



DC Family Policy Seminar

A community service project of Georgetown University

Do School-Based Mental Health Services Make Sense?



BACKGROUND BRIEFING REPORT

The DC Family Policy Seminar provides District policy-makers with accurate, relevant, nonpartisan, timely information and policy options concerning issues affecting children and families.

The DC Family Policy Seminar is part of the National Network of State Family Policy Seminars, a project of the Family Impact Seminars, a nonpartisan public policy institute in Washington, DC.

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Abstract

Mental health problems affect one in every five children and adolescents at any given time in the United States.¹ Children with mental illness often have difficulty learning, develop behavioral and emotional problems, and participate in activities that endanger themselves and others. While a high percentage of these children are genetically predisposed to mental illness, children in poverty face a greater risk of developing mental health problems, and are less likely to receive treatment. The prevalence of and lack of treatment for mentally ill children has noteworthy consequences for the children, their families, and their communities. In light of this, families and communities are seeking new strategies with which to better diagnose and treat mentally ill children. Providing services through school-based health centers and SBMHCs is one option that is gaining attention. A 1998 study concludes that "school-based health centers are particularly successful in improving access to and treatment for mental health problems and substance abuse."² This background report examines the prevalence of children's mental illness and the problems associated with it; looks at the benefits and practical considerations of integrating mental health care into the schools; and highlights creative local and national models.

This seminar, the 23rd in a series sponsored by the DC Family Policy Seminar at Georgetown University, seeks to air a variety of ideas and to discuss the advantages and challenges associated with school-based mental health services. The organizers hope to encourage increased collaboration among community, government, and nonprofit organizations to ensure the improved quality and increased quantity of mental health services for children and youth in the District. The seminar will also highlight several successful programs that may assist District of Columbia officials and service providers if they choose to create more school-based programs.

This report provides a brief introduction to the issue addressed by the DC Family Policy Seminar on November 2, 1999. The authors thank the numerous individuals in the District of Columbia government and in local and national organizations for contributing their time and effort to this seminar. Special thanks are given to Kristine Kelty, Leslie Gordon, Vince Hutchins, Mark Rom, Donna R. Morrison, and the staff of the National Center for Education in Maternal and Child Health (NCEMCH) for hosting this seminar, and to Stephen Moseley and the staff of the Academy for Educational Development for providing space and technical assistance. This briefing report and seminar are funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services, under its cooperative agreement with NCEMCH (MCU-119301).

Do School-Based Mental Health Services Make Sense?

This seminar is the 23rd in a series designed to bring a family focus to policymaking. The panel features the following speakers:

- Shalini Madan-Benson, Associate Director of Prevention, National Mental Health Association
- Olga Acosta, Associate Director, Center for School Mental Health Assistance
- Deborah Hobbs, Chief of Community Programs, Child and Youth Services Administration, DC Commission on Mental Health Services
- William Granatir, Project Chair, The Pilot Project of Enhanced Mental Health Assistance at Miner Elementary School

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I. Introduction

Mental health problems affect one in every five children and adolescents at any given time in the United States.¹ While a high percentage of these children are genetically predisposed to mental illness, there are many risk factors associated with poor mental health. These include poverty, physical abuse, emotional abuse or neglect, harmful stress, discrimination, loss of a loved one, frequent moving, alcohol and drug use, trauma, and exposure to violence.³ The presence of one or more of these factors puts thousands of children in the District of Columbia (DC) at high risk for developing mental health disorders. For example, well over half the children in DC are growing up in homes from which the father is absent (which can result in children's neglect or can place them under stress), many children move frequently and spend time in homeless shelters, and the number of child abuse cases filed with the DC courts increased by 20 percent from 1997 to 1998. In addition, 25 percent of DC children live in poverty, as compared to the national average of 18.9 percent.⁴ Children in poverty not only face a greater risk of developing mental health problems but also are less likely to receive treatment for such problems.

The prevalence of and lack of treatment for mentally ill children has noteworthy consequences for the children, their families, and their communities. Children with mental illness often have difficulty learning, develop behavioral and emotional problems, and participate in activities that endanger themselves and others. Moreover, between 60 and 80 percent of children with mental health problems do not receive needed care. In light of this disturbing statistic, families and communities are seeking new strategies with which to better diagnose and treat mentally ill children.⁵ Providing services through school-based health centers (SBHCs) and school-based mental health centers (SBMHCs) is one option that is gaining attention. A 1998 study concluded that "school-based health centers are particularly suc-

cessful in improving access to and treatment for mental health problems and substance abuse."²

This report begins with a discussion of the costs of failing to detect and treat mental illness in children and adolescents, and an overview of issues related to young peoples' mental health. It then examines the advantages and challenges associated with school-based mental health programs, and highlights several successful programs. It closes with a summary of best practices that may assist DC officials and service providers if they choose to create more school-based programs.

In the literature and in this briefing report, the terms "mental health problems," "mental disorders," and "mental illness" are used interchangeably. The Center for Mental Health Services (CMHS) defines them as "problems that affect one's thoughts, body, feelings, and behavior. They can be severe and can severely interfere with a person's life and may cause a person to become disabled. Some of these disorders are known as depression, bipolar disorder (manic-depressive illness), attention deficit hyperactivity disorder, anxiety disorders, eating disorders, schizophrenia and conduct disorder."³ The CMHS estimates that anxiety disorders affect 1 in 10 young people, and as many as 1 in every 33 children and 1 in 8 adolescents may suffer from clinical depression.⁶ Schizophrenia, although rarer, affects about 3 of every 1,000 adolescents, and 7 to 14 of every 10,000 children may have autism spectrum disorders.⁶

II. The Costs of Failing to Detect and Treat Mental Illness

When mental health problems go undetected or are untreated or misdiagnosed, the consequences can be severe and expansive. Family members, other children, and communities, as well as the mentally ill children themselves, are negatively affected.

Costs for Children

Acting Out and Criminal Activity

Adolescent and child misbehaviors are a normal part of growing up. However, for some youth, disruptive behavior may be symptomatic of “a more constant state of internal distress. It is as if these children are trying to demonstrate to the world their internal feelings of distress and upset through outward actions of disruptive behavior.”^{7(p221)} Problematic behaviors may include repeated episodes of serious fighting, torturing of small animals, and setting damaging fires.^{7(p221)} It is common for children to be expelled or suspended from school for such behaviors. While this may be an appropriate disciplinary consequence of unacceptable conduct, it does, nevertheless, disrupt students’ learning and threaten their ability to stay on grade level and graduate.

In the long term, acting out and problematic behaviors all too often evolve into criminal and illegal activities. Juvenile justice officials estimate that of the 100,000 adolescents in juvenile detention, 60 percent have behavioral, mental, or emotional problems. A 1994 Office of Juvenile Justice and Delinquency Prevention study reveals that 73 percent of newly admitted juveniles reported having one mental health problem, and 57 percent had received prior mental health treatment or been hospitalized for mental illness.¹ Despite the strong correlation between mental illness and criminal activity, however, there is little coordination between the mental health and juvenile justice systems. As a result, many children move back and forth between the two systems.⁸

Poor School Performance

Children with undiagnosed and untreated mental illness suffer emotional and developmental impairments that limit their ability to think and learn.⁵ Because depression and other mental illnesses often manifest themselves as persistent listlessness, sleep disturbances, and an inability to concentrate, these children’s cognitive, emotional,

and social development can be stunted.⁹ This is often the beginning of a downward spiral characterized by high truancy rates, disciplinary problems, falling grades, low test scores, and failure to graduate from high school.

DC students in every grade level score below the national average on the Stanford 9 Achievement Tests for Mathematics, and in all but three grade levels they fall short of the national average on reading achievement tests. The national average score on the Scholastic Aptitude Tests is approximately 200 points higher than the District of Columbia Public Schools (DCPS) average, and while the national average is slowly increasing, the District average has been falling since 1995.⁴ It may be that these chronically low test scores (and graduation rates that hover in the 50 percent range) are, in part, attributable to the large number of children and adolescents who do not receive necessary mental health care. It is possible that more expansive provision of mental health services would improve test scores, grades, and the graduation rate.

