GUIDE 6

Instituting School-Based Links With Mental Health and Social Service Agencies

NORTHWEST REGIONAL
EDUCATIONAL LABORATORY

SAFE AND DRUG-FREE
SCHOOLS PROGRAM
U.S. DEPARTMENT OF
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Instituting School-Based Links With Mental Health and Social Service Agencies

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NORTHWEST REGIONAL
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FOREWORD

School safety requires a broad-based effort by the entire community, including educators, students, parents, law enforcement agencies, businesses, and faith-based organizations, among others. By adopting a comprehensive approach to addressing school safety focusing on prevention, intervention, and response, schools can increase the safety and security of students.

To assist schools in their safety efforts, the Northwest Regional Educational Laboratory (NWREL) has developed a series of eight guidebooks intended to build a foundation of information that will assist schools and school districts in developing safe learning environments. NWREL has identified several components that, when effectively addressed, provide schools with the foundation and building blocks needed to ensure a safe learning environment. These technical assistance guides, written in collaboration with leading national experts, will provide local school districts with information and resources that support comprehensive safe school planning efforts.

One objective of the guides is to foster a sense of community and connection among schools and those organizations and agencies that work together to enhance and sustain safe learning environments. Another objective is to increase awareness of current themes and concerns in the area of safe schools.

Each guide provides administrators and classroom practitioners with a glimpse of how fellow educators are addressing issues, overcoming obstacles, and attaining success in key areas of school safety. These guidebooks will assist educators in obtaining current, reliable, and useful information on topics that should be considered as they develop safe school strategies and positive learning environments.

Each of the guidebooks should be viewed as one component of a school's overall effort to create a safer learning environment. As emphasized in *Threat Assessment in Schools: A Guide to Managing Threatening Situations and to Creating Safe School Climates,* a joint publication of the U.S. Secret Service and the U.S. Department of Education, creating cultures and climates of safety is essential to the prevention of violence in school. Each guidebook contains this message as a fundamental concept.

Under No Child Left Behind, the education law signed in January 2002, violence prevention programs must meet specified principles of effectiveness and be grounded in scientifically based research that provides evidence that the program to be used will reduce violence and illegal drug use. Building on the concept in No Child Left Behind—that all children need a safe environment in which to learn and achieve—these guides explain the importance of selecting research-based programs and strategies. The guides also outline a sample of methods on how to address and solve issues schools may encounter in their efforts to create and enhance safe learning environments.

Guide 1: Creating Schoolwide Prevention and Intervention Strategies, by Jeffrey Sprague and Hill Walker, is intended to put the issue of schoolwide violence prevention in context for educators and outline an approach for choosing and creating effective prevention programs. The guide covers the following topics:
- Why schoolwide prevention strategies are critical
- Characteristics of a safe school
- Four sources of vulnerability to school violence
- How to plan for strategies that meet school safety needs
- Five effective response strategies
- Useful Web and print resources

Guide 2: School Policies and Legal Issues Supporting Safe Schools, by Kirk Bailey, is a practical guide to the development and implementation of school policies that support safe schools. Section 1 provides an overview of guiding principles to keep in mind when developing policies at the district level to prevent violence. Section 2 addresses specific policy and legal components that relate to such topics as discipline and due process, threats of violence, suspension and expulsion, zero tolerance, and dress codes. Checklists are included to ensure that schools attend to due process when developing policies for suspensions or expulsions, search and seizure, or general liability issues.

Guide 3: Implementing Ongoing Staff Development To Enhance Safe Schools, by Steve Kimberling and Cyril Wantland, discusses the role of staff development within the context of school safety. The guide addresses how staff development should be an integral part of the educational planning process and discusses what its relationship is to safety-related outcomes and overall student achievement.

Guide 4: Ensuring Quality School Facilities and Security Technologies, by Tod Schneider, is intended to help educators and other members of the community understand the relationship between school safety and school facilities, including technology. The guide covers the following topics:

- Crime Prevention Through Environmental Design (CPTED)
- Planning To Address CPTED: Key Questions To Ask
- Security Technology: An Overview
- Safety Audits and Security Surveys

Guide 5: Fostering School-Law Enforcement Partnerships, by Anne Atkinson is a practical guide to the development and implementation of partnerships between schools and law enforcement agencies. Section 1 provides an overview of community policing and its relationship to school effectiveness. Section 2 focuses on developing the school-law enforcement partnership from an interagency perspective. Section 3 focuses on steps for implementing school–law enforcement partnerships in schools. Also included are descriptions of the roles of law enforcement in schools with examples of many strategies used to make schools safer and more effective.

Guide 6: Instituting School-Based Links With Mental Health and Social Service Agencies, by David Osher and Sandra Keenan, discusses how schools can improve their capacity to serve all students by linking with mental health and social service agencies. Agency staff members can contribute to individual and schoolwide assessment, planning, implementation, and evaluation. Agency resources can enhance schools' capacity to provide universal, early, and intensive interventions. Links with agency resources can also align school and agency services.

Guide 7: Fostering School, Family, and Community Involvement, by Howard Adelman and Linda Taylor, provides an overview of the nature and scope of collaboration, explores barriers to effectively working together, and discusses the processes of establishing and sustaining the work. It also reviews the state of the art of collaboration around the country, the importance of data, and some issues related to sharing information.

Guide 8: Acquiring and Utilizing Resources To Enhance and Sustain a Safe Learning Environment, by Mary Grenz Jalloh and Kathleen Schmalz, provides practical information on a spectrum of resources that concerned individuals and organizations can use in the quest to create safe schools. It draws on published research and also includes interviews with experts working on school safety issues at the state and local levels. Major topics covered include:

- What are resources?
- What role do resources play in safe school planning?
- Identifying and accessing resources
- Appendix of online and print resources

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INTRODUCTION

Instituting links with schools and mental health and social service agencies is one of the essential components of safe school planning, as determined by the Northwest Regional Educational Laboratory (Pollack & Sundermann, 2001). All components are integral to the process of safe school planning, and can be addressed together through the six-step strategic process for designing a safe school. Throughout this guidebook, we will explore how one essential component of safe school planning—instituting links with mental health and social services—fits into this process. The steps to the strategic process for designing a safe school are:

1. **Developing school-community partnerships.** Section 1 considers the benefits of school-community collaboration and different ways to approach it. When collaborating with mental health and social service providers, it can be beneficial to seek connections with school-based and community providers in addition to the traditional providers hired by schools.

2. **Conducting a comprehensive needs assessment.** By gathering data about the needs and resources of a school community, the school is better able to set goals and priorities for improvement. Additionally, having gathered initial data in the needs assessment, the school will have an accurate baseline from which to measure progress. How to conduct a needs assessment will be discussed in greater detail in Section 2.

3. **Developing a comprehensive school plan.** Schools can use the data gathered in the needs assessment to set goals, along with measurable objectives. These goals and objectives should incorporate all essential components of safe school planning. Chapter 5 of *Safeguarding Our Children: An Action Guide* (Dwyer & Osher, 2000) provides detailed information about the logistics of how to use a schoolwide team to effectively create and implement a comprehensive plan. The schoolwide team responsible for creating a comprehensive school plan should include administrators, teachers, students, and staff, family, and community members. Section 1 details some of the benefits of collaborating with families and mental health/social service providers.

4. **Identifying strategies and implementing programs.** To implement the goals and objectives of the comprehensive school plan, it is important to choose programs that address your needs at all levels. Section 2 discusses the differences among prevention, early intervention, and intensive intervention programs, and why all three are necessary. Appendix A of *Safe, Supportive, and Successful Schools: Step by Step* (the implementation guide) contains program briefs of exemplary intervention programs. The programs listed were selected by a panel of experts as meeting the following six criteria:
   - The program has documented effectiveness and is based on sound theory
   - The program can be easily integrated with existing school practices
   - There are data to establish the effectiveness or ineffectiveness of the program with particular student groups
   - The data must indicate that the program has a positive impact on student achievement
   - Sufficient technical assistance or other resources are available to support the effective implementation of the program
   - Program components focus on promoting positive solutions to behavioral and emotional problems

5. Conducting evaluation. Measurable objectives should be part of the school's comprehensive plan, allowing for evaluation of progress at various stages. This can include evaluation of both the process and the outcomes of a program. All programs that are part of the comprehensive school plan should be evaluated.

