IN DEFENSE OF OUR SCHOOLS

COOPERATIVE WORKING AGREEMENT
BETWEEN MENTAL HEALTH AND ACADEMIC FACILITY

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NARRATIVE:

School mental health services are vital to student success. Mental health is as important and directly impacts their learning and development. Children cannot learn effectively if they are struggling with a mental health problem, such as depression, or feel overwhelmed by academic, social, or family pressures. It is important to recognize that mental health is not simply the absence of mental illness; it also means having the skills necessary to cope with life’s challenges.

Students, families, schools, and society at large benefit when schools meet the needs of the whole child by fostering social-emotional skills and identifying and preventing mental health problems early.

These are the things discussed in the meeting to facilitate a working relationship between mental health and school districts.

- Create contracts for counselors to work in both of those environments addressing things like time spent at each location and who pays for the expenses.
- Facilitate information exchanges regarding needs of mental health individuals as well as potential threats.
- Create a close working partnership between schools and the mental health community to better serve the mental health needs of students.

The City of New York has started a School Based Mental Health Program in some schools and has resources already in use.

The Department of Education in New York City has partnered up with the Department of Health and Mental Hygiene. They have come up with several School Based Mental Health Programs.

This is how they describe a School Based Mental Health Program: A School-Based Mental Health Program (SBMH) is like a mental health office inside a school. SBMH offer a wide range of full, comprehensive mental health services in the school and have been providing on-site mental health services to Department of Education students for over 20 years. Attached is a brochure explaining what programs they provide.

Some of the programs include:

**On-Site Mental Health Programs** – offers individual treatment, groups, family counseling, and crisis interventions on school campus.
Mobile Response Team (MRT) Program – offers assessments, consultations, classroom observations, crisis interventions, professional development for teachers, parent trainings, and referrals for treatment in the community.

STARS (Screening the At-Risk Student) – implemented by nurses in middle schools. Offer suicide and depression screenings and referrals for further psychological assessments as needed.

Early Recognition and Screening Program - Community mental health providers offer screenings school-wide for underlining emotional and behavioral issues. With parental consent, student can be referred for further assessment and offered treatment if indicated.

The State of Illinois has put out a helpful packet called Guidelines for School-Community Partnerships: Addressing the Unmet Mental Health Needs of School Age Children. The Illinois State board of Education and the Illinois Children’s Mental Health Partnership worked together in coming up with the guidelines. Attached is the packet.

RESOURCES AND POTENTIAL COST NECESSARY FOR IMPLEMENTATION:

Minimal – Would need to coordinate details between organizations and work out contract details.

REFERENCES:

http://schools.nyc.gov/offices/health/sbhc/mentalhealth.htm
http://www.icmhp.org/icmhpproducts/gdlnsclcmnty.html

Cooperative Work Agreement between Mental Health and Academic Facility

SUBMITTED BY:

Working Group #11
Stacia Boden, General Counsel, Wright Business College

Additions and modifications made by:

Officer Heidi Johnston OPPD
Mental Health Interventions cont’d...

DOE Contract for School Based Mental Health Services:

- The New York City Department of Education (NYCDOE), on behalf of the Office of School Health, seeks to expand school-based mental health services, crisis intervention services and additional supplemental services to school age children (ages 5-18).

- This program allows schools to contract with existing/established Mental Health treatment and support centers in order to provide unmet needs in the school setting.

  How Schools Obtain Services

- Schools seeking treatment services will contract with a Mental Health Services Provider by providing an annual percentage estimate of children eligible through Medicaid and/or third party insurance reimbursements based on prior year of student population.

- Principals are responsible for providing a safe and secure space where students can receive clinical services.

- The New York State Office of Mental Health licenses any program operating on school site.

- Principals may also purchase supportive supplementary services to fit the needs of their schools in coordination with the implementation of clinical services such as:
  
  - Clinical Treatment Services: These include diagnostic, evaluative and therapeutic services. Individual and family therapy, psychiatric evaluations and crisis interventions are a few examples.

  - Supportive Supplementary Services: These services focus on the whole school through an assessment of the school environment.

A Menu of Services...

School Based Mental Health Programs:
216 Schools with on-site interventions

STARS:
- Nurses Screening The At-Risk Student program at select schools

MRT:
- Select Middle Schools have Mobile Response Team program

SBHC:
- 239 School-based health centers with mental health services

For a complete list of schools with School Based Mental Health Programs:
http://schools.nyc.gov/Offices/Health

For more information on these programs or on other Mental Health and Behavioral Services for schools please contact:

Scott Bloom, LCSW
Director of School Mental Health Services
Office of School Health
52 Chambers Street
Room 209
New York, NY 10007
212-374-6846
SBloom5@schools.nyc.gov
School Based Mental Health Programs

School-Based Mental Health Clinics (SBMHCs) provide on-site mental health services—including preventive and crisis interventions—to students throughout New York City. The SBMHC provide children experiencing, or at risk of developing, social/emotional difficulties with the mental health services they need and enables teachers to focus on teaching rather than behavior management. To receive mental health services through a SBMHC, students must have a signed consent form by their parents/guardians.

Individual student records are confidential, and information is not shared with school staff without parent review and consent.

School Based Mental Health Programs also...

- Provide additional services, including family therapy, case management, school consultations and parent workshops.

- Provide scheduled and walk-in services when school is in session and 24-hour telephone coverage to assist with out-of-school problems. Many are open during holiday periods and over the summer.

- Are operated by independent institutions, and the staff is not employed by the Department of Education. The New York State Office of Mental Health monitors the performance to assure that they are providing high quality care.

- Do not bill students or parents for care. Though Agencies may bill an insurance company, such as Medicaid, for the care provided.

STARS: Screening the At-Risk Student.

STARS aims at identifying and ensuring appropriate treatment for middle school students with depression who are at risk for suicide or other harmful behaviors.

Why Mental Health Services in Schools?

Outcomes for schools and students:

Studies report the following outcomes from School Mental Health Services:

- A significant decline in disciplinary referrals and police/court contacts

- Increased classroom attentiveness and decreased distractive behaviors

- Significantly less rebellious behavior, less victimization, increased positive peer associations

- Improved grades and fewer special education referrals

NYC Youth:

- It is estimated that there are 106,915 children age 9 to 17 with serious emotional disturbance in New York City.

- A total of 16,811 children under the age of 18 were served by a public mental health program.

- 200,000 NYC youth, ages 9-17 years old, are living with mental health or substance abuse disorders

- 61,762 children under the age of 18 were served in the public mental health care system in 2011.

Nation-wide Youth:

- 96% of individuals who were referred for school-based counseling followed through, compared only to 13% of individuals referred for community based treatment

- Only 16 percent of all children receive any mental health services. Of those receiving

Citations available by request

Mental Health Interventions:

The Mobile Response Team (MRT) serves a cluster of 5 schools, with the goal of helping them to better meet the mental health needs of their students. In response to school staff referrals, the MRT conducts assessments and links students to mental health and other social services. It provides outreach, training and consultation to build the capacity of school staff and families to recognize and respond to mental health problems; responds to crises and provides supports and interventions to students and school staff.
care, 70—80 percent receive that care in a school setting.
Illinois Children’s Mental Health Partnership

Guidelines for School-Community Partnerships
Addressing the Unmet Mental Health Needs of School Age Children

Barbara Shaw, Chair
School Age Committee

Maria McCabe and
Peter Tracy, Co-Chairs
Lasting educational success can only happen when a well woven net of services has been created to support the varied gamma of needs that our children present in the school setting. The Illinois State Board of Education values the leadership of the Illinois Children’s Mental Health Partnership in developing these “Guidelines for School-Community Partnerships”. It is thanks to these collaborative efforts that all benefit from the diversity of expertise and cultural backgrounds. These relationships bring innovative ways to serve our children and their families. Partners contribute toward common goals, and address unmet needs as gaps are identified, ensuring greater access to comprehensive and cohesive mental health support systems. The Illinois Board of Education relies on this collaborative support to bring alive its mission.

Beth Hanselman
Assistant Superintendent of Special Education and Support Services
Illinois State Board of Education
Appreciation is due to the many people who lent their expertise and dedication to development of the *Guidelines for School-Community Partnerships* (Guidelines). The Illinois Children’s Mental Health Partnership (ICMHP) has flourished for the past four years, guided by the astute leadership of Barbara Shaw as Chair. The ICMHP School Age Committee, under the direction of Maria McCabe and Peter Tracy as Co-Chairs, took on the task of writing the *Guidelines* with enthusiasm. They are to be commended for their dedication to this project. Rosario Pesce served as Chair of the School-Community Partnership Subcommittee and gave tirelessly of his time and school-based expertise to assure the success of this endeavor. Laura Hurwitz provided essential staff support to the work of the Subcommittee and created initial drafts of the *Guidelines*. Her hard work was fundamental to shepherding the *Guidelines* through various iterations. School Age Committee members reviewed and provided comments on drafts of the *Guidelines* that were well informed and grounded in the realities of day-to-day work in schools and community agencies. Karen Van Landeghem, ICMHP Associate Director, and Colette Lueck, Managing Director, provided critical input and essential revisions to the final drafts. Voices for Illinois Children, under the leadership of Gaylord Gieseke, provided crucial support to the ICMHP, including serving as its fiscal and physical home. The Center for Mental Health in Schools Program and Policy Analysis at the University of California Los Angeles and The Center for School Mental Health Analysis and Action at the University of Maryland both provided research and information that was invaluable throughout the process of crafting the *Guidelines*. Finally, the *Guidelines* document was designed by Steve Hartman, president, Creativille, Inc. (www.creativille.net)
## School Age Committee Members

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<thead>
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<th>Name</th>
<th>Organization/Institution</th>
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<tbody>
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<td>Gene Amberg</td>
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<td>Jennifer Axelrod***</td>
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<td>Debbie Bretag</td>
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<td>Ray Conner</td>
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<td>Melba Nicholson</td>
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* Co-Chairs, Illinois Children’s Mental Health Partnership School Age Committee
** Chair, Guidelines for School-Community Partnerships Subcommittee
*** Member, Guidelines for School-Community Partnerships Subcommittee
Research indicates that school mental health programs improve educational outcomes by decreasing absences, decreasing discipline referrals, and improving test scores. Citing this evidence, the President’s New Freedom Commission on Mental Health recommends that schools work collaboratively with families and mental health providers to develop, evaluate, and disseminate effective approaches for providing mental health services and supports to children and youth in schools along a critical continuum of care. Schools are in a key position to identify mental health problems early and to provide a link to appropriate services. Schools cannot, however, adequately address the mental health needs of school-age children absent community and mental health provider support and partnerships. Students all too often come to school bringing into the classroom all the issues we collectively face as a society—homelessness, cultural disconnects, poverty, community violence, and lack of appropriate child care and after school programming. At the same time schools are all too often under resourced, classrooms are over crowded and teachers lack support. While strong school mental health programs can attend to the health and behavioral concerns of students, reduce unnecessary distress, and help ensure academic achievement, meeting the mental health and social needs of school-age children is a shared responsibility.

Illinois became a nationwide leader in addressing the mental health needs of children and youth when it enacted the Children’s Mental Health Act of 2003, forming the Illinois Children’s Mental Health Partnership (ICMHP) and charging it with developing a statewide strategic plan to reform the Illinois children’s mental health system. In crafting the strategic plan, ICMHP identified key issues facing children, youth and their families, including challenges to access of services, and gaps in mental health programs and services for children. Through public forums across the state, the Partnership heard from parents, grandparents, advocates, teachers, doctors, childcare workers, school nurses, public health professionals, psychologists, psychiatrists, special education teachers, school social workers and counselors, child welfare workers and others. What was learned was striking and sobering:

- Many schools lack sufficient and appropriately trained staff to handle the numbers of students with mental health needs.
- There are not enough mental health providers available to meet the demand for mental health services, particularly in rural and other underserved areas.
- Families who have children with mental health needs must navigate multiple, complex and uncoordinated systems in order to obtain services.
- Opportunities are often missed for educating parents, other caregivers and educators about the impact of children’s social and emotional development on academic outcomes.

The Strategic Plan for Building a Comprehensive Children’s Mental Health System in Illinois, as developed by the ICMHP, is a roadmap, covering a range of recommendations and strategies necessary for reform. One key recommendation from the Plan is to “promote increased collaboration and partnerships among schools and school-based mental health, community mental health, juvenile justice, substance abuse, developmental disability, Early Intervention (Part C of IDEA), child care programs and systems, families/caregivers, and others to promote optimal social and emotional development in children and youth and access to appropriate services.”


2 Illinois Children’s Mental Health Partnership. (2005). Strategic Plan for Building a Comprehensive Mental Health System in Illinois (The Plan can be viewed in its entirety at www.IVPA.org)
diverse community agencies, including non-traditional organizations, was one identified strategy towards achievement of this recommendation. The Guidelines for School-Community Partnerships (Guidelines) is the result of a two-year long effort on the part of the ICMHP’s School Age Committee. The Guidelines document is intended to be an important resource for moving ahead the comprehensive, coordinated children’s mental health system comprised of prevention, early intervention and treatment programs and services for children ages birth to eighteen in normalized settings that the partnership envisions. Development of local and statewide cross system collaborations is crucial to this vision. With the goal of creating cross system shared ownership for the mental health and social and emotional development of school-age children, the Guidelines identifies key development steps to support a sustainable structure wherein all members share in the research, design, implementation and evaluation of efforts undertaken collectively to assure the academic success and mental health of school age children and youth.
GUIDELINES FOR SCHOOL-COMMUNITY PARTNERSHIPS
Addressing the Unmet Mental Health Needs of School-age Children

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A significant number of Illinois students experience difficulties in attaining the social, personal, educational and vocational skills needed to succeed in life. Approximately 9-13 percent of all children and youth face serious emotional or behavioral challenges. In schools serving low-income populations, the number of students with psychosocial problems is even greater.3 Prevention programming designed to develop social and emotional learning skills and mental health programming based on early identification and intervention can improve academic outcomes by decreasing school absences, decreasing discipline referrals, and enhancing student engagement with school and with learning.4

Key national and state statistics highlight the magnitude of the problem:

• One-quarter to one-third of young children are perceived as not being ready to succeed in school, with many affected by social and emotional issues.
• Nationally, over 20 percent of youth experience a diagnosable mental health problem.
• Nearly one-quarter of Illinois adolescents and one-third of Chicago adolescents reported signs of depression, for two or more weeks in a row, severe enough to keep them from doing usual activities.
• Suicide is the third leading cause of death for adolescents and young adults.