Substance Abuse

The correlation between mental illness and substance abuse in children and adolescents is clear: studies show that more than half of young persons identified as substance abusers also have a diagnosable mental illness. Many mental health and addiction counselors believe that people with the symptoms of a mental health problem frequently turn to drugs or alcohol to self-medicate.¹⁰ Both alcohol and drugs are extremely accessible to children and adolescents. According to one 1998 study of adolescents, teachers, and principals, 56 percent of 17-year-olds knew a drug dealer at school, and 17 percent said they could buy marijuana in an hour or less. Statistics on alcohol use are even more troubling. Nationwide, 79.1 percent of students had had at least one alcoholic drink during their lifetime, and 33.4 percent had had at least one episode of heavy drinking (five or more drinks at one sitting) within the previous 30 days.¹¹

Dual diagnosis complicates treatment approaches because many traditional programs designed to treat mental illness do not treat individuals with substance abuse problems, and programs for substance abusers are not geared for people with mental illness. A substance abuse problem often masks underlying mental illness, and, frequently, adolescents are referred to treatment for their substance abuse but not for the mental illness.¹⁰

Suicide

While the suicide rate among the general population is declining, the reported rates among adolescents and young adults have nearly tripled since 1952. From 1980 to 1996, the rate of suicide among persons ages 15 to 19 increased by 14 percent, and the rate for children between the ages of 10 and 14 increased by 100 percent.¹² Suicide is currently the leading cause of death for 5-to-15-year-olds, and the third leading cause of death among young people ages 15 to 24.¹³ More adolescents and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined.¹²

Suicide and attempted suicide are complex issues, and almost all victims have a diagnosable mental illness or substance abuse disorder, or both. Frequently, the mental illness is depression, bipolar disorder, or impulsive disorder. Studies of the brains of individuals with these illnesses, as well as findings from autopsies of suicide victims' brains, have revealed altered levels of the neurotransmitter serotonin.¹³ The availability and efficacy of new medications that adjust serotonin levels in the brain offer hope that the early recognition and treatment of depression and other mental illnesses can prevent many suicides.

Costs to Society

Untreated child and adolescent mental illness do not affect only the individual child and his or

her family. The disruption that these young people can cause in the classroom often interferes with other students' learning, and teachers may be forced to spend their time dealing with disciplinary issues rather than focusing on academics. Additionally, a mentally ill student's classmates may be secondarily affected by the drug use, violence, and other negative behaviors associated with mental illness and discussed above.

There are also tremendous financial costs to society if children and adolescents with mental health problems are not diagnosed and treated early and appropriately. According to the National Mental Health Association, placing one child in a residential treatment program for an episode of mental illness costs three to four times more per episode than does providing a full year of day treatment.⁵ The implication is that a mental illness caught early on can be treated relatively inexpensively as compared with a mental illness left untreated until the individual requires a residential treatment program. The economic burdens imposed by undiagnosed and untreated mental illness on publicly funded schools and juvenile detention systems are also considerable. It is believed that many children with mental illness are misdiagnosed and placed in special education programs, or are placed there because school principals have no other option. Once children enter the more costly special education system, they commonly remain there until they graduate or drop out.¹⁴ Clearly, the large number of incarcerated youth who have a diagnosable mental illness indicates that the criminal justice system is also bearing some of the costs associated with untreated mental health problems. It is highly probable that early treatment could prevent at least some criminal activity.

III. School-Based Mental Health Centers as a Treatment Approach

One of the emerging approaches to addressing children's mental health problems is to offer mental health services where adolescents and

children are located: in school. The past decade has witnessed phenomenal growth in both the number of SBHCs that provide mental health services and the number of stand-alone SBMHCs. The Center for School Mental Health Assistance (CSMHA) explains this proliferation of school-based health centers as a “natural response to the pressures facing today’s school-aged youth: they make mental health services more accessible to students.”¹⁵ A 1998 Making The Grade national survey of SBHCs classified 25 percent of all student visits to SBHCs as mental health visits; no other single category accounted for more than 15 percent of total visits, and most individual categories accounted for 3 to 9 percent each.¹⁶

What Are School-Based Mental Health Centers?

There is no conclusive definition of SBMHCs, because such centers have developed and evolved according to the specific needs of certain groups of students and depending on the resources available to particular schools and mental health providers. In some communities, mental health programs are part of well-established, comprehensive SBHCs; elsewhere, they have developed independently. In both cases, the mental health centers are located on school premises, provide comprehensive mental health care to youth in both regular and special education classes, and are engaged in collaborative relationships with community mental health centers.¹⁷ Some SBMHCs offer only counseling, and will refer students to the partner community mental health service. Others provide a broad range of services (including assessment, treatment, case management, prevention, and individual therapy), and refer out only for the most severe cases or for ongoing family therapy.¹⁸

The Technical Assistance Sampler on School-Based Health Centers, produced by the Center for Mental Health in Schools, provides the following model of school-based mental health services:

- Centers are located in schools.
- Parents sign written consents for their children to enroll in the health center.
- An advisory board of community representatives, parents, youth, and family organizations participate in planning and oversight of the health center.
- The health center works cooperatively with school nurses, coaches, counselors, classroom teachers, and school principals and their staff to ensure that the health center is an integral part of the life of the school.
- Clinical services are the responsibility of a qualified health provider (hospital, health center, health department, group medical practice, etc.).
- A multidisciplinary team of nurse practitioners, clinical social workers, physicians, and other health professionals care for students.
- The health center provides a comprehensive range of services that specifically meet the serious health problems of young people in the community and provide general medical care.¹⁹

Although many SBMHCs do not deny service to more affluent students, they frequently target students who do not have access to a family doctor or whose families have little or no health insurance.²⁰

What Are the Advantages of School-Based Mental Health Programs?

Easier Access

One of the biggest challenges facing adolescents and children who need mental health services is gaining access to the health providers and clinics offering services. Several barriers can prevent young people and their families from taking advantage of services available at community mental health centers. These barriers include financial constraints, the stigma attached to mental illness, and the logistical challenges of

arranging transportation to and from the mental health clinic.²¹ Because schools are the hub of many activities, and because adolescents and children are legally required to spend time at school, it is relatively easy for them to keep appointments and come to meetings held on school premises.

One of the leading causes of missed appointments at community mental health centers is the stigma attached to mental illness. Many parents and children do not want to be seen entering a mental health clinic. A recent survey revealed that this stigma is still alive and well, despite the fact that mental health disorders are receiving more attention than they have in the past, and that there is more available information. Among those surveyed, 71 percent believed that mental illness is caused by emotional weakness; 65 percent believed that it is caused by bad parenting; 35 percent believed that it is caused by sinful or immoral behavior; and 43 percent believed that it is brought on in some way by the individual.¹ Because many school-based mental health programs are part of broader SBHCs, the reason for a student's appointment need not be known to anyone other than the student; therefore, the stigma associated with mental illness may be less likely to prevent him or her from keeping the appointment. Furthermore, schools are familiar to students and, therefore, less threatening than stand-alone mental health clinics.²²

In addition, it is logistically easier for students to keep appointments at SBMHCs. Financial constraints and difficulties arranging transportation may have less of an affect on their receipt of care when the facility is located on the school premises, where they are already likely to be. Most young people are not known for their organization skills; if mental health centers are located in schools, the incidence of appointments missed as a result of external distractions may decrease. As one early advocate of school-based mental health care has said, "Services need to be where students can trip over them. Adolescents do not carry appointment books."²³

Although few studies have been done on school-based mental health programs, results of those that have been conducted suggest that such programs do increase the rates of service use. According to the 1995 Great Smoky Mountains Study of Youth population-based community survey (with a sample of 1,015 children), there is a strong relationship between school-based programs and the receipt of mental health services. The education sector was the sole source of mental health care for 70 to 80 percent of children surveyed. By contrast, only 11 to 13 percent of children receiving mental health services reported using the general medical sector for those services. While a few children with serious emotional disturbances received services from the child welfare system and/or the juvenile justice system, the researchers concluded that "The major player in the *de facto* system of care was the education sector."²⁴

Another study conducted in Denver, CO, explores the use of physical and mental health services for 342 adolescents enrolled in managed care, two-thirds of whom had access to a school-based clinic. The results indicate that the adolescents with such access were more than 10 times as likely as the others to make a mental health or substance abuse visit, and 98 percent of these visits were to the SBHC. The authors concluded that "school-based health centers seem to have a synergistic effect for adolescents enrolled in managed care, ... and school-based health centers are particularly successful in improving access to and treatment for mental health problems and substance abuse."²

Increased Interagency Coordination and Comprehensive Service Provision

In a 1995 *Health Affairs* commentary, Mary Jane England and Robert F. Cole stated, "If the correction of our failed child and family mental health policy could be found in a phrase, it would be integration of effort."²⁵ The current mental health system does an inadequate job of delivering the multidisciplinary, preventive, and often time-intensive care that children and adolescents need.

