# MENTAL HEALTH SERVICES AND PUBLIC EDUCATION

Prepared for Southeastern Wisconsin School Alliance

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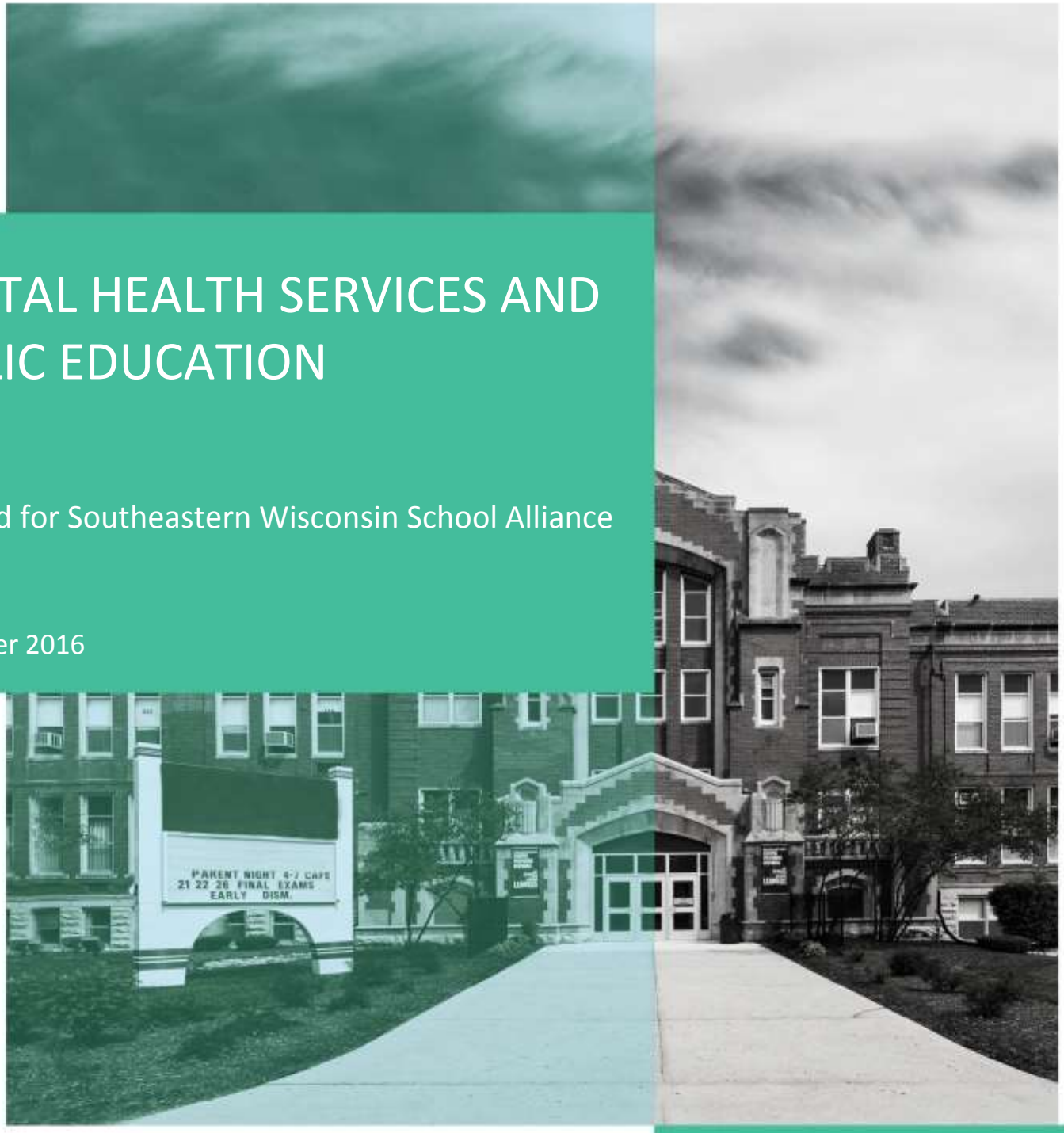


In the following report, Hanover Research discusses the literature related to expanded school mental health programs and best practices in implementing school mental health programs and integrating community-based mental health supports.

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# EXECUTIVE SUMMARY AND KEY FINDINGS

## INTRODUCTION

According to an article from the National Public Radio (NPR), as many as 20 percent of the over 50 million school-aged children in the United States may suffer from a mental health disorder. When such disorders go untreated – as research indicates that the percentage may be as high as 80 percent – students suffer academically, socially, and emotionally.[1] While schools have become a more common location for addressing youth mental health issues, school mental health efforts face a variety of challenges, including overwhelmed staff, insufficient funds, and disjointed systems of school and community mental health providers.[2] A common solution to address these challenges and to provide students with a system of wraparound supports that extend from the classroom to students' homes is the implementation of extended school mental health (ESMH) programs, which integrate school and community resources to provide a collaborative continuum of mental health care.[3]

To support Southeastern Wisconsin Schools Alliance (SWSA) in its consideration of ESMH programs, this report reviews the literature related to the integration of school and community-based mental health supports. Specifically, this report includes the following three sections:

- **Section I: Mental Health and Academics** presents an overview of the common mental health issues and trends in school-aged children and their impacts on academics.
- **Section II: Supporting Mental Health in Schools** describes a Multi-Tiered System of Supports framework to guide effective school mental health program implementation and the integration of community-based mental health services.
- **Section III: Funding and Data Management** addresses two challenges that school-based mental health programs face – sustainable funding sources and data sharing among school and community mental health providers.

## KEY FINDINGS

- **The Wisconsin Department of Public Instruction (WIPDI) and the existing research recommend that schools adopt a Multi-Tiered System of Supports framework to guide their mental health programs and the integration of community-based supports.** A three-tiered system of mental health supports provides a universal level of mental health supports necessary to meet the needs of all students, and offers

[1] "A Silent Epidemic." NPR, September 7, 2016. http://apps.npr.org/mental-health/
[2] Anderson, Meg. "Here's How School Can Support Students' Mental Health." NPR, September 20, 2016. http://www.npr.org/sections/ed/2016/09/20/459843929/heres-how-schools-can-support-students-mental-health
[3] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports." Wisconsin Department of Public Instruction, 2015. p. 1. http://dpi.wi.gov/sites/default/files/imce/sspw/pdf/mhframework.pdf

more intensive, targeted interventions to selected students. Typically, school mental health staff provide or support Tier 1 and 2 interventions on school site and refer students to community-based providers for more intensive Tier 3 interventions. However, this may change in more collaborative partnerships between school mental health programs and community-based providers.

- **Sustainable partnerships between schools and community-based mental health providers often feature a shared vision, a contract that specifies responsibilities and services to be provided, and continual collaboration among staff.** While school mental health programs may form partnerships with a range of public and private community-based health providers, schools frequently partner directly with non-profit and local government health agencies. Experts stress the need for collaborating organizations to clearly define their respective roles and the specific responsibilities of school staff and community providers, who, in some partnerships, may be school-based.
- **Effective universal interventions (i.e. Tier I) aim to prevent mental health issues and promote social, emotional, and academic competencies.** For example, a 2011 meta-analysis that included over 270,000 K-12 students found that, in comparison with students in control groups, students who participated in programs that promoted social and emotional wellbeing demonstrated an 11-percentile-point gain in achievement, as well as improved social and emotional skills, attitudes, and behavior. Correspondingly, the WIDPI suggests that universal strategies should focus on social-emotion and mental health skill building.
- **Universal mental health screening measures, as well as tools for monitoring the efficacy of mental health interventions, complement the three-tiered school health care model and promote early identification of mental health concerns among students**. Experts recommend time-efficient, self-administrable screening tools that assess multiple areas of mental health. Examples include the Achenbach System of Empirically Based Assessment, the Beck Youth Inventories, and the BASC-2 Behavioral and Emotional Screening System.
- **Financially sustainable ESMH programs typically use braided and/or blended funding to leverage multiple funding streams, including third-party insurance and Medicaid.** Experts find that blended funding, which allows programs to combine funds into a single budget for discretionary use, is more flexible and sustainable, and reduces administrative burdens in comparison with braided funding, where funds are only allocated to specific programmatic components. Exemplary ESHM programs often initially rely on local and federal funding and then expand to accept Medicaid and third-party insurance reimbursements.
- **The WIDPI recommends that districts and schools use tiered consent forms to facilitate information sharing across mental health providers and other youth-serving agencies.** Federal and state regulations on data privacy and sharing (e.g., Wisconsin Statutes 118.125 and the Health Insurance Portability and Accountability Act) present a challenge to ESMH programs, which need to share student information between school and community-based providers. Consent forms that

specify which information can be shared with whom would facilitate information sharing and allow students and families to determine and change how much information they wish to be shared across providers.

# SECTION I: MENTAL HEALTH AND ACADEMICS

This section presents an overview of mental health issues and trends among school-aged children, and discusses the effects of mental health challenges on academics.

## OVERVIEW

**Similar to physical health, mental health is a spectrum that may range from a high level of wellness to severe illness.**[4] Experts note that mental health "is not merely the absence of disease or a mental illness," but more broadly includes emotional, psychological, and social well-being.[5] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services, mental wellness in youth means that they "have positive regard for themselves, enjoy positive relationships with the people who are important to them, and are generally resilient when faced with challenges in their lives at home and school." Conversely, mental illness "is a condition that impacts a young person's thinking, emotions, and mood such that it interferes with his or her daily functioning at home and school.[6] According to the WIDPI, school mental health programs should specifically address "all aspects of social-emotional development of school-aged children including wellness, mental illness, substance abuse, and effects of adverse childhood experiences."[7]

### YOUTH MENTAL HEALTH NATIONWIDE

**Research estimates that 20 percent or more of school-aged children have diagnosable mental disorders nationwide.** Accurate estimates of the number of school-aged youths with mental disorders are difficult to calculate due to their reluctance (especially in adolescents) to self-report disorders, varying definitions of mental disorders, and the need in many cases for clinical diagnoses.[8] However, based on the data from 1994 to 2011, the Centers for Disease Control and Prevention (CDC) found that, in a given year, the percentage of students experiencing a diagnosable mental disorder ranged from 13 to 20 percent. Moreover, over this period, the percentage of school-aged children with mental disorders appeared to be on the rise. In 2010, suicide – which, according to the CDC, may be the "result from the interaction of mental disorders and other factors"– was the second most common cause of death for adolescents aged 12 to 17 years.[9]

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[4] [1] "Issue Brief: Mental Health and Academic Achievement." Substance Abuse and Mental Health Services Administration, 2016. p. 1. http://dpi.wi.gov/sites/default/files/imce/sspw/pdf/mhissuebrief.pdf [2] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 3.

