, and preventing the onset of symptoms all together. Through a population-based approach, strategies are used to define the problem, identify risk and protective factors, develop, implement and evaluate interventions, and bring the models to scale with the aim of improving the emotional, behavioral, and social health of the school-aged population. A number of conceptual approaches of school mental health based on the public health prevention model have evolved over time (Kutash, Duchnowski, & Lynn, 2006), with the most effective models being locally developed and adopted by schools and communities to fit their unique configurations (K. Kutash, personal communication, January 7, 2008).

Weisz, Sandler, Durlak & Anton (2005) propose an inclusive model of care that links prevention strategies with

mental health treatment approaches that can effectively be offered in schools and helps organize the variety of mental health interventions provided on-site by a number of qualified providers. Weisz and his colleagues include 'health promotion/positive development strategies' at one end of the spectrum, with universal, selective, and indicated prevention strategies at the core of their model, and treatment strategies (time-limited therapy, enhanced therapy, and continuing care) representing the opposite end of the spectrum to address youth with high symptom levels or diagnosable mental illnesses. The array of services outlined represents a full continuum of outpatient services most likely to effectively meet the needs of most school-aged children attending our public schools.

In line with the public health framework and the enhanced model developed by Weisz et al. (2005), Weist and Murray offer a definition of school mental health as "a full continuum of mental health promotion programs and services in schools, including enhancing environments, broadly training and promoting social and emotional learning and life skills, preventing emotional and behavioral problems, identifying and intervening in these problems early on, and providing intervention for established problems" (Weist & Murray 2007, pg. 3).

Critics of applying the public health approach to school mental health programs argue that community mental health services are rarely integrated within the fabric of schools and that mental health administrators and providers easily overlook the fact that the main mission of schools is to help children learn. Newer paradigms are emerging that acknowledge some of these truths and help reframe school-based mental health services, particularly those offered in poor, urban schools, by using an ecological model informed by public health and organizational theories (Cappella, et al., in press). A major aspect of this model, thought to facilitate better school-community integration, is a uniform focus on educational goals and mental health practices that directly impact school success.

Consistent with the latest SAMHSA report to Congress on the advancements known regarding prevention (SAMHSA, 2007), the DC school mental health programs have maintained a strong emphasis on mental health promotion and mental illness prevention. The D.C. school system has also invested in building an infrastructure for

the early identification and treatment of students over the past five years. A State Incentive Grant (SIG) awarded to the District a number of years ago helped provide training and support to local school staff on the utilization of Student Support Teams (SST), early identification and intervention processes, and in the implementation of practices consistent with Positive Behavior Supports. Some of the SIG grant activities included an overhaul of SST policies, procedures and training processes as well as the implementation of other effective school practices.

Positive Behavior Supports (PBS), nationally recognized as a system-wide approach to preventing and improving problem behaviors in classrooms and schools, utilizes the public health model to promote safe and healthy school environments. PBS aims to improve outcomes for all students and is comprised of a broad range of individualized strategies, effective practices, interventions, and systems change strategies that have been demonstrated to be effective. National dissemination of this approach is underway with the U.S. Department of Education Office of Special Education Programs leading the charge (Refer to Appendix B for School-wide Positive Behavior Support, Implementers' Blueprint and Self-Assessment, 2004). The successful collaboration of community mental health and public school systems in the implementation of PBIS is noted in other cities (i.e., Chicago, IL; Atkins, Graczyk, Frazier, & Abdul-Adil, 2003).

What we can learn from other states & localities

Information gathered for this report found that a number of state public mental health agencies are engaged in developing partnerships with education agencies and with promoting a public health model to serve as a framework for school-based mental health services (e.g., Maryland, Illinois, New York, Pennsylvania, Ohio, Texas, Michigan, and South Carolina). These initiatives are summarized below. Because the City of Baltimore has been particularly active in creating school-connected mental health programs, this summary of relevant programs begins with that unique city.

- *Baltimore City.* Baltimore City has a number of well-established school mental health programs sponsored by the University of Maryland, Baltimore or Johns Hopkins University. Dr. Joshua Sharfstein, the

Commissioner of Health in Baltimore, requested a review of the city's service model and stated that a "comprehensive and integrated model is clearly the ideal for any expanded school mental health program" (Baltimore City Health Department, 2006, p.12). This ideal model would include universal prevention (designed to develop the social, coping, and problem-solving skills of all students), selective prevention (designed to identify students at elevated risk of developing mental health problems and provide them with early and focused interventions), indicated prevention (designed to provide support and intervention for students with established emotional and behavioral difficulties who do not meet DSM-IV diagnostic criteria) and treatment services (therapeutic interventions for students with emotional and behavioral difficulties who do meet DSM-IV diagnostic criteria). The result of the Commissioner's review was a revised Request For Proposals whose intent was to reduce the number of providers in schools, create one point of accountability (Baltimore Mental Health Systems, Inc. -- the Core Service Agency for Baltimore), and standardize the school mental health programs available throughout their public schools (Baltimore City Health Department, 2006).

When an ideal model of services did not prove feasible, Commissioner Sharfstein suggested that a plan be developed under which all Baltimore schools would receive at least one of three tiers of intervention (Baltimore City Health Department, 2006):

- Tier 1- Baseline Services Consisting of Technical Assistance and Training
 - Establish a help line for phone consultation to school staff
 - Minimal on-site consultation for crisis intervention
 - Online and hard copy educational materials
 - Resource mapping to identify community supports and resources
 - Training on classroom management
 - Identification of students in need of mental health support
 - Assistance with developing referral procedures
 - Identification of school needs (gaps and resources)

- Tier 2- Expanded Services for Existing SMHPs
 - Ensure adoption of universal standards
 - Continue evaluation of program efficacy
 - Engage in professional development activities to enhance evidence-based skills
- Tier 3- Model Programs
 - Fully implement best practice model programs in a smaller number of schools
- *New Orleans, Louisiana.* In response to the traumatic events related to Hurricane Katrina, local social service agencies, schools, and national experts joined forces to pilot an intermediate and long-term school mental health consultation model for children exposed to trauma. The project, called Project Fleur-de-lis™, employs three trauma interventions -- Classroom-Based Intervention (CBI), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), and Trauma Focused- Cognitive Behavioral Therapy (TF-CBT). Two intervention pathways were developed that relied on using existing resources and a collaborative peer consultation process where community mental health providers offer consultation to existing school mental health staff (i.e., school counselors) on challenging issues presented by students (Walker, 2007). The cost to fund the core team is approximately \$500,000 but when fully functional the team should be able to manage the mental health needs of students in 60 schools.
- *Illinois.* The Illinois Children's Mental Health Act of 2003 led the way in presenting a model for how school districts could strengthen their capacity to identify and meet the mental health needs of students in natural settings (schools), with an emphasis on early intervention. This legislation laid the foundation for the State Department of Education to implement a grant program, the School Mental Health Support program, and to spend \$850,000 to develop the capacity of schools to provide mental health supports for students. Grants under this initiative encourage school districts to formalize partnerships with community mental health providers to provide school-based and/or school-linked services by a qualified mental health professional. Funded services include screening and assessment, individual and group counseling, skill-building activities, family support, teacher consultation, school-wide mental health prevention, targeted group early intervention, and crisis intervention. (Illinois Violence Prevention Authority, 2007).
- *Ohio.* The Ohio Community Collaboration Model for School Improvement (OCCMSI) is a community-centered model, sponsored by the Ohio Department of Education in collaboration with the College of Social Work at The Ohio State University and the Department of Psychology and Center for School-Based Mental Health at Miami University, that assists schools in expanding their traditional school improvement processes, which primarily focus on academics, to include efforts to address non-academic barriers to learning. This initiative has already demonstrated early success in building collaborative leadership structures to help integrate school- and community-based resources and services (Dawn Anderson-Butcher, personal communication, January 18, 2008).
- *New Mexico.* The state Department of Health, Office of School Health in New Mexico funded a project where five Masters-level clinicians, School Mental Health Advocates, provide consultation and training of educators, health professionals, parents, and other community members in specific regions around the state. These individuals are charged with creating regional networks of schools and mental health providers to expand understanding and local capacity for school-connected prevention, early intervention, and treatment services for students. Training opportunities were developed using pooled resources from the Interdepartmental School Behavioral Health Partnership, a state-level, interdepartmental collaborative developed to expand school mental health programs for New Mexico's children. This level of infrastructure was one the state could manage and maintain, and that has demonstrated success across the state (Steve Adelsheim, personal communication, February 19, 2008).
- *Arkansas.* The Arkansas Department of Education, Special Education Unit has created the School-Based Mental Health Network made up of programs that foster access to a full array of mental health services within Arkansas public schools. This unit within the Department of Education monitors compliance among members (school districts and mental health

providers) to specific standards and guidelines, and delineates a process for application to the Network. (Refer to Appendix B for the full title of the corresponding policies and procedures manual).

- *Texas.* The Children’s Hospital Association of Texas (CHAT) commissioned an assessment of children’s mental health in Texas (the report is listed in Appendix B). Among its findings: the authors encourage further development of prevention and early intervention services for mental health, additional support for community-based care (such as services provided in schools), as well as a greater number of integrated mental health and substance abuse programs for youth. In addition, the authors warn about the detrimental results of poor system capacity and coordination, as well as of the limitations of public and private insurance plans to adequately address the mental health needs of the state’s residents.

School mental health in the District of Columbia: Opportunities and challenges

“I do expect there to be additional resources made available to school-based mental health services. ... This has been the subject of a lot of discussion between the Executive, the City Administrator’s office, the Department of Mental Health and of course this Committee. I expect there to be a really statistically significant increase in school mental health funds. ... What we have is a very good program that could be made better. This remains a priority of the Mayor, the Chancellor and this Committee.” David Catania, Council member, District of Columbia City Council, Chairman, Committee on Health, Public Hearing April 17, 2008.

The 2007 swearing-in of Mayor Adrian Fenty and establishment of his new administration, together with the formation of the Office of the State Superintendent of Education (OSSE) and the appointment of a Chancellor to preside over the DC Public School system are the most significant environmental changes impacting the expansion and sustainability of school mental health programs in D.C. With new leadership in the city have come adjustments to citywide priorities, revised goals for District agencies, and new structures for accountability. The biggest challenge this presents to DMH if it moves to become a public mental health authority providing

oversight but not direct service for a school-based mental program is that some relationships, alliances, and supports are no longer present. Thus, during the first year of the Fenty administration, DMH and SCC have moved to inform the new leadership about their mission and goals. And while gaining the ear of a new administration is challenging, the alignment of the DMH School Mental Health Program with others in the administration who support prevention and early intervention services and supports for the District’s young people and their families creates on-going possibilities for Program growth.

Relevant DC Agencies, Initiatives, and Activities That Could Broaden Support for SMH

Office of the Mayor, Deputy Mayor for Education (DME)

- Title V of Public Education Reform Amendment Act of 2007 (<http://www.dccouncil.washington.dc.us/images/00001/20070423153411.pdf>)
 - This piece of legislation established the Interagency Collaboration and Services Integration Commission (ICSIC) charged with “developing a pilot school-based program involving school-based clinicians, clinician training, a services integration database, and program evaluation” and with implementing evidence-based practices in schools.
 - ICSIC will set priority goals around improving the welfare of children in D.C., coordinate interagency youth initiatives connected to education, and develop innovative early intervention programs in schools. One such pilot, around the assessment and counseling services provided by ICSIC school-based clinicians (DC START), is in the early implementation phase but has the potential to exist simultaneous to both the DMH SMHP and SCC SMHP.
 - Citywide goals that drive activities within ICSIC are 1) Children are Ready for School, 2) Children and Youth Succeed in School, 3) Children and Youth are Healthy and Practice Healthy Behaviors, 4) Children and Youth Engage in Meaningful Activities, 5)

Children and Youth Live in Healthy, Stable, and Supportive Families, and 6) All Youth Make a Successful Transition into Adulthood. Although programs and services offered through DMH may impact developments across all six goals, DMH has been most actively engaged in addressing Goal #3.

- CapStat review is a performance-based accountability process that identifies opportunities for D.C. government to run more efficiently and ensure high quality care to its residents. D.C. agency directors must participate in these reviews and evaluate their performance on a number of goals and priorities for children’s health established by the Mayor and monitored through the ICSIC.

Office of the State Superintendent of Education (OSSE)

- *Special Education Reform.* The recent agreement reached in the Blackman/Jones class action lawsuit against the District of Columbia requires DCPS and OSSE to implement a number of reforms that would impact the coordination and delivery of services for students identified with disabilities. Most relevant to DMH, the agreement mandates that the defendants “improve the delivery of mental health services to students” and that the resulting plan has been developed in collaboration with DMH (among other agencies).
- *Truancy policy.* D.C. Board of Education published a Resolution on Enhancing the Truancy Policy for the District of Columbia Public Schools (2005) that included recommendations on the use of early intervention with students and parents and indicated that aggressive interventions for the child and family should be implemented. Currently, a truancy task force, chaired by the Deputy Mayor of Education and the Chief Judge of the Family Court meets monthly and has been piloting an early intervention model called the “Byer Model” in which a Judge visits schools weekly to meet with truant middle school youth and their families. DMH has played an active role in the program from its inception. To the degree that this task force will oversee demonstration projects and

inform policies and best practices around truancy prevention, DMH should remain an active contributor to this initiative.

DC Public Schools

“We must make sure that DCPS and DMH realize the extent of the benefits that can be derived by having a SMHP provider in their school. Principals who have had successful SMHP programs in their schools need to share the best practices with their colleagues, school communities and other appropriate administrators throughout the District government. We need to make sure the principal knows that there is an investment in time and resources required at the front end but that it is worth it in the end.” Peter Parham, former Chief of Staff, DC Public Schools, personal communication, February 23, 2007.

- The District of Columbia Public Schools Master Education Plan (2006) is intended to drive all aspects of instruction by establishing direction for curriculum and coordinating all elements that impact learning.
- One goal outlined in the Plan states that every school will have a Student Support Team (SST), considered a national best practice. These school-based committees/teams are central to a school’s early intervention process and help identify students early who would benefit from academic and/or behavioral interventions. According to the Plan, teams, made up of education and health professionals, will participate in monthly professional development sessions on identifying research-based interventions and creating intervention plans for students. The State Incentive Grant previously awarded to DCPS boosted efforts to train school administrators and staff on best practice principles for SST. The ongoing funding source for this additional level of training and the management of SSTs across DCPS is not clear. DMH staff have offered expertise to DCPS by helping to identify and implement evidence-based interventions, assisting with the training offered to school leaders and staff, and most importantly, being an active member of the SST in schools that have a SMHP provider.

- A second goal of the Plan calls for establishing policies and protocols that invite parents into the schools and classrooms as respected participants in their children’s education. DMH SMHP could play a central role in developing materials or conducting workshops to help create welcoming environments for parents and families.
- DC Health Learning Standards developed by OSSE have been drafted and provide guidance about the content of health education to be provided in the public schools. The goals of these standards are to teach students the knowledge and skills they need to reduce health risks and increase positive health behaviors to ultimately enhance their academic achievement. There are six strands outlined in the standards, all of which have an emotional health component. School mental health providers assigned to schools can facilitate the implementation of these standards throughout all grade levels in collaboration with school-hired pupil support or health education staff.
- The Office of Youth Engagement within DCPS provides direct and indirect supports to students, families, and schools. This office is responsible for those functions that address health, wellness, student safety, school climate, student discipline, residency verification and academic supports for hospitalized, homebound and homeless students. This office is responsible for implementing the federally-funded Peaceable Schools Initiative, supported by the Title IV, Safe and Drug-Free Schools and Communities Act, and aims to build and sustain safe, drug-free, disciplined, and peaceable learning environments in which all students can achieve high academic standards. OSSE is responsible for the federal Title IV state functions, while the LEA Title IV functions remain the authority of the Office of Youth Engagement within DCPS. LEA Title IV funding is being allocated to support the Peaceable Schools Summer Institute, peer mediation programs in the schools, and intensive truancy interventions and supports provided through attendance intervention centers.
- DC Public Schools was previously awarded a State Incentive Grant (SIG). One part of that SIG involved educating staff within 47 selected schools in Positive Behavior Supports (PBS). In schools where there was a SMHP provider, he/she was an active member of the PBIS local school team. The understanding is that OSSE now has authority over this initiative, but there has been little mention publicly of the continued commitment to this multi-year project.
- While the public charter schools have access to expertise on evidence-based practices and mental health services from the Student Support Center (SSC) through several federal grants they have been awarded, SSC is a not for profit service agency that lacks the authority to direct planning for the charters. That role falls to the Charter Board and OSSE.

Department of Health

- District of Columbia’s State Health Plan
 - Under Focus Area 18: Mental Health and Mental Disorders (pg. 79), the DOH lists the expansion of prevention-oriented services for children in public schools as an objective and targets a 20% increase in the number of children served through SMHPs. Given this agency’s interest in seeing an increase in the number of children served through school mental health programs, an exploration of their investment in expansion is warranted.
- School Nursing Contract with Children’s National Medical Center (CNMC)
 - The DOH subcontracts with CNMC to manage the school nursing program for D.C. By law all public schools in DC must have at least a part-time (20 hours/week) nurse available to students. Consistent with the SAMSHA survey (Foster, et al., 2005) school nurses in D.C. indicate that they are

often the first professional in a school to meet with students experiencing an emotional or behavioral problem. Attempts have been made, and should continue, to support school nurses' ability to identify and screen students with mental health concerns. DMH should explore the possibility of institutionalizing training, consultation, and education to the School Nurse Program as a way to enhance the skills and competences of these school health professionals.

- **Addiction Recovery and Prevention Administration (APRA)**
 - APRA is responsible for the prevention and treatment of substance abuse in the District of Columbia and provides oversight, ensures access, sets standards and monitors the quality of services delivered. APRA's prevention programs and services are administered through the Office of Prevention and Youth Services (OPYS). OPYS generally utilizes a broad range of proven prevention strategies (using universal, selective, and indicated prevention measures), a number of which are provided in after-school and family centered environments. Twenty prevention program grants are disbursed by APRA to community-based organizations that deliver science and evidence-based Alcohol Tobacco and Other Drug (ATOD) prevention program models. Little has been done to integrate goals, objectives, or funds for DMH SMHPs and APRA/OPYS. DMH should explore any possibility for closer collaboration with this agency.

- **Community Health Administration (CHA)**
 - The CHA's (formerly the Maternal and Family Health Administration) Title V Block Grant Application 5 Year Needs Assessment (October 2005) cites the need for mental health services, and for primary prevention programs, as high priorities in the city. This report indicates that one of five priority areas are to "Increase awareness of the role of mental health in adolescent risk behaviors, school achievement and perinatal outcomes;

and increase availability of preventive services" (pg. 2). The need for the CHA to be more strategic about collaborating with DMH is noted and their recommendation to "Establish (and institutionalize) a coordinating committee to strengthen system links" with public mental health is an invitation for DMH to strengthen its interagency relationship.

Early Care and Education Administration

"Linking school mental health to a model like this, as a way to sort out what we might do for children that are younger so they are ready to learn, is very promising". Barbara Kamara, former Director of Early Care and Education Administration, personal communication, August 7, 2007.

- The Early Care and Education Administration (ECEA) provides support for and collaborates with other public and private child and family organizations to formulate an effective continuum of services and care for District children 5 years of age and younger. ECEA also provides access to before and after school services for eligible children up to age 12.

- There are a number of activities that are focusing on the early childhood mental health needs of DC's youngest residents. The Early Childhood Mental Health Taskforce, a subcommittee of the Mayor's Advisory Council on Early Childhood Development, is examining best practices in the promotion of mental health and socio-emotional learning within the 0-5 population. The Early Childhood Comprehensive Systems Steering Committee, of which DMH is a member, is focused on the development of a system of care approach to benefit young children and their families.

Important Committees and Council members within the City Council of the District of Columbia

- David Catania, Chairman, Committee on Health
- Vincent Gray, Chairman-At-Large and Chair of the Council's Special Committee to Prevent Youth Violence
- Tommy Wells, Chairman, Committee on Human Services

Additional city agencies that have collaborated in the past with DMH around the SMHP include the Metropolitan

Police Department, Department of Parks and Recreation, Child and Youth Services Administration, Department of Human Services, and the Youth Rehabilitation Services. Although specific information about these agencies is not included here, an examination of their prevention and early intervention initiatives and priorities would greatly serve DMH in order to forward the integration of supports offered in school settings.

Recommendations for DMH

Primary Recommendations

- At present there are a significant number of plans and initiatives that are driving the development of school-connected interventions for youth in D.C. (refer to Appendix F for a list of school health programs and initiatives for 2008). Although ICSIC is intended to coordinate children's programs, initiatives, and funding, fragmentation continues to affect management, implementation, and priority-setting of child health initiatives. The broad scope of the Commission makes a focused discussion on school mental health programs and policies difficult. Furthermore, the law establishing the ICSIC limits its membership to District agencies, preventing direct input from public charter school administrators, community health and mental health providers, academic institutions (i.e., D.C. universities and colleges), and other non-profit or private organizations with a vested interest in child-serving initiatives. Given these weaknesses, DMH leadership might suggest leading or co-leading an ICSIC workgroup specifically on school mental health that would encourage participation from additional organizations in D.C. This workgroup would design, implement, evaluate and advocate for an integrated school mental health master plan that would incorporate all related mandates and programs across city agencies impacting public schools. (Appendix G offers a guide for mapping existing initiatives.)

Secondary Recommendations

- Although the Clinical Administrator of Prevention and Early Intervention Programs from DMH participates in a number of meetings about the development of children's services in DC, the Director of DMH and his staff (i.e., the Director of Children's Services, the Clinical Administrator of Prevention and Early Intervention Programs, and

the Program Manager of the School Mental Health Program) should continue to monitor and track all child-related initiatives, activities, and reforms in order to expand and sustain school mental health programs in D.C. Building citywide alliances requires sustained education, advocacy, and networking by the lead administrators at DMH with colleagues across city government to ensure the well-being of the program. Meeting informally with corresponding administrators at each key agency listed above, at least annually, to highlight progress on projects/programs, outline new initiatives for the future, and discuss opportunities for collaboration will foster the inter-agency support vital to the continued success of the SMHP.

- Given the high rates of suicide attempts in the District and the significant risk among GLBTQ youth in particular, preventing suicide among youth should be a public health priority for DMH and DOH. DMH, through the previously awarded SAMHSA STOP Suicide grant, engaged in a proactive strategy for preventing suicide that included evidence-based screening, classroom-based prevention strategies, and gatekeeper training implemented primarily by the DMH school mental health clinicians. In addition, in 2007, DMH submitted their Child Mental Health Plan to city administrators with goals related to reducing depression and preventing suicide among youth. Logically, these preliminary activities would culminate in the development of a citywide suicide prevention plan that includes school-based interventions. Unfortunately, there is no such plan in DC, although 47 of 50 states have a statewide suicide prevention plan currently in place (see Suicide Prevention Resource Center; <http://www.sprc.org/stateinformation/plans.asp>). SAMHSA has also previously made funding available through the State/Tribal Youth Suicide Prevention Grants (also called the Cooperative Agreement for State-Sponsored Youth Suicide Prevention and Early Intervention) to assist states in the development of their plans and future funding may be available again. The absence of a citywide plan signifies a lack of appreciation for the severity of the risks experienced by DC youth. Suicide prevention must be elevated to a much higher level of importance among DOH, DMH, and OSSE leaders.

SECTION III: FINDINGS AND OBSERVATIONS

While direct provision of services requires investment in staffing, supervision, training, and clinical documentation, overseeing direct provision of services requires investment in an institutional infrastructure that enables the contracting agency to carry out its obligation to assure that those who are served receive the right care in the right way at the right time. And a corollary of the oversight function is assuring that the direct provider organizations have the capacity to provide the needed services.

“The school-based mental health program works. We are very excited about its growth and plan to continue this expansion early next year.” Stephen T. Baron, Director of the Department of Mental Health, DMH Press Release, November 21, 2007.

Organizational management

There is no consensus on ‘best practices’ in the management of school mental health programs at the state level, especially as it relates to arrangements between school districts or local schools and community mental health providers. State public mental health agencies do not typically provide direct services in the schools to students and their families, but they do subcontract, either directly or indirectly, through various arrangements with community mental health providers who deliver mutually agreed upon services (Brener, 2007). While direct provision of services requires investment in staffing, supervision, training, and clinical documentation, overseeing direct provision of services requires investment in an institutional infrastructure that enables the contracting agency to carry out its obligation to assure that those who are served receive the right care in the right way at the right time. And a corollary of the oversight function is assuring that the direct provider organizations have the capacity to provide the needed services.

There are various options that are available with relative advantages and disadvantages with regard to quality control and cost effectiveness. In sum, in planning how to expand school mental health programs in the city, DMH will need to do three things: confirm the availability of community-based providers who are competent and willing to provide or effectively link prevention, early intervention, and treatment services for children and their families in schools; delineate the functions that DMH will undertake if it assumes an oversight role, and identify the resources and institutional structures essential to do its new job. As noted above, most states are not in the business of direct service delivery, but instead function as state public mental health authorities.

What the research and the experts say about organizing school mental health programs

Although national principles for best practices in school mental health have been developed (Weist, et al., 2005), these principles do not yet provide specific guidance to state and local agencies on implementation. A mental health authority should generally perform five main functions: 1) foster and monitor high quality care through performance-based accountability and quality management processes, 2) provide technical assistance and training around programs and practices that would strengthen the delivery of school mental health services, 3) create and implement an advocacy/communications strategy that successfully engages leading stakeholders and decision-makers about the public health approach to school mental health, 4) build sustained and varied funding to support the continuum of services provided through school mental health programs, and 5) create and/or support policies that ensure high quality comprehensive mental health care.

While efforts to strengthen internal systems operations are underway, DMH will need to simultaneously examine ways to mobilize external resources so that the goals of integration, sustainability, and the ultimate institutionalization of school mental health programs are achieved. Patience will be required by DMH and its stakeholders while this process plays out since a number of years are required before system-wide reforms and

organizational changes take hold and yield desired impacts (Chorpita & Donkervoet, 2006; Daleiden, Chorpita, Donkervoet, Arensdorf, & Brogan, 2006).

What we can learn from other states & localities

Although focused on state and local education agencies, the recently launched School Mental Health Capacity Building Partnership (CDC funded initiative managed by the National Assembly on School-Based Health Care- NASBHC) offers insights that are applicable. This initiative aims to improve access to high quality, school-based mental health services by disseminating model mental health policies, programs, and services to State Education Agencies (SEAs) and Local Education Agencies (LEAs). An in-depth analysis of school mental health policy and practice in four states (Maryland, Missouri, Ohio and Oregon) identified challenges commonly experienced. Typically the four states:

- Lacked a unified statewide vision for school mental health, lacked a statewide agenda, and experienced fragmentation/duplication of programs across the state
- Lacked organizational infrastructure and accountability mechanisms
- Lacked sustainable funding models to support comprehensive school mental health programs
- Contended with attitudes that believed that the requirements for academic progress required limitations on school mental health programs
- Had limited youth and family involvement
- Had limited professional development and pre-service training for educators and mental health providers
- Had difficulty identifying and implementing evidence-based SMH programs and models appropriate for school settings
- Lacked effective social marketing or public awareness efforts, and
- Lacked coordinated and uniform data collection systems

Similar to Maryland, Missouri, Ohio and Oregon the District of Columbia and DMH struggle with a majority of these challenges that will require remediation before strong statewide programs emerge.

