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Schools as a Vital Component of the Child and Adolescent Mental Health System

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Schools as a Vital Component of the Child and Adolescent Mental Health System

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Highlights.

- Most children with mental health needs receive support in the schools, with students achieving greater access, adherence, and participation in school mental health interventions than those offered in other community mental health settings.
- Shifts in the education and mental health systems in recent decades have led to increased engagement of these two systems, including school-based mental health screening and treatment, to address child and adolescent mental health.
- Research and policies have advanced a framework of mental health integrated into education, known as *Comprehensive School Mental Health Systems*, that draws on the resources and professionals in each to improve student success, including mental health and academic outcomes.
- The establishment of a full system of care for children and adolescents will require all states and districts to install multi-tiered systems of mental health support, systematic student mental health monitoring, and coordination with other community child-serving systems.

Abstract

Objective: This review examines the history and contemporary landscape of school mental health, offering evidence for schools as an essential component of the child and adolescent system of care and recommendations for advancing this vital care delivery system.

Methods: A literature review of scientific data and policy and practice shifts in school mental health documents the evolution of education and mental health system integration to support student mental health and provides best practice strategies and examples for how to achieve *Comprehensive School Mental Health Systems* in states and local communities.

Results: Data demonstrates that multi-tiered systems of mental health support and services in schools, including mental health promotion, prevention, early intervention, and treatment, improves academic and psychosocial functioning, and reduces risk of poor outcomes, including mental illness and school failure. Policy and practice shifts in the field reflect a movement toward integrating mental health systems into the education sector, including preparing the education workforce to promote mental health and support early identification and intervention of mental illness.

Conclusions: To realize a full continuum of mental health supports for students, states and districts must draw on national best practices and state exemplars to install multi-tiered systems of mental health supports in all schools, conduct universal student mental health monitoring, and seamlessly coordinate school and community mental health systems.

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Introduction

One in five children currently are adversely impacted by a mental health condition (1). Yet, less than one-half of these children will receive any treatment (2), and of those who do, only those receiving mental health services in schools will usually be seen more than three to four times (3, 4). For those in poverty, without insurance, or of color, the numbers are bleaker (2, 5). In addition to the low likelihood of receiving care, these youth will more likely find themselves in the juvenile justice system for management of their mental health conditions (6).

The most viable place to identify, manage, and sustain progress for children with mental health problems is within schools (7). An ever-growing body of evidence indicates that integrating mental health supports and services directly in the school setting is an effective delivery system for children's mental health programming (8, 9). Delivering mental health treatments in schools has substantial benefits:

- Improved access to care for far more children (7, 10, 11);
- Improved adherence and participation in treatment (12);
- Early problem identification and diminished impacts of mental health conditions (13);
- Decreased stigma among both children and their families (14, 15); and
- Positive impacts on academic and psychosocial functioning (16).

School mental health also offers the opportunity for a multi-disciplinary team of adults specialized to support children in a natural, inclusive setting. When more intensive services are needed for mental health challenges, they can often be seamlessly added, along with other specialty supports (*e.g.,* speech therapy, occupational therapy, behavioral specialists), to a foundation of universal supports in schools. Since the school is the common meeting place for all children, the school often provides a more accessible and comfortable site for students and their families to receive mental health services than do hospital or community mental health settings (17). This review examines the history and contemporary landscape of school mental health, offering evidence for schools as an essential component of the child and adolescent system of care, and recommendations for advancing this vital care delivery system.

The Evolution of School Mental Health

Current efforts to deliver mental health supports and services in schools were born out of significant changes within both the education and mental health systems in recent decades. The education sector formally recognized its responsibility to address students with disabilities, including *serious emotional disturbance (SED)*, with the passage of the Education for all Handicapped Children Act in 1975, now known now known as the *Individuals with Disabilities Education Act (IDEA)*. Similarly, *Section 504 of the Rehabilitation Act of 1973* mandates that children with disabilities are entitled to a free and appropriate education and that children with a

documented "physical or mental impairment that substantially limits one or more major life activities" must receive supports (18). Both policies facilitated movement toward schools delivering mental health support and necessary educational accommodations for students with emotional and behavioral disabilities (19).

Simultaneously, the mental health sector saw an increase in federally funded community mental health demonstration projects that included children's (not just adult) services, eventually leading to a mandate for children's services to be part of community mental health programming. However, insufficient federal and state funding left these mandates largely unmet.

