Report of the Expert Panel

School-Based Behavioral Health Workforce Development

Mental Health—Education Integration Consortium

Submitted to

THE ANNAPOLIS COALITION ON THE BEHAVIORAL HEALTH WORKFORCE

Senior Advisors: Carl Paternite, Ph.D.
Mark Weist, Ph.D.
Report Date: January 17, 2006

Panel Report on School Mental Health Workforce Issues

Carl E. Paternite, Mark D. Weist, Jennifer Axelrod,
Dawn Anderson-Butcher, and Karen Weston

(written on behalf of the Mental Health—Education Integration Consortium)

January 17, 2006

Section I: Planning Process for the School Mental Health Content Area

History of the Mental Health—Education Integration Consortium

The Mental Health—Education Integration Consortium (MHEDIC), a 20-member, multidisciplinary group, is serving as a *school mental health* (SMH) expert panel for the Annapolis Coalition. MHEDIC emerged from a *critical issues* planning meeting, convened in May 2002 by the Center for School Mental Health Assistance (now the Center for School Mental Health Analysis and Action) at the University of Maryland (http://csmha.umaryland.edu). The one-day meeting focused on: 1) the realities of providing mental health supports in the educational system, and 2) the training needs of both SMH providers and educators to more effectively address the unmet mental health needs of students. This meeting served as a springboard for the formation of MHEDIC (9 of the 20 current MHEDIC members were participants in the 2002 critical issues meeting). The work of MHEDIC evolved initially through a series of conference calls, e-mail exchanges, and face-to-face meetings at the CSMHA-sponsored annual school-based mental health national conferences (Philadelphia, 2002; Portland OR, 2003; Dallas, 2004), with membership expanding strategically since 2002.

Currently, the membership of MHEDIC reflects a broad range of disciplinary backgrounds, including representatives from clinical psychology, school psychology, social work, school health, public health, child psychiatry, teacher education, educational leadership,

mental health administration, and educational administration (see Appendix A). However, MHEDIC does not intend to represent the official views or positions of any professional organization regarding workforce preparation or deployment issues. The consortium is co-facilitated by three of its members: Carl E. Paternite (Center for School-Based Mental Health Programs [CSBMHP] and Department of Psychology, Miami University), Robert Burke (Department of Teacher Education, Miami University), and Jennifer Axelrod (Collaborative for Academic, Social, and Emotional Learning [CASEL]). MHEDIC's mission is described below. Goals associated with this mission are detailed at the MHEDIC website (http://www.units.muohio.edu/csbmhp/mhedic/index.html).

> ***MHEDIC Mission*:** **The mission of the Mental Health—Education Integration Consortium is to advance a systematic and emergent agenda that promotes the mental health professional preparation of educators and all other school personnel at all levels [pre-service, graduate, and in-service] as well as the professional preparation of mental health clinicians in understanding and working in educational environments. In addition, the mission includes effort towards promoting the integration of education and mental health systems as well as effective school-based mental health programs.**

Overview of MHEDIC Activities Addressing Workforce Issues

MHEDIC members have collaboratively undertaken an extensive array of activities related to the consortium's emergent mission and goals (see Appendix B for MHEDIC's vita of representative recent presentations and publications). In addition, since 2002 MHEDIC has organized a training track that addresses mental health—education systems integration and workforce preparation issues, with these presentations being among the most widely attended at the annual CSMHA-sponsored school mental health conference.

In December 2003, six MHEDIC representatives participated in a summit facilitated by the Center for the Advancement of Children's Mental Health at Columbia University that brought together over 50 experts in SMH research, policy, and advocacy. The goals of the

summit included: 1) identifying obstacles to the implementation of evidence-based SMH programs, and 2) reaching consensus about effective strategies to overcome these obstacles. As an outgrowth of that Summit, the participants formed the School Mental Health Alliance (SMHA) to help move the Summit recommendations forward. With funding from the Lowenstein and Klingenstein Foundations, five SMHA workgroups were formed in 2004. MHEDIC co-facilitator Paternite is chairing the workgroup on Educator Training, and several other MHEDIC members are participating. One product of this workgroup will be a report on the mental health-related education and training needs of educators in schools, as well as recommendations regarding curricula, training, and credentialing. We believe the report produced by the Educator Training workgroup will be a valuable companion document to the current report for the Annapolis Coalition focusing on mental health provider training needs to work effectively in schools.

Coinciding with the SMHA collaboration, MHEDIC efforts to develop a workforce training agenda (training models, curricula, and processes) have been enhanced through a planning grant awarded by the Ohio Department of Mental Health, along with additional support provided by the IDEA Partnership. The IDEA Partnership, which is funded through the Research to Practice Division of the federal Office of Special Education Programs (OSEP), is dedicated to improving outcomes for students with disabilities, by joining federal and state agencies and stakeholders through shared, collaborative transformative learning and work. MHEDIC is working with the IDEA Partnership by contributing to a national dialogue about mental health—education integration and related workforce preparation issues. Most recently MHEDIC has agreed to work with the Center for School Mental Health Analysis and Action (CSMHA) by conducting and disseminating policy analyses on SMH workforce issues and on the promotion of

family, education and mental health systems integration. As a CSMHA-funded partner, MHEDIC has made a commitment to develop and disseminate a minimum of one policy brief per year, with the first brief on *Enhancing Teacher Education, Training and Support to Foster Mental Health in Schools* disseminated by July 2006.

To facilitate the above noted work and other ongoing initiatives of MHEDIC, two 2-day work sessions have been convened at Miami University within the last 13 months (December 11-12, 2004 with 14 members; and July 15-16, 2005 with 13 members). The next 2-day work session of MHEDIC will take place in February 2006. Shortly before the July meeting, MHEDIC was asked to serve as a *school mental health* expert panel for the Annapolis Coalition. During the July meeting, and in subsequent e-mail and phone consultations, significant attention has been directed to the request from the Annapolis Coalition to specifically address recommendations regarding the professional training and preparation of the behavioral health workforce involved in schools. The content in this report is derived from themes and recommendations that have emerged over the past several years in the context of all of the collaborative activities described above, including careful review of the extant research literature on workforce preparation/training issues pertinent to SMH practices.

A preliminary draft of MHEDIC's expert panel report was prepared for discussion at the Annapolis Coalition's senior advisors meeting on September 13-14, 2005; and at the same time the draft was distributed to the MHEDIC expert panel for additional review and comment. Two additional MHEDIC conference calls were convened in late September 2005 to work on revisions to the preliminary draft, and a revised report was submitted to the Annapolis Coalition

on October 15, 2005. Based on feedback that was received subsequent to the October 15th submission the current report was further revised.[1]

Section II: Overview of School Mental Health Workforce Issues

Context: The School Mental Health Imperative

The President's New Freedom Commission (2003) concluded that improvement and expansion of school mental health (SMH) programs are essential to transforming mental health care for children and youth in America—a conclusion that is echoed by other significant federal and national reports (e.g., American Academy of Pediatrics Committee on School Health, 2004; National Institute of Mental Health, 2001; U.S. Department of Health and Human Services, 1999, 2000). The New Freedom Commission noted that schools offer unparalleled access as points of engagement with youth to address their interrelated academic *and* mental health needs (see www.mentalhealthcommission.gov; Huang et al., 2005). In addition to enhancing access to treatment for youth (Weist, Meyers, Hastings, Ghuman, & Ham, 1999), SMH programs and services also can:

- reduce the stigma of help seeking (Nabors & Reynolds, 2000);
- promote generalization and maintenance of treatment gains (Evans, 1999);

---

[1] During October-December, 2005 feedback on the October 15th report was received from official representatives of the National Association of School Psychologists (NASP), the School Social Work Association of American (SSWAA), and the American Counseling Association (ACA). The information from the NASP and SSWAA representatives included letters summarizing their feedback, phone and in person consultations, and recommended revisions submitted via the "track changes" feature of MS Word. The feedback from ACA consisted of an informative letter summarizing feedback and recommended revisions. All of this feedback was thoroughly considered by the MHEDIC writing team (Drs. Paternite and Weist [clinical psychologists], Axelrod [school psychologist], Anderson-Butcher [social worker], and Weston [educational psychologist]) in preparing this newly revised version of the report. Many of the suggested revisions have been incorporated into this revised report. We would like to acknowledge, with gratitude, the thoughtful feedback received from Ted Feinberg, NASP; Judith Shine, Myrna Mandlawitz, and Randy Fisher, SSWAA; and Patricia Arrendondo, ACA.

- enhance capacity for prevention and mental health promotion (Elias, Gager, & Leon, 1997; Weare, 2000);
- foster clinical efficiency and productivity (Flaherty & Weist, 1999); and
- promote a natural, ecologically grounded approach to helping children and families (Atkins, Adil, Jackson, McKay, & Bell, 2001).

Further, effective SMH practices offer significant potential to substantially address the mandates of the reauthorized 2002 Elementary and Secondary Education Act (No Child Left Behind, 2002) and the recently reauthorized Individuals with Disabilities Education Act (Individuals with Disabilities Education and Improvement Act) (Huang et al., 2005; School Mental Health Alliance, 2005; Weist et al., 2005; Weist & Paternite, in press). In this regard, there is compelling evidence not only that there are strong positive associations between mental health and academic success, but also that mental health problems are *significant* barriers to learning (e.g., Adelman & Taylor, 1999, 2000; Atkins, Frazier, Adil, & Talbott, 2003; Bishop et al., 2004; Catalano, Haggerty, Oesterle, Fleming, & Hawkins, 2004; Klern & Connell, 2004; Libbey, 2004; McNeely & Falci, 2004; Weist, 1997; and Wilson, 2004).

School mental health programs and services, *when done well*, are associated with strong satisfaction by diverse stakeholder groups, improvement in student emotional and behavioral functioning, and improvements in school outcomes; for example, enhanced climate and student connectedness to school, improved attendance, fewer inappropriate referrals into special education, reduced bullying and violence, and reduced school suspensions (see Atkins, Graczyk, Frazier, & Abdul-Adil, 2003; Evans, Langberg, Raggi, Allen, & Buvinger, in press; Han, Catron, Weiss, & Marciel, 2005; Masia-Warner, Klein, Dent, Fisher, Alvir, Albano, et al., 2005; Owens,

Richerson, Beilstein, Crane, Murphy, & Vancouver, in press; Stormshak, Dishion, Light, & Yasui, 2005; Weist et al., 2005; Weist & Paternite, in press).

In addition to findings noted above, compelling epidemiological data provides a strong basis for asserting this *School Mental Health Imperative* (cf. Adelsheim, Jennings & Weist, 2002; Weist, 1997; Weist, Paternite & Adelsheim, 2005). Namely,

- between 20% and 38% of youth in the United States (U.S.) have diagnosable mental health disorders, and 9-13% of youth have serious disturbances (Goodman et al., 1997; Grunbaum et al., 2004; Marsh, 2004). In addition, many more youth are at risk or could benefit from help;
- as few as one-sixth to one-third of youth with diagnosable disorders receive any treatment, and, of those who do, far less than half receive adequate treatment (Burns et al., 1995; Leaf et al., 1996; Weisz, 2004); and
- for the small percentage of youth who do receive services, most actually receive them within a school setting (Rones & Hoagwood, 2000; U.S. Department of Health and Human Services, 1999, 2001).

All of the above noted findings provide support for a *School Mental Health Imperative,* by raising questions about the insufficiency of the mental health field's commitment to the delivery of ecologically sensitive and effective services, and by reinforcing the importance of a comprehensive school—community continuum of mental health promotion and intervention for all youth, with schools serving as a key setting for mental health education, problem prevention, and intervention programs and services.

The idea of developing a comprehensive continuum of mental health supports for children in U.S. public schools dates back to the early 20th century (see Flaherty & Osher, 2003).

However, recent dramatic growth of SMH programs and services has been spurred by increasing recognition of the findings and reports summarized above.

School mental health services have been delivered in a variety of forms (Weist, Evans & Lever, 2003), and there is not an explicit "best practice" model. However, the term *expanded school mental health* (Weist, 1997; Weist et al., 2005) describes programs and services that incorporate key elements reflected in the recommendations of the New Freedom Commission (2003). These elements include:

- family-school-community agency partnerships, involving close collaboration between school-employed mental health staff and community-employed mental health professionals working in schools;
- commitment to a continuum of mental health education, promotion, assessment, problem prevention, early intervention and treatment; and
- services for youth in general and special education.