Making it happen: strengthening and improving systems operations

Improvements in child academic, emotional, and behavioral functioning require greater attention by DMH as well as other District agencies on the unique needs of youth. The DC Behavioral Health Association (BHA), an organization of mental health providers in the public and private sectors that provide community based mental health and support services, identified a number of barriers and proposed solutions to the delivery of children’s mental health services. The mission of the BHA is to expand and improve community based services through its activities in policy advocacy and professional staff development. In a proposal provided to DMH, the BHA states that the Children’s Division of DMH is “severely understaffed and underdeveloped” and that DMH should hire staff specifically assigned to develop children’s services (District of Columbia Behavioral Health Association, 2007). Further, as is the case with the Student Support Center (SSC), a number of children’s mental health providers who are members of BHA are leaving the DMH Medicaid structure because they are unable to meet their expenses through DMH billing mechanisms and cannot afford to remain a Core Service Agency (E. Brooks, personal communication, February 8, 2007). This exodus results in fewer qualified providers and diminished clinical capacity for SMH, negatively impacting plans for program expansion.

The majority of the offices within DMH are structured to support the implementation of the Mental Health Rehabilitation Services (MHRS) system, the fee-for-service model that allows the District to be reimbursed by Medicaid for delivering mental health services. As noted by the former director of behavioral health services for SSC, in order for SMHPs to survive and thrive a community needs “the organizational investment to be there in spite of the fact that individuals come and go- this has to be an organizational priority that is supported by adequate local and state funding sources.” (O. Bubel, personal communication, August 31, 2007). Suggestions are offered below on adjustments to the roles and functions of various DMH offices that would facilitate the continued development of SMH services in D.C.

Child and Youth Services Division, Prevention and Early Intervention Programs

The Deputy Director of the Office of Programs, Policies, and Planning (OPPP) oversees the development, management, and funding for all child and adult mental health services offered through DMH. The Director of Child and Youth Services, who reports to the Deputy Director, is in charge of all child and youth initiatives and services at DMH, both prevention and treatment. The Director of Child and Youth Services position was vacant for six months and the position was filled in the Fall of 2008. The CYS Clinical Program Administrator for Prevention and Early Intervention Programs reports to the Director of Child and Youth Services, who then reports to the Deputy Director of OPPP, and manages a number of prevention/early intervention initiatives, including two school-connected programs, the SAMHSA funded STOP Suicide grant and the School Mental Health Program (SMHP). The Clinical Program Administrator is supported by two administrative staff that help manage a number of grant awards and a significant number of staff. (Appendix H outlines a table of organization for the OPPP and the Prevention and Early Intervention Programs at DMH.) In addition to a Program Manager (who handles the day-to-day operations), the 48 clinicians within the SMHP have access to and are supported by evaluation staff (an Evaluation Manager and Program Evaluator) and three supervisors (a supervisory psychologist and two supervisory social workers).

Quality Management and Performance-Based Accountability

There are four main offices/divisions within DMH that have direct influence on the agency's ability to hold providers accountable for meeting high quality standards: the Office of Accountability, Office of Provider Relations, Contracts and Procurement, and Information Systems. The role of each office as it relates to the management of school mental health programs under an authority arrangement is outlined below.

Office of Accountability

The Office of Accountability provides input regarding all issues involving provider compliance with Mental Health Rehabilitation Services (MHRS) certification standards. With regard to providing future oversight over SMH programs, this office would monitor providers and

agencies offering school mental health services through contracts let through DMH and implement quality management review procedures and audit activities to monitor performance. We have learned from several counties and cities around the country that in order to effectively monitor the quality of mental health services, those working to assure accountability should have expertise in the content areas monitored. For example, the Montgomery County Department of Health and Human Services employs a licensed clinician to monitor contracts for their school-based mental health programs. We have included documents in Appendix B from other cities/states (e.g., Seattle, WA, Baltimore, MD, Texas Department of State Health Services) that detail requirements made of vendors as part of their agreement with the contracting agency. If a unique certification of school-based providers is developed in the future, this office could also assist in the implementation of that process.

Office of Provider Relations

This office provides input to DMH on clinical/administrative issues specific to the MHRS community mental health provider. The office plays an important consultative role and is the liaison between DMH and community mental health providers. Staff within this office could help strengthen the capacity of agencies delivering school-based mental health care through training, coaching, and monitoring of care. In addition, Provider Relations liaisons could identify gaps in policy and practice guidelines from a provider's perspective that would improve the delivery of services to children and their families.

Contracts and Procurement Office

Staff within this office manage the contracting process and ensure that binding agreements are developed and competed in compliance with DC government regulations. The procurement process can drive quality and the implementation of policies deemed important to creating a cohesive vision for public mental health. A Request for Proposals (RFP) for SMH should outline national best practices and standards, with incentives that reinforce adherence to policies and standards. In addition, RFPs can set performance measures/indicators to gauge contractor progress. For example, Seattle, WA provides a percentage of their payment to a contractor only when certain targets are met and the Texas Department of State

Health Services has issued an RFP that details specific performance measure guidelines for applicants expanding their mental health services in schools (see Appendix B for these RFPs). Accountability processes can also be outlined in contracts, such as is found in Charlotte, NC where internal utilization and random chart reviews are required on a regular basis.

The contracting process is one way to ensure particular standards and performance benchmarks are met. DMH can also set standards around staffing ratios (i.e., the number of FTEs per school), staff diversity, educational/training qualifications, and can determine allowable contracting periods (allowing for clinicians to be employed during a 10-month school year as opposed to 12 months). The RFP should support time for supervision, quality management activities, and staff meetings since these activities increase the likelihood that quality care is provided.

Office of Information Systems

The degree to which DMH can monitor services and performance of providers is directly dependent on the amount and quality of data collected from provider agencies. One of the main weaknesses of the DMH SMHP, as noted by the Office of the Inspector General (OIG), is the continued absence of an electronic data system for collecting, storing, analyzing, displaying, and reporting data (OIG, 2008). The Office of Information Systems has reviewed plans for a web-based program to be used with the DMH SMHP but to date no information system has been developed. This office should develop a plan of action for the implementation of an information system with a billing platform that would help DMH monitor progress and outcomes among school-based mental health programs across the city. Other city agencies have offered their software programs to collect data, but DMH is not clear how compatible these systems are with their broader billing systems. Whatever system is chosen, it will need to be in compliance with regulations distributed through the DC Office of the Chief Technology Officer (OCTO).

Technical Assistance and Training

The DMH Training Institute was created to provide the agency with system-wide staff development and “to develop strong working relationships with local universities and other professional resources, and to provide a continuous learning environment for consumers, community stakeholders, staff and providers.” The

Training Institute should continue to provide training free of charge around best practices and evidence-based programs, strategies and tools that would foster dual-diagnosis capabilities with child-serving providers, as well as clarify the mandates and policies enforced by DMH. A stronger focus on critical issues and effective practices in school mental health would aid efforts at capacity building. (Please refer to the “Training/Professional Development” section for more detailed information and recommendations on training.)

Advocacy/Communications Strategy

The Communications Office within DMH manages communications across agencies, with the community, and with various media outlets. To support the development of SMH programs, a communications strategy for developing and disseminating information and progress regularly with stakeholders would help brand school mental health services and sustain this particular initiative. Currently there is no systematic way in which DMH disseminates information about SMHP to the public or its elected representatives. The Office of Consumer and Family Affairs could also be helpful in linking DMH to social marketing efforts or stigma reduction campaigns aimed at consumer groups, parents, youth, and other stakeholder groups.

Sustained and Varied Funding

DMH plays a key role in illuminating viable funding options available to support the maintenance and expansion of SMHPs, as well as leveraging existing dollars within DMH and in other city agencies involved in improving school health care. (Please refer to the “Financing” section for more detailed information and specific recommendations on financing.)

Policy/Standards Development

There are a number of offices and staff within DMH that have input into the creation and dissemination of mental health policies and practice standards (i.e., Office of Strategic Planning, Policy and Evaluation, General Counsel, Provider Relations, Accountability). Some of these individuals would also monitor and clarify existing policies and regulations that impact SMH service delivery, such as policies related to data collection and dissemination, legal issues around information sharing and privacy laws (Mental Health Information Act, DC Minor Consent Law, Mental Health Establishment Act,

Our investigation found that there are no national uniform school mental health practice standards.

HIPPA, and FERPA), and processes for consenting for services. DMH should also partner with other agencies and organizations in D.C. in the development of policies and plans that support prevention efforts citywide (i.e., state suicide prevention plan, socio-emotional learning standards, child health standards, etc.).

Our investigation found that there are no national uniform school mental health practice standards. Few state and county mental health agencies have developed practice standards for school mental health professionals or practice guidelines for the scope, duration, and frequency of services offered. New York City uses their state outpatient mental health standards and applies them to certified providers working in schools. In most other states, a clinician practices under requirements set forth by their state licensing and credentialing board (Weist & Paternite, 2006). With stronger service standards, clear reporting requirements, training and consultation support, as well as a smooth contracting process, there would be a greater opportunity to engage local community mental health agencies in addressing children’s mental health problems. As part of the agreement developed by DMH, SSC and CHHCS, draft practice standards for school mental health have been developed that reflect standards developed for similar school health programs across the country (see Appendix I: Template for the Development of Standards for School Mental Health Programs in D.C.). It is recommended that this draft be used a starting point for seeking community input that can lead to a final product.

Mobilizing Resources

In expanding school mental health services, DMH must strengthen mechanisms for communication and collaboration within the agency, between the agency and other public entities in the District, and between the agency and community organizations. The creation of mechanisms for cross-communication and the development of structures to foster mission alignment and shared advocacy are essential for success (Hunter, et al., 2005). A common agenda and shared ownership of

the School Mental Health Program between public mental health and education is essential, but it is also important that DMH collaborate with the public health agency and its school health initiatives as well as with child welfare and juvenile justice agencies around initiatives focused on the prevention of social, environmental, and personal risk factors.

Other states/cities that have built collaborative partnerships include:

- *Texas.* The Texas Collaborative for Emotional Development in Schools (TxCEDs) project, that includes representatives of numerous organizations (i.e., Texas Education Agency, several Texas school districts, Regional Education Service Centers, Texas Association of School Psychologists, several Universities, numerous state departments and commissions, and Family to Family Network), are generating activities to develop a guiding policy focused on the well-being and mental health of all students; identifying barriers to student learning and performance; identifying existing and emerging evidence-based interventions and systems of support; and designing a system for accessing and reporting data. This Collaborative has developed a Texas School-Based Social/Emotional Wellness Model based on the framework of the Positive Behavior Supports (PBS) that will recommend policies and practices to support school-owned programs that are integrated (or braided) with community-owned resources.
- *Maryland.* To build a systematic state initiative for school mental health (SMH), and to integrate other initiatives (such as Positive Behavior Supports- PBS), key local and state agencies in Maryland, along with their national partners, formed the School Mental Health Alliance. The goal of the Alliance is to advance school-mental health system integration in Maryland, and it involves the Maryland State Department of Education, the Governor’s Office for Children, the Maryland Coalition of Families for Children’s Mental Health, the Maryland Department of Juvenile Services, and the Mental Hygiene Administration Department of Health and Mental Hygiene, among others.
- *Illinois.* The Illinois Children’s Mental Health Act of 2003 created the Illinois Children’s Mental Health

Partnership (ICMHP), a collaboration of state agency leaders and other key stakeholder groups, and charged it with developing the state-wide Children’s Mental Health Plan containing short-term and long-term recommendations for providing comprehensive, coordinated mental health prevention, early intervention, and treatment services for children from birth to age 18. (Refer to Appendix B for Illinois Children’s Mental Health Partnership Strategic Plan for Building a Comprehensive Children’s Mental Health System in Illinois, 2006 Annual Report to the Governor). The partnership is also working to integrate state-wide initiatives including Positive Behavior Support (PBS), Socio-Emotional Learning (SEL) standards, SMH Supports, student assistance programs, and Response to Intervention (RTI). The partnership includes representatives from the Illinois State Board of Education, Illinois Department of Human Services, the Office of the Governor, and many others.

- *Michigan.* The Michigan Department of Education, Michigan Department of Community Health, and the School Community Health Alliance of Michigan were recently awarded a grant by the US Department of Education to develop a statewide policy, the Student Mental Health Linkage policy, which would coordinate school and community services for children through the formation of an Integration of Schools and Mental Health Committee.
- *Berkeley, California.* The goals of the Berkeley Alliance, a partnership between the Berkeley Unified School District, the City of Berkeley, the University of California-Berkeley, and Berkeley community organizations, were broadened to include a focus on the integration of school and community resources aimed at improving student wellness and learning. The initiative is being called the Berkeley Integrated Resources Initiative (BIRI), and those involved in BIRI will utilize the Comprehensive Systemic Intervention Framework (refer to the Center for Mental in Schools for more information on this framework, <http://smhp.psych.ucla.edu>) in order to develop a continuum of interconnected intervention systems.

Communication and Collaboration

“The partnership with education is really critical. One of the big misunderstandings is that prevention competes with deep end interventions, but we can do a lot to reframe and rethink this issue”. Joyce Sebian, Senior Policy Associate, National Technical Assistance Center for Children’s Mental Health, personal communication, January 4, 2008.

Some of our key informants noted that the No Child Left Behind (NCLB) legislation and its accountability measures can make it difficult to maintain the attention of education partners.

Partnership development at the agency level and interdisciplinary collaboration are critical to the successful expansion of SMH (Rappaport, Osher, Garrison, Anderson-Ketchmark, & Dwyer, 2003). Every individual interviewed for this report stated that “it’s all about the relationships” when it comes to the key ingredient of sustained collaboration. Dr. Al Zachik, Assistant Director, Child and Adolescent Services, Maryland State Department of Health and Mental Hygiene states “success of school mental health really is a matter of personal relationships and building collaborative partnerships” (personal communication, January 15, 2008). Some of our key informants noted that the No Child Left Behind (NCLB) legislation and its accountability measures can make it difficult to maintain the attention of education partners. Understanding education mandates and linking early intervention/early identification initiatives to these mandates will improve opportunities for DMH to link with education efforts and align with programs, such as SST and PBS, used in the public and public charter schools. One way to facilitate communication and institutionalize collaboration is to establish job positions and/or programmatic initiatives that are jointly funded by several state or local agencies.

Efforts that have integrated the work of several agencies in other states and localities include:

- *Ohio.* The Ohio Department of Mental Health (ODMH) and the Ohio Department of Education (ODE) jointly funded the Ohio Mental Health

Network for School Success, a set of action networks in six regions of Ohio that are working to inform stakeholders about the available school-based mental health resources in their area.

- *Pennsylvania.* The Pennsylvania State Department of Mental Health and Substance Abuse and the State Department of Education are working together to implement PBS in all schools across the state. The Departments of Mental Health, Education, and Health are also jointly funding the implementation of student assistance programs across the state as an important early intervention process.
- *Illinois.* In Illinois, the State Board of Education, the Department of Human Services, Division of Mental Health, Department of Juvenile Justice, and the Illinois Children’s Mental Health Partnership (ICMHP) jointly applied and were awarded a grant from the US Department of Education to fund two positions (one at the Board of Education and one at the Division of Mental Health). These two staff members will work together to provide technical assistance to schools funded by the 2007 School Mental Health Support Grants, formalize agreements between the state partners, and to develop a state-level evaluation process. Both the Board of Education and the Division of Mental Health plan to continue funding these positions after the grant ends as part of their plan for sustainability.
- *California.* The California Department of Mental Health has agreements with the State Department of Education and California Department of Health Services to fund positions to improve integration and sustainability of school health services and have used some administrative funds from the Mental Health Services Act for this purpose.
- *New York City and Baltimore, MD.* In New York City, the position of Director of School Mental Health Services in the Department of Education was established and funded jointly by the Departments of Education and Health and Mental Hygiene. Similarly, the Coordinator of School Mental Health at Baltimore Mental Health Systems, Inc. is a jointly funded position supported by the local education and mental health agencies.

Building Program Champions

Many interviewees concurred that champions are needed inside the participating systems to advance the development of school mental health services. In Maryland, South Carolina, and California parents have been strong advocates in maintaining or expanding SMH services in those States. As noted by a state mental health administrator, “parents are underutilized in terms of their advocacy and their ability to generate the compelling need for the leadership across systems to address school mental health. A strong parent voice can make a big difference.” (K. Rietz, personal communication, January 17, 2008). While parent participation has long been recognized as a key piece to program effectiveness, big agendas and limited staffing can get in the way of developing a long-term strategy for parent inclusion. Further consultation with those who have had success in this arena may be fruitful strategies to pursue.

Recommendations for DMH

DMH should be acknowledged for the establishment of a nationally recognized program. There are additional considerations that may strengthen the organizational structure and management of this expanding program.

Primary Recommendations

- Once DMH has evaluated the costs and benefits of using contracted providers to staff the SMHP a determination should be made of the long-term feasibility of this approach. Regardless of whether DMH remains the direct provider or subcontracts that service, there are significant management costs that DMH will incur and a reallocation of resources that DMH must consider if it is to provide sufficient oversight to the program.

Secondary Recommendations

- Evaluate the roles and responsibilities of key DMH administrators and delineate tasks more appropriately. For example:
 - Clinical Administrator of Prevention and Early Intervention Services –aligns interagency missions, builds relationships with important stakeholders including education leaders, participates in key leadership meetings, helps to develop overarching plans for children’s services, helps determine

citywide priorities for children’s health and assists with decisions about service and program expansion, advocates for a public mental health model that includes school mental health programs, creates opportunities for braided funding for SMH.

- Manager of School Mental Health - develops request for proposals, drafts program, clinician, and supervision standards and certification processes, helps organize and implement relevant trainings, conducts outreach to local principals and assists with community awareness and education, aids in the development of quality management mechanisms including monitoring of program fidelity.
- Staff within other divisions - program evaluation staff would collect and summarize key data; accountability staff would monitor contractors providing school mental health services; provider relations staff would assist agencies in implementing DMH regulations and requirements.
- Implement a communications/social marketing plan that would brand the SMH model and simultaneously explain the role of mental health prevention and early intervention within a system of care framework. This would address fears that funding prevention will mean less money for those needing intensive services. The plan could involve a web-based strategy to educate local constituents of developments in children’s mental health, which could be modeled after a website created for the greater Cincinnati area (see <http://www.mindpeacecincinnati.org/aboutUs.shtml#text>). In addition, communication strategies would include tactics for regularly sharing information with stakeholder groups on the progress for SMH programs (e.g., monthly newsletter for principals, news story or Op-Ed for the newspaper, quarterly briefs to the chancellor/mayor).
- Identify local champions who can adopt this cause, including finding ways to have family advocates centrally involved and in some cases, leading the way. The School Mental Health Coalition, an advisory group for the DMH SMHP, can and should be used more effectively in forwarding some of the goals related to the communication and advocacy needs for SMH in D.C. Exploring the possibility of financially

supporting family and community involvement and consultation may also be a path worth pursuing.

- Institutionalize program and services information into existing orientation programs. For example, DMH can help orient new principals to some of the critical issues facing their students and teachers. DMH should also host an annual orientation/planning meeting with school leadership as way to gauge or reaffirm commitment, share new information, and build a network of supporters. In order for this to be successful, this requires the support of the Chancellor and the Office of State Superintendent of Education.

Program development and evidence-based practices

The establishment of school-based mental health programs require the developer to find a balance between addressing the unique needs and characteristics of individual students and individual schools and institutionalizing what constitutes ‘best practice’ in the care of all students. To achieve those goals, a program has to adopt both specific evidence-based programs to be used in schools and consult with educators, families, and the Program’s mental health providers on the real world applicability of the interventions chosen (see Appendix J for a list of evidence-based and promising programs used in the DMH SMHP). A key step in developing an effective school mental health program is gathering information on the needs, available resources, and gaps in service that can inform program administrators and mental health providers about the most effective strategies to achieve program goals.

While the value of evidence-based programs in achieving desired program outcomes seems self-evident, the challenges to identifying the right programs and implementing them successfully are less well understood and frequently underappreciated. The impact of particular school-based mental health interventions is determined by a number of factors: receptivity of the school staff and student body, the fit between the types of interventions and the needs of the students and the school, and the skills of the mental health clinician or school staff member providing the interventions. In this section we review both research and experience related to implementing evidence-based programs and conclude that insufficient

attention to any one of these factors can significantly undermine attempts at positive outcomes. The time that communities, organizations, and individuals dedicate to making careful judgments about what interventions to use and how to implement them are well worth the time dedicated.

Overview of what the research and the experts say

There is a good deal of help available to DMH and the city as it plans to implement high quality programs. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines a prevention or treatment intervention as evidenced-based if it draws on theory and if it has undergone ‘scientific’ evaluation. The mental health authority in the state of Oregon uses a broader definition by stating that evidence-based practices are “programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence and the values of the persons receiving the services. These programs or practices will have consistent scientific evidence showing improved outcomes for clients, participants or communities. Evidence-based practices may include individual clinical interventions, population-based interventions, or administrative and system-level practices or programs” (Oregon Addiction and Mental Health Division, 2007).

There is no single understanding of evidence-based practice in mental health and the controversies affecting this field underscore the challenges of making sure that findings from research inform school mental health programs. A recent article in *Health Affairs* suggests the difficulties (Tanenbaum, 2005). While ‘evidence-based practice’ has wide-spread support in clinical settings, mental health research initiatives, and public policy venues, there are at least three key controversies that cloud the discussion of this topic. First, there is no agreement on the meaning of ‘evidence’. Second, there is no agreement on how to translate research evidence (however defined) into clinical or programmatic practice. And, third there is no agreement on the meaning of the word ‘effective.’ What does it mean for a program to ‘work’? And how are we to weigh the outcomes associated with a rigorously evaluated randomized clinical trial with the outcomes of an intervention study in which participants may be more culturally and racially diverse but the study was not experimental in design? These are serious questions with

real implications for school mental health programs that want to use the very best interventions possible. The DC School Mental Health Program will be challenged to design its interventions informed by research but recognizing that there are no straight paths to selecting evidence-based interventions.

Reviews of the effects of child therapy programs for youth with diagnosable problems indicate that evidence-based treatment programs are generally more effective than providing no treatment or offering the usual care provided in clinical settings (Weisz & Simpson Gray, 2008). Although our knowledge of this aspect of the field has grown, evidence-based programs are still not widely used in everyday practice settings, such as schools. Concerns about the applicability of such programs (which are typically designed for single problem areas) with youth presenting with multiple and chronic disorders, the perceived inflexibility of these programs, and the investment in training time required before implementation can begin account for much of the resistance found among practicing clinicians. These views were corroborated by a local study that found that school-based clinicians in DC required to implement evidence-based programs within their assigned schools cited program length, ease of implementation, colleague opinion, and perceived fit with the school/student culture as important factors impacting their choices (Anderson-Hoagland, 2008).

A number of interventions and programs have been deemed effective by evaluation researchers (Wilson & Lipsey, 2007) and other authorities using well defined but varying criteria (Hahn, et al., 2007). Much pressure exists around the identification and selection of the ‘right’ program to pilot in a community struggling with limited resources. Resource constraints are made more difficult by a propensity to want to address all risk factors that impact mental well-being at once. One can easily feel overwhelmed and confused by the number of programs that appear to deserve consideration for and lend themselves to large-scale implementation across school districts and cities (see Appendix K for sites featuring school-based interventions that have been shown to produce desirable outcomes). Research illustrates that one large category of evidence-based programs, clinical treatment programs, can actually be distilled into a smaller grouping of effective strategies common to many of the treatment programs for use in clinical settings (Chorpita, Becker, & Daleiden, 2007;

Chorpita, Daleiden, & Weisz, 2005). These findings have significant implications for the training of mental health providers and the allocation of resources.

Ensuring successful implementation and securing long-term commitment to effective programs at a school level, though, is much more complicated than matching a program to local needs. One challenge is simply that the evidence-base is always changing and, therefore, creating an infrastructure for any service delivery model that relies on a specific evidence-based program creates a faulty foundation from which to build an effective and responsive system of care. *“There can be risks associated with institutionalizing any particular evidence-based program, because in theory practices should be replaced or updated as the literature evolves. A system should be in a position to embrace new and effective programs as they are identified, and those updates and innovations need to be efficient .”* Bruce Chorpita, Director, Center for Cognitive Behavior Therapy, personal communication, February, 19, 2008.

Introducing new ideas about innovative programs, practices and policies is never easy and takes careful planning. Implementation involves “a specified set of activities designed to put into practice an activity or program of known dimensions” (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005) and is not a single event but can be accomplished through a number of stages (see Table 6).

Experts developing the science behind implementation warn that decisions about which evidence-based programs to adopt cannot be divorced from decisions about the quality of implementation efforts, the feasibility of adopting particular approaches, concerns of fidelity, and

“People use what they know, so even though individuals are trained in new methods or to run new programs, it takes a lot to have them actually change their practice.” Lisa Jaycox, Senior Scientist, RAND, personal communication, August 28, 2007.

determinations of school, organizational, and community readiness. Researchers recommend the use of evidence-based processes and tools to help communities assess readiness of practitioners, organizations, schools, and communities to gauge awareness, interest, and motivation in making changes to practice (Flashpohler, Anderson-Butcher, Bean, Burke, & Paternite, 2008). One instrument that has been used nationally to assess perspectives of school mental health needs and services is the Survey of the Characteristics and Funding of School Mental Health Services School Questionnaire 2002-2003 (SAMHSA, 2003).

Researchers have also found that there are interactive processes (i.e., implementation drivers) that influence the extent to which a program or innovation is adopted into a system and which are key to programmatic success (see Table 7). Finally, however, many agree that unless the individual delivering the essential components of a program is well-prepared and confident in his/her skills, efforts to implement even the most widely known and effective national programs will not succeed. Training and coaching are, therefore, key activities in bringing about effective implementation of new programs or practices. Context (the elements necessary for high performance), compliance (the core intervention

Table 6. Stages of the Implementation Process

Program Stage	Description
Exploration and Adoption	Assess the fit between program and community needs
Program Instillation	Gather resources and initiate supports necessary to implement
Initial Implementation	Push for change in the overall practice environment
Full Operation	Run program with full staff complements and full client loads
Innovation	Review information on impact and make adjustments to practice or program
Sustainability	Ensure long-term survival of a program despite changing conditions

Source: Fixsen, et al., 2005

Table 7. List of Core ‘Implementation Drivers’

- Staff selection
- Pre-service and in-service training
- Ongoing consultation and coaching
- Staff performance assessment
- Decision support data systems
- Facilitative administrative support
- Systems interventions

Source: Wallace, Blase, Fixsen, & Naoom, 2007

components), and competence (the degree to which the components are delivered with skill) fidelity measures will then help determine the degree to which a program is likely to produce the positive effects it was intended to (Fixsen et al., 2005).