Many mentally ill adolescents and children slip between the cracks or are shuffled between the justice system, the special education system, and children's service agencies. Adolescents ages 17 to 19 are at particular risk, because they frequently fall into the gap between mental health agencies for children and those for adults. Proponents of school-based mental health approaches stress their belief that effective programs have helped bridge these gaps by establishing collaborative relationships with community mental health providers, teachers, school administration and staff, and law enforcement officials. Because school-based mental health programs depend upon the coordination of multiple agencies and departments, their mere existence can encourage and foster integration. In addition, the fact that these mental health clinics are often part of more broadly defined SBHCs allows and encourages staff members to treat each child holistically, provide a full range of treatment services, and offer focused evaluation and referral services.²²

A Focus on Prevention and Education

Because school-based mental health services are located on school premises, health center staff are able to provide mental health education to students, parents, and teachers; coordinate school-wide campaigns; and establish peer mentoring programs.²¹ Educating adults about warning signs and risk factors is a critical component of the movement toward treatment approaches that address young people's mental health problems before they become severe. Making parents and teachers aware of the physiological causes of mental health problems may help minimize the stigma and blame they attach to these problems. Furthermore, teaching children that mental illness is not something to be ashamed of may help prevent the transference of these stigmatizing views to younger generations. According to Dr. William Granatir, children do not refrain from seeking help because of others' opinions; rather, they are reluctant to meet with new or unfamiliar health practitioners,

and they like to talk with mental health staff with whom they are familiar and comfortable.¹⁴

Improved Outcomes

Although they are limited in number, evaluation studies do provide evidence that school-based mental health services improve students' emotional and academic well-being. At a Baltimore high school, researchers assessed the treatment outcomes of 73 students receiving mental health services at an SBHC. As compared with the 34 students who did not participate in individual and group therapy sessions, the 39 treated students showed improvements in self-concept, and decreased depression scores. Moreover, while depression scores decreased for the treatment group, they actually increased for the students in the comparison group.²³ An evaluation conducted by the Dallas Public Schools School-Based Mental Health Centers for the 1996–97 school year reported a 95 percent decrease in discipline referrals, a 13 percent decrease in course failures, and a 32 percent decrease in school absenteeism among students enrolled in the comprehensive SBMHCs.²⁶

Challenges and Potential Problems

Collaboration Can Be Difficult

One of the main ideas expressed at a 1998 Center for School Mental Health Assistance Critical Issues Planning Session was that "in spite of all the talk, collaboration remains a buzz word."²⁷ This is not surprising. Integration that involves multiple state and local agencies, and community service providers, requires that individual bureaucratic and institutional interests be set aside. Often, people who must work together are accustomed to working against one another to obtain limited funding and personnel to ensure their survival. A coherent policy for child and family mental health care is likely to threaten many of their institutions.²⁵ In some communities, tensions have actually increased between school-district service personnel and community-based health personnel.

In these areas, school personnel feel threatened and view the involvement of “outsiders” as discounting their skills. “Outsiders,” in turn, feel unappreciated.²³

Other researchers suggest that the expectations placed upon the new clinic staff are often unattainable, and that staff members feel destined to fail.²¹

Incongruity with Schools’ Missions

Critics of school-based mental health programs believe that schools are too frequently asked to perform duties that fall outside their mission of educating children and adolescents. They contend that schools are serving as proxy parents, providing health education, assisting in developing after-school activities, and providing child care services and parenting classes. Sheila Maloney, Executive Director of the Eagle Forum stated, “Our kids can’t read. They can’t add. Yet there seems to be this massive emphasis on health care.”⁹

In many respects, the fear that schools will make non-instructional activities a top priority is about limited financial resources. Opponents of school-based mental health clinics argue that activities not directly related to instruction take resources away from the school’s primary mission.²³ Although school-based mental health clinics are usually funded through a variety of state, local, and federal public and private sources, as well as by Medicaid (for those eligible), these concerns over resource allocation are not unwarranted.⁹ Many policymakers and legislators do believe that linking services will allow community mental health resources to go further and fund both community- and school-based clinics. The reality is that the available assets are “woefully inadequate,” and, in many communities, agencies have stretched their resources to the limit.²⁸ Education officials fear that once a clinic has been established on school property, they will be asked to contribute either funds or administrative personnel if the collaborating community mental health agency is unable to unilaterally support the clinic.¹³

Family Privacy Issues

Karen Holgate, president of the Parents National Network, stresses that taking care of a child’s mental health is the family’s responsibility, not the taxpayers’. Critics of the school-based system contend that the potential exists for school-based mental health clinics to “go too far,” and invade families’ and children’s privacy. Many of the arguments against school-based mental health services are similar to the objections of 10 years ago against SBHCs: that the services threaten to undermine parental authority and invade families’ and children’s privacy. Although parental consent is usually required and obtained before any clinic visit, Holgate and Moloney cite numerous examples of elementary school children being sent to school psychologists and asked intimate questions about their families. Other critics object to the phrasing of some value-based questions and would like to require that parents be allowed to review the questions that their children will be asked.⁹

Opponents of school-based mental health programs have also expressed concerns about the confidentiality of information obtained during school-based therapy sessions. In fact, advocates and coordinators of school-based mental health programs are also concerned about how to best handle confidentiality and release of information to other professionals in the school (e.g., school counselors), who will then make the information part of their notes.²⁹ In the long term, critics contend, better policies pertaining to the future release of children’s records are needed, so that such records do not haunt students who later apply for health insurance or military service.⁹

IV. Factors to Consider in Program Implementation

While there is disagreement on whether schools are the most appropriate venue in which to provide mental health services, it is clear that better service provision for children is needed

throughout the country and in the District of Columbia. As discussed previously, children and adolescents living in DC are at high risk for developing mental illness, and, because so many of them live in poverty, they frequently do not receive necessary treatment. This section introduces several factors that should be considered during the process of developing and implementing school-based mental health services; the next section examines school-based mental health programs in three communities and discusses the situation in the District.

Clarify the School-Based Mental Health Program's Role and Purpose

One frequent criticism leveled against the organization and implementation of school-based mental health services is that the process is often unsystematic, fragmented, and ad hoc.²⁸ A well-organized planning stage is extremely important if clinic staff hope to earn the respect of parents, teachers, school officials, and mental health providers. Susan Addison, the Clinical Supervisor of the Denver School-Based Health Centers Mental Health Corporation, encourages organizers to enlist key mental health or related service providers in the school and in the district in this process. These social workers, school counselors, and psychologists, among other providers, can assist in identifying the needs of the school or the community and in pinpointing existing personnel and program strengths. In this way, the SBMHCs can enhance rather than replace existing services.³⁰

Once the strengths and needs of the school or community have been evaluated, it is important to define the role of the mental health clinic as separate and unique from that of other providers already in the school. This clear definition is essential to the process of minimizing, and ideally eliminating, turf battles and job security issues, and of establishing boundaries for and limiting the types of services to be provided.³⁰

Coordinate School and Community Mental Health Providers

SBMHCs can only succeed if personnel from the schools and the collaborating community mental health clinics establish strong alliances. In fact, the idea behind moving services to the schools is to eliminate fragmented, ineffective systems. If the stakeholders involved do not collaborate, school-based mental health clinics may become just one more fragmented system of care.²⁸ Because school-based mental health clinics often refer children and families who require long-term therapy to outside clinics, it is important that they develop a comprehensive referral base. In doing so, one strategy they can employ is to continue fostering relationships with many of the physical, mental, and substance abuse service providers outside the school system who previously offered insights about the needs and strengths of the community and schools.³⁰

Establish a Solid Funding Base

No matter how good the intentions of school-based mental health program organizers and providers are, clinics cannot survive in the absence of sustainable funding.² While many programs are currently supported by foundation grants, these grants were not designed to be long-term funding sources. In reality, the best way to obtain funding is to have a clearly defined school-based mental health program that provides something not being offered by other groups, and to gain the support and effect the collaboration of the public and private agencies involved in the provision of mental health services, both on and off school campuses, to children and adolescents.