6. Sharing outcomes and making adjustments. As you gather and evaluate data, and this information is shared with members of the school community, you will be able to assess whether the interventions you chose to implement have been successful in addressing the needs of your school. If your comprehensive school plan has not achieved its goals and objectives, you can refine the plan. Alternately, the needs of the school may have changed, in which case it is time to return to the first step in this process and conduct another needs assessment to determine the new needs of the school.

These six steps will help guide your school community from planning through implementation through continuous improvement.

Why Schools Need To Link With Mental Health and Social Service Agencies

Schools can improve their capacity to serve all students by linking with mental health and social service agencies. Agency staff can contribute to individual and schoolwide assessment, planning, implementation, and evaluation. Agency resources can enhance the schools' capacity to provide universal, early, and intensive interventions. Links with agency resources can also align school and agency services (e.g., universal after-school programs, early interventions for families whose circumstances place children at risk, and individualized mental health interventions for children with intense levels of need).

The *Report of the Surgeon General's Conference on Children's Mental Health* (U.S. Public Health Service, 2001) underscores the need to focus on mental health as a critical component of children's learning and general health. The report calls for creation of a community health system that balances health promotion, disease prevention, early detection, and universal access to health care. Specifically, the report recommends training for teachers and others who work directly with children to recognize early symptoms of emotional or behavioral problems for intervention. The report also calls for better coordination of services to end the fragmentation that spreads mental health services across many institutions.

There are many other reasons to link with mental health and social service agencies. Consider the following:

Funding. Both schools and agencies struggle with limited financial resources. Responsible, strategic use of limited resources requires collaboration. A well-planned and coordinated effort will better identify needs and deploy resources, resulting in more comprehensive, integrated, and cost-effective programs and services. Collaboration also would foster enhanced accountability for public dollars. There is a need to pool resources and coordinate service planning to address the urgent mental health needs of children, youth, and school personnel (National Association of State Mental Health Program Directors [NASMHPD], 2002).

While schools and agencies are concerned with the same children, they have access to different funding streams. By aligning their efforts they can leverage each other's resources. Sometimes this can be done by combining funds; at other times this can be done by braiding funds (where categorical funds do not lose their identity). At still other times, school and agency initiatives can just be coordinated to enhance the cost efficiencies of different investments.

Improving outcomes. Both schools and agencies are accountable for improved outcomes. Just as students' school experiences affect mental health outcomes, so the mental health supports provided to students can help improve academic outcomes. Collaboration can improve both sets of outcomes.

Location. Public schools provide a natural environment within which to offer all students, including students with emotional needs, the support they need. The use of evidence-based and best-practice clinical interventions—including psychotropic medications and a range of psychosocial treatments—have demonstrated effectiveness in improving treatment outcomes in school-based settings (Elliott, Hamburg, & Williams, 1998).

Locating services in schools can provide necessary support for all students while preventing restrictive placement for children with emotional and behavioral disorders. According to the values and principles for a system of care, principle three states that "children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate" (Burns & Goldman, 1999). Similarly, the Individuals With Disabilities Education Act mandates that students receive educational services in the least restrictive environment appropriate. (See Page 14 for a more detailed discussion of IDEA.) Strengthening school mental health resources can help schools and agencies achieve least restrictive interventions. This is particularly important because from one-third to one-half of all referrals to mental health agencies are for aggressive behaviors or conduct problems (Atkins et al., 1998), and because behavior problems contribute to school removal and often deprive students of learning opportunities.

Removing barriers. Expanding mental health services in schools can address a number of barriers that make it difficult for children and families to access appropriate mental health care. Inadequate insurance, lack of transportation, misinformation and stigma about mental health services, family management problems, a limited number of outpatient clinics, and long waiting lists are some of the obstacles children and families can face when seeking care (Weist, 1997). Thus, for most children, but especially for poor and minority youth, schools are the most readily available and easily accessible sites for the provision of a continuum of community-based mental health services (Tuma, 1989).

Staffing needs. Schools often cannot afford all the personnel necessary to support safe schools (including social workers, psychologists, and psychiatrists). Also, schools and other human services agencies face serious difficulties recruiting and retaining enough qualified and well-trained staff members, especially in rural areas (NASMHPD, 2002). It makes sense to share resources, expertise, and dollars.

Recent research has identified practices integral to the linkage between schools and community agencies. In a publication entitled *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Vol. III* (Woodruff et al., 1999), six practices integral to success regarding the use of personnel and service delivery systems emerged across the sites studied. These include:

- The use of clinicians or other student-support providers in the schools to work with students, their families, and all members of the school community, including teachers and administrators.
- The use of school-based and school-focused wraparound services to support learning and transition.
- The use of school-based case managers. Case managers help to determine needs; they help identify goals, resources, and activities; they link children and families to other services; they monitor services to ensure that they are delivered appropriately; and they advocate for change when necessary.
- The provision of schoolwide prevention and early intervention programs. Prevention helps those students with, or at risk of developing, emotional and behavioral problems to learn the skills and behaviors that help in following school rules and enjoying positive academic and social outcomes. Early intervention allows schools to provide students with the support and training they need to be more successful in managing their behavior.
- The creation of "centers" within the school to provide support to children and youth with emotional and behavioral needs and their families. Students in the centers interact with caring staff members who can help students and their families connect with the entire system of care to help in meeting their needs.
- The use of family liaisons or advocates to strengthen the role and empowerment of family members in their children's education and care. All the sites studied have harnessed the power that involving family members as equal partners brings to their comprehensive programs.

What This Guide Includes

This guidebook is intended to help improve a schools capacity to provide universal, early, and intensive interventions in order to serve all students by linking with mental health and social service agencies. It will cover the following topics:

- School–Community Collaboration
- Wraparound Care
- Three Level Approach To Preventing Violence
- Who's Who in Mental Health Services

SECTION 1
SCHOOL–COMMUNITY COLLABORATION

SHARED RESPONSIBILITY WITH OTHER RESOURCES IN YOUR COMMUNITY

Nine types of services for children and families should be considered when you begin to work on building collaborative relationships with other resources in your community. These are described in two monographs that address prevention and treatment in mental health and juvenile justice (Stroul & Friedman, 1996; Leone, Quinn, & Osher, 2002). The following nine dimensions attempt to address all potential areas of need of a child and family:

- Mental health services—a range of nonresidential and a range of residential services
- Social services—child protection services, financial assistance, home aid services, respite care, shelter services, foster care, and adoption
- Educational services—assessment and planning, special education, home-based instruction, residential schools, and alternative schools
- Health services—health education and prevention, screening and assessment, primary care, acute care, and long-term care
- Substance-abuse services—prevention, early intervention, assessment, outpatient services, day treatment, ambulatory detoxification, relapse prevention, residential detoxification, community residential treatment and recovery services, and inpatient hospitalization
- Vocational services—career education, vocational assessment, job survival skills training, vocational skills training, work experiences, job finding, placement and retention services, and supported employment
- Recreational services—youth-development activities, relationships with significant others, after-school programs, summer camps, and special recreational programs
- Juvenile justice—prevention, diversion, treatment, and after-care services
- Operational services—case management, family support, self-help groups, advocacy, transportation, and legal services

Communities will vary in regard to which agencies provide these services. In addition, a variety of agencies may provide some or all of each type of service. It is important to focus first on the service provided, not on the agency that provides it. This allows for greater collaboration among agencies, and individualization of services to the specific needs of a child and family. However, because agencies have different mandates, policies, regulations, and cultures, it is also important to acknowledge and address the differences among different agencies (Rappaport et al., 2002; Flaherty & Osher, in press).