Knowing that a program has demonstrated strong outcomes in a given community does not necessarily speak to the program’s availability, affordability, feasibility or ultimate successful implementation in new contexts or communities (Han & Weiss, 2005; Andrews & Buettner, 2004), especially as it relates to the implementation of classroom based programs (Han & Weiss, 2005). Given the diversity of populations and the idiosyncratic issues impacting local communities, many agree that achieving fidelity to model implementation is not an all or none proposition. Evidence-based programs can rarely be implemented exactly as described in other communities. Community demographics, the cultural nuances, as well as the program design must be taken into account. Core program components, which must not be tampered with, need to be well described and understood so that necessary adaptations to reflect cultural norms can be made with some assurance that the program will continue to demonstrate its intended results.

Two elements in particular may have particular impact on the successful identification and implementation of evidence-based programs: the involvement of local stakeholders in the selection of programs and the development of a committee or task force made up of parents and youth, stakeholders, community leaders, and local experts that has meaningful input into the implementation process (Fixsen et al., 2005). Assessing the feasibility of program implementation in a particular school or geographic region is best done with input

from local stakeholders knowledgeable about social, political, and environmental conditions. Key decision-makers can assess the aspects of the program that are considered core intervention components and make determinations about whether those core components can be maintained given the local climate and resources. Local experts (such as university faculty or local researchers) can then be engaged to create measures to assess fidelity to the intervention model and monitor the appropriate adoption of core program elements of selected programs.

Apart from making important choices about what programs to implement in local public schools, administrators must also make decisions about strategies or processes that will influence the adoption of selected programs. Experts point to the central, yet often overlooked, role teachers and other educators can play in the development of school mental health programs (Paternite & Johnston, 2005). A truly integrated system of school mental health acknowledges that educators are not simply witnesses to the delivery of mental health services or the recipients of mental health consultation, but can become effective implementers of prevention and early intervention services and powerful advocates for the expansion of school mental health programs. *“If you keep socio-emotional learning and instruction implementation conducted by mental health professionals alone, then you never build the capacity of schools to implement these programs and you undercut their sustainability”* (Lucille Eber, Illinois Statewide Director, PBIS Network, personal communication, March 7, 2008.) The value of educators as program implementers, though, can only be realized if adequate attention is given to factors known to promote their continued success (Han & Weiss, 2005). Examples of successful engagement of educators as school mental health partners can expand the breadth of possibilities for D.C. in its quest to meet the growing mental health needs of children and youth (Atkins, Graczyk, Frazier, and Abdul-Adil, 2003; Paternite, 2004).

What we can learn from other states & localities

- *Ohio.* Miami University and Ohio State University have both worked closely with the state departments of education and mental health in Ohio to assess the effective

dissemination and adoption of evidence-based programs and practices in various counties and school districts across the state. These partners have jointly designed indicators and engaged in a number of systematic evaluations of school readiness to implement various initiatives. In selecting pilot schools for the Ohio Community Collaborative Model for School Improvement (OCCMSI) and for the Health Foundation of Greater Cincinnati's Evidence-Based Practices for School-Wide Prevention Programs Initiatives, university collaborators found responses to certain demands made of schools or school districts reflected readiness for change and ultimately related to the smoother implementation of new programs. Strategies such as mandating that school teams be formed to participate in informational orientation meetings, that potential pilot schools collect new and share existing data on readiness, and that school administrators obtain formal commitments from stakeholders helped to differentiate schools at varying levels of readiness and their capacity to forward an initiative. In addition, schools reported that actively participating in assessing their own readiness increased their appreciation for and competence with data-driven decision-making, a very useful skill for school personnel responding to pressures around accountability. Those involved conclude "a systematic assessment of readiness [is] an integral part of moving effective SMH practices, programs, or innovations into new contexts..." (Flashpohler et al., 2008). Additionally, 22 school districts across Ohio have used the Survey of the Characteristics and Funding of School Mental Health Services School Questionnaire 2002-2003 to assess school mental health needs and services.

- *Chicago, Illinois.* Research from the University of Illinois at Chicago conducted with the Chicago Public Schools has led to the establishment of processes that identify and utilize lead teachers, also known as Key Opinion Leaders (KOL), to implement classroom-based behavior management strategies for students in some

of their low-income urban schools (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003). The utilization of school teams involving KOLs and mental health providers is yielding some promise as a strategy for implementing innovation within classrooms.

- *Hawaii.* The State of Hawaii Department of Health and the Department of Education were charged with strengthening their system of care to address the inadequacies in mental health and special education services for children and youth as dictated by the Felix Consent Decree. Part of this state reform involved the dissemination of evidence-based services and their role in improving child outcomes. The focus was in designing a comprehensive treatment system and developing a clinical decision-making process that is evidence-based, influenced by existing services research literature, and that relies on case-specific historical evidence (through the development of on-line clinical reports called "clinical dashboards"). These clinical dashboards are also aggregated across providers, yield a timely reflection of the effectiveness of the statewide system, and offer a mechanism for quality management. The Child and Adolescent Mental Health Division (CAMHD) within the Department of Health has dedicated agency resources to collect, analyze, and digest relevant information which informs the development of Department standards and guidelines and directs performance contract monitoring activities across the division. Furthermore, a statewide training institute/ practice development office was established to disseminate current service research information and provide training, mentoring, and consultation through state-funded practice development specialists who provide case-based 'expert' consultation to providers (Daleiden & Chorpita, 2005; Daleiden, Chorpita, Donkervoet, Arensdorf, & Brogan, 2006).

Recommendations for DMH

Primary Recommendations

- DMH should actively participate in, and potentially co-lead, a multi-agency citywide team that would oversee the selection and implementation of evidence-based mental health programs implemented in DC public schools. This would allow for some consensus to be achieved between both the DMH and SSC SMH programs, two agencies that have both invested heavily in a number of evidence-based and promising programs. Resources would then be more efficiently utilized, infrastructure development can be undertaken, and sustainability of individual programs pursued.
- Given the current organizational structures in place in DC, a school mental health team could operate as a work group under ICSIC, assuming that community experts (such as community-based practitioners and academic researchers) could participate and share their knowledge and experience with ICSIC members. The collective group of experts would be charged, along with a number of tasks outlined below, with assessing a school's capacity and readiness to implement new programs and to help decrease the likelihood of duplication or fragmentation of services offered in schools. The work group could assess that systemic, organizational, and programmatic supports are in place in a school to increase the likelihood that a proposed initiative would be a sound investment in that school. To succeed, the work group would need consistent support from the Mayor, DMH Director, the Chancellor of DCPS, and the State Superintendent of Education in order to effectively guide successful implementation of model programs. The team or work group could undertake a number of critical tasks, including:
 - Examining and identifying appropriate evidence-based programs, reviewing the relevant research literature and emerging best practices information
 - Assessing the fit between program, local population needs, and citywide goals
 - Obtaining clarity around the core practice and implementation components of a program

- Accounting for and authorizing use of relevant resources
- Monitoring and supporting efforts for training and coaching of practitioners
- Creating structures and processes to improve implementation (i.e., developing communities of practice)
- Developing school readiness assessments and application processes requiring an examination of the school's capacity for the integration of school mental health services with important school personnel (i.e., principal, SST chair, counselor, school nurse)
- Setting the bar for fidelity and determining accountability measures
- Developing long-term sustainability plans and creating a reasonable timeline for determining a program's effectiveness before efforts are abandoned or expanded

Training/professional development

“The tendency in the field tends to be to narrowly use practice standards of the discipline for the person being hired. This, in my view, contributes to the problem we face with staff being inadequately prepared/trained to work in the cross- and interdisciplinary world of school mental health.” Carl Paternite, Director, Center for School-Based Mental Health Programs, Miami University of Ohio, personal communication, January 3, 2008.

DMH has an important and unique role in supporting the professional development of mental health providers practicing in DC and in utilizing the most effective and cost efficient methods available to impart knowledge and increase provider competence.

DMH has an important and unique role in supporting the professional development of mental health providers practicing in DC and in utilizing the most effective and cost efficient methods available to impart knowledge and increase provider competence. There is also a role DMH can and should play to enhance the training and skills of

educators and mental health professionals working in the DC public schools, who may or may not be licensed or certified, but who nonetheless provide support services to youth and their families. As research papers and expert opinion tell us, the quality of any school-based program is determined not only by its effectiveness or efficacy but also by the competence of the individual who delivers it.

Overview of what the research and the experts say

Professional Development for Mental Health Providers

While there is a push for the implementation of evidence-based programs, the selection of the right staff to conduct mental health interventions, while equally critical to success, often can be overlooked (Fixen, et al., 2005). Commonly, organizations have focused their limited time and resources on recruitment efforts and screening of candidates to ensure they meet minimal qualifications. Less time and attention is given to personality characteristics, depth of training and experience, and interaction styles. Failure to take the time to match the individual and his/her strengths and skills to the expected tasks can contribute to ongoing staff burnout, turnover, and weak program implementation. In the child mental health arena and more significantly in the school mental health arena, there are no graduate training programs that prepare mental health professionals with the skills, competencies, and techniques necessary to successfully implement school mental health programs. Currently there is only one known post-doctoral fellowship in school mental health located at the University of Maryland, Baltimore.

Beyond clinical training, there is also a lack of understanding about critical education laws and regulations that impact the school environment where services are being delivered. Lack of knowledge and consideration for the education system also leads to clinician frustration and burnout.

The Annapolis Coalition on the Behavioral Health Workforce (2007) developed a comprehensive plan to address the nation's growing crisis around efforts to recruit, retain, and effectively train a prevention and treatment workforce in the mental health and addiction fields. The authors warn that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the needs of American consumers of mental health

care. The human capital resources are even smaller for the number of behavioral health professionals trained to provide prevention and intervention services in our schools. Even more rare are graduates with knowledge or experience in using strengths-based and resilience-oriented strategies.

The Annapolis Coalition on the Behavioral Health Workforce (2007) developed a comprehensive plan to address the nation's growing crisis around efforts to recruit, retain, and effectively train a prevention and treatment workforce in the mental health and addiction fields. The authors warn that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the needs of American consumers of mental health care.

There is also a disappointingly small number of child and adolescent mental health providers adequately trained to work in schools and who can effectively implement evidence-based programs. Finding a well-trained mental health provider who is also dual-diagnosis capable is almost impossible. The Annapolis Coalition points out the incidence of co-occurring mental and addictive disorders has increased dramatically in this country with D.C. being no exception. Most of the workforce lacks the needed complement of skills to effectively work with individuals with such complex needs. They state that "training and education programs largely have ignored the need to alter their curricula to address this problem and, thus, the nation continues to prepare new members of the workforce who simply are under prepared from the moment they complete their training." (Annapolis Coalition, 2007, p.1)

Mental health providers need to be firmly grounded as clinicians and interventionists. They also need to be well prepared to deliver the components of a given program in order for emotional or behavioral improvements to be achieved. Fixen and his colleagues (2005) indicate that although training in an identified program is absolutely necessary, it is not sufficient and alone does not lead to positive outcomes. Knowing how to maximize learning

among participants is key given limited resources and time. Essential to the reinforcement of training and skill development is staff coaching that requires time and commitment. Beyond identifying the ‘right’ programs for DC youth and families there is a responsibility to ensure a commitment to use of limited resources and time in order to be successful.

Professional development for school-based/school-hired professionals

The School Mental Health Alliance (SMHA), a group of over fifty experts in the field of school mental health, developed a position paper that recommended strategies to strengthen the link between mental health and school performance (Hunter, et al., 2005). The SMHA stated that an important obstacle to the implementation of evidence-based school mental health interventions was inadequate mental health professional development for school staff. Many school-hired mental health providers (i.e., school counselors, psychologists, social workers) lack the training needed to deliver high quality interventions along the full continuum of care (prevention, early intervention, and treatment). When sufficiently trained, they often are unable to implement their knowledge due to competing academic/school demands. School counselors, considered important contributors to improvements in emotional/behavioral functioning for students in regular education, are typically considered an underutilized group of school professionals (A. Brown, personal communication, April 28, 2008). School counselors have been known to spend a great deal of their time on academic/vocational counseling, scheduling, and college assistance (Texas Education Agency, 2005), and have struggled with expectations that they manage discipline, monitor attendance, or coordinate academic testing sessions in local schools, tasks that divert them from counseling students on their mental health challenges.

Teachers and other school staff frequently lack education in mental health issues and child development (Weist & Paternite, 2006). Knowing the many environmental and individual risk factors facing youth and the potential for their issues to spill over into classroom conduct problems, it is not surprising that teachers in school classrooms find behavior management both challenging and overwhelming. A comprehensive school mental health model must include teacher and school staff consultation as an integral part of the services offered.

Giving all adults in schools the information, skills, and techniques to manage problem situations allows them to feel prepared and competent to handle the dynamics of any classroom or school setting. While this remains a critical part of the SMH model it is not a funded or billable activity and therefore not always appreciated, discussed, or implemented.

As mentioned previously, teachers are important partners in the implementation of classroom-based mental health prevention programs (Paternite & Johnston, 2005). There are examples of school districts that have encouraged mental health professionals, parents, and teachers to partner to determine the best interventions available in addressing disruptive behaviors among students (i.e., Chicago Public Schools) (M.Akins, personal communication, January 2, 2008). The availability of resources to support teachers in program implementation is oftentimes tenuous. Therefore efforts to maintain program fidelity require a long-term vision and strategic planning.

Researchers have found that specific school, teacher, and program factors predict the level of fidelity and duration of program implementation. Critical factors that influence outcomes include support provided by school principals, amount of teacher burnout, the match between the program type and severity of emotional/behavioral problems encountered, and the provision of performance feedback (Han & Weiss, 2005). These factors have implications for teacher training delivered by community mental health professionals but also for the development of system-wide policies and priorities around school mental health training.

What we can learn from other states & localities

- *New York City.* A model for training clinicians in evidence-based child psychotherapy programs has been developed and is being disseminated (refer to the Reach Institute; <http://www.thereachinstitute.org>). These intensive training programs (which include a few days of on-site training, regular phone consultation with national experts, and result in a certificate from the Office of Mental Health upon completion) are costly (estimates range from \$1200-\$1500 per trainee) but the attention to

the fidelity of quality treatment approaches make this a promising method for enhancing the skills of the clinical workforce.

- *Illinois.* The Illinois State Board of Education and Illinois Department of Human Services, Division of Mental Health created and implemented a joint training series: The Integration of Mental Health in Schools Training and Networking Series. The purpose of the trainings is to assist school districts awarded the Illinois School Mental Health Support Grants through provision of information on best practices, targeted technical assistance, and fostering collaboration across grantee sites. In addition, the goal of implementing PBS across Illinois has required the development of a state structure to support ongoing training throughout the state.
- *North Carolina.* In North Carolina, orientation of new school-based mental health staff requires them to perform ‘nontraditional’ work in an assigned school for 3 weeks and then shadow a veteran clinician for 3 weeks. After this period, a mentor is assigned from within the program to help with the clinician’s ongoing adjustment and with program development.
- *Los Angeles.* Officials in Los Angeles County, California have only a limited number of evidence-based programs they will endorse and support at a given time. This allows a unified vision and sustained efforts around training and supervision necessary to maintain the quality of services. Some experts argue that the underlying risk factor influencing behavioral problems are similar and can be effective in obtaining the mental health outcomes desired – leading to the use of fewer programs in schools. The underlying premise is that more does not necessarily equal better.
- *Maryland.* To address recruitment, training and retention of qualified professionals and paraprofessionals who work with children

and youth with mental health needs and their families, the Division of Special Education/ Early Intervention Services, Maryland State Department of Education and the Mental Hygiene Administration within the State Department of Health and Mental Hygiene jointly sponsored the Mental Health Workforce Summit in 2005.

- *Missouri.* The Center for the Advancement of Mental Health Practices in Schools in Missouri created the first online graduate programs accredited by the American Psychological Association (<http://education.missouri.edu/orgs/camhps>). The purpose was to educate school-based personnel (i.e., educators, administrators, health services professionals) on prevalent mental health problems and the impact on academic success for today’s youth. The courses offer practical applications of psychological concepts and utilize research-based techniques to help school-based professionals address the risk factors that threaten the mental health of children and adolescents. Professionals learn skills to promote positive mental health, encourage positive social emotional development, and increase student learning.

Recommendations for DMH

Primary Recommendation

- DMH, through its Training Institute, should offer trainings geared toward the development of clinical skills for child mental health providers in DC, especially those working in community settings such as schools. The DC School Mental Health Coalition and school partners should provide input on topics and qualified trainers. Policies should discourage engagement in ‘one shot’ trainings. Instead, resources should be identified and dedicated to coaching and ongoing consultation for trainees. A continual investment in training of mental health staff is likely to help improve work-related stress and reduce staff turnover, a challenge for both SMH programs. DMH would yield great benefit from working closely with DC public school system personnel, charter school administrators, and managers of health professional groups (i.e.,

school nurses) to develop and implement a plan for cross training of various mental health and health providers working in schools. An understanding of roles, abilities, knowledge, standards, and regulations pertaining to each group would enhance collaboration and facilitate the integration of services.

Secondary Recommendations

- DMH should develop guidelines that assist community mental health providers in the effective recruitment and retention of mental health professionals. Guidelines should address what training, experiences, and personal characteristics a school mental health candidate should possess in order to successfully work in schools.
- The DMH should revisit the CCISC (Comprehensive, Continuous, Integrated System of Care) initiative. This initiative represents a missed opportunity to promote the development of a dual diagnosis competent child mental health system of providers. Early efforts and training under this program focused only on adult services and consumers and failed to address the unique needs of DC youth. The CCISC initiative, a systems change model, aimed to move both agencies and their subcontracted providers toward becoming “dual diagnosis competent” in caring for those persons addicted to substances and with mental illness.
- DMH Administrators are encouraged to work with local universities and other training programs to develop courses, certification programs, and/or professional development approaches for individuals interested in developing an expertise in school mental health. These programs need to reinforce development of the core competencies outlined by the Annapolis Coalition on the Behavioral Health Workforce.

Financing school mental health: Some initial thoughts

Although this report on the DC school mental health program focuses on operational issues within the context of similar initiatives across the nation, ignoring what we have learned about financing school mental health programs would not serve the DMH school mental health program well. Thus, this section offers an overview of current funding arrangements, and suggests directions for future examinations.

Current funding arrangements for the DC school mental health program

The programs sponsored by DMH and by the Student Support Center are separate from those provided by the DC Public and Charter Schools to students enrolled in special education. Special education students have been assessed as requiring mental health services to benefit from educational services. The DMH and SSC services also do not reflect the guidance counselor and social work prevention and mental health promotion services offered by schools.

The DC School Mental Health Program and Student Support Center services are primarily funded by city-appropriated dollars and federal grants. In FY 2007, these DC-supported mental health services fully subsidized 63 mental health professionals (48 through the DC Department of Mental Health and 15 through the Student Support Center) to provide services in schools throughout the city. The annual cost in FY 2007 was \$4.2 million for DMH (paid through DMH city appropriated dollars) and \$1 million for the SSC (paid through federal grant dollars). In FY 2008, DMH expanded into more schools by contracting with two community-based agencies that hired 6 mental health professionals who were assigned to 6 schools. Thus, DMH supported 48 mental health providers to serve 58 public schools and spent \$4.35 million, while the SSC school mental health services began to diminish as their second SS/HS grant neared its end.

As noted previously, development of the DC SMHP was initiated with support from a federal Safe Schools/Healthy Students grant in 1999 and initially implemented in public charter schools. To date the city has benefited from approximately \$8 million in school mental health services provided through three Safe Schools/Healthy Students (SS/HS) grants awarded to DC (two awarded to the Charter Schools and one to DCPS). In the early years, SS/HS grant dollars typically supported total costs associated with program staffing. When the initial SS/HS grant concluded, the city – through DMH – agreed to pick up the cost of the initial 16 mental health providers assigned to public charter schools, and thereafter embarked on a deliberate path to expand mental health services, increasing access for DC students. During the third SS/HS grant, public charter schools began to co-fund clinician salaries in order to address one of the goals

of the SS/HS grant to build braided funding for school-based services. According to Eve Brooks, founder of the Student Support Center, all schools currently participating in the Safe Schools/Healthy Students initiatives paid 20% of the salary and fringe cost of the clinicians hired by the SSC under the SS/HS grant (E. Brooks, personal communication, February 8, 2007).

In the 2008-2009 school year, as the SS/HS grant phases out, the majority of the 8 charter schools collaborating with SSC assumed 50% of the cost of their mental health clinicians and one charter declined to provide a match. That so many public charter schools in DC were willing to finance 50% of a SMH clinician encourages re-examination of the ways in which education can invest in the sustainability and financing of school mental health services (Cooper, 2008). Whether the city will be willing to sustain the mental health services in the public charter schools by replacing the Safe Schools/Healthy Students money when the grant funds run out at the end of 2008 – 2009 school year remains an unanswered question but the SSC and public charter school leaders do not feel encouraged about the prospects of future city funding. Although the funds provided by these charter schools will maintain some preexisting school mental health services, city and grant subsidized services for regular education students in the charter schools will likely diminish by 50% while services to DCPS schools through DMH and other City sources are increasing (see Table 8).

Future sources of funding

The potential role of Medicaid reimbursement in sustaining the school mental health services has been a subject of long-running debate. Until very recently, the City Medicaid managed care plan would not permit schools to bill Medicaid for services provided to regular education students. Many in city government believe that, because a number of services offered through the SMHP are Medicaid-covered and provided to Medicaid-enrolled students, Medicaid (and hence the Federal government) should help pay for the program. This approach would enable state-appropriated dollars to go further. However, during the first seven years of the SMHP, DC Medicaid and the Department of Mental Health concluded that billing Medicaid for services delivered by DMH-employed staff was not possible given the program's structure. In the last two years, DMH has begun the process of

credentialing their SMHP staff in order to facilitate future Medicaid billing. In May of 2008, changes were made to acknowledge schools as approved places of service, which will allow for the reimbursement of school mental health services in the near future.

Recently the DC Assembly on School Health Care completed a preliminary analysis of challenges that prevent Medicaid reimbursement for school-based health centers in DC (see Appendix B for report titled Opportunities and Barriers for Medicaid Reimbursements for School Health Centers in Washington, DC). Although some of the issues outlined in this brief report may be unique to school-based health centers, many of the recommendations can be generalized to school mental health programs. These school health advocates have concluded that if the District of Columbia clarifies its Medicaid rules, it can make the changes necessary to permit the DMH SMHP and private providers to bill for services provided to students.

Over the last eight years, the DC Department of Mental Health has explored the possibility of utilizing various funding streams to support its school mental health services but has been unable to dedicate the resources to research, design, and implement an effective funding strategy.

During this past year, DMH administrators responded to the city's interest in diversifying the School Mental Health Program funding sources by piloting a contractual arrangement with the city's Core Service Agencies. Under this arrangement, the Core Service Agencies (CSA), organizations that have been certified by Medicaid to be reimbursed for approved mental health services, could compete for DMH funding to initiate school-based treatment services that can be reimbursed by third party payers. When DMH established the program, it was expected that 33% of the clinicians' time would be spent providing brief treatments to students and that 50-70% of these services would be billable to Medicaid. (See Appendix B for the DMH solicitation to expand SMH services in 2007). Because the contracts under this initiative began offering services less than one year ago, information on the successes and challenges of the pilot will not be available until late this Winter. However, it has been reported that the solicitation for bids did not entice many CSAs to compete for contracts. If true, this suggests that financing mechanisms will be challenged to

Table 8. School Mental Health Services in the District of Columbia for Regular Education Students by Year, Source of Funding, & Number of Schools Served

School Year	Funding Source	DCPS SMH Schools**	Charter SMH Schools**	Subtotal	Grand Total	Provider
2000-2002 (Covers 2 years)	Federal	0	16	16	16	DMH
2002-03	DMH Appropriated Funds	16	10	26	29	DMH
	Federal	0	3	3		SSC
2003-04	DMH Appropriated Funds	16	10	26	29	DMH
	Federal	0	3	3		SSC
2004-05	DMH Appropriated Funds	21	10	31	36	DMH
	Federal	0	5	5		SSC
2005-06	DMH Appropriated Funds	24	10	34	47	DMH
	Federal	0	13*	13		SSC
2006-07	DMH Appropriated Funds	31	11	42	63	DMH
	Federal	0	21*	21		SSC
2007-08	DMH Appropriated Funds	37	11	48	65	DMH & DMH Contractors
	DC Funds	2	0	2		Dept Mayor of Ed
	Federal	0	15*	15		SSC
2008-09	DMH Appropriated Funds	47	11	58	82	DMH & DMH Contractors
	DC Funds	15	0	15		Dept Mayor of Ed & OOSE
	Federal/School (50-50)	0	9*	9		SCC
2009-10 (projection)	DMH Appropriated Funds	47	11	58	73	DMH & DMH Contractors
	DC Funds	15	0	15		Dept Mayor of Ed & OOSE
	Federal/School (50-50)	0	0	0		SCC

*Served both special and regular education students

**These numbers represent the number of schools served and not the number of FTEs dedicated

overcome structural difficulties in the city’s mental health service delivery system.

Another potential source of funding is the local education agency (either DCPS or the public charter schools). As noted earlier, DCPS and the public charter schools received a base foundation of \$7,600 per student in Fiscal Year (FY) 2007 as determined by the Uniform Per Student Funding Formula (UPSFF). This formula, which varies annually, is the minimum foundation amount that is needed to provide an adequate level of services to the school system on a per-student basis. Once a local education agency (LEA) receives this funding from the city, budgets are established that allocate funds needed to cover facilities costs, operations, special education, professional development and central overhead. The remainder of funding (usually about 50 percent of the total) is allocated

to local schools, using the Weighted Student Formula (WSF). Under the WSF, similar to the UPSFF, a certain amount of base funding is allocated to each student, with additional funding provided if the student is deemed to have special needs. Unlike the UPSFF, the WSF also increases funding to account for the student’s economic status. This funding is intended to follow each student to his or her school and to provide a sufficient proportion of the total funding for the local school to fully staff its local administration, classrooms and custodial operations to best serve its students. Difficulties around the equity of the system and the purchasing power held by local school principals have been noted (DC Public Schools Master Education Plan, 2006). DCPS school principals also have access to a portion of the DCPS LEA budget to support additional staff or pay for local school planning efforts.

Overview of what the experts say

The national experience of school-based mental health programs reflect a variety of funding sources, including federal and state grants, local and national foundation funds, fee-for-service billings to insurers, and contracts with local public agencies. A recent report suggests that behavioral health services in schools may be best sustained through billing Medicaid. In Ohio, it was found that at least 28 Medicaid encounters per week were necessary to cover the cost of care for a community mental health provider and still be able to offer some preventive services to the uninsured (see Appendix B for the preliminary report to the Health Foundation of Greater Cincinnati about the sustainability of school based mental health). This strategy has not yet been implemented in Ohio and its feasibility remains unknown. Further, each state develops its own Medicaid program that complies with its state regulations. While Federal law requires that Medicaid be the first payer for medical and mental health services provided under IEPs, there is no best practice for the use of Medicaid funds to pay for school based services provided to regular education students. Federal regulations, however, require that schools choosing to bill Medicaid for services for children in regular education programs cannot provide the same services to non-Medicaid eligible students unless they establish a sliding scale fee structure and the capacity to bill private insurance plans.

