



Bringing Health Care To Schools For Student Success

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# Using Coordinated School Health to Promote Mental Health for All Students

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<sup>1</sup> The SMH-CBP is a national initiative to improve access to high quality, school mental health supports and services for young people by building the capacity of state and local education agencies. The SMH-CBP brings best practice information related to exemplary models, policies, programs, processes, and services to education leaders, policymakers and other school mental health stakeholders so that they can make informed decisions regarding the integration of school mental health supports and services into their school systems. For more information on NASBHC's school mental health capacity building partnership, go to: [www.nasbhc.org/MHcapacitybuilding](http://www.nasbhc.org/MHcapacitybuilding).

## **Introduction**

*School mental health* is a growing movement that recognizes the critical role schools play in addressing the social and emotional needs of students. A growing body of research indicates that providing mental health programs and services in schools, often referred to as *school mental health*, can improve both academic and treatment outcomes. (Throughout this document we use the term *school mental health* to refer to policies, strategies, supports, and services along a full continuum of mental health promotion, prevention, and intervention efforts that are offered to *all* students in the school setting.)

Schools may not, however, be universally eager to embrace a mental health agenda as part of their academic mission due to increased pressure to raise academic standards, improve test scores, and increase graduation rates. With scarce resources, they may be reluctant to attend to the mental health needs of students.

The purpose of this white paper is to present an approach to school mental health that both supports schools' academic priorities and makes use of existing school infrastructure, policies, and programs to support students. The goals of the paper are to:

- 1) Define the scope of mental health programs and services available in the school setting;
- 2) Highlight the growing body of research illustrating the link between health, mental health, and academic success; and
- 3) Present *Coordinated School Health* (CSH) as a structure and process that can build capacity and create sustainability of school mental health.

## **What Is Children's Mental Health?**

McKenzie and Richmond (1998) make the case in the book, *Health is Academic: A Guide to Coordinated School Health Programs*, that the link between children's health status and learning is robust. When discussing health, however, most people think only in terms of *physical health* and tend to overlook the critical importance of *mental health*<sup>2</sup> (Donnelly, Eburne, & Kittleson, 2001). Yet physical health and mental health are inextricably connected components of overall well-being (U.S. Surgeon General, 1999). Issues related to mental health, such as low self-esteem, stress, and coping with emotional responses have a clear impact on physical health. Conversely, poor physical health is associated with mental health concerns, such as stress, depression, and anxiety (Donnelly et al., 2001).

Unfortunately, mental health concerns are so common in children and youth—with some disorders such as anxiety more common even than most physical health problems (McLoone, Hudson, & Rapee, 2006)—that they are reaching epidemic levels (see text box). Children suffer from a range of social, emotional, and mental health problems including trauma, family conflict, depression, anxiety, ADHD, and substance abuse.

Approximately 20 percent of children and adolescents suffer from mental health problems that result in mild functional impairments (Duchnowski, Kutash, & Friedman, 2002; Power, Eiraldi, Clark, Mazzuca & Krain, 2005)

10 percent of children and adolescents have moderate to severe impairments (Duchnowski, Kutash, & Friedman, 2002; Power, Eiraldi, Clark, Mazzuca & Krain, 2005)

Less than 50 percent of children and adolescents with a mental illness receive adequate (or any) services, especially children with minority status (Kataoka, Zhang, Wells, 2002; Leaf et. Al., 1996)

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<sup>2</sup> According to the Surgeon General, mental health is the "successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem." (U.S. Department of Health and Human Services, 1999)

## **Why Address Mental Health in Schools?**

While some may argue that schools are in the business of education, not the business of mental health, untreated mental illness among students has a significant and harmful impact on schools. Whereas education is certainly the primary mission of schools, there is solid evidence that academic learning is impeded significantly or prohibited entirely when youth suffer from mental health concerns. Below are several key reasons that schools should adopt and implement school mental health:

### **1. Evidence clearly demonstrates that addressing children’s mental health needs is associated with positive school outcomes.**

Research shows that when students’ mental health needs are properly addressed, the likelihood of school success increases. High quality, effective school mental health promotion has been linked to increases in academic achievement and competence; decreases in incidence of problem behaviors; improvements in the relationships that surround each child; and substantive, positive changes in school and classroom climates (Elias, 2006; Greenberg et. al., 2004; President’s New Freedom Commission, 2003). In addition, Payton and his colleagues (2008) report that when social and emotional learning is a component of education, students’ standardized test scores—a hallmark of school accountability structures—increase between 11 and 17 points.

And although emotional, behavioral, and social difficulties diminish a child’s ability to participate in the educational process (Rones & Hoagwood, 2000), schools are able to support learning by working in partnership with various service providers to offer ongoing academic and behavioral supports to individual students and to the whole school population (Weist and Evans, 2005). Furthermore, researchers are increasingly examining treatment effectiveness in the school setting (Kutash, Banks, Duchnowski, & Lynn, 2007; Kutash, Duchnowski, & Lynn, 2006) and narrowing the “research-to-practice gap” by focusing on school functioning as a key element of child well-being (Flaspohler, Anderson-Butcher, Paternite, Weist, & Wandersman, 2006). Schools providing mental health services and supports, therefore, benefit from efforts to promote mental health in significant ways.

In contrast, schools that ignore the mental health needs of students “miss reaching an entire population of children whose academic ability is affected by emotional distress” (Hoganbruen et al., 2003). Compared with typically developing peers, students with mental health challenges display moderate to severe academic deficits (Greenbaum et al., 1998) and these deficits appear early in life (Kauffman, 2001). They earn lower grades across all academic subjects, have higher course failure rates, and are more likely to drop out of school than any other disability group (Greenbaum et al., 1998; Reid, Gonzalez, Nordness, Trout, & Epstein, 2004; U.S. Department of Education, 1994; Woodruff et al., 1999). Rates of absenteeism and tardiness are much higher for students with untreated mental health disturbances than those who are receiving treatment (Gall, 2000). Simply stated, unmet mental health needs impede students’ overall success in school.

### **2. School mental health promotion activities are essential to creating an environment where students can learn.**

As mentioned in the previous section, school mental health is linked to positive changes in the school climate (see text box). It is understood that the school and classroom climates relate directly to academic achievement (Battistich, Solomon, & Delucchi, 1993), and, therefore may serve as mediators between school-wide mental health approaches and school-wide indicators of academic success (such as the percentage of students reading with proficiency or the percentage of students that graduate from high school). More and more, schools are implementing school climate improvement strategies and working to address the emotional well-being of all students. According to Cohen, Pickeral, and McCloskey (2009):

*Comprehensive school climate data can powerfully support the tenets of the Whole Child initiative [see resource section] by providing meaningful information about how healthy, safe, engaged, supported, and challenged students feel. When schools use these data to create positive learning environments, they help students develop the social-emotional competencies and ethical dispositions that predict success in school and life. (p.45)*

Researchers from the National School Climate Council (2007) agree that four major factors shape **school climate**:

- 1) safety,
- 2) relationships,
- 3) teaching and learning
- 4) institutional environment.

(Cohen, Pickeral, and McCloskey, 2009)

School climate is also related indirectly to achievement through individual effects on student *engagement* or their feelings of *connectedness* to schools (Battistich et al., 1993; Solomon, Battistich, Watson, Schaps, & Lewis, 2000; Solomon et al., 1996). Student engagement and connectedness are known to be among the strongest mediators between teacher instruction and academic success (Greenwood, Terry, Marquis, & Walker, 1994), and many schools are focusing on building the developmental assets or protective factors that ensure that all students feel connected to caring adults and peers and feel confident in their abilities (Benard, 1995, 1997). A recent CDC publication (2009) highlights the positive impact of school connectedness on a number of school-related outcomes and offers concrete strategies for fostering connectedness in schools. Research suggests that such programming in schools effectively promotes mental health, reduces problem behaviors, improves classroom environments, increases school bonding, and enhances youth competence (Elias et al. 1991; Fredericks, Blumenfeld, & Paris, 2003; Greenberg, Domitrovich, Graczyk & Zins, 2005).

### **3. School mental health programs and services are essential for improving teaching conditions for teachers and school staff.**

The increasing unmet mental health needs of youth cause teachers and other school staff to feel unprepared, overwhelmed, and helpless as school and classroom learning conditions are compromised (Anderson-Butcher, 2006; Burke & Stephan, 2008; Koller et al, 2004; Williams et al, 2007). Stress among teachers has never been so high, especially given the accountability structures put in place by legal mandates such as No Child Left Behind (Bauer, Unterbrink, Hack, Pfeifer, Buhl-Griehaber, Muller et al., 2007). Teacher attrition is also high, particularly within the first few years of teaching (Leukens, Lyter, & Fox, 2004), and may be affected by the behavior problems that often result from underlying mental health issues. Moir and Gless (2001) found that new teachers working in classrooms with a larger percentage of students with behavior problems are much less likely than their peers to report a good first-year teaching experience, to plan to continue teaching, and to plan to remain in the same school.