• Students ages 12 through 18 were victims of approximately 186,000 violent crimes in schools; nearly 500,000 witnessed violent crimes away from school.5

Despite these challenges, mental health promotion and early intervention efforts have been shown to reduce the impact of emotional problems for many students. Indeed, childhood is the best time to promote optimal social and emotional development and to mitigate the impact of mental health issues. Prevention programs and early intervention efforts can improve school readiness, health status, academic achievement, and reduce the need for grade retention, special education services, and welfare dependence. In fact, strong social skills, problem solving abilities, and conflict resolution skills are essential for all students if they are to maximize their academic potential.

Schools are Critical to Promoting Children’s Optimal Social and Emotional Development

Schools play a key role in promoting children’s social and emotional development and overall mental health and are a key access point for reaching school-age children for mental health promotion, early intervention, and treatment efforts. Increasingly, schools recognize that attention to social and emotional learning can assist in the achievement of their core mission by improving students’ development, readiness to learn, classroom behavior, and academic performance. In

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3 Freidman RM, Kutask K, and Duchnowski, AJ. (2002). Policy Leadership Cadre for Mental Health in Schools
fact, some educators are shifting traditional emphases on teaching the “three R’s”—reading, writing and arithmetic—to a new framework: rigor, relevance and relationships.6

Even though many educators recognize the importance of children’s mental health to school success, schools confront significant barriers to providing services to support the social and emotional development and mental health needs of students. Schools are under immense pressure to focus on external accountability and test scores. Additionally, existing financial and personnel resources are insufficient to provide the necessary array of supports to teachers, especially as they attempt to manage difficult student behaviors. Every school day, one thousand teachers leave the field. Among teachers who transfer schools, 53 percent cite problems with student behavior as a reason. The cost of replacing these teachers is $4.9 billion every year.7

Recognizing that the mental health needs facing many school-age children are complex and require multiple systems (e.g., schools, health care, mental health, social services) to collaborate and integrate efforts, schools are logical sites to initiate community collaborations. Effective school-community partnerships, particularly those between schools and community mental health agencies, can provide a range of mental health services, maximize and leverage scarce resources, secure additional resources, improve ratios of mental health/support staff to students, and help schools reach their goals for student achievement. Partnerships can also focus on supporting school staff, providing consultation to teachers, working to engage parents, or improving school climate by bringing additional resources and expertise to the collaboration.

Framework for Addressing the Mental Health Needs of School-Age Children

- **Prevention:**
  - Coordinated systems for promoting healthy social and emotional development in all children, including public education and awareness, social and emotional development programs and social skills education.
  - Environments and interventions that nurture and support the social and emotional well being of all students and promote positive child, youth and family development.

- **Early Intervention:**
  - Coordinated systems for early detection, identification and response to mental health needs, including consultation, student support services, short term interventions and supports, crisis supports and targeted skill building curricula.
  - Timely and targeted interventions and supports for students or groups of students with identified moderate needs or challenges, or at risk of needing more serious interventions.

- **Intensive Interventions and Supports:**
  - Coordinated systems of care providing comprehensive treatment and family supports for school-age children with the greatest level of need.
  - Coordinated and comprehensive supports for students and their families with serious challenges or at greater risk for serious emotional problems.8

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7 Alliance for Excellent Education. (August 2005). Issue Brief: Teacher Attrition: A Costly Loss to the Nation and to the States

8 Adapted from: Minnesota Children’s Mental Health Task Force, Minnesota Framework for a Coordinated System to Promote Mental Health In Minnesota; Center for Mental Health in Schools, Interconnected Systems for Meeting the Needs of all Youngsters; National Association of State Mental Health Program Directors and the Policymaker Partnerships for Implementing IDEA at the National Association of State Directors of Special Education Mental Health Project Work Group (2002). Mental Health, Schools, and Families Working Together for All Children and Youth: Toward a Shared Agenda
Effective School-Community Partnerships Can Maximize Efforts and Resources

Families, youth service organizations, community partners, mental health organizations and schools all share key goals and values. Each stakeholder wants safe and effective schools, homes and communities; students that are positively engaged with the community; parents that are knowledgeable about successful parenting practices; and teachers that are not frustrated by childhood behaviors that are unmanageable. Moreover, all stakeholders acknowledge the need to improve positive family participation and cultural responsiveness to families. Collaboration on mutual goals and agendas is a logical next step when many common values and goals already exist.9

Delivering social supports to students through school-community partnerships is not a new concept. Many schools have developed linkages and partnerships to deliver programs that address a range of mental health and psychosocial concerns. Indeed, almost half of all school districts use contracts or other formal agreements with community-based individuals and/or organizations to provide mental health services to students.10 Most efforts between schools and community mental health providers have tended to be either student or situation specific (e.g., a school crisis, a consultation addressing the behavior of a particular student, a group intervention to address an identified issue) with one party identifying the need, the appropriate intervention, and the desired outcome. These efforts are frequently person dependent and based on positive, trusting relationships that develop between personnel in key positions. When the causal situation is resolved or key personnel change positions, the collaborative effort is often not sustained.

As schools face increased demands to meet the comprehensive needs of children and families, sustainable and effective school-community partnerships with mental health, social services, and health systems are critical. School mental health programs, school-based health centers, after-school networks, community schools, and systems of care bring together families, schools, mental health and other community systems to develop an array of effective programs and services that can improve a school environment, promote achievement, reduce barriers to learning, and provide prevention, early intervention, and treatment services.11

Additionally, providing programs and services through a partnership creates organizational and systemic benefits. Partnerships can provide resources to enrich programs of all member institutions, garner public support for a school or community organization by raising the profile of an institution, reduce fragmentation and duplication of services, and build a sense of community trust that agencies and schools can work together to solve community-wide problems.

Partnerships are organic in nature, typically follow a development course, but always begin with relationships. Teachers, social workers, community mental health providers and/or parents find or create opportunities to work together, develop trust, share knowledge and gradually come to believe that their ability to solve problems is greater when they work together.

9 National Association of State Mental Health Program Directors and the Policymaker Partnerships for Implementing IDEA at the National Association of State Directors of Special Education Mental Health Project Work Group (2002). Mental Health, Schools, and Families Working Together for All Children and Youth: Toward a Shared Agenda


11 A system of care incorporates a "broad array of services an supports that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery and policy levels." (Pires 2002).
“Without the support of a community agency it would have been impossible to implement an evidence based practice in our school. The agency brought financial resources, expertise about the issues students faced in the community, and training for parents. Together we began to build an understanding in the community about why social and emotional learning was so important for students, and linked to their academic success and effective teaching. Based on the partnership that was established, we were able to apply for and receive a $20,000 grant, which went a long way to buying much needed materials for staff development. Our success served as a model for other schools in the district.”

Ruth Cross, Naperville School District

Shared Planning Among Schools, Families and Community Groups Can Improve Results and Outcomes

All successful partnerships are outcome-driven. Partnerships are not an end unto themselves but a process for delivering services, supports or interventions that strengthen schools, students, families and communities. For partnerships to survive, they must be able to demonstrate that they are an effective and necessary means to achieve positive outcomes for children and youth. Partnerships must identify shared outcomes and build upon common ground. Ownership over a common set of outcomes nurtures mutual responsibility. Academic success becomes not just a school responsibility but also the responsibility of service providers, families and the community at large.

Potential Benefits Of Collaboration Between Community Groups And Schools

**SCHOOLS**
- Improved student academic outcomes
- Improved student attendance and school engagement
- Training for educators on the identification of mental health issues
- Consultation for teachers on management of student behaviors
- Greater teacher job satisfaction
- Increased family and caregiver involvement
- A more supportive school climate and culture
- Improved compatibility and coordination between educational and mental health approaches
- Shared authority and accountability

**COMMUNITY AGENCIES**
- Reduced rate of failed/cancelled appointments
- Greater access to students in normalized settings
- Enhanced access for underserved populations
- Increased awareness of educational outcomes and the impact of mental health issues on school success
- Increased coordination and efficiencies
- Shared authority and accountability

**FAMILIES**
- Reduced mental health stigma
- Greater access to needed services and supports
- Reduction in cross system barriers
- Reduction in conflicting recommendations given to families by various stakeholders
- Increased school involvement by parents and caregivers
- Improved educational outcomes
- Improved readiness for learning
- Improved social and emotional functioning
- Enhanced parenting skills
What is a School-Community Partnership?

For the purpose of these Guidelines, a school-community partnership is defined as: any collaboration between a school and a community organization, public agency, business and/or other group that mutually agrees to jointly address the mental health needs of school-age children by providing a range of mental health services and supports that promote students’ academic, social, and emotional development and/or addresses a specific mental health need. In order to be effective and sustainable, school-community partnerships require an intentional commitment on behalf of all involved.

True partnerships involve more than simply working together. They are broader than a multidisciplinary or an interagency team, committee or work group. The hallmark of a partnership is a formal or informal agreement among participants to establish a process and structure for achieving goals that no one member can achieve independently. Partnerships typically take a development course, moving towards more formal structures and processes. They typically begin with relationships that are acknowledged for the mutual support provided to partners and evolve through trust and commitment. A second step often involves shared resources and the realization by stakeholders that leveraging each partner’s strengths maximizes the impact of the school as a community resource, while providing school staff and teachers increased support which enhances their effectiveness working on behalf of students. A fully developed partnership requires shared governance, including power, authority, decision making, accountability and blending of resources to pursue shared visions or goals. Stakeholders must find the partnership relevant to its organizational mission, and complementary to its structures and purpose. Partnerships can be challenging but are well worth the effort. Partnerships, while varying greatly in size and structure, are based on a set of core principles that are described below.

Common Principles of a School-Community Partnership

- Each member will respect the norms and cultures of all partnering members or organizations, and most particularly those of the “host” setting.
- Programs and services develop over time to become part of a comprehensive spectrum that includes prevention, early intervention and treatment.
- Programs and services address an identified school and/or student need.
- Programs and services are coordinated and integrated into the school environment and activities.
- The partnership is collaborative and a joint responsibility of all parties.
- When appropriate, programs and services are delivered in accordance with state and federal confidentiality laws [e.g., programs and services are provided with student and parental consent and involvement in accordance with existing Illinois and federal confidentiality, consent, reporting and privacy laws and policies, including the Family Educational Rights and Privacy Act (FERPA), the Mental Health and Developmental Disability Confidentiality Act, and the Health Insurance Portability and Accountability Act (HIPAA)].
- Programs and services are accessible (e.g., location is convenient, services affordable).
- Programs and services are culturally competent and family centered.
- Services build on the strengths of the students and families.
- The partnership incorporates accountability by: 1) utilizing best practices and established protocols, 2) establishing shared priorities and outcomes, and 3) establishing systems for monitoring and evaluation.
- The partnership includes mechanisms to establish ongoing and open communication.

12 Adelman HS and Taylor L. Addressing Barriers to Learning. Center for Mental Health in Schools Program Policy and Analysis at UCLA, Volume 12, Number2, Spring 2007.

Challenges to Collaboration Can be Overcome

While there are many benefits to school-community collaborations, numerous challenges also exist including lack of appropriate buy-in from school and community leadership, funding, and staff time. For instance, dedicated staff time to working on the collaborative effort is an essential resource for both schools and mental health agencies. Taking time from current responsibilities to assume the planning and organizational tasks necessary for a successful collaboration can be time intensive, but results in a greater return in staff investments evidenced by better outcomes for students, greater efficiencies for staff, and shared responsibilities.

Many school-community stakeholders might think that the most formidable challenge to establishing and sustaining school-community partnerships is adequate funding. However, developing a partnership need not be costly, particularly in the start-up phases of the partnership and when resources are shared between partnership members. Initial partnership costs are primarily related to staff time to attend meetings, meeting expenses, and development of the infrastructure (e.g., staff person to coordinate meetings) to support the Partnership. However, delivering services, supports or programming through the partnership requires adequate funding. Strategic use of limited resources demands a shared planning process to identify needs, deploy resources, and increase efficiencies, resulting in more comprehensive, integrated and cost-effective programs and services. While mental health funding has been targeted primarily towards persons with diagnosable mental illnesses, there is an increasing trend toward funding programs that foster social and emotional development as well as school and community collaboration. As a result, school-community partnerships that focus on the continuum of mental health services (i.e., prevention, early intervention and treatment) are funded through a wide range of sources.14

Finally, additional system barriers include different policies, procedures and cultures between schools and mental health agencies; diverse understandings of common mental health issues, causality, and effective treatments and services; dissimilar legal requirements and mandated populations; and dissimilar understandings of shared language (including the term “mental health”). These system barriers are often readily addressed and overcome once strong communication and decision making pathways are well established through the collaborative process.