Recommendations about the successful provision and reimbursement of mental health services in primary care settings offered in a recent report jointly funded by three federal agencies bear direct relevance to school-based services (Kautz, Mauch, & Smith, 2008). The experts contributing to the report stressed a) the need to clarify policies, definitions, and allowable services, b) the importance of broadly disseminating the clarifications through training and technical assistance, and c) the value of targeted collaboration among the local public agency and national organizations as critical actions likely to improve Medicaid reimbursement of mental health services. Although these analyses offer some promise for diversified funding, in terms of dollar totals federal grants and programs remain the largest contributor to the development and expansion of full service school mental health programs nationwide (see Appendix L for a list of federal grant programs used to fund school mental health programs).

Funding sources often pose restrictions or regulations mandating how funds may or may not be used. Funding from state and county public mental health agencies are traditionally designed to pay for treatment services for diagnosable illnesses and not for mental health prevention or promotion activities. Prevention and mental health promotion activities are more often supported through grant dollars and require ongoing advocacy and work to sustain. This reality contrasts with recent recommendations from the public policy arena where an increased focus on early identification and treatment has resulted in new dollars for prevention and early intervention. Especially within the last two years, there has been a push to move policy and program support at the state and federal levels in the direction of prevention, early intervention, and mental health promotion (e.g., Mental Health Services Act of California, the Minnesota Comprehensive Children's Mental Health Act, and the Illinois Children's Mental Health Act- see Appendix E for other examples of state mental health laws that address a continuum of children's mental health care and the role of schools).

At the federal level there are some promising bills pending that will either increase dollars available or help make programmatic changes so that SMHPs will have access to established grant funds. Bills include H.R. 3430 Mental Health in Schools Act of 2007, whose purpose is to amend the existing Public Health Service Act so it revises and extends projects and increases access to school-based comprehensive mental health programs; S. 1337: Children's Mental Health Parity Act which is a bill to amend Title XXI of the Social Security Act to ensure equal coverage of mental health services under the State Children's Health Insurance Program; and S. 578: Protecting Children's Health in Schools Act of 2007, a bill to amend Title XIX of the Social Security Act to improve requirements under the Medicaid program for items and services furnished in or through an educational program or setting to children, including children with developmental, physical, or mental health needs. Although these bills will likely not be adopted early in this Congressional cycle, their consideration reflects a growing federal interest in school-based mental health care.

What we can learn from other states & localities

- In Baltimore, Maryland*, a 10-year old city initiative suggests the possibility of sustaining a school mental health program long-term when the city and state collaborate. Maryland has some of the most well-established school mental health programs in the country. The city of Baltimore, in particular, has succeeded in diversifying its funding of school-based services so that mental health support at all levels of care are financially supported. In 2004, Baltimore Mental Health Systems (BMHS), the single core service agency in Baltimore, was funded primarily by the city to create an RFP for mental health providers to offer prevention and consultation services in schools. These services are considered highly desirable by school officials but are not included as billable services under Medicaid (see Appendix B for Baltimore City Request for Proposals, February 23, 2007). With contracts from BMHS and fee-for-service Medicaid billings, outpatient mental health centers have been providing a full range of services in schools for more than a decade. The school district provides the majority of the funding to support school-based mental health services through its office of third party billing (approximately \$1.6 million). Fifteen years ago, the school district created this entity to bill Medicaid for services provided by the school district to children enrolled in special education. The office receives the Medicaid reimbursements and allocates these dollars among its school-based services. The Office of Third Party Billing sets aside 10% of these Medicaid revenues to provide on-going funding for prevention services. Baltimore officials are adamant that a blend of fee-for-service and contract funding is essential if local governments are to maintain school mental health programs, and that programs built on fee-for-service dollars alone are not sustainable.
- In New York State*, another city-state partnership has launched a school-connected mental health initiative that serves a narrower purpose. In 2007, the New York State Office of Mental Health launched a \$33 million program, “Child and Family Clinic Plus” that provides free voluntary screening, prevention, and early intervention in community settings such as schools to help identify youth needing mental health care. The program is also intended to increase use of evidence-based services offered in natural settings such as in the home, school, or community (New York State Office of Mental Health Guidance Document, 2007). The program is partly funded through Medicaid enhancements provided to the community-based organization delivering the services. For example, in New York City, under a contract between the provider and the City Medicaid office, enhanced rates will be provided for home visits and face-to-face contacts at \$50 more than the hourly treatment rate normally reimbursed. Contracts for screening will be \$8 per screening per child.
- Arkansas*. The School-Based Mental Health Network programs monitored by the state Department of Education defines best practice as 30% of a mental health providers’ time dedicated to non-billable services (such as prevention, education, and early intervention services) and 70% time dedicated to direct billable services. Medicaid billing is considered one important aspect of a program’s financial sustainability (although not the only one). In order to bill Medicaid for mental health services, one member of the partnership (the school district or the mental health provider) must be enrolled as a Medicaid provider and school districts that receive reimbursement from Medicaid are required to use state and local funds to pay the local match. Additional recommendations made to the Network include that school districts contribute \$25,000 per therapist per year for the mental health services provided.

Several states have initiated grant programs as vehicles to drive the expansion of school mental health programs.

- *In Minnesota*, in late 2007, the Department of Human Services, through its Children's Mental Health Division, released a Request for Proposals totaling \$12.5 million to fund projects that would develop the infrastructure for school-based mental health throughout the state. Successful applicants would receive 3-year contracts with an option for one or two-year extensions (Minnesota Department of Human Services Children's Mental Health Division Request for Proposals, 2007; see Appendix B for this document). Under this initiative, mental health centers will be required to provide at least one of a number of school-located or school-linked mental health interventions. These interventions are treatment-oriented but these funds can be used to support services closely connected to clinical care, such as consultation with parents and school staff, two pre-diagnostic meetings with the student and/or family, participation in IEP meetings, or use of translation services. Applicants may request additional funds for starting up and phasing in the infrastructure components of a school mental health program. These funds could cover establishing billing procedures, developing partnerships with school personnel, providing staff development in mental health and socio-emotional learning, and building outreach activities and referral networks.
- *In Illinois*, the Illinois Children's Mental Health Act of 2003 established the Illinois Children's Mental Health Partnership (ICMHP) and authorized it to develop a statewide strategic plan for reforming the children's mental health system. In line with the goals of this strategic plan, in FY 2007 the Governor authorized \$850,000 in School Mental Health Support Grants to support the pursuit of three goals across the state: 1) to increase the capacity of schools to provide mental health supports for students, with an emphasis on early intervention services; 2) to coordinate the student mental health support system and integrate that system with community mental health agencies, and 3) to reduce the stigma associated with mental illness within the school community (Illinois Violence Prevention Authority, 2006).
- *In California*, innovative legislation (known as the Mental Health Services Act, or Proposition 63) currently authorizes the California Department of Mental Health to establish guidelines and dispense funds to counties for community planning, infrastructure development, the implementation of prevention and early intervention activities, and workforce education and training (California Department of Mental Health, 2007). Administrators acknowledge that if the act did not specifically include a provision for prevention and early intervention there would likely be no emphasis on prevention in mental health throughout the state of California. Thus, a lesson from California is that state legislators can play a very important role in creating a broad vision and sustained support for prevention and promotion. Assessments of the impact of this policy change are in progress (Center for Mental Health in Schools, 2008).
- *In Michigan*, a strong school-based health center (SBHC) initiative offers mental health care through many of its 87 sites. Core funding for this initiative comes primarily through the state department of education. SBHC leaders have recently concluded an agreement with local managed care plans that will allow for the reimbursement of services delivered to children through SBHCs. Under this agreement, the centers and plans have begun a pilot program in which qualified school social workers will provide mental health care through the SBHCs and can be reimbursed for services. Additionally, increased funds for school-based health care will soon be available in a number of counties throughout Michigan as a result of an agreement between the local public

health office and the board of commissioners that allows school districts dollars transferred to the local public health agency to be used to draw down additional federal funds. The local public health system then subcontracts with community mental health providers to deliver school-based services across the schools in that district (D. Brinson, personal communication, January 10, 2008). While no data is available yet to determine the efficiency of this new financing model, such innovative approaches bear watching.

- *In Pennsylvania*, mental health services in schools are partly funded through EPSDT dollars. Once a child has been designated as meeting the EPSDT standard of disability he or she can be categorized as a “family of one” and be automatically eligible for Medicaid. State regulations around EPSDT interpret federal guidelines to allow both psychiatrists and licensed psychologists to determine medical necessity and prescribe needed behavioral health services (S. Mrozowski, personal communication, January 16, 2008).
- *In Ohio and South Carolina*, local foundations have been important partners in supporting innovation in school mental health. In Ohio the Health Foundation of Greater Cincinnati has funded pilot schools to implement prevention programming across counties in the state. In South Carolina the Blue Cross/Blue Shield Foundation has made seed grants available to help supplement school mental health clinician salaries in order to retain them in professional shortage areas around the state.

Recommendations for DMH

Primary Recommendation

- Authorize a comprehensive examination of all viable funding options for SMH in D.C., including grants, contracts, fee-for-service payments, interagency agreements, and pooled funding to advance youth initiatives. The goal of this examination would be

a comprehensive plan to guide development of a systematic blended-funding strategy to support school mental health programs.

Secondary Recommendations

- In partnership with OSSE, conduct an analysis of federal and state/city education funds to determine their availability to underwrite non-academic learning supports.
- In addition to federal grants, foundation funds, local agency dollars, and contracts with local education agencies (LEAs), DMH should work collaboratively with the Mayor’s Interagency Collaboration and Services Integration Commission (ICSIC) to explore the desirability of pooling various block grant funds to support early intervention mental health services. In addition to the Community Mental Health Services Block Grant, other potential sources include the Social Services block grant, Juvenile Accountability block grant, Education block grants, Early Childhood block grants, and the Community Development block grants.
- Align SMHP goals with education priorities and explore the possibilities for direct education funding for mental health promotion and early intervention. In Ohio and North Carolina federal education funds have been used to support implementation of evidence-based mental health programs and practices. Among the sources of support from the federal education act: Title I, Part D: Children and Youth Who are Neglected, Delinquent or At-Risk; Title IV, Part A: Safe and Drug Free Schools and Communities, Part B: 21st Century Community Learning Centers; Title V: Promoting Informed Parental Choice and Innovative Programs. Additionally, the Individuals with Disabilities Education Act (IDEA) allows for a percentage of special education dollars given to the state to be used for youth who have not yet qualified for services but are earlier in the intervention trajectory, meaning that early intervention work can be funded with these dollars. Provisions of IDEA 2004 require that 15% of the IDEA dollars be spent on early intervention services if disproportionality is identified in a local district. There is debate about whether this provision creates a targeted pot of money that would

fund the implementation of new strategies to divert children from special education or if these funds are earmarked to improve the quality of instruction for all students including those in general education. The flexibility and the possible interpretations of this legislation could result in a significant funding stream for a segment of school mental health care and, therefore, further exploration is warranted.

- Following the Michigan example, the District might also consider looking at the possibility of funding school mental health as a component of a comprehensive school-based health center initiative. Several states have specifically increased funding for SBHCs to expand and improve mental health services delivered in schools (i.e., Texas, New Mexico, Colorado, New York, Michigan). Given the city's interest in expanding the number of SBHCs, especially in high schools, possibility of additional support may become a reality.
- DC may also explore the possibility of committing general school district funds (i.e., district tax dollars that are not tied to any particular program) to support the delivery of mental health services in schools as has been achieved in other parts of the country (Los Angeles County in California and the 2004 Families and Education Levy in Seattle, Washington).
- Build the capacity of DMH and other city organizations to compete successfully for federal grant funds. Successful approaches will include institutionalizing collaborative partnerships, strengthening inter-agency communications, refining system of care models, and continuing to identify champions who advocate for policy and program changes.

Program evaluation and outcomes research

"One of the only mental health services that have worked in the past 15 years has been school mental health. It is one of the only programs that has worked in this city". Tommy Wells, City Council Member, personal communication, March 30, 2007.

Mental health programming in District of Columbia schools is at a crossroads. Increased recognition of mental health needs among the city's young people together with broad community support for meeting these needs through school-based programs has created a solid foundation for expanding the existing programs. The next challenging question is: How best to proceed? What are the most effective ways to organize these services? Which services and programs have the most impact? And what has been learned about the best way to document the benefits of school mental health? This chapter reviews current efforts in the District to assess the impact of its school mental health programs, summarizes findings from research and evaluation studies of school mental health programs, and suggests lessons to be learned from other city and state program evaluations.

Current approaches to evaluating school mental health services in the District of Columbia

Program development and evaluation depend on the availability of data describing the prevalence of mental health conditions among District children and adolescents as well as services utilization by this population. The availability of these "baseline" data is critical to the city's ability to measure progress once new services are implemented. According to a recent study by the RAND Corporation, these data are almost non-existent in the District of Columbia, and this deficiency exists across all District of Columbia service systems (Lurie, Gresenz, Blanchard, Ruder, Chandra, et al., 2008). The lack of baseline information on functioning, both for individual children as well as the systems that serve them, puts decision-makers at a significant disadvantage for making informed choices about the distribution of limited resources. Despite this system-wide limitation, both the DMH SMHP and SSC have collected data on key aspects of their programs for a number of years.

Evaluation objectives: Measuring program and service goals

The DMH SMHP and SCC have each established goals and outcomes for their programs. As indicated in Table 9, these organizations have focused particularly on institutional goals. Over the years the DMH SMHP and the SSC programs have collected substantial quantities of data that describe service utilization and staff productivity,

student-client satisfaction and satisfaction among others affected by the services, and youth emotional, behavioral, and educational outcomes.

The differences between the two programs’ goals evident in Table 9 can be attributed to a) the requirements of the primary funding sources, b) the need to focus on infrastructure building to support mental health service delivery, especially for the charter schools, and c) variations in the program models being used. From a citywide perspective, standardizing school mental health program goals across service providers would help policymakers assure consistency in benefits to students and families across the programs.

Evaluation of clinical services

The DMH SMHP and the SSC SMHP have provided students in the DC public and public charter schools with in-school mental health services for the past 8 years. A large number of youth have utilized these services. Descriptive statistics on service users have been reported regularly to the city’s program and political leadership. Data elements have included demographic information on students, referral sources, reasons for student referrals, clinician productivity, types of services provided and modalities of treatment offered. The absence of national and local standards makes it impossible to determine whether programmatic benchmarks around staffing, productivity, penetration rate, and the scope/breadth of services have been met.

The need to identify clinical measures that were relatively easy to administer, score, and interpret and that assessed strengths and weaknesses using information obtained from numerous sources, led both the DMH SMHP and the SSC SMHP to adopt the Ohio Youth Problem, Functioning, and Satisfaction Scales (“Ohio Scales”; Ogles, Melendez, Davis, & Lunnen, 1999). The scales identify student problems, guide treatment planning and track progress for students receiving services, while measuring problem severity, functioning, hopefulness, and satisfaction among students being treated as well as their caregivers and their mental health providers. When used to screen for problems, students demonstrating high scores on particular subscales of the tool receive a second round of screening for depression, anger and aggression using other validated measures.

After a determination is made about the focus of treatment and the level of care needed, progress on emotional and behavioral outcomes are tracked using additional clinical tools. Table 10 lists the child/youth outcomes used in the DMH SMHP program evaluation plan and the measures employed to indicate changes in emotional and behavioral functioning.

The DMH SMHP has documented significant improvement in psychological functioning among its student-clients over time. Pre-post testing following treatment interventions

Table 9. Program Goals for the DMH and SSC School Mental Health Programs

DMH SMHP Program Goals	SSC Program Goals (MH Prev and Intervention)
Assure continuous quality improvement of services to align operations, curriculum and program to achieve desired outcomes	Increase the availability of school-based early intervention assessments and mental health counseling services for pre-K through high school in the charter schools
Facilitate student improvement in functioning	Develop functioning Student Support Teams (SSTs) in every school site
Assess stakeholder satisfaction	Develop and pilot braided funding and sustainability techniques for schools
Document the program’s impact on important systems surrounding the child	

Sources: Acosta Price, Mack & Spencer (2005) & Brooks, SS/HS Grant Report Yr 2 (2007)

Table 10. Child/Youth Outcomes and Measures for DMH School Mental Health Program

Emotional & Behavioral Outcomes	Measurement/Tool
Increase Utilization of MH Services	Monthly Report Form
Improved Satisfaction	Child/Youth, Parent, Teacher Satisfaction Forms
Reduce Anger	Beck Anger Inventory for Youth & Children's Inventory of Anger
Reduce Aggressive Behavior	Beck Disruptive Behavior Inventory for Youth & The Aggression Questionnaire
Reduce Levels of Depression	Reynolds Child & Adolescent Depression Scale
Reduce Symptoms of Trauma	Trauma Symptom Checklist for Children
Improve attendance, reduce suspensions	Attendance data, suspension data, truancy data, drop-out data (obtained from participating schools/school district)

Source: Joel Dubinetz, personal communication, February 15, 2008

has demonstrated clinically significant changes in self-reported experiences of emotional distress especially in reduced levels of depression, anger, and aggression among students. (Acosta, Mack, & Spencer, 2005). These changes are robust for internalizing problems, but less is known about the impact of the program's services on students' externalizing problems such as disciplinary infractions and behavioral acting out. To assess that impact, DMH will need access to behavioral data collected by schools and this will require greater collaboration between individual schools, the school system, and DMH SMHP. This access may not be easily achieved, but would certainly enhance the agencies' knowledge about how to help troubled students.

Administrators at SSC have invested significantly in the development of individualized assessments of progress among children receiving treatment services. Following up from the Ohio Scales, SSC clinicians have tracked individual client changes and made clinical decisions using the Reynolds Child and Adolescent Depression Scale (RCADS) and the Global Assessment of Functioning (GAF). Additionally, SSC has implemented a number of

evidence-based programs that have associated measures in order to document functioning before and after the intervention (e.g., the Incredible Years program and Guiding Good Choices) (Carolyn Gardner, personal communication, May 5, 2008).

Among students participating in mental health interventions provided in the SSC schools, an independent evaluation for the 2006 - 2007 academic year found improvements in emotional functioning, particularly with self-reported depression and anxiety among high school students. Reports of bullying, being bullied, and carrying weapons showed lower rates as did self-reported absences from school and days skipped (Youth Policy Institute, 2007a; 2007b). Aggression, violence, and alcohol/drug use did not diminish during the same time period, particularly among high school students (Youth Policy Institute, 2007b).

There are a number of limitations associated with the evaluations of both DMH SMHP and SSC programs. While the descriptive data characterizing students who use the services offer a valuable look at risk factors and

the student's social context, little can be said about the effectiveness of any specific program, component, or service as a result of these investigations. Additionally, the majority of outcome data is based on self-report (i.e., student, parent, teacher) that is infrequently corroborated by other objective information (i.e., collateral observations or reports, attendance data, disciplinary reports) due to the organizational barriers often experienced by program administrators and evaluators. Furthermore, it is difficult to attribute any student or school-level improvements to the interventions provided by DMH or SSC clinical staff without more carefully controlled studies.

The lack of rigorous experimental or quasi-experimental research that has been conducted in DC hinders program development, especially in light of the significant financial and social investments made in these programs. Although findings have been encouraging, the absence of control groups for which to compare results of any previous evaluation studies significantly limits the interpretation of emotional, behavioral, or academic changes seen among students receiving school-based mental health services.

The absence of carefully controlled studies is especially troublesome in light of the changes recently made to the DMH SMHP. Fiscal constraints and external pressures have necessitated an expansion of the DC SMHP into an additional 10 DC public schools in the 2008-2009 school year, without an increase in funding from DMH, City Council, or the Mayor. This change will result in the implementation of a two-tiered approach, with Tier 1 schools maintaining the current model of prevention, early intervention, and brief treatment services and Tier 2 schools being offered specialized services or an abbreviated version of the model. In twenty schools, where enrollment is generally less than 200 students and/or schools do not demonstrate a readiness for a full-time clinician, a school mental health provider will be assigned to the school on a part-time basis to conduct a specific program or curriculum, depending on the identified needs of the school community. DMH leaders and administrators report they have a plan in place to monitor the impact this modification will have on clinical, behavioral, and academic outcomes exhibited by student, school staff, and families.

Evaluation of organizational structure

An organization's structure determines how well their

functions and processes ease the attainment of an expressed goal – in this case the expansion of school mental health programs throughout Washington, D.C. An effective organizational structure enables better working relationships among various entities within and outside of the organization and sets controls to monitor the efficiency of important processes. The evaluation of DMH and SSC organizational infrastructures could include an examination of staff selection criteria, the development of processes to monitor staff competence and productivity, an analysis of internal and external communications, the implementation of supervision and training standards, and other activities that assess quality of school mental health services (Weist & Paternite, 2006). Although these are processes that can, theoretically, be evaluated, neither organization has demonstrated advancements in this area. Resources would be needed to conduct these activities, but the investment would facilitate data-based decision-making.

Over the last several years DMH SMHP administrators have implemented a continuous quality improvement (CQI) plan to assess the quality of services and establish structures for accountability. The DMH SMHP formed an internal CQI committee, that is not formally part of the Office of Accountability, that meets monthly to address a specific focus area. The committee has developed a clinical chart review process and procedures for the completion of clinical paperwork (i.e., intake forms, assessments, treatment plans, etc.). Additional aspects of school-based care that are being developed by the committee include procedures for conducting needs assessments, identifying and implementing evidence-based practices, increasing stakeholder involvement and feedback, utilizing clinical outcome and utilization data in clinical decision-making, demonstrating improvements in staff development efforts, facilitating linkages to community resources, and delineating clear procedures for access to care/crisis responses.

There has been no consistent quality improvement program at the SSC due mainly to the absence of a clinical director to manage these activities. The SSC is now engaged in discussions at an agency level about the quality indicators they would like to track (Carolyn Gardiner, personal communication, May 5, 2008).

Research findings on school mental health programs

National studies have confirmed that the unique advantage of school-based mental health services is that they are accessible and utilized by students with identified mental health needs more often than services offered through community-based settings (Atkins, et al., 2006; Armbruster & Lichtman, 1999; Weist, 1997). Although establishing successful school-based mental health programs requires attention to a number of contextual and systemic factors (Acosta, Tashman, Prodent, & Proescher, 2002), such efforts have been known to yield benefits for students from inner-city public schools in particular (Atkins, et al., 2006; Costello-Wells, McFarland, Reed, & Walton, 2003; Jennings, Pearson, & Harris, 2000). Researchers interested in the impact of school-based mental health services have generally studied outcomes related to two areas: emotional/behavioral functioning and academic performance. A number of school-based interventions and programs have demonstrated positive outcomes in both of these domains (Catron, Harris, & Weiss, 1998; Rones & Hoagwood, 2000; Stoep, Weiss, Kuo, Cheney, & Cohen, 2003; Tsoi-A-Fatt, 2008; Walter, 2007; Woodruff, et al., 1999).

Prevention and positive long-term outcomes

While the societal benefits and cost-effectiveness of mental health promotion and prevention efforts are now more clearly articulated and understood (SAMHSA, 2007), prevention researchers warn that school-based programs must be coordinated with school operations, integrated with existing initiatives, and utilize practices and programs that can yield obvious improvements (Greenberg, et al., 2003). A review of prevention programs and their capacity to prevent risk of psychopathology in youth concluded that multi-year and multi-component prevention programs are more likely to show long-term impact than short-term programs (Greenberg, Domitrovich, & Bumbarger, 2000). This review also states that the impact of prevention programs is typically underestimated since some of the more effective programs demonstrate stronger impacts at long-term follow up than at the end of the intervention. The bottom line is that clinicians, administrators, and evaluators must commit to a program or set of programs that will be implemented consistently over a number of years and assessed for immediate and longer-term impacts.

Prevention researchers warn that school-based programs must be coordinated with school operations, integrated with existing initiatives, and utilize practices and programs that can yield obvious improvements (Greenberg, et al., 2003).

School mental health and emotional/behavioral outcomes

Research reviews indicate that a number of school mental health interventions demonstrate improvements in psychosocial functioning and a reduction of symptoms across a variety of emotional and behavioral problems in children (Walter, 2007; Rones & Hoagwood, 2000; Catron, Harris, & Weiss, 1998). These improvements include the reduction of aggressive behaviors (Wilson, Lipsey, & Derzon, 2003) enhancements in student functioning as well as cognitive-behavioral changes (Hoagwood & Erwin, 1997) and behavioral (Wilson, Lipsey, & Derzon, 2003). Programs with a strong impact on individual symptom reduction share five common elements:

1. consistent program implementation,
2. involvement of parents, teachers or peers in the intervention,
3. use of multiple modalities and the focus on changing specific behaviors and skills,
4. integration of program content into the classroom curriculum, and
5. inclusion of developmentally appropriate program components (Rones & Hoagwood, 2000).

To achieve notable improvements in student social, emotional, and behavioral functioning requires an investment of time and effort for those implementing, managing, and funding school mental health programs. The development of a standardized evaluation plan with details of data elements that should be monitored over time will require a preliminary decision about the intervention(s) that will be employed citywide.

School mental health and educational outcomes

Previous research has suggested that school mental health programs have a positive impact on academic functioning (Jennings, Pearson, & Harris, 2000). A recent review

of studies that looked at the mental health and academic outcomes of school mental health programs found a lack of rigor in both research areas (Hoagwood, et al., 2007). Despite these and other limits, several conclusions can be drawn from the review by Hoagwood and her colleagues. First, the impact of school mental health interventions on educational outcomes appears modest, does not seem to last, and is poorly understood. The lack of persuasive research makes it difficult to urge the inclusion of specific academic and education-related data elements in any school mental health program evaluation. Yet, program supporters and funders consistently view attendance, grades, scores on standardized tests, disciplinary referrals, suspensions, referrals to special education for emotional disturbance (ED), promotion rates, and changes in numbers of drop outs as key indicators to monitor – despite the difficulty of establishing causality between the mental health and educational outcomes and despite the difficulties of securing education information from school systems.

The Hoagwood review cautions that the academic outcomes included in many research studies (i.e., grades, test scores, school drop out) do not necessarily have a direct relationship to the mental health interventions. Other variables such as the number of disciplinary actions and classroom factors (i.e., teacher behaviors, classroom organization, and school climate) appear to have a stronger effect on academic outcomes and educational performance and are more readily influenced by mental health interventions. On the other hand, given the high correlation between failure to complete secondary school and the presence of an emotional/behavioral disability (Stoep, Weiss, Kuo, Cheney, & Cohen, 2003; Tsoi-A-Fatt, 2008; Woodruff, et al., 1999) and the strong relationship between education, health, and future success (Robert Wood Johnson Commission to Build a Healthier America, 2008), including academic variables in an evaluation of the impact of school mental health services is rational.