Expanded conveys augmenting the programs and services that exist in most schools, including the expertise and work of school-employed mental health staff (e.g., school psychologists, social workers, counselors, school nurses, and teachers with behavioral intervention skills) to provide the full continuum of social and emotional supports for children, youth, and families. Given the tremendous need for mental health services and the established issues with traditional models of mental health service provision, it is critical to develop innovative methods to meet the mental health needs of children and youth. Expanded school mental health programs attempt to address these issues (e.g., long wait-times for appointments in agencies, very high student to staff ratios for school-employed mental health professionals, students only receiving supports once their mental health needs have become significant enough

to allow them entrance into the mental health system or the special education system) by braiding together agency, school, and community supports. Much has been documented to provide guidance for enhancing these linkages. Specifically, collaborative strategies for SMH programs and services have been documented in “Full-Service School” models (American Psychological Association, 1994; Dryfoos, 1994; Dryfoos and Maguire, 2002; Flaspohler, Anderson-Butcher, Paternite, Weist & Wandersman, 2006; Marx, Wooley & Northrop, 1998; NASP, 2002). Such models focus on linking school and community agencies (including health and mental health) in order to provide comprehensive services to children and families. In this context and through effective partnering with and leadership by school-employed mental health staff, community agency-employed mental health professionals move beyond a limited “co-location” approach to develop real interdisciplinary collaboration with SMH staff, educators, education leaders, and youth and families, and meaningful integration into the school community. The impact of these types of partnerships is documented in the literature. Specifically,

> research shows that collaborative efforts improve working relationships between schools and community mental health, juvenile justice, and other child-serving agencies and result in improved outcomes for children and their families. In addition to improved service delivery, streamlining of services through collaboration avoids duplication, provides for a continuum of service delivery options, and is cost effective. (NASP, 2002, p. 1)

The successes of these collaborative efforts between agency- and school-employed staff are predicated on a recognition of the unique and complementary nature of the differing training and professional preparation of the providers which, when combined, create a whole that is

larger than the sum of the parts. These combined resources of school- and agency-employed staff establish a "continuum of care" that significantly strengthens the available services and delivery mechanisms for children, youth and families. Furthermore, expanded school mental health programs explicitly acknowledge that family engagement is essential and that additional critical elements include empirically supported practice, ongoing quality assessment and improvement, knowledge of school system dynamics, and culturally competent services.

School Mental Health Workforce Issues

Historically, SMH programs and staff (e.g., social workers, psychologists, counselors), especially those entering the school from the community, often have been considered by educators to be "add ons" (Sedlak, 1997; Paternite, 2004; Paternite & Johnston, 2005; School Mental Health Alliance, 2005). The seeming incompatibility between the "nonacademic" interests of mental health providers and the "academic" interests of educators has resulted, at best, in uneasy cooperation (Staup, 1999). In order for mental health providers and educators to effectively serve students with emotional and behavioral needs and their families, to enable these students to succeed in school, and to successfully promote the interrelated mental health and school success for all students, all professionals must collaborate in the provision of best practices in their fields. To collaborate meaningfully, however, will require frank examination of current practices, and re-appraisal and pertinent re-design of the training and professional preparation of both educators and mental health providers. Well-trained school-employed mental health staff, such as school psychologists, school social workers, and school counselors, can be a valuable resource in conceptualization of such re-design because their "best practice" training models focus quite specifically on the delicate relationship between student academic and mental health needs (e.g., for school psychology see Thomas & Grimes, 2002). Maximizing the benefits

of SMH programs and services will require mental health and education professionals skilled in a specific set of competencies that include a strong cross-discipline knowledge, skill, and ability base to guide practice, as well as interdisciplinary communication, collaboration, and consultation skills uniquely demanded of professionals working in our nation's schools. It is this set of competencies that MHEDIC, and other groups, are seeking to define, operationalize, and bring to the mental health and education workforce.

Integration of the fields of mental health and education, in the context of SMH programs and services, while making intuitive sense, has been problematic both at the training and practice levels. Barriers include limited pre-service and in-service training expectations and curricula, different and at times confusing credentialing requirements, professional jargon and distinct disciplinary heritages, the continuing perception that mental health and education are distinctly different fields, and a wide range of logistic and financial issues (e.g., differing confidentiality standards and statutes, work schedules, conditions for employment, constraints of funding) that make collaboration very difficult in everyday practice (Doll, 1996; Weist & Paternite, in press). In the following, we review two overarching themes most relevant to the improvement of workforce training for mental health providers working in schools. (As mentioned, workforce issues related to education staff are being addressed in a complementary report by MHEDIC for the School Mental Health Alliance):

Theme 1: Interdisciplinary Practice, Effective Collaboration, and Standards of Practice in School Mental Health

Interdisciplinary practice and effective collaboration. The training of clinical and counseling psychologists, clinical social workers, child and adolescent psychiatrists, and alcohol/drug counselors, in contrast to the training of many traditional school-employed mental

health professionals (e.g., school psychologists, school social workers, school counselors) generally does not emphasize learning to work effectively in schools or with education professionals. As a result, evidence indicates that this lack is associated with ineffective SMH practices (see Paternite & Johnston, 2005; Waxman, Weist & Benson, 1999), due to poor knowledge and appreciation of school culture and education laws and regulations (e.g., the Individuals with Disabilities Education and Improvement Act), and a failure to integrate mental health issues, needs, and services in school terms. Specifically, in schools terms, the provision of SMH services is best viewed as a means to an end, and not an end in itself. Such services should support the primary educational mission of the schools. That mission takes precedence over health and mental health issues in their own right. Mental health professionals entering schools from the community must, but often fail to, recognize that it is the academic and functional implications of their services that are of primary interest to educational professionals. For instance, such mental health providers collaborating with educators to develop integrated approaches to reduce both academic and nonacademic (mental health) barriers to learning often are biased toward measurement of emotional/behavioral outcomes. As a result they seldom consider measuring educational outcomes of **most** interest to school administrators and families (e.g., school attendance, academic performance, school behavior) (see Collaborative for Academic, Social, and Emotional Learning [CASEL], 2003; Rones & Hoagwood, 2000; Zins, Weissberg, Wang & Walberg, 2004; Weist & Paternite, in press).

An example of attending to the academic and functional implications of SMH services helps to clarify the issue raised above. Within the accountability structure and mandates of *No Child Left Behind*, schools are required to demonstrate Adequate Yearly Progress (AYP) on measures of academic achievement administered to all students, including students receiving

special education services. Failure to make AYP places a school in jeopardy of losing its autonomy and its students, who then take with them the state subsidy money when they transfer to a different school. This failure might also result in punitive withdrawal of funds not related to student attrition. Adequate Yearly Progress scores of students receiving special education services, as a group, must be presented in disaggregated form; they cannot be folded in with data from other students. Students with serious emotional disturbances typically qualify for special education services under the emotional disturbances (ED) category of IDEA. School mental health providers often offer "related services" to help these students succeed in school, which, in turn, helps schools make AYP. However, approximately 50% of students in the ED category drop out of school, the highest dropout rate of any disability group (U.S. Department of Education, 2001).

Part of the reason for dropout is that these students often require accommodations by general education classroom teachers who typically have little training and/or preparation in how to meet their emotional/behavioral and learning needs, or how to structure appropriate academic environments so that they can learn in the least restrictive educational setting. Without regular and timely consultation with SMH providers appropriately trained on *academic issues*, teachers often fail to facilitate meaningful learning for ED-designated students, the students often become behavior problems in the classroom, and the schools, fearful of their AYP standing, look for opportunities to remove these students from the school. Without adequate training on how to help teachers and other school staff accommodate to meet the *learning needs* of these students, SMH providers also will fail to meet the *emotional and behavioral needs* of students whom they are treating. Thus, for effective practice in schools all mental health providers should be trained

in understanding developmentally appropriate and culturally sensitive learning strategies for students with emotional and behavioral needs.

School psychologists, school social workers and school counselors, should, for many reasons, be leaders in efforts to train other mental health providers in how to work effectively in schools. These school-based professionals, and others such as school nurses, typically are on the front line in supporting students with emotional and behavioral needs to improve their access to learning, educational success, and social/emotional health. At the national level, school psychology, school social work, and counseling leaders, scholars, and practitioners have independently designed training and professional practice standards that have been shaping provision of services by their respective professions in schools for many years (e.g., Professional Conduct Manual, Principles for Professional Ethics, and Guidelines for the Provision of School Psychological Services, NASP, 2000a; Standards for Training and Field Placement Programs in School Psychology and Standards for the Credentialing of School Psychologists, NASP, 2000b; NASW Standards for School Social Work Services, National Association of Social Workers, 2002; Standards, Council for Accreditation of Counseling and Related Educational Programs, 2001; and School Counseling Standards, National Board for Professional Teaching Standards, 2002). Nonetheless, the ability of these professionals to fulfill a leadership role in *expanded school mental health*, in training of other mental health providers in how to work effectively in schools, and in promoting interdisciplinary practice and effective collaboration is hampered partially because of current job roles and responsibilities. In large part this is due to glaringly high staffing ratios that typically far exceed the recommended ratios of their national organizations, contributing to significant position-related constraints on role functioning. For example, in many school districts school psychologists typically spend a lot of their time in

assessment related functions for students in or being referred for special education services. The time demands of providing these services may mitigate against other involvements such as mental health promotion and problem prevention activities, or individual, family and group interventions. Efforts of school psychology, as a field, to move beyond roles that primarily emphasize assessment have been challenging. In a similar way, school counseling as a field has been struggling to move beyond role definition that emphasizes academic advisement (see Power, DuPaul, Shapiro, & Kazak, 2003; Rappaport, Osher, Garrison, Anderson-Ketchmark, & Dwyer, 2003; Weist, 2003). However, it should be noted that progress in these fields is being made reflecting the strong goal of professional organizations representing school-employed mental health professionals that they be involved in the full continuum of effective school mental health promotion and intervention.

Thus, assuring that *all* mental health professionals who work in and with schools share a common knowledge base and an equal commitment to the provision of a full continuum of mental health services will require an integrated approach on multiple levels. It also will require interdisciplinary training opportunities reflecting a shared vision in which the child serving systems and different disciplines work together, actively guided by families, youth and school and community leaders (see Lever et al., 2003).

Standards of practice. Related to the above workforce preparation needs, SMH staff from diverse disciplines often have different standards of practice. School psychologists and school social workers typically receive licensure or certification to practice in schools, whereas clinical and counseling psychologists and clinical social workers are licensed to practice in the community. In general, certification, licensure, and practice standards across these various professions are not well integrated. For example, in some states community providers can

practice in schools under their professional licenses, which do not assure adequate training to work in school settings (see Adelsheim, 2004; Rappaport et al., 2003; Waxman et al., 1999). These differing standards in many cases do not reflect the reality that the functions of various disciplines are blurring together. For example, school psychologists are practicing in community and clinical settings; clinical and counseling psychologists are working in schools; and all mental health providers working in schools are increasingly involved in case management and outreach in the community, traditionally the emphasis of social work (Weist, Ambrose, & Lewis, in press). Thus, there is a need for clear standards of practice, which specify common areas of competency and functioning for all SMH providers of different disciplines, as well as areas of distinct competency and functioning. These standards then could logically inform and structure a meaningful certification process for advanced interdisciplinary mental health practice in schools; certainly not to supplant existing certification standards and processes for specific disciplines (e.g., school psychologists, social workers, and counselors), but to enhance interdisciplinary practice and effective collaboration among *all* SMH and educational practitioners.