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14 According to SAMHSA's School Mental Health Services in the United States, 2002–2003, the top sources of funding used by U.S. schools for mental health intervention services are: Individuals with Disabilities Education Act (63% of school districts); state special education funds (55%); local funds (49%); state general funds (41%); Medicaid (28%); and Title I of the Elementary and Secondary Education Act of 1965, Improving Academic Achievement of the Disadvantaged (20%). The top sources of funding for mental health prevention services are Title IV Safe and Drug-Free Schools and Communities (57%); local funds (43%) and state general funds (39%).
These *Guidelines* have been developed for schools, community mental health agencies, and other community-based organizations to encourage the creation of new partnerships, enhance existing partnerships that promote social and emotional development, and increase the availability and access of mental health services for school-age children. While there is no “one size fits all” approach to developing a partnership, the *Guidelines* are meant to serve as a flexible framework for partnerships in varying stages of development. Key steps and recommendations are intended to be fluid, circular rather than linear. For example, a new partnership may use the *Guidelines* to establish priorities, formalize a structure, and/or develop a formal working agreement. An existing partnership may use tools from these *Guidelines* to accelerate planning. A long-term partnership may use evaluation or strategic planning tools to improve quality or expand services. Finally, the *Guidelines* can provide information and resources for funders, policymakers, and other stakeholders to increase awareness about the importance and process of developing school-community partnerships.

Building a school-community partnership is an evolutionary process that involves the active participation and commitment of anywhere from two to multiple stakeholders including schools, community mental health agencies, social service providers, child welfare agencies, youth groups, parents, family support and advocacy organizations, substance abuse providers, primary care providers (e.g., pediatricians, family physicians), community groups, and others. The following steps can assist schools in building a structure to support and sustain a school-community partnership. Using these key steps, schools can build a strong foundation for a partnership that can achieve its goals yet remain flexible enough to adapt to the changing needs of school-age children, schools and communities.

**Conduct an Assessment of Existing Efforts**

Before launching into a formal partnership process it is essential that the stakeholders are invested in the idea of a partnership and that a school is motivated to take on the task of creating and sustaining a partnership. A range of stakeholders—a key visionary leader, a small group of personnel with a history of successful working relationships, a group of concerned parents, or a group of stakeholders as required by a funding opportunity—can initiate first steps towards development of a collaborative infrastructure. Initial meetings need to focus on the benefits for each potential partnership member. The organizing individual or group should be prepared with multiple strategies aimed at motivating and engaging potential partnership members. This might include surveying current efforts within the community to address the social and emotional or mental health needs of school-age children, particularly those efforts that occur as part of an existing collaborative structure.

The following are helpful to ensure a commitment to the partnership from all stakeholders:

- Survey or assess existing efforts in the community that focus on the mental health needs of school-age children.
- Document the need/rationale for the partnership.
- Initiate the idea of a partnership through networking. Personal interaction and face-to-face meetings are the most effective.
- Clearly outline and promote the benefits of the partnership to all parties using common language.
- Ensure buy-in from the principal as indicated by willingness to attend meetings or to assign a designee to the process and providing resources such as space.
- Identify potential community partners (e.g., community mental health agencies, mental health providers, primary care providers, community organizations).
- Involve all stakeholders in the decision-making process from the beginning.
- Develop a clear vision to encourage the commitment of individuals amenable to a partnership.
Develop a Collaborative Stakeholder Group

The stakeholder group is most easily established by initially engaging groups where relationships already exist. Collaboration can involve a single school, multiple schools or a school system together with community-based agencies or organization(s) and other groups. The structure can build on existing community collaborative groups [e.g., wellness councils, School Crisis Assistance Teams (SCAT), School Boards, and Local School Councils (LSCs), Local Area Networks (LANs)] as identified by the partnership assessment or newly developed by interested stakeholders.15

The composition of the stakeholder group is flexible based on the developmental phase or identified scope of the partnership, but ideally should be culturally diverse and include, for example, some of the following individuals and/or groups:

- Someone with decision making authority from partner institutions and groups
- Key players of partner institutions and groups
- Stakeholders from the community (e.g., community mental health agencies, mental health providers, primary care providers)
- Family members and their supportive cohort/community members
- Teachers
- School support staff
- Youth
- Faith-based organizations

Skills that contribute towards successful partnerships and promote flexibility among partners and open communication include:

- Ability and desire to contribute to a shared vision and commitment to collaboration
- Ability and desire to devote necessary time to collaboration
- Training, skills, institutional and collegial support
- Qualities of trust, motivation, competence, energy, dependability, and collegiality
- Ability to represent and report back to school or agency
- The ability to be flexible
- Willingness to communicate effectively with other partnership members and other key stakeholders, family members, or system representatives

15 School Crisis Assistance Teams are formed in collaboration with the Mental Health Association of Illinois, the Community Behavioral Healthcare Association and the Illinois State Board of Education to provide support during and after a violent incident or other traumatic event and assist in the training of local school teams.

Local Area Networks are local collaborations (a total of 64 covering the State of Illinois) that bring together stakeholders, including parents, to coordinate services for students with emotional or behavioral disorders, primarily using wraparound as a service delivery planning process.
Determine a Collaborative Structure and Leadership

One of the first tasks of any new partnership is to establish a leadership structure and assign key roles and responsibilities. The leadership structure may be developed according to available resources, existing leadership structures, and/or requirements of a funding source. Since programs and services are directed to school-age children, it is likely that the school will be the convener of the school-community partnership.

The following are some of the leadership functions helpful to establishing and maintaining an effective school-community partnership. Not all partnerships will initially require each of the functions described below, as partnerships evolve and develop over time.

• **Decision-maker/gate-keeper:** The decision-maker (e.g., Principal/designee and agency director/designee) makes key decisions (e.g., administrative, financial) about the school-community partnership and clarifies those recommendations needing final approval by the school and/or school system.

• **Convener:** The convener initially brings together the stakeholders and is someone highly invested in the process (e.g., member of school support staff, school based community agency staff) who has good relationships with all stakeholders.

• **Facilitator:** The facilitator sets meeting agendas, facilitates meetings, and handles communication between the school and agency. This may be the same person as a convener. The facilitator may change as the partnership evolves.

• **Site Administrative Leader:** The site administrative leader provides oversight of the structure and serves as the liaison to governance and administrative bodies (e.g., Local School Councils (LSC), School Boards, Board of Directors, Parent Groups, Community Groups).

• **Project Coordinator:** The project coordinator monitors implementation of any project the collaborative may undertake.

• **School and Community Staff:** Key opinion leaders, from the cadre of line staff involved in the school-community partnership, play vital roles in implementing, and monitoring the projects undertaken by the partnership. They often bring good problem solving skills to the process.
**Strategic Planning, Implementation and Oversight**

The partnership is responsible for developing its mission and goals, identifying resources, and establishing mechanisms to ensure that the goals are achieved. Planning is critical to the initial work of the partnership and is inextricably linked to its long term success. The needs of school-age students are real and often pressing, resulting in a temptation to move into an action phase quickly. However, if the partnership does not establish a clear plan and a working structure with clearly defined leadership roles and responsibilities, and member communication and accountability pathways, it risks succumbing to pressures once members face difficult decisions such as how to expend funds, or resolve conflicts. Based on the defined activities and scope of work, the partnership may need to break into subcommittees or teams (e.g., resource, program, evaluation). Please see the appendix for information on tools and resources related to key areas (e.g., conducting a needs assessment). Steps to plan and implement an effective partnership include:

1) Develop a clear mission.
   - Identify the needs of school-age students or the school through a review of existing data/information, teacher report, surveys or a needs assessment.
   - Examine the strengths and internal capacity of the school to meet those needs.
   - Ensure that the broad, overarching goals of the school-community partnership are consistent and complementary with the school’s strategic plan and the partners’ mission statements.

2) Develop a structure to coordinate and steer the process.
   - Anticipate barriers to success (e.g., limited time of educators to participate in meetings, proximity of community agency) and identify strategies to address those barriers.
   - Develop a clear partnership structure (e.g., quarterly meetings, retreats, list serves, conference calls).

3) Identify partnership plan priorities.
   - Based on a review of current needs, develop criteria for prioritizing the order in which needs will be addressed, utilizing conflict resolution and decision making strategies to ensure that multiple perspectives are represented and considered.
   - Develop an initial plan, including goals and objectives, roles and responsibilities, and outcome measures. Plans may be simple or complex, depending on the issue that is to be addressed.
   - Develop costs including staff resources, space, materials, etc.
   - Build a budget that might include contributions from each partner, in-kind match, grant dollars, etc.
   - Identify, develop, and secure adequate resources (e.g., time, space, materials, equipment) to support the plan, with attention to the strengths and resources that stakeholders bring to the partnership.
4) Monitor ongoing process.
   • Review outcomes.
   • Modify goals, objectives and strategies based on
     evaluation data and/or feedback.

5) For those partnerships that provide a specific service
   and/or program (e.g., community mental health agency that
   will provide services or take referrals), develop the terms of a
tailored working agreement that includes but is not limited
   to the following components. (A sample working
   agreement is included in appendix A).
   • Expectations of both parties, using common lan-
     guage between schools and community organi-
     zations and agencies.
   • Clearly defined roles and responsibilities.
   • Realistic timelines to accomplish goals.
   • Policies to protect confidentiality in congruence
     with all state and federal laws and mandates (e.g.,
     Mental Health and Developmental Disabilities
     Confidentiality Act, HIPPA and FERPA).

Nurture Collaboration

In order to sustain the partnership, it is critical that
the stakeholder group is maintained and enhanced
as necessary. The following steps will increase the
probability that the partnership will exist long-term,
become established on a large-scale, and/or become
institutionalized.

   • Provide the opportunity for continuous, personalized
     guidance and support to key staff.
   • Revisit strategic plan and revise as necessary.
   • Identify opportunities for ongoing staff development,
     continuing education, and cross-training for
     stakeholders (e.g., Regional Offices of Education
     (ROE’s), Institute Days).
   • Connect the partnership to current initiatives [e.g.,
     Social and Emotional Learning (SEL) Standards,
     Positive Behavioral Interventions and Supports
     (PBIS), System of Care, No Child Left behind
     (NCLB)].

   • Monitor any proposed policy or legislative changes
     at the state or federal level for potential impact on
     efforts.
   • Address absences and vacancies of members prompt-
     ly and make an effort to orient and engage all new
     members.

Schools are located in communities but often are iso-
lated from those communities. Families live in neigh-
borhoods, but often are isolated from each other. Com-
munities, schools, and families want similar outcomes
for children and youth—school readiness, academic
success, well developed social skills, employment or
advanced education readiness, and strong connections
to adults and communities – yet often there is no ven-
ue for coordinating efforts to meet these mutual goals.
Interrelated solutions and supports are more effective
and more efficient, but require collaboration.

For schools, successful collaborations can translate
into enhanced academic performance, fewer disci-
pline problems, reduced drop out rates, higher staff
morale and improved use of resources. For families
and community groups, collaborations with schools
and with each other can enhance parenting skills and
opportunities for socialization, enhance access to
mental health services and supports, and strengthen
the fabric of family and community life.16 Well es-

tablished collaborative relationships bring more re-
sources to bear to the complex issues that students
present in schools and to teachers. They also can cre-
ate stronger sense of community commitment to the
successful academic and social outcomes or achieve-
ments for all students. Partnerships are a process that
evolves over time, strengthened by the commitment
of the stakeholders to the belief that they can achieve
more together than they can alone, and that educating
students is everyone’s responsibility.

16 Adelman HS and Taylor L. Addressing Barriers to Learning.
   Center for Mental Health in Schools Program Policy and Analysis
   at UCLA, Volume 12, Number2, Spring 2007.
Recommended Working Agreement Components

A working agreement is a mechanism that formalizes the school-community partnership process, particularly for partnerships between schools and community mental health agencies and/or other mental health providers or community groups. By developing a working agreement, both parties are held accountable to agreed upon expectations. It is recommended that a working agreement should be collaboratively developed between the two or more parties once expectations for services are negotiated and agreed upon by the collaborative stakeholder group. The working agreement is not a “one size fits all” and should be tailored to address the shared priorities and outcomes of the partnership. Once an agreement is developed, it should be reviewed by an attorney. The agreement should be reviewed and revised on a periodic basis to meet the changing needs of the students, school and community agency.

Key Elements Of A Working Agreement:

- Statement of need/purpose of agreement
- Names, titles, contact information of both parties
- Relationship between parties
  ~ School/contractor, not employer/employee
  ~ No subcontracting
- Expectations of both parties
  ~ Description of services
  ~ Term of contract
  ~ Timelines
  ~ Use of relevant protocols (e.g. referral, crisis, treatment)
- Roles of all parties
- Communication and coordination
  ~ Participation in meetings
  ~ Consultation
  ~ Dispute resolution
  ~ Clearly defined communication pathways between all members
- Confidentiality (HIPAA, FERPA, Mental Health and Developmental Disabilities Confidentiality Act)
- Guardian and student consent
  ~ Written consent for services
  ~ Written release of information and/or disclosure of records
- Monitoring and evaluation
  ~ Consumer satisfaction
- Signature and date of both parties

Appendix A. Sample Working Agreement
The following are ADDITIONAL ELEMENTS that you may want to consider making part of an agreement:

• Target Population
  ~ General population, grade, classroom, high risk students
  ~ Geographic boundaries/Jurisdiction

• Environment
  ~ Location of services
  ~ Designation and maintenance of adequate space
  ~ Utilities
  ~ Hours of access; arrangements for continuity of care over summer, school holidays, etc.