V. Model Programs

Numerous existing school-based mental health care programs can serve as models for policy-makers and practitioners searching for better mental health treatment approaches. Programs in Baltimore, Dallas, Denver, and the District have

incorporated many of the 12 qualities of an ideal school mental health program identified by The Center for School Mental Health Assistance. These qualities are as follows:

1. The program is developed where there is a need.
2. Stakeholders have input into goals and services, and remain involved.
3. The program is accessible.
4. The program provides a range of preventive and intervention services.
5. The program involves collaboration at all possible levels.
6. Parents are partners.
7. The program is integrated with other school and community programs.
8. The program is integrated with clergy and religious institutions.
9. Interventions focus on strengths and are empirically supported.
10. Staff and interventions are developmentally and culturally sensitive.
11. There is a focus on quality of services.
12. Evaluation is ongoing and shows positive effects.³¹

Baltimore

Baltimore's school-based mental health programs are nationally known for their number, scope, and quality of services. In 1987, three Baltimore schools had mental health programs. In 1994, such programs had been established in over 30 schools, and by 1996 there were more than 60 mental health programs in Baltimore schools. The programs target and reach a broad student body population, not just those in special education, and they incorporate treatment and intervention at several levels. This multi-level treatment approach provides services to students with estab-

lished mental health problems as well as to those experiencing the onset of mental illness. In addition, the SBMHCs offer services designed to prevent the development of problems.¹⁷

The high quality of Baltimore's programs is in part a result of successful collaborative agreements. The Baltimore City Public Schools, the Baltimore City Health Department, the Department of Social Services, the Juvenile Services Administration, and the Department of Social Services work together to provide on-site services at schools, thereby minimizing communication gaps between the various agencies. These on-site clinical services take the form of focused evaluations; individual, group, and family therapies; and, for more intensive services, the referral of youth to collaborating community mental health clinics. This focused coordination has resulted in less service duplication and has minimized competition.¹⁷

Baltimore's school-based mental health programs have also benefited from collaborative partnerships with the Departments of Psychiatry at the University of Maryland at Baltimore and Johns Hopkins University. The affiliation with these respected academic institutions has enhanced the legitimacy and credibility of the school clinic programs. In addition, the universities provide ongoing evaluation, better access to financial grants, and well-trained on-site clinical staff who keep abreast with the latest clinical theories and practices.¹⁷

The success of Baltimore's school-based mental health programs is also due in part to their management's searching for new partners and striving for ongoing improvements. Currently, the management is working to break down the barriers between the mental health and religious communities and to encourage parishioners to serve as youth mentors in the schools.¹⁸

Dallas Youth and Family Centers

The "Dallas Model Program" of school-based mental health has been recognized as a "School

Mental Health Program That Works” and is the recipient of a 1999 National Assembly on School-Based Health Care Award.^{26,33} This program comprises 10 school-based Dallas Youth and Family Centers (DYFCs) that provide health and mental health services to children and families. Each DYFC is located on a middle or high school campus and provides mental health services to students in 20 to 25 “feeder” schools in that system. (A feeder school is an elementary or middle school that feeds into a larger high school.)³³ Although the centers sit administratively within the Dallas Public Schools Division of Student Support, their success depends upon the formal collaboration established in 1995 between the Dallas Public Schools, the Mental Health Commission, and the Parkland Health and Hospital System.³²

Each DYFC manager is a licensed mental health worker employed by the school district, and is responsible for the center staff pooled from the three collaborative agencies. For each center, the Dallas Public Schools also provide a data specialist; 4 to 10 part-time school psychologists, social workers, counselors, creative/recreation teachers, school nurses, and parent educators; and 1 clinical supervisor to each center. The Mental Health Commission supplies 2 child and adolescent psychiatrists, 4 intake/assessment team members, and 2 licensed mental health therapists. The Parkland Health and Hospital System supplies the services of a part-time pediatrician a nurse practitioner, and other medical staff. In addition, the DYFCs benefit from well-established relationships with the Departments of Psychiatry and Psychology at the University of Texas Southwestern Medical Center.²⁶

The Dallas Public Schools provide another important personnel resource to help identify and provide services to children in need: teachers. Once the school clinic staff identifies a student, obtains parental permission, and reviews the health, attendance, grades, and discipline files of that student, they meet with the student’s teacher to learn about the student’s social interactions, behavior in school, and current academic perfor-

mance. Evaluation and assessment take place at the school center, and the treatment team develops an individualized service plan for the student.²⁶ Such individualized service plans often include classroom behavior-management plans; student support groups; parent education; family, couples, or individual therapy; and after-school activity programs. For those children and adolescents with serious emotional disturbances, the individualized service plan incorporates long-term individual, group, family, or play therapy, and may include psychopharmacological medications, if necessary.³²

The Dallas Model Program, the first school-based health center program in the country to track educational outcomes, can point to solid achievements. Among the 1,043 students who received comprehensive mental health services at the DYFCs during the 1996–97 school year, there was a 95 percent decrease in discipline referrals, a 13 percent decrease in course failings, and a 32 percent decrease in absenteeism. Furthermore, 93 percent of the children and adolescents who participated in the program were “happy or very happy” about the services they received, and 96 percent of parents said they would return to the SBMHC if they had another problem.²⁶ According to coordinator Jenni Jennings, much of this success is attributable to the “entrepreneurial spirit of the staff” and to the interagency coordination that has helped minimize any turf issues between the school and the community mental health providers.³³

Denver School-Based Health Centers

The Denver School-Based Health Centers (DSBHCs), which received a National Assembly on School-Based Mental Health 1999 Safe Passage: Models of Excellence in School-Based Health Care Award, serve over 5,400 students in 12 elementary, middle, and high schools. The awards committee called the “impressive collaboration the program has achieved among community stakeholders” the most outstanding single aspect of the DSBHCs.³³

This “impressive collaboration” and inter-agency cooperation is evident in the DSBHCs’ elaborate organizational system. The system uses three levels of administration. The first of the three levels is located at the school health centers, where multidisciplinary teams meet weekly to discuss the clinic’s agenda and to manage patient cases; the teams consist of a physician consultant, a pediatric nurse practitioner or physician assistant, a licensed mental health therapist, a certified substance abuse counselor, a Denver Public School nurse, a school social worker, and a school psychologist. The second level of administration is the management team that supervises the staff on site and serves as a liaison between the health center staff and the members of the health council. The health council forms the third administrative tier and is made up of members of the six signatory agencies responsible for the SBHCs. The council meets monthly to strategize and make long-term plans regarding issues such as how to use funds, and how to better integrate topics of risk avoidance and health education into the Denver Public Schools curriculum.³⁴ There is also frequent interaction between administrators, on-site providers, school staff, and health council and management teams, which all also regularly evaluate the program.³³

DSBHCs are comprehensive health centers, so when a student keeps a mental health-related appointment, no one else need know that he or she is doing so. This is an advantage of comprehensive centers, but one challenge associated with providing mental health services as part of a comprehensive health center is that mental health services tend to be marginalized in times of limited funding and resources. The DSBHCs have worked diligently to stabilize services and establish clearly defined goals to ensure that this does not happen in their program. The DSBHC staff have also been willing to make necessary adjustments. For example, a management task force was created to better define the counselors’ role in substance-use prevention counseling and to better coordinate the responsibilities of the counselor vis-à-vis outpa-

tient referrals. In addition, clinic staff ask any student seen for a physical ailment to fill out a complete teen health history questionnaire to assist providers in determining whether there is an underlying mental health problem. If such a problem is identified, on-site staff are available to provide both individual and family therapy. Center staff also integrate mental health issues into the school curriculum through classroom presentations on depression, substance abuse, and drug prevention strategies.^{33,34}