It was not until the 1980s, amidst growing recognition of the inadequacy of children's mental health care quality and access, and overreliance on residential treatment (20), that mental health systems began to reflect child- and family-centered care in the "least restrictive environments." Investment by the National Institute of Mental Health in the Child and Adolescent Services System Program (CASSP), now managed by the Substance Abuse and Mental Health Services Administration (SAMHSA), in the Systems of Care effort led the way for child-serving systems, including schools, to become committed partners in addressing the mental health of our nation's youth. In contrast to the fragmentation too often characteristic of the child mental health system, Systems of Care emphasized a shared responsibility of agencies (mental health, education, juvenile justice, child welfare) to coordinate a full array of community-based services for children and their families (21, 22). This was a key advance in the integration of schools and mental health; schools were no longer left to manage mental health problems alone during school hours, yet they were also no longer able to deem mental illness the burden of the mental health sector.

Shifts in delivery systems also gave way to a recognition that educators were well-positioned to identify and address student mental health concerns. Almost two decades ago, the U.S. Surgeon General identified teachers as "frontline" mental health workers and advocated training for them to help recognize and manage child and adolescent mental health difficulties, beyond just generally supporting positive social-emotional development for all students. Since school staff engage with students 6 hours per day, 5 days per week, for ~30 weeks per year, while exerting "performance demands" daily on children, they are the best positioned to recognize any emerging or persisting struggles in those same children.

More importantly, they are similarly best positioned with families to make organized responses, align interventions, and employ strategies in naturalistic situations where substantial feedback can be provided these students to employ skills while they access the curriculum. While teachers are not mental health clinicians, much of what they provide students are the skills to manage stress with healthy alternatives (exercise, music, artistic expression), problem-solve, work with helpful others (staff and students), and manage daily "failures." Moreover, the density of diverse services provided now in public schools provides teachers consultative and team support to manage complex student issues.

Mental health treatment historically has occurred outside of schools, where a mental health clinician, psychiatrist, or primary care clinician attempts to coalesce an understanding of the

child's predicament, recommend some interventions (usually with the family or through medication), essentially in isolation from interventions that may occur within the school. Clinician-school personnel interaction is both rare and infrequent; any extrapolation of skills developed in a clinician visit to the school, the site of most expectations for the child, is too often coincidental, rather than purposefully constructed, monitored, and revised to ensure changes or improvements occur. In simpler terms, there is no shared investment in outcomes; while both the school and mental health clinicians would likely wish for school success and positive mental health, there is rarely any sharing of responsibilities (or accountability) for outcomes. When mental health clinicians are integrated into the school setting in a seamless system built on the foundational mental health promotion, prevention, and early intervention efforts of educators, there is greater likelihood of optimizing outcomes for students.

A strong research literature now exists demonstrating that integrating mental health systems directly into schools leads to positive social, emotional, behavioral, and academic outcomes. Mental health promotion efforts for all students, including social-emotional learning programs and efforts to elicit positive student behaviors, such as Positive Behavioral Interventions and Supports (PBIS), reveal positive skill development (23, 24 , 25), reduction in conduct problems and unwanted school outcomes (suspensions, office discipline referrals) (26, 27), and even the prevention of student anxiety and depression (28, 29). Similarly, early intervention and treatment in schools have demonstrated success at reducing mental illness, including substance use (30,31, 32, 33, 34, 35, 36). Finally, one of the most compelling arguments to educators for incorporating mental health supports and services in schools is the mounting evidence of its positive impact on academic indicators, including test scores, attendance, and grades (23, 16).

For several decades, our federal health and education administrations in the United States have invested in the integration of mental health supports and services in schools, including support for national, regional, and state technical assistance and policy centers to advance school mental health (19). This trend is similarly reflected in international efforts to improve child mental health systems, with many countries recognizing the opportunity provided by schools serving as a venue for mental health promotion, early identification and intervention, and treatment (37, 38). This is particularly evident in low- and middle-income countries most lacking in child mental health resources that recognize the importance of educators and primary care providers in supporting youth mental health (17).

Despite increases in funding and policy support for school mental health, and a steadily growing evidence base for the positive impact of providing a continuum of mental health supports to students in schools, implementation of beneficial, cost-effective mental health treatment within schools still lags, for myriad reasons.