• Referral Process
  ~ Who can refer
  ~ To whom do they refer
  ~ How do they refer (phone/written)
  ~ When do they refer – for what reasons
  ~ Communications and feedback regarding referral

• Record keeping/documentation
  ~ Where files are maintained
  ~ How files are accessed and shared
  ~ Data management
  ~ Reporting

• Qualifications of project staff and school personnel
  ~ Professional licensure and certification
  ~ Criminal background check
  ~ Child Abuse and Neglect Tracking Systems (CANTS)
  ~ Liability
  ~ Professional, malpractice, worker’s compensation and bonding
  ~ Indemnification – hold party harmless of liability, loss, damage, cost or expenses

• Nondiscrimination - compliance with ADA

• Compliance with laws

• Payment, costs and billing mechanisms
  ~ Billing Medicaid, third party payers
  ~ Submission of invoices
  ~ Responsibility of payment of taxes

• Termination clause, waiver, or breach of contract
Sample Working Agreement

PARTNERSHIP BETWEEN _______________ SCHOOL AND _______________ COMMUNITY AGENCY FOR PROVISION OF MENTAL HEALTH/SUBSTANCE USE SERVICES

The language below is intended to be as comprehensive as possible. Language should be tailored to the needs and requirements of each institution. It is not necessary to include all the sections below.

1. MISSION

The mission of this School-Community Partnership is to create a safe and supportive environment for students at ____________ School. This mission supports the mission of the school to create an environment of lifelong learners who achieve their maximum potential to participate and contribute to a democratic society.

2. STATEMENT OF NEED/PURPOSE OF AGREEMENT

In response to _________________________________________________________________________________ ____________________________________________________________________________________________, the ______________ School, with the help of its Collaborative Stakeholder Group, conducted a needs assessment of its students. The results of this assessment indicated a high number of students reporting signs of mental health/substance use problems, substance abuse and exposure to violence. In tandem with the needs assessment, the Collaborative Stakeholder Group conducted an asset mapping survey to assess what services and supports are available to the students in their school environment. The results of this survey indicated an insufficient number of staff to address students presenting with mental health problems as well as a lack of information and inadequate knowledge about how to intervene with the reported problems. In response to the high degree of mental health needs of students and staff limitations in addressing those needs, the ______________ School and the __________ Community Agency have cooperatively designed a program that provides prevention, early intervention and treatment services to the students of the ______________ School.

During a 2-year period, objectives, which must be measurable are:

1) Increase students’ and staff knowledge of social and emotional development, mental health and substance use.

2) Decrease reported incidents of violence, substance abuse, suspensions, and absences.

3) Increase number of mental health referrals made by school personnel.

4) Increase percentage of students accessing and receiving mental health/substance use services.

3. RELATIONSHIP BETWEEN PARTIES

THIS AGREEMENT is made as of this ___ day of _____, 200_ by and between the _______________ School hereinafter referred to as the “School,” and the _______________ Agency, hereinafter referred to as “Consultant.” The term of the contract will be effective _______ and reviewed yearly. At any time, the School or Consultant may terminate this contract with a 30 days prior written notice without incurring any liability.

The School and Consultant acknowledge that for the purposes of services rendered pursuant to this Contract that the Consultant is an independent contractor and neither the Consultant nor any of the Consultant’s employees is an employee of the School. Consultant must give full personal attention to the faithful execution of this Agreement. Consultant shall not subcontract or assign any part of the Agreement without written consent of the School.
4. CONTACT INFORMATION OF BOTH PARTIES

All written notices and communications concerning this Agreement should be sent by the School to the Consultant and shall be addressed to: ____________________________________________________________
(Include name, title, and mailing address)

All written notices and communications concerning this Agreement should be sent by the Consultant to the School and shall be addressed to: ____________________________________________________________
(Include name, title, and mailing address)

5. EXPECTATIONS OF BOTH PARTIES

Description of Services

In support of our mission to create a safe and supportive environment for students at the ______________ School, we agree to support the School-Community Partnership in the following ways:

The School will:

• Maintain continued membership and active participation in the School-Community Partnership.
• Provide administration and fiscal oversight for the project.
• Be responsible for hiring the Project Coordinator and monitoring the entire project.
• Provide facility space for contracted providers for the delivery of program services and activities.
• Promote program services and activities in the community.
• Maintain ongoing, consistent communication between the School and Consultant.
• Provide data necessary for evaluation of this proposal to the local evaluator(s).
• Follow established protocols for referral, crisis and treatment protocols that specify procedures for: a) Who refers, b) How and to whom to refer (phone/written), c) When to refer, for what reasons, d) What action is taken with the referral, e) How are communications and feedback handled regarding referral

The Consultant will:

• Maintain continued membership and active participation in the School-Community Partnership.
• Assure the provision of consultation, education, screening, assessing, referring, treatment and coordination of services for youth in need of mental health services (on-site and off-site).
• Collaborate with the School and other project partners to ensure the linkage and delivery of services that respond to the family’s needs. (Includes, but is not limited to: social services, mental and physical health assessment, and mental health services).
• In compliance with mental health confidentiality law and HIPAA regulations, provide data necessary for evaluation of this proposal to the local evaluator(s).
• Follow established referral, crisis and treatment protocols that specify procedures for: a) Who refers, b) How and to whom to refer (phone/written), c) When to refer, for what reasons, d) What action is taken with the referral, e) How communications and feedback are handled regarding referral.
• Collaborate with school to tailor classroom observation, skill training, school wide interventions and prevention activities (e.g. social and emotional development, educational information about risk and protective factors for mental health, substance abuse and violence prevention.).

**Expected Outcomes:**

• Consultant will provide ____ FTE in the school.

• Consultant will provide a minimum of ____consultations to school staff on mental health, substance use, and social and emotional development.

• Consultant will serve at a minimum of ____students.

• Absentee rate will decrease by ____ percent.

• Suspension rate will decrease by ____ percent.

• Reported incidents of violence will decrease by ____ percent.

• Reported incidents of substance abuse will decrease by ____ percent.

**6. COMMUNICATION AND COORDINATION**

The Project Coordinator for the SCP will be responsible for coordinating communication and information sharing among participating partners. Methods for sharing information will include quarterly meetings of the Collaborative Stakeholder Group, written status reports, and monthly meetings between the Project Coordinator and the Principal or Principal’s designee.

**7. CONFIDENTIALITY**

The Contractor agrees that any information obtained concerning persons served by the agency will remain confidential. The Contractor agrees not to disclose any information concerning said persons without written authorization from said persons, and only for purposes directly connected with the administration of the program and services, or as may be required by State or Federal law:

- HIPAA
- FERPA
- Mental Health and Developmental Disabilities Confidentiality Act
- Mandated abuse and neglect reporting

**Written release of information and/or disclosure of records.** Contractor shall request authorization in writing from the minor and their parent or guardian to release any information to the school, including assessment, treatment planning, and discharge summary.
8. MONITORING AND EVALUATION

The Collaborative Stakeholder Group will evaluate the implementation of the Agreement annually. The School and Consultant will develop criteria based on expected outcomes to evaluate the implementation of the Agreement using existing review data and monitoring procedures of each agency.

ACTIVITIES MAY INCLUDE:

1. **Training and Technical Assistance.** The Collaborative Stakeholder Group will assess training and technical assistance needs related to collaboration and service coordination for the target population. During quarterly meeting of designated agencies, training and technical assistance needs will be discussed and strategies for collaborative support and assistance will be developed.

2. **Performance Evaluation.** The School or Collaborative Stakeholder Group may conduct an evaluation for the Consultant’s performance under this Agreement. Consultant shall fully cooperate with the School and shall provide such information and documents as may be requested to conduct the performance evaluation.

3. **Quality Management.** The School and Consultant must follow the procedures set in place by the Collaborative Stakeholder Group to resolve disputes between agency and school staff.

4. **Consumer Rights.** Each student must be treated with dignity and afforded full rights as an individual to make decisions and participate in treatment planning. There shall be a written complaint/grievance process, visible to students, through which a student may appeal a dispute with the Agency.

9. **TARGET POPULATION**

The program will target high school-age children who attend the Illinois School District #00 with three levels of interventions:

1. **General Education Population** – Students who would benefit from participating in programs that promote social and emotional learning.

2. **High Risk Students** – Students who have been identified by teachers or support staff as displaying behavioral and/or emotional problems and need to be assessed for possible services.

3. **Students experiencing mental health problems** – Students who have experienced a mental health crisis and/or history of mental illness who require short term diagnostic and treatment services.

10. **ENVIRONMENT**

Services will be provided in the school building. The school is expected to provide the Agency with a mailbox, a workspace that permits confidential interviews and access to a phone for confidential calls. The workspace will be made available to the agency during on ____ (day of week) during the hours of _____. When school is closed for vacation or holidays, the agency can access the space by submitting a written request to __________. The school and school’s respective custodial contractor will clean and maintain the space with the baseline regulations established for the entire building.
11. RECORD KEEPING/DOCUMENTATION

**Records.** The Consultant will keep working files for each student in a locked cabinet in the designated office, which can also be locked. As cases are closed, files will be transported to the Agency and kept in a secure space. Policies regarding access and maintenance of records, including electronic records, will be developed and followed by the partnership.

**Reporting.** On a quarterly basis, the Consultant agrees to submit documentation identifying the number of students referred, the number of assessments made, and the number of students receiving services. A summary of program activities for the school year will be submitted annually by ____ (date), and will include: demographic information on each child receiving services, a summary of the activities of the Consultant, and a summary of evaluations completed by the school principal and members of the Collaborative Stakeholder Group.

12. ROLES AND QUALIFICATIONS OF STAFF

**Professional Licensure and Certification.** In the event that the services to be provided by the Consultant must by law be provided by individuals who are licensed and/or certified, the Consultant shall only assign individuals to provide services under this Agreement who are licensed, certified, and/or credentialed in accordance with the law. All such individuals assigned by the Consultant to provide services shall maintain their license and/or certification in good standing during the term of this Agreement. Consultant shall, prior to providing services, submit documentation that the individuals assigned to provide services are properly credentialed and are licensed and/or certified to: ______________________.

**Criminal Background Check.** It is the responsibility of the Consultant to make certain that its employees, agents, volunteers and contractors who may have contact with students are in compliance with the School Code of Illinois.

13. INSURANCE

The Consultant shall maintain current insurance coverage for itself and each staff who provides services pursuant to the Agreement in an amount satisfactory to the School. Such coverage shall include professional liability, malpractice, worker’s compensation and bonding. Before any services are provided hereunder and upon execution of this Agreement, contractor shall furnish the school certificates for coverage.

**Indemnification.** Contractor hereby agrees to indemnify and hold harmless the School, its officers, agents and employees against any and all claims, directly or indirectly arising out of or relating or resulting from the furnishing of services described herein, and caused by negligence of Consultant or its staff.
14. PAYMENT, COSTS AND BILLING MECHANISMS

OPTIONS MAY INCLUDE:

1. **Billing Medicaid.** The School agrees that the Consultant shall be responsible for billing Medicaid and other third party payers for the Consultant’s services rendered hereunder. Consultant reserves right to keep any such payment collected.

2. **Costs for Services.** In return for services provided by the Consultant, the School will reimburse for services provided in accordance with the attached budgets upon completion of any and all require documentation (e.g. evaluation reports, time sheets, logs, receipts). Payment will be made monthly (or in aggregate amount) not to exceed $xx. This amount may be increased to $xx pending review by Project Coordinator.

3. **Submission of Invoices.** All invoices for services need to be turned in on a monthly basis with a description of services, the number of hours, social security numbers of clients, and the cost for each service. The parties agree that the Consultant invoices are to be submitted to the School in a timely manner, after the services have been provided to the School. If invoices are submitted after six months after the last date the services have been rendered, then the School shall have no obligation to pay for the stale invoices.

4. **Taxes.** The Consultant is responsible for complying with all Federal and State laws as to tax and Social Security payments to be withheld from wages paid to said employees. The School assumes no responsibility for the payment of any compensation, wages, benefits, or taxes by, or on behalf of the Consultant, its employees and/or others by reason of this Agreement.

15. NONDISCRIMINATION

The Consultant agrees to comply with ADA, Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, the Constitution of the United States, the 1970 Constitution of the State of Illinois and any laws, regulations or orders, State or Federal, which prohibit discrimination on the grounds of race, sex, religion, national origin, inability to speak or comprehend the English language, or by reason of disability.

16. LIABILITY

The School assumes no liability for actions of the Consultant under this Contract. The Consultant agrees to hold harmless, the School, against any and all liability loss, damage, cost or expenses arising from wrongful or negligent acts of the Consultant, which School may sustain, incur or be required to pay as a result of Contractor’s performance under this contract.

