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\textbf{ABSTRACT}

Recent health care reform provides many new opportunities to expand mental health and behavioral support to students in schools and school–community partnerships. Through newly available funding sources, as well as expanded legislative initiatives, school psychologists can advocate for and become leaders in delivering universal programming, tiered mental health supports, and formalized collaborative efforts with community agencies. The authors highlight the application of tiered levels of services, with current practice samples, designed to address students’ mental and behavioral health. Implications for practice are discussed.

There has perhaps been no other time in history where there has been as great a focus on children’s mental health. Through a series of tragic events, legislative will, and grassroots advocacy, various laws and policies recently have been enacted calling attention to, and allocating funds for, children’s mental and behavioral health services. The most well known, the Patient Protection and Affordable Care Act (ACA; 2010), expanded Medicaid coverage for children and renewed the Children’s Health Insurance Program through 2019 (National Association of School Psychologists, 2013). In addition to these formalized policies, the Now is the Time document (White House, 2013) called for an increase in school safety and enhanced access to mental health services, with an emphasis on addressing these needs in school settings. This heightened focus on children’s mental health services holds important implications for school psychological practice. The purpose of this article is to articulate steps that school psychologists can take to serve as mental health leaders in their buildings and districts, enhance the services provided to all students, and access potential funding sources for their efforts.

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The statistics regarding children’s mental health are grim and findings regarding families’ access to mental health services for their children have remained virtually unchanged over the last 20 years (U.S. Department of Health and Human Services, 2000). When children and adolescents do receive mental health care, it most likely is provided within school-based settings (Farmer, Burns, Phillip, Angold, & Costello, 2003; Rones & Hoagwood, 2000). In fact, Lear (2007) described a vast hidden system of health care within schools that has been overlooked by community health care providers, legislators, and insurance companies. Using a combination of sources, Lear estimated that during the early 21st century there were approximately “56,000 school nurses, 1,725 school-based health centers, 99,000 school counselors, 30,000 school psychologists, and 14,000 school social workers” who were “working in 95,000 public schools serving more than fifty million students across the county” (p. 410). If community systems and school-based resources were able to bridge their services, the supports to children in the areas of physical, behavioral, and mental health would be expanded substantially.

Integration of children’s education, mental or behavioral health, and medical care represents one of the newest challenges and opportunities for school psychologists. The definition of health now includes educational outcomes, effectively making a child’s education a health outcome (National Research Council and Institute of Medicine, 2004). This connection is highlighted in the research demonstrating the negative health outcomes for those with limited education due to expulsion, school dropout, or other barriers that interfere with educational attainment (Telfair & Shelton, 2012; Vaughn, Salas-Wright, & Maynard, 2014). A public health model represents an established model for approaching children’s mental and behavioral health and aligns with the Model for Comprehensive and Integrated School Psychological Services developed by the National Association of School Psychologists (2010).

**School mental health as public health**

Over the past three decades, there has been a growing recognition among school psychologists that we cannot provide effective services by supporting children one at a time and only after they have begun to fail. This recognition has led to alternative methods of service delivery that include comprehensive, integrated services designed to promote positive outcomes and prevent problems (Cummings et al., 2004; Dawson et al., 2004; Hess, Short, & Hazel, 2012). Further, there is a growing emphasis on programming that fosters the adaptive functioning and social emotional growth of all children by developing effective systems for recognizing and dealing with early signs of distress. To advance this preventive model, school psychologists must think about their roles differently and consider how they can create the broadest level of service delivery through their own services and through collaboration with others (Sheridan & Gutkin, 2000). Systemic approaches such as primary prevention programs and school–community linkages help to ensure that services are provided to all students.

These types of approaches align with a public health model that emphasizes prevention, promotion of positive outcomes, population-based assessment and
interventions, and comprehensive services (Hess et al., 2012). The public health model defines issues and clinical problems as being multidetermined and existing along a developmental continuum. Effective public health interventions rely on careful identification of systemic problems and focus treatment on important individual, family, school, and community targets. A multtiered system of supports (MTSS) fits effortlessly within a public health model, and when implemented together broadens the scope and definition of children’s mental and behavioral health services to include a full continuum of service provision.