Foremost, schools have multiple societal roles and are subject to expectations relating to preparing children academically and then vocationally. Under local control, schools often vacillate in priorities as they address diverse, often transitory, objectives lauded by local community and school board members, not taking the long view on how such priorities may shape future citizenry.

Second, school and mental health systems have operated largely in isolation. This silo effect resulted in part from what now are recognized as antiquated misconceptions about mental illness, and its potential for contagion, like polio, within schools. The stigma of mental illness, primarily resulting from lack of understanding, both by communities and even clinicians (who at times postulated that all mental illness was somehow attributable to bad, blameworthy parenting) culminated in families seeking treatment in the privacy of mental health clinics, hospitals, or secluded offices. Not only did this tacitly sustain perceptions that mental health is taboo to discuss publicly, but this *de facto* drove mental health care underground, where only the affluent few, or most seriously mentally ill, would pursue treatment. Perhaps worse, those with serious mental health conditions more often found themselves excluded from school or managed within the juvenile justice system, in yet another system configuration that sustained the stigma of mental illness and impeded early detection and response to mental health symptoms. (This remains prominent, particularly for the poor or those of color, whose behavioral manifestations of emotional and behavioral disorders are criminalized and referred to the justice system for management.)

Third, mental health systems are not facile at navigating delivery systems (and reimbursement for services) within schools, often hindered by reimbursement models that do not recognize schools as sites of service for children (despite schools being the place most frequented by children).

Finally, the impetus for school mental health too often arises in the wake of catastrophes, most recently incidents of mass violence, with an urgency to "make schools safe." In these circumstances, bursts of interest in school mental health often give way to the subsequent concern *du jour*, and investments are typically not well-organized or sustained, often collapsing when grant funding provided in response to the violent incident(s) goes away.

School mental health investments resulting from incidents of violence also present a layer of complexity for the mental health advocacy community; while, on the one hand, funding and attention to mental illness and the role of schools in supporting mental health is welcomed, the potential to further stigmatize mental illness by tying it to violence presents a conundrum. For all these reasons, schools and mental health systems have struggled to consistently develop and sustain adequate supportive and ancillary services (*e.g.,* teacher consultation or student team meetings) essential to quality care in schools.

Creating Comprehensive School Mental Health Systems

The evidence shows that schools enhance both access and quality of mental health supports and services for students while our current community mental health system is inherently limited to supporting those young people most in need of care. The impacts of student (and staff) well-being on student performance have become increasingly vivid and motivating for those committed to school achievement, uncovered through the efforts of researchers examining factors related to academic achievement across all countries (39). Hence, the education sector is primed to accept mental health into their sphere, both as a part of their overall mission to produce healthy and productive citizens, and in their effort to optimize student academic performance.

National school mental health performance standards in the United States emphasize a model of "*Comprehensive School Mental Health Systems (CSMHSs)*" [40, 41]. These CSMHSs provide a full array of *tiered* services, including universal mental health promotion activities for all students, early intervention services for some students with mild impairment or at risk for mental concerns, and treatment for students with severe impairment. CSMHSs rely on collaborative partnerships between school systems and community partners such that mental health supports offered by school-employed mental health professionals (*e.g.,* school psychologists, school social workers, school counselors) are meaningfully augmented by community mental health providers (*e.g.,* community mental health centers, hospitals, and universities). Recent efforts by federal partners, namely the Health Resources and Services Administration (HRSA) and the Substance Abuse Mental Health Services Administration (SAMHSA), in partnership with national, state, and local leaders, have led to guidance from the field on the core components and strategies needed to actualize CSMHSs (41).

Those **core features** of comprehensive school mental health systems include*:

- A full complement of school and district professionals, including specialized instructional support personnel, who are well-trained to support the mental health needs of students in the school setting;
- Collaboration and teaming among students, families, schools, community partners, policymakers, funders, and providers to address the academic, social, emotional. and behavioral needs of all students and the predictable problems of practice in crossing systems and roles;
- A thorough and continuous needs assessment of school and student needs and strengths, coupled with resource mapping of school and community assets, to inform decision-making about needed supports and services;
- A full array of tiered, evidence-based processes, policies. and practices that promotes mental health and reduces the prevalence and severity of mental illness;
- Use of screening and referral as a strategy for early identification and treatment;
- Use of evidence-based and emerging best practices to ensure quality in the services and supports provided to students;
- Use of data to monitor student needs and progress, assess quality of implementation, and evaluate the effectiveness of supports and services; and
- Diverse and leveraged funding and continuous monitoring of new funding opportunities from national/federal, state, and local sources to support a sustainable comprehensive school mental health system.