Theme 2: Quality Assessment/Improvement and Evidence-Based School Mental Health Practices

Quality assessment and improvement in school mental health programs and services. Ongoing quality assessment and improvement (QAI) within SMH programs is essential in order to inform training and guide implementation of findings into SMH service delivery. Unfortunately, training, research, and practice in QAI have been limited in the child and adolescent mental health field, and especially within SMH programs (see Leatherman & McCarthy, 2004; Weist, et al., 2002). In general, the literature describing QAI approaches tends to focus on bureaucratic processes (e.g., credentialing, adherence to paperwork requirements,

outputs such as number of students served) and/or liability protection (e.g., procedures for handling crises) (Weist et al., 2002). In recent years the importance of QAI in SMH programs has received increased attention, and numerous dimensions of quality have been articulated, including: a) amount and quality of stakeholder input in program development, guidance, and evaluation, b) extent of collaborative relations among families, school staff and community providers, c) range of preventive and treatment services, d) productivity of staff, e) training and supervision of staff, f) coordination and avoidance of duplication of services, g) use of evidence-based interventions, h) use of appropriate evaluation strategies, i) use of evaluation findings to continuously improve programs and services, and j) use of evaluation findings to broaden awareness of and support for school mental health efforts (see Ambrose, Weist, Schaeffer, Nabors, & Hill, 2002; Evans, Sapia, Axelrod, & Glomb, 2002; Lever, et al., 2003; Nabors, Lehmkuhl, & Weist, 2003).

With support from the Agency for Healthcare Research and Quality, and the National Institute of Mental Health, Weist and colleagues have developed an expanded version of a SMH report card—the School Mental Health, Quality Assessment Questionnaire (SMHQAQ, see Weist et al., 2005). The research-based SMHQAQ is being used in a randomized controlled study of QAI with SMH staff from programs in three states. Participants focus either on systematic QAI or enhancement of personal wellness. In the QAI intervention, clinicians working in small groups strive toward indicators of best practice. They share ideas, provide mutual support to each other, and receive ongoing training in cognitive behavioral skills during weekly team meetings guided by experienced clinicians. Many of the QAI indicators in the SMHQAQ focus on evidence-based practice, and the intent of the QAI intervention is to provide

meaningful and manageable training and support to clinicians in their efforts to evaluate and to improve the quality of services, with emphasis on empirically supported practices.

The pursuit of common principles and indicators for best practice helps to structure the independent variable of *school mental health* as a template for training and for effective practice. This has important implications for developing a *training—research—services—policy agenda* in SMH. This agenda contrasts with SMH research, reflected in much of the published literature, which focuses either on very specific interventions for highly select, narrowly defined problems (see Rones & Hoagwood, 2000) or very broad-scale preventive interventions (see Botvin, 2000; Durlak & Wells, 1997, 1998). The need to expand and to improve training and research on everyday SMH services is supported by recent studies documenting the importance of program adherence to system of care principles in promoting improved behavioral outcomes for youth (Stephen, Holden, & Hernandez, 2004).

Evidence-based SMH practices. Although there is a growing evidence base of what works in SMH, there is also evidence that SMH staff generally are not being trained in or implementing evidence-based practices (EBPs). Further, few receive training, ongoing pragmatic support, and user-friendly resources for adaptation strategies and processes that often are necessary to implement effective practices in school settings given the operating realities in those settings (see Flaspohler, Anderson-Butcher, Paternite, Weist, & Wandersman, 2006; Graczyk, Domitrovich, & Zins, 2003; Jensen, Hoagwood & Trickett, 1999; Rones & Hoagwood, 2000; Schoenwald & Hoagwood, 2001; Weist & Paternite, in press). A major factor contributing to this lack of preparation is that the credentialing processes for child and adolescent mental health professions, including psychology (school, clinical and counseling), social work, professional counseling, and child and adolescent psychiatry, generally do not require training in evidence-

based practices and principles, nor do they consistently require sufficient attention to the contexts (e.g., schools) in which mental health interventions are practiced. For example, Shernoff, Kratochwill, and Stoiber (2003) documented the inadequate attention to and training in evidence-based practices in school psychology graduate programs, which is also an issue in other graduate training programs (e.g., clinical and counseling psychology, social work) in child and adolescent mental health (Evans & Weist, 2004). This is a serious matter that may be due, in part, to funding issues (i.e., accrediting bodies would lose substantial income if many training programs became ineligible). For these and other reasons, therefore, it is imperative that the public participates in the dialogue about mental health workforce training in general, and in discussions about mental health practice in schools, in particular. Clearly, there is a strong need for well linked connections between enhanced undergraduate education, graduate education, post-graduate education, and on the job training in evidence-based practices as applied in schools. There also is a salient need for enhanced infrastructure and resources to support SMH staff from diverse disciplines as they strive to implement effective practices in schools.

Importantly, the SMH workforce also must have firm abilities with and commitment to services that are individualized in a manner that demonstrates support and respect for family and cultural values (Simpson et al., 2001). SMH practices must be tailored to the cultural norms, values, and beliefs of children, families, and the community; they must recognize and adapt to racially and culturally diverse families, integrally engaging recipients of services as active and equal partners in identifying needs, setting goals and implementing interventions (e.g., Bricker et al., 2004; emphasis on cultural competence in the NASP Standards for Training and Field Placement Programs in School Psychology and Standards for Credentialing of School Psychologists, NASP, 2000; and in NASW Standards for School Social Work Services, NASW,

2002). To achieve the goal of cultural competence, providers must be aware of how their own family and cultural values influence their beliefs about *normal* development and how families *should* raise children and adolescents.

SMH practices also should be strength-based, solution-focused, and oriented toward the "whole child," promoting healthy cognitive (i.e., academic), social, emotional, physical and spiritual development—and allowing for children and families to experience success as their strengths and assets are built upon within the intervention. This highlights the importance of interventions that are family-centered, ensuring that programs and services are oriented toward the whole family (including mothers, fathers, grandparents, and other caregivers) and not just one child (Edelman, 2004; Simpson et al., 2001; Weatherston, 2001). By forming a strong alliance with the child or adolescent's family, the SMH provider can understand how families demonstrate warmth, sensitivity, and guidance in ways that might be different than the mainstream culture.

In addition, within the context of SMH programs, and the school-based and school-linked activities that are inherent in *expanded school mental health*, commitment to service delivery in a variety of natural contexts (e.g., classroom, playground, home, neighborhood, after school program, daycare) should be emphasized (Edelman, 2004). Whole-child and family-centered SMH approaches also call for neighborhood-based and school district feeder pattern (i.e., early childhood, elementary, middle, and high school cone systems) approaches, in which services are integrated for siblings and entire families.

In reference to best practice principles and processes, reflecting cultural competence, it is important to acknowledge that the SMH field has not done well in addressing transitions into and out of elementary and secondary schools. The need for early childhood mental health services

and the importance of early intervention with this population are well supported in the literature (e.g., Bricker, Davis & Squires, 2004; Knitzer, 2000; Weatherston, 2005). While knowledge of the positive impacts of daycare and other preschool programs such as Head Start as effective venues for promoting mental health in very young children is growing (Knitzer, 2000; Kunesh & Farley, 1994; Melaville & Blank, 1991; Svanberg, 1998; Simpson, Jivanjee, Koroloff, Doerfler & Garcia, 2001), there is limited literature and attention to the ways in which such knowledge should inform K-12th grade SMH programs and services. Similarly, although there are a few helpful programs in post secondary institutions that can help late adolescents transition from high school, in general, this is an area in need of substantial attention in SMH programs (Gallagher, 2002; Taylor, 2002).

From a workforce training perspective, greater emphasis is needed on helping SMH professionals develop competencies to meet the mental health needs of pre-school and post high school youth in transition. It is incumbent upon SMH staff to apply best practice principles of early childhood mental health services. Commitment to and competence in the practice of these principles is essential to effective mental health promotion, problem prevention, early identification, and treatment in these critical early years and through childhood and adolescence.

Section III: Recommended Intervention for the National Strategic Plan

Based on the themes discussed above, we offer the following workforce training recommendations for mental health providers who are likely to work in and/or with schools.

Recommendations

Please note that the five-person writing team for this revised report, and the larger MHEDIC consortium that endorses the report, drew upon diverse sources of information for the development of the recommendations that follow below, including review of a large published

literature; research findings from studies the co-authors are involved in; and guidelines for training, core competencies and certification published by professional associations for mental health providers from relevant disciplines (e.g., school, clinical and counseling psychology; school and clinical social work; school counseling). The recommendations are intended to go beyond discipline-specific frameworks to focus on core competencies that are relevant *across* school mental health (SMH) disciplines and that ideally should be applied to workforce preparation that reflects an interdisciplinary philosophy and is informed by appreciation of the context of schools. Thus, the expert panel strongly suggests the development and implementation of a sequential and iterative School Mental Health workforce training strategy that includes five specific recommendations:

1) Systematically identify and validate the core competencies for *Advanced Interdisciplinary Mental Health Practice in Schools*;
2) Design training curricula, methods, and experiences for developing these critical competencies of SMH providers;
3) Implement, strategically pilot test, and evaluate the curricula, methods, and experiences, within the context of model community—school partnerships that serve as *real world learning opportunities*;
4) Develop a common certification process and mechanism for *Advanced Interdisciplinary Mental Health Practice in Schools*, which requires mastery of the core competencies; and
5) Influence university-based mental health training programs and accreditation by reviewing and disseminating to them current exemplary training processes and practices, and involving them in developing and implementing the certification process for *Advanced Interdisciplinary Mental Health Practice in Schools*.

Goal Addressed With these Recommendations

The goal is to create and to sustain a workforce that can facilitate *improvement and expansion of school mental health programs and services* (cf. President's New Freedom Commission, 2003), to effectively serve children and adolescents with mental health needs and their families, to enable these students to succeed in school, and to successfully promote the interrelated mental health and school success for all youth.

Proposed Intervention

Recommendations 1 and 2. The first two recommendations involve definition of the core competencies for effective *Advanced Interdisciplinary Mental Health Practice in Schools*, and development of the content and strategies for teaching the competencies. The competencies should be based on a clear understanding and articulation of standards of practice that delineate common and distinct areas of functioning for the variety of mental health providers who work in schools. At a minimum, the common core competencies for all SMH providers should include:

- ✓ well-developed cross-discipline knowledge, skills, and abilities to guide practice in schools;
- ✓ clear understanding of the background, training, professional identity, and professional standards (e.g., ethical, confidentiality, consent) of the other disciplines;
- ✓ strong interdisciplinary and jargon free communication, collaboration, and consultation skills and abilities uniquely demanded of professionals working in our nation's schools;
- ✓ firm understanding and appreciation of school culture and education laws and regulations, and related skills and abilities to integrate mental health issues, needs, and services in school terms;

- ✓ strong abilities to engage in and promote ongoing quality assessment/improvement and effective (best practice) SMH programs and services, that reflect and are responsive to the operating realities of schools; and
- ✓ well-developed skills, abilities, and commitment to demonstrate support and respect for family and cultural values in all SMH practices.

A more elaborated example of a preliminary set of common core competencies for *Advanced Interdisciplinary Mental Health Practice in Schools* has been compiled by MHEDIC colleagues working with four interdisciplinary SMH research, training, and technical assistance Centers (see Appendix C). Within MHEDIC a project is currently underway to "cross walk" this set of core competencies with discipline-specific competencies articulated by national and state professional organizations and certification bodies.

Work undertaken by MHEDIC thus far (see Section II) suggests that there are substantial unmet training needs for most current SMH providers (including school- and community-employed) and educators. In this regard, there are many important questions that can be addressed once the SMH competencies and teaching methods are defined. For example, it will be important to examine: a) the perceived value of these advanced interdisciplinary competencies by a variety of professional groups, parent and family advocacy organizations, and other community partners; b) the extent to which these competencies exist for SMH providers from various disciplines currently practicing; c) the degree to which, and ways in which, the competencies are addressed in university training programs and in continuing education; and d) costs and benefits to SMH programs that differ in the degree to which staff demonstrate the core competencies.

MHEDIC, through its connection to numerous state and national partners, is undertaking systematic study and development of training approaches addressing core competencies in SMH. Work already undertaken by the Annapolis Coalition is highly relevant to this effort, and provides an invaluable foundation for targeted focus on the SMH workforce. For example, the Annapolis Coalition's cogently distilled summary of best practice principles in behavioral health workforce education and training is an invaluable resource (Hoge, Huey, & O'Connell, 2004).