One of the key components of a public health model is an emphasis on prevention. Research has consistently demonstrated that adverse childhood experiences (ACEs) are linked to psychological difficulties across the lifespan (e.g., Anda et al., 2002; Chapman et al., 2004). Therefore, one of the growing areas of need is to provide supports for youth who have experienced adversity. Adverse conditions are commonly identified as problems related to family situation such as parental separation, unemployment, substance abuse, or being sent away from home. Additionally, home and community violence (through child abuse, being a victim of violence, being threatened, held captive, or sexually abused or assaulted, or witnessing serious violence), and childhood neglect also are measured. In a community sample of 1,093 high school seniors living in diverse communities, Schilling, Aseltine, and Gore (2007) found that the most common ACEs reported were parental separation (27.5%), followed by parental unemployment (17.6%), witnessing serious injury or murder (16.6%), and parental substance abuse (14.2%). Females experienced higher levels of sexual abuse and assault than males, as well as more physical abuse and neglect. Boys reported higher levels of witnessing violent events, experiencing physical assault, and being threatened or held captive as compared with girls. So too, important ethnic differences emerged with Black and Hispanic high school seniors witnessing serious violence at a rate twice that of White adolescents. Alternatively, White students reported much higher rates of parental substance abuse than did either Black or Hispanic adolescents.

The findings of Schilling et al. (2007) highlight the important public health impact of these adverse events on youth given the strong association between ACEs and future negative outcomes such as depression, substance use, and antisocial behaviors that persist into adulthood. Many of these negative outcomes can be avoided with the provision of early intervention programming, as it is effective in reducing later incidence of mental health problems (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). For school psychologists, certain challenging student behaviors such as truancy, disruptive behaviors, and substance use may be viewed as indicators of distress, which may be related to having experienced multiple ACEs. Screening for ACEs allows school psychologists and other school-based mental health professionals to help link students to services and supports that reduce risk. Although we may not be able to remove all adverse events for youth in our schools, developing early intervention systems that help to reduce risk through universal programming (e.g., stigma reduction, mental health first aid [MHFA], improved school climate, reduced school violence), selective programming for high-risk groups (e.g., skill-building classes, psychoeducational groups, check in/check out with school
mentors), and indicated services (e.g., wraparound services, school-based health centers, collaboration with community agencies) can help to mitigate the negative impact of these negative life events.

**Mental health programming across levels of need**

The work of schools is to enhance the education of our nation’s youth. Yet, students’ capacity to learn in these environments is influenced by a number of factors, including the amount of available support services. A growing body of research demonstrates academic gains when schools proactively address the social and emotional development of their students. For example, a recent study of more than 270,000 students demonstrated academic achievement was 11–17 percentile points higher in schools that implemented universal social and emotional learning programs (Durlak et al., 2011). As it is mandated that children and adolescents must attend schools, the school setting is an ideal location for addressing many of student’s mental health needs through universal prevention and early intervention efforts (Lendrum, Humphrey, & Wigelsworth, 2013; National Association of School Psychologists, 2016).

School psychologists are in a unique position to build systems of support that enhance the development of students and counteract some of the adverse experiences that are all too common for youth. Through their leadership and collaborative efforts, school psychologists can build responsive and supportive systems in which all students can learn. Although this change in practice may seem daunting, we provide an overview of some of the actions and strategies that school psychologists can take to act as leaders in this change. In the following sections we highlight the different levels of service delivery (e.g., universal, selective, indicated) and provide examples of districts and agencies that have taken on the challenge of expanded services to all youth. These examples come from different areas of the United States and were selected because they reflected an exemplary approach to meeting some of the needs of children and adolescents. These types of programs can be implemented by school psychologists who wish to be mental health leaders and advocates in their settings and promote preventive mental health and well-being for all students.

**Universal approaches**

There are many different approaches for creating supportive and positive school environments relevant to all students’ mental health and behavioral well-being. Typically developing youth experience challenges while navigating childhood and adolescent tasks, such as building positive peer relations and identity development. Yet, for youth with mental health disorders, the impact of stigma and discrimination can have profound implications in their developmental trajectory (U.S. Department of Health and Human Services, 2000). To address this need, the National Institutes of Health Office of Science Education and the National Institute of Mental Health sponsored the development of the Science of Mental Illness curriculum that is
targeted to students in middle school. This program introduces the biological bases of mental illnesses through modules that cover the development and identification of disorders such as attention-deficit/hyperactivity disorder, depression, and schizophrenia. After widespread implementation in the United States, an evaluation of this program conducted by Watson et al. (2004) indicated that students who received the curriculum demonstrated significant improvements in knowledge and attitudes regarding mental illness; gains were the greatest for those who had initially indicated more negative attitudes. Implementation of this type of curriculum may help reduce stigma and discrimination toward those with mental illness, which may, in turn, encourage more students who are in distress to seek help.