The first steps that education and agencies must take to align policy with practice and enhance collaboration include identifying common values and goals; committing to family centeredness; designing integrated training; pursuing shared accountability; coordinating funding and budgeting; and creating flexibility that supports local initiatives (NASMHPD, 2002).

A second step to collaboration is providing for regular meetings to coordinate efforts. One community, for example, arranged for quarterly meetings with all community partners to coordinate the delivery of services. These meetings included school administrators, support personnel, local police, family representatives, mental health staff, clinicians, community-based therapists, juvenile court representatives, and child protective agents. The meetings served as a quality check to ensure that all agencies were working cooperatively, communicating the appropriate information, and utilizing services for the best results for children and families (Keenan, 1997). A similar model exists in the community-based systems of care. The communities establish a local coordinating council or board, which is composed of representatives of all the child-serving agencies and families. The council or board meets on a regular basis to set policy and oversee the development of a coordinated system of care that responds to the mental health needs of children and their families.

Policy Support for Collaboration Between and Among Schools and Agencies

While there are varying levels of state and local oversight, local school districts have a great deal of autonomy. As a result, school districts' inclusion and collaboration around mental health programs and services differ widely (NASMHPD, 2002). However, there is nothing in the law to prohibit including or collaborating with mental health and social service agencies. In fact there are many aspects of current laws that support this linkage and collaboration. Several major public laws since 1995 have added support to the movement to provide mental health services in schools. The Improving America's Schools Act and Goals 2000 mandated the development of a more comprehensive approach to meeting the needs of low-achieving students. In 1997, the IDEA Amendments were enacted, providing increased support for improvement grants through state education departments and for prevention and early-intervention programming. IDEA calls for functional behavioral assessments and behavioral-intervention supports for students with disabilities experiencing behavioral and disciplinary problems [34CFR300.520(b)(1)]. It also strongly promotes interagency agreements for the coordination and delivery of services from other public agencies that have responsibility for paying or providing needed services(34CFR300.142).

The No Child Left Behind Act of 2001 reauthorizes and amends the Elementary and Secondary Education Act of 1965. Subpart 14, titled Grants to Improve the Mental Health of Children, Section 5541, Grants for the Integration of Schools and Mental Health Systems, addresses student access to quality mental health care by developing innovative programs to link local school systems with the local mental health system (see sidebar).

No Child Left Behind Act of 2002, Subpart 14, Section 5541

© USE OF FUNDS. A state, local, or tribal agency that receives funds under this section shall use it for the following:

1. To enhance, improve, or develop collaborative efforts between school-based service systems and mental health service systems to provide, enhance, or improve prevention, diagnosis, and treatment of services to students.
2. To enhance the availability of crisis intervention services, appropriate referrals for students potentially in need of mental health services, and ongoing mental health services.
3. To provide training for the school personnel and mental health professionals who will participate in the program carried out under this section.
4. To provide technical assistance and consultation to school systems and mental health agencies and families participating in the program carried out under this section.
5. To provide linguistically appropriate and culturally competent services.
6. To evaluate the effectiveness of the program carried out under this section in increasing student access to quality mental health services, ….

Section 2 of this guide describes the specific expertise of mental health and social service agencies, and some of the challenges and benefits to collaboration.

SHARED RESPONSIBILITY WITH PARENTS

Treatment of children and youth with emotional disturbance is moving from a more provider-driven, yet family-focused care, to *family-driven planning and care.* Collaboration with families has been recognized as being central to improving the outcomes for students with emotional and behavioral disorders, according to the *National Agenda for Achieving Better Results for Children and Youth With Serious Emotional Disturbance* (U.S. Department of Education, 1994). The paradigm shift is far-reaching and can be explained as it applies to eight different facets of care. In each of the areas discussed below, a significant change is underway. For another view of family collaboration, see *Guide 7: Fostering School, Family, and Community Involvement.*

Who is viewed as the source of solutions? In the past, professionals—be they care providers, teachers, or administrators—were expected to be the "experts," and were charged with providing solutions and making decisions that related to the care of a child or family. As care becomes more family driven, we recognize the inherent expertise of a child and family members to know their own strengths. Families, as partners, are expected to share in the responsibility of finding solutions to the challenges faced by the child and family. Additionally, we recognize that when a child and family help to discover a solution, they are more likely to buy into the process.

What is the relationship between the child and family, and agency staff? The relationship between a child and family and a care provider is becoming more of a partnership. A child and family are no longer expected to blindly carry out the instructions of a provider. A relationship built on trust grows between the child and family and their team of providers, and can expand to have a broader impact than just the immediate child and family.

How are problems and needs defined? The way in which we look at a problem affects what we do to fix it. In the past, the focus has very much been on fixing distinct "problems" as they arise. A family-driven focus broadens the scope. We no longer look only at specific problems, but how to affect an entire system for good. We look more holistically at a child and family and attempt to improve the quality of that child and family's life. Additionally, school interventions do not focus only on intensive intervention programs created to address existing severe problems, but also encompass prevention programs and early intervention programs that serve a broader school audience.

What is the approach to assessment? Traditional assessment has focused on deficits, and often locates the problem within the child and/or family. Current approaches, while addressing needs, focus on strengths. Current approaches have an ecological component that looks at how environmental factors (e.g., what the teacher does, how the class is organized, how the school is organized) set the stage for or reinforce problem behavior.

What are expectations? By having low expectations, we are likely to experience modest successes at best. From this perspective, not getting any worse is considered a success. In contrast, family-driven care acknowledges that the status quo simply isn't good enough. Higher expectations provide greater challenge to improve.

What is the approach to planning? The shift that has occurred in planning means that family-driven care asks different questions than does provider-driven care. Provider-driven care asks the question, "How can the needs of this student be addressed within the context of the available services?" Family-driven care asks a much simpler question: "What do we need to do to address the issues this student faces?" Services become much more individualized and tailored to the specific needs of a given child and family.

How is access to services provided? Once we have created individualized plans that address unique needs, it is necessary to provide the resources to back up plans. That means providing comprehensive services at times and places that are convenient to the child and family being served. Provider-driven care forced the child and family to be accommodating to the resources and schedules of others. Students were more likely to be placed in more restrictive care settings, requiring them to be removed from their peers, families, and communities.

What are expected outcomes? When the scope of the "problem" is defined in a finite, specific fashion, the outcomes of an intervention are measured in a finite, specific way. Is the problem fixed? Is there relief from the symptoms? A family-driven approach to outcomes looks at the quality of life of the child and family and whether the desires of that child and family are being met. For example, is the child succeeding in school, academically (e.g., better grades, fewer disciplinary referrals, more academic engagement)?

In all areas of care, a family-driven approach means that the scope is going to be larger. As a result of this broader ecological perspective, more people bring their creative resources to the table, committed to implementing lasting, real solutions.

One example of an approach for providing services to children with serious emotional disturbance and their families that encompasses the above goals of collaboration with both community resources and families is called wraparound. This approach will be described in the following section.

What Is a System of Care?

A system of care is a coordinated network of agencies and providers that makes a full range of mental health and other necessary services available as needed by children with mental health problems and their families.

The core values and principles of systems of care are (Stroul & Friedman, 1986):

Core Values—systems of care are:
• Child centered, family focused, and family driven
• Community based
• Culturally competent and responsive

Principles—systems of care provide for:
• Service coordination or case management
• Prevention and early identification and intervention
• Smooth transitions among agencies, providers, and to the adult service system
• Human rights protection and advocacy
• Nondiscrimination in access to services
• Comprehensive array of services
• Individualized service planning
• Services in the least restrictive environment
• Family participation in ALL aspects of planning, service delivery, and evaluation
• Integrated services with coordinated planning across the child-serving systems

What Is Wraparound Care?

Wraparound is a process of providing care for children and families at the *individual level* and involves the implementation of a *community-level* collaboration of services and supports, often called a system of care.

Researchers have described the wraparound process as "a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes" (Woodruff et al., 1999). This definition can be expanded to encompass the following values associated with the wraparound process:

• **The wraparound process is community based.** Children deserve to grow up in their natural environment, among their families and peers. The wraparound team is challenged to find the strengths of the community in which a child and family exist and find ways in which the existing community can meet the needs of the child and family.