17. SIGNATURE OF BOTH PARTIES

__________________________________________________________________________________________
Agency Director                                                                                     Date of Signature

__________________________________________________________________________________________
Authorized School Official                                                                         Date of Signature
This sample working agreement was developed with input from the following documents:

1. Mental Health Association of the North Shore (MHANS) Community Partnering Program for Social- Emotional Wellness
3. Chicago Public Schools Policy for School Based Health Centers
4. Contract Agreement between Baltimore Mental Health Systems Inc and the University of Maryland, Baltimore School Mental Health Program
5. Contract between County Head Start/Early Head Start Program and County Mental Health Center
6. Contract for physical therapy, occupational therapy and speech/language/pathology services between the Rainbow Center and Naperville Community Unit School District
7. Contractual Agreement for Safe Schools/Healthy Students Partners, Fillmore Center for Human Services & Community Care Options and Morton School District
8. Contractual Agreement for Safe Schools/Healthy Students Partners, J. Sterling Morton High School District and Cook County Department of Public Health
9. Education Referral Protocol for Referrals to the Mental Health System of Care, Champaign County
11. Letter of Agreement between Community Counseling Centers of Chicago and Asian Human Services
12. Letter of Agreement between Community Counseling Centers of Chicago and Institute for Juvenile Research
13. Master Professional Services Agreement between the Baltimore City Board of School Commissioners and University of Maryland, Baltimore
14. Memorandum of Agreement for Safe Schools Healthy Students Initiative, We Go Together (West Chicago Elementary District #33 and collaborating agencies) Service Provision Protocol Agreement between Community Counseling Centers of Chicago and Chicago School Readiness Project
15. Skilled Nursing Service Agreement between Midwest Home Health Care and Naperville CUFD
Financing strategies are as varied and complex as school-community partnerships themselves. School-community partnerships can blend funds from various sources to share personnel and expand access to programs. Partnerships can redeploy, refinance or restructure their existing funds to develop new funding mechanisms. Other strategies used may include matching state dollars with federal dollars, billing for third party reimbursement, applying for public and private grants and contracts, and/or establishing a self-pay system.

The most important financing strategy for a school-community partnership is to draw from the widest array of sources possible. It is important to consider all sources of funding and identify those sources that may provide funds to schools-community partnerships as well as for the type of mental health services provided through the partnership. When programs are limited in the number of funding sources they utilize, they become limited in their scope. The more funding sources available, the more flexibility a partnership will have. For a more comprehensive and detailed overview of funding strategies, see articles and issue briefs in the References section of these Guidelines.

The following are public and private funding sources at the national, state and local levels:

**1. FEDERAL PROGRAMS** – Over 1000 grant programs are offered by the 26 federal grant-making agencies, and a number of federal grant programs specifically support mental health prevention, early intervention and treatment. Education, child welfare, social service, juvenile justice, and healthcare funds can also be used to support school community collaborations. The following are some of the key federal programs that fund school mental health:

- Title I – Improving the Academic Achievement of the Disadvantaged
- Title IV – Safe and Drug Free Schools and Communities Program
- Title V - Maternal and Child Health Block Grant
- Title 19 (Medicaid)
- Title XXI (SCHIP)
- Title IV-E waivers
- Individuals with Disabilities Education Improvement Act of 2004 (IDEA)
- No Child Left Behind (NCLB) Act of 2001
- Substance Abuse and Mental Health Services Administration (SAMHSA) - Safe Schools, Healthy Students
- SAMHSA - Community Mental Health Services Block Grant
- Bureau of Primary Health Care - Healthy Schools Grant
- Centers for Disease Control and Prevention- Division of Adolescent and School Health (DASH)

**2. PUBLIC HEALTH INSURANCE PROGRAMS** – State and local governments increasingly use Medicaid and the State Children’s Health Insurance Program (SCHIP) to finance children’s mental health services provided by other public sectors, including the mental health and educational systems. Medicaid is available to low-income individuals and families who fit into an eligibility group recognized by federal and state law. SCHIP is the federal program that extends health insurance benefits to children whose family income exceeds that for Medicaid eligibility. Medicaid covers about 20% of all funding for mental health care including inpatient, outpatient and physician mental health visits. Illinois’ health insurance program for children, “All Kids,” provides complete healthcare, including mental health services, but has restrictions on provider types and services.

Children insured under Medicaid may receive mental health services through Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), a comprehensive and preventive child health benefit in Medicaid for individuals under the age of 21. Under EPSDT, eligible
children are entitled to a range of services including the diagnosis of a mental disorder as well as treatment for any condition that is diagnosed.

In July 2004, Illinois state funding began a shift from the historical grant-based contracts model to a performance-based fee-for-service reimbursement system. While this change maximizes Illinois’ ability to obtain more federal dollars through Medicaid’s matching funds, this system continues to have restrictions on the types of mental health services and providers that can be reimbursed. A full range of Medicaid billable services can be provided in school settings; therefore, making Medicaid a source of financing for school-based mental health services.

More information on Medicaid (including EPSDT) and SCHIP, and EPSDT can be found on the Centers for Medicare and Medicaid Services website www.cms.hhs.gov and the Center for Healthcare in Schools at www.healthinschools.org.

3. STATE GOVERNMENT – In addition to redistributing federal funding (e.g. block grants, etc.), Illinois invests its own resources into children’s mental health and school partnerships by directing general revenue into school community initiatives as well as using specific revenue sources to support new statewide and local programs. State agencies, such as the Department of Human Services and the Illinois State Board of Education offer numerous direct grant opportunities through state and federal funds received or administered by each agency.

More information on funding in the State of Illinois can be found in the Illinois Funding Sources chart below.

4. LOCAL GOVERNMENT - Both federal and state funds from many different state agencies can be distributed to local agencies to finance school-community partnerships and mental health services. Some key sources of funding for local mental health efforts include:

• Local school systems or Regional Offices of Education (ROE) receive locally appropriated funds through Title I or Safe and Drug Free School Program.

• The Community Mental Health Services Block Grant, a joint Federal-State partnership, supports existing public services and encourages the development of creative and cost-effective systems of community-based care for people with serious mental disorders.

• Community Mental Health Boards (“708”), administered directly by a township, have the authority to provide funding for mental health programs, developmental disability and substance abuse services.

• The Local Area Network (LAN) effort, cooperatively funded by the Illinois Department of Children and Family Services and the Illinois State Board of Education, provides funding to create child specific supports that do not already exist in the child’s community but which are necessary to provide successful intervention.

• The United Way is a not-for-profit organization that invests in critical health and human service programs and coordinates community initiatives to improve lives and strengthen communities. Local chapters of United Way often offer grants for specific community based initiatives.

5. PROFESSIONAL ORGANIZATIONS – Grants from professional organizations (e.g. American Psychological Association, National Education Association) may provide funding for specific activities (e.g. professional development, research) offered through a school-community partnership.

6. PRIVATE SOURCES

• Private Foundations are non-governmental, non-profit organizations that have their own funds or endowments that support educational, charitable, social, religious or other activities serving the common good. In Illinois alone there are over 2500 private foundations that give to a wide range of statewide and community activities. See the chart below for ways to identify specific foundations that may fund activities provided through a school-community partnership.

• University Departments may have research funds that can support the evaluation component of a school-community partnership.

• Corporate Giving Programs use their endowments, as well as their marketing, public relations and advertising budgets, and have multiple ways of supporting non-profits such as school-community partnerships.
**CHART OF FUNDING SOURCES**

The charts below provides a short description of each funding resource, grant, and/or program as well as internet links that help identify funding opportunities that are currently available.

### NATIONAL PUBLIC FUNDING SOURCES

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>GRANTS.GOV</td>
<td><a href="http://www.grants.gov">www.grants.gov</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>Allows organizations to electronically find and apply for more than $400 billion in federal grants. Grants.gov is the single access point for over 1000 grant programs offered by all Federal grant-making agencies.</td>
</tr>
<tr>
<td>Catalog of Federal Domestic Assistance</td>
<td>12.46.245.173/cfda/cfda.html</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>Provides access to a database of all federal programs available to state and local governments; domestic public, quasi-public, and private profit and nonprofit organizations and institutions; specialized groups; and individuals.</td>
</tr>
<tr>
<td>Catalog of Federal compendium of Domestic Assistance</td>
<td><a href="http://www.cfda.gov">www.cfda.gov</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>Provides a government-wide federal programs, projects, services, and activities, which provide assistance or benefits to the American public. It details every federal grant, including its description, eligibility, deadlines, and award procedures.</td>
</tr>
<tr>
<td>Centers For Disease information on the Control and Prevention (CDC)</td>
<td><a href="http://www.cdc.gov/od/pgo/funding/grantmain.htm">www.cdc.gov/od/pgo/funding/grantmain.htm</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>Provides grants process and funding opportunity announcements. CDC awards grants and cooperative agreements to eligible organizations annually based on funding made available through its appropriations. CDC's Division of Adolescent and School Health (DASH) provides funding to build state education and state health agency partnerships and capacity to implement and coordinate school health programs across agencies and within schools.</td>
</tr>
<tr>
<td>Department of Education</td>
<td><a href="http://www.ed.gov/fund/grant/find/edlite-forecast.html">www.ed.gov/fund/grant/find/edlite-forecast.html</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>Provides information regarding Forecast of Funding programs and competitions for which the Department of Education has invited or expects to invite applications for new awards.</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>Lists information on current open discretionary grants made by the Department for which the Department has discretion, or choice in, which applicants get funded. Virtually all of the Department's discretionary grants are made based on a competitive review process.</td>
</tr>
<tr>
<td>Department of Education – Title IV funding - Office of Safe and Drug Free Schools</td>
<td><a href="http://www.ed.gov/about/offices/list/osdfs/programs.html">www.ed.gov/about/offices/list/osdfs/programs.html</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>Provides financial assistance for drug and violence prevention activities and activities that promote the health and well being of students in elementary and secondary schools, and institutions of higher education. Activities may be carried out by state and local educational agencies and by other public and private nonprofit organizations. Website describes programs and provides information on grants for creating safe schools, responding to crises, drug abuse and violence prevention.</td>
</tr>
<tr>
<td>Department of Education Title I Funding – Improving the Academic Achievement of the Disadvantaged</td>
<td><a href="http://www.ed.gov/policy/elsec/leg/esea02/pg1.html">www.ed.gov/policy/elsec/leg/esea02/pg1.html</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>Describes Title I funding, the largest federal investment in education, providing school systems with funding to improve educational outcomes for students at risk of educational failure.</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>Describes NCLB Act that allows for more flexibility of funding at state and local level and enables schools to use funding for enhancing student/learning supports in low performing schools. The 21st CCLC Program, a key component of the NCLB Act, is an opportunity for students and their families to continue to learn new skills and discover new abilities after the school day has ended. This program provides youth development activities, drug and violence prevention programs, counseling and character education to enhance the academic component of the program.</td>
</tr>
<tr>
<td>Department of Education Office of Special Education Programs (OSEP) - Individuals with Disabilities Education Improvement Act of 2004 (IDEA)</td>
<td><a href="http://www.ed.gov/about/offices/list/osers/osep/index.html">www.ed.gov/about/offices/list/osers/osep/index.html</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>Describes IDEA's three non-competitive formula grant programs. Under IDEA, schools are required to provide services to enable children with a disability to participate fully in the education available. Recently, under the reauthorization of IDEA, state and local education authorities are able to use a portion of these funds for the general education populations.</td>
</tr>
</tbody>
</table>
Health Resources and Services Administration (HRSA)
Bureau of Primary Health Care Grants
bphc.hrsa.gov/Grants/Default.htm
DESCRIPTION: Includes information on HRSA funding opportunities including program summaries, application procedures, and standard Grant Application Forms. HRSA Primary Health Care grants and cooperative agreements support innovations and expanded access to health care services in medically underserved areas and improve the health status of medically underserved populations.

Bureau of Primary Health Care - Healthy Schools Grant
www.federalgrantswire.com/healthy_schools_healthy_communities.html
DESCRIPTION: Supports the development and operation of school-based health centers that provide preventive and comprehensive primary health care services, including mental health services, to children at risk for poor health outcomes and other medically underserved populations.

SAMHSA Center for Mental Health Services, Center
www.samhsa.gov/grants06/apply.aspx
DESCRIPTION: Provides information on new SAMHSA grants, Requests For Applications (RFAs), grant application forms, new grant making procedures, technical assistance and training. Future funding falls into three program areas: Services; Infrastructure; and Best Practices.

SAMHSA Center for Mental Health Services - Safe Schools Healthy Students (SS/HS)
www.sshs.samhsa.gov/apply/default.aspx
DESCRIPTION: Contains information on application procedures for SS/HS. Through grants made to local education authorities, the SS/HS Initiative provides schools and communities with the benefit of enhanced school and community-based services. School districts submit comprehensive plans created in partnership with law enforcement officials, local mental health authorities, and often with juvenile justice officials and community-based organizations.

SAMHSA Center for Mental Health Services, Center (Part B of Title XIX of the Public Health Service Act)
www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0022/#where
DESCRIPTION: The Community Mental Health Services Block Grant is the single largest federal contribution dedicated to improving mental health service systems across the country. The Center for Mental Health Services’ Community Mental Health Services Block Grant awards grants to the states to provide mental health services to people with mental disorders.

National Education Association
www.nea.org/grants/archive.html
DESCRIPTION: Lists information on grants and awards provided by the National Education Association (NEA), the nation’s largest professional employee organization, committed to advancing the cause of public education.