Recommendation 3. The third recommendation involves implementation, pilot testing, and evaluation of SMH workforce training curricula, methods, and experiences. For this work model partnerships (e.g., community mental health center and a school building/district) should be established that include families, universities, community and school mental health professionals who are being trained in the advanced interdisciplinary competencies of SMH and who are working together with families and teachers for the benefit of children. These model partnership sites should be strategically selected to reflect diverse economic, racial, ethnic, and geographic contexts, and they should serve as *real world learning opportunities* for: a) development or enhancement of partnerships with local universities; b) comparison and refinement of training procedures to identify the most efficient and effective methods for SMH workforce training; c) examination of benefits to children and adolescents, of professionals having mastered core competencies; d) examination of new models of enhanced interdisciplinary mental health services; and e) documentation of challenges to and benefits of meaningful across-systems collaboration.

Recommendation 4. The fourth recommendation involves developing a certificate of completion of training for *Advanced Interdisciplinary Mental Health Practice in Schools*. The lessons learned through field-testing in conjunction with recommendation 3, as well as the

definition of core competencies (recommendation 1), should provide a basis for developing the advanced training. This certificate would be for professionals already in the field to ensure a coordinated set of educational experiences that take advantage of workshops, seminars, on-line courses, and on the job supervision and coaching. This certificate would allow for the development of shared knowledge and experiences for all SMH professionals, including school-employed, community-based, and nontraditional mental health providers (e.g., juvenile justice staff, primary care physicians and nurse practitioners working in school-based health centers) that build on their own unique professional identities. The professional development for the certificate of training for *Advanced Interdisciplinary Mental Health Practice in Schools* would provide opportunities for cross-disciplinary learning, as well as for establishing a common foundation of knowledge and a shared language to support the provision of the full array of mental health supports in schools. Expansion of "train the trainers" approaches also should be prioritized to increase the number of participants trained in *Advanced Interdisciplinary Mental Health Practice in Schools*.

Given the current emphasis in federal legislation on integrated approaches to addressing mental health supports for children and youth, the creation of an advanced certificate that provides opportunities for SMH professionals to enhance skills and create connections provides a wonderful opportunity for diverse professionals to develop a common set of competencies. Ideally, the certificate of *advanced interdisciplinary training* would be supported and endorsed by the major national professional organizations and would reflect the vision for best practice in continuing education that involves active sharing and collaboration of the diverse mental health disciplines who may practice in the schools. This recommendation is quite consistent with the recently published recommendation of the American Psychological Association (APA) for

further development of practice guidelines related to serving "emerging, underserved, or vulnerable client populations" and to "new, expanded, or complex multidisciplinary roles" for psychologists (APA, 2005, p. 977).

Recommendation 5. The final recommendation focuses on influencing university-based mental health training programs and accreditation. There is a great need for careful re-examination of discipline-specific training programs, ensuring that professionals working in their respective fields have the capacities to work in interdisciplinary settings. Interprofessional collaboration and leadership courses are emerging in higher education systems to address this growing need. In addition, some individual disciplines are enhancing their current curricula in order to ensure professionals are trained to integrate education with mental health. For instance, some university training programs for mental health providers (i.e., social work, psychology, school counseling) are strengthening their curricula to ensure graduates understand schools as organizational settings with core academic missions and accountabilities. Further, in psychology, some training programs (e.g., Counseling, Clinical, School Psychology Program of the University of California, Santa Barbara, Graduate School of Education) are operating from the foundational reality that the work of the various child-focused mental health disciplines is in fact blending together. Likewise, teacher preparation courses are beginning to explore new curricular options related to addressing non-academic barriers to learning in classrooms and developing strategic school-family-community partnerships and integrated service delivery systems. There are obvious challenges in relation to acting upon these curricular training needs, especially given accreditation and licensure requirements governing higher education and discipline training programs.

An initial step to promote progress to improve university training to prepare graduates for *Advanced Interdisciplinary Mental Health Practice in Schools*, would be to review exemplary university training programs that currently exist, distill from this review key themes and lessons learned, and share the review in publications and forums (discipline specific and interdisciplinary) where leaders of university training programs in child and adolescent mental health convene. In the future, progress in improving university child and adolescent mental health training programs would be propelled through publicizing to and involving them in the certification process for *Advanced Interdisciplinary Mental Health Practice in Schools*.

Concluding Comment on Recommendations. Ultimately, to promote the development of an effective SMH workforce through implementation of recommendations 1 through 5, and to promote improved and expanded SMH practices, there is a need for a substantial interconnected policy—training—practice—research agenda, with key elements described in Figure 1 (see Kratochwill, Albers, & Shernoff, 2004; Lever et al., 2003; Weist et al., 2005; Weist, 2005; Weist & Paternite, in press). To achieve desired outcomes for students, effective mental health promotion through intervention services are needed. To ensure effective SMH practices, a critical quality assessment and improvement (QAI) agenda must be undertaken, which subsumes culturally competent evidence-based practices that are reflective of strong family and community engagement. Infrastructures that reflect effective communication, strong collaboration, and meaningful training underpin the successful development and implementation of such practices. Policies to promote effective SMH practices must be based on a clear understanding of the current status and needs of the field and must inform strategic planning. Such policies and planning are needed to ensure adequate resources (new and reallocated) that are foundational to advancement of the field. Resources must be allocated judiciously to support well-coordinated,

non-duplicative SMH services that reflect a common agenda for families and other stakeholders in child serving systems (education, mental health, health, child welfare and juvenile justice). These key elements reflect SMH as a cornerstone in the development of a *public mental health promotion* system in the U.S., emphasizing more preventive services for children and youth "where they are" and consistent with positive experiences occurring in other nations (see Rowling & Weist, 2004; Weist, 2005).

Likely Impact on Consumers, Family Members, the Workforce, and Delivery Systems

As noted previously in Section II, SMH programs and services, *when done well*, are associated with strong satisfaction by diverse stakeholder groups, improvement in student emotional and behavioral functioning, and improvements in school outcomes; for example, enhanced climate and student connectedness to school, improved attendance, fewer inappropriate referrals into special education, reduced bullying and violence, and reduced school suspensions (see Atkins et al, 2003; Evans et al., in press; Owens et al., in press; Weist et al., 2005; Weist & Paternite, in press).

Obstacles and Change Strategies

Many of the obstacles described in detail by the Annapolis Coalition to moving an evidence-based workforce strategic plan forward apply to these SMH workforce recommendations. A vital additional challenge for the SMH field in general, and for moving a workforce strategy forward, involves effectively answering the question "Why integrate mental health programs and services into schools?" For example, school leaders might resist an agenda to expand attention to mental health issues in schools, based on a conviction that schools are not in the *mental health business.* Relatedly, schools might be concerned about assuming excessive responsibility for students' emotional and behavioral problems. This concern, which directly

contributes to reticence to take on a mental health agenda can be related to a number of factors, including stigma and/or poor understanding of mental health issues, insufficient appreciation of the critical links between mental health and school success, the lack of precedent in a school for focusing on the reduction of adacemic and non-academic barriers to learning, and the lack of a true shared agenda in which families, schools and other community agencies and programs work collaboratively and share resources in advanicng SMH programs and services (see Weist & Paternite, in press). In this regard, ultimately schools must assume a greater level of responsibility for the emotional and behavioral needs of children, and they must be assisted in understanding the undeniable and substantial links between education outcomes and mental health. Change strategies for enhanced SMH workforce development, and for improvement and expansion of SMH programs and services (cf. President's New Freedom Commission, 2003), are emerging at all levels through the efforts of partners described below.

Potential Partners and Available Materials, Resources, and Successful Models

Building on the supportive and influential reports and recommendations noted in Section II (page 4), many partners are emerging. Recent federal investments in SMH provide opportunities for heightened commitment to a meaningful workforce training strategy. This support includes: a) two HRSA- and SAMSHA-funded national school mental health policy analysis centers at the University of Maryland (Center for School Mental Health Analysis and Action, www.csmha.umaryland.edu) and at UCLA (Center for Mental Health in Schools, www.smhp.psych.ucla.edu); b) the National Mental Health Promotion and Violence Prevention Center funded by SAMHSA; c) research and training centers for children's mental health at the University of South Florida, Georgetown University and Portland State University funded by SAMHSA, the Department of Education, and the Administration for Children and Families; d)

special education resource and training centers addressing Positive Behavior Intervention and Support, Children with Disabilities, and Collaboration and Effective Practice, funded by the Office of Special Education Programs (OSEP); e) the Mental Health—Schools—Families Shared Agenda Initiative (2002) and the IDEA Partnership of the U.S. Department of Education, OSEP; f) the Coordinated School Health Program of the CDC, and g) the Safe Schools/Healthy Students and Violence Prevention Initiatives involving a consortium of federal agencies, and coordinated by SAMHSA (see Anglin, 2003). Additional federal and national investments in SMH have been made through: a) the Child and Adolescent Service System Program of SAMHSA; b) the Maternal and Child Health Block Grants of HRSA; c) the Mental Health Block Grants of SAMHSA (e.g., in Ohio block grant funds are partially supporting the work of the Ohio Mental Health Network for School Success); d) the Title IV Safe and Drug-Free Schools Programs; e) research programs of these federal agencies and National Institute of Mental Health (NIMH), National Institute of Child and Human Development (NICHD) and the National Institute of Justice; f) investments made by the National Assembly on School-Based Health Care; and g) efforts of national professional organizations representing the variety of disciplines invested in effective SMH practices (any omission of federal and national support in this list in unintended).

Workforce issues are beginning to be prioritized within the context of SMH policy advocacy, service-delivery, and technical assistance that are emerging in some U.S. cities (e.g., Baltimore, Dallas, Los Angeles, Memphis) and states (e.g., Hawaii, Maryland, New York, New Mexico, Ohio, South Carolina). Collaborative SMH networks and training initiatives also have developed at state, national and international levels (e.g., Ohio Mental Health Network for School Success, www.units.muohio.edu/csbmhp/network.html; New Mexico School Mental Health Initiative, www.nmsmhi.org; Mental Health—Education Integration Consortium

(http://www.units.muohio.edu/csbmhp/mhedic/index.html); Collaborative for Academic, Social and Emotional Learning, www.casel.org; IDEA Partnership, www.ideapartnership.org; School Mental Health Alliance, www.kidsmentalhealth.org; and the International Alliance for Child and Adolescent Mental Health and Schools, www.intercamhs.org).

A growing collaboration between the IDEA Partnership and the Center for School Mental Health Analysis and Action (CSMHA) also is encouraging. In October, 2004 and October, 2005, respectively, they co-sponsored an inaugural and second meeting of over 60 national organizations representing families, schools and other community systems to move through discussion and action toward the development of a national community of practice in school mental health (Wenger, 1998; Wenger, McDermott, & Snyder, 2002). The group reached consensus on building this community, as well as plans for mobilizing Practice Groups—with one of the groups to focus explicitly on SMH workforce issues (MHEDIC is contributing to the dialogue on workforce issues within the national Community of Practice). The national Community of Practice, and its specific Practice Groups, are envisioned as vehicles to enable active communication, the exchange of ideas, collaboration in grant seeking and programming, and the development of "multi-scale learning loops" between and among experiences occurring at national, state and local levels. The progress of the community is being tracked by the IDEA Partnership (www.ideapartnership.org).

Finally, the recently awarded planning grants to states and local education systems from the U.S. Department of Education (Office of Safe and Drug Free Schools) to integrate schools and mental health systems is particularly noteworthy and encouraging. Such planning grants can provide important opportunities to carefully study and to develop plans for workforce development and service delivery on both state and local levels.

Resources Needed

School mental health is an emerging field with challenges being confronted at many levels, and actions to advance a workforce development strategic plan are inextrably linked to many other actions. Adequate resources (new and reallocated) are foundational to developing and sustaining a competent workforce and to effective SMH practices (see Figure 1).