- **The wraparound process is individualized and based on strengths.** Services are created to meet the individual needs of a child and family; the child and family being served are not expected to conform to fit the available resources. For that reason, the wraparound process is not considered a specific intervention program. The way that the process is implemented is unique to the needs of each individual child and family. A strengths-based approach focuses on building the strengths of a child and family. The wraparound process does not dwell on problems, deficits, or diagnoses.

- **The wraparound process is culturally competent.** The wraparound process respects the unique culture of each family, and draws on the strengths provided by the culture of a family and the community in which the family exists.

- **The wraparound process is family driven.** The effect of a family-driven process is described above, and represents a huge paradigm shift from conventional, provider-driven services. Families should be full and active partners in all aspects of the wraparound process. The wraparound process gives the child and family voice, choice, and ownership of the process.

- **Wraparound is a team-based process.** The wraparound team includes the child, family, natural supports such as friends or clergy, members of different agencies serving the child and family, and community services. All these members are considered partners in the process. Individuals are invited to become part of a wraparound team because of their relationship with the child and family, and not because of their roles or titles. Because the wraparound process incorporates all agencies and resources that are providing services or have a stake in the welfare of a child and family, it is not just a school-based program. Historically, the wraparound process has been led by the mental health sector (Woodruff et al., 1999), but includes members of many other service agencies, such as child welfare, education, juvenile justice, substance abuse, and developmental disabilities. In order for wraparound to be successful, the agency players must have some agreements in place up front as to how the process will work and the parameters of their individual responsibilities. A case monitor should be assigned monitor the plan and progress of each child and family.

- **The wraparound process requires flexible funding.** Because the wraparound process involves creative ways to address the unique challenges of a child and family, it also must have access to both flexible funding and a flexible, creative approach to the services provided.

- **The wraparound process includes conventional and natural supports.** Natural supports are important and need to be incorporated as they are generally more enduring, less costly, and potentially more culturally relevant than conventional supports.

- **The wraparound process requires an unconditional commitment.** A "no eject, no reject" policy in a wraparound team means that as challenges arise and change throughout the process, the service plan is allowed to evolve to reflect changing needs, given the financial limitations of agencies involved. Elimination of services is not an option in the wraparound process.

- **The wraparound process requires the service/support plan be developed and implemented through an interagency, community–neighborhood collaborative process.** Resources from all parts of a community should be used in the development, implementation, and evaluation of a wraparound plan.

- **Documenting outcomes and ensuring quality services are important in the wraparound process.** The outcomes measured should be those that are deemed important by the wraparound team. Continual evaluation of outcomes allows changes to be made to the service plan as they become necessary.

The following is an example of how the wraparound process was used for a 12-year-old girl named Sara, living in a rural community in the Northeast.

First, there was a referral by a child-serving agency (the school). The family service coordinator contacted family members, and gathered from them a list of potential team members to invite to a planning meeting. This was based on agency involvement with the child and family (child protective services, a local women's resource center, school personnel, and the child's social worker), potential resources in the community (representative from YMCA or Big Sisters), and members that the family chose to invite (minister of the family church, an aunt). The initial meeting was scheduled in the child's neighborhood school in the early afternoon. This time worked for the parent, the school staff, agency personnel, and other invited participants.

Sara was then in the sixth grade at her neighborhood middle school. She was experiencing a great deal of difficulty with her academic work; she was absent from school two to three days each week; she had already repeated an earlier grade. Sara was diagnosed with depression and post-traumatic stress disorder (PTSD). She was under the supervision of the child protective services because of past abuse by her natural father, who was serving time in jail. The mother was working a part-time job and trying to find full-time employment. Sara had been working with a therapist in the community, but had to travel 12 miles each way to get the service. There was no public transportation in this rural area.

Strengths. The presenting strengths were Sara's willingness to participate in therapy and her desire for things to be better in her life; Sara's interest in riding horses some day; Sara's relationship with her mother; Sara's connection with her church community; Sara's mother, who was committed to the process and to Sara's well-being; and an aunt who was supportive of Sara and her mom. At the time, Sara was passing two of her classes at school even with all the absences. The school referral showed a willingness to partner and collaborate in service delivery for Sara and her mother. What's more, when Sara attended her therapy sessions on a consistent basis, she would stabilize, her family would stabilize, and outcomes would improve.

Needs. These included more consistent attendance at school and therapy sessions; improved academic performance in the two major subjects that posed challenges for Sara; her mother's need for a full-time job; the need for consistent transportation (mother's car needed repair); and Sara's need for physical activity and recreation.

The team met and discussed all the strengths and needs of Sara and her mother. Together, team members developed a plan that satisfied both Sara and her mother. The plan included:

- Flexible funds of $200 to repair the family vehicle so Sara's mother could use it to drive Sara to school, if she missed the bus, to her therapy sessions, and to search for a new job.
- The women's resource center would continue to work with Sara's mother to help her find a full-time job.
- The minister knew of a family in the church who had a small farm with a few horses. He said he would call and ask about the possibility for Sara to help a few afternoons a week on the farm, in exchange for riding lessons. He also would look for volunteers from the church who might be able to provide some tutoring.
- The school made a commitment to add after-school tutoring three days per week, until Sara's attendance was more stable and her grades improved. The school staff also made a commitment to maintain regular contact, on a weekly basis, with the therapist regarding Sara's attendance and performance at school.
- Big Sisters organization offered to accept an application from Sara and her mother for a big sister. The family service coordinator would assist the mother with the paperwork, and follow up with calls.
- The child and family team agreed to meet again in 12 weeks to check progress and make any additional arrangements that were needed.

SECTION 2
DEVELOPING PLANS FOR PROVIDING SCHOOLWIDE, EARLY INTERVENTION, AND INTENSIVE SERVICES

CONDUCTING A COMPREHENSIVE NEEDS ASSESSMENT

A needs assessment identifies areas for improvement, and provides baseline data from which to work. According to Osher, Dwyer, and Jackson (in press) a needs assessment should include three steps: identifying the problem and available resources, analyzing the problem, and identifying the solution. In the course of identifying problems and resources, a good place to start might be to evaluate the school on the 13 character-istics of a responsive school, outlined in *Early Warning, Timely Response: A Guide to Safe Schools* (Dwyer, Osher, & Warger, 1998). A responsive school:

- Focuses on academic achievement
- Involves families in meaningful ways
- Has effective links to the community
- Emphasizes and develops positive relationships among and between students and staff
- Discusses safety issues openly
- Treats all students with equal respect
- Has created ways for students to share their concerns
- Helps students feel safe expressing their feelings
- Has in place a system for referring children who are suspected of being abused or neglected
- Offers extended-day programs for children
- Promotes good citizenship and character and socially responsible behavior
- Identifies problems and assesses progress toward solutions
- Supports students in making transitions, including the transition to adult life and the workplace

There are many ways that a school can gather the necessary data to sufficiently identify and analyze existing problems. Data can come from existing information that the school already gathers, or from new information, gathered specifically as a part of the needs assessment. Information that a school already gathers can include information such as schoolwide test scores or statistics around referrals, suspensions, or expulsions for vio-lence. Additional school information can be gathered by interviewing various members of the school commu-nity, holding focus groups with members of the school community, or conducting a survey of members of the school community.

    In addition to collecting information about the school, you can get a broader perspective of the school community by gathering information about the community in which the school exists. Pertinent information might include demographics of the community as well as statistics related to violence, substance abuse, and so forth (Pollack & Sundermann, 2001).