Moreover, it is evident that inappropriate attributions for misbehavior (e.g., student defiance, aggression, bullying, and lack of motivation) can interfere with effective teacher-based interventions (Chang, 2003; Mavropoulou & Padelidiadu, 2002; Soodak & Podell, 1994; Weisel & Tur-Kaspa, 2002). Teachers who cling to idealized concepts of classroom life may struggle to

create an atmosphere in which all students have an equal opportunity to learn and, as a result, may feel ineffective and demoralized when they do not achieve the ideal (Anderson-Butcher, 2006; Williams, Horvath, Wei, Van Dorn, & Jonson-Reid, 2007).

An important function of school psychologists, counselors, and social workers is providing support to teachers and other school professionals as they work with difficult students. School mental health programs and services often include in-services, consultation, and information to assist teachers in creating classroom environments that promote positive behaviors and to allow them to identify students with mental health problems early, before their problems interfere with functioning in the classroom. Moreover, the mental health staff in schools can provide support for basic classroom management and interventions to help teachers handle and support students who struggle to meet the social-emotional and behavioral expectations of school. As such, mental health programs and services improve conditions in the classroom as students' needs are met and teachers' stress and feelings of helplessness are reduced (Weston, Anderson-Butcher, & Burke, 2008).

#### **4. Schools are where the children are located: promoting mental health in schools increases the impact of prevention, early intervention, and treatment efforts.**

Most children and adolescents spend a significant part of each day inside a school building. Not only does this make the school an ideal location for accessing a large number of young people for mental health promotion and prevention activities (Weist and Evans, 2005; Weist, 1999), but this also provides families with increased opportunities to access treatment services for their children and to access them earlier. Of those children and youth who receive mental health services, the majority are served within the public school setting (Weist and Evans, 2005; Rones & Hoagwood, 2000; U.S. Department of Health and Human Services, 1999, 2001; Weist, 1999) (see text box). Currently, about 75 percent of children receiving mental health services receive them in schools (Burns, et al., 1995; Government Accountability Office, 2007; Rones & Hoagwood, 2000).

The increased access to school-based or school-linked services is significant, as approximately one-half of adults with mental illness experience symptoms prior to age 14 (with three-fourths experiencing symptoms prior to age 24; Kessler et al., 2005). For example, in one study, 74 percent of 21-year-olds with mental disorders reported experiencing symptoms as a child (U.S. Surgeon General, 1999). Children from low-income families are especially vulnerable given that they are more likely to have mental health problems than their peers and less likely to have access to high-quality, culturally-relevant services.

The CDC's 2006 School Health Policies and Programs Study (SHPPS) indicates that:

- 77 percent of schools have a person who oversees or coordinates school mental health and social services
- 80 percent of schools have student support teams
- 84 percent of schools provide case management for students with emotional or behavioral problems
- 70 percent of schools review mental health and social services records to identify students with chronic problems and ways to prevent further occurrences of these problems

## 5. Attending to mental health in schools reduces costs.

While identifying funding for school mental health services may require creativity, failure to meet the mental health needs of children and adolescents can be extremely costly (Wade, Mansour, Guo, Huentelman, Line, & Keller, 2008).

Childhood mental disorders — such as depression and anxiety — persist into adulthood and often worsen if left untreated, thereby increasing the length and associated direct cost of treatment. Such delays can also encumber the individual with indirect costs that come with increased risk of school dropout (see text box), underemployment, incarceration, substance use, and co-morbid illness (NIMH, 2005; SAMHSA, 2004a, 2004b, 2005). The indirect costs of failing to appropriately address mental health issues early affect not only the individual, but society as well. The heavy toll placed on systems of health care, welfare, education, business, industry, justice, and public safety by unmet mental health needs cause society to absorb significant costs (NIMH, 2004). Finally, considering that the average lifespan of an adult with mental illness is more than 25 years less than the average for an adult without mental illness (Parks, et al, 2006), failure to provide prevention and early intervention allows for unconscionable human costs and suffering.

Given the benefits described above, having access to mental health programs and services in schools is central to students' success. The school setting provides opportunities for supporting school improvement, particularly relative to the school-wide outcomes that are critical for supporting both students' learning environments and teachers' working climates.

### **COSTS OF SCHOOL DROPOUT**

School dropout places both a social and economic burden on our nation. Each year, approximately 1.2 million students fail to graduate from high school, more than half of whom are from minority groups. Both academic and social engagements are factors in high school completion. Research shows that a lack of student engagement is predictive of dropping out, even after controlling for academic achievement and student background.

Over the course of his or her lifetime, a high school dropout earns, on average, about \$260,000 less than a high school graduate. If U.S. high schools and colleges raise the graduation rates of Hispanic, African American, and Native American students to the levels of white students by 2020, the potential increase in personal income would add more than \$310 billion to the U.S. economy. (Alliance for Excellent Education, 2009)

## **Coordinated School Health: A Structure for Promoting and Expanding School Mental Health**

Allensworth's and Kolbe's (1987) Coordinated School Health (CSH) Program, now simply referred to as CSH, is designed to promote health and mental health in schools by addressing the physical, social, emotional, and general needs for student well-being (Comb-Orne, Heflinger, & Simpkins, 2002). CSH consists of eight interrelated components:

1. comprehensive health education,
2. physical education,
3. health services,
4. nutrition services,
5. counseling, psychological, and social services,
6. healthy school environment,
7. health promotion for staff, and
8. family/community involvement.

Whereas each component addresses a distinct aspect of school health, school health activities often connect to one or more of the components. As depicted in the image below, school mental health programs and services have maximum benefit when integrated into all eight CSH components.

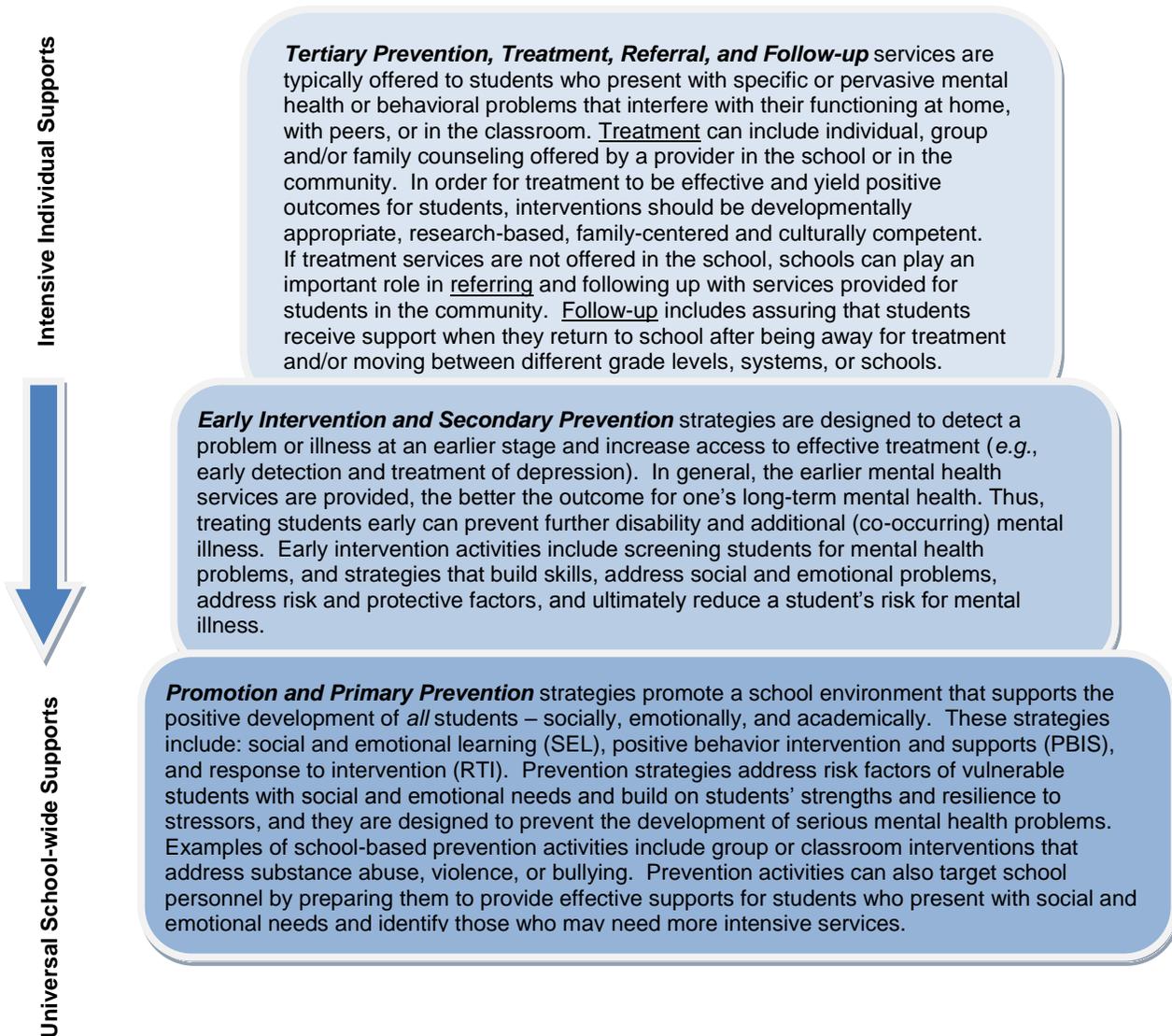


Adapted From CDC's CSHP Model (2007)