National Criminal Justice Reference Service
www.ncjrs.gov/fedgrant.html
DESCRIPTION: Provides information on three types of Office of Justice Programs (OJP) funding opportunities to state, local, and private agencies and organizations including: formula (or Block), discretionary, and congressional earmarks. Most OJP funds are dispersed through Formula programs and congressional earmarks.
**ILLINOIS FUNDING SOURCES**

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donors Forum Illinois Funding Source (IFS)</td>
<td>ifs.donorsforum.org</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Updated monthly, IFS delivers the latest details on</td>
<td></td>
</tr>
<tr>
<td>newly established foundations, changes in foundation contacts,</td>
<td></td>
</tr>
<tr>
<td>priorities, and updated grants list. IFS combines two powerful tools:</td>
<td></td>
</tr>
<tr>
<td>FunderSource, a searchable directory of 2800+ Illinois foundations,</td>
<td></td>
</tr>
<tr>
<td>and GrantSource, an essential research database that indexes over</td>
<td></td>
</tr>
<tr>
<td>$3.2 billion in grants dollars awarded by local funders.</td>
<td></td>
</tr>
<tr>
<td>Illinois Federal Clearinghouse</td>
<td>www100.state.il.us/fedclear/state_grants.cfm</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Provides information for state and local agencies</td>
<td></td>
</tr>
<tr>
<td>about federal funding opportunities, federal grants flowing into</td>
<td></td>
</tr>
<tr>
<td>Illinois and contacts for key agencies.</td>
<td></td>
</tr>
<tr>
<td>Maternal and Child Health Block Grant (Title V, Social Security Act)</td>
<td><a href="http://www.dhs.state.il.us/dhs_mchbgFFY06AFFY04R.asp">www.dhs.state.il.us/dhs_mchbgFFY06AFFY04R.asp</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> The Illinois Department of Human Services (IDHS)</td>
<td></td>
</tr>
<tr>
<td>administers the Maternal and Child Health Services Block Grant.</td>
<td></td>
</tr>
<tr>
<td>IDHS uses these funds for school based health programs and to</td>
<td></td>
</tr>
<tr>
<td>provide preventive and primary care services to women, infants,</td>
<td></td>
</tr>
<tr>
<td>children and adolescents throughout the state.</td>
<td></td>
</tr>
<tr>
<td>Illinois Department of Human Services (IDHS)</td>
<td><a href="http://www.dhs.state.il.us/grants/gas/onenet.aspx?item=4620">www.dhs.state.il.us/grants/gas/onenet.aspx?item=4620</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Includes information on grant opportunities in</td>
<td></td>
</tr>
<tr>
<td>human services through a Grants Alert System (GAS), IDHS Request For</td>
<td></td>
</tr>
<tr>
<td>Proposals (RFP’s), and a list serve.</td>
<td></td>
</tr>
<tr>
<td>Illinois Violence Prevention Authority (IVPA)</td>
<td><a href="http://www.ivpa.org/grants.html">www.ivpa.org/grants.html</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Provides information on funding available under</td>
<td></td>
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<tr>
<td>IVPA's grant programs. IVPA distributes grants statewide for</td>
<td></td>
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<tr>
<td>programs that address a wide range of violence prevention efforts,</td>
<td></td>
</tr>
<tr>
<td>including school-based violence prevention programs. IVPA is</td>
<td></td>
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<tr>
<td>increasingly moving towards funding more comprehensive, community-wide,</td>
<td></td>
</tr>
<tr>
<td>collaborative approaches to violence prevention.</td>
<td></td>
</tr>
</tbody>
</table>

**WEB SITES/LINKS TO PUBLIC AND PRIVATE FUNDING NOTICES**

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center for Health and Healthcare in Schools</td>
<td><a href="http://www.healthinschools.org/grants/alerts.asp">www.healthinschools.org/grants/alerts.asp</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Posts daily alerts with information and application</td>
<td></td>
</tr>
<tr>
<td>deadlines for grant opportunities for school health programs and</td>
<td></td>
</tr>
<tr>
<td>services.</td>
<td></td>
</tr>
<tr>
<td>The Finance Project</td>
<td><a href="http://www.financeproject.org/fedfund/">www.financeproject.org/fedfund/</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Maintains up-to-date, online tool that enables</td>
<td></td>
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<tr>
<td>leaders to search for federal funding sources relevant to their</td>
<td></td>
</tr>
<tr>
<td>specific needs.</td>
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</tr>
<tr>
<td>School Grants</td>
<td><a href="http://www.schoolgrants.org/">www.schoolgrants.org/</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Includes a collection of resources and information</td>
<td></td>
</tr>
<tr>
<td>for kindergarten through 12th grade educators about how to apply for</td>
<td></td>
</tr>
<tr>
<td>and obtain grants designed for a variety of school-related projects</td>
<td></td>
</tr>
<tr>
<td>GrantsAlert</td>
<td><a href="http://www.grantsalert.com/">www.grantsalert.com/</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Designed for organizations, schools, districts,</td>
<td></td>
</tr>
<tr>
<td>consortia and state education agencies to search for grants and</td>
<td></td>
</tr>
<tr>
<td>funding opportunities.</td>
<td></td>
</tr>
<tr>
<td>National Center for Mental Health Promotion and Youth Violence</td>
<td><a href="http://www.promoteprevent.org/resources/grant_opportunities">www.promoteprevent.org/resources/grant_opportunities</a></td>
</tr>
<tr>
<td>Prevention Grant Opportunities</td>
<td></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Includes current open grant and funding opportunities</td>
<td></td>
</tr>
<tr>
<td>for federal, state, and private sources.</td>
<td></td>
</tr>
<tr>
<td>The Foundation Center</td>
<td><a href="http://www.foundationcenter.org/">www.foundationcenter.org/</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Provides education and training on the grant-seeking</td>
<td></td>
</tr>
<tr>
<td>process and provides public access to information and services</td>
<td></td>
</tr>
<tr>
<td>through a website, print and electronic publications, five library/</td>
<td></td>
</tr>
<tr>
<td>learning centers, and a national network of Cooperating Collections.</td>
<td></td>
</tr>
<tr>
<td>The Foundation Finder, an online searchable database, has basic</td>
<td></td>
</tr>
<tr>
<td>information on more than 86,000 grant makers in the U.S.—including</td>
<td></td>
</tr>
<tr>
<td>private foundations, community foundations, grant making public</td>
<td></td>
</tr>
<tr>
<td>charities, and corporate giving programs.</td>
<td></td>
</tr>
<tr>
<td>Center for Disease Control - Healthy Youth Funding Database</td>
<td>apps.nccd.cdc.gov/HYFund/</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> The Healthy Youth Funding Database contains active</td>
<td></td>
</tr>
<tr>
<td>information about funding opportunities for adolescent and school</td>
<td></td>
</tr>
<tr>
<td>health programs. These funding opportunities are from federal</td>
<td></td>
</tr>
<tr>
<td>agencies and the private sector. Each funding opportunity is</td>
<td></td>
</tr>
<tr>
<td>carefully selected based on its relevance to adolescent health, or</td>
<td></td>
</tr>
<tr>
<td>one or more of the eight components of a Coordinated School Health</td>
<td></td>
</tr>
<tr>
<td>Program.</td>
<td></td>
</tr>
</tbody>
</table>
The following tools can be used by stakeholders during various stages of development of a school-community partnership. This is not an exhaustive list. The Illinois Children’s Mental Health Partnership does not endorse any of the following tools. Rather, the list is provided as reference to be explored by those seeking to develop school-community partnerships. Several tools can be used to better understand the needs and resources available in the school and community in the initial stages of planning and developing a partnership. Other tools may be helpful to assure that structures are in place for coordinating the delivery of effective programs and services. The tools can also be used for ongoing quality improvement to evaluate or monitor the progress of the partnership and improve or expand upon existing programs. Finally, funders may find some of these tools useful for developing requests for proposals (RFPs) or for evaluating applications.

### Assessment Tools

(Tools in Assessment section can also be used for Evaluation)

<table>
<thead>
<tr>
<th>NAME OF TOOL</th>
<th>WHERE TO FIND IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Strengths and Needs Assessment</td>
<td>Coalition of Community Schools Toolkit <a href="http://www.communityschools.org/index.php?option=content&amp;task=view&amp;id=29&amp;Itemid=51">www.communityschools.org/index.php?option=content&amp;task=view&amp;id=29&amp;Itemid=51</a></td>
</tr>
<tr>
<td>DESCRIPTION: Parent survey aimed at assessing the supply and quality of services in a community, the unmet needs of the community, and the likelihood of participation in new programs. Also asks questions aimed at compiling demographic data.</td>
<td></td>
</tr>
<tr>
<td>School and Family Partnership Surveys</td>
<td><a href="http://www.csos.jhu.edu/p2000/bluelist.htm">www.csos.jhu.edu/p2000/bluelist.htm</a></td>
</tr>
<tr>
<td>DESCRIPTION: Available from the Center on School, Family and Community Partnerships. Surveys for teachers and parents in elementary and middle school grades, and teachers, parents, and students in high schools. The quantitative information collected from the surveys helps parents and schools develop a comprehensive, successful partnership program. A checklist, “Starting Points,” is also available to help schools and parent groups develop their partnerships.</td>
<td></td>
</tr>
<tr>
<td>Organizational Readiness for Change (ORC)</td>
<td>Institute of Behavioral Research, Texas Christian University, Fort Worth, TX 76129, USA. <a href="mailto:w.lehman@tcu.edu">w.lehman@tcu.edu</a> <a href="http://www.lbr.tcu.edu/resources/TCU-ORC-AFS.pdf">www.lbr.tcu.edu/resources/TCU-ORC-AFS.pdf</a></td>
</tr>
<tr>
<td>DESCRIPTION: A comprehensive assessment of organizational functioning and readiness for change, the ORC focuses on motivation and personality attributes of program leaders and staff, institutional resources, and organizational climate as an important first step in understanding organizational factors.</td>
<td></td>
</tr>
<tr>
<td>School Health Index (SHI)</td>
<td>apps.nccd.cdc.gov/shi/default.aspx</td>
</tr>
<tr>
<td>DESCRIPTION: The SHI is a self-assessment and planning tool for schools to use to improve their health and safety policies and programs. The SHI is completed by school teams and involves school and community members discussing what the school is already doing to promote good health, identifying its strengths and weaknesses, and developing an ongoing process for monitoring progress.</td>
<td></td>
</tr>
<tr>
<td>The School Health Policies and Programs Study (SHPPS) – Mental Health and Social Services Questionnaire</td>
<td><a href="http://www.cdc.gov/HealthyYouth/shpps/index.htm">www.cdc.gov/HealthyYouth/shpps/index.htm</a></td>
</tr>
<tr>
<td>DESCRIPTION: Developed by Health Schools, Healthy Youth program of the Centers for Disease Control's Division of Adolescent and School Health. The School Health Policies and Programs Study (SHPPS) is a national survey periodically conducted to assess school health policies and programs at the state, district, school, and classroom levels.</td>
<td></td>
</tr>
<tr>
<td>DESCRIPTION: Developed by the National Center for Cultural Competence. Checklists assess attitudes, practices, structures and policies of programs and personnel to plan for and incorporate cultural and linguistic competency within organizations. Checklists can easily be adapted to school or community setting.</td>
<td></td>
</tr>
</tbody>
</table>
Strengthening Partnerships: Community School Assessment Checklist.

**DESCRIPTION:** A series of checklists to assist school and community leaders in creating and/or strengthening community school partnerships. The first checklist assesses the development of a school-community partnership. The second checklist takes an inventory of existing programs and services in or connected to your school that support children, youth, families, and other community residents. The third checklist catalogs funding sources that support these programs and services.

Wilder Collaboration Factors Inventory

**DESCRIPTION:** The Wilder Collaboration Factors Inventory surveys twenty factors that influence the success of collaboration. The inventory can be used to assess the likelihood of success before beginning collaborative work or to analyze the strengths and weaknesses of your collaborative venture.

Program Quality Self Assessment Tool

**DESCRIPTION:** Prepared by the New York State After School Network. This self-assessment tool provides an opportunity for program leaders and key staff, in collaboration with other stakeholders, to utilize a common set of standards to assess, plan, design and execute strategies for ongoing program improvement.

**Evaluation Tools**
(Tools in Assessment section can also be used for Evaluation)

<table>
<thead>
<tr>
<th>NAME OF TOOL</th>
<th>WHERE TO FIND IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benchmarks for Monitoring and Reviewing Collaborative Progress</td>
<td>Tools from the School Community Partnerships: A Guide V-5-6 smhp.psych.ucla.edu/specres.htm</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Used to monitor the implementation of evaluation plans, readiness, start-up institutionalization.</td>
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</tr>
<tr>
<td>Mental Health - Program Evaluation Template (MH-PET)</td>
<td>Prepared by the National Assembly on School Based Health Care (NASBHC) <a href="http://www.nasbhc.org/EO/Newsletter/Mental%20Health%20Evaluation%20Template.pdf">www.nasbhc.org/EO/Newsletter/Mental%20Health%20Evaluation%20Template.pdf</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Used for assessing and improving the quality of mental health services provided in school based health centers. Measures pre-conditions for a successful program, staff and training, programs and services, coordination, and quality improvement.</td>
<td></td>
</tr>
<tr>
<td>School Mental Health Quality Assessment Questionnaire (SMHQAQ)</td>
<td>Developed by the Center for School Mental Health Analysis and Action (CSMHA) as part of a research grant, “Enhancing Quality in Expanded School Mental Health.” National Institute of Mental Health, U.S. Department of Health and Human Services. Available at csmha.umaryland.edu/</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Evaluates clinicians’ current practice and progress towards achieving ten principles of best practice in Expanded School Mental Health.</td>
<td></td>
</tr>
</tbody>
</table>

**Mapping Tools**

<table>
<thead>
<tr>
<th>NAME OF TOOL</th>
<th>WHERE TO FIND IT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DESCRIPTION:</strong> A capacity inventory that looks at the building of an asset-based approach to community development and helps shift people from problem/deficit-oriented approaches to strengths or asset-based strategies.</td>
<td></td>
</tr>
<tr>
<td>Community Resource Mapping Inventory</td>
<td>From Building Sustainability in Demonstration Projects for Children, Youth, and Families (pp. 23-26) prepared by the Institute for Education Leadership ojdp.ncjrs.org/resources/files/toolkit2final.pdf</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> A Planning Tool to identify formal and ‘informal’ community resources, assess duplication and build comprehensive, sustainable resources.</td>
<td></td>
</tr>
</tbody>
</table>
Who and What Are at the School?