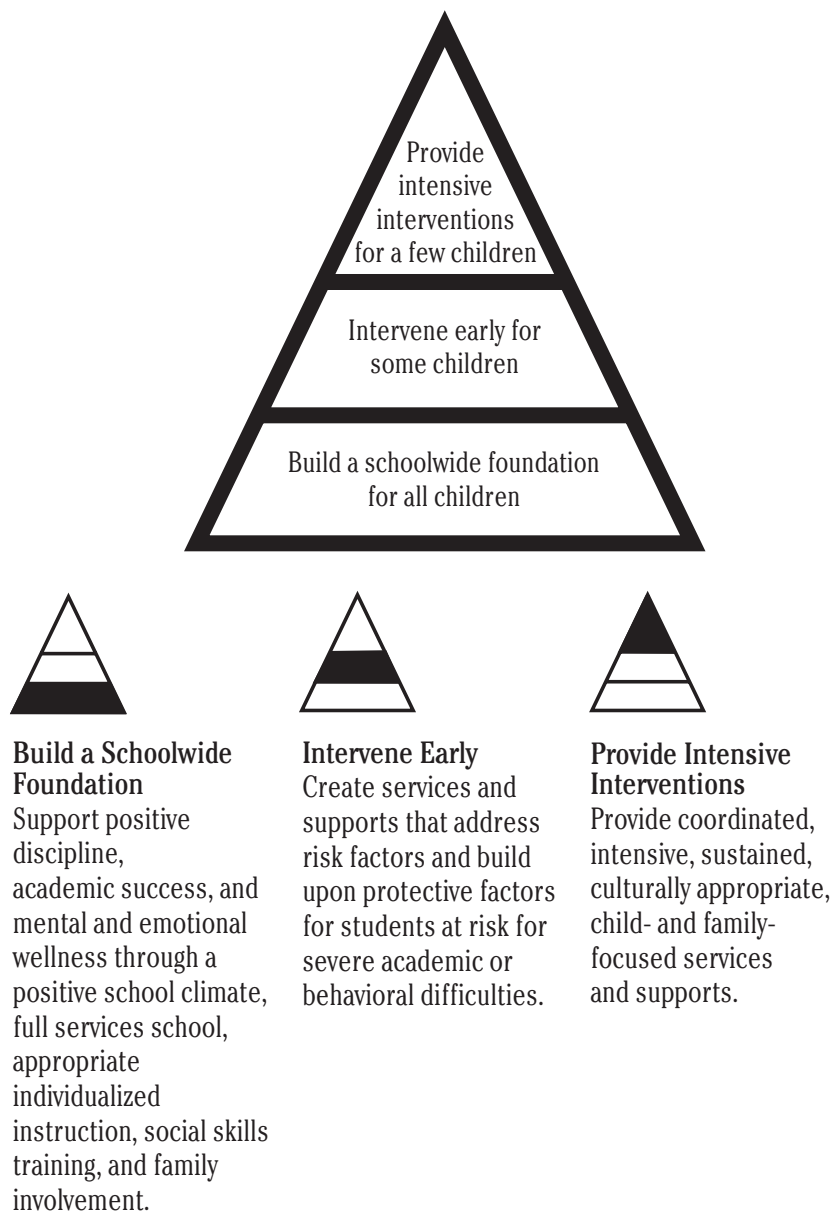## Developing a Comprehensive School Plan

The information gathered can be used to create a school–community profile that will provide information about the baseline status of the school and community. This information will be used as a schoolwide team moves forward in developing a comprehensive plan to address the needs of the school community. The school-wide team should include a broad array of perspectives, including students, teachers, school administration and staff, parents, and members of the larger community. Everyone who will be affected by the schoolwide plan should have a voice in its development. As explained in Dwyer and Osher (2000), the role of the school-wide team in developing a comprehensive school plan includes:

- Link to all school improvement efforts
- Align school efforts with community efforts and services
- Gain understanding and support from all members of the school community: students, teachers, staff, administrators, school board members, families, and other community members
- Include all three levels of prevention: a schoolwide foundation, early intervention, and intensive intervention
- Reflect an understanding of how to use early warning signs appropriately
- Include an efficient process for referral, problem solving, consultation, and intervention
- Employ effective evidence-based interventions that align with the school's structure, culture, needs, and resources
- Align with special education requirements and all other schoolwide efforts, such as extracurricular activities for English language learners

Identifying Strategies and Implementing Programs

As mentioned above, three major classes of intervention programs can be incorporated as part of a compre-hensive school plan. Each level of intervention is focused at a different audience and has different character-istics. A comprehensive program should incorporate prevention programs, early intervention programs, and intensive intervention programs. Dwyer and Osher's (2000) three-level approach to preventing violence is depicted as a triangle with three layers (see Figure 1). The bottom layer is prevention, which builds a school-wide foundation for all students; the middle layer is early intervention for some students; and the smallest, top layer is providing intensive interventions for a few students.

Figure 1: A Three-Level Approach To Preventing Violence

Provide intensive interventions for a few children

Intervene early for some children

Build a schoolwide foundation for all children

Build a Schoolwide Foundation
Support positive discipline, academic success, and mental and emotional wellness through a positive school climate, full services school, appropriate individualized instruction, social skills training, and family involvement.

Intervene Early
Create services and supports that address risk factors and build upon protective factors for students at risk for severe academic or behavioral difficulties.

Provide Intensive Interventions
Provide coordinated, intensive, sustained, culturally appropriate, child- and family-focused services and supports.

Prevention. It is important for programs included in the comprehensive plan to address the welfare of all students, and not only the relative few who express some need of intervention. A prevention program should be directed at the whole school community, and should include the following components:

- Compassionate, caring, respectful staff who model appropriate behaviors, create a climate of emotional support, and are committed to working with all students
- Developmentally appropriate programs for *all* children that teach and reinforce social and problem-solving skills
- Teachers and staff who are trained to support positive school and classroom behaviors
- Engaging curricula and effective teaching practices
- Child- and family-focused, culturally competent approaches
- Collaborative relationships with families, agencies, and community organizations

A prevention program should address any of the 13 characteristics of a safe and responsive school that were found to need improvement in the needs assessment. Examples of prevention activities include the posting of school rules and expectations, a buddy program for new students, substance abuse education, support for transitions, social skills curriculum integrated into major subject content, peer mediation, peer tutors, community volunteers, good communication with families and community agencies, and homework clubs. Communitywide prevention activities can include effective after-school programs and communitywide (as opposed to schoolwide) substance abuse prevention programs. Communitywide activities will be more effective if they align with and are linked to school activities. For example, is there a plan to help students who lack other transportation to help them get to appropriate after-school programs? Or, after they get to after-school programs, are they provided with support to help them do their homework?

The best current evidence indicates that the most effective and promising programs for deterring school violence are preventive and comprehensive, and involve parents, students, and the community. Experts have consistently recommended approaches such as violence prevention or social problem-solving curricula, improved behavior management, mentoring, and restorative justice that teach students alternatives to violence for solving personal and interpersonal problems (Skiba, 2001).

Examples of these approaches include a weekly social skills lesson co-taught in each fourth-grade class by the classroom teacher and the behavior specialist or school social worker; or community learning experiences, where students would be assigned a set numbers of hours of service in the community that would equal the number of hours of suspension that they would typically receive according to a school handbook policy. In many of these situations, the experience became a mentoring relationship between the student and an adult in the community setting, with very positive outcomes (Keenan, 1997).

Early intervention. An early intervention program should focus on providing services to the 10 to 15 percent of students who exhibit early warning signs of violence. As defined by Dwyer, Osher, and Warger (1998), the early warning signs are:

- Social withdrawal
- Excessive feelings of isolation or being alone
- Excessive feelings of rejection
- Being a victim of violence
- Feelings of being picked on and persecuted
- Low school interest and poor academic performance
- Expression of violence in writing and drawings
- Uncontrolled anger
- Patterns of impulsive and chronic hitting, intimidating, and bullying behavior
- History of discipline problems
- History of violent and aggressive behaviors
- Intolerance for differences and prejudicial attitudes

- Drug use and alcohol use
- Affiliation with gangs
- Inappropriate access to, possession of, and use of firearms
- Serious threats of violence (also an imminent warning sign)

It is important to note that teachers and staff need to be trained to recognize the early warning signs, and that training should include discussion of the five principles for using the early warning signs of violence:
- Do not harm
- Understand violence and aggression within a context
- Avoid stereotypes
- View warning signs within a developmental context
- Understand that children typically exhibit multiple warning signs

Again, the programs used to serve children exhibiting early warning signs should focus on the needs identified in the needs assessment, and outlined in the comprehensive school plan. Some examples of early intervention include small-group activities, support groups, behavioral support plans, behavioral support centers, after-school programs, and dropout reentry programs. Mentoring is an example of an effective community-based early intervention. Effective mentoring involves the appropriate training of mentors, the appropriate matching of mentors and mentorees, and the provision of support to ensure that the mentoring relationship perseveres and succeeds. Big Brothers Big Sisters is an example of a good implementation of mentoring (Mihalic, Irwin, Elliott, Fagan, & Hansen, 2001).