The important point here is that a program evaluation plan needs to examine the impact of school-based interventions with an understanding of the primary focus of the intervention and to look for outcomes that demonstrate changes in that arena. For example, universal prevention programs that target changes in a student's ability to make good choices or develop positive relationships should not be expected to demonstrate immediate grade improvements since that is not the focus of the intervention.

School mental health and school climate

“Whole school climate has to do with everyone’s efforts to promote mental health. Everyone is involved. The entire school community can feel they can have an impact on making every child feel valued in terms of their social and emotional well-being. Qualified mental health providers can be important resources in this process”. Joyce Sebian, Senior Policy Associate, National Technical Assistance Center for Children’s Mental Health, personal communication, January 4, 2008.

Growing evidence suggests that school-wide interventions aimed at improving school climate compliment the more targeted curriculum-based interventions frequently used in school mental health programs. “School climate reflects the physical and psychological aspects of the school that are more susceptible to change and that provide the preconditions necessary for teaching and learning to take place” (Tableman, 2004, pg. 2). Poor school climate contributes to a number of negative outcomes for students including behavioral and emotional problems, alcohol and tobacco use, and increased aggression, while programs aimed at improving school climate effectively promote a number of positive outcomes (Greenberg, Domitrovich, Graczyk & Zins, 2005). Recently, research has confirmed that changes made to a schools’ overall organization, policies, practices, culture, or environment were associated with increased student participation, improved relationships, greater connection to schools, improvements in truancy, and reduced drug use (Fletcher, Bonell, & Hargreaves, 2008). In particular, the connection to school, or the extent to which a student feels accepted, welcomed, and respected in his/her school, is meaningfully related to better academic and psychosocial outcomes (Shochet et al., 2006). Interventions that focus on fostering school connectedness help ameliorate a variety of emotional and behavioral problems, such as decreases in depression, substance use, and violent or deviant behavior, and support better academic performance (Anderman, 2002; Blum, 2005; Shochet et al., 2006).

The benefits are not only evident among students but can also be seen among teachers. School mental health programs have been shown to improve teacher retention and reduce burnout. Stress among teachers has never been so high (Bauer, et al., 2007) and educators openly report feeling overwhelmed and helpless when faced with the mental health needs of their students (Williams, et al.,

2007). This challenge is not confined to the U.S., with international statistics indicating that almost 50% of new teachers will leave the profession within a 5-year period (Bauer, et al., 2007), which helps explain a teacher turnover rate of almost 17% nationally and over 20% among teachers working in urban schools (NCTAF, 2007). As a result, effective school mental health programs must support the advancement of nurturing conditions in classrooms to address both teacher stress and student psychosocial problems (Weston, Anderson-Butcher, & Burke, 2008). A study that compared Baltimore City elementary schools with and without school mental health programs found that teachers in schools with mental health programs referred fewer students to special education for emotional or behavioral problems and felt they had more supports available to them than teachers in schools without that resource (Bruns, Walrath, Glass-Siegel, & Weist, 2004). This outcome suggests the possibility of real financial benefits from implementing comprehensive mental health programs in schools.

The relationships between school climate and student achievement, teacher retention and satisfaction, and school violence are strong -- suggesting that leaders of school mental health programs may wish to develop and use well-designed assessment tools to track changes in school climate and levels of school connectedness. Several organizations have rated instruments that both measure school climate and can be used to monitor improvements in school environments (Tableman, 2004). These include:

1. The Collaborative for Academic, Social and Emotional Learning (CASEL, <http://www.casel.org/assessment/climate.php>),
2. The Center for Social and Emotional Education (CSEE, http://csee.net/climate/csciasessment/csci_survey.aspx), and
3. The Western Alliance for the Study of School Climate-WAASC web-based classroom climate surveys (http://www.calstatela.edu/centers/schoolclimate/classroom_survey.html) and school climate surveys (http://www.calstatela.edu/centers/schoolclimate/school_survey.html#culture)

One state agency, the Ohio Department of Education, has acknowledged the influence environmental conditions have on academic performance and as a result implemented

the Ohio School Climate Guidelines to encourage school districts throughout Ohio to invest in the maintenance of positive learning environments (<http://www.ode.state.oh.us/GD/Templates/Pages/ODE/ODEDetail.aspx?Page=3&TopicRelationID=433&ContentID=1841&Content=47610>).

Appropriate clinical evaluation tools

The impact of a clinically-focused program evaluation depends on the quality and reliability of the assessment tools used, their psychometric properties and their relevance to the intended outcomes. Selecting the right instruments for screening and assessing students at school is a complex endeavor requiring a keen understanding of strengths and weaknesses of available instruments (Levitt, Saka, Romanelli, & Hoagwood, 2007). Some web-based resources offer help in identifying the right tools for particular symptom clusters and audiences (www.schoolpsychiatry.org), but typically they do not provide information on the psychometric properties of the tools. A national push to implement universal screening in schools has not been accompanied by guidance on how to effectively screen large populations of children (New Freedom Commission, 2003). Only recently have criteria been suggested to help educators and mental health professionals make informed decisions about the most suitable tools to use in assessing students within school settings (Glover & Albers, 2007).

Quality assessment in school mental health programs

In addition to examining the outcomes associated with school mental health services, well-established programs have dedicated resources to continuously assess the quality of services provided. The Center for School Mental Health, one of the national centers for school mental health at the University of Maryland, has developed resources on quality improvement to help program administrators identify priority areas for enhancing school mental health services (Lever, Ambrose, Anthony, Stephan, Moore, et al., 2007). The School Mental Health Quality Assessment Questionnaire (SMHQAQ; Weist, Stephan, Lever, Moore, & Lewis, 2006) is a tool using 40 indicators reflecting 10 principles of care that can be used by school mental health practitioners to assess strengths and weaknesses of their programs. The Mental Health Planning and Evaluation Template (MHPET;

NASBHC, 2007), a similar tool developed jointly by the National Assembly on School-Based Health Care (NASBHC) and the Center for School Mental Health, is typically used by administrators or managers to assess programmatic strengths and weaknesses. The MHPET is a 34-item measure that is organized into eight dimensions: 1) operations, 2) stakeholder involvement, 3) staff and training, 4) identification, referral, and assessment, 5) service delivery, 6) school coordination and collaboration, 7) community coordination and collaboration, and 8) quality assessment and improvement. Because these are both recently developed tools, findings on their effectiveness are not yet available.

To the extent that school mental health clinicians are expected to be the main source for data gathering, information systems should be identified or designed that allow information to be captured in the course of ‘business as usual’ to reduce drain on clinical staff.

Program evaluation is a worthwhile endeavor and a necessary investment for a state agency, but there are a number of challenges in conducting school mental health program evaluation that must be balanced with the importance of documenting program impact. These challenges include addressing the realistic difficulties of conducting research in the field where many factors cannot be controlled, allowing clinician’s the time and resources to be involved in evaluation activities, and convincing teachers, parents, and school administrators of the merit of supporting and participating in evaluation (Weist, Nabors, Myers, & Armbruster, 2000). To the extent that school mental health clinicians are expected to be the main source for data gathering, information systems should be identified or designed that allow information to be captured in the course of ‘business as usual’ to reduce drain on clinical staff.

What we can learn from other states & localities

School mental health programs in other states and counties, their experiences with the use of specific data elements, measurement tools, and information management systems, can inform decisions made in DC.

Evaluation data collected

- *Baltimore, MD.* The Baltimore school system has historically provided school-level data but only recently has the Division of Research, Evaluation, and Accountability agreed to provide child-level data directly to the city school mental health programs using the student identification number. In the near future, agencies that provide school-based mental health services will calculate attendance, academic performance and promotion rates, suspensions, and special education placements for students seen in treatment at least 4 times and compare them against the student’s own performance before he or she began treatment, as well as against their same-aged peers.

Measurement tools used

- *Ohio & Texas.* The Ohio scales are used at the state level both in Ohio and Texas, but only for students engaged in treatment services. Ohio collects youth self-report on the healthy and well-being measures of the Ohio Scales and collects life satisfaction data from all students not engaged in treatment services (using the Strengths and Difficulties Questionnaire - SDQ; <http://www.sdqinfo.com/b1.html>). In addition, 25 school-based health centers (SBHCs) in Texas will be using the Mental Health Planning and Evaluation Template (NASBHC, 2007) to assess the development of their mental health services.
- *South Carolina.* The South Carolina Department of Mental Health, School Based Mental Health Programs assess all school mental health programs using a clinician-rated instrument (the Child and Adolescent Functional Assessment Scale- CAFAS) and by analyzing satisfaction surveys from children, family members, and school administrators. The latest published program evaluation report (the Department of Mental Health Outcome Report FY 2006-2007) summarizes that school-based programs are serving children with needs as severe as those attending other community mental health programs and are demonstrating significant impact on children’s functioning (through statistically significant differences between CAFAS admission and discharge scores) (South Carolina Department of Health, 2008).

Data Systems

- The data management systems used in many state

and county school mental health programs are rudimentary. Some counties/cities collect evaluation data using Excel spreadsheets (Seattle, WA). Others have developed Access databases (South Carolina), or report data to a central office using Microsoft Word (Baltimore, MD). Other jurisdictions have decided to use available county dollars to develop ‘home grown’ software programs that can examine correlations between treatment transactions and child attendance, suspensions, and grades (Montgomery County, MD).

- In states where there are statewide initiatives that require specific data collection systems (such as School-Wide Information Systems (SWIS) used within PBS – refer back to page 11 for more information on PBS), school and mental health administrators are trying to determine if school-based data collection efforts can be streamlined (i.e., in Illinois).

Recommendations for DMH

Primary Recommendation:

- Without a method to reliably collect and analyze school-level and student-level data, the Department of Mental Health will remain handicapped in its ability to make data-driven or data-informed decisions about the allocation of resources for school mental health programs. The Department must immediately develop or identify an information system to monitor and evaluate all school mental health programs across the city. This system must collect utilization, satisfaction, and outcome data. The information system must also support the continued development of quality improvement initiatives. Encouragingly, progress in this regard has been reported from DMH (Joel Dubinetz, personal communication, February 15, 2008), but delays in implementation are significant and frustrates the best efforts of providers. Once the system is established, DMH will need to track its accuracy and functional abilities by obtaining regular feedback from clinicians. To ensure sustainability of this data gathering tool, DMH should explore how the information system, particularly if web-based, can be used not only by DMH SMHP providers, but by all other school-based mental health providers, such as those in the SSC program and other community mental health agencies. The information system should be assessed for its potential to integrate and

‘talk’ with other data collection programs used by other child-serving agencies (i.e., public school system, child welfare, public health system, juvenile justice).

Secondary Recommendations:

- One benefit of greater involvement by DMH in citywide evaluation activities would be the execution of a coordinated plan that would involve all school-based mental health providers and agencies using standardized tools and common definitions of target outcomes. (Refer to Appendix M to view draft proposal to implement citywide school mental health evaluation plan.)
- DMH should advocate for, and when possible fund, research on outcomes associated with the SMHPs that employ more rigorous study designs. For example, a wait-list control study or a matched school design comparing DC SMHP schools with SSC schools and control schools that have not received services under either program would not necessarily be costly (especially if existing data were utilized) and could sufficiently highlight the strengths and weaknesses of either program. This comparison should include carefully selected school-level outcomes (related to both education and school climate) and student-level outcomes (both individual academic performance and emotional/behavioral functioning). Research partners can be critical players in the identification, design, implementation, and/or analysis of future studies.
- Research continues to suggest that a strong relationship exists between SMHP interventions and school climate. DMH should continue discussions with DCPS and charter school leaders to determine the possibility of collecting school-wide climate data in order to assess the impact of mental health services delivered in schools. Again, local research partners can be of great help in advancing these efforts.

CONCLUSION

The ever-changing landscape in D.C. – new city leaders, new child health priorities, and myriad other alterations in the policy landscape that inevitably accompany the arrival of a new administration – challenged the development of a report whose recommendations would remain relevant.

However, despite this rapidly evolving environment, one factor has remained constant during the past 18 months: school-based mental health services have proven a reliable and valuable service delivery model for school-aged children and adolescents who otherwise might not receive needed attention. Building on the passion, commitments, relationships, and advocacy evident for school mental health programs, the following recommendations are offered to strengthen the organization and management of the growing numbers of school mental health programs in D.C.

Toward a Vision for School Mental Health Expansion

“There is a systemic problem but not a systemic approach as a solution”.

Angela Brown, Office of the State Superintendents Office of Education, Washington, D.C., personal communication, April 28, 2008.

Implementing a Framework for a Full Continuum of School-based Mental Health Promotion and Care

As the city’s authority on the mental health issues impacting its residents, DMH is obliged to oversee the delivery of mental health services, forge policies, offer ongoing training and technical assistance, and establish monitoring standards and systems that enable providers to build a system of supports that are coordinated with other important citywide initiatives. The greatest challenge facing the District of Columbia in its desire to meet the mental health needs of children and youth through school-connected programs is the proliferation of disconnected initiatives. Missing from these myriad efforts is consensus on an overarching framework for organizing, implementing and assessing school-based strategies.

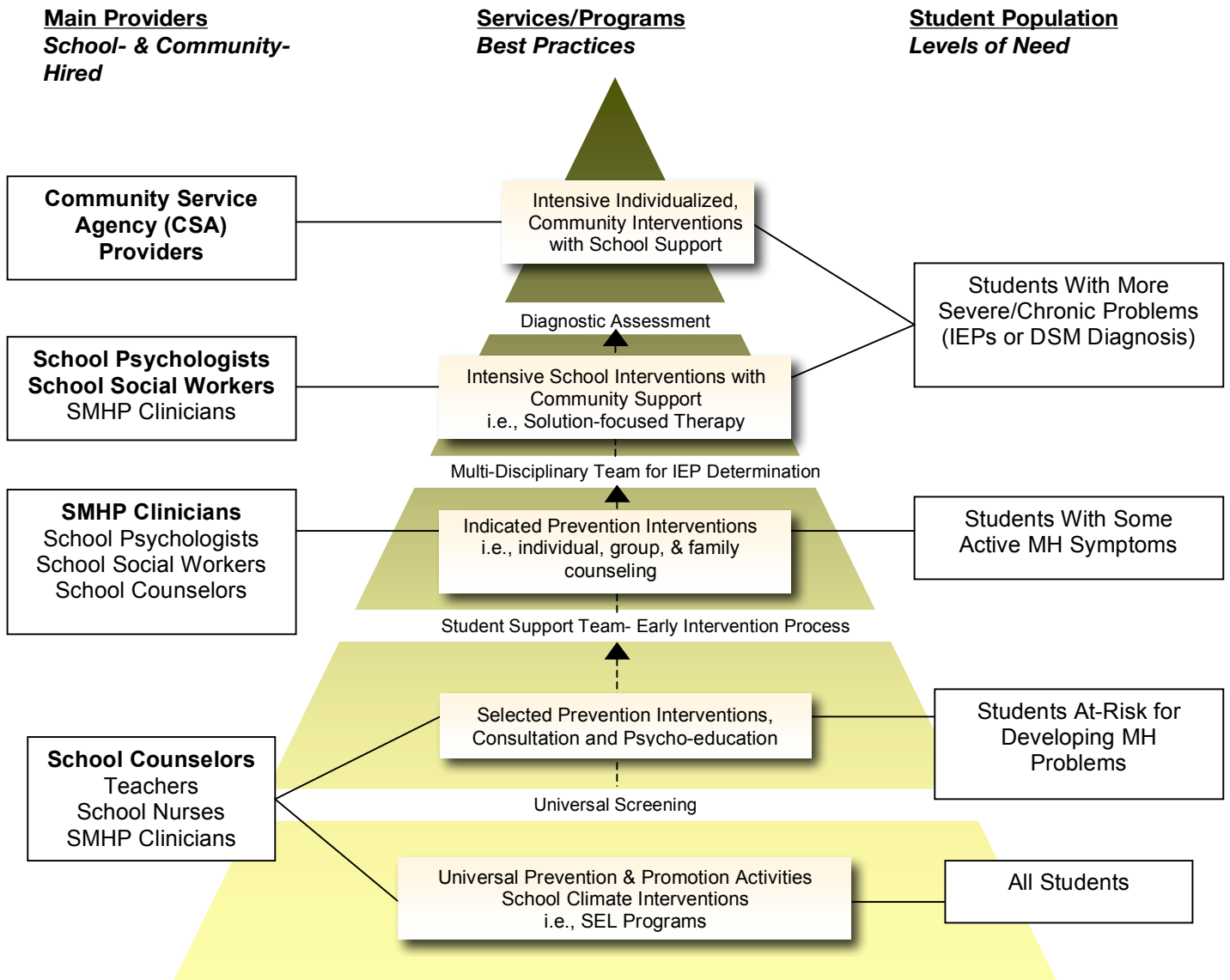
As suggested earlier in this report, the authors recommend a school-based mental health model founded on a public health approach that offers a range of interventions and programs reflecting differing levels of care (see framework on page 51). Using this approach, the needs of all students can be considered – those in general education as well as special education, and all qualified mental health providers can be utilized. In addition, this organizing structure or framework would clarify how past and current initiatives can be coordinated, where impacts should be expected, where gaps might still exist, and how resources are deployed.

The DMH SMHP has, since its inception, used a public health approach to drive the organization and delivery of school-based interventions. However, to ensure a full integration of services, a refinement of this model is warranted (refer to Cappella, et. al., in press). As part of this approach, mental health referral processes need to be clearly established and articulated, screenings and assessments should be coordinated, roles of mental health professionals who work in schools need to be clearly defined and explained to school staff and parents, and the availability of various prevention, early intervention, and treatment services should be incorporated into the fabric of school operations so that students are able to take full advantage of any support available to them without the fear of marginalization. The inability of either the school system or community mental health system alone to meet the emotional and behavioral needs of all students (Weist & Paternite, 2006) requires both systems to collaborate (Taras, et.al., 2004). Experts note that successful implementation of innovative models, programs, strategies, or approaches requires the identification of existing school and community resources and a willingness for realignment when necessary (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003)

For realignment to be successful, policy and practice guidance is available to local schools and school districts engaged in restructuring efforts and school improvement planning. Much of this guidance incorporates recommendations for addressing barriers to learning and teaching (see the Center for Mental Health in Schools at UCLA at <http://smhp.psych.ucla.edu> for materials focused on school reorganization and on developing a comprehensive, multifaceted continuum of interventions to support learning and healthy development. For an updated discussion refer to Frameworks for Systemic Transformation of Student and Learning Supports, 2008).

Certainly public health agencies and community health organizations have a role to play in supporting schools undertaking systemic reforms. Yet, it is clear that systems outside of the school often have little influence or authority in the development or implementation of reforms carried out by schools. Furthermore, pressures from federal and state mandates force schools to marginalize anything not directly related to instruction.

Figure 1. A Framework for the Allocation of Resources for School Mental Health Services in the District of Columbia



Source: Adapted from "Communication Planning and Message Development: Promoting School-Based Mental Health Services" in *Communique*, Vol.35, No. 1. National Association of School Psychologists, 2006

That often leaves public health systems feeling powerless and left out of major child health and education initiatives lead by school systems. Although this is reality for many states and counties around the country, there is still a meaningful role that public mental health agencies like DMH can play in fortifying efforts to sustain and expand school-based mental health services so that collaboration moves beyond the simple co-location of mental health staff on school sites. A more detailed conceptualization of the organization of school mental health resources and operations is provided next.

As Figure 1 illustrates, mental health services and programs fall into different levels of intensity and those services and programs can be provided by school-hired or community-hired professionals. Ideally, school counselors would be assigned to every public school in D.C. and would acquire the requisite skills and training to conduct universal and selected prevention strategies across the entire school system. Teachers could also be enlisted as partners in implementing classroom-based prevention programs, as is seen in other school systems, but only if time, training, and coaching are made available. Given the urgency for school reform in the District of Columbia, it is impractical to expect teachers to be responsible for implementing anything outside the academic curricula in the near future. On the other hand, building the foundation for the expansion of effective school mental health programs without including strategies for building the capacity of school staff to promote positive mental health would be a lost opportunity. School nurses, another key resource, can effectively identify and assist students who need help. Currently the nurses in the DC school nursing program are not positioned to assume these additional responsibilities. As a result, community mental health providers, assigned through DMH or SCC, continue to have a central role in the delivery of prevention and early intervention services for the District's students. The extent to which school-hired professionals and others within the education system acquire the skills, supports and staff to implement prevention and early intervention activities, would determine at what point clinicians could draw back into more treatment-focused and consultation activities.

The lack of recent epidemiological data on the mental health needs among DC youth prevents us from estimating the percentage of students who need more than prevention services and who require more support

in order to function effectively in school. Students with some active mental health symptoms but who do not meet criteria for a psychiatric diagnosis (and therefore do not meet 'medical necessity' criteria established by Medicaid) would be appropriate recipients of indicated prevention interventions. Although school counselors, psychologists, and social workers might provide these services, their primary responsibility for service delivery within other levels of care would suggest that school mental health providers are the best professionals to serve this group of youth.

For students with severe mental health problems that require psychiatric intervention or a consistent amount of adult supervision, a core service agency (CSA), that is, a community-based mental health agency, may be best equipped to serve as the main provider of care to these youth and their families. Certification standards in the District of Columbia require CSAs to have safeguards in place that make them the best providers of care for youth with more intensive mental health needs, including 24 hour clinical coverage. Best practice dictates, though, that intensive community and home-based interventions, to yield the greatest effect, should be coordinated with any school-located mental health programs for students..

Common Elements of Effective School Mental Health Programming and Management

The Department of Mental Health has been working to establish a separate "Authority" role for the agency since 2001 when it finalized a court-ordered plan that would allow DMH to emerge from receivership (Jones, 2001). If DMH is to "...establish a mental health agency with a meaningful separation between its authority and provider functions" (pg. 3), particularly as it relates to school-based mental health services, there are a number of recommendations DMH must consider.

Recommendations Regarding Intra-agency Functioning

I. DMH must be explicit in its commitment to the School Mental Health Program and put in place the infrastructure that will support this commitment:

1. Strong leadership and support for school mental health should be exemplified at both the executive and program/policy levels.
2. DMH must make a firm commitment to data-driven decision making processes

and invest in information systems that are compatible across systems and agencies, that are web-based, that support billing, and that are flexible enough to grow with the expansion of the program. A weak approach to gathering, analyzing, and reporting data will significantly undermine the program's potential to create and sustain fundamental change. Furthermore, accountability and quality improvement practices must integrate 'real time' information for maximum benefit and effectiveness.

3. Execution of a communications and social marketing plan that articulates the benefits associated with this school mental health program model and builds support for the dissemination of promising practices among parents, mental health agencies, schools, and other partners is an important role for DMH to undertake.

II. *If DMH is to adopt a primary role as oversight authority for school-based mental health services, the agency must be prepared to:*

1. Support the development of clinical capacity building among community mental health providers who can deliver a continuum of school-based services. The Manager of School Mental Health could lead this charge, along with staff from Provider Relations and the Director of the Training Institutes. Additional school mental health staff would likely be necessary to effectively build community capacity to deliver school mental health care, particularly as detailed in the draft standards (i.e., Levels 1-3 as outlined in Appendix I).
2. Foster and monitor high quality care through performance-based accountability and quality management processes. This would include a role for the Clinical Administrator, the Manager of School Mental Health and select staff within the Office of Accountability, as well as child-focused staff within the Office of Information Systems/Evaluation Department.
3. Provide technical assistance and training for programs and practices that would strengthen the delivery of school mental health services. This would directly involve the Manager of

School Mental Health and the Director of the Training Institute at DMH. Additional school mental health trainers and consultants would likely be necessary to achieve this goal.

4. Create and implement an advocacy/communications strategy that successfully engages leading stakeholders and decision-makers about the public health approach to school mental health. The Clinical Administrator and Manager of School Mental Health would work closely with the DMH Public Information Officer to accomplish this objective.
5. Build sustained and varied funding to support the full array of services provided through school mental health programs, and develop a process for contracting services that is transparent. The Clinical Administrator would have a significant role to play in the development of creative funding strategies, while the Manager of School Mental Health and select staff within Contract and Procurement Division would be responsible for the implementation of these strategies.
6. Create and/or support policies that ensure high quality comprehensive mental health care delivered through school mental health providers. The Clinical Administrator and Manager of School Mental Health would have primary responsibility for this task, as well as staff within the Policy and Evaluation Divisions.

Recommendations Regarding Inter-agency Functioning

DMH should propose the creation of a school mental health workgroup within ICSIC to ensure interagency collaboration, communication, and accountability for school-based initiatives.

DMH must be prepared to assume leadership in the development of a school mental health services master plan that includes specific strategies around strengthening and connecting universal prevention, early intervention, and treatment services into a coordinated continuum of care for school-based and community-based youth programs. The menu of services and programs, which would be assessed for their applicability and effectiveness with urban children of ethnic minority descent, should

be offered to schools in proportion to the intensity of needs, amount of available resources, and the readiness for implementation.

Having a single decision-making body would facilitate an integration of programs, reduce fragmentation, and help illuminate where service and policy gaps continue to exist. This group, which should be co-facilitated by DMH and DCPS, would maintain a focus on the specific delivery of mental health services and programs in schools and would help determine the programs and practices that best match DC's strengths, challenges, resources, and gaps. Furthermore, understanding what resources and supports are available in schools, regardless of who provides them, will lead to a more reliable assessment of what agency or organization (within the mental health or educational systems) are best suited to take responsibility for sustaining the various components associated with each intervention level. This group would work to ensure a cohesive citywide plan for SMH is designed and implemented, that limited resources are used efficiently, and that integration of initiatives and efforts are achieved. Ensuring that systemic, organizational, and programmatic supports are in place in schools will increase the likelihood that any proposed initiative would be a sound investment. To ensure sustainability of successful interventions, the work group would need consistent support from the Mayor, the DMH Director, the Chancellor of DCPS, and the State Superintendent of Education.

DMH should also examine the possibility of establishing a regional coordinating network in the DC metro area. The network would bring together SMH administrators from Baltimore City, Montgomery County, Northern Virginia, Prince Georges County and Washington, DC to create a forum for exchange of information, sharing of resources, and a network of support across the region. The network could work toward consensus on regional standards for school mental health and jointly develop local organizational structures to support the maintenance and expansion of school-based health care in the DC metro region.

Thoughts on Expanding into Additional Public Schools

Despite fiscal constraints, agency leadership and political leadership should come together to develop a model of intervention that would allow all schools to have school mental health expertise available to them. For schools

that do not have a mental health clinician assigned to them, DMH could consider subcontracting with a cadre of trained professionals that would meet with schools quarterly to support school leaders and school staff by providing information on accessible community mental health resources and services, consult on how to handle particular emotional or behavioral issues that arise, and assist them on assessing and tracking their students' needs. Although not the comprehensive SMHP model, this outreach and education would serve to bridge community mental health resources and services and the school community. Where full SMHP supports are not possible or indicated, some consultation, training, or early identification services can be offered. (Refer to standards document in Appendix I). Like Baltimore, Maryland conceptualizes, District leaders can establish a process that would equitably distribute these services based on the data collected by schools and other District agencies.