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Recommendations to Advance Comprehensive School Mental Health Systems

To fully realize schools as a vital component of our system of care for children and adolescents, state education and mental health leadership must collaborate to support local establishment of multi-tiered systems of mental health support in schools, including installation of systematic monitoring of students' social, emotional, and behavioral functioning in schools. To that end, we offer three primary recommendations:

1. Install **multi-tiered systems of mental health supports** in all schools, with adequate funding to support a full continuum of supports and services delivered in partnership by school and community professionals.
2. Conduct **universal mental health monitoring** to support early identification and intervention connected to this multi-tiered system of mental health supports.
3. Seamlessly **coordinate school and community mental health and school systems**.

1. Install multi-tiered systems of mental health supports in all schools.

CSMHSs rely on a public health framework, striving to prevent problems before they become worse, often referred to in the education sector as a multi-tiered system of supports (MTSS). Aligned with tiered academic support models, MTSS for mental health most often employ a three-tiered model, as illustrated in Figure 1. Schools already operate from tiered systems of academic supports, designed to catch academic problems early (or ideally before they occur through screening), and so are well-positioned to implement a tiered framework for mental health.

Tier 1: Universal Mental Health Promotion and Prevention for All Students

Universal services and supports (Tier 1) are mental health-related activities, including promotion of positive social, emotional, and behavioral skills and wellness, designed to *meet the needs of all students regardless of whether they are at risk for mental health problems*. These activities can be implemented school-wide at the grade level and/or at the classroom level. One of the most well-researched and recognized universal mental health examples is the Good Behavior Game. Over 60 studies have reviewed the Good Behavior Game (a 20-minute daily classroom activity to encourage working well as teams, sustaining focus, etc.). Not only does this universal intervention benefit student behavior and achievement during the school year (42), but the positive outcomes persist into adulthood, with lasting effects on young adult behaviors, including lower rates of substance use disorders, delinquency/incarceration, and suicide ideation [43].

Multiple universal mental health promotion and prevention programs involve the promotion of social and emotional competence in all students, teaching of core positive behaviors and relationship skills, and mental health literacy. A solid evidence base exists for the impact of school-based primary prevention (*see* http://www.CASEL.org for a review of model programs). Students engaged in social-emotional learning (SEL) programming demonstrate a significant increase in standardized academic test scores compared to their peers not engaged in SEL training (23). In addition to positive student outcomes, educators trained to implement SEL curricula report lower depression and job-related anxiety (44), higher quality interactions with students (45 , 46), and greater perceived job control than (47) those not trained in SEL.

The importance of these traits for school and life beyond the school years has resulted in 25 states now having learning goals that articulate what students should know and be able to do socially and emotionally, up from only 4 states doing so in 2015. Meta-analyses indicate that students participating in school social-emotional learning programs show significantly greater social-emotional skills, positive self-image, and prosocial behaviors, and significantly fewer

conduct problems, emotional distress, and substance use problems than their peers not exposed to SEL training programs (29, 24).

Tier 2: Selective Mental Health Services for Students At-Risk for Impairing Mental Health Conditions

Mental health early intervention (Tier 2) services and supports, sometimes referred to as mental health *prevention or secondary prevention* services, are strategies designed to address mental health concerns for *students experiencing mild distress or functional impairment or being at risk for a given problem or concern*. Tier 2 interventions include small group therapies for students identified with similar needs, brief individualized counseling/coaching (*e.g.,* motivational interviewing and problem solving), mentoring, and/or low intensity classroom-based supports (*e.g.,* a daily teacher check-in, and/or daily/weekly home-school note system.

School-based prevention and early intervention efforts have been effective in addressing risk factors associated with youth mental health problems, including conduct problems and substance misuse. For example, the *Coping Power Program* has demonstrated success in decreasing aggressive behavior, drug misuse, and delinquency among students identified as at-risk for developing such concerns (48). Evidence is also mounting for selective school-based approaches to support specific populations at greater risk of developing mental health concerns, including refugee students and those from low-income, urban settings (49, 50).