Another universal strategy for addressing students’ mental health is training school-based non–mental health professionals in mental health first aid (Kitchner & Jorm, 2008). This program was identified as the first component in a two-pronged federal initiative called Project AWARE (Advancing Wellness & Resilience in Education) which is designed to ensure that children, adolescents, and young adults are referred for, and receive, the mental health care they need (White House, 2013). MHFA has been adapted from its original use with adults to meet the need of those who work with adolescent populations (13–18 years old). Similar to the Red Cross’s first aid and cardiopulmonary resuscitation training, the objective is to provide the nonprofessional with tools to assess whether an individual is in critical need, to stabilize the person as possible, and get him or her to a professional. The general outline for this course teaches a MHFA action plan that follows the acronym ALGEE. These letters stand for the following actions: (a) Assess the risk of suicide or harm, (b) Listen nonjudgmentally, (c) Give reassurance and information, (d) Encourage appropriate professional help, and (e) Encourage self-help strategies (Jorm, Kitchner, Sawyer, Scales, & Cvetkovski, 2010). This program has great potential for helping all school personnel to have increased knowledge and awareness of mental health concerns, to be able to identify signs of early risk, and to reduce stigma within the school setting.

In a randomized control study at seven schools in Australia, teachers received a modified version of the MHFA program. After the training, teachers demonstrated increased knowledge about mental health issues, endorsed beliefs about mental health issues that were more consistent with mental health professionals, reported reduced stigma regarding individuals with mental health needs, and increased confidence in helping a student with mental health concerns as compared to teachers at the wait-list control schools (Jorm et al., 2010). Additional analyses indicated that students reported receiving more mental health information from their teachers. However, there were no changes in teachers’ individual support provided to students with mental health concerns. Most of the changes were still present at a six-month follow up. Given the promising nature of this program, as well as available funding to support this training, some school districts in the United States have enacted efforts to train all school personnel in this approach, with school psychologists serving as trainers.
Universal example: Preparing a district in MHFA

In one large Mid-Atlantic school district, the Psychological Services Unit contracted with a local community mental health organization to train 12 of their school psychologists and social workers as MHFA trainers. During the summer, this group of mental health professionals attended a five-day training to become certified MHFA trainers, with the commitment to providing a minimum of three MHFA trainings per year to district employees. The MHFA trainings have been included as one of many professional development opportunities that all district employees, including contract staff (such as bus drivers and cafeteria workers), can access. The district-led MHFA training was a cotaught by two of the trained mental health professionals, capped at 25 participants per session due to the interactive nature of the training, and offered as two 4-hr trainings or one 8-hr training. As with all professional development, district employees received release time to participate (i.e., substitutes are provided for teachers who attend).

The district goal was that all non–mental health professionals who interacted with students would be trained in MHFA. With six teams of mental health professionals each providing three trainings per year to approximately 20 participants per session, 360 district employees were trained in MHFA each year. One of the MHFA trained school psychologists in the district attributed the district’s commitment to mental health awareness and early intervention to three sources. First, the district had recently hired a new superintendent who previously had been a special education teacher for students who were identified under the federally defined, emotional disturbance category. Under his leadership, the district had developed a strategic plan to realize its mission statement that “Every student will have the academic, creative problem solving, and social emotional skills to be successful in college and career.” This revised mission statement placed an emphasis on developing students’ social emotional skills and recognizing that social emotional skills impact academic outcomes, an emphasis that previously had not been evidenced. The second facilitator of the MHFA training was a growth surge in the student population, with no commensurate increase in school psychological services. Therefore, the mental health service unit needed to increase the capacity of all staff to respond appropriately to students’ mental health needs. MHFA was seen as a systematic means to “give psychology away” (Miller, 1969, p. 1071), such that staff would know when and how to make mental health referrals. Third, the mental health service unit had documented an increase in the mental health needs of its student population.