## Eight Interrelated Components

1. **Counseling, Psychological, and Social Services** (often referred to as the “mental health” component) includes services provided to improve students’ mental, emotional, and social health. Traditionally, these services are provided by school counselors, psychologists, nurses, and social workers, and place emphasis on serving students with or at-risk for emotional disorders. Although interventions by these providers are critical to serving the needs of students and creating an environment where all students do well, isolating this component does not fully capitalize on the power of CSH to promote positive mental health and prevent mental illness. By embedding mental health into *all* components of CSH, schools have expanded opportunities to promote the positive social and emotional development of all students, intervene early with students who are at risk of developing mental health problems, and intervene directly with students with more serious mental health disorders. Offering this full continuum of mental health programs and services (see figure below) aligns with current mental health best practice which stresses a public health approach including mental illness prevention and mental health promotion (Hoagwood & Johnson, 2003). A public health model of school mental health practice emphasizes prevention and early *detection*, as opposed to simply early *intervention*. A public health model also emphasizes *population-based*

(i.e., whole school or whole subgroup) interventions, as opposed to solely individual interventions (U.S. Department of Health and Human Services, 1999).



- 2. Healthy School Environment:** In addition to focusing on physical and psychological safety, the school environment holistically includes the attitudes, feelings, and values of students and staff as well as positive interpersonal relationships. Students who feel safe and cared for at school are more likely to be successful and resilient (Henderson & Milstein, 1996; Stormont, 2007) and are less likely to engage in risky or problem behaviors, including violence (Kauffman, 2005; Stoiber & Good, 1998). According to the Education Development Center, Inc.'s, Center for School Health, a safe, clean, and well-maintained school with a positive social climate and culture can foster school connectedness, which in turn boosts student and staff health as well as students' educational achievement. While school administrators have the overall responsibility for a school's physical and psychosocial environment, creating a healthy environment requires the commitment of everyone in the school (CDC, 2009). This includes students, administrators, teachers, custodial and maintenance staff, school counselors, school nurses, and nutrition services workers.

Strategies for integrating mental health into the school environment may include:

- Including mental health in school wellness policies (see text box) and school improvement plans.
- Developing disciplinary policies that are consistent with promoting students' mental health.
- Implement a school-wide violence prevention/anti-bullying initiative.
- Training staff to build positive relationships with students in order to increase school connectedness.
- Training students in conflict resolution and peer mediation techniques that allow them to take responsibility for maintaining a positive school climate.
- Developing a mental health awareness campaign aimed at reducing stigma surrounding mental illness and promoting tolerance for individual differences.
- Creating a physical environment (including noise, temperature, and lighting) that is safe, comfortable, and appealing to students.
- Introduce social and emotional learning into the academic curriculum.

In the Child Nutrition and WIC Reauthorization Act of 2004, Congress established a requirement that all school districts with a federally-funded school meals program develop and implement **wellness policies** that address nutrition and physical activity. When developing wellness policies, school districts must take into account the unique circumstances, challenges, and opportunities in their schools. School districts may choose to use model policies or adapt them to meet local needs and reflect community priorities. ([www.schoolwellnesspolicies.org](http://www.schoolwellnesspolicies.org))

- 3. Comprehensive Health Education Curriculum:** The K-12 comprehensive health education curriculum, tailored to each age and developmental level, includes classroom instruction on the physical, mental, emotional, and social dimensions of health. By integrating mental health into the K-12 curriculum, students have opportunities to acquire knowledge, attitudes, and skills about mental and emotional concerns, as well as develop pro-social and life skills. (Resources specific to CSH curriculum development can be found at the end of this document.)

Strategies for incorporating mental health into a comprehensive K-12 health education curriculum include:

- Reviewing adopted health education curricula for accuracy and breadth related to mental health, and providing teachers with updated instructional materials to complement existing units.
- Reviewing existing evidence-based health education curriculum materials that address specific behavior areas (e.g., tobacco/drug/violence prevention, HIV/STI prevention, pregnancy prevention) and highlighting skills (e.g., communication, goal setting) that promote positive mental health.
- Considering the inclusion of the following topics in the health education curriculum: recognition of signs and symptoms related to mental health illness, mental health stigma, substance abuse, and stress management.
- Involving community members and mental health providers in collaborative curriculum development and teaching for content related to mental health.

- 4. Nutrition Services:** Hungry or malnourished children have a harder time focusing on basic core subjects. Students with eating disorders, or who are obese, often suffer from poor nutrition (CDC, 1996). School nutrition services can offer nutritious and affordable meals, nutrition education, resources for nutrition-related community services, and a school environment that promotes healthy eating habits for all children. They can have greater impact when they are integrated with mental health services. Providing students with nutritious meals, such as those offered in a

school breakfast program, can improve academic, behavioral, and emotional functioning, and reduce tardiness and absenteeism (Brown et al, 2008).

Strategies for incorporating mental health into nutritional services include:

- Training students and staff to recognize the physical signs of anorexia and bulimia and to recognize the interrelationship between mental health and eating disorders and between mental health and obesity.
- Encouraging students to contact the school nurse or school counselor if they suspect a friend might have an eating disorder.
- Providing information and support to students on issues such as nutritional guidance, healthy body image, and weight management.
- Establishing a school breakfast program if child hunger and/or malnutrition are common in the school population.

**5. Physical Education:** Research demonstrates a link between physical activity and emotional well-being (Edwards, et al, 2007). In fact, physical activity is prescribed as part of the treatment for mental health disorders such as depression and anxiety (Brown, Welsh, Labbe, Vitulli, & Kulkarni, 1992), and physical activity is known to improve academic performance in students (Castelli, Hillman, Buck & Erwin, 2007). Quality physical education programs promote optimum physical, mental, emotional, and social development. Schools should use physical education curricula that include learning experiences and a variety of activities that promote health related fitness as well as content on the physical, psychological and social benefits of physical activity. Schools can further promote physical activity and its social and emotional benefits through after-school activities, extra-curricular sports, and programs targeting students with special needs.

Strategies for incorporating mental health into physical education include:

- Utilizing the physical education class as a venue for teaching life skills (e.g., teamwork, social competence, stress management).
- Encouraging after-school activities and extra-curricular sports to promote team-building skills, self confidence and self esteem.
- Providing teachers and coaches with training on how to promote students' mental, emotional and social development through physical activity (e.g., avoiding use of physical activity as discipline strategy, increasing sensitivity to differences in students' physical abilities).

**6. Health Services:** Students perform better when they show up for class, healthy and ready to learn (NASBHC, 2009). School health services are provided by school-based health centers (see text box), school nurses, and wellness programs. They include access or referral to: prevention and control of communicable disease, chronic illness, and other health problems; emergency care for illness or injury; counseling on healthy behaviors; and activities that promote the health of all students. Ideally, school health services should include mental health services, as there is an increasing understanding among researchers, policymakers, and advocates that *there is no health without mental health* (Prince et al, 2007). When health and mental

**School-based health centers**

**(SBHCs)** bring the doctor's office to the school so students avoid health-related absences and get support to succeed in the classroom. Of school-based health centers surveyed in 2007-08, approximately 75 percent of SBHCs offer on-site mental health services by a licensed mental health professional. Mental health and counseling services in SBHCs include mental health assessments, crisis intervention, brief and long term therapy, family therapy, teacher consultation, and case management. Primary care providers also provide mental health services such as referrals (72%), screening (59%), and crisis intervention (56%) when there is no mental health staff at the SBHC. (Strozer, Juszczak, & Ammerman, 2010).

health services are integrated, providers have increased capacity to identify mental health problems sooner; provide services more efficiently and effectively, and address the emotional factors related to students' physical health problems (e.g., psychological adjustment to asthma).

Strategies for incorporating mental health into health services include:

- Providing counseling to students with health problems to address associated mental or emotional factors (e.g., psychological adjustment to asthma).
- Training school health personnel to recognize early signs of mental illness (e.g., chronic physical complaints associated with emotional difficulties).
- Involving the school nurse in student support teams to address health and mental health concerns of individual students.
- Partnering with school-based, school-linked, and community health providers (e.g., school-based health centers) to ensure access to health and mental health services.