[5] "Mental Health." Youth.gov. http://youth.gov/youth-topics/youth-mental-health

[6] "Issue Brief: Mental Health and Academic Achievment," Op. cit., p. 1.

[7] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 3.

[8] Murphey, D., M. Barry, and B. Vaughn. "Adolescent Health Highlight." *Child Trends*, 1, 2013. p. 2. http://www.childtrends.org/wp-content/uploads/2013/03/Child_Trends-2013_01_01_AHH_MentalDisordersl.pdf

[9] Perou, R. et al. "Mental Health Surveillance Among Children — United States, 2005–2011." Centers for Disease Control and Prevention, 2013. http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm

**Surveys also indicate that the majority of school-aged children with mental disorders go untreated and those who do receive treatment often receive inadequate care.** Despite the prevalence of mental illness in children, evidence suggests that less than a third of children with diagnosable mental illnesses receive services from a mental health specialist.[10] Additionally, fewer than 10 percent of the children who receive treatment receive mental health services for more than three months.[11] For example, surveys from 2009 to 2013 of Wisconsin adolescents aged 12 to 17 years indicated that 9.4 percent of all surveyed adolescents (approximately 41,000) experienced at least one Major Depressive Episode (MDE) within the 12 months prior to the survey. However, more than half of those adolescents did not receive any treatment for depression.[12]

## YOUTH MENTAL HEALTH IN WISCONSIN

**In Wisconsin, surveys indicate that, on average, one in four high school students show signs of depression.** Partially, since the youth suicide rate in Wisconsin has historically exceeded the national average, past discussions of youth mental health in the state often centered on the prevalence of depression and suicide.[13] While data from the most recent Wisconsin Youth Risk Behavior Survey (YRBS) indicates a downward trend for the percentage of students at-risk of committing suicide, in 2013, 13 percent of high school students reported having considered committing suicide in the 12 months leading to the survey. Moreover, within certain student subgroups, such as female students and/or students identifying as gay, lesbian, or bisexual, the percentage of students considering suicide is higher.[14] Figure 1.1 below lists the primary mental health indicators connected with suicide and depression, based on the responses of 2,843 Wisconsin high school students across 53 public schools in the spring of 2013.

[10] [1] Behrens, D., J. Graham, and O.A. Price. "Improving Access to Children's Mental Health Care: Lessons from a Study of Eleven States." The Center for Health and Health Care in Schools, 2013. http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1066&context=sphhs_prev_facpubs [2] Cook, C. et al. "An Integrated Approach to Universal Prevention: Independent and Combined Effects of PBIS and SEL on Youths' Mental Health." *School Psychology Quarterly*, 30:2, June 2015.

[11] Behrens, Graham, and Price, Op. cit.

[12] "Behavioral Health Barometer Wisconsin, 2014." Substance Abuse and Mental Health Services Administration, 2014. pp. 5–6. http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_2/BHBarometer-WI.pdf

[13] [1] Gordon, S. "Wisconsin's Youth Mental Health Challenges Vary by Region." WisCONTEXT, August 28, 2015. http://www.wiscontext.org/wisconsins-youth-mental-health-challenges-vary-region [2] "2013 Youth Risk Behavior Survey." Wisconsin Department of Public Instruction, 2013. p. 3. http://dpi.wi.gov/sites/default/files/imce/sspw/pdf/yrbs13execsum.pdf

[14] Ibid.

**Figure 1.1: Wisconsin High School Student Suicide Rates, Spring 2013**

| Mental Health Indicator* | All Students | Males | Females | Heterosexual | Gay, lesbian, bisexual |
|---|---|---|---|---|---|
| **Feeling sad or hopeless, two weeks in a row** | 25% | 12% | 33% | 22% | 57% |
| **Considered suicide** | 13% | 10% | 16% | 11% | 49% |
| **Made a plan to attempt suicide** | 12% | 9% | 15% | 10% | 41% |
| **Attempted suicide** | 6% | 6% | 6% | 4% | 28% |

*Over the past 12 months
Source: Wisconsin Department of Public Instruction[15]

**In parts of Wisconsin, substance abuse issues appear to be declining as indicators of depression and suicide rise.** The most recent 2016 Leading Indicators for Excellence (LIFE) survey of the Fox Cities region in northern Wisconsin found that, while the percentage of high school students who reported substance abuse problems decreased from2013 to 2016, the percentage of students considering and attempting suicide rose over the same period. Specifically, the percentage of students considering suicide rose from 13.2 to 15.3 percent (compared to a national average of 17.0 percent) from 2013 to 2016, and the percentage of students having attempted suicide doubled from 6.0 to 12.0 percent (compared to a national average of 8.0 percent). The United Way for Fox Cities notes that these results "may highlight a need for more intervention programs and supportive services for youth who seriously considered suicide" in Wisconsin.[16]

## Common Mental Health Challenges

**The most common types of mental health issues facing school-aged youth include (1) social, interpersonal, or family problems; (2) aggressive and disruptive behavior; and (3) behavior problems associated with neurological disorders.** Based on a nationally representative sample of 83,000 K-12 students, SAMHSA finds that schools most frequently provide mental health services to students with social, interpersonal, or family problems or aggressive and disruptive behavior. Figure 1.2 below displays the types of psychosocial or mental health issues commonly addressed by schools. When asked to indicate the three most common mental health concerns, schools noted the following common problems, with the top six issues highlighted in bold font.[17]

**Figure 1.2: Types of Common Mental Health Concerns**

- **Adjustment issues**
- **Social, interpersonal, or family problems**
- **Anxiety, stress, or school phobia**
- **Depression, grief reactions**
- Suicidal or homicidal thoughts or behavior
- Substance use/abuse
- Eating disorders
- Concerns about gender or sexuality

[15] Figure adapted from: Ibid.
[16] "Health and Wellness." United Way for Fox Cities, 2016. http://www.foxcitieslifestudy.org/indicators/health-wellness/
[17] Foster, S. et al. "School Mental Health Services in the United States: 2002-2003." Substance Abuse and Mental Health Services Administration, 2005. pp. 15–16. http://files.eric.ed.gov/fulltext/ED499056.pdf

| | |
|---|---|
| ▪ **Aggression or disruptive behavior**<br>▪ **Behavior problems associated with neurological disorders**<br>▪ Delinquency or gang-related behavior | ▪ Physical or sexual abuse<br>▪ Sexual aggression<br>▪ Major psychiatric or developmental disorders |

Source: Substance Abuse and Mental Health Services Administration [18]

**Reported mental health concerns vary by gender and grade level.** Male students are more likely to exhibit aggressive and disruptive behavior and high school students are more likely to report symptoms of depression. Over the 2002-2003 school year, SAMHSA found that approximately 20 percent of the surveyed students from a nationally representative random sample of 2,125 regular K-12 public schools and 1,595 associated districts received school-based mental health services and their mental health problems varied by gender and grade level.[19] Figure 1.3 below presents the most commonly reported mental health concerns, listed by gender and grade level.

**Figure 1.3: Reported Mental Health Concerns by Gender and School Level**

| GENDER | ELEMENTARY | MIDDLE SCHOOL | HIGH SCHOOL |
|---|---|---|---|
| Males | ▪ Behavior problems associated with neurological disorders<br>▪ Aggressive and disruptive behavior | ▪ Aggressive and disruptive behavior<br>▪ Social, interpersonal, or family problems | ▪ Depression<br>▪ Substance use/abuse |
| Females | ▪ Adjustment issues<br>▪ Aggressive and disruptive behavior<br>▪ Behavior problems associated with neurological disorders | ▪ Social, interpersonal, or family problems<br>▪ Adjustment issues<br>▪ Aggressive and disruptive behavior<br>▪ Behavior problems associated with neurological disorders | ▪ Depression<br>▪ Substance use/abuse |

Source: National Association of State Directors of Special Education [20]

**With regard to specific diagnoses of mental illness, attention deficit hyperactivity disorder (ADHD), behavioral or conduct problems, and anxiety are the most common mental health disorders diagnosed in school-aged youth**. The U.S. Department of Health defines mental health disorders as "serious deviations from expected cognitive, social, and emotional development."[21] Based on a range of survey data from 1994 through 2011, the CDC finds that the most commonly diagnosed mental illnesses in school-aged youth include:[22]

- ADHD (6.8 percent of all school-aged young people);

[18] Figure adapted from: Ibid.
[19] Sopko, K.M. "School Mental Health Services in the United States." National Association of State Directors of Special Education, 2006. pp. 3–4. http://nasdse.org/DesktopModules/DNNspot-Store/ProductFiles/180_a75a2595-fb39-4f38-ac15-46b4d9bc45b6.pdf
[20] Figure adapted from: Ibid., p. 4.
[21] Perou et al., Op. cit.
[22] Bullets adapted from: Ibid.

- Behavioral or conduct problems (3.5 percent);
- Anxiety (3.0 percent);
- Depression (2.1 percent); and
- Autism spectrum disorders (1.1 percent).