Sometimes, students exhibit imminent warning signs that require immediate attention, because the students may be a threat to themselves or others. In these situations, a threat assessment may be necessary. A threat assessment is a method by which appropriate authorities gather information and evaluate facts to determine whether a student poses a threat of violence to a target (see sidebar) (Fein et al., 2002).

Imminent warning signs include:
- Serious physical fighting with peers or family members
- Severe destruction of property
- Severe rage for seemingly minor reasons
- Detailed threats of lethal violence
- Possession and/or use of firearms and other weapons
- Other self-injurious behaviors or threats of suicide

The "planning centers" model was developed to provide support to children and families within the school. Such centers facilitate the early identification of, and interventions into, problems students are having; staff can then work with students to teach them coping and problem-solving skills to manage their difficulties. These centers also serve to prevent the escalation of inappropriate behaviors by addressing academic, emotional, or behavioral problems before they become crises (Woodruff et al., 1999).

Threat Assessment

The purpose of threat assessment is to prevent targeted violence. There are six principles that form the foundation of threat assessment:
- Targeted violence is the end result of an understandable, and oftentimes discernible, process of thinking and behavior.
- Targeted violence stems from an interaction among the individual, the situation, the setting, and the target.
- An investigative, skeptical, inquisitive mind set is critical to successful threat assessment.
- Effective threat assessment is based upon facts, rather than on characteristics or "traits."
- An "integrated systems approach" should guide threat assessment inquiries and investigations.
- The central question in a threat assessment inquiry or investigation is whether a student poses a threat, not whether the student has *made* a threat.
(Fein et al., 2002)

Intensive interventions. Intensive interventions are for the 3–10 percent of students with significant emotional and behavioral problems that cannot be fully addressed through an early intervention program. Intensive interventions should be individualized to a student and family, and often benefit from the wrap-around process described previously. Examples of intensive interventions include home-based services; respite care; individual, group, or family therapy; therapeutic foster care; crisis intervention; intensive after-school programs; in-school aides; after-school behavioral support; flexible school days; flexible programming (such as half-day in public school and half-day in day treatment program); and transportation aides. These interventions often benefit from links with community agencies that can provide trained staff, and, in some cases, access to additional funding streams, which can be leveraged to fund intensive interventions.

When choosing strategies and programs to include in a comprehensive school plan, it is important to make sure that the scope of the program you plan to implement matches the scope of your need. When choosing strategies and goals for the individual plans, it is important that clinical information and treatment goals include those related to academic and school-based outcomes as well. For additional information on creating schoolwide prevention strategies, see *Guide 1: Creating Schoolwide Prevention and Intervention Strategies.*

Types of Expertise Mental Health and Social Service Agencies Provide

Creating Comprehensive and Collaborative Systems is Target 7 for the *National Agenda for Improving Results for Children and Youth With Serious Emotional Disturbance* (U.S. Department of Education, 1994). Collaboration is often difficult because of the vast differences in organizational culture among agencies. By understanding these differences better, we are better able to forge relationships and collaborate. While there will be differences that are unique to a specific agency or organization, two of the major commonalities among mental health agencies that differ from schools are their focus on individual children and families, and their autonomy as organizations (Rappaport et al., 2002).

Mental health agencies are designed to serve individual children, not groups of children.
While schools are charged to educate all children, and typically group children by age and grade level, mental health agencies customize treatment plans to the individual needs of each child and family. Schools do individualize services, as a need becomes apparent, but when a seven-year-old is registered for classes, she is likely to be placed in a generic first-grade class. If the same seven-year-old is brought in for treatment at a mental health agency, an intake counselor will discuss the needs of the child and family, and will likely discuss multiple options for treatment with the family. The team will collaboratively decide the appropriate next step.

Mental health agencies are freestanding organizations. While individual schools are part of a much larger system, with influences and mandates at the local, city/county, state, and federal levels, most mental health organizations are much more autonomous. This autonomy allows some mental health agencies to specialize in a few types of services, while others offer a broader array of services. An agency may provide assessment and outpatient treatment, but not be equipped to provide crisis residential services. Schools offer a more comprehensive base level of services that must be provided for all students.

Additional differences in the culture of mental health agencies will depend on the specific type of agency with which you are dealing. Certainly, you will expect different climates in an agency primarily focused on prevention programs than in one that provides a therapeutic camp setting. In addition to the variation among mental health agencies, the cultural gaps widen when you consider the different backgrounds, training, and vocabulary used by other collaborative members of child-serving teams representing child welfare, juvenile justice, substance abuse, or primary care.

Who's Who in Mental Health Services

A number of job titles, training, and backgrounds are associated with the different individuals who may provide mental health services to children, either in a school setting or outside the school. Each plays a somewhat different role. Some schools and communities may not have access to the full array of these personnel and may expand the function of the professional (mental health) resources that are available in their school and community. The major categories of positions are described below.

School-hired psychologists provide a range of services to the students, families, and staff of a school. They are available to provide counseling, conduct psychological and educational assessments, and evaluate educational and treatment plans to address specific needs of individual students. At the schoolwide level, they participate in the development of prevention and early intervention plans, as well as intensive interventions with students and families who need more intense services. They are vital in the development of a crisis-intervention plan for the school and community.

School-based psychologists share many of the same responsibilities as school-hired psychologists, but differ from school-hired psychologists in that they provide contracted services that take place within the school. School-based psychologists are less likely to be at one school full time. They may split their time among multiple schools or between one or more schools and a private practice.

School-hired or school-based psychologists also can be used in providing staff development training to teachers and other staff members of a school, in which they facilitate members of the school community in recognizing students who may be exhibiting early warning signs or are otherwise in need of counseling.

School social workers support the school community through providing case management, making referrals for interventions, training staff members, and providing some counseling. School social workers often are involved in coordinating many services being provided for a child and family through a school. In a community-based system of care utilizing a wraparound model, the school social worker serves as a "systems liaison" and assists in facilitating communication among systems.

Child and adolescent psychiatrists have medical training. They are able to provide diagnostic evaluations, and suggest courses of treatment, for students with mental health issues. Usually, there are fewer child psychiatrists in an area than other mental health personnel. However, when they are available and incorporated into the student's team, they can expand the range of options available for the team and child. In some cases, the psychiatrist may be linked to a clinic that offers additional services for the family or more intensive services when needed for the child.

One school system established an agreement with an area psychiatric hospital. That agreement helped the school access supplementary mental health services. They secured the services of a psychiatrist as well as a clinical psychologist (a type of specialist who was not otherwise available to the school system) who worked for a satellite program of the hospital. They met with the psychiatrist on a routine basis to review progress of students within the program and any possible medication issues. The clinical psychologist also met with high school staff, students, and families as needed, and provided options that could be more or less restrictive, depending on what was needed for the child.

As a result of the agreement with the hospital, one option was a day treatment program, for full day or partial day, as well as inpatient or outpatient hospital-based services through the hospital. The staff within the school system program had access to a beeper for the clinician and his team. Treatment plans were coordinated with all stakeholders, and crisis-intervention plans were developed as well. This provided the opportunity to allow students to experience less restrictive options, because movement to more restrictive was already structured as part of their intervention plans.