**7. Health Promotion for Staff:** In order to optimally support students, staff must first take care of their own health and well-being. It is estimated that 30 percent - 50 percent of all teachers leave the profession within five years of starting (National Commission on Teaching and America's Future, 2007), and teacher turnover costs the nation's schools an estimated \$7.3 billion per year. Health promotion -- including health assessments, education, and fitness activities -- is designed to improve health and overall well being through a commitment to healthy lifestyle choices. Health promotion for staff provides students with positive role models, increases staff morale, prevents absenteeism, and increases productivity, all of which contribute to a healthy school climate for students.

Strategies for incorporating mental health into health promotion for staff include:

- Encouraging staff to model self-care for students (e.g., use of coping strategies, anger management techniques, stress reduction practices).
- Providing teachers with strategies for preventing 'burnout' (e.g., teaching effectiveness, classroom management, peer mentoring).
- Providing health and mental health programming for school staff (e.g., local gym membership, staff retreats, support groups, faculty walking clubs).
- Establishing a standing committee to assess needs of all school employees (including administrators, faculty, school support staff, bus drivers, food service workers, and custodians), identifying resources, and evaluating the impact of school-site health promotion efforts.
- Offering employee assistance programs that offer free and confidential counseling and substance abuse services for employees.

**8. Family and Community Involvement:** Students thrive most when parents and caregivers are involved in their children's school lives and engaged as key collaborators in providing emotional support and reducing external stressors (e.g., sibling conflict, loss, violence) that affect mental health. As mental health promotion efforts become systemic across all fronts, such efforts must comprehensively involve schools, families, and communities (American Academy of Pediatrics, 2004). More specifically, school-based personnel, community mental health workers, and families should work together to plan prevention and intervention strategies across all components of school health and mental health.

Strategies for incorporating mental health into family and community involvement include:

- Developing effective partnerships with youth, families, and community members.

- Identifying community agencies that provide services to youth and family members (e.g., outpatient therapy, substance abuse, social services).
- Developing Memoranda of Understanding (MOUs) and/or linkage agreements with community agencies that stipulate how they can partner with schools to provide a range of services to students (e.g., staffing a provider role on-site, developing a linkage referral system).
- Providing Family Resource Centers in schools and community facilities with resources and support.
- Utilizing forums (e.g., PTSA, parent liaisons, advisory boards) as a way to engage family members in promoting positive mental health of students.
- Involving youth, family, and community members in school committees.
- Involving family members in child-family team meetings to get input on how a student's illness affects their academic work, peer relationships, and interaction with others in the school community.

## **Coordinated School Health: A Process for Providing Sustainable School Mental Health Services**

CSH cannot be maintained without explicit attention to management, stewardship, ongoing funding support, and coordination and integration of services. CSH should be connected to other school initiatives and structures that similarly have integral components of promoting student well-being and academic success. Some school districts, in fact, use CSH as an 'umbrella framework' for the integration of other school initiatives, providing sustainability and preventing the competition, duplication, and/or fragmentation of services and programs.

CSH can only be successful by attending to the processes that create an effective and sustainable system that addresses the multiple needs of students through the eight components. Sustainable initiatives are built to last. Several core elements -- coordination, partnerships, planning and evaluation, professional development and training, and policies -- contribute to the sustainability of CSH by maximizing current resources, bringing in new resources, and increasing efficiency.

Below is a description of each of these core elements followed by profiles that illustrate how three communities used a coordinated school health approach for providing integrated and effective school mental health services.

### **Core Elements for Sustainability**

1. **Coordination**. Integrating mental health into each component of the model, as discussed above, requires coordination. By coordinating all eight components, schools have a more efficient and effective way to use existing resources; minimize duplication, gaps and fragmentation of services; and increase the potential impact of each individual component (Allensworth, 1994). Coordination is best achieved by creating a coordinating body or infrastructure that consists of a school health team or *school health advisory council* (see text box) convened by a *school health coordinator*. Central to building this infrastructure are clear delineations of leadership and coordination of roles and responsibilities among people working in the school. A skilled and trained professional must be designated as the coordinator of the CSH. This person is invaluable

The **School Health Advisory Council** (SHAC) is a group of individuals who represent both the school and the community. The group acts collectively to provide advice to the school system on aspects of the school health program. Most often, the SHAC advises an entire school system (district), but a SHAC may also be operate at an individual school building level. The SHAC is responsible for planning, assessment, implementation, training, and evaluation of all school health programs. The SHAC serves not only the school but the surrounding community; it can withstand a change in school leadership and contribute to the sustainability of school mental health programs. The SHAC meets regularly, has clearly defined roles and priorities, works as a team and shares a common vision.

to connecting all the dots within the school to the valuable community-based resources that support school success from outside the building. Often, individuals involved in the mental health sector (i.e., counselors, social workers) serve as lead coordinators for CSH (see text box).

According to the School Health Policies and Programs Study (SHPPS, 2006) nationwide,

- 60.8 percent of schools had someone at the school to oversee or coordinate school health (e.g., a school health coordinator).
- 76.8 percent of schools had a person who oversees or coordinates standard mental health or social services at the school.
- 62.2 percent of districts and 44.8 percent of schools had a contract, memorandum of agreement, or other similar arrangement to provide mental health or social services to students through arrangements with organizations or professionals outside the school.

2. Partnerships. A successful CSH program is developed by establishing both informal and formal partnerships to build linkages among the eight components of the model. These partnerships involve groups that are invested in the long-term sustainability of student health and mental health, including school personnel, family members, community organizations, and child-serving agencies. Schools benefit greatly from school-family-community partnerships, as these partnerships typically make a wider array of services available to students and mobilize community members to support school and student success.
3. Data-driven planning and evaluation. Sustainability hinges on the school's ability to demonstrate the impact that services have on the school environment and

student achievement. Successful school mental health programs accurately assess the needs of the student population, evaluate the quality of programs and services, and measure the processes and outcomes to determine the program impact. Reliable data, collected using valid and reliable tools (see "CSH Tools" in the resources section of this document) can be used in planning, policy development, decision-making, prioritizing program activities, and advocating for more resources. Evaluation should be incorporated into a sustainability plan to ensure that goals are being met and programs and services are on track.

4. Professional development and training. Effective professional development and training can prepare members of an advisory council, coordinators, and school staff to plan and implement effective school mental health programs and practices. Information sessions can create awareness of the link between mental health and academic success and assist school staff in understanding their specific role in supporting students, the classroom, and the school environment. Skill-building workshops can impart the knowledge, skills, and attitudes needed to fill these roles, as well as strategies for managing crisis situations. Professional development can help demonstrate how to work collaboratively across disciplines and enable school administrators to implement policies that promote student health and mental health.
5. Policies. When schools establish, adopt, and monitor comprehensive school wellness policies, they are better able to garner support for the coordination of all eight CSH components. School administrators and SHACs need to assess their current policies (written or implicit) related to mental health and the emotional well-being of students and staff. Schools can develop stand-alone policies that support mental health as well as expand existing policies (e.g., mandated wellness policies) to address the health and mental health needs of the student body, school, and community. Policies help establish consistent procedures across classrooms, schools, and districts to ensure accountability and sustainability. Policies can also help formalize roles and other partnerships, promote the use of data for ongoing improvement and evaluation, and ensure that professional development and training is offered to all school personnel.

## **How Three Schools/Districts Have Used CSH to Promote School Mental Health**

### **Profile: School District of Random Lake: Random Lake, Wisconsin**

#### **TAKING ACTION TO ADDRESS STUDENTS' MENTAL HEALTH NEEDS**

Random Lake School District – a rural, high poverty, Southeast Wisconsin community used a CSH approach to address specific student mental health needs.

Utilizing the Youth Risk Behavior Survey (YRBS), made available online by Wisconsin's Department of Public Instruction (DPI), Random Lake Public Schools compared local data on students' behaviors with state and national data (CORE ELEMENT #3<sup>3</sup>). The school district found that significantly more students in their district (compared to the state averages) reported feeling sad and hopeless for two weeks in a row, considering suicide, and making a plan to attempt suicide.

In order to address this major mental health concern, the School Health Advisory Council (SHAC) requested that the DPI hold a day-long training (CORE ELEMENT #4) for the district superintendent, building administrators, pupil services professionals, and health educators. The training included facts about youth suicide in Wisconsin, a gatekeeper training for school staff, and an overview of DPI's middle and high school suicide prevention units of instruction.

After the training, the SHAC met to develop a strategic plan for the 2008-2009 school year that addressed suicide by integrating mental health into several CSH components.

*As a result of this planning process:*

- a) Random Lake Public Schools will include a suicide prevention unit of instruction in several curriculum content areas including language arts, health education, and social studies.
- b) Pupil services will conduct suicide screenings and lead groups for students at risk of suicide.
- c) The school will offer a 'meet and greet' for parents in order to explain the suicide prevention strategy.
- d) In coordination with community mental health providers, the school will develop a district-wide system to handle mental health referrals. (CORE ELEMENT #1)

### **Profile: New Urban High School: Milwaukie, Oregon**

#### **USING A CSH PLANNING PROCESS TO EXPAND MENTAL HEALTH SERVICES**

In the 2006-2007 academic year, New Urban High School participated in a mental health demonstration project as part of "Healthy Kids Learn Better," Oregon's CSH Program.