Tier 3: On-Site Mental Health Treatment for Students Impeded by Mental Health Conditions

Indicated (Tier 3) services and supports to address mental health concerns are individualized to meet the unique needs of each *student who is already displaying a concern or problem and displaying significant functional impairment*. Sometimes these are referred to as mental health "intervention" or "tertiary" or intensive services.

Much effort is spent focused at the Tier 3 end of our child mental health system of care. Young people with the most complex and intensive needs place the highest burden on child and family quality of life and on system resources. School mental health is not a substitute for high-quality, intensive care that may be necessary for youth with significant mental illness. However, adequate resourcing of a full continuum of mental health supports in schools may, in fact, reduce the need for increasing expenditures in intensive services.

Treatment interventions delivered in schools effectively reduce the impacts of mental illness. School-based interventions for internalizing disorders have demonstrated improvements in students' anxiety and depression (28, 37), while treatments for child and adolescent post-traumatic stress delivered in schools have shown decreases in traumatic stress, anxiety, and depressive symptoms (30, 31). Tier 3 services in schools have also been effective in treating behavior disorders (33,34) and substance use problems (35, 36). While comparable in effectiveness to community-based treatments, school-based treatments are likely to reach more youth because of greater accessibility and higher attendance (12). The *extent* to which mental health supports are integrated into the school setting and curriculum predicts positive implementation (10).

School-Community Partnerships

To leverage the resources and expertise of both school and community professionals, MTSS efforts rely on partnerships with community mental health providers. These partnerships should be aligned around common goals, usually improved interpersonal functioning and classroom behavior, and academic success. Community partners can augment services within the school building, support mental health with administrators and staff, and link students to other services and supports in the community. Successful and sustainable school mental health systems integrate mental health partners to complement the mental health supports and services offered by districts and schools. In many schools, community partners are integrated across all tiers of support, but are primarily involved in more intensive treatment supports for youth with identified mental health challenges.

Funding

Ultimately, comprehensive school mental health systems will only succeed when political and societal will is matched by a level of resource allocation that supports a sustainable delivery system. Federal funding streams to expand school mental health efforts are helpful to seed state and local efforts, but unreliable in sustaining programs on their own. Although Medicaid reimbursement remains a critical source of funding for school mental health systems, state budgets (which vary widely) represent the largest share of funding for school mental health programming. To achieve a fully resourced system of care for children, state leadership from all child-serving sectors must commit to engaging education as a partner, including identifying funding to support a full continuum of school mental health supports and services, in seamless coordination with community mental health providers.

2. Conduct universal mental health monitoring for all students

Reducing the incidence of mental illness through screening and early intervention not only improves quality of life for those starting to experience mental health impairments, but also more effectively reduces the fiscal burden of mental health conditions (51, 52). The more a student deteriorates, the more that limited resources are needed, both in density (more staff) and intensity (more staff time). This economic burden immediately costs school districts more to educate struggling students (as well as their family members, whose mental health conditions may also spill over to deleterious impacts on their children) and later takes an economic toll on the community, in service costs as well as lost productivity (22).
Schools have engaged in health screening of students for over a century, initially for vision and hearing, so such practices are familiar and feasible for schools to provide. Mental health screening requires two fundamental practices to be helpful and effective in schools:

A. Screening needs to be re-conceptualized as ongoing mental health *monitoring*, where identification of mental health problems moves beyond one-time screenings to instead involve a continuous monitoring of students. While screening measures may be used at various points in one's school career, such screening is better intended to attune students and staff to the symptoms of mental health conditions than to detect the incidence or prevalence of mental health disorders within a school's population. Embedding mental health literacy into both the

curriculum for students and staff training are a significant stride forward beyond the use of a screening measure. Several specific steps can be helpful in this process:

- Students should be taught mental health literacy in the classroom continuously across the curriculum and at all grade levels (*i.e.,* what is positive mental health, how to recognize psychological distress and disorders, and how to seek help for self and others). Multiple states (*e.g.,* Florida, New York, Virginia) have recently mandated the inclusion of mental health literacy in their school curriculum. For example, New York has devised a guide recognizing four key mental health literacy components (53): 1) Understanding how to obtain and maintain good mental health; 2) Decreasing stigma related to mental health; 3) Enhancing help-seeking efficacy (knowing when, where, and how to obtain good health with skills to promote self-care); and 4) Understanding mental disorders (*i.e.,* anxiety and depression) and treatments.