A formidable alliance between the education and mental health sectors must be created in order to achieve comprehensive and complimentary child health priorities, initiatives, and services. Child advocates and parents bitterly recall that a host of community-based child and youth programs have come and gone over the years and caution that program implementation without infrastructure building will no longer be publicly supported. Political leaders must step forward to support school mental health programs and invest in a long-term examination of the refinements needed to yield the most effective system development strategy. An alignment is also needed between the political support and agency support. A former school district administrator warns that the way to ensure the failure of program expansion is to “rush to ramp it up to scale”. A predictable consequence of diving headfirst into expansion without looking forward or back is that District leaders will make avoidable and costly mistakes. Mapping out a plan for success includes considerations of capacity building, community engagement, effective communications, and long-term sustainability. Shortcuts will only lead to deserving communities being short-changed. Our residents and our children have a right to expect our best thinking and our best effort as we move a stronger child mental health agenda forward.



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APPENDICES:

Appendix A: Interviewees for DMH school mental health report

Howard Adelman

Co-Director
School Mental Health Project
Center for Mental Health in Schools
Department of Psychology
University of California, Los Angeles
Los Angeles, CA

Steve Adelsheim

Professor
University of New Mexico
Department of Psychiatry
Albuquerque, NM

Dawn Anderson-Butcher

Associate Professor
College of Social Work,
Ohio State University
Columbus, OH

Anita Appel

Acting Director
New York City Field Office,
New York State Office of Mental Health
New York, NY

Marc Atkins

Professor of Psychology in Psychiatry,
University of Illinois at Chicago
Director, Psychology Training Institute
for Juvenile Research
Chicago, IL

Steve Baron

Director
DC Department of Mental Health
Washington, DC

Lisa Betz

School Mental Health Coordinator
Illinois Department of Health,
Division of Mental Health
Chicago, IL

Scott Bloom

Director of School Mental Health Services
New York City Department of Education
New York, NY

Jackie Bowens

Vice President and Chief
Government and External Affairs Officer
Children's National Medical Center
Washington, D.C.

Debbie Brinson

Executive Director
School Community Health Alliance
of Michigan
Okemos, Michigan

Eve Brooks

Executive Director
Student Support Center
Washington, DC

Angela Brown

Coordinator of Behavior Supports
Office of the State Superintendent
of Education
Washington, DC

Owen Bubel

Vice President
Clinical Operations for United Behavioral
Health
Philadelphia, PA

Juana Burchel

School Mental Health Coordinator
Illinois State Board of Education
Department of Specialized Support
School and Mental Health Integration
Springfield, IL

Carlos Cano

Acting Director
DC Department of Health
Washington, DC

Bruce Chorpita

Director
Center for Cognitive Behavior Therapy
University of Hawaii
Honolulu, HI

TJ Cosgrove

Department of Public Health, Community
Health Services Division,
Seattle, WA

Ray Crowell

Vice President
ICF International
Fairfax, VA

Dana Cunningham

Coordinator
Prince George's School Mental Health
Initiative
Forestville, MD

Laura Danna

Assistant Clinical Director
Mercy Family Center
Metairie, LA

Jacqueline Duval-Harvey

Director, East Baltimore Mental Health
Partnership
Baltimore, MD

Lisa DeShong Sadzewicz

Operation's Director
Biopolymer Core Facility
University of Maryland School of
Medicine
Baltimore, MD

Anthony Diallo

Program Manager, Community Services
Division, Department of Human Services
Washington, DC

Joel Dubenitz

Program Evaluator
School Mental Health Program
D.C. Department of Mental Health
Washington, DC

Albert Duchnowski

Professor and Deputy Director
Research and Training Center for
Children's Mental Health
Florida Mental Health Institute
University of South Florida
Tampa, FL

Lucille Eber

Statewide Director
Illinois Statewide Technical
Assistance Center
PBIS Network
LaGrange Park, IL

Nancy Eichner

School Health Program
Child Health and Safety Group
Texas Department of
State Health Services
Austin, Texas

Pia Escudero

Field Coordinator; Crisis Counseling
and Intervention Services
Project Manager LAUSD/RAND/UCLA
Trauma Services
Los Angeles Unified School District
Los Angeles, CA

Paul Flashpohler

Assistant Professor
Department of Psychology and Center
for School-Based Mental Health Programs
Miami University of Ohio
Oxford, OH

Andrea Foggy Paxton

Program Officer, Education
Bill & Melinda Gates Foundation
Washington, DC

Evelyn Frankford

Founder
Frankford Consulting
Peabody, MA

Elizabeth Freeman

Program Director
School Based Services
SC Department of Mental Health
Columbia, SC

Carolyn Gardner

Deputy Director
Student Support Center
Washington, DC

Marcia Glass Siegel

Coordinator, School-Based
Mental Health Services
Baltimore Mental Health Systems, Inc.
Baltimore, MD

Charity Hallman

Special Assistant
Special Education Reform
Office of the State Superintendent
of Education
Washington, DC

Sherri Hammack

Office of Program Coordination
for Children and Youth
Health and Human Services Commission
Austin, TX

Jacqueline Duval-Harvey

Director, Community-Based Services
East Baltimore Mental Health Partnership
Baltimore, MD

John Hatakeyama

Former Deputy Chief of County Services
for LA County
Department of Mental Health
Los Angeles, CA

Kimberley Hoagwood

Professor, Director of Research on Child
and Adolescent Services,
Columbia University,
Center for the Advancement of
Children's Mental Health
New York, NY

Julie Hudman

Former Lead Staff of Interagency Commission
D.C. Office of the Mayor
Washington, DC

Laura Hurwitz

School Mental Health Coordinator
National Assembly of School-Based
Health Care
Washington, DC

Deborah Irvin

Associate Director
Family Support Center
Bethesda, MD

Lisa Jaycox, PhD

Senior Behavioral Scientist
RAND Corporation
Arlington, VA

Deborah Johnson

Primary Project
Children's Institute
Rochester, NY

Barbara Kamara

Former Director
Early Care and Education Administration
DC Department of Human Services
Washington, DC

Kate Keller

Senior Program Officer
The Health Foundation of Greater
Cincinnati
Cincinnati, OH

Susan Keys

Former Chief
Prevention Initiatives and Priority
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Appendix B: List of supplemental reports available upon request

1. Examples of Request for Proposals to Fund School Mental Health Services
 - a. Expanded School Mental Health Programs in Baltimore City Public Schools, Request for Proposals, February 23, 2007
 - b. Illinois Violence Prevention Authority, Request for Proposals FY 07, School Mental Health Support Grants, February, 2007.
 - c. Texas Department of State Health Services, FY09 Competitive Request for Proposals (RFP) for School-Based Health Centers, DSHS School Health Program, RFP#: DPIS/SCHOOL-0276.1, February 19, 2008.
 - d. Minnesota Department of Human Services Children's Mental Health Division Request for Proposals for Qualified Grantees to Provide School-Linked Mental Health Services, December 10, 2007
 - e. District of Columbia, Department of Mental Health, School Mental Health Expansion Program, RM-07-N-0082-VM, June 25, 2007
2. Other Relevant Reports
 - a. DC Assembly on School Health Care, Opportunities and Barriers for Medicaid Reimbursements for School Health Centers in Washington, DC
 - b. Baltimore City Expanded School Mental Health Programs Findings and Recommendations, August 2006
 - c. South Carolina Department of Mental Health School Based Mental Health Programs Annual Report Summary FY 2004-2005
 - d. South Carolina Department of Mental Health School Based Mental Health Programs Outcome Report FY 2006-2007, http://www.state.sc.us/dmh/best_practices/sb_annual_report.pdf
 - e. Illinois Children's Mental Health Partnership Strategic Plan for Building a Comprehensive Children's Mental Health System in Illinois, 2006 Annual Report to the Governor
 - f. New York State Office of Mental Health Guidance Document, June 2007, http://www.ohm.state.ny.us/omhweb/clinicplus/support_network/providers/guidance.html
 - g. Arkansas Department of Education, Special Education Unit. School-Based Mental Health Network: Policy and Procedures Manual, <http://arksped.k12.ar.us/documents/medicaid/SBMHPandPManual.pdf>
 - h. Health Foundation of Greater Cincinnati, Preliminary Report: Sustainability of School Based Mental Health in Ohio, July 12, 2005
 - i. Children's Mental Health in Texas: A State Of The State Report. Children's Hospital Association of Texas, May, 2006.
 - j. Office of Special Education Programs, Center for Positive Behavioral Interventions and Supports, University of Oregon (2004). School-wide Positive Behavior Support, Implementers' Blueprint and Self-Assessment. <http://www.nichcy.org/toolkit/pdf/SchoolwideBehaviorSupport.pdf>
3. Other Related Documents
 - a. Mental Health Services Quality Review: Supporting School Success. Seattle & King County School-Based Mental Health Scope of Services
 - b. Baltimore Mental Health Systems, Inc., Contract Deliverables and Provider Progress Report
 - c. School-Based Mental Health Programs, composite Program Summary of Statistical Information, Baltimore, Maryland.
 - d. Arkansas School Based Mental Health Student Assessment and Referral Application (SARA), User's Guide, January 2007

Appendix C: District of Columbia schools with school mental health professionals

Department of Mental Health School Mental Health Professionals - Public ES, MS, and Junior HS (SY 2007-08)						
School	Ward	Grades Included	Student Enrollment	# Students Receiving >50% Special Education Instruction	# English Language Learners	% Eligible for Free/ Reduced Lunch †
Benning ES	7	PS-6	178	26	*	46
Bunker Hill ES	5	PK-6	246	20	3	52
Burrville ES	7	PS-6	419	38	5	69
Charles Young ES	5	PK-6	313	49	3	81
Davis ES	7	PS-5	287	44	*	71
Drew ES	7	PS-6	319	52	7	51
Emery ES	5	PS-6	200	45	8	77
Ferrebee-Hope ES	8	PS-5	277	45	*	68
Garrison ES	2	PS-6	272	23	33	79
Gibbs ES	6	PS-6	296	19	4	88
Houston ES	7	PS-6	303	31	3	43
JC Nalle ES	7	PS-5	421	36	3	52
LaSalle ES	4	PS-6	268	25	19	62
MC Terrell ES	8	PS-6	371	64	*	74
Myrtilla Miner ES	6	PS-6	506	93	4	73
River Terrace ES	7	PS-6	246	29	*	60
RK Webb ES	5	PS-6	379	39	1	54
J.O. Wilson ES	6	PS-6 & ungraded	319	40	5	70
Harriet Tubman ES	1	PK-6 & ungraded	420	59	163	55
Turner ES	8	PK-6	387	37	1	79
Merritt MS	7	PS-8	247	53	1	68
PR Harris Educational Center	8	PS-8	636	90	*	72
Thurgood Marshall Educational Center	5	PS-8	256	39	3	60
Bertie Backus MS	5	6-8	188	36	9	60
Garnett-Patterson MS	1	6-8 & ungraded	265	60	22	94
Kelly Miller MS	7	6-8 & ungraded	401	81	*	51
Kramer MS	8	6-8	343	91	*	72
Lincoln Multicultural MS	1	6-8	454	52	123	*
MacFarland MS	4	6-8	295	57	56	66
Ron Brown Junior HS	7	6-8 & ungraded	254	58	*	74
Eliot Junior HS	6	7-9	274	84	1	*
Browne Junior HS	5	7-9	335	111	*	81

† Calculated based on the number of students eligible for free/reduced lunch and the student enrollment reported by the Government of the District of Columbia (see citation below).

* None reported

Source: Government of the District of Columbia. (2007). DC school search. Retrieved January 28, 2008, from <http://dcschoolsearch.dc.gov/schools/index.asp>

Appendix C, cont.: District of Columbia schools with school mental health professionals

Department of Mental Health School Mental Health Professionals - Public Senior HS (SY 2007-08)						
School	Ward	Grades Included	Student Enrollment	# Students Receiving >50% Special Education Instruction	# English Language Learners	% Eligible for Free/ Reduced Lunch †
Bell Multicultural Senior HS	1	9-12	808	59	360	*
Eastern Senior HS	6	9-12	674	137	*	51
HD Woodson Senior HS	7	9-12	714	160	1	49
M.M. Washington Career HS	5	9-12	264	34	1	*
Spingarn Senior HS	5	9-12	520	154	6	*
Department of Mental Health School Mental Health Professionals - Public Charter Schools						
School	Ward	Grades Included	Student Enrollment	# Students Receiving >50% Special Education Instruction	# English Language Learners	% Eligible for Free/ Reduced Lunch †
Booker T. Washington PCS for the Technical Arts	1	9-12 & adult	293	15	6	55
Cesar Chavez PCS HS	1	9-12	423	62	26	*
Children's Studio ES	1	PS-6	82	6	11	72
Friendship Blow-Pierce PCS	7	6-8	764	91	*	*
Friendship Collegiate Academy, PCS	7	9-12	1213	107	*	*
Friendship Woodridge PCS	5	PK-8	665	56	*	*
Maya Angelou PCS MS	7	6-7	75	*	*	*
Maya Angelou PCS HS (Shaw campus)	1	9-12	116	32	*	*
Meridian PCS	1	PS-8	547	64	43	87
Nia Community PCS	8	PK-3	118	4	*	89
Options PCS MS	6	5-8	237	130	*	87

† Calculated based on the number of students eligible for free/reduced lunch and the student enrollment reported by the Government of the District of Columbia (see citation below).

* None reported

Source for Maya Angelou PC Middle School: See Forever Foundation & Maya Angelou Public Charter School. (2007). Maya Angelou Public Charter School. Retrieved January 31, 2008, from <http://www.seeforever.org/MAPCS/index.html>

Source for all others: Government of the District of Columbia. (2007). DC school search. Retrieved January 28, 2008, from <http://dcschoolsearch.dc.gov/schools/index.asp>

Appendix C, cont.: District of Columbia schools with school mental health professionals

Student Support Center School Mental Health Professionals - Public Charter Schools (SY 2006-07)						
School	Ward	Grades Included	Student Enrollment	# Students Receiving >50% Special Education Instruction	# English Language Learners	% Eligible for Free/ Reduced Lunch†
Academic Bilingue de la Comunidad (ABC)	1	6-8	108	17	23	*
Academy for Learning Through Arts (ALTA) PCS	1	PK-6	86	4	*	*
Appletree Early Learning PCS	6	PS-PK	36	*	*	50
Barbara Jordan PCS	4	5-8	107	20	*	79
Bridges PCS	4	PS-PK	67	24	35	*
City Lights PCS	5	9-12	54	54	*	100
Community Academy PCS- Butler Bilingual Campus	2	PS-4	171	7	48	*
Community Academy PCS- Rand Campus	4	PS-8	304	43	27	*
D.C. Bilingual PCS	1	PS-2	193	20	132	85
Hyde Leadership PCS	5	K-12	760	91	1	74
E.L. Haynes PCS	1	PK-4	191	27	48	64
Friendship PCS- Chamerlain Campus	6	PS-6	771	38	0	70
Latin American Montessori Bilingual (LAMB) PCS	4	PS-2	104	8	40	25
Mary McLeod Bethune PCS- 16th St. Campus	4	PK-3	76	2	*	*
Mary McLeod Bethune PCS- 42nd St. Campus	7	PK-6	66	8	*	*
Tree of Life Community PCS	5	PK-8	253	18	*	90
Tri-Community PCS	4	PK-5	107	2	0	78
Two Rivers PCS	6	PS-5	261	25	4	30
Washington Academy PCS - Kingsman Campus	6	PK-3	127	12	*	*
Washington Academy PCS - Pennsylvania Ave. Campus	7	PK-3	134	20	*	*
Washington Academy PCS - Castle Campus	6	4-7	176	38	*	*
William E. Doar Jr. PCS for the Performing Arts	5	PK-9	360	20	*	65
Young America Works PCS	4	9-11	221	59	*	48

† Calculated based on the number of students eligible for free/reduced lunch and the student enrollment reported by the Government of the District of Columbia (see citation below).

* None reported

Source: Government of the District of Columbia. (2007). DC school search. Retrieved January 28, 2008, from <http://dcschoolsearch.dc.gov/schools/index.asp> & DC Public Charter School Board (2008), retrieved from <http://www.dcpubliccharter.com/publications/docs/SPR2008BOOK.pdf>

Appendix D: Comparison of Staff Requirements, Cost, and Productivity Between DC and Other Cities

Location	Staff requirement	Range of cost per clinician	Productivity Requirements/Billable Services
Washington, DC (SMHP)	Doctor in psychology, Master of social work, or counseling, with a license in mental health in the District of Columbia preferred, including the areas of social work (LICSW, LGSW, LISW), psychology (Ph.D., Psy.D.), and counseling (LPC). Completion of required criminal background check.	\$40,000-\$92,000 per FTE ⁱ (dependent upon discipline and licensure level)	A minimum of ten students on a caseload, maximum 20 10 hours per week conducting prevention programming 10 hours per week conducting targeted interventions 12 hours per week providing brief treatment services 2 in-service presentations for school staff 1 parent workshop per school year Currently require at least 2 evidence-based prevention/early intervention/treatment programs implemented per school year in each school with the focus/topic determined by school need.
Washington, DC (SSC)	Masters or doctoral level clinician with license preferred. If unlicensed, clinician will be supervised and working on licensing requirements.	\$46,000-75,000 per FTE (dependent upon discipline and licensure level)	Caseloads of 15-20 Weekly participation in SST
Washington, DC SMHP (Contracted Provider) ⁱⁱ	In compliance with MHRS standards ⁱⁱⁱ . Licensed Independent Social Workers	\$50,000-\$ 60,000 per FTE	10-12 cases/1.0 FTE/week 10 hours per week conducting prevention programming 10 hours per week conducting targeted interventions 12 hours per week providing brief treatment services (Projected 10 hours of billable services per week) Currently require at least 2 evidence-based prevention/early intervention programs implemented in each school determined by school need.
Baltimore, MD	Licensed MH provider or authorized per COMAR standards ^{iv}	\$65,000-\$79,000 per FTE ^v ; contract covers \$20,000 per 0.5 FTE, \$40,000 per 1.0 FTE ^{vi}	Per 0.5 FTE ^{vii} : 60 consultations to teachers and other school staff; 30 group prevention activities/groups per school year; 5 school teams and committee meetings per school year; 2 in-service presentations for school staff, Per 1.0 FTE ^{viii} : Same as for 0.5 FTE, except 60 group prevention activities, 9 school teams and committee meetings, and 3 in-service presentations per school year.
Seattle, WA	Prefer licensed MH provider but will hire MA-level if supervised by licensed staff ^{ix}	Approximately \$57,500-\$74,000 per FTE	5 mental health encounters/ 1.0 FTE/day ^x
Charlotte, NC	Licensed MH provider (social workers, licensed professional counselors, or psychologists)	\$38,355-57,072 (In actuality the pay range is 31,348-46,099 since clinicians are 10 month employees and are not paid during the summer months)	5 treatment cases/1.0 FTE/day (55% direct bill)
South Carolina	MA level MH provider +2 years experience	\$40,000-\$52,000 per FTE ^{xi}	4-5 billable hours/1.0 FTE/ day

Appendix D, cont.: Comparison of Staff Requirements, Cost, and Productivity Between DC and Other Cities

Sources:

- ⁱ Acosta Price, O.M., Mack, A., & Spencer, S. (2005). School Mental Health Program Retrospective Report: 2000-2005. Washington, D.C.: DC Department of Mental Health
- ⁱⁱ District of Columbia, Department of Mental Health, Solicitation Number RM-07-N-0082-VM (Issued June 25, 2007)
- ⁱⁱⁱ Mental Health Rehabilitation Services Provider Certification Standards, Chapter 34, Title 22A, D.C. Code of Municipal Regulations 5682
- ^{iv} Baltimore City Expanded School Mental Health Programs Findings and Recommendations - August 2006, page 11
- ^v Funding Request February 15, 2007
- ^{vi} Baltimore City Expanded School Mental Health Programs Findings and Recommendations - August 2006, page 5
- ^{vii} Baltimore Mental Health Systems, Inc. FY08 Appendix "A" Contract Deliverables & Provider Progress Report, page 12
- ^{viii} Baltimore Mental Health Systems, Inc. FY08 Appendix "A" Contract Deliverables & Provider Progress Report, page 12
- ^{ix} Personal communication with TJ Cosgrove: Email 01/03/08; Interview (December 6, 2007)
- ^x Scope of Work, Puget Sound Neighborhood Health Centers, September 1,2007 - August 31, 2008, page 3; and Personal communication with TJ Cosgrove Interview (December 6, 2007)
- ^{xi} Personal Communication with Elizabeth Freeman, Interview (January 19, 2008)

Appendix E: Examples of state mental health laws that address a continuum of children’s mental health care and the role of schools

State	Name of Legislation	Source/Citation
California	Mental Health Services Act of California	http://www.dmh.ca.gov/prop_63/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf
Illinois	Illinois Children’s Mental Health Act	http://www.hfs.illinois.gov/cmh/930495.html
Indiana	Children’s Social, Emotional, and Behavioral Health Plan	http://www.in.gov/legislative/ic/code/title20/ar19/ch5.html
Missouri	Children’s Mental Health Reform Act	http://www.senate.mo.gov/04info/billtext/tat/sb1003.htm
Minnesota	Minnesota Comprehensive Children’s Mental Health Act	https://www.revisor.leg.state.mn.us/statutes/?id=245.487
New York	Children’s Mental Health Act of 2006	http://assembly.state.ny.us/leg/?bn=A06931&sh=t

Appendix F: List of school health programs and initiatives in DC for 2008 (as of April 2008)

Initiative Name	Lead Entity (Person)	School Level(s)	#	Expansion Plan	Intervention Level	Brief Description
DC Start	ICSIC (Philip Uninsky)	Elementary schools	2	4-6 elementary schools in the 08-09 SY	Early Intervention & Treatment	Use of multidisciplinary assessment Use of EB treatments (CBT and child centered play therapy) Clinician to do service coordination and planning Use of interagency database
Full Community Schools (Middle School Project)	OSSE/DMH (Knutte Rotto)	Middle schools	8	To start in 08-09 SY	Early Intervention & Treatment	Part of Blackman-Jones agreement Involves PBIS, wraparound care coordinator, behavioral skill building, & clinical services Inclusionary spec ed program Secondary and tertiary school-based interventions provided
Case Management Program	First Home Care (CSA) (Rose Bruzzo)	Pre-k-12	*	Up to 400-500 youth in program	Intervention & Treatment	Part of Blackman-Jones agreement Children with IEPs have case manager- agreed to hire 30 case managers 15 children per case manager
School-Wide Applications Model (SAM)	DCPS (Richard Nyan-kori)	Elementary schools	8	To start in 08-09 SY	Prevention, Early Intervention & Treatment	Structural school reform model Emphasizes PBS, data-driven decision making, and RTI logic model
School Wellness Teams	DCPS (Richard Nyan-kori)	Pre-k-12	*	To begin 08-09 SY	Prevention, & Early Intervention?	Structural school reform model Emphasizes PBS, data-driven decision making, and RTI logic model
Quality Service Review (QSR)	OSSE (Paul Vincent)	Pre-k-12	*	Unknown	Program Evaluation	Staffing model of student support teams to be required in every DCPS Team to include social worker, counselor, psychologist, behavior interventionist, & nurse
Incentive Seats	OSSE (Tami Lewis)	*	8	To begin 08-09 SY	Treatment	Part of Blackman-Jones agreement Pilot will provide incentives to high quality schools to increase the number of 'seats' to spec ed students returning from non-public placements Will receive % of money spent on nonpublic placement to invest in services
SMHP	DMH (Barbara Parks)	Pre-k-12	48	To expand into an additional 10 schools for 08-09 SY ¹	Prevention, Early Intervention & Treatment	School-based prevention, early intervention, and brief treatment services Will shift to two tier service model (1 with FT clinician and 1 with PT clinician)
STOP Suicide Project	DMH (Julie Goldstein)	Middle Schools & High Schools	21	Unknown (depends on whether they can acquire additional funds)	Universal Screening & Suicide Prevention	Universal Screening (using Columbia Teen-Screen) QPR training for school staff and parents SOS training in classrooms
SS/HS	SSC (Eve Brooks)	Pre-k-12 (Charters)	18	Funding will end in 2009	Prevention, Early Intervention & Treatment	Integrated community-school collaborative using EBP Addresses 6 core elements, including safety planning, violence and SA prevention, SMH prevention and treatment, early childhood services, and safe school policies (i.e., PBIS) Hope to be sustained through DC funding
Coordinated School Health	DOH (Carlos Cano)	High Schools	1	Being negotiated to pilot a new SBHC in a high school for 08-09 SY	Prevention, Early Intervention & Treatment	SBHC to include MH services
School Nurse Program	DOH/CNMC (Joe Wright & Barbara Scott & Carlos Cano)	Pre-k-12	*	Goal is to have at least a half time nurse in every public school in DC	Prevention & Early Intervention	Track and refer for immunizations Hearing and vision screenings Provide services to students with special health care needs

*Some information is unknown to the authors.