As Figure 1.3 indicates, **among adolescents aged 12 to 17, depression is the most common mental disorder, with more than 25 percent of all adolescents self-reporting mild or more severe symptoms.** Adolescents are more likely to have anxiety disorders (10 percent), of which the most common are Obsessive Compulsive Disorder (OCD), post-traumatic stress disorder, and phobia.[23] Research also finds that adolescents with mental disorders are more likely to develop substance abuse problems.[24] Based on the CDC study, an estimated 4.2 percent of adolescents have struggled with an alcohol abuse disorder in the year leading to the study and 2.8 percent have reported cigarette dependence in the previous month.[25]

## IMPACTS OF MENTAL HEALTH ON ACADEMICS

**Students experiencing mental illness may exhibit poor attendance, low self-confidence, difficulties with social interaction, and difficulty concentrating, all of which affect student achievement in school.[26]** A large body of research links mental health problems with lower academic performance, increased interpersonal problems, elevated high school dropout rates, and later unemployment in adulthood.[27] Over the past several decades, schools have become a more common location for providing mental health services to school-aged children. However, a 2015 article published in *School Psychology Quarterly* notes that the traditional school infrastructure may not be suited to address the variety of student mental health needs and appropriately provide services to them.[28]

### EFFECTS OF SCHOOL MENTAL HEALTH PROGRAMS

**Research finds that school mental health programs can have positive effects on a variety of academic outcomes, including standardized test scores, grades, and attendance.** For example, according to a 2012 research brief from the National Association of School Psychologists that examined a list of over 25 studies, universal and targeted mental health interventions have positive effects on achievement, as well as factors linked to achievement such as school climate, behavior, social and emotional skills, attendance, and disciplinary occurrences. Notably, many of the studies focused on the implementation of universal social and emotional programming, typically around preventative interventions. Research

[23] Murphey, Barry, and Vaughn, Op. cit., p. 3.
[24] Ibid., pp. 1–2.
[25] Perou et al., Op. cit.
[26] "Youth Mental Health and Academic Achievement." National Center for Mental Health Checkups. http://www.flgov.com/wp-content/uploads/childadvocacy/mental-health-and-academic-achievement-2-24-12.pdf
[27] Cook et al., Op. cit.
[28] Ibid.

consistently finds that such universal programming leads to positive academic outcomes, as measured by both standardized tests and grades.[29]

**Similarly, in a 2015 report to Congress, SAMHSA highlighted the positive effects that community mental health services had on children with serious emotional disturbances (SEDs) on behavioral and emotional health, as well as attendance**.[30] Based on over 12,000 K-12 students who received intensive mental health care and substance use disorder services, funded by the Children's Mental Health Initiative (CMHI), interventions led the percentage of students who missed no more than one day of school per week to increase from 76.6 percent to 87.8 percent after 6 months and to 83.8 percent after two years. Similarly, the percentage of students who were suspended or expelled also decreased from 39.9 percent to 19.6 percent after two years of interventions.[31]

[29] Charvat, J. "Research on the Relationship Between Mental Health and Academic Achievement." National Association of School Psychologists, 2012. https://www.apsva.us/wp-content/uploads/legacy_assets/www/c99886fc16-SSAC_Attachment_6_Research_on_the_Relationship_Between_Mental_Health_and_Academic_Achievement_2.pdf

[30] "The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbance Program: 2015 Report to Congress." Substance Abuse and Mental Health Services Administration, 2015. p. 1. http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

[31] Ibid., pp. 5–10.

# SECTION II: SUPPORTING MENTAL HEALTH SERVICES IN SCHOOLS

This section presents an overview of a Multi-Tiered System of Supports framework for school mental health programs, and discusses typical school-based and community-based mental health services and interventions. We also present some of the recommended models for integrating community and school mental health supports.

**Experts emphasize the value of comprehensive, school-based mental health programs and services to improve student performance outcomes and to support mental wellness in the larger student population.** The American Academy of Pediatrics (AAP), for instance, cites multiple advantages to expanding schools' mental health resources. Establishing mental health programs and services in schools eliminates barriers to access to mental health care, such as the need for transportation, and helps facilitate parent participation in student health. Including such resources in schools may also lessen the stigma of seeking out mental health services, because these services are located in a familiar place for students and parents. Finally, school-based services may also improve the accuracy of diagnosis, as teachers and school staff interact with students on an almost daily basis, allowing staff to continually assess student progress.[32]

## MULTI-TIERED SYSTEM OF SUPPORTS

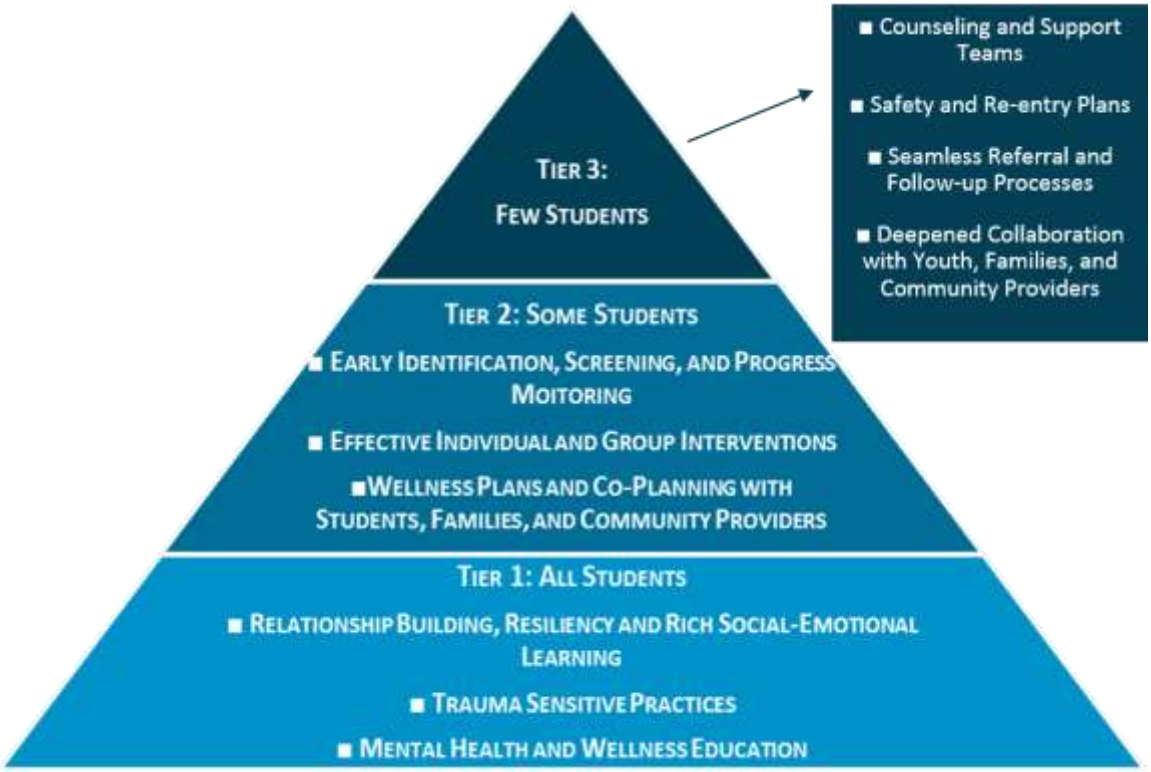
**To provide mental health supports and services to all students, the AAP and other experts often recommend that schools use a Multi-Tiered Systems of Supports (MTSS) framework to guide their mental health programs.[33]** Traditional approaches, which focus on addressing the mental health needs of a small number of identified students that require targeted support, are reactive and do not aim to prevent mental illness developing in the student body at large.[34] According to a 2010 study published in *School Mental Health* by Dowdy et al., such traditional, individual-focused approaches to intervention (e.g., the refer-test-place model) leave large swathes of students undiagnosed with mental illness or emotional and behavioral disorders. To ensure that school-based mental health services address the needs of all students, rather than a small group of the most at-risk students, the WIDPI recommends that districts implement a ***whole school, preventative approach*** to providing mental health services that feature a "continuum of support for school-aged children" around a MTSS. [35]

As Figure 2.1 shows, the Wisconsin School Mental Health Framework published by the WIDPI is a three-tiered system that provides three broad levels of support to students –

[32] Satcher, D. "School-Based Mental Health Services." *Pediatrics*, 113:6, June 6, 2004. p. 1841.
[33] [1] Ibid., p. 1839. [2] Dowdy, E., K. Ritchey, and R.W. Kamphaus. "School-Based Screening: A Population-Based Approach to Inform and Monitor Children's Mental Health Needs." *School Mental Health*, 2:4, December 2010.
[34] Dowdy, Ritchey, and Kamphaus, Op. cit.
[35] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 3.

universal prevention, selective programs and interventions, and intensive targeted treatments. As Dowdy et al. note, in such framework, "the explicit focus is on society, not the individual, and on prevention, as opposed to intervention."[36]

**Figure 2.1: Wisconsin School Mental Health Framework**




Source: Wisconsin Department of Public Instruction[37]

**Additionally, the WIDPI recommends that schools integrate health and wellness supports through their established Positive Behavioral Interventions and Supports (PBIS) frameworks.**[38] PBIS is a preventative framework that addresses inappropriate behavior through role modeling and the reinforcement of positive behaviors. The PBIS framework corresponds with a three-tiered MTSS framework where all students receive the Tier 1, preventative-based intervention and students with special needs receive more targeted interventions (Tiers 2 and 3).[39]

Similarly, the Office of Special Education (OSEP)'s Technical Assistance Center on PBIS (part of the U.S. Department of Education), supports the integration of school mental health services with PBIS. In a 2014 report, the OSEP notes that almost 20 percent of U.S. schools have included some elements of PBIS and that PBIS, as with school mental health programs,

[36] Dowdy, Ritchey, and Kamphaus, Op. cit., p. 3.
[37] Figure adapted from: "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 7.
[38] Ibid.
[39] "MTSS." PBIS. https://www.pbis.org/school/mtss

intends to improve student academic achievement.[40] To guide the implementation of a MTSS framework for mental health services and the integration of mental health programs with PBIS, the WIDPI offers 10 foundational principles, eight of which are also "fundamental PBIS components identified by the Wisconsin PBIS Network."[41] Figure 2.2 below explains these principles in detail.

**Figure 2.2: Foundational Principles for Comprehensive School Mental Health Systems**

- **Strong Universal Implementation.** Strong universal implementation relates to relationship building, mental health and wellness education, rich social-emotional learning (SEL), resiliency building, trauma sensitive practices, and collaborative systems and practices that are accessible, effective, and reflective of all.
- **Integrated Leadership Teams**. A representative group has responsibility to lead and oversee implementation of a culturally responsive multilevel system of supports.
- **Youth-Family-School-Community Collaboration at all Levels.** Districts and schools have strong youth-family-school-community partnerships. The district and school teams engage families, community members, and community organizations to advance student health and learning. Community-based mental health service providers are welcomed as collaborative partners with school personnel and families in the design and sometimes delivery of universal, selected, and intensive school mental health supports.
- **Culturally Responsive Evidence Based Practices**. School staff and school mental health providers need to recognize the needs of students from diverse cultural backgrounds and offer programs that reduce disparities in services.
- **Data-Based Continuous Improvement.** Data-based continuous improvement means ongoing, reflective analysis of data comparing current status to desired future along with a commitment to act accordingly.
- **Positive School Culture and Climate**. Positive school culture and climate is a collective sense of purpose and commitment to ensure the well-being, sense of belonging, safety and success of every youth and student. Rather than focus on control and punishment, schools focus on creating positive classroom and school environments with social-emotional and mental health skill building using clear and consistent expectations.
- **Staff Mental Health Attitudes, Competencies, and Wellness**. Adults in school must shift their perspectives to understand that attention to their students' social-emotional and mental health needs is critical for their academic success.
- **Systemic Professional Development and Implementation.** Collaborative teams are implemented systemically across all levels of the school and…Systemic professional development is provided in a way that is coordinated with school and district improvement priorities and reflected in the school improvement plan.