With specific reference to the SMH workforce training strategy proposed in this report, overarching funding support is needed to expand and to sustain networking among individuals and organizations committed to enhancing SMH workforce preparation. In addition, funding support is needed to implement and to sustain *each* of the five recommendations. For example, with reference to Recommendations 1 and 2 infrastructure and personnel investments will be necessary to identify and to validate core competencies for *Advanced Interdisciplinary Mental Health Practice in Schools* and to develop and adapt training methods and experiences. Developing and sustaining model community-school partnerships (Recommendation 3), which will serve as essential *real world learning opportunities* for workforce training, will require funding support to insure dedicated time investment of a broad range of stakeholders and to engage in ongoing quality assessment and improvement of the partnerships' workforce training efforts. In addition, achieving Recommendations 4 and 5, focused on certification and changes in university-based training and accreditation, will require substantial resource investments in dissemination of findings to policy makers at all levels and in building and sustaining strong collaborative relationships with universities, professional organizations, and accrediting bodies.

Contact Information for Carl E. Paternite and Mark Weist (technical advisors to the Annapolis Coalition)

- Carl E. Paternite, Professor of Psychology and Director, Center for School-Based Mental Health Programs, Department of Psychology, Miami University, Oxford, OH 45056, Phone: (513) 529-2416, paternce@muohio.edu.

- Mark D. Weist, Professor and Director, Center for School Mental Health Analysis and Action, University of Maryland School of Medicine, 737 W. Lombard Street, 4th Floor, Baltimore, MD 21201, Phone: (410) 706-0974, mweist@psych.umaryland.edu.

Information About the Forum in Which Recommendations Were Developed

The recommendations and the framework for this report were developed by MHEDIC, as described in Section 1 and Appendix A. The report was written primarily by a five-person writing team of MHEDIC members, consisting of Carl E. Paternite and Mark D. Weist, clinical psychologists; Jennifer Axelrod, school psychologist; Dawn Anderson-Butcher, social worker; and Karen Weston, educational psychologist. The full MHEDIC membership provided input for revisions to draft versions of this report. We wish to particularly acknowledge substantial specific text contributions by MHEDIC members Bob Burke, Jennifer Green, Steve Evans, Julie Owens, Ed Morris, and Marcia Rubin. Finally, as noted earlier, we acknowledge the helpful feedback and suggestions offered by individuals not currently involved in MHEDIC, including Ted Feinberg, NASP; Judith Shine, Myrna Mandlawitz, and Randy Fisher, SSWAA; and Patricia Arrendondo, ACA.

Reference List

Adelman, H. S., & Taylor, L. (1999). Mental health in schools and system restructuring. *Clinical Psychology Review*, *19*, 137-163.

Adelman, H. S., & Taylor, L. (2000). Promoting mental health in schools in the midst of school reform. *Journal of School Health*, *70*, 171-178.

Adelsheim, S. (2004). *Recommendations to improve child and adolescent and school mental health*. Unpublished manuscript.

Adelsheim, S. Jennings, J., & Weist, M.D. (2002, September). *The school mental health imperative*. Presentation to the President's New Freedom Commission on Mental Health. Chicago.

Ambrose, M. G., Weist, M. D., Schaeffer, C., Nabors, L. A., & Hill, S. (2002). Evaluation and quality improvement in school mental health. In H. Ghuman, M. D. Weist, & R. Sarles (Eds.), *Providing mental health services to youth where they are: School- and community-based approaches* (pp. 95 - 110). New York: Brunner-Routledge.

American Psychological Association (1994). *Comprehensive and coordinated psychological services for children.* Washington, D.C: Author.

American Psychological Association (2005). Determination and documentation of the need for practice guidelines. *American Psychologist*, *60(9)*, 976-978.

Anglin, T. M. (2003). Mental health in schools: Programs of the federal government. In M. D. Weist, S. Evans, & N. Tashman (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 89-106). New York: Kluwer Academic/Plenum Publishers.

Atkins, M., Adil, J., Jackson, M., McKay, M., & Bell, C. (2001). *An ecological model for school-based mental health services*. 13th Annual Conference Proceedings: A System of Care for Children's Mental Health: Expanding the Research Base. Tampa: University of South Florida.

Atkins, M., S., Frazier, S. L., , Adil, J. A., & Talbott, E. (2003) School-based mental health services in urban communities. In M. Weist, S. Evans, & N. Tashman (Eds.), *School mental health handbook.* (pp. 165-178). New York: Kluwer Academic/Plenum Publishers.

Atkins, M.S., Graczyk, P. A., Frazier, S. L., & Abdul-Adil, J. (2003). Toward a new model for promoting urban children's mental health: Accessible, effective, and sustainable school-based mental health services, *School Psychology Review*, *32*, 503-514.

Bishop, J. H., Bishop, M., Bishop, M., Gelbwasser, L., Green, S., Peterson, E., Rubinsztaj, A., & Zuckerman, A. (2004). Why we harass nerds and freaks: A formal theory of student culture and norms. *Journal of School Health*, *74*, 235-251.

Botvin, G. J. (2000). Preventing drug abuse in schools: Social and competence enhancement approaches targeting individual-level etiologic factors. *Addictive Behaviors, 25*(6), 887-897.

Bricker, D., Davis, M. S., & Squires, J. (2004). Mental health screening in young children. *Infants & Young Children: An Interdisciplinary Journal of Special Care Practices, 17*(2), 129-144.

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E., et al. (1995). Children's mental health service use across service sectors. *Health Affairs*, *14*, 147-159.

Catalano, R. F., Haggerty, K. P., Oesterle, S., Fleming, C. B. & Hawkins, J. D. (2004). The importance of bonding to school for health development: Findings from the Social Development Research Group. *Journal of School Health*, *74*, 252-261.
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.
Committee on School Health (2004). School-based mental health services. *Pediatrics*, *113*, 1839-1845.
Council for Accreditation of Counseling and Related Educational Programs (2001). *Standards*. Alexandria, VA: Author. Available: http://www.cacrep.org/2001Standards.html
Doll, B. (1996). Prevalence of psychiatric disorders in children and youth: An agenda for advocacy by school psychology. *School Psychology Quarterly*, *11*, 20-47.
Dryfoos, J.G. (1994). *Full-service schools: A revolution in health and social services for children, youth, and families*. San Francisco, CA: Jossey-Bass.
Dryfoos, J.G., Maguire, S. (2002). *Inside full-service community schools.* Thousand Oaks, CA: Corwin Press.
Durlak, J.A., & Wells, A.M. (1997). Primary prevention mental health programs for children and adolescents. *American Journal of Community Psychology, 25,* 115-152.
Durlak, J.A., & Wells, A.M. (1998). Evaluation of indicated preventive interventions (secondary prevention) mental health programs for children and adolescents. *American Journal of Community Psychology, 26,* 775-802.
Edelman, L. (2004). Principles & strategies for family-centered home-based services. *Resources and Connections, 3*(1), Retrieved August 1, 2005, from http://www/cde/state/co.us/earlychildhoodconnections/Technical.htm
Elias, M. J., Gager, P., & Leon, S. (1997). Spreading a warm blanket of prevention over all children: Guidelines for selecting substance abuse and related prevention curricula for use in the schools. *Journal of Primary Prevention, 18*, 41-69.
Evans, S. W. (1999). Mental health services in schools: Utilization, effectiveness and consent. *Clinical Psychology Review, 19*, 165-178.
Evans, S. W., Sapia, J. L., Axelrod, J., & Glomb, N. K. (2002). Practical issues in school mental health: Referral procedures, negotiating special education, and confidentiality. In H. Ghuman, M. Weist, & R. Sarles (Eds.), *Providing mental health services to youth where they are* (pp. 75-94). New York: Brunner-Routledge.
Evans, S. W., Langberg, J., Raggi, V., Allen, J., & Buvinger, E. (in press). Development of school-based treatment program for middle school youth with ADHD. *Journal of Attention Disorders*.
Evans, S.W., & Weist, M.D. (2004). Implementing empirically supported treatments in schools: What are we asking? *Child and Family Psychology Review, 7,* 263-267.
Flaherty, L. T., & Osher, D. (2003). History of school-based mental health services. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 11-22). New York: Kluwer Academic/Plenum Publishers.
Flaherty, L. T., & Weist, M. D. (1999). School-based mental health services: The Baltimore models. *Psychology in the Schools, 36*, 379-389.
Flaspohler, P., Anderson-Butcher, D. A., Paternite, C. E., Weist, M. D., & Wandersman, A. (2006). Community science and expanded school mental health: Bridging the research to practice gap to promote child well being and academic success. *Journal of Educational*

and Child Psychology, *23(1)*, 27-41.
Gallagher, R.P. (2002). *National Survey of Counseling Center Directors.* Alexandria, VA: International Association of Counseling Services.
Goodman, S. H., Lahey, B. B., Fielding, B., Duncan, M., Narrow, W., & Rigor, D. (1997). Representatives of clinical samples of youths with mental disorders: A preliminary population-based study. *Journal of Abnormal Psychology*, *106*, 3-14.
Graczyk, P. A., Domitrovich, C. E., & Zins, J. E. (2003). Facilitating the implementation of evidence-based prevention and mental health promotion efforts in schools. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health programs: Advancing practice and research*. (pp. 301-318). New York: Kluwer Academic/Plenum Publisher.
Grunbaum, J. A., Kann, L., Kinchen, S., Ross, J., Hawkins, J., Lowry, R., et al. (2004). Youth risk behavior surveillance - United States, 2003. *Morbidity and Mortality Weekly Report, 53*, 1-95.
Han, S. S., Catron, T., Weiss, B., & Marciel, K. K. (2005). A teacher-consultation approach to social skills training for pre-Kindergarten children: Treatment model and short-term outcome effects. *Journal of Abnormal Child Psychology*, *33*, 681-693.
Hoge, M.A., Huey, L.Y. & O'Connell, M.J. (2004). Best practices in behavioral health workforce education and training. *Administration and Policy in Mental Health*, *32*, 91-106.
Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S., et al. (2005). Transforming mental health care for children and their families. *American Psychologist*, *60*, 615-627.
Jensen, P. S., Hoagwood, K., & Trickett, E. J. (1999). Ivory towers or earthen trenches? Community collaboration to foster real-world research. *Applied Developmental Science*, *3*, 206-212.
Klern, A. M., & Connell, J. P. (2004). Relationships matter: Linking teacher support to student engagement and achievement. *Journal of School Health*, *74*, 262-273.
Knitzer, J. (2000). Early childhood mental health services: A policy and systems development perspective. *Handbook of early childhood intervention (2nd ed.).* (pp. 416-438) Cambridge University Press, New York, NY, US.
Kratochwill, T. R., Albers, C. A., & Shernoff, E. S. (2004). School-based interventions. *Child and Adolescent Psychiatric Clinics of North America*, *13*, 885-903.
Kunesh, L. G., & Farley, J. (1994). *Collaboration: The prerequisite for school readiness and success.* Champaign, IL: Clearinghouse on Elementary and Early Childhood Education, University of Illinois at Urbana-Champaign.
Leaf, P. J., Alegria, M., Cohen, P., Goodman, S. H., Horwitz, S. M., Hoven, C. W., et al. (1996). Mental health services use in the community and schools: Results from the four-community MECA study. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 889-897.
Leatherman, S., & McCarthy, D. (2004). *Quality of healthcare for children and adolescents: A chartbook*. New York: The Commonwealth Fund (www.cmwf.org).
Lever, N. A., Adelsheim, S., Prodente, C., Christodulu, K. V., Ambrose, M. G., Schlitt, J., et al. (2003). System, agency and stakeholder collaboration to advance mental health programs in schools. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 149-162). New York: Kluwer