These centers are managed by Denver Health through a memorandum of understanding with the Denver Public Schools, and they receive funding from several sources. One-third of the program’s funding is in the form of grants from the Maternal and Child Health Bureau, the Robert Wood Johnson “Making the Grade” initiative, and federal Bureau of Primary Care grants. The remaining financial support comes from Denver Health, the Mental Health Corporation of Denver, Arapahoe House, The Children’s Hospital, and the Denver Public Schools. To evaluate the centers’ efficacy and to identify problems, the DSBHCs collaborate with the University of Colorado Health Sciences Center for School-Based Information and Research.³⁴

Washington, DC

More than two dozen schools in the District have on-site mental health programs funded by the DC Mental Health Commission’s Child and Youth Services Administration (CYSA). CYSA social workers, psychologists, case managers, art therapists, and psychiatry residents divide their time between their assigned schools and the Northwest Family Center or the Child and Family Therapy Center. CYSA staff provided services such as classroom observations, child screening, formal assessment administration, art therapy, and individual or group therapy to more than 300 children per month last year. Children who require more intensive therapy are referred for ongoing treatment to either the Northwest Family Center or the Child

and Family Therapy Center.³⁵

School-based CYSA staff members are also involved with parents and teachers. Family members often attend meetings with clinicians and teachers at schools, rather than having to travel to a mental health clinic. In addition, staff members meet with teachers and school counselors to discuss children with behavioral and learning problems, and offer the teachers solutions that do not always require placing the children in special education programs.³⁵

Miner Elementary School in northeast Washington has created a complete on-site mental health team using social workers from the Northwest Family Center, third- and fourth-year psychiatry residents from the DC Commission on Mental Health Services, doctoral students in psychology from George Washington University, and the school guidance counselor. The guidance counselor and involved community members have also sought out volunteers from the Institute for Mental Health Initiatives, Bowie State University, Howard University, the University of the District of Columbia, and Gallaudet University.³⁵

This multidisciplinary on-site mental health team meets once a week to discuss individual children and to collaborate on the type of assistance needed by the child in question. Services include play therapy, individual or family therapy, administration of psychotropic medication, and, in some cases, referrals for academic tutoring or speech and language therapy. At these meetings, the staff work together to determine whether treatment is needed for emotional or academic problems, or both. As a result of this more comprehensive approach, far fewer children are being recommended for special education than have been in the past.³⁵

Both the DC Public Schools Student Intervention Services Director and the Director of CYSA hope to replicate the Miner School project at other schools in the District. Toward this end, the two agencies are collaborating with the Addiction Prevention and Recovery Administration, the

Community Justice Services, the DC Early Intervention Program, the Family Advocacy and Support Association (FASA), and the DC Superior Court to obtain Substance Abuse and Mental Health Services Administration grants to provide enhanced school-based mental health services to children and adolescents in the District.³⁵

Although there are far fewer SBMHCs in DC than in Baltimore, Dallas, or Denver, the ongoing collaboration between different agencies, and the involvement of universities, bodes well for the growth and continued success of programs like the Miner School Pilot Project.

VI. Considerations and Conclusions

As of 1997, there were 65,800 children between the ages of 4 and 17 in DC.⁴ According to national statistics, 13,160 of these children have a mental health problem at any given time. The fallout from failing to help these children will affect tens of thousands of other District residents. As discussed in this brief, school-based mental health services are one way that schools, mental health commissions, and community members are trying to provide better access to services for children and adolescents. In the last decade, several changes have enabled school-based mental health programs to exist and to grow. The expansion of SBHCs, the realization that mental health is a priority at any age, and new funding options have all contributed to the rapid progress of this health movement.¹⁵

There are many advantages to moving toward school-based services in lieu of community mental health centers. Students have easy access to school-based services, and, perhaps even more important, the fact that their health center appointments may be mental health-related can be kept relatively confidential, which is significant in light of the stigma often attached to mental illness.

However, adopting a school-based mental health service model does not come without challenges, including the always-difficult challenge of

how to allocate limited resources. For example, discussion was under way about establishing a program modeled after the one in Miner Elementary School at another District school, but the identified space was assigned for use as an English-as-a-second-language classroom instead.¹⁴ Clearly, if District education and mental health officials seek to increase the number of school-based mental health programs, they will need to find space for them, which may mean taking that space away from other school-based programs. This allocation of resources away from schools' primary mission is a concern of opponents of SBMHCs.

If District officials, service providers, and families determine that school-based mental health programs do make sense, there are numerous national and local resources available to assist them in implementing the programs. Furthermore, researchers have identified successful approaches, and several community programs can be used as models of both what and what not to do when establishing such a program. Continued discussion and collaboration among policymakers, officials, service providers, and families is essential if we hope to make accessible, quality mental health care available to children and adolescents in the District of Columbia.

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Appendix A

District Resources

Child and Youth Services Administration of the DC Commission on Mental Health Services

Contact: Deborah Hobbs, Community Programs
4301 Connecticut Avenue, N.W., Suite 240
Washington, DC 20008
Phone: (202) 282-0300
Fax: (202) 282-0343

The CYSA develops and administers a comprehensive system of family-centered mental health services for infants, children, youth, and their families. This division of the DC Commission on Mental Health Services, in collaboration with DC Public Schools, the Addiction Prevention and Recovery Administration, Community Justice Services, the DC Early Intervention Program, the Family Advocacy and Support Association (FASA), and the DC Superior Court, has submitted three grant proposals for enhancing school-based services to the Substance Abuse and Mental Health Services Administration (SAMSHA). Some of the CYSA programs are described in detail below.

CYSA—Acute Inpatient Services

St. Elizabeth's Hospital
2700 M.L.K. Jr. Avenue, S.E., CT-8
Washington, DC 20032
Phone: (202) 373-7100

St. Elizabeth's Hospital, located in southeast Washington, provides 24-hour psychiatric inpatient services to adolescents ages 13 to 17.

CYSA—Central Intake/Crisis Outreach

1905 E Street, S.E., Building #14
Washington, DC 20003
Phone: (202) 673-9040
Fax: (202) 698-3172

The Central Intake/Crisis Outreach program serves as point of entry for emergency and hospital

care for children and adolescents with mental illness. In addition, it provides emergency outreach and walk-in crisis stabilization and evaluation services. The unit serves as the only walk-in crisis intervention facility expressly for children in the public sector of Washington, DC. In this capacity, it provides immediate crisis intervention, stabilization, evaluation, and referral to outpatient mental health clinics in the CYSA, and in the larger Washington, DC, community.

CYSA—Child and Family Therapy Center

51 N Street, N.E., 7th Floor
Washington, DC 20002
Phone: (202) 724-5370

The Child and Family Therapy Center provides outpatient psychiatric services to children and youth ages 5 to 18 and their families. Services offered include individual, family, and group counseling, and psychotherapy. The center also conducts workshops and provides consultation services to other agencies.

CYSA—Northwest Family Center

1536 U Street, N.W., 3rd Floor
Washington, DC 20009
Phone: (202) 673-2048

The Northwest Family Center provides a comprehensive range of outpatient mental health services that are accessible and responsive to the needs of children, youth, and their families. ADHD and hearing-impaired services are also available.

CYSA—Parent & Infant Development

51 N Street, N.E., #700A
Washington, DC 20002
Phone: (202) 724-5299

The Parent & Infant Development office provides comprehensive, multidisciplinary screenings, evaluations, assessments, and treatment to children from birth to age 5, pregnant women and adolescents, parents, and their families.

CYSA—Residential Placement Unit

St. Elizabeth's Hospital
2700 M.L.K. Jr. Avenue, S.E., L Building
Washington, DC 20032
Phone: (202) 373-6438

The Residential Placement Unit determines Medicaid eligibility for placement in Medicaid-certified residential treatment facilities and provides case-management services to children and youth in residential placements. Unit staff monitor residential facilities for appropriateness and effectiveness and ensure that the full range of residential and alternative programs are available to meet the needs of emotionally disturbed children, adolescents, and their families.

CYSA—Youth Forensic Services

300 Indiana Avenue, N.W., #4032
Washington, DC 20001
Phone: (202) 724-4377

The Youth Forensic Services provides comprehensive and emergency psychiatric evaluations for youth who have been referred for services by the courts.