Source: Wisconsin Department of Public Instruction [42]

**A key feature of the WIDPI comprehensive school mental health system is that it integrates both school-based and community-based mental health supports to address**

[40] "Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide Positive Behavior Support." OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2014. https://www.pbis.org/common/cms/files/Current%20Topics/Final-Monograph.pdf

[41] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 11.

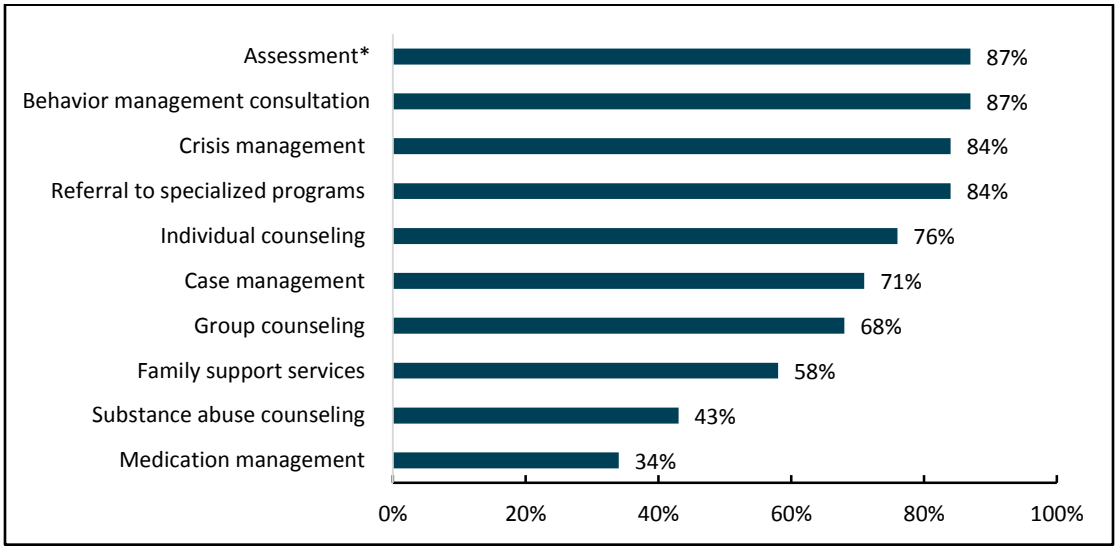
[42] Figure bullets quoted verbatim from: Ibid., p. 7.

**diverse student needs in a system of care.** School staffing and other resources, as well as the case-by-case nature of mental health issues, will determine whether students receive services provided by their schools, community-based providers, or a combination of the two. However, the WIDPI notes that, in general, schools should provide or support Tier 1 and 2 interventions and refer students to community-based providers for more intensive Tier 3 interventions.[43] The following pages describe the typical roles of school mental health programs and community-based mental health providers in providing a range of interventions, from universal prevention to intensive, individual-targeted interventions.

## SCHOOL-BASED SERVICES

**School mental health programs typically provide students with a variety of short-term mental health interventions, as well as a universal level of services intended to prevent mental health issues.**[44] School mental health program staff may include psychologists, social workers, and/or counselors.[45] Based on the most recent SAMHSA survey of school mental health services (2002-2003), 87 percent of schools "assess mental health problems and engage in behavior management consultation, and crisis intervention."[46] Schools typically provide short-term interventions and refer students to community-based providers for longer-term services. Figure 2.3 below outlines the most common mental health services provided by school mental health programs.

**Figure 2.3: Most Common School-Provided Mental Health Services**




* For emotional or behavioral problems or disorders
Source: SchoolMentalHealth.org[47]

[43] Ibid., p. 8.
[44] [1] "Fact Sheet on School Mental Health Services." SchoolMentalHealth.org. p. 2. http://www.schoolmentalhealth.org/Resources/Fam/SMH%20Services-%20Bazelon.pdf [2] "Behavioral Health Barometer Wisconsin, 2014," Op. cit., p. 8.
[45] Richardson, T., M. Morrissette, and L. Zucker. "School-Based Adolescent Mental Health Programs." *Social Work Today*, 12:6, December 2012.
[46] "Fact Sheet on School Mental Health Services," Op. cit., p. 2.
[47] Figure adapted from: Ibid.

## UNIVERSAL LEVEL OF SUPPORTS

**The foundation of MTSS is the universal level of intervention, typically provided or supported by school mental health program staff, that aims to prevent mental health issues and to promote the social, emotional, and academic competencies of students.**[48] According to the WIDPI, all students should receive mental health supports to develop their social and emotional skills.[49] As part of the universal level of supports, the WIDPI highlights the importance of exposing students to "practices that promote high level wellness," for example, through modeling and teaching positive relationship building skills, "the subtle rules for getting along," and positive sleep, mindfulness, eating, and exercise habits. Students should learn how to recognize warning signs in friends indicating mental health issues and how to provide supports.[50]

Despite the importance of universal prevention, educators lack the agreement on the specific frameworks to integrate these supports into daily instruction.[51] In a 2015 article published in *School Psychology Quarterly,* Cook et al. note that, as different theoretical frameworks "target different social, emotional, or behavioral outcomes [and] emphasize different intervention components," individual frameworks to guide universal prevention may not meet the mental health needs of all students. As such, the authors argue that schools should provide universal mental health support through a combination of PBIS and Social Emotional Learning (SEL), which are "two of the most widely-adopted, evidence-based approaches that have been advocated to address student mental health."[52] Broadly, Cook et al. find that curriculum-based SEL complements PBIS and centers on "teaching and reinforcing observable behavioral expectations."[53]

### *SOCIAL AND EMOTIONAL LEARNING (SEL)*

**Research finds that SEL improves children's mental health through the development of basic social and emotional competencies.** A research brief published in 2014 by the University of Minnesota notes the following:[54]

> SEL is…a powerful mechanism for improving children's mental health. Focusing on helping young people develop SEL skills provides a strength-based, developmental approach to addressing the high rates of mental health challenges and increasing young people's resilience so that they are better equipped to handle future challenges.

[48] Cook et al., Op. cit.
[49] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 16.
[50] Ibid., p. 17.
[51] Cook et al., Op. cit.
[52] Ibid.
[53] Ibid.
[54] Quoted verbatim from: Michaels, C. and E. Hagen. "Social and Emotional Learning: Implications for Enhancing Children's Mental Health." University of Minnesota Extension, 2014. p. 1. http://www.extension.umn.edu/youth/research/sel/docs/issue-brief-implications-for-enhancing-health.pdf

Similarly, research finds that SEL has significant positive effects on student achievement. For example, one of the most comprehensive studies on the effects of mental health programs is the meta-analysis of 213 school-based, universal SEL programs published in 2011 in *Child Development*. The analysis, which included over 270,000 K-12 students, found that, in comparison with students in control groups, students who participated in SEL programs "demonstrated significantly improved social and emotional skills, attitudes, behavior, and academic performance that reflected an 11-percentile-point gain in achievement."[55]

**The WIDPI emphasizes that schools should implement universal strategies that focus on social-emotional and mental health skill building.[56]** While the WIDPI does not refer to the SEL curriculum specifically, it highlights the importance of resiliency, coping strategies, self-confidence, and self-management, all of which SEL supports. Additionally, the WIDPI recommends that schools integrate "skills-based social and emotional learning opportunities throughout the school day" through the application of evidence-based and practice-based methods, a focus that aligns with the SEL curriculum.

The Collaborative for Academic, Social, and Emotional Learning (CASEL) describes SEL as "the process of developing basic social and emotional competencies that serve children (and adults) in all areas of life."[57] Appropriate social and emotional skills enable children to understand and manage emotions, feel and show empathy, develop positive relationships, achieve self-set goals, and make responsible decisions.[58] CASEL, a major source of research and guidance regarding SEL, identifies "five interrelated sets of cognitive, affective, and behavioral competencies" that comprise SEL, as shown in Figure 2.4 below.[59]

**Figure 2.4: Five Core Competencies of Social and Emotional Learning (SEL)**

- **Self-awareness:** The ability to accurately recognize one's emotions and thoughts and their influence on behavior. This includes accurately assessing one's strengths and limitations and possessing a well-grounded sense of confidence and optimism.
- **Self-management:** The ability to regulate one's emotions, thoughts, and behaviors effectively in different situations. This includes managing stress, controlling impulses, motivating oneself, and setting and working toward achieving personal and academic goals.
- **Social awareness:** The ability to take the perspective of and empathize with others from diverse backgrounds and cultures, to understand social and ethical norms for behavior, and to recognize

[55] Durlak, J. et al. "The Impact of Enhancing Students' Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interventions." *Child Development*, 82:1, February 2011. p. 405.
[56] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 16.
[57] "School-Family Partnership Strategies to Enhance Children's Social, Emotional, and Academic Growth." Collaborative for Academic, Social, and Emotional Learning (CASEL), 2011. p. 1. http://static1.squarespace.com/static/513f79f9e4b05ce7b70e9673/t/5307ad29e4b0ebfe8b3ed620/1393012009663/school-family-partnership-strategies-to-enhance-childrens-social%2C-emotional%2C-and-academic-growth.pdf
[58] "What is Social and Emotional Learning?" Collaborative for Academic, Social, and Emotional Learning (CASEL). http://www.casel.org/social-and-emotional-learning/
[59] [1] "About CASEL." Collaborative for Academic, Social, and Emotional Learning (CASEL). http://www.casel.org/about [2] "Social and Emotional Learning Core Competencies." Collaborative for Academic, Social, and Emotional Learning (CASEL). http://www.casel.org/social-and-emotional-learning/core-competencies

family, school, and community resources and supports.