- Students should engage in frequent "well-being check-ups" to identify any concerns. This model is being implemented in the Los Angeles Unified School District, where parents are asked to provide active consent for their children to engage in a social-emotional well-being curriculum that includes wellness check-ups.

- Teachers should be trained how to continuously monitor student mental health, including training on cultural and linguistic understanding and expressions of mental health and illness, and they should be provided tools for approaching and referring students for additional supports, as needed.

B. Screening should be broadened from focusing on psychopathology to instead focus on a "*dual-continua*" model of mental health (54, 55). Sometimes referred to as "complete mental health," this dual model assesses for symptoms of psychological distress *and* the experiences of positive affective experiences and a generalized satisfaction with life. School-based screening until now has been incomplete, focusing almost exclusively on risk factors or symptoms of mental distress (56, 57) and not including items that assess complete mental health (58). Students with higher levels of strengths and lower levels of distress report better quality of life, academic performance, and higher life satisfaction. Moreover, students with complete mental health (high social well-being and low psychopathology) report better outcomes than do vulnerable students (low social well-being despite low psychopathology) (54). Students who report low life satisfaction also report the lowest sense of school belonging compared to their peers, regardless of psychological distress level (59).

Student subjective well-being predicts multiple specific problem behaviors, including antisocial behaviors, alcohol use, tobacco use, suicidal tendencies, bad nutritional habits, and dropping out of school (60). Instruments have recently been devised to assess the dual-continuum approach (*e.g.,* Behavioral and Emotional Screening System [BESS] Social-Emotional Health Survey [SEHS]), which position schools to triage students by assessing both their mental health risk symptom *and* their strengths (*e.g.,* the highest priority group score high on BESS and low on SEHS) (61, 62).

Significant implementation planning is required for any student mental health monitoring, including how parents and families will participate in the process (*e.g.,* prioritizing what to assess at different student ages, description of monitoring to students and parents, and how the school and community providers will respond to positive, or concerning, monitoring findings), what instrument(s) to use, and how to configure appropriate and timely follow-up. Table 1 describes frequent concerns about school mental health screening and monitoring as well as strategies to address these challenges.

A recent "playbook" on school mental health screening published by the National Center for School Mental Health reviewed best practices for the screening implementation process (63). Beyond choosing psychometrically sound and feasible measures, the playbook emphasizes the importance of consent and assent procedures, describing options for both active and passive (or "opt out") parental consent. Family engagement can be facilitated by sharing screening information in multiple formats, including automated phone calls to all families, information on the school website, written notification, and signage in the school building. Prior to initiating screening, a triage system should be put in place that includes guidelines for referring students to in-school or community services depending on identified need, and timelines for addressing needs based on level of severity (with protocols for responding to urgent needs immediately).

3. Seamlessly coordinate school and community mental health systems

The purpose of advancing school mental health as a vital component of the children's mental health system is not to dissuade contemporary community mental health for children; rather, children's mental health concerns are simply much more likely to be recognized and addressed in school settings than in the community. In addition, parents understandably often wrestle with the implications of taking their child to current community mental health settings. The ambivalence of parents ("Will I be reported as a bad parent? Am I an inadequate parent? Is my child really in that much of a need? How will I take time off for the available appointment times?") suggests the community mental health center model may not be the optimal site for early identification and intervention. Compared to other community mental health settings, schools can much more easily provide mental health promotion, ongoing progress monitoring, and interventions for specific issues impeding a child's progress, while minimizing logistical barriers.

Schools cannot bear the burden of children's mental health alone, and community mental health still has an important role in supporting child and adolescent mental health. Students with complex and intensive mental illness or those whose families would prefer accessing services outside of the education sector may still benefit from more traditional models of community mental health. Students who present with behaviors that threaten the safety of themselves or others in the school environment may also best be managed in a non-school setting, at least until their behaviors resolve.

However, our historical approach to isolating mental health care in a community mental health center, separated from students' educational experiences, does not reflect a "whole child" approach that coordinates all child-serving systems in working toward mutual goals. In fact, when students' educational needs are not addressed while in more intensive psychiatric care in

the community, they are more likely to struggle when they return to school and be readmitted to inpatient care (64). Too many children with psychopathology are still managed initially and primarily in the juvenile justice or child welfare systems, calling for coordination across all child sectors, not just education and mental health.