¹Also in 7 schools to be closed, so 17 new schools for 08-09 SY

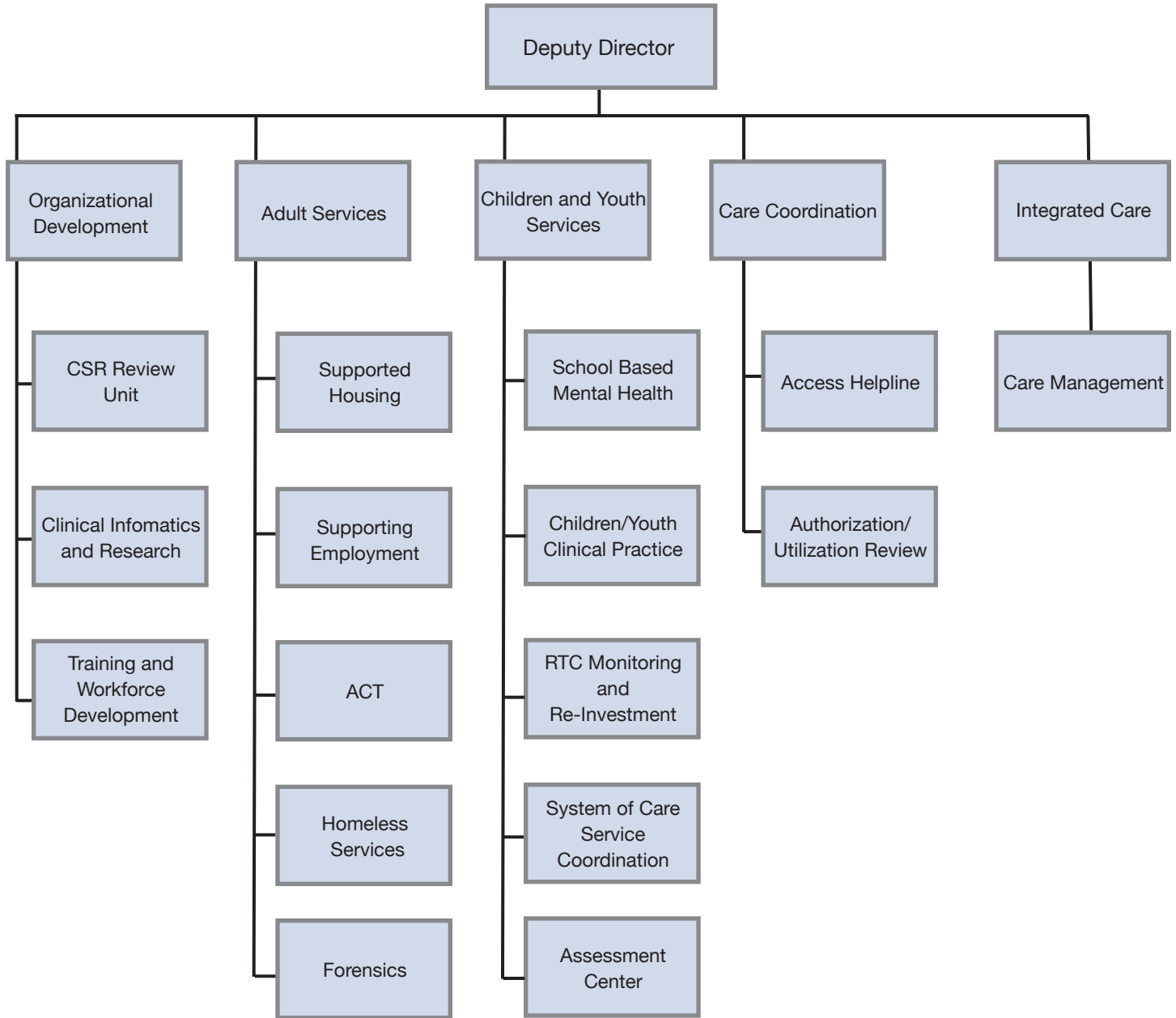
Appendix G: A guide for mapping school-based mental health activities

Programmatic Activities*	Levels or Systems of Interventions		
	<i>Screening/ Prevention</i>	<i>Early Intervention</i>	<i>Treatment Services</i>
School environment interventions/ School-focused strategies			
Classroom-focused strategies			
School staff consultation/ education on MH issues			
Family-centered interventions/ assistance			
Child-centered interventions/ assistance (individual or group)			<i>Brief Counseling (no MH diagnosis and/ or few symptoms)-</i>
			<i>More intensive (active symptoms and/ or MH diagnosis)-</i>
			<i>Continuing Care/ more intensive services (MH diagnosis)-</i>
Case management/ coordination of services and supports			
Other training/education activities			
Crisis prevention, management, and response			
Linkage and referrals			

* This table is not intended to be comprehensive. It is suggested that representatives from all relevant agencies and organizations convene to jointly map local resources and identify initiatives underway.

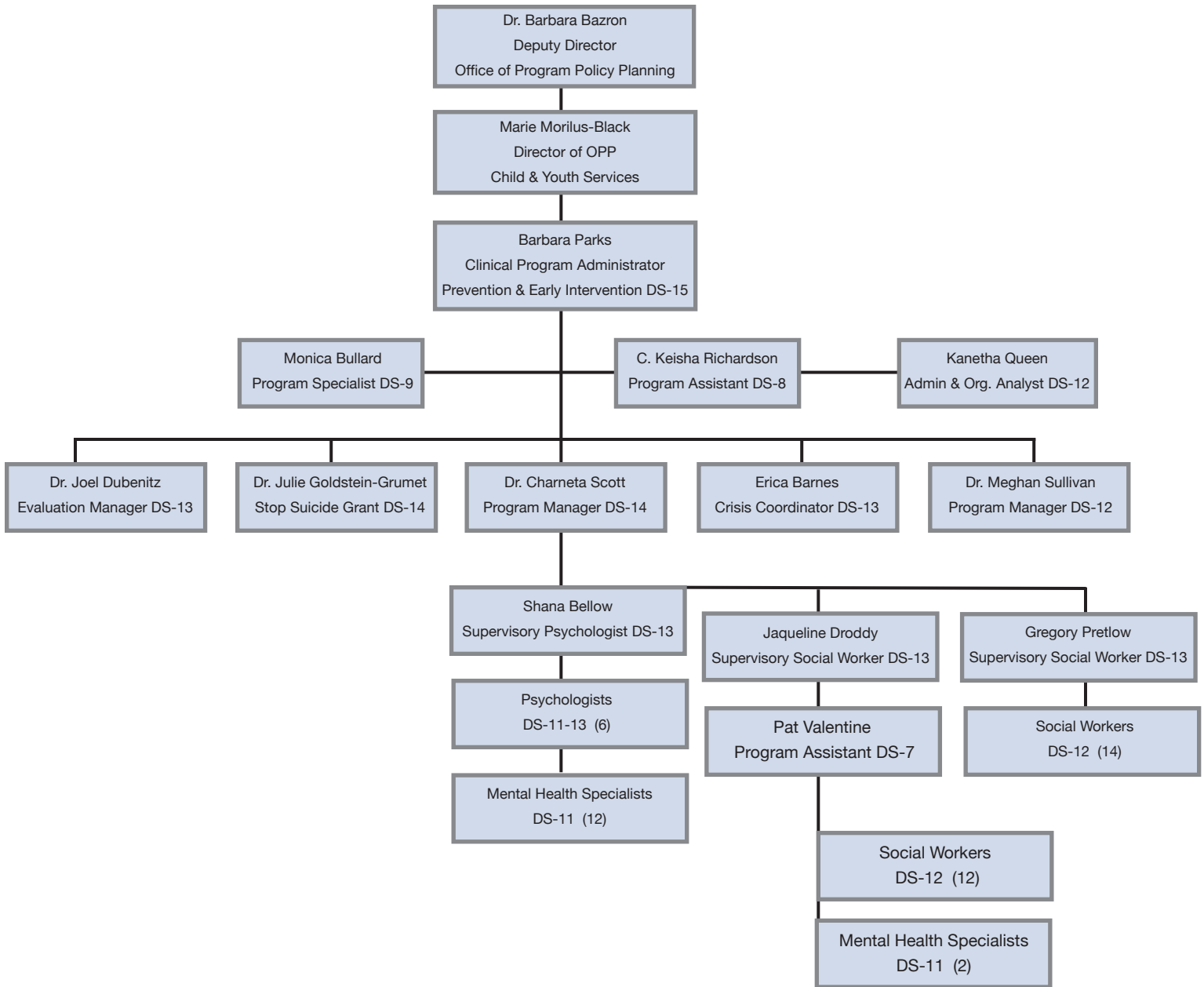
Appendix H:

D.C. Department of Mental Health
Office of Programs
Table of Organization



Appendix H: *continued*

D.C. Department of Mental Health
Prevention & Early Intervention Programs
Table of Organization



Appendix I: Template for the development of standards for school mental health programs in DC

A template for the development of standards for the practice of school mental health is provided (the essential sections are in bold), with draft language or examples included below where information has previously been crafted by other state departments of mental health or by the DC Department of Mental Health (DMH). Content for the standards will vary depending on whether DMH transitions into a contracting relationship with community mental health organizations as the main providers of care or whether DMH will maintain primary responsibility for program implementation in addition to exercising oversight authority over community-based agencies that also provide mental health care in the schools.

This **draft** does not represent a comprehensive draft and may not identify all relevant and applicable city or federal regulations, statutes, or rules. It is strongly encouraged that a final set of standards be developed that will define minimum requirements for all community mental health providers conducting school mental health services. These standards should be the product of a collaborative process with key education and health partners, community mental health providers, family members and students participating.

Section 1.0 Vision, Mission, Goals, and Guiding Principles

1.1 Vision²

The vision of the SMH program is:

- 1.1.1 To positively impact every student in all schools with a SMH presence.
- 1.1.2 To foster and develop student and family's utilization of internal and external resources to promote student's academic, social and emotional success.
- 1.1.3 To ensure that all students learn in a safe, supportive and responsive environment.
- 1.1.4 To consult and collaborate with all service providers involved in the system of care for students with mental health and co-occurring disorders to address the diverse needs of the students and their families.
- 1.1.5 To reduce the stigma associated with receiving mental health services.
- 1.1.6 To provide technical assistance to key stakeholders locally and nationally.

1.2 Mission²

The mission of the Department of Mental Health (DMH) School Mental Health (SMH) Program is to maximize the potential for students to become successful learners and responsible citizens by reducing the barriers to learning and fostering resiliency. The SMH program will actively collaborate with key stakeholders (students, families, District of Columbia Public and Public Charter Schools, core service agencies, public and private community agencies, and the faith community) to enhance the system of care's ability to deliver culturally competent and developmentally appropriate services to school-aged children and their families.

1.3 Goal

The goal of school mental health programs in the District of Columbia is to improve the emotional and behavioral health of students in order to reduce barriers to learning.

1.4 Guiding Principles⁷

- 1.4.1 All youth and families are able to access appropriate care regardless of their ability to pay.
- 1.4.2 Programs are implemented to address needs and strengthen assets for students, families, school, and communities.
- 1.4.3 Programs and services focus on reducing barriers to development and learning, are student and family friends, and are based on evidence of positive impact.
- 1.4.4 Students, families, teachers and other important groups are actively involved in the program's development, oversight, evaluation, and continuous improvement.
- 1.4.5 Quality assessment and improvement activities continually guide and provide feedback to the program.
- 1.4.6 A continuum of care is provided, including school-wide mental health promotion, early intervention, and treatment.
- 1.4.7 Staff holds to high ethical standards, is committed to children, adolescents, and families, and displays an energetic, flexible, responsive and proactive style in delivering services.
- 1.4.8 Staff is respectful of, and competently addresses developmental, cultural, and personal differences among students, families and staff.
- 1.4.9 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.
- 1.4.10 Mental health programs in the school are coordinated with related programs in other community settings.

Section 2.0: Staffing

2.1 Minimum Job Qualifications²

2.1.1 School mental health programs shall hire qualified mental health professionals to provide services, interventions, and consultation in schools. Job qualifications will vary depending on the level of service provided (prevention, early intervention, or treatment service).

2.1.2 Prevention/ Early Intervention- Individuals providing school-based mental health prevention and early intervention services shall have at least a Bachelors degree in psychology, social work, or counseling. A Masters degree in psychology, social work, or counseling with previous experience in child and adolescent mental health is preferred.

2.1.3 Treatment- Qualified mental health practitioners shall include professionals from the following disciplines (i) a psychiatrist; (ii) a psychologist; (iii) an independent clinical social worker; (iv) a licensed professional counselor; (v) an independent social worker; and (vi) an addiction counselor, and are defined as follows⁴:

2.1.3.1 Psychologist - a psychologist is a person licensed to practice psychology in accordance with applicable District laws and regulations.

2.1.3.2. Psychiatrist - a psychiatrist is a physician licensed in accordance with applicable District laws and regulations who has completed a residency program in psychiatry accredited by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education and is eligible to sit for the psychiatric board examination.

2.1.3.3 Social work- Independent clinical social worker (LICSW) and Licensed independent social worker (LISW) are persons licensed in social work in accordance with applicable District laws and regulations. An LICSW and an LISW are qualified practitioners.

2.1.3.4 Counselor

i. *Addiction counselor* – an addiction counselor is a person who provides addiction counseling services to persons with co-occurring psychiatric and addictive disorders and is licensed or certified in accordance with applicable District laws and regulations.

ii. *Licensed professional counselor (LPC)* - a licensed professional counselor is licensed in accordance with applicable District laws and regulations.

2.1.4. All mental health professionals working in school mental health programs and hired by DMH or

a contracting agency shall provide documentation of completion of required criminal background check, as stipulated by the Criminal Background Checks for the Protection of Children Act of 2004, mandatory drug and alcohol testing, as stipulated in the Child and Youth, Safety and Health Omnibus Act of 2004, and annual health screenings as required by DMH policy (DMH Policy Number 716.1).

2.5 Preliminary List of Core Workforce Competencies for Advanced Interdisciplinary Mental Health Practice in Schools³

2.5.1 Participate effectively in planning, needs assessment and resource mapping with families and school and community stakeholders to develop, introduce, and sustain SMH program and services.

2.5.2 Develop and sustain relationships with school administrators, school-employed mental health staff, teachers and support staff, families, and community partners.

2.5.3 Maintain thorough and up-to-date knowledge of major educational initiatives and policies that impact schools at the federal/national, state, and local level; and ensure that SMH practices align with those educational realities.

2.5.4 In all work, demonstrate an understanding of factors influencing school culture and climate, educators' potential roles as mental health/wellness change agents.

2.5.5 Demonstrate a thorough understanding of systems change theory and best practices and demonstrate an ability to work in complex systems.

2.5.6 Effectively represent SMH to the school (orally and in writing) and develop program and service delivery referral mechanisms that are responsive to local needs. Implement a full continuum of school-wide mental health promotion, prevention, early intervention and treatment available to all students including those in general and special education.

2.5.7 Demonstrate an ability to sustain prioritized focus on mental health promotion, prevention, and early intervention; rather than succumbing to exclusive (or near exclusive) delivery of intensive intervention services.

2.5.8 Develop and continuously enhance communication channels and relationships with school staff.

2.5.9 Develop and continuously enhance strategies for outreach to students and families for services and for active program guidance.

2.5.10 Maintain appropriate student and family privacy and confidentiality, guided by standards of practice.

2.5.11 Develop and continuously enhance collaborative relations with teachers in working together to improve classroom environments and student behaviors.

2.5.12 Assist teachers in learning skills that can be shared with students that reduce mental health barriers to learning.

2.5.13 Assist teachers in proactively identifying students contending with stress/risk and/or presenting emotional/behavioral problems.

2.5.14 Participate effectively in school decision-making teams including those focusing on services and supports for individual students and those focusing on school improvement.

2.5.15 Participate in collaborative actions that improve the school environment and/or broadly teach students important and evidence-based life skills.

2.5.16 Implement prevention and skill training group interventions that are based on evidence of positive impact with similar students.

2.5.17 In all work, demonstrate an understanding of normal patterns of human physical, cognitive and social-emotional development, patterns of development that influence optimism and resiliency, varieties of human diversity, and how issues of diversity (culture, ethnicity, race economics, gender) influence mental health.

2.5.18 In all work, demonstrate an understanding of differences between a deficit and strengths-based model for mental health; and frame SMH programs and services in positive and proactive ways to advocate for mental wellness.

2.5.19 In all work, demonstrate an understanding of common childhood and adolescent stressors and effective coping strategies, common problems impacting development, and common mental health challenges faced by all stakeholders connected with schools (students, staff, families).

2.5.20 Conduct integrated academic and mental health assessments in a manner that is therapeutic for students and families.

2.5.21 Appropriately use paper and pencil assessments, behavioral observations, and other measures to enhance assessment for students being considered for or in early stages of services.

2.5.22 Actively share assessment findings with students and families (and when appropriate, school staff) and involve them as active and equal collaborators in decision-making.

2.5.23 Implement preventive and supportive

interventions for youth presenting needs for assistance, including those without psychiatric diagnoses, using evidence-based strategies.

2.5.24 Implement treatment for youth meeting criteria for psychiatric diagnoses using evidence-based strategies.

2.5.25 Implement systematic quality assessment and improvement (QAI) strategies to monitor and continually improve the quality of all services.

2.5.26 Actively and on an ongoing basis use appropriate evaluation methods focusing on academic and behavioral outcomes that are valued by families and schools, and that are proximal to delivered interventions.

2.5.27 Share evaluation findings and outcome data with students, families, and school staff and integrate their feedback into QAI planning and action.

2.5.28 Assist the school in developing and implementing strategies to prevent and reduce all forms of violence, as well as assist students and staff who are exposed to violence.

2.5.29 Assist the school in developing and implementing effective plans to prevent and respond to crises.

2.5.30 Address high-risk student problems, including reports of abuse and neglect, and suicidal and homicidal ideation and behavior.

2.5.31 Enthusiastically participate in training, supervision and ongoing coaching and supportive actions to enhance school mental health promotion and intervention competencies of all stakeholders, in all instances utilizing evidence-based approaches.

Section 3.0 Levels of Service

3.1 Minimum Requirements

At a minimum, all school mental health professionals shall work collaboratively with school-hired student support staff (i.e., school counselors, social workers, psychologists), educators, and other community providers to implement an integrated set of services and supports that reflect a public health approach to mental health service delivery. The public health approach includes prevention, early intervention, and treatment services available on-site or through a school-linked referral process with community providers. The following three levels of care outline incremental stages to service delivery and detail staffing requirements.

3.2 Level I: Comprehensive School Mental Health Designation¹

Definition- Level I or Comprehensive SMH programs shall deliver consultation, crisis management services,

treatment services, participation in early intervention team planning, and assistance with universal prevention programs by a qualified professional. Additional services shall include early intervention services and a full array of prevention services. Comprehensive SMH programs may rely on other community mental health providers for year-round accessibility and/or twenty-four hour coverage. Comprehensive SMH services are not available during the summer or when school is not in session.

Availability of Services- Level I SMH programs shall be available five days per week for a minimum of 40 hours, with 36 hours for on-site services to the school. SMHP professionals must have a minimum caseload of 20 students, conduct at least two therapy or prevention groups per week, and provide at least 100 consultations during the school year. SMH professionals shall implement a policy for referrals to other qualified mental health professionals in and out of the school to provide other necessary services.

Staffing Requirements- Level I SMH programs shall include, at a minimum, a licensed or license eligible mental health professional.

3.3 Level II: Expanded School Mental Health Designation¹

Definition- Level II or Expanded SMH programs shall deliver consultation, crisis management, participation in early intervention team planning, and assistance with universal prevention programs by a qualified professional. Additional services shall include mental health treatment services (individual, family, and/or group counseling/therapy). Expanded SMH programs may rely on other community mental health providers for year-round accessibility and/or twenty-four hour coverage. Expanded SMH services are not available during the summer or when school is not in session.

Availability of Services- Level II SMH programs shall be operational a minimum of 20 hours per week, with at least 16 hour for on-site services to the school. SMHP professionals must have a minimum caseload of ten students, conduct at least one therapy or prevention group per week, and provide at least 50 consultations during the school year. SMH professionals shall implement a policy for referrals to other qualified mental health professionals in and out of the school to address some student and family treatment needs and provide other necessary services.

Staffing Requirements- Level II SMH programs shall include, at a minimum, a licensed or license eligible mental health professional.

3.4 Level III: Core School Mental Health Designation¹

Definition- Level III or Core SMH programs shall deliver consultation to teachers, school staff, and parents and crisis management services by a qualified mental health professional. Services can include assistance with implementing school-wide or classroom-based universal prevention services, as well as participation in early intervention team planning. Core SMH programs may rely on other community mental health providers for year-round accessibility and/or twenty-four hour coverage. Core SMH services are not available during the summer or when school is not in session.

Availability of Services- Level III SMH programs shall have a minimum of four and a maximum of eight hours per week with a qualified mental health professional. SMH professionals shall implement a policy for referrals to other qualified mental health professionals in and out of the school to address student and family treatment needs and provide other necessary services.

Staffing Requirements- Level III SMH programs shall include, at a minimum, a licensed or license-eligible mental health professional.

Section 4.0 Facility Requirements/Premises

4.1 Space Requirements

4.1.1 The provider of service shall maintain premises which are adequate and appropriate for the safe and effective operation of a school mental health program that complies with all applicable District, federal, and HIPAA requirements. School administrators shall designate a private office for school mental health professionals to conduct their services. This private office shall allow for proper adherence to confidentiality and shall be consistent with the capacity and purpose of the program.

4.1.2 The SMHP office shall be easily and safely accessible to students and parents. If an intercom system exists for the school at large, one shall be provided to the central SMHP office or an adequate alternative will be provided in order for the SMHP professional to be notified of school announcements and emergencies.

4.2 Equipment Requirements

4.2.1 School mental health programs shall provide for appropriate equipment, therapeutic materials, and supplies for the school mental health professional consistent with the purpose of the program and the population being served.

4.2.2 School administrators shall provide for appropriate furnishings for the designated office, including:

- 4.2.2.1 A desk and chairs
- 4.2.2.2 A locking filing cabinet
- 4.2.2.3 A phone and dedicated phone line
- 4.2.2.4 A computer (preferably connected to the internet) and printer or access to a printer
- 4.2.2.5 Answering machine or voice mail system

4.3 Administrative Requirements

4.3.1 The hours a school mental health professional is available shall be clearly posted.

4.3.2 Medical, fire, and emergency instructions and other procedures, including telephone numbers, shall be posted in a central location.

4.3.3 Assigned SMHP staff shall have keys for all locked areas, the locked office, and the locking filing cabinet.

Section 5.0 Sponsoring Agencies or Contracting Organization Requirements

* For sponsoring agencies that contract with the DC Department of Mental Health and that are required to be a core service agency, guidance is provided by the Mental Health Rehabilitation Services Provider Certification Standards- Chapter 34 Title 22A 52 DCR 5682⁴.

5.1 The sponsoring agency or contracting organization shall have a written agreement/Memorandum of Understanding with DMH and with the school system to provide an approved set of services.

5.2 The sponsoring agency or contracting organization shall be responsible for developing necessary policies and overseeing quality improvement measures.

Section 6.0 Consent and Authorization

6.1 Identification/Screening

6.1.1 Every school mental health program sponsor

agency shall work collaboratively with the local school to determine how students will be identified and/or screened for school mental health selective or indicated services.

6.1.2 Any students screened with mental health needs shall be provided mental health services or referred to a qualified mental health provider within a reasonable period of time after such screening has been concluded.

6.2 Eligibility

6.2.1 All students enrolled in the school shall be eligible to participate in school mental health services and interventions regardless of insurance status or ability to pay, with the exception of treatment services as defined by MHRS standards⁴.

6.2.2 The school mental health program sponsor agency shall determine the eligibility requirements for their school mental health treatment services and whether an Axis I mental health diagnosis is required before a student can receive mental health treatment.

6.2.3 These requirements shall comply with the Mental Health Rehabilitation Services standards if the agency is certified to provide Medicaid reimbursable services (refer to Chapter 34 Title 22A 52 DCR 5682⁴).

6.3 Referral Process²

6.3.1 Every school mental health program shall have a clearly written referral process developed to request mental health services for a child/adolescent. The early intervention teams (EIT) student support teams (SST) within public schools shall be used to triage cases, coordinate services, and facilitate appropriate referrals. The school-based clinician shall be an active member of the SST or equivalent mental health team.

6.3.2 Referrals shall be received from any party concerned with the student's welfare through the written referral process developed for that school. A referral form shall be used to document the date of the referral, the urgency of the referral, and the presenting problem. Policies outlining how long a clinician will take to make contact with a referred child shall be developed by the sponsoring agency.

6.3.3 Feedback shall be provided to the referral source in compliance with Mental Health Information Act regulations, on the status of the referral as quickly as possible after the initial referral is made. Extreme care shall be taken to protect the students' confidentiality.

6.3.4 Referrals, when necessary, shall be made to outside agencies for more intensive or specialized

services. An “Authorization to Use or Disclose Protected Health Information” shall be obtained from the parent/guardian (or the adolescent if he/she provided the original consent to services) to send or receive information regarding the client (D.C. Mental Health Information Act; DMH Policy 645.1). The SMH clinician shall facilitate the referral for the family and monitor whether contact is made between the child/family and the referral agency.

6.4 Consent²

6.4.1 In accordance with the Mental Health Service Delivery Reform Act of 2001, the school mental health provider shall make every effort to obtain consent from the child’s parent or legal guardian prior to providing mental health services. Written consent shall be required for all students. However, a clinician may deliver outpatient mental health services and mental health supports to a minor who is voluntarily seeking such services without parental or guardian consent for a period of 90 days if the clinician determines that 1) the minor is knowingly and voluntarily seeking services and 2) the provision of services is clinically indicated for the minor’s well-being. At the end of the 90-day period, the clinician shall make a new determination that mental health services are voluntary and are clinically indicated.

6.4.2 Mental health clinicians shall routinely encourage students to inform and involve their parents in treatment, and concerted efforts shall be demonstrated in this regard.

6.4.3 In emergency situations, such as potential for dangerousness to self and/or others, and child protective services involvement, a clinician shall intervene, regardless of whether consent has been obtained from a parent or guardian, yet consent for services shall be sought before interventions are offered whenever possible.

6.5 Authorization for Release of Information²

6.5.1 An “Authorization to Use or Disclose Protected Health Information” form shall be signed by the individual who consented to services if the clinician is to obtain or share clinical information with any other source or provider outside of the DMH/SMH program (D.C. Mental Health Information Act; DMH Policy 645.1).

Section 7.0 Scope of Services

7.1 Services Requirements

7.1.1 Mental Health Risk and Diagnostic

- Assessment
- 7.1.2 Mental Health Treatment
 - 7.1.2.1 Individual counseling/therapy
 - 7.1.2.2 Family counseling/therapy
 - 7.1.2.3 Group counseling/therapy
- 7.1.3 Mental Health Crisis Intervention
- 7.1.4 Teacher/Staff/Family Consultation
- 7.1.5 Case Management
- 7.1.6 Psychiatric Evaluation
- 7.1.7 Psychiatric Medication Management
- 7.1.8 Drug/Alcohol Use Risk Assessment
- 7.1.9 Drug/Alcohol Treatment

Section 8.0 Mental Health Records and Confidentiality

8.1 Mental Health Record Content²

8.1.1 Individual clinical records shall be developed for students who are seen for intensive mental health services. Records shall be maintained in accordance with recognized and acceptable standards of record keeping as follows⁵

8.1.1.1 Record entries shall be made in non-erasable ink or typewriter

8.1.1.2 Records shall be legible

8.1.1.3 Records shall be periodically reviewed for quality and completeness, and

8.1.1.4 All entries shall be dated and signed by appropriate staff

8.1.1.5 All entries shall be completed within 48 hours following a clinical encounter

8.1.2 Students seen in individual counseling or in therapeutic group counseling shall be considered clients of the sponsoring agency and charts will include mandatory forms as outlined by this agency as well as those required by DMH.

8.1.3 A mental health record shall at minimum include the following:

8.1.3.1 Contact information

8.1.3.2 Informed consent (from student and/or guardian)

8.1.3.3 Joint Consent Form (HIPAA)

8.1.3.4 Authorization for Disclosure Form (HIPAA)

8.1.3.5 Referral form

8.1.3.6 Intake form/Client history

8.1.3.7 Diagnostic assessment

8.1.3.8 Treatment plan and reviews

8.1.3.9 Progress notes

8.1.3.10 Discharge plan and summary

8.1.4 Where applicable, the mental health record

may also include the following:

- 8.1.4.1 Psychological evaluations
- 8.1.4.2 Educational reports and information
- 8.1.4.3 Pre- and Post-tests
- 8.1.4.4 Correspondence
- 8.1.4.5 Work samples
- 8.1.4.6 Referrals for outside services

8.2 Mental Health Record Confidentiality²

8.2.1 All mental health providers shall abide by the Mental Health Information Act, a DC statute that dictates how mental health information should be shared and with whom, and with HIPAA (Health Insurance Portability and Accountability Act) regulations and FERPA (Family Education Rights and Privacy Act) laws.