A team from New Urban High School participated in a series of five trainings provided by the Healthy Kids Learn Better program. This professional development series (CORE ELEMENT #4) used a train-the-trainer model that took the team through all elements of the CSH planning process. One of the first steps the staff at New Urban took was to create a school health advisory council (SHAC) (CORE ELEMENT #1). Next, school staff analyzed youth risk behavior data (CORE ELEMENT #3) obtained from the Oregon Healthy Teens Survey (OHT) to assist in identifying student mental health needs and strengths. The school continued this analysis by conducting a needs assessment (using the School Mental Health Inventory<sup>4</sup>) to determine what policies, programs, and protocols were currently in place to support student mental health.

<sup>3</sup> Core elements are described on pp. 13-14 of this document.

<sup>4</sup> The School Mental Health Inventory is a tool being piloted by the Oregon Public Health Division's Healthy Kids Learn Better Program. The tool is modeled after the Center for Disease Control and Prevention's School Health Index. The tool reflects school mental health best practices from several national sources including the *Health, Mental Health and Safety Guidelines for Schools*

Utilizing information from OHT and the School Mental Health Inventory, as well as feedback from youth and adults on campus, the SHAC prioritized needs and created a sustainable action plan utilizing measurable objectives. The school identified the need for increased mental health services, primary care services, and alcohol and other drug interventions.

*As a result of this process:*

- a) The school administration designated a space, an underused storage area, in which to offer services for students. Seven community partners now provide groups for students on topics including: domestic violence, coping with stress and anger, and smoking. Forty percent of New Urban students enrolled in a group at the "Health Room."
- b) Community partners (CORE ELEMENT #2) were brought into the school to provide psycho-educational programs, counseling, and primary care services, including: a mobile primary care clinic stationed in the parking lot and interns from Oregon Health Sciences University's Psychiatric Nurse Practitioner Program
- c) New Urban High School applied for and was awarded a school-based health center planning grant from the Oregon Department of Human Services.
- d) New Urban High School is now mentoring two other high schools in the same district to address school mental health through the CSH process.
- e) The school is engaging in a process to revise its mission and policies to include (or place) an emphasis on mental health promotion (CORE ELEMENT #5).

### **Profile: Cincinnati Public School District: Cincinnati, Ohio**

#### **THE IMPORTANCE OF PARTNERING**

Breaking bounds of the traditional definition of a school, Cincinnati Public Schools (CPS) transformed 36 public schools into Community Learning Centers (CLCs). Using a CSH approach, CLCs incorporated the school, the neighborhood, and the community partners to support student achievement, strengthen schools, and revitalize neighborhoods.

In order to improve access to quality mental health care for children in Greater Cincinnati, a collaborative of partners (CORE ELEMENT #2) was formed with a specific focus on developing school-based mental health services within the CLC model. Led by MindPeace (a non-profit advocacy organization that provides the school-based mental health services) and the Hamilton County Mental Health & Recovery Services Board, the collaborative also includes representatives from CPS, the Growing Well Health Collaborative, and various school-based mental health providers. Each CLC has a full-time resource coordinator to assist students and families with accessing services and coordinating the various partner agencies that provide services (CORE ELEMENT #1). Reflecting several of the eight CSH components, community partners and district administrators are organized into teams to oversee the partnership and to meet the community's and school district's overall shared goals.

*As a result of this innovative partnership:*

- a) Mental health services are provided in the CLC space,
- b) Mental health providers are gathering school data using the School Health Index (Core Element #3), and
- c) The school district has enhanced its data management information system to include academic performance data as well as non-academic health and behavioral-related information.
- d) 36 Cincinnati Public Schools serving approximately 30,000 pre K-12 students have incorporated the CLC model of school-based mental health services.

## **Conclusion**

In many instances, schools have become a *de facto* mental health system for children. Given the growing number of students in public schools with significant emotional issues and the impact of mental health on school success, schools must attend to children's social and emotional health. However, helping students in this arena is challenging. Students' lives are complex, communities are dispersed, resources are scarce, and leaders come and go.

Schools across the country are stepping up to the plate and recognizing the critical role that they can play in all areas of students' life – academics, physical health, and social and emotional well being. Schools, in partnership with communities and families, have instituted successful programs that promote mental health as part of the overall well-being of children. Research shows that schools with well-functioning and coordinated mental health programs, practices, and policies have a number of positive outcomes for schools and for students, including improved graduation rates, better classroom climate, higher academic performance, and an increased connectedness to school.

CSH provides a practical and effective framework for schools to integrate mental health into all facets of schools and into existing programs. Not only does CSH allow for connections and coordination between health and mental health activities, but a CSH approach strengthens and makes sustainable those critical partnerships among students, families, health and mental health providers, teachers and administrators, and community agencies. Such school-family-community collaboration creates a necessary and dynamic systemic change that improves the health and wellbeing of students and can result in the dramatic and necessary positive changes in the classroom, school building, and community.

## RESOURCES

### **School Mental Health – Basics**

**Center for Health & Health Care in Schools (CHHCS)** is a policy and program resource center that seeks to strengthen the well being of children through effective health programs and health care services in schools, including mental health programs within the school system. <http://www.healthinschools.org>

**Center for School-Based Mental Health Programs** (Miami University, Ohio) seeks to promote the development and implementation of effective programs to both enhance healthy psychological development of school-age students and to reduce mental health barriers to learning. <http://www.units.muohio.edu/csbmhp/>

**Community and Youth Collaborative Institute**, led by faculty and staff within the College of Social Work at Ohio State University, focuses on the development of school-family-community partnerships and family support initiatives; youth development, sport, and after-school programming; and the assessment and evaluation of youth development, family support, and school social work practices. [www.csw.osu.edu/cayci](http://www.csw.osu.edu/cayci).

**IDEA Partnership's** [www.sharedwork.org](http://www.sharedwork.org) is a forum for communities of practice whose members learn from each other and take action together in coordinated ways. This site provides networking with colleagues and a wealth of informal information, to those who join.

**National Assembly on School-Based Health Care's** *School Mental Health Capacity Building Partnership*, funded through a cooperative agreement with the CDC-DASH, provides capacity building assistance to state and local education agencies and their partners. Information about the initiative, materials, and resources are available on NASBHC's website. [www.nasbhc.org/mentalhealth](http://www.nasbhc.org/mentalhealth).

**UCLA's School Mental Health Project (SMHP)** was created in 1986 to pursue theory, research, practice and training related to addressing mental health and psychosocial concerns through school-based interventions. SMHP works closely with school districts, local and state agencies, special initiatives, and organizations across the country. The SMHP has a one-stop shopping website for health and mental health professionals, including guidebooks, introductory packets, training modules, and policy briefs. <http://smhp.psych.ucla.edu>

**University of Maryland Center for School Mental Health (CSMH)** analyzes diverse sources of information, develops and disseminates policy briefs, and promotes the utilization of knowledge and actions to advance successful and innovative mental health policies and programs in schools. CSMH administers [www.schoolmentalhealth.org](http://www.schoolmentalhealth.org), a website that provides practical information and tools for anyone interested in learning more about how to enhance school mental health.

### **Coordinated School Health – Basics**

**CDC's Coordinated School Health Model.** This website of the CDC-DASH, provides information about what CSH is and describes the various components of the model. Additional information about the model and various resources are also provided. <http://www.cdc.gov/HealthyYouth/CSHP>

**Complementary Models.** Lohrmann, D. (2008, November-December). *A Complementary Ecological Model of the Coordinated School Health Program*, Public Health Reports vol. 123. This article proposes a complementary model to the Coordinated School Health Program (CSHP) model conceptualized by the CDC. The model offered is not to replace the CDC model, rather to expand the way practitioners and researchers think of the model.

**CSHP's At-A-Glance.** Hosted by the Education Development Inc. this Web site provides detailed information about the CSH model. Information about the rationale for implementing this program, along with the components and steps required to establish a program are also provided. There is also information for teachers, community leaders, family members, school administrators, and state agencies. The site provides links to resources and additional information about CSH.

<http://www2.edc.org/makinghealthacademic/cshp.asp>

### **Coordinated School Health – Building Capacity & Sustainability**

**North Carolina Healthy Schools** is a collaboration between the Public Schools of North Carolina and the Department of Health and Human Services. *Effective School Health Advisory Councils: Moving from Policy to Action.* (October 2003) outlines approaches to council organization, function, and operation.

<http://www.nchealthyschools.org/docs/schoolhealthadvisorycouncil/advisorycouncilsmanual.pdf>

**Healthy Kids Learn Better: State of Oregon, Public Health Division, Adolescent Health Section** *Lessons Learned from Oregon's Coordinated Health Project* (July 2007). Conducted by the HKLB partnership, this report summarizes two evaluation case studies since the first schools adopted CSHP in Oregon. Using interviews and survey results, the report identifies ten factors as major determinants of the success of CSHP efforts. Contact [Isabelle.S.Barbour@state.or.us](mailto:Isabelle.S.Barbour@state.or.us) for a copy.