DC Commission on Mental Health Services

Contact: Scott Nelson, Office of the Receiver
4301 Connecticut Avenue, N.W., Suite 310
Washington, DC 20008
Phone: (202) 364-3422

The District's public mental health system is under the management of a court-appointed Receiver. This office oversees all services of the system; addresses issues related to systemwide program planning and coordination; provides advocacy for consumers and families in the system; administers the system of advocacy for consumers and for the resolution of consumer complaints; and is responsible for monitoring the organization's performance and for ensuring continuous

quality improvement. Their mission is to ensure that well-run mental health services are available to the residents of and visitors to DC, and to provide excellence in the assessment, treatment, and provision of a continuum of care for the mental health consumer.

District of Columbia Public Schools

Contact: Local School Counselors
825 North Capitol Street, N.E., Suite 9026
Washington, DC 20002
Phone: (202) 442-5635 (public information)
Web site: <http://www.k12.dc.us/DCPS/home.html>

The purpose of the District of Columbia Public Schools (DCPS) is to make dramatic improvements in the achievement of all students today to prepare them for their world of tomorrow. Students having difficulty in school may receive individualized assistance provided by pupil-services team at their schools. Either the student's parents or a member of the school staff may request such services. An Individual Student Assistance Plan is developed for each of these students and is implemented by the team, which may include a counselor, teacher, nurse, parent, social worker, psychologist, and speech and language pathologist. DCPS, in collaboration with the Commission on Mental Health, Child and Youth Services Administration, has established the Mental Health Resource Linking Project partnership with private providers and agencies to identify and assist schools with the greatest need for school-based mental health programs. The project coordinates volunteer psychiatrists, psychologists, social workers, counselors, and agencies. DCPS also provides a resource directory of free or reduced mental health services for students. This directory is available through public school counselors.

Mental Health Association of the District of Columbia

Contact: Mary G. Jones
1628 16th Street, N.W.
Washington, DC 20009
Phone: (202) 265-6363
Fax: (202) 265-3265

The Mental Health Association of the District of Columbia (MHA DC) works in coalition with a variety of community organizations and advocates to address problems that have a negative impact on the community's mental health and morale. MHA DC is a nonprofit organization, a member agency of United Way, and a division of the National Mental Health Association. MHA DC promotes community understanding of mental illness; fosters conditions that lead to sound mental health; develops model programs that serve unmet needs; advocates policies, programs, and services to prevent mental illness and improve mental health; and exercises leadership among community mental health organizations. Under a grant from the Substance Abuse Mental Health Administration (SAMHSA), MHA DC is producing a directory entitled "Keep Your Kids Healthy Mentally," to be published in fall 1999. It will be a significant information resource that the community can use to access children's preventive mental health services.

NAMI DC

Contact: Nancy Lee Head
422 8th Street, S.E.
Washington, DC 20003
Phone: (202) 546-0646
E-mail: namidc@aol.com
Web site: <http://www.nami.org/about/namidc>

NAMI DC is the local affiliate of the National Alliance for the Mentally Ill, and the nation's leading grassroots advocacy organization solely dedicated to improving the lives of individuals with severe mental illness. NAMI's efforts focus on supporting people and the families of people with serious brain disorders; advocating for nondiscriminatory and equitable federal, state, and private-sector policies; researching the causes, symptoms, and treatments for brain disorders; and providing education to eliminate the pervasive stigma surrounding severe mental illness. NAMI DC works primarily with adults but collaborates with other groups that deal with children. NAMI DC sponsors weekly support meetings for families coping with

mental illness and for afflicted individuals. NAMI DC also sponsors educational meetings and the annual Candlelight Vigil for Mental Awareness Week.

Office of Consumer and Family Affairs

Contact: Margaret Worthy, R.N.
4301 Connecticut Avenue, N.W., Suite 310
Washington, DC 20008
Phone: (202) 364-3422
Fax: (202) 364-4886

The mission of the Office of Consumer and Family Affairs is to promote the full inclusion of consumers and family members in the planning, developing, monitoring, and delivery of mental health services. Through this office, consumers and family members work inside the Commission for system changes while advocating for an understanding of mental illness and for the public's acceptance of recovery-focused treatment.

Appendix B

National Resources

Advocates for Youth Support Center for School-Based and School-Linked Health Care

1025 Vermont Avenue, N.W., Suite 200

Washington, DC 20005

Phone: (202) 347-5700

Fax: (202) 289-0776

E-mail: info@advocatesforyouth.org

Web site: <http://www.advocatesforyouth.org/>

The Support Center for School-Based and School-Linked Health Care provides information, technical assistance, training, policy analysis, and advocacy to assist in establishing school-based and school-linked health centers, and in enhancing their operations. The Support Center promotes SBHC models of adolescent health services delivery by providing information and technical assistance to program planners and policymakers. The Support Center provides publications, individualized technical assistance, training on how to start a SBHC and how to advocate for SBHCs, and referrals to SBHC experts across the country. Its database includes information on SBHC/SLHC services, staffing, populations served, financing, and more.

The American Academy of Pediatrics Committee on School Health

141 Northwest Point Boulevard

Elk Grove Village, IL 60007-1098

Phone: (847) 228-5005

Fax: (847) 228-5097

E-mail: schoolhealth@aap.org

Web site: <http://www.schoolhealth.org/cslist.htm>

The American Academy of Pediatrics Committee on School Health (COSH) is composed of six pediatricians and multiple liaisons from organizations such as the American Medical Association (AMA), the Centers for Disease Control and Prevention (CDC), the National Association of

School Nurses (NASN), the American School Health Association (ASHA), and the American Association of School Administrators (AASA). Through policy development, special projects, educational programming, and liaison relationships, COSH addresses issues of major concern, such as education, policy development, and program development (especially of comprehensive health-related programs for school-age children). COSH is conducting a 5-year project entitled the Comprehensive School Health-Capacity and Policy (CSH-CAP) Initiative to increase the number of pediatricians involved in school health programs through national training efforts; COSH is also developing a database and other resources to assist these pediatricians.

The Center for School Mental Health Assistance

Contact: Olga Acosta, Department of Psychiatry,

University of Maryland

680 West Lexington Street, 10th Floor

Baltimore, MD 21201-1570

Phone: (410) 706-0980; (888) 706-0980 (toll free)

E-mail: csmha@csmha.ab.umd.edu

Web site: <http://csmha.ab.umd.edu>

The Center for School Mental Health Assistance (CSMHA) provides leadership and technical assistance to advance effective interdisciplinary school-based mental health programs. It strives to support schools and communities in the development of programs that are accessible, family-centered, culturally sensitive, and responsive to local needs. CSMHA offers a forum for training, the exchange of ideas, and the promotion of coordinated systems of care that provide a full continuum of services to enhance mental health, development, and learning in youth. CSMHA's objectives are to provide technical assistance and

consultation; conduct national training and education; analyze and promote discussion of critical issues; gather, develop, and disseminate resource materials; and facilitate networking between programs and individuals involved and/or interested in school mental health.

Healthy Schools, Healthy Communities

Contact: The Director of School Health Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
Phone: (301) 594-4450
E-mail: feedback@hrsa.dhhs.gov
Web site:

<http://www.bphc.hrsa.dhhs.gov/hshc/hshc1.htm>

Healthy Schools, Healthy Communities (HSHC) is a program administered by the Bureau of Primary Health Care. It provides a model of how to use schools effectively as primary care access points for at-risk children. Since the 1970s, the Bureau of Primary Health Care (BPHC) has supported and promoted the concept of school-based health centers. Through state-based cooperative agreements and the publication of both a directory and a descriptive evaluation entitled "School-Based Clinics That Work," BPHC has promoted school health centers as an effective way to improve access to health services for vulnerable children and adolescents. HSHC projects provide family-centered, community-based primary care. Mental health and dental services are included.

Institute for Mental Health Initiatives

4545 42nd Street N.W., Suite 311
Washington, DC 20016
Phone: (202) 364-7111
Fax: (202) 363-3891
E-mail: info@imhi.org
Web site: <http://www.imhi.org/>

The Institute for Mental Health Initiatives (IMHI) is a nonprofit foundation that promotes mental health by building bridges between mental health professionals and the public. It uses information, education, and positive role models to

reduce problems caused by emotional disorders. Services to consumers include referrals, publications, and reference information.