The current need is to align these different locations of children's services to optimize identification and coordination of care, particularly in early recognition of mental health symptoms and using all available locations to cultivate strengths to diminish the impacts of those symptoms. Moving children back into the least restrictive settings to widen social, career, and academic opportunities favors schools being "at the table" whenever a child is being served by other systems, including juvenile justice, child welfare, or intensive psychiatric care. Community mental health remains the hub of mental health delivery for adults, and therefore strategic planning must account for the transition of students receiving school mental health supports once they graduate and are likely to move to community-based supports. Ultimately, coordination is best achieved when all systems are actively engaged in a process of defining roles and responsibilities and aligning supports and services to promote efficiencies, avoid redundancy, and promote quality care.

State/Provincial Examples of Advancing School Mental Health

Across the United States and internationally there exist many exemplars for moving toward comprehensive school mental health. Table 2 provides a few such exemplars to illustrate the diverse strategies being employed to develop and sustain effective integration of mental health into education systems. These range from locally-driven statewide learning communities to innovative statewide funding strategies and may be generalized to other communities seeking to advance school mental health.

Conclusion

Young people spend approximately 15,000 hours in schools by age 18, so schools are, *de facto*, a significant partner, invested daily in cultivating each child's social-emotional health and skills for coping with stress and adversity. Schools are a vital component of the mental health system for ensuring *all* our nation's youth have access to a comprehensive array of mental health supports and remedying many of the limitations of existing mental health systems that are not truly accessible for too many students. Federal, state and local investments in school mental health acknowledge this potential, with MTSS now a regular part of the dialogue among educators.

A systematic and streamlined partnership between schools and communities to support a full continuum of mental health supports in schools can lead to better mental health for all students and increased access, earlier identification and intervention, and ultimately better outcomes for those students with mental health challenges. This approach embraces natural supports for students, includes families and educators as team partners for children, and demands less from a mental health system with a limited children's mental health workforce and limited resources.
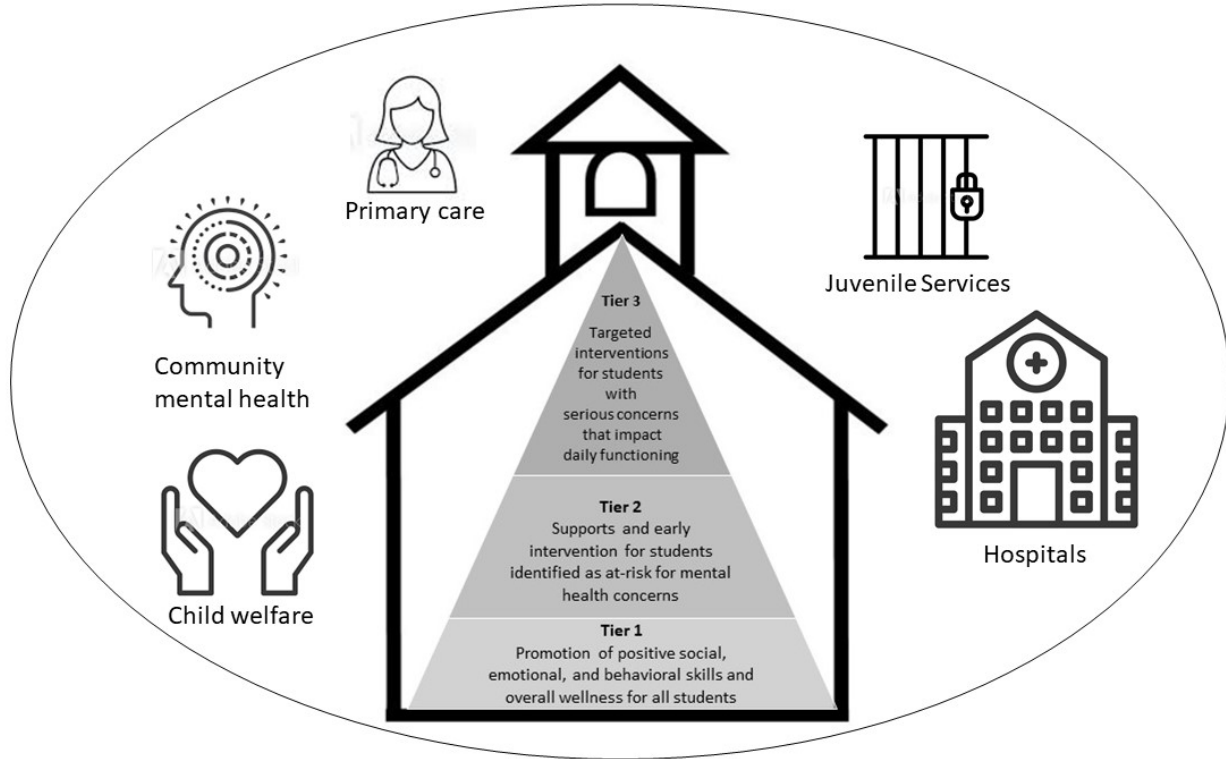
Figure 1.