In the community that this district served, there were high numbers of families who experienced transience, homelessness, and other traumatic events; were recent immigrants; or who had military involvement. Oftentimes, district personnel attributed students’ misbehavior to insubordination and unintentionally escalated situations. The goals of implementing MHFA training with all district personnel who interact with students were to (a) increase appropriate referrals and decrease inappropriate referrals to special education, (b) decrease the stigma regarding mental illness and needing mental health support, and (c) help staff reframe
students’ willful and intractable misbehavior as possibly representing a mental health need. In each case, the overall effort was directed at appropriately identifying and intervening with students to create positive behavior changes. Relatedly, the district was under scrutiny from its State Department of Education for its high number of suspensions and the racial disproportionality of students who received punitive discipline. The school psychologist expressed the hope that MHFA would lead to attitudinal changes toward students with mental health needs among teachers and administrators. She and the other school psychologists proposed that the district evaluate this aspect of the program.

**Selective interventions**

Universal programming that facilitates increased knowledge and capacity of school personnel and students is an important component of MTSS. An effective tiered system provides seamless programming at increasingly intensive levels of support and serves as an effective framework for addressing, monitoring, and improving students’ behavioral and mental health outcomes. Consistent with the National Association of School Psychologists Practice Model (National Association of School Psychologists, 2010), these tiered levels of support represent an important component of the Interventions and Mental Health Services to Develop Social and Life Skills domain. In short, the implementation of MTSS for students with behavioral and mental health challenges across all ages and intervention intensity levels may enhance overall school climate, improve student behavioral health outcomes, and decrease inappropriate or disproportionate discipline and labeling practices (Hess, Pejic, & Sanchez Castejon, 2014).

One of the key elements of delivering tiered services is the ability to identify those students who would benefit from additional supports beyond those provided at the universal level. Creating a safe environment through stigma reduction and greater awareness of mental health concerns represents an initial step, but more focused identification strategies also are needed. Universal screening is critical to identify at-risk students who need supplementary behavioral and mental health services. When prevention and early intervention efforts have not been successful, implementation of more selective interventions is needed. These selective, or Tier 2, interventions include strategies that have been proven effective and can be implemented quickly. For example, Tier 2 interventions may focus on providing additional psychoeducational approaches (e.g., anger management, stress reduction), additional opportunities for practice (e.g., coping skills, mindfulness), and goal setting through existing support programs in the school. By providing a high level of practice and reinforcement with a smaller number of targeted students, school personnel increase the probability that students will experience success and generalize new behaviors to the broader school context. When behavioral concerns co-occur with social emotional needs, social skill interventions, check in/check out, behavioral contracts, and self-management strategies may be an additional programming element delivered at Tier 2 (Hawken, Vincent, & Schumman, 2008). These selective or
targeted interventions can address the needs of vulnerable students in a small group setting by enhancing the ecology of the school environment while also increasing connections with peers—a vital aspect of student success (Doll, Spies, & Champion, 2012).

Programs that are designed to improve the mental and behavioral health of students also meet the goal of increasing school safety. For example, when teachers and other educational personnel have increased trust and communication in their schools, they are better able to detect potential threats (Eliot, Cornell, Gregory, & Fan, 2010). Furthermore, many of the programs that are designed to improve school climate (e.g., Positive Behavioral Interventions and Supports) also are effective at reducing bullying and other types of violence. In some districts, many students have been exposed to community violence, which not only has a negative impact on students’ mental health (Chapman et al., 2004; Schilling et al., 2007), but also increases the likelihood that they themselves will commit violent acts (Baskin & Sommers, 2014). Therefore, school-based violence prevention programs, mental health services that address trauma and anxiety, and educational curricula that teach conflict resolution are essential to any comprehensive model of student support.

**Selective example: Comprehensive behavioral health model**

In 2011, the school psychologists and leadership of the Boston Public Schools (BPS) sought to enhance the school and community-based behavioral health services available to the 55,000 students in this urban district. This district provides educational experiences to a highly diverse community; over 100 different languages are spoken in homes of students attending schools in this area. The student body comprises multiple racial and ethnic groups, including Hispanic (43%), African American (34%), White (13%), and Asian American (8%) youth. Nearly 45% of students do not have English as a first language and a significant percentage of students (70%) are from low-income families (Amador et al., 2013). Students in need of behavioral health supports primarily are serviced through special education with nearly 20% of the students in Boston receiving identified for these special educational services (Massachusetts Department of Elementary and Secondary Education, 2017). Within this subgroup of students, nearly 13% received services under the federal classification of emotional disturbance (ED), making it the second largest disability group in the district, and at a rate much higher than state or national averages (9.3% to 8.4%, respectively). Furthermore, in comparison with all students, African American students were being disproportionately identified as having an ED, while Asian students were under-identified.