- **Relationship skills:** The ability to establish and maintain healthy and rewarding relationships with diverse individuals and groups. This includes communicating clearly, listening actively, cooperating, resisting inappropriate social pressure, negotiating conflict constructively, and seeking and offering help when needed.
- **Responsible decision making:** The ability to make constructive and respectful choices about personal behavior and social interactions based on consideration of ethical standards, safety concerns, social norms, the realistic evaluation of consequences of various actions, and the well-being of self and others.

Source: Collaborative for Academic, Social, and Emotional Learning [60]

According to Cook et. al, "**SEL consists of adopting a specific curriculum to deliver lessons that teach social, genitive, or emotional skills that help guide students' decision making and behavior**."[61] While the majority of students' needs are met by this general curriculum that promotes SEL competencies, smaller groups of students may also need targeted interventions. As SEL is built on a three-tiered model, targeted small group interventions (Tier 2) and intensive individual interventions (Tier 3) also need to align with broader school-based mental health frameworks.[62] As with all mental health interventions, schools or community providers may offer more intensive mental health services, depending on the service type. Figure 2.5 below provides some examples of how educators could integrate SEL into their daily math and English language arts curricula.

**Figure 2.5: Examples of Integrating SEL into Universal Instruction**

- **SEL integrated into math curriculum:** The Greater Good Science Center, part of the University of California at Berkeley, notes that the "self-management" SEL competency promotes the ability to understand and persevere to solve math problems. An example of integrating SEL curricula into math curriculum could be having students take a few minutes at the beginning of class to practice mindfulness. Teachers can also "help students see how their personal goals align with math outcomes."
- **SEL integrated into language arts curriculum:** According to an article from the Greater Good Science Center, research finds that reading literacy fiction help develop empathy in students. An example of integrating SEL into an existing language arts curriculum could be having students create a journal where students describe the emotions of the characters in a novel they are reading, as well as record their own emotions and reflect on their own emotional experiences.

Source: Greater Good Science Center[63]

## SELECTED LEVEL OF SUPPORTS

**The WIDPI recommends that school mental health programs establish an identification system to identify unmet student needs and guide further interventions.** According to the WIDPI, Tier 2 of school mental health supports should promote early identification of more

[60] Figure bullets quoted verbatim from: Ibid.
[61] Cook et al., Op. cit.
[62] Michaels and Hagen, Op. cit., p. 3.
[63] Figure bullets adapted from: Zakrzewski, V. "How to Integrate Social-Emotional Learning into Common Core." Greater Good Science Center, January 22, 2014. http://greatergood.berkeley.edu/article/item/how_to_integrate_social_emotional_learning_into_common_core

serious mental health concerns, effective screening practices, and progress monitoring of students receiving additional interventions beyond the universal level of mental health supports.[64] Different levels of support may include individual and group interventions, the development of wellness plans for students with mild to intensive mental health or substance use challenges, and collaborative planning with students, families, and community providers. The WIDPI notes that collaborative planning may begin at a parent-teacher conference and expand to add community providers as soon as they are involved in the student's intervention.[65] Specific recommendations for providing Tier 2 mental health supports include:[66]

- The school should have a formal referral process in place.
- All school staff members must understand how and to whom they should refer students for more specialized services.
- Families need to receive information about how to access the referral system and support services.
- School leaders need to work with all school staff and community mental health professionals to create a streamlined referral system for students with mild to critical mental health needs.
- The school must ensure adequate systems and resources are in place so that students who are referred get the support they need.

### *Screening and Monitoring Tools*

**For identification and monitoring strategies, the WIDPI highlights the Screen, Brief Intervention, Referral to Treatment (SBIRT) framework and PBIS progress monitoring strategy called "Check in-Check out."** Universal mental health screening tools, as well as tools for monitoring the efficacy of mental health interventions, complement the three-tiered school health care program model recommended by the WIDPI and ensure that students' needs are identified and addressed effectively. SBIRT is an evidence-based practice developed for health care settings that can guide the delivery of selective or intensive interventions, as well as universal prevention.[67] Check in-Check out (CICO) involves daily student-teacher check-ins at the start of the school day to assess and mark progress on a goal sheet. Students take the goal sheet home for parents to sign each night and return the sheet to teachers in the morning.[68]

**School should use universal mental health screening tools that are time-efficient and assess multiple areas of mental health.[69]** While the WIDPI only cites strategies to guide

[64] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 17.
[65] Ibid., p. 19.
[66] Quoted verbatim from: "Behavioral Health Barometer Wisconsin, 2014," Op. cit., p. 17.
[67] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 18.
[68] "Check In Check Out." PBISWorld. http://www.pbisworld.com/tier-2/check-in-check-out-cico/
[69] Dowdy, Ritchey, and Kamphaus, Op. cit.

school mental health programs' use of specific tools, a host of screening and monitoring tools exist to assess and monitor mental health in children. In their examination of population-based approaches to promoting children's mental health, Dowdy et. al. note that the Youth Risk Behavior Surveillance System (YRBSS), a tool developed by the CDC, is broadly accessible and administrable by schools. The YRBSS is designed to be administered to secondary school students biannually, allowing school mental health programs to benchmark students individually and by grade level, and measure progress across years. However, despite its prevalence, Dowdy et al. find that YRBSS does not assess multiple areas of mental health or provide specific information on emotional and behavioral concerns, including inattention, hyperactivity, and anxiety. Based on the appropriateness, technical adequacy, and usability, Dowdy et. al. identify the following "commonly utilized instruments as being potentially useful for universal school-based mental health screening:"[70]

- Strengths and Difficulties Questionnaire (SDQ);
- BASC-2 Behavioral and Emotional Screening System (BESS);
- Pediatric Symptom Checklist (PSC); and
- Systematic Screening for Behavior Disorders (SSBD).

**Screening tools should also be easy for non-mental health professionals to administer and allow students to self-report indicators of mental health.** A 2014 article published in *Child and Adolescent Psychiatry and Mental Health* discusses and identifies a series of self-report measures for children to assess their broad mental health and/or wellbeing. The authors only include measures that are completed by children and have "been validated in a child or adolescent context."[71] Moreover, all included measures are administered by non-mental health professionals, take less than 30 minutes to complete, are designed for a broad age range, have been tested in a variety of populations, and not primarily employ open-ended responses. Figure 2.6 below lists five of the 11 self-report measures that the authors identify as having the potential for "use in routine practice in child and adolescent mental health services." [72]

[70] Bullets adapted from: Ibid.
[71] Deighton, J. et al. "Measuring Mental Health and Wellbeing Outcomes for Children and Adolescents to Inform Practice and Policy: A Review of Child Self-Report Measures." *Child & Adolescent Psychiatry and Mental Health*, 8:14, 2014. http://download.springer.com/static/pdf/749/art%253A10.1186%252F1753-2000-8-14.pdf?originUrl=http%3A%2F%2Fcapmh.biomedcentral.com%2Farticle%2F10.1186%2F1753-2000-8-14&token2=exp=1474306164~acl=%2Fstatic%2Fpdf%2F749%2Fart%25253A10.1186%25252F1753-2000-8-14.pdf*~hmac=98cb03634bfade2c0013146fd2889e1fa375951ed9dd2551e8f610e28b2b556b
[72] Ibid.

**Figure 2.6: Self-Report Measures for Universal Screening**

| MEASURE | AGE | DESCRIPTION |
|---|---|---|
| **Achenbach System of Empirically Based Assessment** | Ages 1.5-18 (multiple versions) | Covers the following domains: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior. Also summed into internalizing and externalizing subscales |
| **Beck Youth Inventories (BYI)** | Ages 7-18 | Five child self-report inventories: depression inventory, anxiety inventory, anger inventory, disruptive behavior inventory, self-concept inventory |
| **Behavior Assessment System for Children (BASC)** | Ages 2-21 | Covers the following: hyperactivity, aggression, conduct problems, anxiety, depression, somatization, attention problems, learning problems, withdrawal, a-typicality, adaptability, leadership, social skills and study skills |
| **Behavioral and Emotional Rating Scale (BERS)** | Ages 5-18 | Factors: interpersonal strength, family involvement, intrapersonal strength, school functioning, affective strength, career strength (CS is new to BERS-2) |
| **Child Health Questionnaire (CHQ)** | Ages 10+ | 12 concepts (10 scales and 2 items), including physical functioning, bodily pain, general health perceptions, self-esteem, mental health, behavior |

Source: Child and Adolescent Psychiatry and Mental Health[73]

In addition, **school mental health programs may identify appropriate screening and monitoring measures through resources targeted for mental health professionals.** Such measures may be more appropriate for students receiving selected and intensive interventions, rather than as universal screening tools. For example, both the Center for Human Services at the University of California, Davis and the Department of Health and Human Services have extensive lists of screening measures and related resources.[74]

## EVIDENCED-BASED INTERVENTIONS

**Experts recommend that school mental health programs implement evidence-based interventions that target students within the classroom, as well as in small group and individual settings.** A 2014 article published in *Lancet Psychiatry* notes that, in some cases, universal preventative interventions are more effective in addressing mental health problems such as anxiety, than more targeted, individual or group-based interventions. In other cases, universal preventative interventions appear to be less effective in addressing student depression compared to individual counseling sessions. As such, a combination of universal classroom and selected targeted interventions may be appropriate.[75]

[73] Figure text quoted verbatim with minor changes from: Ibid.
[74] [1] Williams, S. "Mental Health Screening and Assessment Tools for Children Literature Review." Center for Human Services at UC Davis, 2008. https://humanservices.ucdavis.edu/sites/default/files/104056-MentalHealthLR.pdf
[75] Fazel, M. et al. "Mental Health Interventions in Schools in High-Income Countries." *Lancet Psychiatry*, 1:5, October 2014.