Table 1. Frequent concerns about school mental health screening and monitoring and strategies to address these

Frequent screening/monitoring concerns	Strategies to address concerns
Mental health is a family/personal concern, not a school concern	- mental health impacts academic success - student and family input will shape implementation
Measurement error – e.g., "false positives"	- utilize psychometrically sound measures to identify problems early - multi-gated procedure produces more accurate findings - continuous monitoring (instead of one-and-done screening) - measure impact on functioning beyond symptomatology
Inadequate staffing and resources	- start small (limit number of students screened, scope of screening target) - leverage school and community resources and staffing - use no-cost/low-cost tools - cost benefits of early identification/intervention
Disagreement among reporters	collect information from multiple reporters, resolve discrepancies
Privacy of information and data	- develop consent/assent process that allows students and families to opt in or out - address concerns about data privacy (e.g., HIPAA, FERPA)
Stigma of mental illness/labeling	- mental health literacy for students, families and school staff to decrease stigma and promote help-seeking - address student and family concerns about how findings will be used - assess student strengths and assets to avoid pathologizing and negative impact of labeling

Table 2. State/Provincial examples of school mental health innovations

State/Province	Innovation	Details
Wisconsin	Leveraging federal funding to establish state school mental health framework	• Three large-scale grants awarded in 2014: Safe Schools/Healthy Students, Project AWARE and School Climate Transformation • Adoption of State School Mental Health Framework • Establishment of State and Community Management Teams to carry out efforts • Braided funding from these to engage 100+ schools in professional development, technical assistance and coaching https://dpi.wi.gov/sspw/mental-health or www.schoolmentalhealthwisconsin.org/
Massachusetts	Locally-driven statewide school mental health consortium to enhance shared learning and networking across districts	• Initiated by Director of School Counseling in one local district • Relied on a "Community of Practice" framework to develop a rapidly evolving network of local school districts, all interested in joining a community focused on improving school mental health quality • Member districts voluntarily participate based on their recognition of the growing mental health and substance use needs of students • Promotes shared learning, collaboration and consultation between districts • Gained support from state education and behavioral health agency leadership http://www.methuen.k12.ma.us/departments/special-education/guidance/massachusetts-school-mental-health-consortium-masmhc
Minnesota	Using local school mental health impact data to compel state government and Medicaid leaders to fund statewide school mental health	• Local district demonstrated success of community-partnered school mental health efforts through systematic data collection and dissemination • Local success led state legislature to fund state infrastructure grants that now support school-linked mental health services throughout state • Partnered with state Medicaid leadership to amend Medicaid state plan to provide reimbursement for ancillary mental health supports in school (e.g., teacher consultation, school team meetings) • Starting in 2018, $4.9 million in School Innovation Grants awarded to five districts over

		two years to improve student mental health, including returning students to home school district and reversing disproportionate impact on students of color
Ontario	Provincial school mental health implementation support entity funded by Ministry of Education	• Provincial implementation support team designed to support all Ontario school boards (districts) to promote student mental health and well-being using evidence-based approaches • Infuse implementation science into local school mental health efforts via Mental Health Leadership Team, offering direct support to local boards through ongoing coaching and resources • Support scaling up of evidence-based, multi-tiered mental health supports and services via ACQESS framework, emphasizing **A**lignment, **C**onsistency, **Q**uality, **E**ngagement, **S**calability and **S**ustainability https://smh-assist.ca/
Maryland	Building school mental health infrastructure, training and implementation support into state school safety budget	Passage of the 2018 Safe to Learn Act included mandates and funding to support: • Within all local school districts, appointment of mental health services coordinators to develop plans and maximize funds for mental health and wraparound services and ensure students referred for mental services receive care • Grants from Safe Schools Fund may be used to develop plans and provider training to deliver school mental health services https://www.safeschoolsmd.org/

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