**DESCRIPTION:** Provides a template to clarify the people and positions at a school that provide services and programs related to mental health and/or school support.

**Survey of System Status at a School**

**DESCRIPTION:** Helps review how well the systems have been developed and are functioning.

**Mapping Matrix for Analyzing School-Community Partnerships Relevant to Addressing Barriers to Learning and Promoting Healthy Development**

**DESCRIPTION:** Analyzes prevention, early intervention and treatment activities offered as part of school-community partnerships and assessed functioning at the national, state, and local levels.

**School-Community Partnerships; Self-Study Surveys**

**DESCRIPTION:** These instruments map and analyze the current status of school-community partnerships and can be used for program quality review.

**Analysis of Mechanisms for Connecting Resources**

**DESCRIPTION:** List of questions regarding existing mechanisms in school and community for integrative intervention efforts and how mechanism could strengthen school-community partnerships.

### Financing Tools

<table>
<thead>
<tr>
<th>NAME OF TOOL</th>
<th>WHERE TO FIND IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mapping Funding Sources</td>
<td>Resource Mapping and Management to Address Barriers to Learning: An Intervention for Systemic Change. Center for Mental Health in Schools at UCLA (2002) <a href="http://smhp.psych.ucla.edu/qf/funding_qt/">smhp.psych.ucla.edu/qf/funding_qt</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> This tool can be used as a guide for identifying the various sources that may be providing funds for programs and services at a school. As existing funding is identified, it can be mapped in a standard budgeting spreadsheet format.</td>
<td></td>
</tr>
<tr>
<td>Grant-Writing Tips</td>
<td><a href="http://www.schoolgrants.org/grant_tips.htm#Grant-Writing%20Tips">www.schoolgrants.org/grant_tips.htm#Grant-Writing%20Tips</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Contains tips for writing proposals including a sample letter of proposal, how to write an organizational mission statement, and how to create a grant writing team.</td>
<td></td>
</tr>
<tr>
<td>A Self-Assessment and Planning Guide: Developing a Comprehensive Financing Plan</td>
<td><a href="http://rtckids.fmhi.usf.edu/study03.cfm">rtckids.fmhi.usf.edu/study03.cfm</a> University of South Florida 13301 Bruce B. Downs Boulevard Tampa, FL 33612-3899</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Develop a better understanding of what are the critical financing structures and strategies to support system</td>
<td></td>
</tr>
</tbody>
</table>
Development, examine how these strategies operate separately and collectively.

### Planning Tools

<table>
<thead>
<tr>
<th>NAME OF TOOL</th>
<th>WHERE TO FIND IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gap Analysis/Build Consensus</td>
<td>Tools from the School Community Partnerships: A Guide</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Analysis of vision, policy infrastructure, leadership, staff, and resources. Describes process of analyzing scope of gap between vision and current status.</td>
<td>p. IV.1-IV.2</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Provides questions and outline for group process to develop objectives, strategies, persons who will carry out strategies, timeline, and possible barriers.</td>
<td>p. IV.3-IV.5</td>
</tr>
</tbody>
</table>

### Group Facilitation Tools

<table>
<thead>
<tr>
<th>NAME OF TOOL</th>
<th>WHERE TO FIND IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and Facilitating Effective Meetings</td>
<td>Tools from the School Community Partnerships: A Guide</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Guidelines for forming a working group, meeting format, promoting positive group dynamics, and problem solving.</td>
<td>p. III.5</td>
</tr>
<tr>
<td>Group Facilitation Skills Self Assessment</td>
<td><a href="http://www.communityschools.org/index.php?option=content&amp;task=view&amp;id=39&amp;Itemid=61">www.communityschools.org/index.php?option=content&amp;task=view&amp;id=39&amp;Itemid=61</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> A self-assessment tool that assists facilitator in assessing which group facilitation tasks are performed successfully and in which tasks coaching would be helpful.</td>
<td></td>
</tr>
<tr>
<td>Ten Things To Do About Resistance</td>
<td><a href="http://www.nsdclibrary/publications/jsd/janas193.cfm">www.nsdclibrary/publications/jsd/janas193.cfm</a></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> Describes types of staff resistance to change, and lists behaviors and actions that can help prevent or minimize staff resistance.</td>
<td>From Monica Janas’ article, “Shhhhh, The Dragon Is Asleep And Its Name Is Resistance.” Journal of Staff Development, Spring 1998 (Vol. 19, No. 3)</td>
</tr>
</tbody>
</table>
REFERENCES


8. Center for Mental Health in Schools at UCLA (2002), Financial Strategies to Aid in Addressing Barriers to Learning, Los Angeles, CA. http://smhp.psych.ucla.edu


10. Center for Mental Health in Schools at UCLA. Interconnected Systems for Meeting the Needs of All Youngsters.

11. Center for School Mental Health Assistance (2002), Funding Expanded School Mental Health Programs, Baltimore, MD: Author http://csmha.umaryland.edu


33. Pires SA. Building Systems of Care: A Primer, National Technical Assistance Center for Children’s Mental Health Center for Child Health and Mental Health Policy Georgetown University Child Development Center, Washington DC, Spring 2002

34. PMP/NASMHPD School Mental Health Project Work Group. Mental Health, Schools and Families Working Together for Children and Youth: Steps Toward a Shared Agenda Concept Paper, 2001


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MENTAL HEALTH, SCHOOLS AND FAMILIES WORKING TOGETHER FOR ALL CHILDREN AND YOUTH: TOWARD A SHARED AGENDA

A Concept Paper

The National Association of State Mental Health Program Directors and The Policymaker Partnership for Implementing IDEA at The National Association of State Directors of Special Education
This concept paper was sponsored by the U.S. Department of Education, Office of Special Education Programs (OSEP) under cooperative agreements #H326A980003-99 and #H326A000001-01. However, the opinions expressed herein do not necessarily reflect the position of the U. S. Department of Education, and no official endorsement by the Department should be inferred. 2002
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The National Association of State Mental Health Program Directors and The Policymaker Partnership for Implementing IDEA at The National Association of State Directors of Special Education
FOREWORD

This Concept Paper is an initiative funded by the Office of Special Education Programs (OSEP) through the Policymaker Partnership with the support of two national organizations: The National Association of State Mental Health Program Directors (NASMHPD) and The National Association of State Directors of Special Education (NASDSE).

The U.S. Department of Education Office of Special Education Programs (OSEP)

OSEP is dedicated to improving results for infants, toddlers, children and youth with disabilities, ages birth through 21, by providing leadership and financial support to assist states and local districts. OSEP administers the Individuals With Disabilities Education Act (IDEA). IDEA authorizes formula grants to states, and discretionary grants to institutions of higher education and other non-profit organizations to support research, demonstrations, technical assistance and dissemination, technology and personnel development and parent-training and information centers. These programs are intended to ensure that the rights of infants, toddlers, children, and youth with disabilities and their parents are protected.

Policymaker Partnership (PMP)

PMP/NASDSE is one of four linked partnership projects funded by the United States Department of Education’s Office of Special Education Programs. The projects are designed to deliver a common message about the 1997 landmark amendments to the Individuals with Disabilities Education Act (IDEA) to policymakers, local administrators, service providers and families and communities.

The National Association of State Mental Health Program Directors (NASMHPD)

Members are the Commissioners or other top administrators of state mental health programs throughout the country and territories. The purposes of the organization include providing a forum for state leaders in mental health services to share information and ideas, delivering state-to-state technical assistance to its members, developing policy recommendations, and advocating on behalf of its members and those persons the members serve. One of the five divisions of NASMHPD is its Division of Children, Youth, and Families. Made up of state-appointed children’s mental health adminis-
trators, this group advises NASMHPD on all matters concerning mental health issues relating to children and youth.

NASMHPD is one of eleven primary partners in the Policymaker Partnership (PMP). This Concept Paper is the first product of an initiative that brings these two organizations together to forge stronger partnerships between state public mental health systems and state education systems.

The National Association of State Directors of Special Education (NASDSE)

The National Association of State Directors of Special Education, Inc. (NASDSE) promotes and supports education programs for students with disabilities in the United States and outlying areas.

NASDSE operates for the purpose of providing services to State agencies to facilitate their efforts to maximize educational outcomes for individuals with disabilities. Its official membership is made up of the state-designated directors of special education.

The National Association of State Directors of Special Education (NASDSE) is the host organization for the Policymaker Partnership.
PURPOSE OF THIS CONCEPT PAPER

The purpose of this paper is to encourage state and local family and youth organizations, mental health agencies, education entities and schools across the nation to enter new relationships to achieve positive social, emotional and educational outcomes for every child. This paper offers recommendations and encouragement to family and youth organizations, state mental health and education leaders for policy development and changes needed to move toward systemic collaboration to coordinate and integrate programs and services. The aim is to align systems and ensure the promise of a comprehensive, highly effective system for children and youth and their families.
HOW THE CONCEPT PAPER WAS DEVELOPED

In late summer 2000, discussions began between the Policymaker Partnership at the National Association of State Directors of Special Education (PMP/NASDSE) and the National Association of State Mental Health Program Directors (NASMHPD) on how the two entities could collaborate to promote closer working relations between state mental health and education agencies, schools, and family organizations on behalf of children. In late 2000, the sponsoring associations hired a consultant to oversee a joint project. NASMHPD and PMP/NASDSE decided that the first step in this project would be to develop a Concept Paper for policymakers at the state and local levels to lay the groundwork for building partnerships to address the social-emotional and mental health needs of all children.

A work group was formed of over thirty (30) experts from mental health, education, and family support and advocacy groups to advise in the development of the Concept Paper. Over the months, that group expanded to over forty (40) members. Work group members participated in monthly conference calls and held two face-to-face meetings from January through July to provide guidance and advice. They reviewed various drafts of the document.

In October 2001, the Concept Paper was submitted to NASMHPD and PMP/NASDSE for endorsement and dissemination. Activities following the dissemination of the Concept Paper will include presentations of the findings and recommendations of the paper at national conferences and other venues before a wide variety of audiences who have an interest in this work. Other activities may include identifying and publicizing states or localities already practicing the values, beliefs, and strategies promoted in the Concept Paper, bringing focus and support to this issue at state and national policy academies, legislative conferences, and other policy meetings and providing or brokering technical assistance to states and communities interested in developing a shared agenda on behalf of all children and youth in public settings and their families.
A Vision for a Shared Education and Mental Health Agenda

Schools, families, child-serving agencies, and the broader community will work collaboratively to promote opportunities for and to address barriers to healthy social and emotional development and learning. The project's aims are to ensure that:

- All children and youth (including infants, toddlers, and preschoolers) have an equal opportunity to develop to their fullest cognitive, social, and emotional capacities; and
- The needs of those who experience psychosocial problems and emotional and behavioral disabilities are effectively addressed.

Schools, families, child-serving agencies, and the broader community will be continually involved in shaping policies, practices and strategies to develop comprehensive, multifaceted, and cohesive approaches that encompass systems of:

- Positive development of children (including infants, toddlers, and preschoolers), youth, families, and communities, and prevention of problems;
- Early identification — interventions for children (including infants, toddlers, and preschoolers) and youth at risk or shortly after the onset of problems; and
- Intensive interventions.

Such approaches will be integrated and will not only meet the needs of children and youth, but will also help strengthen the nation's families, schools and neighborhoods.
Mental Health, Schools and Families Working Together for All Children and Youth: Toward a Shared Agenda

Executive Summary

The challenges of the 21st century demand collaboration across groups to assure both achievement and well being for America’s children and youth. Public mental health and education agencies, schools and family organizations must work together to meet the positive social, emotional and educational needs of every child. Schools urgently need a broad range of mental health programs and services, including strategies for building a supportive school environment, strategies for early intervention, strategies for intensive intervention and a framework for trauma response. These needs have been evident and are well documented in a series of national reports. The critical natures of these efforts are underscored by the events of September 11, 2001.

This paper encourages and offers recommendations to policymakers for systemic collaboration. The emphasis is on developing a shared agenda for children’s mental health in schools. The aim is to create and sustain comprehensive, multifaceted approaches to social and emotional development, problem prevention, and appropriate interventions for mental health concerns. The goal is to support both well being and achievement in America’s children and youth.

This document describes key characteristics of state mental health and education agencies and family organizations and highlights the rationale for partnerships for a shared agenda to accomplish agreed upon outcomes. Each potential partner brings to the enterprise both assets to build upon and challenges to overcome.

As a foundation for developing a shared agenda, a conceptual framework for meeting the social-emotional and mental health needs of all children is outlined. The framework encompasses a continuum of interventions, including the following:

- Positive development of children (including infants, toddlers, and preschoolers), youth, families, communities, and prevention of problems;
- Early identification — interventions for children (including infants, toddlers, and preschoolers) and youth at risk or shortly after the onset of problems; and
- Intensive interventions.
This conceptual framework will provide the basis for clearly articulated policies and should drive the development and implementation of a shared agenda that yields a continuum of systematic interventions. By providing a full continuum of efforts, students will receive the kind of support to build their academic and interpersonal resources. By delivering appropriate interventions earlier, fewer children may ultimately need complex, intensive and expensive interventions.

This paper includes strategic recommendations for action that incorporate phases of systemic change. These recommendations emphasize readiness for change and durable partnerships. This document encourages the following next steps:

1. NASMHPD and NASDSE should work through the Policymaker Partnership and the IDEA Partnerships to lead a pilot effort that affiliates states committed to a shared education/mental health agenda.

2. NASMHPD and NASDSE should establish and maintain a cross sector national advisory body that includes researchers, practitioners, technical assistance providers and family members.