Medication management and coordination is a critical component of the treatment program. Usually, the child has completed some initial assessment or evaluation, and the physician has made a decision to try a certain medication. The child would have a follow-up appointment usually within six to eight weeks, but sometimes 12 weeks. At this time, the physician would ask the child and family members how things were going, and if the child had had any problems taking the medication. There was no connection to the school, what was happening for six hours per day, or if the medication had affected the child's performance and success in that setting. This type of care and treatment, managed only in the clinic, did not allow for the most comprehensive assessment and measure of the impact of the medication.

However, the results can be very different within a school district that incorporates protocols for coordinated communication. When we established a school-based support service team, we realized how important medication management was for all children involved in the support program. For most of them, their success in school at home and in the community was directly tied to the decrease in symptoms or behaviors that were interfering with school attendance, work completion, and interactions with peers, teachers, and other adults. Therefore, it was imperative that information regarding those three areas was communicated on a regular basis to both the parent and the clinician. This is the best way to make informed decisions about maintaining, altering, or stopping the medication.

School guidance counselors, school adjustment counselors, substance abuse counselors, nurses, art therapists, and special education teachers are all involved in the delivery of some type of mental health services within the school. Their roles, and the degree of their involvement in support of individual students or groups, has a great deal to do with their abilities to balance their job descriptions with the actual functions they perform on a daily basis. Each of these positions may be providing mental health support; whether it is formal or informal depends on the planning and coordination of the system. Students seek out those people they feel they can trust, and who care about them. In many situations, this group of personnel fills that need. Many times the support they are providing is added onto a full load, because it has occurred by natural selection. It would be important when conducting a needs assessment to survey these providers as to the types of support and time involved for them.

CONCLUSION

Education policy focuses on the school's critical role in promoting mental wellness of all students and its role in promoting a healthful school climate and improving educational outcomes. Mental health policy stresses the importance of integrating child and youth development, and prevention and early intervention programs and services into the natural settings of children and youth, in addition to providing services and programs for children and adolescents with emotional disturbances. The emphasis on prevention and early intervention can enhance communitywide mental wellness and reduce costs by reducing the numbers who need the much more expensive interventions (NASMHPD, 2002). It seems a natural fit to blend the two policies and collaborate to improve the outcomes for children and families.

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RESOURCES

The SafetyZone

www.safetyzone.org

The SafetyZone, a project of the Northwest Regional Educational Laboratory's Comprehensive Center, Region X, provides technical assistance related to school safety and violence prevention. The center also provides information and a variety of resources, as it tracks the latest research about possible causes of violence and the best practices that foster resilient youth and promote safe and productive schools and communities.

> 101 S.W. Main St., Ste. 500
> Portland, OR 97204
> Phone: 1-800-268-2275 or (503) 275-0131
> Fax: (503) 275-0444
> E-mail: safeschools@nwrel.org

Northwest Regional Educational Laboratory (NWREL)

www.nwrel.org

NWREL is the parent organization of the SafetyZone, a project of the Northwest Regional Educational Laboratory's Comprehensive Center, Region X. It provides information about coordination and consolidation of federal educational programs and general school improvement to meet the needs of special populations of children and youth, particularly those programs operated in the Northwest region, through the U.S. Department of Education. The Web site has an extensive online library containing articles, publications, and multimedia resources. It also has a list of other agencies and advocacy groups that addresses issues pertaining to, among other things, school safety issues as well as alcohol and drug abuse.

> 101 S.W. Main St., Ste. 500
> Portland, OR 97204
> Phone: (503) 275-9500
> E-mail: info@nwrel.org

American Academy of Child and Adolescent Psychiatry (AACAP)

www.aacap.org

The AACAP, a 501(c)(3) nonprofit organization, was established in 1953. It is a membership-based organization, composed of more than 6,500 child and adolescent psychiatrists and other interested physicians. Its members actively research, evaluate, diagnose, and treat psychiatric disorders and pride themselves on giving direction to and responding quickly to new developments in addressing the health care needs of children and their families.

> 3615 Wisconsin Ave., N.W.
> Washington, DC 20016-3007
> Phone: (202) 966-7300
> Fax: (202) 966-2891

American Counseling Association (ACA)

www.counseling.org

The ACA is a nonprofit professional and educational organization that is dedicated to the growth and enhancement of the counseling profession. Founded in 1952, ACA is the world's largest association exclusively representing professional counselors in various practice settings.

    5999 Stevenson Ave.
    Alexandria, VA 22304
    Phone: 1-800-347-6647
    Fax: 1-800-473-2329
    TDD: (703) 823-6862

American Psychiatric Association

www.psych.org

The American Psychiatric Association is a medical specialty society recognized worldwide. Its 37,000 U.S. and international member physicians work together to ensure humane care and effective treatment for all persons with mental disorder, including mental retardation and substance-related disorders. It is the voice and conscience of modern psychiatry. Its vision is a society that has available, accessible, quality psychiatric diagnosis and treatment.

    1400 K St., N.W.
    Washington, DC 20005
    Phone: 1-888-357-7924
    Fax: (202) 682-6850
    E-mail: apa@psych.org

American Psychological Association (APA)

www.apa.org

Based in Washington, D.C., the APA is a scientific and professional organization that represents psychology in the United States. With more than 155,000 members, APA is the largest association of psychologists worldwide.

    750 First St., N.E.
    Washington, DC 20002-4242
    Phone: 1-800-374-2721

American School Counselor Association (ASCA)

www.schoolcounselor.org

The ASCA is a worldwide nonprofit organization based in Alexandria, Virginia. Founded in 1952, ASCA supports school counselors' efforts to help students focus on academic, personal/social, and career development so they not only achieve success in school but are prepared to lead fulfilling lives as responsible members of society. The association provides professional development, publications and other resources, research, and advocacy to more than 12,000 professional school counselors around the globe.

    801 N. Fairfax St., Ste. 310
    Alexandria, VA 22314
    Phone: (703) 683-ASCA

Center for Effective Collaboration and Practice
www.air.org/cecp
The Center for Effective Collaboration and Practice supports and promotes a reoriented national prepared-
ness to foster the development and the adjustment of children with or at risk of developing serious emotional
disturbance. To achieve that goal, the center is dedicated to a policy of collaboration at federal, state, and
local levels that contributes to and facilitates the production, exchange, and use of knowledge about effective
practices.

    1000 Thomas Jefferson St., N.W., Ste. 400
    Washington, DC 20007
    Phone: 1-888-457-1551
    TTY: (877) 334-3499
    Fax: (202) 944-5454
    E-mail: center@air.org

Center for School Mental Health Assistance (CSMHA)
http://csmha.umaryland.edu/csmha2001/main.php3
The 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. The center offers a forum
for training, the exchange of ideas, and the promotion of coordinated systems of care that provide a full con-
tinuum of services to enhance mental health, development, and learning in youth.

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    Fax: (410) 706-0984
    E-mail: csmha@psych.umaryland.edu

Council for Children With Behavioral Disorders (CCBD)
www.ccbd.net
The CCBD is a division of the International Council for Exceptional Children. The Division's primary purpose
is to promote the education and general welfare of children and youth with emotional/behavioral disorders.
CCBD encourages research, promotes professional growth, and supports those who serve children and youth
with behavioral disorders and emotional disturbance.

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Federation of Families for Children's Mental Health (FFCMH)
www.ffcmh.org
The FFCMH is a national parent-run organization focused on the needs of children and youth with emotional, behavioral, or mental disorders, and their families. The federation's mission is to provide leadership in the field of children's mental health and to address the unique needs of children and youth with emotional, behavioral, or mental disorders from birth through transition to adulthood.

   1101 King St., Ste. 420
   Alexandria, VA 22314
   Phone: (703) 684-7710
   Fax: (703) 836-1040
   E-mail: ffcmh@ffcmh.org

Judge Bazelon Center for Mental Health Law
www.bazelon.org
The Bazelon Center is a national legal-advocacy organization that pursues system-reform litigation and policy work for the civil rights and human dignity of all adults and children with mental disabilities. Bazelon publishes and disseminates advocacy materials and action alerts on Medicaid and managed behavioral healthcare, children's supplemental security income (SSI) program, fair housing, special education, and the Americans with Disabilities Act. At the Bazelon Center's Web site, there are lists of publications and excerpts from various resources, especially those on children and families.