Approximately 20% of the community’s school-age students experienced a mental health disorder, similar to national public health data (e.g., Kessler & Wang, 2008); yet the barriers to receiving health care services were profound (Boston Public Health Commission, 2013). Caregivers struggled to get their children to needed health care services due to barriers related to affordability, as restrictions with insurance reimbursements and inconsistent partnerships limited accessibility
to care. The families indicated a need for a centralized location where their children could have their emotional and physical needs met. Even though BPS offered an array of behavioral health services and facilitated partnerships with multiple community agencies, the lack of systematic identification of student needs and fragmented support services for the most at-risk children left many vulnerable. Services varied greatly from school to school and tended to be provided in a reactive manner after a crisis. Thus, there was a clear need for a service delivery structure, supported in the language of the ACA, to ensure access to preventive health care services, as well as increase opportunities for school-based mental health services for all students (Cunningham, Grimm, Brandt, Lever, & Stephan, 2012).

The pressing behavioral health needs of students and the gaps in service delivery inspired the school psychologists of the BPS district to create a Comprehensive Behavioral Health Model. This model was constructed with the belief that integrating behavioral health services into schools would optimize academic outcomes for all students and create safe and supportive learning environments. Using data-driven and proactive strategies, school psychologists work with classroom teachers and building level teams to screen all students for developing behavioral health issues. Given the vast needs of the students, invested community agencies joined in the partnership of this work, and in January 2012, an Executive Work Group (EWG) was formed. The EWG consisted of individuals representing behavioral health staff of BPS, community mental health providers from Boston Children’s Hospital, and the faculty from University of Massachusetts Boston school psychology program. This workgroup supported the district administration and met weekly to solidify the model, design a timeline and implementation plan, and compile a guidebook for schools to participate in the first pilot year. Specifically, they designed a consistent evaluation framework based on a logic model to measure the effectiveness of programming across different schools by identifying common anticipated outcomes and data points that would serve as indicators of progress toward program goals. Additionally, the EWG strategized about how to best engage and collaborate with other departments in the district, as well as other external community mental health partners. Interviews were conducted with key stakeholders to obtain feedback about the model and to secure buy-in from administrators, teachers, parents, and community members.

Once there was clear support for this prevention and early intervention adaptation to service delivery, a small cohort of schools were identified to be early adopters. Within this time frame, a team of school psychologists and consultants piloted and critically examined five population-based behavior screening systems. These data, in combination with existing data and research, served as the foundation for systematically identifying student needs and for allocating resources for interventions. During the 2012–2013 school year, 10 schools rolled out the model by providing professional development trainings for staff, implementing universal supports (e.g., Second Step, Open Circle), systematically screening students, and targeting evidence-based interventions to address needs. In each of the following years (2013–2014, 2014–2015, 2015–2016, 2016 to present), an additional 10 schools have implemented a
Comprehensive Behavioral Health Model—resulting in 50 schools now providing comprehensive services with behavioral screening of more than 20,000 students. These screenings identify both problem and adaptive behaviors that either act as barriers or contribute to school success—an important indicator of health outcomes. Selective intervention services, such as check in/check out and skills group counseling, have resulted in significant improvements for students demonstrating levels of risk (Snyder, Pearrow, Kaye, & Briesch, 2016). Ongoing data collection and preliminary findings indicate that those schools in their third year of implementation are demonstrating fewer conduct problems and improved social functioning among students. Furthermore, cohort buildings are experiencing fewer referrals for special education, thus reducing overidentification and unnecessary referrals. In turn, school psychologists report having more time for prevention and intervention services (Sheppard, Broadhead, Pearrow, & Snyder, 2015).

**Indicated interventions**

Behavioral health is intimately connected to academic and social success. Students with the most intensive behavioral health challenges experience less school success than any other subgroup (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). Typically, only 1–5% of the student population within a school setting will require the most intensive levels of interventions (Sugai, Horner, & Gresham, 2002). Students identified as needing indicated, or Tier 3, interventions require a more intensive, focused level of service designed to address symptoms and behaviors that represent the highest levels of risk. Although some students may have their needs addressed by receiving services within the school setting, others may need more comprehensive services provided through collaboration with local community agencies and supports. School psychologists must be prepared to help those students and their families find these needed services and to effectively collaborate with other service providers.