**Hoyle, T.B., Samek, B.B., & Valois, R.F. (2008).** Building capacity for the continuous improvement of health-promoting schools. *Journal of School Health, 78*(1), 1-8. This article describes how a school district in Colorado built capacity for the development of schools that promote health services.

**Illinois Children's Mental Health Partnership (ICMHP).** *Guidelines for School-Community Partnerships* identifies key development steps to support a sustainable structure wherein all school and community stakeholders share in the research, design, implementation, and evaluation of efforts undertaken collectively to assure the academic success and good mental health of school age children and youth.

<http://www.icmhp.org/icmhproducts/gdlnsclcmnty.html>

**Johnson, K., Hays, C., Center, H., & Daley, C. (2004).** Building capacity and sustainable prevention innovations: a sustainability planning model. *Evaluation and Program Planning 27*, 135–149. <http://casat.unr.edu/docs/6-kjohnson04article.pdf>. This article presents a definition of sustainability and a model for sustaining innovations within organizations, communities, and state systems. The model is a five-step process and details are presented in the article.

**Shediac-Rizkallah, M., C., & Bone, L., R. (1998).** Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice, and policy. *Health Education Research*, Vol. 13, No. 1, 87-108. This article provides a clear definition of the concept of sustainability and also presents methods for planning for sustainability.

### **Coordinated School Health – Curriculum Development**

**HECAT – Mental Health.** This module of the CDC's Health Education Curriculum analysis Tool (HECAT) contains tools to analyze and score curricula that are intended to promote mental and emotional health. This module uses the *National Health Education Standards* as the framework for determining the extent to which the curriculum is likely to enable students to master the essential concepts (Standard 1) and skills (Standards 2–8) that promote mental and emotional health.

[http://www.cdc.gov/HealthyYouth/HECAT/pdf/HECAT\\_Module\\_MEH.pdf](http://www.cdc.gov/HealthyYouth/HECAT/pdf/HECAT_Module_MEH.pdf)

**Social and Emotional Learning Standards.** The Collaborative for Academic, Social, and Emotional Learning has a useful website that promotes social and emotional learning and wellbeing in education. <http://www.casel.org>. In addition, the Illinois Children's Mental Health Partnership website has information about the Illinois State Board of Education's social and emotional learning standards. <http://www.icmhp.org/icmhproducts/socialmostndrds.html>

### **Texas School Guidance and Counseling Guide for Program Development**

This guide was developed to help ensure that all students in Texas benefit from high quality comprehensive, developmental school guidance and counseling programs. The guide provides a model for such programs and a process for tailoring the model to meet the needs of students in a wide array of school districts. <http://www.tea.state.tx.us/index2.aspx?id=4207>

**The Whole Child Campaign.** Association for Supervision and Curriculum Development (ASCD)'s position is that too much emphasis has been placed on student achievement and as a result, important factors that need to be addressed in children and youth have become de-emphasized. ASCD's campaign to focus on 'The Whole Child' encourages and reminds us of the importance of focusing on more than just academic success based upon standardized tests. [http://www.ascd.org/programs/The\\_Whole\\_Child.aspx](http://www.ascd.org/programs/The_Whole_Child.aspx)

**Wisconsin's Mental Health Curriculum.** Nine lessons for classroom teachers from Department of Public Instruction, WI – *Mental Health Units of Instruction*. This CD-ROM contains curricula on the following 5 topics: 1) Dating Violence; 2) Mental Illness; 3) Suicide Prevention Grades 6-8; 4) Suicide Prevention Grades 8-10; and 5) Social Norms: Using the 2007 YRBS. Contact Linda.Carey@DPI.WI.GOV for a copy.

### **Coordinated School Health – Examples from the Field**

**Findings from Oregon Discussion Groups.** Themes, challenges, and opportunities are summarized from the school mental health stakeholder discussion groups, including one on CSH, conducted by NASBHC's School Mental Health Capacity Building Partnership. <http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.3599739>

**New Mexico State Department of Education.** This webpage provides information from the New Mexico State Department of Education about the eight components of their CSH program. They use the image of a yucca plant to demonstrate how the components all related with one another to provide a healthier environment from which students can learn. Many links for additional resources are also provided. <http://www.healthierschools.org>

**Oregon Healthy Kids Learn Better.** This webpage provides information about Oregon's state programs, services, and philosophy about adolescent health and related issues. <http://www.oregon.gov/DHS/ph/ah/cshp/cshp.shtml>

**State of Maine Guidelines for Coordinating School Health Programs.** The purpose of these guidelines is to focus discussion on and develop consensus concerning the role of schools in contributing to youth health and education and provide general directions and assessment indicators for local schools regarding the development of coordinated and quality school health programs. <http://www.maineeshp.com/Preface.htm>

**Success Stories from States.** This webpage of the CDC-DASH highlights various state success stories and provides additional resources. <http://www.cdc.gov/HealthyYouth/stories/index.htm>

### **Coordinated School Health – Research Findings**

**Behavior, Resilience and Academic Performance.** Hanson, T.L. and Austin, G.A. (2002). *Health risks, resilience, and the Academic Performance Index*. (California Healthy Kids Survey Factsheet 1). Los Alamitos, CA: WestEd. This fact sheet discusses how academic performance is influenced by various health-related indicators. Results for four key variables: eating breakfast on the day of the survey; using alcohol, tobacco, or marijuana at school; school safety; and external assets (resilience) are examined in relation to academic achievement. [http://www.wested.org/cs/chks/print/docs/chks\\_factsheets.html](http://www.wested.org/cs/chks/print/docs/chks_factsheets.html)

**Educational Leadership**, ASCD (2005). *Back to the Whole Child*. This article, written by Elliot Eisner, builds the case for why academic achievement should not be the only marker of student learning. Other factors such as emotional and physical wellbeing – along with other factors – need to be examined in the whole child to determine success.

<http://www.ascd.org/publications/educational-leadership/sept05/vol63/num01/Back-to-Whole.aspx>

**Making the Connection: Health and Student Achievement.** This presentation was developed in 2002 by the Association of State and Territorial Health Officials (ASTHO) and the Society of State Directors of Health, Physical Education and Recreation (SSDHPER) to provide insight into and support for CSH by reviewing some of the primary research that supports components of CSH programs. It is designed to be a persuasive presentation that is backed by credible research.

<http://www.thesociety.org/pdf/makingtheconnection.ppt>

**Risk Behavior and Academic Achievement.** *Health Risk Behavior and Academic Achievement*, CDC. This handout highlights the link between risky behaviors. Data are from the 2003 Youth Risk Behavior Survey Surveillance System (YRBSS). [http://www.cdc.gov/HealthyYouth/health\\_and\\_academics](http://www.cdc.gov/HealthyYouth/health_and_academics)

### **Coordinated School Health – Resources for Stakeholders**

**Action for Healthy Kids.** This website provides information to engage diverse organizations, leaders, and volunteers in actions that foster sound nutrition and good physical activity in children, youth, and schools. <http://www.actionforhealthykids.org/resources.php>

**American Cancer Society.** *Promoting Healthy Youth, Schools, and Communities-A Guide to Community-School Health Councils* (January, 2003). This 148 page document describes the five-steps needed to create a school health council. They are 1) convening a school health council; 2) creating a vision and building ownership; 3) developing an action plan; 4) taking action and getting results; 5) maintaining momentum.

[http://www.cancer.org/docroot/PED/content/PED\\_13\\_4x\\_Guide\\_to\\_Community\\_School\\_Health\\_Councils\\_pdf.asp](http://www.cancer.org/docroot/PED/content/PED_13_4x_Guide_to_Community_School_Health_Councils_pdf.asp)

**American School Health Association.** *Indicators of School Administrator Support.* This one-page document developed by ASHA's Council for Administrative Support was created in response to a meeting among several national organizations to discuss how to reach out to school administrators with school health messages. This document highlights what administrator support for a CSH would look like.

[http://www.ashaweb.org/files/public/Miscellaneous/Indicators\\_of\\_Administrative\\_Support\\_June\\_1\\_09.pdf](http://www.ashaweb.org/files/public/Miscellaneous/Indicators_of_Administrative_Support_June_1_09.pdf)

**How Schools Work and How to Work with Schools.** This 48-page guide for health professionals and others who seek to serve children and youth in school settings includes a summary of the benefits for students when health professionals and educators work together; an overview of the core mission of education; a background chapter on how education works at the school, district, state, and national levels; as well as many practical tips for how to work effectively with educators, school administrators, and policymakers.

[http://store.nasbe.org/merchant2/merchant.mvc?Screen=PROD&Store\\_Code=N&Product\\_Code=HSWS&Category\\_Code=SHSP](http://store.nasbe.org/merchant2/merchant.mvc?Screen=PROD&Store_Code=N&Product_Code=HSWS&Category_Code=SHSP)

**Systems of Care Definition of Family-Driven Care.** This website provides definitions and information about family-driven care principles and how to incorporate them into a Systems of Care model.