KidsPeace—The National Center for Kids in Crisis

5300 KidsPeace Drive
Orefield, PA 18069
Phone: (800) 8KID-123
E-mail: admissions@kidspeace.org
Web site: <http://www.kidspeace.org>

KidsPeace, The National Center for Kids in Crisis, is a private, not-for-profit organization dedicated to helping children overcome crisis through a variety of public education initiatives, prevention efforts, and treatment programs. KidsPeace offers public-awareness outreach (including the distribution of public-service information and free materials); research and development through the organization's Lee Salk Center; and a national referral network that connects parents, doctors, and children to more than 20,000 sources of assistance nationwide. The National Hospital for Kids in Crisis, a division of KidsPeace, provides acute inpatient care for children in crisis. KidsPeace National Centers for Kids in Crisis centers (a division of KidsPeace) is dedicated to helping children overcome crisis through treatment, counseling, and education. Thirty distinct treatment programs at 25 centers across the United States include intensive foster care, diagnostic services, education systems, and treatment facilities.

Making the Grade

Contact: Julia Graham Lear, Program Director
1350 Connecticut Avenue, Suite 505
Washington, DC 20036
Phone: (202) 466-3396
Fax: (202) 466-3467
E-mail: mtg@gwu.edu
Web site: <http://www.gwu.edu/~mtg/>

With support through the Making the Grade (MTG) initiative, state governments are reducing organizational and financial barriers to school-based health care. The goal of MTG is to fund

communities so they can develop districtwide, integrated systems of school health services that link health centers, school nursing, mental health, and special education-related services as part of an effective service-delivery system for children. The MTG Web site has a host of resources related to school-based health centers and comprehensive school health, such as publications, fact sheets, guidelines to organizing SBHCs, technical assistance, and more.

Maternal and Child Health Bureau

Office of Adolescent Health

Contact: Trina Anglin, M.D.

5600 Fishers Lane

Parklawn Building, Room 18A-39

Rockville, MD 20857

Phone: (301) 443-4026

Fax: (301) 443-1296

Web site: http://www.mchb.hrsa.gov/html/adolescent_health.html.

The Maternal and Child Health Bureau (MCHB) provides leadership, partnership, and resources to advance the health of all our nation's mothers, infants, children, and adolescents. MCHB primarily focuses on supporting states and communities in their efforts to plan, organize, and deliver primary and preventive health care. MCHB serves the population of women of childbearing age, mothers, children, youth, and families. The Maternal and Child Health Bureau's Initiative for Mental Health in Schools was created in response to an increasing awareness of the need to make mental health services more accessible for the school-age population. The purpose of MCHB's initiative is to strengthen the capacity of school-based and school-linked health programs to address psychosocial issues and mental health problems by enhancing primary mental health resources and services for school-age children and youth, including those with special health care needs. Programs supported by this initiative are meant to offer assistance during developmental and family crises, provide guidance to promote healthy behavior, and address the psychosocial

aspects of physical disabilities and chronic illnesses. In the school setting, this initiative is intended to raise the level of awareness regarding behavioral dysfunction and emotional distress, help make the academic environment sensitive and supportive, and assist in responding to challenges confronting students when disturbing events such as an outbreak of violence or a completed suicide impact the school community.

The National Adolescent Health Information Center

University of California, San Francisco

400 Parnassus Avenue, Room AC-01

San Francisco, CA 94143-0374

Phone: (415) 476-2059

Fax: (415) 476-6106

The National Adolescent Health Information Center of the University of California, San Francisco, is a joint activity of the Division of Adolescent Medicine and the Institute for Health Policy Studies. The Center's goal is to promote linkages among key sectors of the health care system that affect adolescent health. The Center's activities include increasing the availability of information on adolescent health through a strategy that (1) links collection, analysis, and dissemination of MCH-related and other national and state activities, (2) conducts short- and long-term policy studies to synthesize research findings, (3) identifies health trends, (4) compares policy approaches, (5) analyzes current and proposed legislation affecting adolescents, and (6) develops strategies to increase the public's awareness of the health needs of special populations.

National Alliance for the Mentally Ill

Contact: Brenda K. Suoto, Young Family Outreach Coordinator

200 North Glebe Road, Suite 1015

Arlington, VA 22203

Phone: (703) 524 7600; (800) 950 6264

Fax: (703) 524-9094

Web site: <http://www.nami.org>

The National Alliance for the Mentally Ill (NAMI) is a grassroots, self-help, support and advocacy organization for people with serious mental illness and their families and friends. NAMI's mission is to eradicate mental illness and to improve the quality of life for those who suffer from brain diseases. Services provided by NAMI include a helpline (800 950-NAMI) and support groups for parents, siblings, and children of the mentally ill and for consumers of mental health services. NAMI supports research into etiology, treatments, and cures for neurobiological brain disorders; it also provides technical assistance to affiliates at local and state levels who wish to advocate for improved, nondiscriminatory services for neurobiological brain disorders. NAMI also sponsors educational programs such as the "Family-to-Family" education program presented in localities nationwide, regional conferences, an annual convention held each July, and an annual Mental Illness Awareness Week that takes place in early October.

National Assembly on School-Based Health Care

Contact: John Schlitt, Executive Director
666 11th Street, N.W., Suite 735
Washington, DC 20001
Phone: (202) 638-5872; (888) 286-8727 (toll free)
Fax: (202) 638-5879
E-mail: info@nasbhc.org
Web site: <http://www.nasbhc.org/>

The National Assembly on School-Based Health Care (NASBHC) is dedicated to promoting accessible, quality, school-based primary health and mental health care for children and youth through interdisciplinary and collaborative efforts. It supports the institutionalization of school-based health care nationwide as an essential strategy for improving the lives of children and optimizing their opportunities for success in school and society. NASBHC provides community, state, and national advocacy; information and knowledge exchange; networking opportunities; and technical assistance regarding multidisciplinary school-based health care.

National Association of State Mental Health Program Directors, Children, Youth, and Family Division

Contact: Roy E. Praschil, Division Administrator, CYF
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
Phone: (703) 739-9333
Fax: (703) 548-9517
E-mail: roy.praschil@nasmhpd.org
Web site: <http://www.nasmhpd.org>

The National Association of State Mental Health Program Directors, Children, Youth, and Families Division (CYF) (formerly known as State Mental Health Representatives for Children and Youth) was established to carry out certain activities and address concerns of the parent organization as they specifically relate to children and youth. The purposes of the CYF Division are (1) to identifiably focus on children's mental health services as a substantial portion of the mental health concerns and programs of the states; (2) to develop forums for effective collaborative planning, programming, and program review in mental health services regarding programs for children and youth; and (3) to analyze pertinent materials and policies as these relate to children's mental health.

National Health and Education Consortium

1001 Connecticut Avenue, N.W., Suite 310
Washington, DC 20036
Phone: (202) 822-8405
Fax: (202) 872-4050
E-mail: nhec@iel.org

The mission of the National Health and Education Consortium (NHEC) is to strengthen communication and dissemination of information between health and education practitioners and policymakers, to identify exemplary program models and practices that more effectively integrate health and education services, and to improve public policy by addressing the need for a better-coordinated health and education delivery system. Primarily, NHEC serves as a formal entity in bridging the gap between cross-sector collaborative efforts.

National Institute of Mental Health

Contact: Joan Abell, Chief, Information Resources and Inquiries Branch

6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663

Phone: (301) 443-4513

Fax: (301) 443-4279

E-mail: nimhinfo@nih.gov

Web site: <http://www.nimh.nih.gov/>

The National Institute of Mental Health (NIMH), a component of the National Institutes of Health, is the federal agency that conducts and supports research seeking to understand, treat, and prevent mental illness. NIMH's mission is to diminish the burden of mental illness through research. Its Information Resources and Inquiries Branch responds to information requests from the public, clinicians, and the scientific community with a variety of publications. Publications include printed materials on subjects such as basic behavioral research, neuroscience of mental health, rural mental health, children's mental disorders, schizophrenia, paranoia, depression, bipolar disorder, anxiety and panic disorders, obsessive compulsive disorder, eating disorders, learning disabilities, and Alzheimer's disease. It also distributes information and publications on the Depression/Awareness Recognition and Treatment Program (D/ART) and on the Anxiety/Disorders Education Program.