For those with the greatest needs, improvements in academic and emotional functioning are demonstrated and maximized when mental health services are integrated into the classroom setting (Kutash, Duchnowski, & Green, 2011). Services infused into the school setting, provided in partnership with local community agencies, including community mental health centers, represents a promising approach for stabilizing and improving the functioning of children with chronic mental health problems. These coordinated care models are sometimes referred to as systems of care (Stroul & Friedman, 1996) in which multiple providers (e.g., schools, mental health, juvenile justice) develop cooperative agreements to meet the needs of children and families in their communities with a focus on the specific needs and strengths of the child and his or her family. Another model based on a similar philosophy is referred to as wraparound (Bruns & Walker, 2010), and it represents a child- and family-centered process for providing comprehensive, research-based, culture-specific services to students with chronic mental health needs through family, school, social services, and community agency collaboration. In
both approaches, these collaborative partners develop, implement, monitor, and evaluate outcomes of specific treatment plans. Due to their specialized expertise, school psychologists have an important role in the coordination of individualized, system-wide service provision to improve the overall functioning of students with serious mental and behavioral health needs.

This more intensive level of integrated services is consistent with the second component of the Project AWARE initiative mentioned previously. To enhance students’ outcomes, efforts must be made to ensure that youth with mental health needs are referred for the services that they need through collaboration with law enforcement, mental health agencies, and other local organizations (White House, 2013). Once these collaborative partnerships are in place for identified students, they may then serve as a type of safety net when those students exit the school system.

As noted, youth with the most severe needs are often served in multiple settings including special education, social services, and juvenile justice (Friedman et al., 2004). As an example of an indicated intervention with children and adolescents with behavioral difficulties and ACEs, some juvenile justice facilities provide a coordinated system of care that aligns well with a comprehensive model of service delivery for school psychologists. The vast majority of youth who are served by juvenile justice agencies have overlapping educational and mental health needs (Cocozza, Skowyra, & Shufelt, 2010), and coordinating services across settings and specialties is necessary to address the multiple needs of this population (Cruise, Evans, & Pickens, 2011; Kinscherff, 2012). In particular, youth served by juvenile justice systems are likely eligible for services in school and community settings under a variety of funding sources and partnerships.

In every state, and within states at the county level, there is a juvenile justice system housed within local governmental agencies (Sander & Fisher, 2014). Most juvenile justice systems, while diverse, prioritize deferral from formal legal proceedings in the interest of rehabilitation, rather than restitution alone. Additionally, most of these systems also have established a priority on preventing future juvenile crime by identifying youth risk factors or challenges to intervene in the trajectory of a specific child or adolescent. These risk factors are well documented and fairly consistent across the United States, including (a) academic skill weaknesses, (b) school failure, (c) mental health needs, (d) substance use issues, (e) traumatic event histories, (f) frequent school disciplinary incidents, and (g) disproportionately high special education participation rates under the ED category (Cocozza et al., 2010). Family system stress, parental substance use, economic strain or poverty, and community exposure to violence also are common challenges for this population. Youth in some juvenile justice settings make academic gains similar to their nonadjudicated peers while detained. Despite these improvements, they follow a trajectory of lower school attainment once they transition back to the community (Cavendish, 2014).

The juvenile justice systems at the policy level are urged to advocate for and refine a collaborative system of care for all juveniles on their caseload. There are initiatives at the federal level to guide services and collaborate across different settings including mental health, education, and school-justice facility coordination. Juvenile facilities are public education agencies, and, as such, they are required to acquire
educational records and coordinate with education professionals to implement the special education services in an individualized education plan (IEP). Juvenile agencies regularly provide and work with school resource officers, who may help facilitate the reintegration of juveniles released from detention or monitor those serving on probation. Additionally, these officers may serve as a law enforcement liaisons who participate on collaborative school teams with the goal of helping keep other students out of juvenile detention and in school.