<http://www.systemsofcare.samhsa.gov/headermenus/deffamilydriven.aspx>

### **Coordinated School Health – Tools**

**CDC Surveillance tools.** This one-page document highlights the three major surveillance tools created by the CDC. They are: 1) Youth Risk Behavior Surveillance System (YRBSS); 2) School Health Policies

and Program Study (SHPPS); and 3) School Health Profiles (Profiles).  
<http://www.cdc.gov/HealthyYouth/SchoolHealth/pdf/SummaryTools.pdf>

**Engaging Parents/Caregivers.** *Assessing Your SBHC's Capacity to Engage Parents/Caregiver* (adapted from Center for Excellence Mount Sinai Adolescent Health Center). This is a tool/assessment that schools can use to determine strengths and weakness areas regarding their ability to engage parents/caregivers.

<http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2564543/apps/s/content.asp?ct=3842969>

**Mental Health Planning and Evaluation Template (MHPET).** Developed by NASBHC in partnership with the Center for School Mental Health, this tool can be used in planning and evaluating activities and services of new or established mental health programs in any school setting. [www.nasbhc.org/MHPET](http://www.nasbhc.org/MHPET).

**School Health Index.** This webpage of the CDC-DASH introduces the School Health Index (SHI) and provides information about using it. Click on the link for the Introduction to the SHI and you will find in-depth information about why one should consider using the SHI and what its various components/modules are. <https://apps.nccd.cdc.gov/shi/default.aspx>.

**School Mental Health Inventory.** This self-assessment and planning guide is modeled after the SHI. Like the SHI, the SMHI is structured around the eight components of the CSH yet has a focus on mental health. The questions are designed to assist lay-staff in a school to determine how school policies, protocols and programs promote mental health and address student mental health needs. The tool was developed as part of the Oregon Healthy Kids Learn Better Mental Health Demonstration Project. Contact [Isabelle.S.Barbour@state.or.us](mailto:Isabelle.S.Barbour@state.or.us) for a copy.

## REFERENCES

- Allensworth, D. (1994) The research base for innovative practices in school health education at the secondary level. *Journal of School Health*, 64(5), 180-187.
- Allensworth, D., Kolbe, L.J. (Eds.) (1987) The comprehensive school health program: Exploring an expanded concept. *Journal of School Health*, 57(10).
- Alliance for Excellence in Education Fact Sheet, Updated February, 2009.
- American Academy of Pediatrics. 2004. School-based mental health services. *Pediatrics*, 113, 1839-1845.
- 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.
- Battistich, V., Solomon, D., & Delucchi, K. (1993). Interaction processes and student outcomes in cooperative learning groups. *The Elementary School Journal*, 94, 19–32.
- Bauer, J., Unterbrink, T., Hack, A., Pfeifer, R., Buhl-Griebhaber, V., Muller, U., Wesche, H., et al. (2007). Working conditions, adverse events and mental health problems in a sample of 949 German teachers. *International Archives of Occupational & Environmental Health*, Vol. 80 Issue 5, p442-449, 8p; DOI: 10.1007/s00420-007-0170-7; (AN 24207201)
- Benard, B. (1995). *Fostering Resilience in Children*. (Report No. EDO-PS-95-9). Champaign, IL: Clearinghouse on Elementary and Early Childhood Education. Retrieved October 30, 2003 from <http://www.resilnet.uiuc.edu/library/benard95.html>.
- Benard, B. (1997). *Turning it Around for All Youth: From Risk to Resilience*. Eric Clearinghouse on Urban Education. Retrieved October 30, 2003 from <http://www.resilnet.uiuc.edu/library/dig126.html>.
- Brown, J.L., Beardslee, W.H., Prothrow-Stith, D. (2008). *Impact of School Breakfast on Children's Health and Learning: an Analysis of Scientific Research*. Sodexo Foundation.
- Brown, S. W., Welsh, M. C., Labbe, E. E., Vitulli, W. F., and Kulkarni, P. (1992). Aerobic exercise in the psychological treatment of adolescents. *Perceptual and Motor Skills*, 74, 555-560
- Burke, R. W., & Stephan, S.H. (2008). Contextual features of public schools in the United States as settings for mental health promotion. *Advances in School Mental Health Promotion*, 1 (1), 52–6.
- Burns, B.J., Costello E.J., Angold, A., Tweed, D., Stangl, D., Farmer, E.M., and Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs*, 14(3), 147-159.
- Castelli, D. M., Hillman, C. H., Buck, S. M., and Erwin, H. E. (2007). Physical fitness and academic achievement in third-and fifth-grade students. *Journal of Sport & Exercise Psychology*, 29, 239-252.
- Census 2004-2005*. Retrieved February 17, 2009, from National Assembly on School-Based Health Care Web site: <http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2564543/apps/s/content.asp?ct=3843961>
- Centers for Disease Control and Prevention. Guidelines for school health programs to promote lifelong healthy eating. *Morbidity and Mortality Monthly Report*, 1996; 45(No. RR-9): p. 4.
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health, Coordinated School Health Program. Retrieved July 14, 2010 from Web site <http://www.cdc.gov/HealthyYouth/CSHP/>.
- Centers for Disease Control and Prevention. School Health Policies and Programs Study (SHPPS) 2006, *Journal of School Health*, Volume 77, Number 8, October 2007.

- Centers for Disease Control and Prevention. *School Connectedness: Strategies for Increasing Protective Factors Among Youth*. Atlanta, GA: U.S. Department of Health and Human Services; 2009.
- Center for Social and Emotional Education, Retrieved September 29, 2009, from Web site <http://schoolclimate.org/climate/index.php>
- Chang, L. (2003). Variable effects of children's aggression, social withdrawal, and prosocial leadership as functions of teacher beliefs and behaviors. *Child Development*, 74(2), 535-548.
- Cohen, J., Pickeral, T., & McCloskey, M. (2009). Assessing school climate. *Education Digest*, 74(8), 45-48.
- Combs-Orme, T., C. A. Heflinger, and C. G. Simpkins. 2002. Comorbidity of mental health problems and chronic health conditions in children. *Journal of Emotional and Behavioral Disorders* 10(2): 116-125.
- Donnelly, J. W., Eburne, N., & Kittleson, M. (2001). *Mental health: Dimensions of self-esteem and emotional well-being*. Boston: Allyn and Bacon.
- Duchnowski, A.J., Kutash, J., & Friedman, R.M. (2002). Community-based interventions in a system of care and outcomes framework. In: BJ Burns & K Hoagwood (Eds), *Community Treatment for Youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press.
- Edwards, S., Roche, D., Stratton, G., Wallymahmed, K., & Glenn, S.M. (2007). Physical activity and psychological well-being in children with Type I diabetes. *Psychology, Health & Medicine*, 12, 353-363.
- Elias, M. J., Gara, M. A., Schuyler, T. F., Branden-Muller, L. R., and Sayette, M. A. (1991). The promotion of social competence: Longitudinal study of a preventive school-based program. *American Journal of Orthopsychiatry*, 61(3), 409-417.
- Flaspohler, P.D., Anderson-Butcher, D., Paternite, C.E., Weist, M., & Wandersman, A. (2006). Community science and expanded school mental health: Briding the research-to-practice gap to promote child well-being and academic success. *Educational & Child Psychology*, 23(1), 27-41.
- Fredericks, J., Blumenfeld, O., & A. Paris. (2003). Culture by Putting Research into Practice: Scarecrow Education, School Engagement: Potential of the Concept, and State of the Evidence. *Review of Educational Research*, Spring 2004, 74(1), 59-109.
- Gall, G., Pagano, M. E., Desmond, S.M., Perrin, J. M., Murphy, M.J. (2000). Utility of psychosocial screening at a school-based health center. *Journal of School Health*, 70(7), 292.
- Government Accountability Office (2007). *School Mental Health: Role of the Substance Abuse and Mental Health Services Administration and Factors Affecting Service Provision*. GAO-08-19R October 5, 2007.
- Greenbaum, P. E., Dedrick, R. F., Friedman, R. M., Kutash, K., Brown, E. C., Lardieri, S. P., et al. (1998). National Adolescent and Child Treatment Study (NACTS): Outcomes for children with serious emotional and behavioral disturbance. In M. H. Epstein, K. Kutash, and A. Duchnowski, *Outcomes for Youth with Emotional and Behavioral Disorders and Their Families: Programs and Evaluation Best Practices* (pp. 21-54). Austin, TX: Pro-Ed.
- Greenberg, M. T., Domitrovich, C. E., Graczyk, P. A., & Zins, J. E. (2005). The study of implementation in school-based preventive interventions: Theory, research, and practice. *Promotion of Mental Health and Prevention of Mental and Behavioral Disorders*. (3). DHHS Pub. No. (SMA). Rockville, MD:

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.  
Retrieved March 10, 2009 from <http://www.casel.org/downloads/Implementation%20VOL%2031.pdf>

Greenwood, C. R., Terry, B., Marquis, J., & Walker, D. (1994). Confirming a performance-based instructional model. *School Psychology Review*, 23, 625-668.