The Rural Health Information Hub cites a variety of evidence-based interventions for a range of mental health concerns for schools to consider. Figure 2.7 below presents several of the cited programs, all of which address different mental health concerns, target different school-aged populations, and have demonstrated success in "producing significant, positive health or behavioral outcomes and/or intermediate policy, environmental, or economic impacts."[76]

**Figure 2.7: Sampling of Evidence-Based Interventions for Schools**

| PROGRAM | PROGRAM FOCUS | TARGET POPULATION | DESCRIPTION |
|---|---|---|---|
| **AlcoholEdu for High School** | Substance abuse | Ages 13-17 | AlcoholEdu for High School is an online, interactive alcohol education and prevention course designed to increase alcohol-related knowledge, discourage acceptance of underage drinking, and prevent or decrease alcohol use and its related negative consequences. |
| **Cognitive Behavioral Intervention for Trauma in Schools** | Post-traumatic stress disorder (PTSD), depression, and behavioral problems | Ages 6-18 | The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based, group and individual intervention. It is designed to reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills. CBITS uses cognitive-behavioral techniques (e.g., psychoeducation, relaxation, social problem solving, cognitive restructuring, and exposure). |
| **Coping and Support Training (CAST)** | Suicide prevention | Age 13-25 | CAST delivers life-skills training and social support in a small-group format. The program consists of 12 (55-minute) group sessions administered over 6 weeks by trained high school teachers, counselors, or nurses with considerable school-based experience. CAST serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide. |
| **Promoting Alternative Thinking Strategies (PATHS)** | Depression and anxiety | Ages 3-13 | PATHS is a school-based prevention program to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem solving. |

Source: Rural Health Information Hub[77]

The SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) features a database of over 380 mental health and substance abuse interventions, a number of which are specifically designed for a school environment. NREPP allows users to search interventions by outcome, age-level, gender, mental health concern, and a variety of other

[76] "Evidence-Based Interventions for School." Rural Health Information Hub. https://www.ruralhealthinfo.org/community-health/mental-health/4/schools/evidence-based-interventions

[77] Figure text quoted verbatim from: Ibid.

factors.[78] SAMHSA evaluates interventions based on the following criteria, which may also guide schools' adoption of specific evidence-based mental health interventions:[79]

- **Rigor**: Rigor assesses the strength of the study methodology. It is composed of multiple elements, including: design/assignment; intent-to-treat – original group assignment (ITT- OGA); and statistical precision, and pretest equivalence.
- **Effect Size:** An effect size is a way to measure whether a program had an impact, how big that impact was, and whether it helped or hurt the treatment group. Effect sizes are calculated when evaluation studies provide the data needed to do so.
- **Program Fidelity**: Reviewers examine the evaluation studies to determine if the program was delivered as intended and to the target population.
- **Conceptual Framework**: This dimension is concerned with how clearly the components of a program are articulated. It is composed of the following elements: program goals, program components, and theory of change.

## COMMUNITY-BASED SERVICES

**Schools often refer students who require intensive or extended mental health services to community-based mental health providers.** While school mental health programs may provide Tier 3 interventions, the WIDPI notes that schools often work with community-based mental health providers to provide targeted support.[80] According to the SAMHSA survey of school health services, 84 percent of surveyed schools provide referrals to specialized programs and over half of them have partnerships or arrangements with community-based mental health organizations and providers of student mental health services.[81] Common community-based providers include county mental health agencies, community health centers, individual providers, juvenile justice systems, and community service organizations. Of these, the SAMHSA survey found that 62 to 86 percent provided their mental health services on the school site.[82]

### INTENSIVE LEVEL OF SUPPORTS

**The WIDPI highlights that intensive level of supports (i.e., Tier 3 interventions) include counseling and wraparound supports, emotional regulation and re-entry plans, seamless referrals to community-based providers, and established follow-up processes.** School mental health programs should link the interventions for the few students requiring

[78] "Find an Intervention." Substance Abuse and Mental Health Services Administration. http://nrepp.samhsa.gov/AdvancedSearch.aspx
[79] Bullets quoted adapted from: "Program Review Criteria." Substance Abuse and Mental Health Services Administration. http://nrepp.samhsa.gov/04e_reviews_program.aspx
[80] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., pp. 20–21.
[81] "Fact Sheet on School Mental Health Services," Op. cit., pp. 2–3.
[82] Ibid., p. 3.

intensive supports with community-based services to create a system of care, defined as the following:[83]

> [A] spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated school network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

When making any referral for community-based providers, school staff should communicate clearly with families to explain the reason for the referral and ensure that students receive the required services. Families should have multiple options, based on location, cost, area of expertise, and other relevant factors when choosing a referral provider. While collaboration between school mental health staff and community-based providers may vary, the WIDPI finds that some level of co-planning between families, providers, and the school mental health program is a standard practice. Collaboration between school staff and community-based providers should continue until students "are demonstrating improvement in all areas of their lives."[84]

## EXPANDING SCHOOL-BASED MENTAL HEALTH SERVICES

**Prominent national research centers recommend that schools form partnerships with community-based mental health providers to provide comprehensive, school-based mental health services.** [85] Whole-school mental health programs aim to support the mental health needs of all students by addressing prevention, early intervention, and treatment provision. To effectively meet the needs of all students, both the Center for School Mental Health at the University of Baltimore (MD) and the Center for Mental Health in Schools at the University of California Los Angeles– two leading research centers in school mental health – support connecting community mental health services with school services to provide a continuum of care.[86]

As the Coalition for Advancing School-Based Mental Health in Wisconsin notes, ESMH programs often integrate "clinical services and consultation into the existing mental health-related services and supports available in the schools." This creates a system of care (or integrates school mental health programs into existing systems of care) where mental

[83] Quote verbatim from Stroul et al., 2010, p.3 taken from: "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 30.
[84] Ibid., p. 21.
[85] Freeman, E. "School Mental Health Sustainability: Funding Strategies to Build Sustainable School Mental Health Programs (Series 1)." Technical Assistance Partnership for Child and Family Mental Health., 2011. p. 1. http://www.air.org/sites/default/files/downloads/report/Why%20School%20Mental%20Health_Connections%20to%20Systems%20of%20Care_1.pdf
[86] Ibid.

health practitioners join the school-based mental health team to collaborate with families and staff and provide a continuum of care through a full array of mental health services.[87]

### *Service Delivery Models*

**In practice, schools typically adopt one of the three general models to guide their partnerships with community and private mental health providers.** While models differ based on the collaboration between community providers and the school-based health program, the WIDPI notes that the school-family-community team typically:[88]

- Focuses on building the capacity of all educators to promote mental health and the competencies of pupil services providers to provide interventions to students with mental health challenges;
- Fosters collaborative relationships with community providers; and
- Builds relationships for improved co-planning with students and families.

Figure 2.8 provides more detail of the three models that intend to guide community and private partnerships, as identified by the WIDPI. Please note that the models become progressively more collaborative to the point where public and private mental health practitioners form part of a student's school-based mental health team. Additionally, in all of the models, school mental health staff typically provide or support universal and selected levels of intervention (Tiers 1 and 2), while community based providers usually provide intensive intervention services (Tier 3). However, this may change in more collaborative partnerships between school mental health programs and community-based providers.

**Figure 2.8: Models of Expanded Mental Health Service Delivery**

| Model 1: Mental Health Services Delivered by Pupil Services Providers with Referral to Community-Based Providers | |
|---|---|
| *The continuum of mental health services for students are supported by school-employed mental health providers as part of the district's service delivery model.* | ▪ **Tier 1 and 2 Interventions:** Universal and selected mental health services designed and implemented by school staff.<br>▪ **Tier 3 Interventions:** Children with acute or chronic mental health needs are referred for community-based services.<br>▪ **Relationship with community mental health services:** In this model, schools map community-based resources and explore collaborative partnerships. |
| **Model 2: School-Based Community Mental Health Clinics, and Pupil Services Providers** | |
| *Public or private mental health clinics or providers can, through a mutual agreement with a district,* | ▪ **Tier 1 and 2 Interventions**: At the universal and selected levels, health services for students are supported or provided by school-employed mental health providers as part of the district service delivery model.<br>▪ **Tier 3 Interventions**: At this level of intervention, typically school-based |

[87] [1] "Advancing Expanded School Mental Health Services in Wisconsin." Coalition for Advancing School-Based Mental Health in Wisconsin, 2016. p. 1. PDF provided by SWSA [2] "Key Terms." Youth.gov. http://youth.gov/youth-topics/youth-mental-health/key-terms-related-mental-health-continuum

[88] Bullets quoted verbatim from: "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 8.

| | |
|---|---|
| *locate a clinic within a school and provide direct mental health services to students utilizing a clinic-employed, mental health provider billing families through Medicaid, private insurance or self-pay.* | public and private mental health providers provide direct mental health services to students.<br>▪ **Relationship with community mental health services:** In this model, schools find ways to promote equal access to school-based community mental health services and strategies to allow for collaboration and coordination of services by the community provider, school personnel and families. |
| **MODEL 3: COMMUNITY-BASED MENTAL HEALTH SERVICE PROVIDERS AS FULL COLLABORATIVE PARTNERS** | |
| *Public or private mental health clinics may provide traditional direct therapy services in the school or a community clinic, as well as indirect services such as consultation and collaboration with schools and parents, paid by a third party, such as insurance or a community fund.* | ▪ **Tier 1 and 2 Interventions:** While universal and selected mental health services are typically implemented by school staff, school staff will likely involve private of mental health providers in the planning process and may provide certain interventions in place of school mental health staff.<br>▪ **Tier 3 Interventions:** Public or private mental health clinics will likely provide these services, or collaborate with school mental health program staff to provide these services.<br>▪ **Relationship with community mental health services:** In this model, collaboration evolves to co-leadership of a comprehensive school mental health approach. In this model, schools focus on seamless referrals, well-planned role distinctions, and goal-oriented collaborative teaming across systems to support students and families. |

Source: Wisconsin Department of Public Instruction[89]

### *BUILDING SUSTAINABLE PARTNERSHIPS*

**While school mental health programs may form partnerships with a range of public and private community-based health providers, schools appear to frequently partner directly with non-profit and local government health agencies.**[90] However, in a 2011 report, the Technical Assistance Partnership for Child and Family Mental Health (TA Partnership), which at the time received funding from SAMHSA, notes that strategies for effective partnerships are relevant for both private and public mental health provider partners.[91] To guide the development of sustainable and effective partnerships, the National Center for Mental Health Promotion and Youth Violence Prevention provides the recommendations listed in Figure 2.9 for building sustainable partnerships between school mental health programs and community-based mental health agencies, both private and public.