Given that counties determine the structure of juvenile justice systems, each agency is as individual as a school building, with few uniform standards of service delivery. The burden of collaboration, partnering, and fostering innovation of new practices and services often is a formidable barrier to a comprehensive and coordinated system. At the same time, some juvenile justice agencies are accomplishing this goal. When the leadership at a specific agency is supportive of fostering multiple community partnerships, this variability can be an asset. As an example, the practices of one county are highlighted subsequently. This agency collaborates with and combines funding streams with schools and other community agencies to provide wraparound services, coordinated care with a plan and vision for service delivery, and consistent participation among stakeholders. All of these tenets also are embedded within the ACA, under the umbrella of Health Homes, which includes funding for collaborative wraparound services that are provided in a coordinated way by multiple professionals and agencies, and is applicable in a school-based mental health setting (see Pires, 2013). Serving children who have chronic, complex behavioral and emotional needs, such as those most likely to be served in juvenile justice settings, is the main focus of that particular ACA program.

**Indicated example: Coordinated systems of care in juvenile justice services**

In recognition of the multiple challenges of youth involved in the juvenile justice system, one agency in central Texas developed a system using collaboration and coordinated services to more effectively meet the needs of youth in their community. Williamson County has grown from a semirural to an urban area with somewhat rapid population growth. A recent influx of ethnically and racially diverse individuals altered the demographics from predominantly White middle class to a population that is diverse both culturally and economically. Currently, Latinos represent roughly 25% of the population with the remaining groups including 65% White/non-Hispanic and approximately 10% Black residents (U.S. Census Bureau, 2014). The county facility serves approximately 3,200 youth per year, about half in prevention and half in their formal services or other community intervention/referral programs.

The vision statement at this juvenile justice agency is “Making a difference in our community: creating opportunities for positive change through hope, empowerment, prevention and accountability” (Williamson County Juvenile Services, 2015, p. 2). As part of this vision, they have infused a framework using the 40 developmental assets from the positive youth development literature (Benson, 2007; Benson &
Scales, 2009) throughout their programs. These assets include the broad life skills of commitment to learning, maintenance of positive values, constructive use of time, and youth empowerment. The agency's programming is tied to these positive elements and the skills are infused and coordinated into their services across different programs and providers to offer a common language around the wide array of youth services and consistency in implementation of a positive developmental approach. Although there are consequences when youth make poor decisions, the use of punitive and harsh punishment is strongly discouraged within this framework. Instead, teaching moments are incorporated regularly by staff, teachers, and probation officers with support for making better choices in the future.

The annual operating budget of this agency is just under $10 million, and they receive funding from a variety of state agencies, federal grant initiatives, school districts, and foundations. Williamson County’s juvenile recidivism rate is only about 20%, which is lower than the state-wide average of 25–40% (Texas Juvenile Justice Department, 2012), and the majority of youth have just one encounter with detention. To facilitate success rates, careful transition planning occurs for all youth and includes a specific community re-entry plan with input from the youth, parents, and community stakeholders prior to discharge. There also is support for youth restitution programs that include community service hours with several partner agencies. One partner is the local animal shelter where juveniles help train adoptable dogs to facilitate their socialization and increase likelihood for adoption.

This juvenile justice agency takes an active role in creating opportunities for various agencies and leaders in the community to collaborate. For example, the county juvenile services agency cohosts an annual conference called the Mental Health in Schools Conference, where the goal is to bring leaders of education, mental health, and juvenile services together to discuss and find ways to collaboratively address the needs in the community. There also is an education-focused conference that includes leadership from all eight school districts in the county with the intention to divert youth from detention and identify areas for early intervention at the school level.

In summary, most youth entering this juvenile justice agency are already screened and a multidisciplinary approach, including a team of educational professionals, mental health staff, positive behavior programs, substance use programs, transition programs, and parenting initiatives is in place to offer coordinated services. The juvenile agency and participating school districts, including school psychologists, school counselors, and educators, work together as coordinated partners, along with other community leaders, programs, and agencies. The shared vision and coordinated delivery models allows this agency to offer programming in a comprehensive manner to youth who are involved in the justice system. However, there continues to be a wide variation in the degree of service coordination across different juvenile justice systems and their local school districts. Although policies that support innovative programs are in place, along with coordinated multidisciplinary approaches and funding opportunities for sustainable services, there is a great need for more partnerships like those illustrated in this example.
Even with these isolated examples such as the one described previously, there are persistent gaps in the mental health delivery, educational services, and interagency collaboration related to youth transitioning from juvenile justice settings back to communities and schools (Leone & Weinberg, 2010). One of the recommended methods for addressing these gaps is by use of a transition specialist. This professional facilitates interagency coordination across multiple systems of care by developing specific transition plans to address educational, vocational, emotional–behavioral, substance use, and general tracking of youth after re-entry. Some preliminary research supports the use of comprehensive transition plans as effective in increasing successful reintegration into schools and the community, including lower recidivism (Clark, Mathur, & Helding, 2011).