National Mental Health Association

Contact: Mike King, Information Center Manager
1021 Prince Street

Alexandria, VA 22314

Phone: (703) 684-7722; (800) 969-NMHA

Fax: (703) 684-5968

Web site: <http://www.nmha.org>

The National Mental Health Association (NMHA) is dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illnesses through advocacy, education, research, and service. NMHA is a voluntary advocacy organization concerned with all aspects of mental health and mental illness. The association provides information on a broad range of mental

illnesses and related issues through the Mental Health Information Center, which maintains descriptions of programs and other resources that aim to prevent mental-emotional disability. The association also provides public education, research, and advocacy services.

School-Based Health Center Information on the Internet

Web site: <http://ericae.net/intbod.stm#AA>

Developed by the Educational Resources Information Center (ERIC) to provide online services and documents pertaining to assessment and evaluation, this Web site contains information on special issues in school-based intervention, test descriptions, lists of online publishers, and more.

School Health Resource Services

School of Nursing, Office of School Health

4200 East Ninth Avenue, C-287

Denver, CO 80262

Phone: (800) 669-9954

Fax: (303) 315-3198

E-mail: shpref@defiance.uchsc.edu

Web site: <http://www.uchsc.edu/sn/shrs>

School Health Resource Services (SHRS) is a direct way to access the diverse resources needed to implement or improve school health programs and services. SHRS is a network of services designed as a coordinating link for the information available from school health, MCH, education, and other disciplines. SHRS provides technical information, resource materials, and research assistance. Its references include the School Health Reference Collection, which contains 5,000 school health-related documents, government publications, model programs, articles, data, policies, videotapes, and much more; SHRS also provides resource packets and information on model programs.

School Mental Health Project

Contact: Howard Adelman, Co-Director, The Center for Mental Health in Schools

Department of Psychology, UCLA
405 Hilgard Avenue
Los Angeles, CA 90095-1563
Phone: (310) 825-3624
Fax: (310) 206-8716
E-mail: smhp@ucla.edu
Web site: <http://smhp.psych.ucla.edu/>

The School Mental Health Project (SMHP) was created in 1986 to pursue theory, research, practice, and training related to addressing mental health and psychosocial concerns through school-based interventions. To these ends, SMHP works closely with school districts, state agencies, the New American Schools Urban Learning Center model, and organizations and colleagues across the country. Its accomplishments include introducing and operating a model for a comprehensive, multi-faceted approach to addressing barriers to student learning and promoting healthy development. Such an approach for enabling learning provides a unifying framework for policy and practice (initial work supported through the U.S. Department of Education).

U.S. Substance Abuse and Mental Health Services Administration

Contact: Mark Weber, Office of Communications
5600 Fishers Lane, Room 13C-05
Rockville, MD 20857
Phone: (301) 443-8956
Fax: (301) 443-9050
E-mail: mweb@samhsa.gov
Web site: <http://www.samhsa.gov>

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) is an operating division within the U.S. Department of Health and Human Services. SAMHSA consists of three centers: the Center for Mental Health Services (CMHS), which provides national leadership in the application of mental health services research; the Center for Substance Abuse Prevention (CSAP), which provides a national focus for federal efforts to demonstrate and promote effective strategies for preventing substance abuse; and the Center for Substance Abuse Treatment (CSAT), which pro-

vides national leadership in efforts to enhance the quality of substance abuse treatment services and to ensure their availability to individuals who need them, including those with co-occurring drug, alcohol, mental, and physical problems. CSAT sponsors a toll-free treatment referral line that callers can access to find resources. The Office of Applied Studies (OAS) gathers, analyzes, and disseminates data on substance abuse practices in the United States. OAS is responsible for the annual *National Household Survey on Drug Abuse* and the *Drug Abuse Warning Network*.

U.S. Substance Abuse and Mental Health Services, Center for Mental Health Services

Contact: Curtis R. Austin, Director, Office of External Liaison
5600 Fishers Lane, Room 13-103
Rockville, MD 20857
Phone: (301) 443-2792
Fax: (301) 443-5163
Web site: <http://www.mentalhealth.org>

The U.S. Substance Abuse and Mental Health Services' Center for Mental Health Services (CMHS) is part of the Substance Abuse and Mental Health Services Administration, a branch of the U.S. Department of Health and Human Services. CMHS, in partnership with states, communities, and other organizations, provides national leadership and funding to improve the delivery and financing of prevention, treatment, and rehabilitation services for all Americans with mental illness, and their families. It also supports innovative programs and communicates important information about those programs to care providers, administrators, consumers, family members, and policy-makers nationwide. Information campaigns help reduce the barriers of stigma and empower consumers and families to make informed mental health decisions and participate in the systems of care. CMHS launched the National Mental Health Services Knowledge Exchange Network (KEN) in 1994 to provide easy access to information about mental health, and it offers a toll-free number: (800) 789-CMHS (2647). It also sponsors the

CARING FOR EVERY CHILD'S MENTAL HEALTH:
Communities Together campaign, which develops
and disseminates educational materials and activi-
ties to improve the public's ability to protect and
nurture the mental health of young people.

**Wisconsin Clearinghouse for Prevention
Resources**

P.O. Box 1468

Madison, WI 53701

Phone: (608) 263-2797; (800) 322-1468

Fax: (608) 262-6346

E-mail: wchpr@www.uhs.wisc.edu

Web site: <http://www.uhs.wisc.edu/wch/>

The Wisconsin Clearinghouse for Prevention Resources (WCH) is an official information and materials resource for the state of Wisconsin that also serves schools, agencies, programs, community groups, and businesses nationwide. Its goal is to strengthen individuals, families, and communities. WCH provides a wide range of educational materials and services to prevention specialists, counselors, and other professionals. Topics include alcohol and other drugs, curricula and teacher resources, high-risk youth and high-risk behaviors, resources for programs and professionals, tobacco and smoking, fetal alcohol syndrome, primary prevention and health promotion, mental health, and substance abuse prevention.

About the DC Family Policy Seminars

The DC Family Policy Seminar (DC FPS) is a collaborative project of the Georgetown Public Policy Institute (GPPI) and its affiliate, the National Center for Education in Maternal and Child Health (NCEMCH). The mission of the DC FPS is to provide District policymakers with accurate, relevant, nonpartisan, timely information and policy options concerning issues affecting children and families.

The DC FPS is coordinated by Leslie Gordon, Project Director, National Center for Education in Maternal and Child Health, 2000 15th Street, North, Suite 701, Arlington, VA 22201; (703) 524-7802.

To receive additional information about the DC FPS, or to request copies of the following briefing reports or highlights, please contact Susan Rogers or Kristine Kelty at (703) 524-7802.

- *Out-of-School Time Activities: Can Families Help Programs and Can Programs Help Families?* May 1999.
- *Quality Housing for All: Family and Community-Led Initiatives.* February 1999.
- *Educating with Peers: Other Do—Should You?* November 1998.
- *Saving Our Schools: Would Vouchers Create New Solutions or New Problems?* April 1998.
- *Finding Families: DC's Foster Family Deficit.* February 1998.
- *Building the Future: Strategies to Serve Immigrant Families in the District.* October 1997.
- *Diverting Our Children from Crime: Family-Centered, Community-Based Strategies for Prevention.* May 1997.
- *The Child Care Crisis in the District of Columbia: Can (or Should) Businesses Fill the Gap?* March 1997.
- *Feeding Our Families: Community Food Security in the District of Columbia.* November 1996.
- *Keeping Our Kids Safe: Preventing Injury in DC Schools.* September 1996.
- *Fundraising for Family-Centered Organizations in the District.* July 1996.
- *Strengthening Families: Parenting Programs and Policies in the District.* April 1996.
- *Transitioning from Welfare-to-Work in the District: A Family-Centered Perspective.* February 1996.
- *Helping Families and Schools Get it Done: Mentoring Interventions in the District.* November 1995.
- *Caring for Our Children: Meeting the Needs of Low-Income, Working Families in the District.* September 1995.
- *Families that Play Together: Recreation and Leisure in the District.* July 1995.
- *HIV/AIDS: Helping Families Cope.* April 1995.
- *Substance Abuse Prevention and Treatment Programs: A Family Approach.* February 1995.
- *Family-Friendly Welfare Reform: Using Welfare Policies to Strengthen the Family.* November 1994.
- *Preventing Family Violence.* September 1994.
- *Preventing Adolescent Violence.* May 1994.
- *Preventing Teen Pregnancies.* December 1993.