Academic/Plenum Publishers.
Libbey, H. P. (2004). Measuring student relationships to school: Attachment, bonding, connectedness, and engagement. *Journal of School Health*, *74*, 274-283.
Marsh, D. (2004). Serious emotional disturbance in children and adolescents: Opportunities and challenges for psychologists. *Professional Psychology: Research and Practice*, *35*, 443-448.
Marx, E., Wooley S.F., and Northrop, D. (1998). *Health is academic: A guide to coordinated school health programs.* Teachers College Press, New York, NY.
Masia-Warner, C., Klein, R. G., Dent, H. C., Fisher, P. H., Alvir, J., Albano, A. M., et al. (2005). School-based intervention for adolescents with social anxiety disorder. *Journal of Abnormal Child Psychology*, *33*, 707-733.
McNeely, C. & Falci, C. (2004). School connectedness and the transition into and out of health-risk behavior among adolescents: A comparison of social belonging and teacher support. *Journal of School Health*, *74*, 284-292.
Melaville, A. I., & Blank, M. J. (1991). *What it takes: Structuring interagency partnerships to connect children and families to comprehensive services.* Washington, DC: Education and Human Services Consortium.
Nabors, L. A., Lehmkuhl, H. D., & Weist, M. D. (2003). Continuous quality improvement and evaluation of expanded school mental health programs. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 275-284). New York: Kluwer Academic/Plenum Publishers.
Nabors, L. A., & Reynolds, M. W. (2000). Program evaluation activities: Outcomes related to treatment for adolescents receiving school-based mental health services. *Children's Services: Social Policy, Research, and Practice, 3*, 175-189.
Nabors, L. A., Reynolds, M. W., & Weist, M. D. (2000). Qualitative evaluation of a high school mental health program. *Journal of Youth and Adolescence, 29,* 1-14.
National Association of School Psychologists (2002). *Position statement on interagency collaboration to support the mental health needs of children and families.* Available: http://www.nasponline.org/information/pospaper_iac.html
National Association of School Psychologists (2000a). *Professional conduct manual, Principles for Professional Ethics, and Guidelines for the provision of school psychological services*. Bethesda, MD: Author. Available: http://www.nasponline.org/pdf/ProfessionalCond.pdf
National Association of School Psychologists (2000b). *Standards for training and field placement programs in school psychology and Standards for the credentialing of school psychologists*. Bethesda, MD: Author. Available: http://www/nasponline.org/certification/FinalStandards.pdf
National Association of Social Workers (2002). NASW Standards for School Social Work Services. Washington, D.C.: Author. Available: http://www.naswdc.org/practice/standards/NASW_SSWS.pdf
National Board for Professional Teaching Standards (2002). *NBPTS school counseling standards*. Arlington, VA: Author. Available: http://www.nbpts.org/pdf/schoolcounseling.pdf
National Institute of Mental Health (2001). *Blueprint for change: Research on child and adolescent mental health, a report of the National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health Intervention and Deployment.*

Rockville, MD: Author.
Owens, J. S., Richerson, L., Beilstein, E. A., Crane, A., Murphy, C. E., & Vancouver, J. B. (in press). School-Based Mental Health Programming for Children with Inattentive and Disruptive Behavior Problems: First Year Treatment Outcome. *Journal of Attention Disorders*.
Paternite, C. E. (2004). Involving educators in school-based mental health programs. In K. E. Robinson (Ed.), *School-based mental health: Best practices and program models* (pp. 6-1 – 6-21). Kingston, NJ: Research Institute, Inc.
Paternite, C. E., & Johnston, T. C. (2005). Rationale and strategies for central involvement of educators in effective school-based mental health programs. *Journal of Youth and Adolescence*, *34*, 41-49.
Paternite, C. E., Weist, M. D., Burke, R., & Flaspohler, P. (2005). School-based mental health programs and services in the United States: Current status and future directions. Submitted for publication.
Power, T. J., DuPaul, G. J., Shapiro, E. S., & Kazak, A. E. (2003). *Promoting children's health: Integrating school, family, and community.* New York: The Guilford Press.
President's New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America*. *Final Report for the President's New Freedom Commission on Mental Health (SMA Publication No. 03-3832)*. Rockville, MD: Author.
Rappaport, N., Osher, D., Garrison, E. G., Anderson-Ketchmark, C., & Dwyer, K. (2003). Enhancing collaboration within and across disciplines to advance mental health programs in schools. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health programs: Advancing practice and research* (pp. 107-118). New York: Kluwer Academic/Plenum Publishers.
Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review*, *3*, 223-241.
Rowling, L., & Weist, M. D. (2004). Promoting the growth, improvement and sustainability of school mental health programs worldwide. *International Journal of Mental Health Promotion, 6*(2), 3-11.
Schoenwald, S. K. & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? *Psychiatric Services*, *52*, 1190-1197.
School Mental Health Alliance (2005). *Working together to promote learning, social-emotional competence and mental health for all children*. New York: Author (Columbia University Center for the Advancement of Children's Mental Health, www.kidsmentalhealth.org). Accessed March 13, 2005.
Sedlak, M. W. (1997). The uneasy alliance of mental health services and the school: An historical perspective. *American Journal of Orthopsychiatry*, *67*, 349-362.
Shernoff, E. S., Kratochwill, T. R., & Stoiber, K. C. (2003). Training in evidence-based interventions (EBIs): What are school psychology programs teaching? *Journal of School Psychology*, *41*, 467-483.
Simpson, J. S., Jivanjee, P., Koroloff, N., Doerfler, A., & Garcia, M. (2001). *Promising practices in early childhood mental health. Systems of care: Promising practices in children's mental health, 2001 series, volume III.* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.
Staup, J. (1999, September). *The integration of mental health and education systems*. Workshop

presented at the Fourth National Conference on Advancing School-Based Mental Health Programs. Denver, CO.
Stephen, R.L., Holden, E.W. & Hernandez, M. (2004). System-of-care practice review scores as predictors of behavioral symptomatology and functional impairment. *Journal of Child and Family Studies*, *13*, 179-191.
Stormshak, E. A., Dishion, T. J., Light, J., & Yasui, M. (2005). Implementing family-centered interventions with the public middle school: Linking service delivery to change in student problem behavior. *Journal of Abnormal Child Psychology*, *33*, 723-733.
Svanberg, P. O. G. (1998). Attachment, resilience and prevention. *Journal of Mental Health (UK), 7*(6), 543-578.
Taylor, S.S. (September 2, 2002). Mental cases? *Community College Week*, 6-8.
Thomas A. & Grimes, J. (Eds.) (2002). *Best practices in school psychology, IV*. Bethesda, MD: National Association of School Psychologists.
U.S. Department of Education, Office of Special Education Programs (2002). *Mental health, schools and families working together for all children and youth: Toward a shared agenda—A concept paper*. Washington, DC: Author. Available at: www.nasdse.org/sharedagenda.pdf; www.nasmhpd.org. Accessed December 31, 2004.
U.S. Department of Education, Office of Special Education Program (2001). *Twenty-third Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act: Results*. Washington, DC: Author.
U.S. Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General- Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health.
U.S. Department of Health and Human Services (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health.
U.S. Department of Health and Human Services (2001). *Youth violence: A report of the Surgeon General*. Washington, DC: Author.
Waxman, R. P., Weist, M. D., & Benson, D., M. (1999). Toward collaboration in the growing education-mental health interface. *Clinical Psychology Review*, *19*, 239-253.
Weare, K. (2000). *Promoting mental, emotional and social health: A whole school approach.* London: Routledge.
Weatherston, D. J. (2005). Returning the treasure to babies: An introduction to infant mental health service and training. *The handbook of training and practice in infant and preschool mental health.* (pp. 3-30). Jossey-Bass, San Francisco, CA, US.
Weatherston, D. J. (2001). Infant mental health: A review of relevant literature. *Psychoanalytic Social Work, 8*(1), 39-69.
Weist, M. D. (1997). Expanded school mental health services: A national movement in progress. In T. Ollendick & R. J. Prinz (Eds.), *Advances in Clinical Child Psychology* (Vol. 19, pp. 319-352). New York: Plenum Press.
Weist, M.D. (2003). Promoting paradigmatic change in child and adolescent mental health and schools. *School Psychology Review*, 32, 336-341.

Weist, M. D. (2005). Fulfilling the many promises of school-based mental health: Moving toward a public mental health promotion approach. *Journal of Abnormal Child Psychology, 33*, 735-741.

Weist, M.D., Ambrose, M., & Lewis, C. (in press). Expanded school mental health: A collaborative community/school example. *Children & Schools.*

Weist, M. D., Evans, S. W., & Lever, N. A. (Eds.). (2003). *Handbook of school mental health: Advancing practice and research.* New York: Kluwer Academic/Plenum Publishers.

Weist, M. D., Myers, C. P., Hastings, E., Ghuman, H., & Han, Y. (1999). Psychosocial functioning of youth receiving mental health services in the schools vs. community mental health centers. *Community Mental Health Journal, 35*, 69-81.

Weist, M.D. & Paternite, C.E. (in press). Building an interconnected policy-training-practice-research agenda to advance school mental health. *Education and Treatment of Children*.

Weist, M.D., Paternite, C., & Adelsheim, S. (2005). *School based mental health services.* Report to the Institute of Medicine, Board on Health Care Services, Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders Committee.

Weist, M. D., Sander, M. A., Lever, N. A., Link, B., Christodulu, K. V., Rosner, L. E., et al. (2002). Advancing the quality agenda in expanded school mental health. *Emotional & Behavioral Disorders in Youth, 2*, 59-70.

Weist, M. D., Sander, M. A., Walrath, C., Link, B., Nabors, L., Adelsheim, S., et al. (2005). Developing principles for best practice in expanded school mental health. *Journal of Youth and Adolescence*, 34, 7-13.

Weisz, J. (2004). *Psychotherapy for children and adolescents: Evidence-based treatments and case examples*. New York: Cambridge University Press.

Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity*. New York: Cambridge University Press.

Wenger, E., McDermott, R., & Snyder, W. M., (2002). *Cultivating communities of practice: A guide to managing knowledge.* Boston: Harvard Business School Press.

Wilson, D. (2004). The interface of school climate and school connectedness and relationships with aggression and victimization. *Journal of School Health*, *74*, 293-299.

Zins, J. E., Weissberg, R. P., Wang, M. C., & Walberg, H. J. (Eds.). (2004). *Building academic success on social and emotional learning: What does the research say?* New York: Teachers College Press.

Appendix A
MHEDIC Participants

Steven Adelsheim, M.D.
Associate Professor
Psychiatry, Pediatrics, and Family and Community Medicine
University of New Mexico Health Sciences Center
625 Silver SW, Suite 201
Albuquerque, NM 87102
Ph: 505-841-5879; steve.adelsheim@state.nm.us

Heather K. Alvarez, Ph.D.
Assistant Professor
Department of Psychology
Ohio University
227 Porter Hall
Athens, OH 45701
Ph: 740-593-1094; alvarez@ohio.edu

Dawn Anderson-Butcher, Ph.D.
Associate Professor
College of Social Work
Ohio State University
325D Stillman Hall
1947 College Road
Columbus, OH 43210-1162
Phone: (614) 292-8596; anderson-butcher.1@osu.edu

Jennifer Lauren Axelrod, Ph.D.
Collaborative for Academic, Social & Emotional Learning
University of Illinois at Chicago
Department of Psychology (M/C 285)
1007 S. Harrison Street
Chicago, IL 60607-7137
Phone: (312) 996-3766; jaxelrod@uic.edu

Ellen Bueschel, Ph.D.
Associate Professor
Department of Educational Leadership
Miami University
Oxford, OH 45056
Phone: (513) 529-6839; bueschme@muohio.edu

Robert Burke, Ph.D.
Assistant Professor
Department of Teacher Education
Miami University
Oxford, OH 45056
Phone: (513) 529-6443; burkerw@muohio.edu

Joanne Cashman, Ed.D.
Director, The IDEA Partnership
National Association of State Directors of Special Education
1800 Diagonal Road, Suite 320
Alexandria, VA 22314
Phone: (703) 519-3800 Ext. 325; joanne.cashman@nasdse.org

Steven W. Evans, Ph.D.
Director, Alvin V. Baird
Attention & Learning Disabilities Center
Professor
Department of Psychology
MSC 9013
James Madison University
Harrisonburg, VA 22807
Phone: (540) 568-2538; evanssw@jmu.edu

Paul Flaspohler, Ph.D.
Assistant Professor
Center for School-Based Mental Health Programs
Department of Psychology
Miami University
Oxford, OH 45056
Phone: (513) 529-2469; flaspopd@muohio.edu

Jennifer Green, Ph.D.
Assistant Professor and Director of Traineeships
Center for School-Based Mental Health Programs
Department of Psychology
Miami University
Oxford, OH 45056
Phone: (513) 529-2448; greenjh@muohio.edu