[89] Figure text adapted and quoted verbatim from: Ibid.
[90] For example, see: Behrens, D., J.G. Lear, and O.A. Price. "Developing a Business Plan for Sustaining School Mental Health Services: Three Success Stories." The Center for Health and Health Care in Schools, 2012. pp. 4–9. http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1065&context=sphhs_prev_facpubs
[91] Freeman, "School Mental Health Sustainability: Funding Strategies to Build Sustainable School Mental Health Programs (Series 1)," Op. cit., p. i.

**Figure 2.9: Recommendations for Building Sustainable Partnerships**

- **Create a shared vision, mission, goals, and objectives for the school mental health program among the school-based leadership team.** This may involve mapping out available resources, developing vision and mission statements, as well as goals and objectives for the program, creating measurable outcomes, and meetings with the school and the potential mental health agency partner.
- **Develop a memorandum of agreement and contract to define the scope of work and funding for school and mental health agency partners.** This will involve discussion with the local partner mental health agency and a contractual agreement that specifics the types of services and resources (including staffing, office space, and funding) that the school and agency will provide.
- **Build mutual respect and trust between school staff and mental health agency partners.** This includes regular meetings to discuss strengths, work collaboratively to address student and programmatic needs, and scheduled trainings for school staff by the mental health agency.
- **Clearly define the roles and responsibilities of school staff and mental health counselors**. This may include collaboration between school mental health program and partner agency staff "to develop SMH program infrastructure: determine referral protocols, designate school-based office space for the community MH counselor, determine work schedules and appropriate times to provide consultation with teachers, plan student assistance and intervention team meetings, and designate times for student counseling sessions."
- **Provide cross-training and professional development opportunities for school staff and community mental health counselors.** This may include developing yearly professional development plans around mental health topics for teachers and larger training on evidence-based interventions.

Source: National Center for Mental Health Promotion and Youth Violence Prevention[92]

**Typical services provided by community-based mental health agencies and health departments include individual, group, and family counseling, as well as an array of diagnostic and consultative services.** A 2012 report published by the Center for Health and Health Care in Schools, a nonpartisan policy, resource, and technical assistance center that is part of George Washington University, profiles three school mental health programs that have adopted ESMH programs.[93] All three programs have external mental health professionals that provide services on site, but vary in the types and scope of services available and the degree of integration within school-funded mental health staff. Notable program trends include a shift toward accepting third-party reimbursement from health care plans (including private insurance and Medicaid), an attempt to serve all students regardless of their ability to pay, and the presence of full or part-time clinicians staffed by the partner organizations who head the school-based mental health clinics. Figure 2.10 below describes these three partnerships in more detail, with a focus on staffing, services provided, and funding.

[92] Bulleted text in bold quoted verbatim from and non-bolded text adapted from: "School Mental Health Sustainability Guide for SS/HS Project Directors: Strategies to Build Sustainable School Mental Health Programs." National Center for Mental Health Promotion and Youth Violence Prevention, May 2011. http://www.promoteprevent.org/sites/www.promoteprevent.org/files/resources/School%20mental%20health%20sustainability.pdf

[93] Behrens, Lear, and Price, Op. cit., p. 3.

**Figure 2.10: Expanded School Mental Health Program Examples**

| ASPECT | SUMMARY |
|---|---|
| **Bucks County Schools (PA)** | |
| **Overview** | Since 1988, the Family Service Association (FSA) of Bucks County has expanded to offer mental health services in nine elementary, two middle, and one high school in Bucks County. In the spring of 2012, FSA provided mental health services for approximately 100 students across the 12 schools. FSA works with schools to determine the number of provider hours each school requires to meet student needs; smaller schools may receive services from a part-time practitioner due to lesser demand. |
| **Staffing** | FSA staffs school mental health sites with licensed clinicians, who mostly work part-time and only during the academic year. Students and families receive services in FSA's main offices over the summer. |
| **Services** | The FSA provides individual and family counseling. The FSA also provides psychiatric evaluations and medication initiations or reviews, but requires students to access those services at FSA's main offices. While FSA accepts all behavioral health referrals made by school staff, FSA only offers on-site services to students who are enrolled in Medicaid. Students with private or no insurance have to access services at FSA's main offices. This is because school mental health offices are not set up to accept private insurance or set up sliding scale fees for uninsured students. |
| **Funding** | Originally, the FSA school mental health program was funded through ha series of private foundation and state grants. After reductions in this funding, the FSA began to accept third-party reimbursement from health care plans. |
| **Twin Cities Area Schools (MN)** | |
| **Overview** | The Washburn Center for Children in Minnesota, a community mental health center in the Twin cities area, has offices in 18 schools across three districts. All enrolled students – regardless of insurance or ability to pay – who experience mental health symptoms or difficulties may access services provided by the Washburn Center (provided a parent has given consent). Typically, a social worker, teacher, administrator, or parent refers the student to the school social worker, who then requests services from the Washburn Center. An initial diagnostic assessment by a therapist, the Washburn Center decides what services are appropriate and if referrals for additional services are necessary. |
| **Staffing** | A full-time, independently licensed mental health professional staffs each of the school-based mental health office, which is open year round. |
| **Services** | The school mental health program, with the services of the Washburn Center, "focuses on providing an integrated continuum of care, including therapeutic assessment, consultation, and care coordination services." Specific services provided on-site include individual, group, and family therapy, and diagnostic assessment. |
| **Funding** | A braided funding strategy which combines third-party reimbursement from health care plans, school district contributions, county funding, and state grants allow the Washburn Center to provide services for all students, regardless of ability to pay. |
| **D.C. Public Schools (D.C.)** | |
| **Overview** | Since the 2000-2001 school year, the D.C. Department of Mental Health (DMH) has managed a school mental health program that, in 2011, was located in 40 D.C. public schools and 13 public charter schools. |
| **Staffing** | The DMH recruits and places full or part-time licensed clinicians in these schools, who offer service five days a week over the academic year. The school mental health program provides services to any student, regardless of ability to pay or demonstrated need. |
| **Services** | The clinicians provide an array of prevention and intervention services, including diagnostic assessment and ground and individual counseling. The clinicians work closely with school staff to improve school climate and develop universal mental health promotion strategies. |

| Aspect | Summary |
|---|---|
| **Funding** | Originally, the D.C. school mental health program was funded by the DMH. While the program continues to receive approximately $5 million in funding for the DMH, the program began accepting third-party reimbursement from health care plans in 2009 to diversify funding streams. |

Source: Center for Health and Health Care in Schools[94]

### *Service Coordination*

**Experts recommend that schools establish a "point person" to coordinate health services between the school mental health program and community-based providers.** A 2012 article in *Social Work Today* states that the most important member of a school mental health team is the point person, who should be responsible for facilitating communication and the mobilization of services across providers. For schools that partner with a community-based health organization to provide on-site services, the article suggests that the on-site care coordinator or clinician serve in this role. For schools that provide more mental health services through school-employed staff members, they usually involve nurses in the coordination process. A 2015 article published in *Psychology in the Schools* notes that school nurses typically are knowledgeable about community-based resources and have experience navigating educational and health care systems.[95]

[94] Figure text adapted from: Ibid., pp. 4–9.
[95] Bobo, N. "Supporting Student Mental Health: The Role of the School Nurse In Coordinated School Mental Health Care." *Psychology in the Schools*, 52:7, August 1, 2015. pp. 714–718.

# SECTION III: FUNDING AND DATA MANAGEMENT

This section of the report discusses strategies for overcoming two of the main challenges that ESMH programs face: sustainable funding and student data confidentiality.

## SUSTAINABLE FUNDING

**Financially sustainable ESMH programs typically use braided and/or blended funding to leverage multiple funding streams.** In particular, the National Collaborative on Workforce and Disability indicates that "blended funding'' is typically used to describe "funding mechanisms that pool dollars from multiple sources and make them in some ways indistinguishable." [96]The Center for Health and Health Care in Schools finds that funding is "the critical challenge to strengthening children's mental health programs," often because these programs are considered low-priorities.[97] Similarly, a 2014 article published in the *Handbook of School Mental Health: Research, Training, Practice, and Policy* notes that, due to budgetary deficits at local, state, and federal levels, districts often struggle to fund ESMH programs.

As a single funding source is typically insufficient to cover the cost of a mental health program, and thus can affect program sustainability if that source reduces available funds, mental health programs often combine funds from local, state, and federal governments, insurance companies, managed care companies, charitable groups, and foundations. [98] Two common strategies to leverage multiple funding streams include:[99]

- **Braided funding:** This strategy involves coordinating multiple funding streams that were initially separate to pay for services provided by a given program. Under braided funding, ESMH programs must maintain the separate budgets of each funding stream and carefully detail how funds from each stream were utilized.
- **Blended funding:** This strategy involves combining funds from multiple funding streams into a single budget. ESMH programs are able to allocate funds to provide services without the need to track and report back to funders which funding stream paid for exactly which services and expenses.

**Experts find that blended funding has the advantages of reducing administrative burdens and improving funding flexibility in comparison with braided funding.** As braided funding strategies require ESMH programs to use funds for specific purposes and document their appropriate use, programs face the risk of funds "becoming 'locked' into providing specific types of services on the continuum, as dictated by contract requirements." As a result, programs may face difficulties in funding all necessary service components, such as universal prevention efforts. In contrast, blended funding allows programs to fund all

[96] "Blending and Braiding Funds And Resources: The Intermediary As Facilitator." National Collaborative on Workforce and Disability. http://www.ncwd-youth.info/information-brief-18
[97] Behrens, Graham, and Price, Op. cit., p. 4.
[98] "Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide Positive Behavior Support," Op. cit., p. 18.
[99] Bullets quoted verbatim, with minor adjustments, from: Ibid., pp. 20–21.

programmatic components according to their discretion and reduces the administrative burden of documenting the uses of various funds.[100] Figure 3.1 lists a series of successful funding strategies that the TA Partnership identified in a 2011 report.