   1101 15th St., N.W., Ste. 1212
   Washington, DC 20005
   Phone: (202) 467-5730
   Fax: (202) 223-0409

National Association of Psychiatric Treatment Centers for Children (NAPTCC)
NAPTCC's mission is to promote the availability and delivery of appropriate and relevant services to children and youth with, or at risk of, serious emotional or behavioral disturbances and their families.

   1025 Connecticut Ave., N.W., Ste. 1012
   Washington, DC 20036
   Phone: (202) 857-9735
   Fax: (202) 362-5145
   E-mail: naptcc@aol.com

National Association of School Psychologists (NASP)
National Mental Health and Education Center
www.naspcenter.org/index2.html
The mission of the NASP is to promote educationally and psychologically healthy environments for all children and youth by implementing research-based, effective programs that prevent problems, enhance independence, and promote optimal learning. This is accomplished through state-of-the-art research and training, advocacy, ongoing program evaluation, and caring professional service.

   4340 East West Hwy., Ste. 402
   Bethesda, MD 20814
   Phone: (301) 657-0270
   E-mail: nasp@naspweb.org

National Association of Social Workers (NASW)

www.naswdc.org

The NASW is the largest membership organization of professional social workers in the world, with more than 150,000 members. NASW works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies.

    750 First St., S.E., Ste. 700
    Washington, DC 20002-4241
    Phone: (202) 408-8600

National Association of State Directors of Special Education (NASDSE)

www.nasdse.org

NASDSE is dedicated to helping state agency staff carry out their mission of ensuring a quality education for students with disabilities. NASDSE provides support to states through training, technical assistance documents, research, policy development, and partnering with other organizations.

    1800 Diagonal Rd., Ste. 320
    Alexandria, VA 22314
    Phone: (703) 519-3800
    Fax: (703) 519-3808

The National Center on Education, Disability, and Juvenile Justice (EDJJ)

www.edjj.org

The EDJJ is a collaborative research, training, technical assistance, and dissemination program designed to develop more effective responses to the needs of youth with disabilities in the juvenile justice system or those at risk for involvement with the juvenile justice system.

    University of Maryland
    1224 Benjamin Bldg.
    College Park, MD 20742
    Phone: (301) 405-6462
    Fax: (301) 314-5757
    E-mail: edjj@umail.umd.edu

National Mental Health Association

www.nmha.org

Through its national office and more than 300 affiliates nationwide, the National Mental Health Association is dedicated to improving the mental health of all people and achieving victory over mental illness.

    Contact: Michael Faenza
    1021 Prince St.
    Alexandria, VA 22314-2971
    Phone: (703) 684-7722
    Fax: (703) 684-5968
    E-mail: nmhaprev@aol.com

National Technical Assistance Center for Children's Mental Health (NTAC)
www.georgetown.edu/research/gucdc/cassp.html
NTAC is part of the Georgetown University Child Development Center. Since 1984, NTAC has been serving as a national resource center for policy and technical assistance to improve service delivery and outcomes for children and adolescents with, or at risk of, serious emotional disturbance and their families.

    Georgetown University Child Development Center
    3307 M St., N.W., Ste. 401
    Washington, DC 20007-3935
    Phone: (202) 687-5000
    Fax: (202) 687-1954
    E-mail: gucdc@georgetown.edu

Oregon Social Learning Center (OSLC)
www.oslc.org
The OSLC is a nonprofit, independent research center located in Eugene, Oregon, dedicated to finding ways to help children and parents as they cope with the day-to-day problems that arise during life today. Since 1990, it has also served as a National Institute of Mental Health Prevention Research Center. Its research focuses primarily on factors related to the family, peer group, and school experience that contribute to healthy social adjustment in key settings, including the home, school, and community during childhood, and the workplace, intimate relationships, and parenting during adulthood. The center also works to identify factors that lead to problems at different stages of life, such as temper tantrums and misbehavior in childhood, delinquency and substance use in adolescence, and failed relationships in adulthood.

    Contact: John Reid
    207 E. 5th, Ste. 202
    Eugene, OR 97401
    Phone: (541) 485-2711
    Fax: (541) 485-7087
    E-mail: johnr@oslc.org

Research and Training Center for Children's Mental Health (RTC)
http://rtckids.fmhi.usf.edu
The mission of the RTC is to improve services for children and adolescents with serious emotional disabilities (SED) and their families by strengthening the knowledge base for effective services and systems of care. The center is seeking to achieve this mission through an integrated set of research, training, and dissemination activities.

    Department of Child and Family Studies
    Louis de la Parte Florida Mental Health Institute
    University of South Florida
    13301 Bruce B. Downs Blvd.
    Tampa, FL 33612-3807
    Phone: (813) 974-4661
    Fax: (813) 974-6257
    E-mail: kutash@fmhi.usf.edu

Research and Training Center on Family Support and Children's Mental Health
www.rtc.pdx.edu
The Research and Training Center on Family Support and Children's Mental Health was established in 1984 at Portland State University, Portland, Oregon with funding from the National Institute on Disability and Rehabilitation Research (NIDRR), U.S. Department of Education, and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. The center is dedicated to promoting effective community-based, culturally competent, family-centered services for families and their children who are or may be affected by mental, emotional, or behavioral disorders. This goal is accomplished through collaborative research partnerships with family members, service providers, policy-makers, and other concerned persons.

    P.O. Box 751
    Portland, OR 97207-0751
    Phone: (503) 725-4040
    Fax: (503) 725-4180
    E-mail: rtcinfo@rri.pdx.edu

School Social Work Association of America
www.sswaa.org
The School Social Work Association of America represents school social workers from across the nation. We are dedicated to promoting the professional development of school social workers in order to enhance the educational experiences of students and their families. We are striving to be a voice for our profession and those we serve in the national area.

    Contact: Randy A. Fisher
    P.O. Box 2072
    Northlake, IL 60164
    Phone: (847) 289-4527
    Fax: (630) 355-1919
    E-mail: sswwa@aol.com

Technical Assistance Center on Positive Behavioral Interventions and Supports (PBIS)
www.pbis.org
The PBIS has been established by the Office of Special Education Programs, U.S. Department of Education, to give schools capacity building information and technical assistance for identifying, adapting, and sustaining effective schoolwide disciplinary practices.

    Behavioral Research and Training
    5262 University of Oregon
    Eugene, OR 97403-5262
    Phone: (541) 346-2505
    Fax: (541) 346-5689
    E-mail: pbis@oregon.uoregon.edu

Technical Assistance Partnership for Child and Family Mental Health
www.air.org/tapartnership
The Technical Assistance Partnership for Child and Family Mental Health operates under a contract with the Federal Center for Mental Health Services to provide community-driven technical assistance to grant communities funded by the Comprehensive Community Mental Health Services for Children and Their Families Program. It is a partnership between the American Institutes for Research and the Federation of Families for Children's Mental Health. The partnership works in collaboration with program partners such as National Indian Child Welfare Association, Vanguard Communications, ORC Macro, and the Georgetown National Technical Assistance Center for Children's Mental Health, among others. Its goal is to support grant communities in their efforts to successfully develop and implement local systems of care. One of the most important features is that it models family–professional partnerships that are encouraged for local systems of care, with family members in key positions.

    1000 Thomas Jefferson St., N.W., Ste. 400
    Washington, DC 20007-3835
    Phone: (202) 342-5600
    Fax: (202) 342-5007
    E-mail: tapartnership@air.org

UCLA School Mental Health Project
http://smhp.psych.ucla.edu
The center's mission is to improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools, with specific attention to strategies that can counter fragmentation and enhance collaboration between school and community programs.

    University of California, Los Angeles
    Center for Mental Health in Schools
    405 Hilgard Ave.
    Los Angeles, CA 90095-1563
    Phone: (310) 825-1225
    Fax: (310) 206-8716
    E-mail: smhp@ucla.edu

Additional Readings

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ABOUT THE AUTHORS

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