James Koller, Ph.D.
Director, Center for the Advancement of Mental Health Practices in the Schools
Department of Educational, School and Counseling Psychology
University of Missouri-Columbia
16 Hill Hall
Columbia, MO 65211
Phone: (573) 882-7731; kollerj@missouri.edu

Sally Lloyd, Ph.D.
Interim Dean and Professor
School of Education and Allied Professions
Miami University
Oxford, OH 45056
Phone: (513) 529-6317; lloydsa@muohio.edu

Jennifer Miller, M.Ed.
Director, Office for Safety, Health, and Nutrition
Ohio Department of Education
25 South Front Street, Mail Stop 303
Columbus, OH 43215-4183
(614) 466-9225 office; Jennifer.miller@ode.state.oh.us

Ed Morris, Ph.D.
307 West Route F
Clark, MO 65243
Phone: (573) 687-3713; morre@socket.net

Julie Sarno Owens, Ph.D.
Assistant Professor
Department of Psychology
Ohio University
Porter Hall 200
Athens, OH 45701
Phone: (7400 593-1074; owensj@ohio.edu

Carl E. Paternite, Ph.D.
Professor of Psychology and Director,
Center for School-Based Mental Health Programs
Department of Psychology
Miami University
Oxford, OH 45056
Phone: (513) 529-2416; paternce@muohio.edu

Kay Rietz, M.S.Ed.
Assistant Deputy Director
Children's Services
Ohio Department of Mental Health
30 E. Broad Street, 8th Floor
Columbus, OH 45056
Phone: (614) 466-0111; rietzk@mh.state.oh.us

Marcia A. Rubin, Ph.D.
Director of Sponsored Programs
American School Health Association
7263 State Route 43
P.O. Box 708
Kent, OH 44240
Phone: (330) 678-1601, ext. 129; mrubin@ashaweb.org

Mark D. Weist, Ph.D.
Professor and Director, Center for School Mental Health Analysis and Action
University of Maryland School of Medicine
737 W. Lombard Street, 4th Floor
Baltimore, MD 21201
Phone: (410) 706-0974; Mweist@psych.umaryland.edu

Karen J. Weston, Ph.D.
Assistant Director
Center for the Advancement of
Mental Health Practices in Schools
Department of Educational, School and Counseling Psychology
University of Missouri-Columbia
Phone: (573) 882-4973; Westonkj@missouri.edu; schoolmentalhealth.missouri.edu

Appendix B

MHEDIC Vita

Representative International Presentations

Axelrod, J., Burke, B., Cashman, J., Koller, J., Morris, E., Paternite, C., Rietz, K., & Weist, M.D. (2005, April) *Mental health-education integration in schools in the United States*. Poster presented at the Third World Conference on Mental Health Promotion, Dublin, Ireland.

Paternite, C., & Weist, M.D. (2005, April). *Strengthening partnerships for school mental health in the United States*. Paper presented at the Third World Conference on Mental Health Promotion, Dublin, Ireland.

Representative National Presentations

Koller, J. (2005, September). *Assisting Those in Need: Helping Qualified Candidates Secure GED Test Accommodations.* Invited keynote address at the 2005 Annual Arkansas State Department of Education, Little Rock, AK.

Paternite, C.E., & Weist, M.D. (2005, September). *School mental health workforce issues*. Presentation to the Annapolis Coalition on the Behavioral Health Workforce, Annapolis, MD.

Weist, M.D., Cashman, J., Paternite, C.E., Rietz, K., Gruttadaro, D., & Dodge, J. (2005, September). *Expanding partnerships in systems of care: Education, mental health and families working together.* National Technical Assistance Center for Children's Mental Health Conference Call Series, Washington, DC.

Weist, M.D. (2005, September). Building *Hawaii's position of leadership in the school mental health movement.* Plenary presentation at a statewide meeting convened by the IDEA Partnership and the Hawaii Department of Education, Honolulu, HI. The National Conference of State Legislatures Annual Meeting, State Stories: "Value Added" through Communities of Practice. August, 2005

Paternite, C.E. (2005, August). *From awareness to public policy to local action in promoting a mental health—schools—families shared agenda: Ohio's experience.* Presentation at a Facilitated Strategic Planning Meeting for School-Based Mental Health Services in North Carolina. Raleigh.

Flaspohler, P., Paternite, C.E., Evans, S., & Weist, M.D. (2005, August). *From policy to practice: Using community science to promote school-based mental health.* Symposium presented at the meeting of the American Psychological Association, Washington, DC.

Price-Ellingstad, D., East, W., & Weist, M.D. (2005, August). *Implications of the IDEA reauthorization on mental health issues.* Workshop presentation at the national Safe and Drug Free Schools Conference, U.S. Department of Education, Washington, DC.

Flaspohler, P., Paternite, C.E., Duvall, N., Anderson-Butcher, D., Maras, M., & Wandersman, A. (2005, June). *Aligning Community Science and school based mental health: Policy and practice*. Symposium presented at the 10th Biennial Conference of the Society for Community Research and Action. Champaign, IL.

Weist, M.D. (2005, June). *Promoting mental health and school success for Mississippi youth*. Keynote presentation at the annual meeting of the Mississippi Association for School Health, Biloxi, MI.

Rush, M.L., Hedrick, B., & Anderson-Butcher, D. (2005, June). *School-community partnerships and school climate*. Paper presented at the 2005 Summer Institute: Schools and Community Partnerships that Work for Students. Columbus, OH.

Anderson-Butcher, D., Stetler, G., & Paternite, C.E. (2005, March). *Promoting school success and student well-being through effective community collaboration.* Presentation at the Partnerships for Success 2005 Evidence-Based Practices Symposium. Columbus, OH.

Koller, J. (2005, March). *Implications of Mental Health Issues in Individuals with Learning Disabilities.* Invited keynote address at the 2005 International Conference on Learning Disabilities, Reno, NV.

Paternite, C., Weist, M.D., Flaspohler, P., & Adelsheim, S. (2005, March). *School mental health topical discussion.* Paper presented at the 18th Annual Conference, *A System of Care for Children's Mental Health: Expanding the Research Base*, Tampa, FL.

Weist, M.D. (2005, March). *Advancing practice, training and education in school mental health.* Keynote presentation at the conference, *Inside the School House Door*, Southern Connecticut State University, New Haven, CT.

Morris, E. (February, 2005). *Community of Practice to Promote a Shared Agenda Across Education, Mental Health, and Family Organizations - Missouri's Seed Grant*. Presented at The IDEA Partnership Winter Meeting.

Weist, M.D. (2005, February). *Mental health screening in schools.* Presentation to the Illinois Children's Mental Health Partnership. Chicago, IL.

Paternite, C.E. & Rietz, K. (2004, December). *Crucial links between mental health and school success*. Presentation to the Ohio Educator Standards Board. Columbus, OH.

Paternite, C.E., Leigh, D., Rietz, K., Garner, T., & Estrop, D. (2004, November). *Addressing noncognitive barriers to learning*. Presentation at the 2004 Capital Conference. Columbus.

Armstrong, M., Duvall, N., Garner, T., Johnston, T., Maxwell, L., Paternite, C.E., Flaspohler, P., & Rietz, K. (2004, October). *From awareness to public policy to local action in promoting a mental health—schools—families shared agenda: Ohio's experience*. Workshop presented at the 9th National Conference on Advancing School-based Mental Health, Dallas, TX.

Burke, R., & Axelrod, J. (2004, October). *Integrating Education and Mental Health*. Discussion session presented at the 9th Annual Conference on Advancing School-Based Mental Health Services, Dallas, TX.

Burke, R. & Paternite, C.E. (2004, October). *The essential role of classroom teachers in promoting academic success and social/emotional well being*. Paper presented at the 5th Annual Conference on Curriculum and Pedagogy, Miami University, Oxford, OH.

Burke, R., Koller, J., Weston, K., & Axelrod, J. (2004, October). *The Missing Person in the School Mental Health Movement: The PK-12 Classroom Teacher*. Intensive training session presented at the 9th Annual Conference on Advancing School-Based Mental Health Services, Dallas, TX.

Garner, T., Paternite, C.E. & Rietz, K. (2004, October). *Building state infrastructure—Real world lessons: Ohio's experience*. Preconference workshop presented at the 9th National Conference on Advancing School-based Mental Health, Dallas, TX.

Johnston, T.C. & Paternite, C.E. (2004, October). *Teachers as partners in effective school-based mental health programs*. Paper presented at the 9th National Conference on Advancing School-based Mental Health, Dallas, TX.

Koller, J. & Evans, S. (2004, October). *Quality assessment and improvement in school mental health.* Informal meeting moderated at the Ninth National Conference on Advancing School-Based Mental Health, Dallas TX.

Morris, E. (October, 2004). *Building State Infrastructure: Real World Lessons*. Presented at the Ninth Annual Conference on Advancing School-Based Mental Health Services, Dallas, TX.

Morris, E. (October, 2004). *Past and Current Mental Health Status among Juvenile Offenders: Implications for School-Based Mental Health Programs*. Paper presented at the 9th Annual Conference on Advancing School-Based Mental Health Services, Dallas, TX.

Owens, J.S., Paternite, C.E., Richerson, L., & Maras, M. (2004, October). *University involvement in mental health—education partnerships: Benefits for all.* Paper presented at the 9th National Conference on Advancing School-based Mental Health, Dallas, TX.

Weston, K. J. (2004, October). *Infusing a mental health curriculum into preservice teacher education.* Paper presented at the Ninth National Conference on Advancing School-Based Mental Health, Dallas TX.

Weston, K. & Axelrod, J. (2004, October). *Involving educators in school mental health*. Informal meeting moderated at the Ninth National Conference on Advancing School-Based Mental Health, Dallas TX.

Paternite, C.E., Weist, M., & Adelsheim, S. (2004, September). *School-based mental health services*. Presentation to the Institute of Medicine Board of Health Care Services. Washington, D.C.

Paternite, C.E., Leigh, D., Rietz, K., Johnston, T., Oberlin, K. (2004, August). *Addressing the crucial links between mental health and school success: Public policy and local action*. Workshop presented at the 4th Annual School Health Interdisciplinary Program, Ellicott City, MD.

Weist, M.D. (2004, June). *No Child Left Behind and New Freedom implications for expanded school mental health.* Keynote presentation at the conference, ABCs of School Success, University of Minnesota, College of Education, Minneapolis, MN.

Armstrong, M., Rietz, K., Black, T., Black, T. Garner, T., Gulley, P., Paternite, C.E. & Powers, B.) (2004, May). *Enhancing collaboration to promote a mental health—schools—families shared agenda: Ohio's experience*. National NASDSE Satellite Teleconference on School-Based Mental Health. Moderator Joanne Cashman (NASDSE), additional presenters, Bill East (NASDSE) and Mark Weist (Center for School Mental Health Assistance). Broadcast from Pittsburgh, PA.

Paternite, C.E. (2004, May). *Best practices in expanded school mental health*. Workshop presented for the staff of the Center for Children and Families, Cincinnati, OH.

Weist, M.D. (2004, May). *Reducing academic and nonacademic barriers to learning through expanded school mental health*. Teleconference presentation, National Association of State Directors of Special Education, Pittsburgh, PA.

Weist, M.D. (2004, May). *Reducing barriers to learning through expanded school mental health*. Keynote presentation at the meeting of the Urban Special Education Leadership Collaborative, Education Development Center, Chicago, IL.

Weist, M.D. (2004, May). *Toward the integration of positive behavior supports and expanded school mental health*. Plenary presentation at a meeting of the IDEA Partnership, National Association of State Directors of Special Education, Alexandria, VA.

Lawson, H.A., Anderson-Butcher, D., Peterson, N., & Briar-Lawson, K. (2004, May). *Interprofessional design teams for learning, training and systems change*. Presented at the Altogether Better Health Conference: Education and Collaborative Practice Conference, Vancouver, BC, Canada.

Paternite, C.E. (with Leigh, D. & Rietz, K.) (2004, April). *Enhancing collaborations to promote a mental health—schools—families shared agenda*, Workshop presented at the 2004 Urban School Conference, Columbus, OH.