**Figure 3.1: Shared Funding Strategies for Sustainable ESMH Programs**

- **Public and private agencies.** The mental health agency has the ability to receive reimbursement from Medicaid and/or insurance payers for mental health services in Tier 3 (intensive/ individualized interventions). It is important for the mental health counselor to build his or her client base primarily in Tier 3 services in order to build sufficient revenues to sustain the mental health program/services prior to the last year of the cooperative agreement.
- **Fee-for-service and third-party funding sources.** Determine the populations to be served in the school mental health program (e.g., Medicaid, third-party payers, self-pay). It will be important to find a mental health agency and/or agencies that will be able to serve these students.
- **County referendums to increase funds specific for school mental health**. Several grantees have garnered community support for school mental health services through their work with local government officials to obtain an additional sales tax "$.01" and "one-tenth of one percent" to fund school mental health programs.
- **Community coalitions**. Community businesses form a coalition to fund school mental health prevention and intervention programs through fundraisers and donations to the coalitions.
- **Funding from** various partner agencies of the system of care governance body (e.g., social service, juvenile justice, health) fund positions and use county funds to support school mental health prevention programs and intervention services.
- **Non-profit organizations**. Community partners form a non-profit organization to open up a new stream of funding opportunities. System of care school mental health prevention program is sustained by non-profit (e.g., hire principal investigator/project director as organizational director, and prevention staff work for the non-profit organization).
- **State/county Temporary Assistance for Needy Families (TANF) funds**. Over the past few years, state programs have not had sufficient staff to develop prevention programs as required by TANF. School mental health programming in Tier 1 and 2 interventions, e.g., program staff salaries (social workers, paraprofessionals) and after-school programs, has been funded through TANF.
- **State-supported legislative line item for school mental health**. Principal investigator/system of care leadership can share outcome data with state-level mental health and education departments, state department of Health and Human Services, and mental health advocacy organizations. These organizations can provide information and educate legislative committees and other state leaders on school mental health outcomes in order to address the need for state-level funding for school mental health programs/services.

Source: Technical Assistance Partnership for Child and Family Mental Health [101]

## ADDITIONAL FUNDING STRATEGIES

**The TA Partnership also notes that sustainable ESMH programs may receive a variety of grant funding, leverage recurring federal and local funds, and employ volunteers and interns.** For example, programs may fund universal interventions and prevention through

[100] Ibid., p. 21.

[101] Figure bullets quoted verbatim from: Freeman, E. "School Mental Health Sustainability: Funding Strategies to Build Sustainable School Mental Health Programs (Series 4)." Technical Assistance Partnership for Child and Family Mental Health., 2011. pp. 1–4. http://www.tapartnership.org/docs/SMHSeries_4.pdf

Title I, Title IV, and Individuals with Disabilities Education Act (IDEA) funds, and through district and individual school budgets. AmeriCorps VISTA volunteers, as well as local university students, may provide low or no-cost staffing. The TA Partnership also notes that sustainable programs may conduct resource mapping and realign staff to address the highest mental health needs.[102]

**Medicaid and third-party insurance are often the principle sources of revenue for ESMH programs and services.**[103] The TA Partnership recommends that school mental health programs partner with community mental health agencies that "are approved providers of Medicaid and/or private insurance." Sustainable programs often leverage the specific reimbursements for Medicaid in school, set by state education departments, for services related to mental health.[104] For example, according to a 2015 overview of Wisconsin school-based services, schools may receive Medicaid reimbursements for providing psychological services, counseling, and social work. Of the three districts described in Figure 2.10, the Center for Health and Health Care in Schools highlights their practices of billing Medicaid and other third-party insurance providers to supplement public and private grants and funds.[105] Specific best practices that contributed to these programs' financial sustainability include:[106]

- **They used "clout" as needed.** All three programs had a source of "clout" (power and influence) that was either intrinsic to the program (as in the case of DC program which is part of the local government) or existed because of established connections to people and/or organizations with influence that helped bring insurance providers to the table to negotiate.
- **They adopted a "no margin, no mission" approach to sustaining their program.** All three community-based programs were committed to serving all students in need of mental health care regardless of ability to pay. They also set clear productivity expectations for clinicians around maintaining a balance of billable versus non-billable services. This approach operationalizes the wisdom of the "no margin, no mission" mantra coined by Sister Irene Krause of the Daughters of Charity National Health Care System, a saying that acknowledges that a commitment to a strong fiscal foundation is essential to achieve their mission of serving all students with mental health needs.
- **They invested in billing infrastructure.** All three community-based programs made an investment in the administrative infrastructure to support their billing capacity. They had a consistent way of collecting financial and insurance information on all students receiving services, verifying eligibility, entering and tracking encounter data, submitting claims and tracking reimbursement. They also had established sliding scale fee structures and a system to collect copayments and deductibles.

[102] Ibid., pp. 4–5.
[103] "School and Mental Health Partnerships: Improving School and Community Outcomes for Children and Adolescents with Emotional and Behavioral Challenges." New York Office of Mental Health, May 2015. https://www.omh.ny.gov/omhweb/Childservice/docs/school-based-mhservices.pdf
[104] Freeman, "School Mental Health Sustainability: Funding Strategies to Build Sustainable School Mental Health Programs (Series 4)," Op. cit., p. 2.
[105] Behrens, Lear, and Price, Op. cit., p. 2.
[106] Bullets quoted verbatim from: Ibid., p. 10.

- **They knew the three E's essential to third party reimbursement.** All three community-based programs knew the eligible services, eligible clients, and eligible providers of the commercial and public insurance providers that covered the students they served. With this essential information in mind, sponsors of the school mental health programs were well positioned to negotiate more effective third-party billing arrangements and rates.

## DATA CONFIDENTIALITY AND COLLABORATION

**The WIDPI recommends that districts and schools use tiered consent forms to facilitate information sharing across mental health providers and other youth-serving agencies.** The OSEP's Technical Assistance Center on PBIS notes that, "an integrated school and mental health data system is needed to ensure that a comprehensive, efficient system of care is available for students in need." [107] However, both state and federal laws can act as barriers to appropriate information sharing, making it difficult for school mental health programs to share information with mental health providers and to monitor student progress.

To address this potential barrier to implementing effective ESMH programs, the WIDPI recommends that districts and schools use "tiered consent forms from families and children and adolescents about what information should and can be shared with the schools." [108] Such forms allow students and families to decide how much information they wish to share across providers and enable district, school, and community mental health providers to "comply with the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and Wis. Stats. 118.125 and 146."[109] Below, Figure 3.2 and Figure 3.3 describe in detail the three federal regulations that affect information sharing.

**Figure 3.2: Health Insurance Portability and Accountability Act (HIPAA)**

| ASPECT | DETAIL |
|---|---|
| **Overview** | Protected health information (PHI) is any information held by a covered entity that concerns health status, provision of health care, or payment for health care that can be linked to an individual. This is interpreted rather broadly and includes any part of an individual's medical record or payment history. Covered entities must disclose PHI to the individual within 30 days upon request and when required to do so by law, such as reporting of suspected child abuse to state child welfare agencies. |
| **HIPAA and Information Sharing** | A covered entity may disclose PHI to facilitate treatment, payment, or health care operations, or if the covered entity has obtained authorization from the individual. Covered entities can use/disclose PHI when the individual (or individual's personal representative when applicable) authorizes use/disclosure. However, when a covered entity discloses any PHI, it must make a reasonable effort to disclose only the minimum necessary information required to achieve its purpose. Information may be shared upon official court orders and subpoenas. |

Source: Technical Assistance Partnership for Child and Family Mental Health [110]

[107] "Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide Positive Behavior Support," Op. cit., p. 58.
[108] "The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports," Op. cit., p. 22.
[109] Ibid.
[110] Figure text quoted verbatim from: Freeman, E. "School Mental Health Sustainability: Funding Strategies to Build Sustainable School Mental Health Programs (Series 2)." Technical Assistance Partnership for Child and Family

**Figure 3.3: FERPA and Federal Drug and Alcohol Law**

**Family Educational Rights and Privacy Act (FERPA)** governs access to and release of educational records by public and private schools that receive Federal funding. A student's education record is defined as records, files, documents, and other materials containing information directly related to a student that are maintained by a school or a person acting for the school.

Parents (natural parent, guardian, or person acting as parent in absence of natural parent) control third-party access to their children's educational records. Parents have the right to review their children's education records, including any health-related information contained in the education record. Education records do not include notes made by a school professional such as a school psychologist or guidance counselor that are in the professional's sole possession and not revealed to any other person except a substitute.

- *FERPA and Information Sharing.*

*Authorizations to release educational records must:*

- Specify the records to be disclosed
- State the purpose of the disclosure
- Identify the party or class of parties to whom disclosure is to be made
- Be signed and dated by the parent

*Permitted disclosures include:*

- Court orders and subpoenas
- Disclosures to other school officials/teachers within the school who have a "legitimate educational interest"
- A student's financial aid application
- A health or safety emergency if knowledge of information is necessary to protect the health or safety of students or others.

**Federal Drug and Alcohol Law (42 C.F.R.) Requirement**. Federal law generally requires a patient's written consent before a provider may disclose any information related to the patient's alcohol or drug abuse treatment. This includes any oral or written information that could identify a patient as a drug or alcohol abuser (e.g., diagnostic information, such as urinalysis results) or verbal communications, such as confirmation that a patient is receiving treatment. "When state law requires parental consent for a minor's substance abuse treatment, Federal law generally prohibits providers from disclosing any information without the written consent of both the minor and the parent". There are a few exceptions that allow disclosure without written consent. For example, providers may disclose to medical personnel any information necessary to provide emergency treatment and they may report child abuse or neglect as required by state law, court orders, and subpoenas.

- *Federal Drug and Alcohol Law and Information Sharing*. Permitted disclosure under Federal drug and alcohol law requires written authorization and may disclose client information when a signed authorization contains these eight elements:
  - Name/designation of persons authorized to disclose information
  - Name/designation of persons or organization authorized to receive the information
  - Patient's name
  - Purpose of disclosure
  - Specifics as to what information is to be disclosed
  - Patient's signature and the date
  - Statement of individual's right/procedure to revoke authorization
  - Expiration data or event

Source: Technical Assistance Partnership for Child and Family Mental Health [111]

Mental Health., 2011. pp. 2–5. http://www.air.org/sites/default/files/downloads/report/Challenges%20to%20Mental%20Health%20Agency%20Partnerships_2.pdf

[111] Figure text quoted verbatim from: Ibid.

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4401 Wilson Boulevard, Suite 400
Arlington, VA 22203
**P** 202.559.0500 **F** 866.808.6585
www.hanoverresearch.com