Healthy Youth! Coordinated School Health Program, Health Promotion for Staff (n.d.). Retrieved March 10, 2009 from Center for Disease Control and Prevention Web site:  
<http://www.cdc.gov/healthyyouth/cshp>

Henderson, N. & Milstein, M. (1996). *Resiliency in schools: Making it happen for students and educators*. Thousand Oaks, CA: Corwin Press.

Hoganbruen, K., Clauss-Ehlers, C., Nelson, D., & Faenza, M. (2003). Effective advocacy for school-based mental health program. In M.D. Weist, S.W. Evans, & N.A. Lever (Eds.), *Handbook of school mental health programs: Advancing practice and research* (pp 45-59). New York, NY: Kluwer Academic/Plenum Publishers.

Hoagwood, K., & Johnson, J. (2003). School psychology: A public health framework I. From evidence-based practices to evidence-based policies. *Journal of School Psychology*. 41(1), 3-21.

Strozer, J., Juszczak, L., & Ammerman, A. (2010). 2007-2008 National School-Based Health Care Census. Washington, DC: National Assembly on School-Based Health Care.

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159, 1548–1555.

Kauffman, J.M. (2001) *Characteristics of Emotional and Behavioral Disorders of Children and Youth* (8th edition). Upper Saddle River, NJ: Merrill/Prentice Hall.

Kessler, R. C., Berglund, P., Demler, O., Jin, R. & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. *Archives of General Psychiatry* 62(6), 593–602.

Koller J. R., Osterlind, S., Paris, K. & Weston, K.J. (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.

Kutash, K., Banks, S., Duchnowski, A., & Lynn, N. (2007). Implications of nested designs in school-based mental health services research. *Evaluation and Program Planning*, 30(2), 161-171.

Kutash, K., Duchnowski, A. J., & Lynn, N. (2006). *School-based mental health: An empirical guide for decision-makers*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Dept. of Child and Family Studies, Research and Training Center for Children's Mental Health.

Leaf, P. J., Alegria, M., Cohen, P., Goodman, S.H., Horwitz, S. M., Hoven, C. W., et al. (1996). Mental health service use in the community and schools: Results from the four-community MECA Study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(7), 889–897.

Luekens, M. T., Lyter, D. M., & Fox, E. E. (2004). *Teacher attrition and mobility: Results from the Teacher Follow-up Survey, 2000-01* (NCES Publication No. 2004-301). Washington, DC: National Center for Education Statistics, U.S. Department of Education.

- Making Health Academic*. (n.d.) Retrieved March 10, 2009, from Education Development Center Inc., Center for School Health: <http://www2.edc.org/MakingHealthAcademic/>
- Mavropoulou, S., & Padeliadu, S. (2002). Teachers' causal attributions for behavior problems in relation to perceptions of control. *Educational Psychology, 22*(2), 191-202.
- McKenzie, F. D., & Roberts, J. B. (1998). Linking health and learning: An overview of Coordinated School Health Programs. In M. E. Marx, S. F. Wooley, & D. Northrop (Eds.), *Health is academic: A guide to coordinated school health programs*. New York: Teachers College Press.
- McLoone, J., Hudson, J. L., & Rapee, R. M. (2006). Treating anxiety disorders in a school setting. *Education & Treatment of Children, 29*(2), 219-242.
- Moir, E. & Gless, J. (2001). Quality induction: An investment in teachers. *Teacher Education Quarterly, 28*(1), 109-114.
- National Commission on Teaching and America's Future (2007). *Policy brief: The high cost of teacher turnover*. Retrieved March 10, 2009, from: [http://www.nctaf.org/resources/demonstration\\_projects/turnover/documents/CTTPolicyBrief6-19.pdf](http://www.nctaf.org/resources/demonstration_projects/turnover/documents/CTTPolicyBrief6-19.pdf)
- National Institute of Mental Health. 2004, February. Preventing child and adolescent mental disorders: Research roundtable on economic burden and cost effectiveness.
- New Freedom Commission on Mental Health (2003), *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.
- Parks, J., Svendsen, D., Singer, P., Foti, M.E. (2006) *Morbidity and Mortality in People with Serous Mental Illness*. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. Alexandria, VA, 2006
- Payton, J., Weissberg, R.P., Durlak, J.A., Dymnicki, A.B., Taylor, R.D., Schellinger, K.B., & Pachan, M. (2008). *The positive impact of social and emotional learning for kindergarten to eighth-grade students: Findings from three scientific reviews*. Chicago, IL: Collaborative for Academic, Social, and Emotional Learning.
- Power, T. J., Eiraldi, R. B., Clarke, A.T., Mazzuca, L.B. & Krain, A.L. (2005). Improving mental health service utilization for children and adolescents. *School Psychology Quarterly, 20*, 187-205.
- Prince, M., Patel, V., Saxena, S., Maj, M., Maserko, J., Phillips, M., & Rahman, A. (2007). No health without mental health. *Lancet, 370*, 859-77.
- Reid, R., Gonzalez, J. E., Nordness, P. D., Trout, A., & Epstein, M. H. (2004). A meta-analysis of the academic status of students with emotional/behavioral disturbance. *The Journal of Special Education, 38* (3), 130-143.
- Rones, M. & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review, 3*, 223-241
- Solomon, D., Battistich, V., Watson, M., Schaps, E., & Lewis, C. (2000). A six-district study of educational change: Direct and mediated effects of the child development project. *Social Psychology of Education, 4*, 3-51.
- Solomon, D., Watson, M., Battistich, V., Schaps, E., & Delucchi, K. (1996). Creating classrooms that students experience as communities. *American Journal of Community Psychology, 24*, 719-748.
- Soodak, L. C., & Podell, D. M. (1994). Teachers' thinking about difficult-to-teach students. *Journal of Educational Research, 88*(1), 44-51.

- Stoiber, K.C., & Good, B. (1998). Risk and resilience factors linked to problem behavior among urban, culturally diverse adolescents. *School Psychology Review, 27*(3), 380-397.
- Stormont, M. (2007). *Fostering resilience in young children vulnerable for failure: Strategies for K-3*. Pearson/Merrill/Prentice Hall: Columbus, OH.
- Strozer, J., Juszczak, L., & Ammerman, A. (2010). 2007-2008 National School-Based Health Care Census. Washington, DC: National Assembly on School-Based Health Care.
- Substance Abuse and Mental Health Services Administration (SAMHSA). 2004a. National Disability Employment Awareness Month. Retrieved October 30, 2006 from <http://mentalhealth.samhsa.gov/highlights/2000/October/Disability/>.
- Substance Abuse and Mental Health Services Administration (SAMHSA). 2004b. DASIS Report: Admissions with co-occurring disorders, 1995 and 2001. Retrieved October 30, 2006 from <http://www.oas.samhsa.gov/2k4/dualTX/dualTX.cfm>.
- Substance Abuse and Mental Health Services Administration (SAMHSA). 2005. DASIS Report: Adolescents with co-occurring psychiatric disorders, 2003. Retrieved October 30, 2006 from <http://www.oas.samhsa.gov/2k5/youthMH/youthMH.cfm>.
- U.S. Department of Education (1994) *National Agenda for Achieving Better Results for Children and Youth with Emotional and Behavioral Disturbance*. Washington, D.C.: Office of Special Education Programs.
- U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General—Executive Summary*. Retrieved February 17, 2009, from U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health Web site: <http://www.surgeongeneral.gov/library/mentalhealth/summary.html>
- Wade, T., Mansour, M., Guo, J., Huentelman, T., Line, K., & Keller, K. (2008). Access and utilization patterns of school-based health centers at urban and rural elementary and middle schools. *Public Health Reports, 123*(6), 739-750.
- Weisel, A., & Tur-Kaspa, H. (2002). Effects of labels and personal contact on teachers' attitudes towards students with special needs. *Exceptionality, 10*(1), 1-10.
- Weist, M.D. & Evans, S.W. (2005). Expanded School Mental Health: Challenges And Opportunities In An Emerging Field. *Journal of Youth and Adolescence, 34*, 3-6.
- Weston, K. J., Anderson-Butcher, D., & Burke, R. W. (2008). Developing a comprehensive framework for teacher preparation in Expanded School Mental Health. *Advances in School Mental Health Promotion, 1*(4), 25-41.
- Williams, J. H., Horvath, V.E., Wei, H., Van Dorn, R. A. & Jonson-Reid, M. (2007). Teachers' perspectives of children's mental health service needs in urban elementary schools. *Children and Schools 29* (2) 95-107.
- Woodruff, D.W., Osher, D., Hoffman, C.C., Gruner, A., King, M.A., Snow, S.T., and McIntire, J.C. (1999). The role of education in a system of care: Effectively serving children with emotional or behavioral disorders. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume III*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.