Garner, T., Paternite, C.E. & Rietz, K. (2004, February). *Enhancing collaborations to promote a mental health—schools—families shared agenda: Ohio's experience.* Research Roundtable presentation at the National Conference of State Legislatures (NCSL) Education Finance Seminar, Santa Fe, NM.

Morris, E. (2003, November). *Children's mental health: How well are elementary teachers prepared?* Presented at Kappa Delta Pi's 44th Biennial Convocation: Successful Teachers, Successful Schools, St. Louis, MO.

Paternite, C., Cashman, J., Axelrod, J., Burke, R., Koller, J., & Morris, E. (2003, November). *Teachers as promoters of student social and emotional health*. Presented at Kappa Delta Pi 44th Biennial Convocation: Successful Teachers, Successful Schools, St. Louis MO.

Weston, K. J. (2003, November). *Retaining quality teachers through wellness management.* Presented at Kappa Delta Pi 44th Biennial Convocation: Successful Teachers, Successful Schools, St. Louis, MO.

Weston, K. J. & Corey, K. (2003, November). *From at-risk to resilient: Changing the odds.* Presented at Kappa Delta Pi 44th Biennial Convocation: Successful Teachers, Successful Schools, St. Louis, MO.

Axelrod, J., Weist, M., & Burke, R. (2003, October). *Bridging the Gap between Education and Mental Health*. Workshop presented at the American School Health Association Conference. El Paso, TX.

Corey, K. & Koller, J. (2003, October). *Training for strengths-based mental health in schools: An online master's degree program*. Poster session presented at the Eighth National Conference on Advancing School Based Mental Health, Portland, OR.

Corey, K. & Koller, J. (2003, October). *Promoting positive mental health practices in university training: An online master's degree focusing on mental health in schools.* Poster session presented at the Eighth National Conference on Advancing School Based Mental Health, Portland, OR.

Morris, E., Koller, J., Weston, K. & Armstrong, D. (2003, October). *Implementing a "Shared Agenda:" A state perspective.* Paper presented at the Eighth National Conference on Advancing School Based Mental Health, Portland, OR.

Parks, N., Osterlind, S., Koller, J., Morris, E. & Carter, P. (2003, October). *Examination of mental health indicators as they relate to population differences: Implications for juvenile justice.* Paper presented at the Eighth National Conference on Advancing School Based Mental Health, Portland, OR.

Morris, E. (October, 2003). *How Can We Better Prepare Elementary Teachers Regarding Children's Mental Health*? Eight Annual Conference on Advancing School-Based Mental Health. Portland, OR.

Weston, K. J. (2003, October). *Children and adolescents with ADHD in our schools: Capitalizing on strengths.* Poster session presented at the Eighth National Conference on Advancing School Based Mental Health, Portland, OR.

Weston, K. J. & Koller, J. R. (2003, October). *Bridging the gap between mental health and education: Developing an effective framework for the translation of mental health into PK-12 classrooms*. Paper presented at the Eighth National Conference on Advancing School Based Mental Health, Portland, OR.

Weston, K. J., Morris, E., Hubbard, C. J., Armstrong, D. (2003, October). *Mental health, schools, and families working together for all children and youth: Toward a shared agenda in Missouri.* Paper presentation at the 8th Annual Conference for Advancing School-Based Mental Health, Portland, OR.

Morris, E. (2003, October). *Implementing A Shared Agenda: A State Perspective*. Paper presentation at the 8th Annual Conference for Advancing School-Based Mental Health, Portland, OR.

Morris, E. (2003, October). *Examination of Mental Health Indicators As They Relate To Population Differences: Implications for Juvenile Justice*. Paper presentation at the 8th Annual Conference for Advancing School-Based Mental Health, Portland, OR.

Koller, J. & Morris, E. (2003, October). *Global implication of a State mental health authority and university collaboration.* Symposium conducted at the International Conference for School Mental Health, Portland, OR.

Burke, R. & Axelrod, J. (2003, April). *Teacher Participation in Expanded School Mental Health*. Workshop presented at the ACEI Annual International Conference and Exhibition. Phoenix, AZ.

Paris, K., Koller, J. R., Osterlind, S., Cramer, M., & Weston, K. (2003, April). *Teachers' perceptions of the role of mental health in education*. Paper presented at the annual meeting of the American Educational Research Association (AERA), Chicago, IL.

Weist, M.D. (2003, April). *Advancing school mental health in Northwest Ohio*. Keynote presentation before education and mental health system leaders, and family advocates and youth, Bowling Green, OH.

Brooks, C. & Koller, J. (2002, September). *The changing face of mental health in schools: Progress towards overcoming administrative, fiscal and ideological barriers.* Paper

presented at the Seventh National Conference on Advancing School-Based Mental Health, Philadelphia, PA.

Koller, J., Schuffman, D. & Morris, E. (2002, September). *Promoting positive mental health practices in university training: Implications for systems change within the school and community.* Paper presented at the Seventh National Conference on Advancing School-Based Mental Health, Philadelphia, PA.

Morris, E. (September, 2002). *The Missouri Approach to a University and Mental Health Training Collaboration*, Paper presentation at the 7th Annual Conference for Advancing School-Based Mental Health. Philadelphia, PA.

Paris, K., Koller, J., & Osterlind, S. (2002, September). *The role of mental health training in the undergraduate education of teachers*. Poster session presented at the Seventh National Conference on Advancing School-Based Mental Health, Philadelphia, PA.

Representative Publications

Weist, M.D., & Paternite, C.E. (in press). Building an interconnected policy-training-practice-research agenda to advance school mental health. *Education and Treatment of Children*.

Evans, S.W., Williams, A., Shultz, B., & Weist, M.D. (in press). Behavioral assessment in schools. In C. Spielberger (Ed.), *Encyclopedia of applied psychiatry*. San Diego, CA: Elsevier Science/Academic Press.

Flaspohler, P.D., Anderson-Butcher, D., Paternite, C.E., Weist, M.D., & Wandersman, A. (2006). Community science and expanded school mental health: Bridging the research to practice gap to promote child well being and academic success. *Journal of Educational and Child Psychology, 23(1),* 27-41.

Anderson-Butcher, D. (2006). The role of the educator in early identification, referral and linkage. In R. J. Waller (Ed.), *Child and adolescent mental health issues in the classroom*. Thousand Oaks, CA: Sage Publications.

Paternite, C.E. (2005). School-based mental health programs and services: Overview and introduction to the special issue. *Journal of Abnormal Child Psychology*, *33*, 657-663.

Paternite, C.E., Flaspohler, P., & Rietz, K. (2005). Promotion of effective school mental health programs and services in Ohio. *Report on Emotional and Behavioral Disorders in Youth*, *5(3)*, 65-66, 69-72.

Paternite, C.E. & Johnston, T.C. (2005). Rational and strategies for central involvement of educators in effective school-based mental health programs. *Journal of Youth and Adolescence*, *34*, 41-49.

Weist, M.D. (2005). Fulfilling the promise of school-based mental health: Moving toward a *public mental health promotion* approach. *Journal of Abnormal Child Psychology*, *33*, 735-741.

Morris, E. (2005). Working Across Systems: The Intersection of Education, Mental Health, and Juvenile Justice. *Counterpoint*. National Association of State Directors of Special Education. Summer 2005.

Axelrod, J., Burke, R., Cashman, J., Evans, S., Koller, J., Morris, E., Paternite, Rietz, K., & Weist, M. (2004). Enhancing student resilience through innovative partnerships. In C. S. Clauss-Ehlers & M. D. Weist (Eds.), *Community planning to foster resiliency in children*. New York: Kluwer Academic/Plenum Publishers.

Koller, J., Osterlind, S., Paris, K., & Weston, K. (2004). Differences between novice and expert teachers' undergraduate preparation and ratings of importance in the area of children's mental health. *International Journal of Mental Health Promotion*, *6*(2), 40-45.

Paternite, C.E. (2004). Involving educators in school-based mental health programs. In K. Robinson (Ed.), *Advances in school-based mental health: Best practices and program models* (pp. 6-1 – 6-21). Kingston, NJ: Civic Research Institute, Inc.

Anderson-Butcher, D. (2004). Transforming schools into 21st Century Community Learning Centers. *Children & Schools*. *26(4),* 248-252.

Morris, E. (2003). Teacher Mental Health Knowledge and Attitudes. *CSMHA Newsletter*. Center for School-Based Mental Health Assistance.

Koller, J. & Svoboda, S. (2002). The application of a strengths-based mental health approach in schools. *International Journal of Childhood Education, 78(*5), 291-295.

Weist, M.D., & Christodulu, K.V. (2000). Better mental health care helps heal kids. *Education Digest* (reprinted from the *Journal of School Health*), *66*, 50-56.

Appendix C
Preliminary List of Core Workforce Competencies for Advanced Interdisciplinary Mental Health Practice in Schools*

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. Develop and sustain relationships with school administrators, school-employed mental health staff, teachers and support staff, families, and community partners.
3. Maintain thorough and up-to-date knowledge of major educational initiatives and polices that impact schools at the federal/national, state, and local level; and ensure that SMH practices align with those educational realities.
4. In all work, demonstrate an understanding of factors influencing school culture and climate, educators' potential roles as mental health/wellness change agents.
5. Demonstrate a thorough understanding of systems change theory and best practices and demonstrate an ability to work in complex systems.
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.
7. 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.
8. 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.
9. Develop and continuously enhance communication channels and relationships with school staff.
10. Develop and continuously enhance strategies for outreach to students and families for services and for active program guidance.
11. Maintain appropriate student and family privacy and confidentiality, guided by standards of practice.
12. Develop and continuously enhance collaborative relations with teachers in working together to improve classroom environments and student behaviors.
13. Assist teachers in learning skills that can be shared with students that reduce mental health barriers to learning.
14. Assist teachers in proactively identifying students contending with stress/risk and/or presenting emotional/behavioral problems.
15. Participate effectively in school decision-making teams including those focusing on services and supports for individual students and those focusing on school improvement.
16. Participate in collaborative actions that improve the school environment and/or broadly teach students important and evidence-based life skills.
17. Implement prevention and skill training group interventions that are based on evidence of positive impact with similar students.
18. 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.

19. 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.
20. 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).
21. Conduct integrated academic and mental health assessments in a manner that is therapeutic for students and families.
22. 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.
23. Actively share assessment findings with students and families (and when appropriate, school staff) and involve them as active and equal collaborators in decision-making.
24. Implement preventive and supportive interventions for youth presenting needs for assistance, including those without psychiatric diagnoses, using evidence-based strategies.
25. Implement treatment for youth meeting criteria for psychiatric diagnoses using evidence-based strategies.
26. Implement systematic quality assessment and improvement (QAI) strategies to monitor and continually improve the quality of all services.
27. 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.
28. Share evaluation findings and outcome data with students, families, and school staff and integrate their feedback into QAI planning and action.
29. 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.
30. Assist the school in developing and implementing effective plans to prevent and respond to crises.
31. Address high-risk student problems, including reports of abuse and neglect, and suicidal and homicidal ideation and behavior.
32. 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.

*Adapted from work underway by:

1) Center for School Mental Health Analysis and Action at the University of Maryland (grants: (a) #U45 MC00174-10-0, 2000-2005, *Achieving the Promise of Expanded School Mental Health*. MCHB, Health Resources and Services Administration; Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; and (b) #1R01MH71015-01A1, 2003-2006, *Enhancing Quality in Expanded School Mental Health*. National Institute of Mental Health, U.S. Department of Health and Human Services);
2) Center for School-Based Mental Health Programs at Miami University (grants: (a) #062984-6B-PB-04P05P/06, 2003-2006, *Mental Health for School Success*, Ohio Department of Education; and (b) #G01085, 2005-2006, *Enhanced Ohio Mental Health Network for School Success*, Ohio Department of Mental Health);
3) Center for the Advancement of Mental Health Practices in the Schools at the University of Missouri, Columbia (portfolio development project for Masters degree program in Mental Health Practices in Schools); and
4) Collaborative for Academic, Social, and Emotional Learning (key informant interview study completed by MHEDIC co-lead Jennifer Axelrod, July-August, 2005).

Figure 1

Factors Necessary to Achieve Desired Outcomes for Youth Through SMH Programs and Services