School psychologists are an ideal professional to join these interdisciplinary teams, and readily can serve as another informed professional in a liaison capacity or as a transition specialist to assist in coordinating services. This type of position could be a jointly funded between the school and county through mental health funding streams. A potential barrier to the implementation of this partnership is that the school psychologist would need to be dually credentialed to offer mental health services outside a school setting, or would need to operate exclusively as part of the public school for the county juvenile system.

The role of school psychologists

This brief review and case examples provide concrete illustrations of how school psychologists are providing leadership by training others, facilitating broad programming through direct service and consultative efforts, and participating on collaborative teams to enhance the behavioral and mental health outcomes for students across a continuum. The National Association of School Psychologists Practice Model (2010) aligns the professional services of school psychologists with the public health model across three specific domains: (a) an emphasis on prevention and early intervention, (b) consultation and collaboration, and (c) systems-level services. Also consistent with the public health model is an underlying emphasis on the use of data to guide decision making.

As outlined by National Association of School Psychologists, school psychologists develop, implement, and evaluate data-based school-wide assessments and programming to create positive, effective learning environments. School psychologists also develop respectful and collaborative policies that foster linkages with community service providers to ensure comprehensive service access and delivery for students and their families. As seen in the examples, school psychologists are instrumental in the implementation of preventive school-wide policies that reach the entire student population. They help to screen for risk factors and develop programming for students at the selective and indicated levels to build student resiliency. Each of these cases also was grounded in comprehensive assessments of both needs and outcomes. This approach allowed the school system and community partners to make the best use of available resources and better meet the needs of all students.
Data-driven, systems-level services are an integral part of the paradigm shift to a public health model and school psychologists have the requisite skills to advocate and support this type of change.

From a public health perspective, it is both more effective and humane to provide early intervention through prevention and wellness promotion, as well as tiered supports for mental health and behavioral problems. Even at the most intensive levels of service, the juvenile justice agency personnel had a prevention emphasis—prevent recidivism and provide preventive mental health supports to the youth. School psychologists can apply their understanding of a comprehensive MTSS to align assessment, intervention, progress monitoring, and outcome evaluations to improve supports for all students’ mental health. By using a school-wide tiered model of service delivery, school psychologists can help target and support students at the earliest level of need to reduce the prevalence of mental health problems in the future. For example, the universal implementation of MHFA training in schools can act as a protective buffer against suicide and other mental health crises by educating non–mental health school personnel on how to recognize the indicators that an individual student needs help.

In each vignette, the school psychologist consulted or collaborated with students, families, and other professionals. Examples of collaboration, consultation, and communication at each of the three tiered levels included providing professional development, consultation, and aligning services with community providers. School psychologists are trained proficiently in these skills and are able to facilitate the collaborative models described in the juvenile justice agency example. Doherty, McDaniel, and Baird (1996) outlined different levels of collaboration between primary care and behavioral health providers and these identified tiers may be helpful for guiding the collaborative efforts between school psychologists and members of community agencies.

One of the greatest barriers to these types of collaborative working relationships is the lack of trust (Pollard et al., 2014). Trust is developed through recognizing the competency of others and believing that others have the best interest of the student in mind (Evans & Kruger, 2011). This process takes time, but through opportunities to meet with one another, attending meetings together, or involvement in community initiatives, these types of relationships can be established and strengthened (Pollard et al., 2014). Through problem solving consultation and collaboration, school psychologists can unite stakeholders in comprehensively supporting the behavioral and mental health needs of students in their schools.

By taking on these types of leadership roles, school psychologists can become change agents in the paradigm shift to providing more comprehensive, preventive behavioral and mental health services at a systems level. Although school psychologists might not be the stated leader of the team, they have a unique set of abilities to bring about change in schools (Shriberg, 2007). These abilities include data-based practice, uniting collaborative team members, building community linkages, accessing the resources necessary for comprehensive programming, staying updated on system-wide information, and advocating for the most beneficial services for
students. With the increased attention and funding for school-based mental health services for students, school psychologists will have an increased ability to use their expertise in new ways to enhance and add to the services in their schools and communities.

References


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