8.2.2 Confidentiality must be respected and maintained at all times. Details of a clinical case cannot be shared with school staff due to confidentiality guidelines unless an emergency occurs where the clinician is obligated to break confidentiality to protect the child and/or others or when written authorization is provided.

8.2.3 Limitations on confidentiality (danger to self, others, or endangerment due to abuse or neglect) will be clearly stated at the initial meeting with the student and his/her family (D.C. Mental Health Information Act; DMH Policy 645.1).

8.3 Mental Health Record Storage²

8.3.1 Charts shall be kept in locked and secure places (i.e., a locking filing cabinet) on school premises to ensure confidentiality of records and timely access to information, as required by HIPAA guidelines.

8.3.2 Mental Health records shall be kept separate from any health information that is part of the student's educational record.

8.3.3 A policy shall be established by the sponsoring agency concerning who has access to the mental health record (i.e., clinician, supervisor), who shall have a copy of the key to the filing cabinet (i.e., agency administrator, supervisor), and who shall have a copy of the key to the school office occupied by the mental health professional (i.e., principal, building janitor).

8.4 Sharing of Mental Health Information²

8.4.1 When a clinical case is opened, any information obtained as a result from this action shall belong to the sponsoring agency and the client and cannot be shared with anyone without a written authorization for disclosure provided by the parent, guardian, or client (D.C. Mental Health Information Act; DMH Policy

645.1).

8.4.2 In the District of Columbia a court order or subpoena and qualified protective order signed by a judge is required before a mental health record can be released to the courts. If a court order or a subpoena is served to the "custodian of the records" and they are referring to the mental health records, the mental health professional shall be responsible for following appropriate procedures outlined by DMH and complying with the law in regards to this request. Consultation with a clinical supervisor and the sponsoring agency's general counsel should occur on cases involving court orders or subpoenas before any communication or record is given.

8.4.3 In order to appropriately coordinate mental health services for students, to inform other providers of services being offered and received, and to assist in authorized data collection activities, administrative information related to the student may be shared with the Principal or a designee without a formal release of information. Information such as the client's name, age, sex, dates and modality of treatment used in sessions (individual or group) shall be disclosed if such disclosure is deemed to be necessary for the provision and coordination of these services.

8.4.4 Documentation in the clinical record regarding unauthorized disclosures (such as for mandated reporting) shall include: date of disclosure, name of person to whom information was disclosed, nature of information disclosed, and purpose of disclosure.

8.5 Mandated Reporting²

8.5.1 When a clinician suspects child abuse or neglect he/she shall immediately make a report to Child and Family Services Agency (CFSA) at 202-671-SAFE.

8.5.2 The Principal and the SMH clinical supervisor shall be informed that a report was made to CFSA by the clinician.

Section 9.0 Data Collection and Reporting

9.1 Any individual or program participating in the delivery of school mental health services in the District of Columbia shall submit required reports to the DC Department of Mental Health. School mental health program sponsors shall complete documentation, data collection, and reporting requirements.

9.2 Data Collection Requirements

9.2.1 The sponsoring agency of the SMH program shall maintain a data collection system, preferably

electronic, which allows for data input, export, aggregation, and analysis.

9.2.2 The data collected shall comply with DC Department of Mental Health, School Mental Health requirements.

9.2.3 Data shall include elements that will track utilization of services, staff productivity, client satisfaction with services provided, emotional, behavioral, and academic outcomes.

9.3 Data Reporting Requirements

9.3.1 The SMHP shall complete the (monthly, quarterly, annual) Productivity Report by (required date) for services offered during the (identify school year).

9.3.2 This information shall be provided to the Clinical Administrator at DMH at regular intervals determined by DMH.

Section 10.0 Quality Assurance

10.1 Continuous Quality Improvement Requirements

10.1.1 The SMH program and its sponsor agency must develop a mechanism to monitor their clinical services and evaluate the goals of their overall program.

10.1.2 The SMH program will either a) set up a continuous quality improvement program, or b) develop a comprehensive practice management improvement plan that incorporates CQI monitoring.

10.1.3 It is recommended that the SMH program use CQI and PMI tools that have been field-tested (for example, the Mental Health Planning and Evaluation Template (MHPET) can be used in evaluating activities and services across the field of school-based mental health, for new or established school mental health programs.⁶⁾

10.1.4 Internal CQI audits shall be conducted at least once a year

10.1.5 SMH programs shall comply with program audits conducted by DC Department of Mental Health.

Section 11.0 Finance/Fiscal Management

11.1 Budget

The sponsor of the SMH program shall have an annual budget that describes sources and uses of funding.

11.2 Billing

11.2.1 The SMH program sponsor agency shall have a written policy that describes how services rendered

are recorded, charged, billed, and collected (when applicable).

11.2.2 Information on dollar amounts of claims submitted to claims paid by the DC Department of Mental Health or MHRS⁴ services provided in designated schools shall be reported.

Section 12.0 Evaluation

12.1 Needs Assessment

12.1.1 To help define the scope and level of services needed, SMH programs shall complete a community and local school needs assessment before services are provided in schools.

12.1.2 A school needs assessment shall be updated annually to monitor changes in student demographics, staffing, resources, and school district requirements.

12.1.3 A community needs assessment shall be conducted every three to five years to monitor the community's needs, concerns, and resources for the physical, mental, behavioral, and academic needs of its children and adolescents.

12.2 Process Evaluation

12.2.1 SMH programs shall conduct process evaluations annually to address client satisfaction, service delivery, and program management.

12.2.2 Satisfaction survey- SMH programs shall conduct client, parent, and school administrator satisfaction surveys on an annual basis as part of the process evaluation.

12.2.3 Focus groups may also be conducted to identify both satisfaction levels as well as perceptions among clients, families, and school staff concerning the functioning of the program.

12.2.4 Service-delivery effectiveness may be assessed using quarterly data reports to calculate provider productivity as measured by number of visits, number of evidence-based interventions implemented, minimum caseloads, amount of time between referral and first visit, etc.

12.2.5 Program management effectiveness may be monitored by using measures of transparency – e.g., availability of information on the SMH program web site; annual report to the public on program performance; supervisory ratios; numbers of presentations to and communications with community groups, school representatives, and key program stakeholders.

12.3 Utilization

SMH programs shall monitor and report service utilization for all prevention, early intervention, assessment, treatment, and

12.4 Outcome/Impact Evaluation

12.4.1 SMH programs shall evaluate the impact of services provided, using pre and post-assessments to evaluate outcomes for predominant symptoms exhibited by the local student population.

12.4.2 Measures shall be conducted the first year program services are offered to establish a baseline and then annually thereafter.

12.4.3 SMH programs shall have indicated students complete the Ohio Youth Problems, Functioning, and Satisfaction Scales- Short form.

12.4.4 Assessments shall be conducted using validated and reliable measurements and tools, including but not limited to:

12.4.4.1 Depression (e.g., the Reynolds Child Depression Scale or the Reynolds Adolescent Depression Scale)

12.4.4.2 Aggression (e.g., the Beck Disruptive Behavior Inventory for Youth, the Aggression Questionnaire)

12.4.4.3 Anger (e.g., the Beck Anger Inventory for Youth or the Children's Inventory of Anger)

12.4.4.4 Trauma (e.g., Trauma Symptom Checklist for Children)

Section 13.0 Enforcement of Standards⁵

13.1 A provider of service shall exercise due diligence in complying with the requirements of outlined standards. Due diligence means the exercise of reasonable and appropriate efforts to ensure compliance with the standards set forth in these standards.

13.2 The DC Department of Mental Health shall review the program and practices of the provider of service in order to facilitate determinations as to whether providers are exercising the requisite due diligence and are otherwise in compliance with these standards.

13.3 If, based on a review of the program and practice of a provider of service, the DC Department of Mental Health determines that a provider of service is not exercising due diligence in complying with the requirements of these standards, the DC Department of Mental Health shall give notice of the deficiency to the provider of service and may also initiate the following:

13.3.1 Request that the provider of service prepare a plan of correction, which shall be subject to approval by the DC Department of Mental Health;

13.3.2 Provide such technical assistance as

the DC Department of Mental Health deems necessary to assist the provider of service in developing and implementing an appropriate plan of correction.

13.3.3 If the provider of service fails to prepare an acceptable plan of correction within a reasonable time or refuses to permit the DC Department of Mental Health to provide technical assistance or fails to promptly or effectively implement a plan of correction which has been approved by the DC Department of Mental Health, it shall be determined that the provider of service is in violation of these standards.

13.3.4 Upon determination that a provider of service is in violation of these standards or upon determination that a provider of service has failed to otherwise comply with applicable statutes, rules, or regulations, the DC Department of Mental Health may revoke, suspend or limit the provider's operations.

Note: Preceding standards have been adapted from the sources referenced below.

1. Maryland School-Based Health Center Policy Advisory Council, Maryland School-Based Health Center Standards, April 2006
2. District of Columbia Department of Mental Health, School Mental Health Program General Operating Procedures, October 11, 2006
3. Paternite, C.E., Weist, M.D., Axelrod, J., Weston, K., & Anderson-Butcher, D. (2006). School Mental Health Workforce Issues. In An action plan for behavioral health workforce development: A framework for discussion. Cincinnati, Ohio: Annapolis Coalition on the Behavioral Health Workforce, January 17, 2006. <http://www.annapoliscoalition.org>,
4. Mental Health Rehabilitation Services Provider Certification Standards, Chapter 34, Title 22A, D.C. Code of Municipal Regulations 5682, http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/policy/Chap_34_Title_22A_52_DCR_5682.pdf
5. New York Codes, Rules and Regulations, Parts 587 and 588, <http://www.omh.state.ny.us/omhweb/policy/policy.htm>
6. National Assembly on School-Based Health Care (NASBHC), Mental Health Planning and Evaluation Template (MHPET), <http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.3015469>
7. Weist, M.D., Sander, M.A., Walrath, C., Link, B., Nabors, L., et al. (2005). Developing principles for best practice in expanded school mental health. *Journal of Youth and Adolescence*, 34(1), 7-13. Revised 5/5/08

Appendix J: List of evidenced based programs or data driven practices or programs for use in the School Mental Health Program for SY 2007-2008

Evidenced-Based SMHP Clinicin LED Programs

Screening:

Columbia Teen Screen – Evidence-Based Prevention – The National Suicide Prevention Resource Center

A screening program developed by Columbia University. Its purpose is to identify and help youth who suffer from depression and other emotional problems.

Prevention Programs:

Connect with Kids – Evidenced Informed – What Works Clearinghouse
Evidenced informed program improves student behavior in significant and important ways across multiple character skills, including teasing and bullying behaviors, cheating and lying, respect for classmates and teachers, violence prevention, and academic perseverance.

Good Touch/Bad Touch – Evidenced Based – The National Mental Health Association’s Clearinghouse

Evidence-based primary prevention/education curriculum, 3-7 sessions. Developed for pre-school – 6th grade students as a tool to teach children the skills they need to prevent or interrupt abuse.

Botvin’s Life Skills Training Program – Evidenced Based – SAMHSA Model Program

Evidence-base Substance abuse prevention program (15-20 sessions), addresses the most important factors leading adolescents to use drugs by teaching a combination of health information, general life skills, and drug resistance skills.

Taking Action – Evidenced Based – National Institute of Health funded study

An 18-session program for the treatment and prevention of pre-teen depression. The program can be delivered using either a group or individual format.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) – Evidence Based – SAMHSA Model Program

CBITS is a cognitive behavioral therapy group intervention for reducing children’s symptoms of post-traumatic stress disorder (PTSD) and depression caused by exposure to violence. CBITS has three main goals: to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support.

Too Good for Violence-Evidence Based – SAMHSA Model Program

A school based prevention program that address the most significant risk and protective factor developmental level to help students learn the skills and attitudes they need to get along peacefully with others. Too good for violence promotes protective factors that help youth get along peacefully: bonding, norms and social/emotional skills.

Parenting for Emotional Growth – Evidenced Informed

Henri Parens, MD and his collaborators have been using this model for over thirty years. They have added new ideas as their experience and current scientific knowledge suggested. This well researched and documented series of workshops for parents is based in the belief that all children can achieve their best individual adaptive abilities and mental health potential when facilitated by parents, family, teachers, and others of significant importance in the family

Evidence-Based School Driven Programs:

Olweus Bullying Prevention – Evidenced Based – SAMHSA Model Program

The Olweus Bullying Prevention Program is a comprehensive, school-wide program designed for use in elementary, middle, or junior high schools. Its goals are to reduce and prevent bullying problems among school children and to improve peer relations at school.

Second Step – Evidenced Based – SAMHSA Model Program

A school based social skills curriculum for children in preschool through junior high school. Spanning a full academic year, the program teaches social skills to reduce impulsive and aggressive behavior in children and increase their level of social competence.

I Can Problem Solve – Evidenced Based – SAMHSA Promising Practice

Evidence-based program that trains children in generating a variety of solutions to interpersonal problems, considering the consequences of these solutions, and recognizing thoughts, feelings, and motives that generate problems situations. By teaching children to think, rather than what to think, the program changes thinking styles and, as a result enhances children’s social adjustment, promotes pro-social behavior, and decreases impulsivity and inhibition.

Positive Behavioral Interventions and Supports (PBIS) – Evidence Based – National Forum for Change

PBIS is an evidence-based program that encourages academic performance and positive classroom climates in schools. PBIS seeks to create effective learning environments by reducing the disruptions caused by problem behaviors and by encouraging constructive behaviors.

Supplemental Programs:

Love and Life: The G-TREM Model – Evidenced Informed

Evidenced-based program, 16+ sessions, Enhance adolescents females' trauma recovery and coping skills, decrease risk of re-victimization and inspire girls to grow into healthy confident women.

Three Dimensional Grief – Promising Practice

Therapeutic grief and loss groups for grieving students or students who have experienced the death of a loved one (PreK-12th grade).

Trauma Intervention Programs – Promising Practice

Short-term trauma intervention for children (6-12 years old) and adolescents (13-18 years old) organized as an 8 session intervention model.

RETHINK Program – Evidenced Informed

Developed by Institute for Mental Health Initiatives and George Washington University School of Public Health and Health Services, 40 sessions for grades K through high school. Empowerment program that provides individuals with the knowledge and skills to manage their angry feelings, situations, and conflicts in constructive ways. Incorporates a service-learning project.

The Empower Program – Evidenced Informed

Evidence-based program 12-20 gender specific sessions – violence/bullying prevention/intervention program, examines and challenges societal and cultural stereotypes and pressures.

RESPECT Program – Promising Practice

Evidence-based program on Violence, bullying, and sexual harassment awareness and prevention program for middle school and high school students, (4-6 sessions).

Appendix K: Sources that have reviewed evidence-based or promising programs for use in schools

Substance Abuse and Mental Health Services Administration (SAMHSA)

The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry, created by SAMHSA, of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The purpose of this registry is to identify approaches to preventing and treating mental and/or substance use disorders that have been scientifically tested and that can be readily disseminated to the field. A search of interventions offered in the school setting yielded 40 evidence-based programs to choose from. NREPP publishes an intervention summary for every intervention it reviews. Each intervention summary includes:

- Descriptive information about the intervention and its targeted outcomes
- Quality of Research and Readiness for Dissemination ratings
- A list of studies and materials submitted for review
- Contact information for the intervention developer
<http://www.nrepp.samhsa.gov/index.htm>

Collaborative for Academic, Social, and Emotional Learning (CASEL)

CASEL is a collaborative that works to advance the science and evidence-based practice of social and emotional learning (SEL). They synthesize scientific evidence around SEL and provide practitioners and school administrators with the guidelines, tools, informational resources, policies, training, and supports they need to improve and expand their SEL programming. One resource they make available is a list of recommended tools for evaluating the social and emotional climate of schools, with descriptions and surveys available to download. <http://www.casel.org/assessment/climate.php>

CASEL also conducted an extensive review of SEL programs and developed a guide of 80 multiyear SEL programs designed for use in general education classrooms. *Safe and Sound: An Educational Leader's Guide to Evidence-Based Social and Emotional Learning (SEL) Program* is a comprehensive report of SEL programming that provides specific strategies for schools and districts interested in launching social, emotional, and academic learning programs. Collaborative for Academic, Social, and Emotional Learning. (2003). *Safe and Sound: An Educational Leader's Guide to Evidence-Based Social and Emotional Learning (SEL) Programs*. Chicago, IL: Author. <http://www.casel.org/pub/safeandsound.php>

Center for the Study and Prevention of Violence (CSPV)

CSPV designed and launched a national violence prevention initiative to identify effective violence prevention programs, calling the project Blueprints for Violence Prevention. Out of more than 600 programs that have been reviewed, the Center has identified 11 prevention and intervention programs that meet a strict scientific standard of program effectiveness and are considered model programs, and another 18 programs have been identified as promising programs.

<http://www.colorado.edu/cspv/blueprints/index.html>

Center for Learning Excellence

The Evidence-Based Program Database contains information on evidence-based programs recommended by research-oriented government agencies, non-profit agencies, and independent publications. The programs in this database have all been shown to be effective at changing youth behaviors.

<http://www.alted-mh.org/ebpd/>

Lifecourse Interventions to Nurture Kids Successfully (LINKS)

LINKS, a program of Child Trends, a nonpartisan research center focused exclusively on children's issues, features experimental evaluations of social programs designed to enhance children's development. They are presented in a user-friendly format for policy makers, program designers, and funders. The purpose of LINKS is to compile a compendium of interventions for children based on the following criteria:

All programs included are social interventions (i.e., not medical). Every study has a treatment group and a control group. Only results based on an intent-to-treat analysis [including all randomized subjects' data in the analysis, regardless of their compliance with the protocol of the study] are reported. Random assignment (i.e., a lottery system) was used to determine placement (of children, classrooms, schools, districts, etc.) into treatment and control groups.

Results were reported if they met the .05 level of significance; any results significant at the .05 to .10 level are described as marginally significant.

- Studies were conducted around the world but all reports are in English.
- Studies are included if they have a response rate as low as 50%, but evaluations with low response rates and other major methodological limitations are noted.
- No restrictions were made based on sample size.
- No statistical re-analyses have been done to adjust or revise the results presented by the studies' authors.

Programs listed in the ‘school-based’ category on the LINKS website have some or all of the program administered in the classroom or across the school.

http://www.childtrends.org/_catdisp_page.cfm?LID=C69A59D5-7C1A-47C1-AB7C751AD5A71718

Additional resources:

Jaycox, L.H., Morse, L.K., Tanielian, T. & Stein, B.D. (2006). How Schools Can Help Students Recover from Traumatic Experiences: A Tool Kit for Supporting Long-term Recovery. Santa Monica, CA: RAND. <http://www.rand.org>

This tool kit is intended to help school administrators and mental health professionals decide how to address the mental health recovery of students following a traumatic event. The authors gathered information about programs that can be implemented in schools, examined the evidence supporting their use, and categorized the information based on type of trauma. The research and the report were guided by the work out of the National Child Traumatic Stress Network (NCTSN) and were funded by SAMHSA.

Duchnowski, A. J., & Kutash, K., (2007). Family-driven care. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies (Appendix C: Compendium of Evidence-Based Behavioral Health Programs, pgs. 44-46). http://cfs.fmhi.usf.edu/resources/publications/fam_driven_care.pdf

This report is aimed at helping family members and middle level administrators in the education and mental health systems understand and implement the concept of ‘family-driven care’. There are two major aims of this report. The first is to acquaint readers with the concept of family-driven care for children who have emotional and behavioral disturbances. The second is to present information about evidence-based practices that are effective interventions to help children and their families.

Appendix L: Sources of Federal funding for school-based mental health care

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

The Safe Schools/Healthy Students Initiative

The purpose of the SS/HS Initiative is to promote the mental health of students, to enhance academic achievement, to prevent violence and substance use, and to create safe and respectful climates through sustainable school-family-community partnerships and the use of research-based prevention and early intervention programs, policies, and procedures.

Systems of Care Program

Systems of care are developed on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. These systems are also developed around the principles of being child-centered, family-driven, strength-based, and culturally competent and involving interagency collaboration.

Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention

Money made available from the Garrett Lee Smith Suicide Prevention Act supports this program designed to assist in developing and implementing statewide youth suicide prevention and early intervention strategies, grounded in public/private collaboration.

Mental Health Transformation State Incentive Grant Program

This program will support an array of infrastructure and service delivery improvement activities to help grantees build a solid foundation for delivering and sustaining effective mental health and related services. These grants are unique in that they will support new and expanded planning and development to promote transformation to systems explicitly designed to foster recovery and meet the multiple needs of consumers.

U.S. DEPARTMENT OF EDUCATION

Mental Health and Education Integration Grant

This program provides grants for the purpose of increasing student access to quality mental health care by developing innovative programs that link school systems with local mental health systems.

Safe and Drug-Free Schools and Communities Act State Grants Program

This program authorizes and supports a variety of activities designed to prevent school violence and youth drug use, and to help schools and communities create safe, disciplined, and drug-free environments that support student academic achievement.

Appendix M: Proposed plan to implement a citywide school mental health evaluation plan

Appendix M: Proposed plan to implement a city-wide school mental health evaluation tool			
Activity	Deliverables	Responsible	Timeline
Issue SMHP Evaluation Contract for Independent Eval TM	<ol style="list-style-type: none"> 1. Descriptive information and narrative summaries on schools, services/programs and recipients of MH interventions 2. Data analysis, data tables and illustrations for a SMHP Evaluation report for SY 2005-2006 & 2006-2007 3. Executive summary, annual reports for 2005-2006, 2006-2007 school year 4. Recommendations for strengthening data collection 5. Template for future annual reporting of SMHP data 	SMHP	Fall 2008 - summer 2009
Confirm or Identify Critical Research Questions	<ol style="list-style-type: none"> 1. Match SMHP intended outcomes with ICSIC & Cap Stat goals 2. Review previous questions & identify new areas for exploration 3. Outline research methodology, identify resource needs, and develop plan/timeline 4. Consider developing ongoing relationship with local university to enhance research capabilities 	SMHP	Fall 2008
Finalize Data Sets and Confirm Definition of Data Elements	See suggested data elements table	SMHP	Fall 2008
Develop data gathering and interpreting capacities	<ol style="list-style-type: none"> 1. Identify or create DMH information system for SMHP 2. Consider use of WellBAT with SMHP treatment services 3. Assess interactivity of DMH system with CHARI (Children at Risk Information) database 4. Revise/Update system per clinician and agency feedback. 	SMHP	

Appendix M, cont.: Proposed plan to implement a citywide school mental health evaluation plan

Appendix M: Proposed plan to implement a city-wide school mental health evaluation tool		
Activity	Deliverables	Responsible
Identify sources for each data set	1. <i>Utilization data</i>	SMHP and sponsor agencies
	2. <i>Process evaluation</i>	SMHP and sponsor agencies
	3. <i>Outcomes - Prevention & Early Intervention</i>	SMHP, sponsor agencies, schools
	4. <i>Outcomes - Clinical</i>	SMHP, sponsor agencies, identified students
	5. <i>Outcomes - Academic</i>	DCPS, Charter Schools, OSSE
Assess capacity of information systems and clarify technology requirements	1. <i>Utilization data</i>	Sponsor agency & DMH
	2. <i>Process evaluation</i>	Sponsor agency & DMH
	3. <i>Outcomes - Prevention & Early Intervention</i>	Sponsor agency & DMH
	4. <i>Outcomes - Clinical</i>	Sponsor agency & DMH
	5. <i>Outcomes - Academic</i>	Sponsor agency, DMH, local school, school district
Complete Memorandum of Understanding Agreements with relevant sources	1. <i>Utilization data</i> between a. sponsor agency & DMH, b. sponsor agency and school	Sponsor agency
	2. <i>Process evaluation</i> between a. sponsor agency & DMH, b. sponsor agency and school	
	3. <i>Outcomes - Prevention & Early Intervention</i> between a. sponsor agency & DMH, b. sponsor agency and school	
	4. <i>Outcomes - Clinical</i> between a. sponsor agency & DMH, b. sponsor agency and school	
	5. <i>Outcomes - Academic</i> between a. sponsor agency & local school and b. DMH and school district	

Appendix M, cont.: Proposed plan to implement a citywide school mental health evaluation plan

Appendix M: Proposed plan to implement a city-wide school mental health evaluation tool			
Activity	Deliverables	Responsible	Timeline
Create Fidelity Assessment Tools for EBPs	1. Universal prevention	Sponsor agency & DMH	
	2. Early intervention		
	3. Treatment services		
	4. Crisis services		
Collect indicated baseline or pre-test data	1. Utilization data	Sponsor agency	
	2. Process evaluation	Sponsor agency	
	3. Outcomes - Prevention & Early Intervention	Sponsor agency & local school	
	4. Outcomes - Clinical	Sponsor agency	
	5. Outcomes - Academic	Sponsor agency & local school	
Expand SMHP Evaluation to Include Assessment of School Climate	1. Identify school climate indicators		
	2. Identify and/or create measurement tool		
	3. Develop plan for implementation		
	4. Obtain agreements from school districts and local schools		
Implement DMH Evaluation Plan	1. Identify partners (may include DCPS, Charter Schools, DOH, OSSE, Deputy Mayor of Education, CSAs or community MH providers, ICSIC)		
	2. Identify resource needs (funding, expertise, capacity, time)		
	3. Identify possible funding sources (DMH, City Council, OSSE, DCPS, Local foundations, block grants)		

Appendix M,
cont.: Proposed
plan to implement
a citywide school
mental health
evaluation plan

Data Type	Data Category	Possible Data Measurements
Utilization	Referrals to SMHP & Referral Sources	Administrators
		Teachers
		Parents
		Other Students
		Self
		Other Programs
	Student Demographics	Gender
		Age
		Grades
		Race/Ethnicity
	Services Delivered	Prevention
		Early Intervention
Identification, Screening & Assessment		
Treatment		
Consultation		
Home Visits		
Process Evaluation	Satisfaction Surveys	Child
		Youth
		Parents
		Teachers/Staff
		Administrators
	Service-delivery effectiveness	# of EB interventions implemented
		Active Caseloads
		Amount of time between referral and first visit
	Program Management Effectiveness	Availability of program information
		Annual report to the public on program performance
		Numbers of presentations to and communications with stakeholders
		Ratios of Supervisor to Clinician
Outcomes - Prevention & Early Intervention	Assets	Protective Factors Among Students
	School/climate	perceptions of safety in school and classrooms
	MH Awareness & attitudes	Staff and parent awareness of MH issues
		Staff and parent attitudes about MH issues
Outcomes - Clinical	Problem Severity	Ohio Scales
	Pre-post assessments	Depression
		Anger
		Aggression
		Trauma
Substance Use		
Outcomes - Academic	Pre-post Assessment	Attendance
		Drop-out Rates
		Truancy
		Discipline Referrals
	Special Education	Referrals for ED
	Behavior	School discipline & behavior policies
Staffing	Existence and functioning of School early Intervention programs	



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