3. NASMHPD and NASDSE should convene teams from interested states to learn from each other and collectively pursue promising practices including:
   - Ways in which the states may identify blended and braided resources;
   - “Change agent” mindset throughout the cross-sector teams;
   - “Bridge building” strategies that link the state agencies with local agencies;
   - Strategies for creating durable partnerships, including alignment of missions, policies and practices across agencies, shared accountability, resource mapping, redeployment of existing resources, and action planning;
   - Methods to facilitate communication, coordination, problem solving, and sharing of lessons learned;
   - Personnel preparation systems that ensure that all personnel are well trained for their roles;
   - Capacity building efforts, including cross-training, that have potential to move the shared agenda beyond demonstration sites and develop efforts at scale across the states; and
   - Strategies that promote leadership across systems at all levels.

4. NASMHPD and NASDSE should engage key researchers, technical assistance providers, and family organizations in making and sustaining change.

Achieving the promises of this shared agenda requires true commitment. Partners must believe that the payoff in better outcomes for children, youth and their families is worth the investment of time, energy and money.

A number of highly successful state and community initiatives demonstrate that such investments are indeed worthwhile. Given the promise of enhanced partnerships, it is time to align policy and practice across agencies and move forward with a shared agenda.
Mental Health in Schools: A Definition

The Policy Leadership Cadre for Mental Health in Schools in a recent publication on school mental health, points out that discussions of mental health usually focus on “mental illness, disorders, or problems.” Moreover, there is a strong tendency to define emotional and behavioral problems as “disorders.” This deficit-based definition is only part of the picture. The authors of the Cadre document refer to the vision statement at the beginning of the Report of the Surgeon General’s Conference on Children’s Mental Health (2000), which states: “Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals.” They point out that the term “mental health in schools” should “encompass considerations of the school’s role related to both positive mental health (e.g., promotion of social and emotional development) and mental health problems (psychosocial concerns and mental disorders) of students, their families, and school staff.” (Policy Leadership Cadre for Mental Health in School (2001), pp. 5-6).
INTRODUCTION

Many children and youth experience difficulties in gaining the social, personal, educational and vocational skills needed to succeed in our society. This paper offers recommendations and strategies to policymakers at all levels of government to help transform the two state-operated, child-serving systems that often do business as separate entities. As well, this paper challenges public systems to engage family organizations in a meaningful relationship that better meets the social-emotional and mental health needs of all children.

This kind of partnership requires policymakers and family organizations to develop and embrace a shared agenda for a coordinated and comprehensive approach to mental health service delivery. This approach encompasses proactive social and emotional development and prevention programs, early identification of and interventions for children at risk of developing emotional problems and intensive interventions and services for students with serious disturbances.

Before exploring the notion of a shared agenda among family organizations, state mental health and education agencies and schools, this paper reviews prevalence data about mental health problems that affect children and youth.

Next, the paper describes both the similarities and unique differences among family and youth organizations and the mental health and education systems. Some of these differences present real challenges to effective collaborations. However, these three potential partners also share many similar goals for children, youth and their families:

- They hold similar values, beliefs and ideals;
- They all face difficult challenges in fulfilling those ideals; and
- They all bring assets and strengths to partnerships designed to work more effectively on behalf of children and youth.

The third section of this paper describes the conceptual shifts in thinking and behavior that will be required to establish a shared agenda that potential partners can create to improve academic, social-emotional and mental health outcomes for all children. It articulates a seamless, fluid, interlinked multi-level framework that encompasses positive child and youth development, prevention, early intervention and intensive interventions.

The fourth section offers recommendations for action to family, mental health and education policymakers to develop partnerships to meet the social-emotional and mental health needs of all children, youth and their families.

The fifth section summarizes the critical need for collaboration. As well, this section emphasizes the will necessary to sustain a commitment and achieve the desired goals.
I. THE CURRENT MENTAL HEALTH STATUS OF CHILDREN AND YOUTH IN STATE MENTAL HEALTH SYSTEMS AND PUBLIC SCHOOLS

In developing a shared agenda, potential partners must grasp the prevalence of mental health problems affecting our children and youth. What proportion of our children and youth experience the most severe and debilitating disturbances? After reviewing the existing research literature, authors of the Surgeon General’s 1999 Report on Mental Health concluded that “one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year.”

In 1993, the federal agency, the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration (SAMHSA) defined “Serious Emotional Disturbance” (SED):

Children with a Serious Emotional Disturbance are persons:

- from birth up to age 18
- who currently or at any time during the past year
- have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM III-R [and subsequent revisions, and the current version of the ICM]; and,
- that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities

Federal Register, May 20, 1993, p. 29425
A national study has not been conducted to examine the prevalence of SED among youth. However, in 1996 Friedman and his colleagues analyzed the results of studies that examined the prevalence of SED in a variety of communities. This investigation concluded that approximately 20 percent of all children and youth have a diagnosable mental disorder.

Friedman and colleagues further delineated the estimated range of children who experience an emotional disorder into two smaller groups based on the amount of impairment associated with the disorder. While 20 percent of all youth may experience a diagnosable emotional disorder, 9-13 percent of these youth will experience a serious emotional disturbance with substantial functional impairment, of that number, 5-9 percent will experience a serious emotional disturbance with extreme functional impairment. Further, Friedman asserts that poverty levels and other measures of low socio-economic status may affect the number of children with emotional disorders and he advises communities with these characteristics to use the high end of the ranges provided to estimate prevalence of youth with emotional disorders.

The 1999 Surgeon General Report on Mental Health seems to corroborate the Friedman estimates in reporting that approximately one in five children and adolescents experiences signs and symptoms of a diagnosable disorder during the course of one year, but only 5% of all children experience "extreme functional impairment". Today, the Center for Mental Health Services (CMHS) still refers to the Friedman study in assisting states to begin planning for services by determining prevalence rates for children and youth with emotional disorders.

**Prevalence of Serious Emotional Disturbance (9 to 17 year-olds)**

<table>
<thead>
<tr>
<th>Population Proportions</th>
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<tbody>
<tr>
<td>5 – 9% Youth with serious emotional disturbance &amp; extreme functional impairment</td>
</tr>
<tr>
<td>9 – 13% Youth with a serious emotional disturbance, with substantial functional impairment</td>
</tr>
<tr>
<td>20% Youth with any diagnosable disorder</td>
</tr>
</tbody>
</table>


Likewise, The Policy Leadership Cadre for Mental Health in Schools, a group of experts under the auspices of the Center for Mental Health in Schools at UCLA notes that large discrepancies exist across socio-economic levels. They reviewed a number of school and mental health data reports and concluded that the number of students with psychosocial problems “in many schools serving low-income populations has climbed over the 50 percent mark, and few public schools have fewer than 20 percent who are at risk.” (Policy Leadership Cadre for Mental Health in Schools, 2001, p. 2).
How Many Children in Schools Receive Services for Emotional Disturbance?

Schools determine special education eligibility for children experiencing “emotional disturbance” using somewhat different criteria than the Center for Mental Health Services uses for “SED.”

The regulations of the Individuals with Disabilities Education Act Amendments of 1997 define “emotional disturbance” as follows:
(Note: this definition may change with reauthorization projected for 2002.)
300.7 (c)(4) Emotional disturbance is defined as follows:
(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:
(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
(C) Inappropriate types of behavior or feelings under normal circumstances.
(D) A general pervasive mood of unhappiness or depression.
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.
(ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

The U.S. Department of Education reported that during the 1998-1999 school year, more than 463,000 children ages 6-21 with emotional disturbances were served in the public schools nationwide. These are only those students who were identified under the Individuals with Disabilities Education Act (IDEA), Part B, under the category of Emotional Disturbance. (U. S. Department of Education, 2000.) An additional undetermined number of children with psychosocial, emotional-behavioral or severe mental health problems are also served under other disability categories, such as “Other health impaired” and various learning disabilities. In addition, there are other students receiving mental health services in schools who are not categorized as disabled under the provisions of IDEA. Even so, the percentage of students with serious behavioral or emotional disabilities who receive mental health services is extremely low. According to a number of experts, at least as many as 3-5 percent of school children are considered to have serious behavioral or emotional disabilities that require intensive coordinated services; however, it is estimated that less than 2 percent of these students receive any mental health services (Hoagwood and Erwin, 1997). For youth in the juvenile justice system the picture is even worse. The prevalence of youth with emotional disabilities is estimated to be at least three to five times greater in juvenile correctional facilities than in public schools (Leone and Meisel, 1997).
II. MENTAL HEALTH IN SCHOOLS: RATIONALE FOR A SHARED AGENDA

Delivering mental health programs and services in the schools is not a new idea. Examples of existing practices include informational presentations to groups on specific mental health topics, consultation and training for teachers and other school personnel, psychoeducational assessment, individual and group therapy, one-on-one aides or mentors in the classroom for students with emotional problems, crisis intervention, post-trauma counseling, social skills training and much more. We have much to learn from these current efforts as we move to develop a shared agenda.

Most schools already employ staff with mental health expertise that offer an array of interventions. These personnel include school counselors, school psychologists, school social workers, nurses and special educators. Some school districts hire other mental health professionals specifically to serve students with serious emotional-behavioral difficulties. In effect, schools constitute one “system” for addressing the mental health concerns of children and youth.

While states provide youngsters with public mental health programs and services primarily through a completely separate system, the systems connect when local or regional public mental health agencies offer interventions in schools. Typically, public mental health providers try to offer the same menu of services at schools as they do at their agency. These efforts usually are the result of local initiatives and not part of a statewide or even district-wide comprehensive plan to provide mental health services in schools. They quite often are “addons” intended to respond to immediate needs of the school or individual students.

In spite of the best efforts of school and mental health systems, families often experience great difficulty navigating the bureaucracy and red tape when seeking the early intervention programs and coordinated services their child needs. In order to have a positive impact on child-serving systems, some family members have learned to band together through membership in support and advocacy groups to gain influence in the places where important decisions are made about service policy and practices. However, most families whose youngsters might benefit from a range of mental health programs have relatively little opportunity to provide policy recommendations to school and mental health agencies.

Schools, state mental health systems and associations representing families operate within different organizational cultures. Thus, before considering the particulars of a shared agenda among these entities, it is important to clarify some key facets of each of them. Then, to further lay a foundation for this Concept Paper, we highlight (a) a rationale for developing a shared agenda, (b) the value of adopting a shared agenda, and (c) some anticipated assets and barriers facing the partners.
Descriptions of Three Potential Partners for Mental Health Programs and Services in Schools

Potential partners for mental health programs and services in schools need to know some basics about the organization, skills, program capacities, practices, and challenges each other's systems face. What follows are brief introductions to each entity.

Public Mental Health Systems

Orientation and Organization

Public mental health systems throughout the nation are primarily the responsibility of state government, not the federal government. State mental health programs and services are typically provided under the auspices of a separate entity, usually a cabinet or department that includes community and institutional services for adults as well. In some instances, the state mental health component for children is a part of the child welfare department or cabinet, which may also include juvenile justice and other human services. Moreover, in many states, the agency that holds authority for mental health services also maintains responsibility for substance abuse and services for persons with mental retardation or developmental disabilities. In some states, those functions are under the auspices of separate or different organizational entities.

Many states use local government or private, not-for-profit community mental health centers (CMHCs) as primary providers of public mental health services for both children and adults. Because of the autonomy that CMHCs enjoy, availability and accessibility to programs and services vary considerably from community to community. Communication about state efforts in this arena is facilitated across the states through the National Association of State Mental Health Program Directors (NASMHPD).

A state's public mental health program for children is often separate from that state's public education program. Although they often serve many of the same children, education and mental health systems operate under separate, and in many ways, different mandates, missions, philosophies, funding streams, goals, and practices.

Historically, public mental health systems have been designed on a medical model that is deficit-based and divides treatment into outpatient services and inpatient care (including residential or hospital services). Up until fairly recently, the mental health professional's authority in all major treatment decisions was generally unquestioned and the role of the family was often ignored or considered detrimental to the child's well being. In the past ten or fifteen years, however, most public state and local mental health agencies have adopted a more family-centered, community-based model for children and their families. This approach stresses the importance of serving children in their own families and communities in ways that are strength based and in partnership with families. Rather than relying solely on outpatient and inpatient care, more agencies recognize the importance of developing a full array of services for children and their families, including service coordination, therapeutic foster care, in- and after-school programming, respite care, crisis stabilization, and other interventions and services.

Significant federal research and technical assistance have been made and targeted toward building relationships with family systems and developing school-based service continuum. In recent years, the U.S. Department of Health and Human Services has made significant invest-
ments in school health (including mental health). For example, the Centers for Disease Control and Prevention (CDC) have provided infrastructure grants to states interested in promoting coordinated school health programs. The Maternal and Child Health Bureau (through its Office of Adolescent Health) and the Bureau of Primary Health Care have provided funding for programs and for technical assistance and training centers to support school health (both physical and mental). The Substance Abuse and Mental Health Services Administration provides Safe Schools/Healthy Students grants that require mental health and education to coordinate services.

MANDATES AND FUNDING

True reform and more recognition of children’s mental health systems on the federal level began to have impact on state policy and funding in the early 1980s. The major stimuli for these reforms have been (1) a relatively small federal grant program—the Child and Adolescent Services System Program (CASSP), and, (2) a number of other related initiatives funded by the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services. As a result, almost every state and territory, at least in some of its communities, has begun to develop a more collaborative system of care for children and youth with severe emotional disturbances. The system of care framework that has nurtured these federal efforts stresses the importance of developing a wide array of community-based services that a child and family accesses through service coordination, usually guided by interagency and interdisciplinary teams. These services strive to be culturally responsive, child-centered and family focused and driven. Implementation of systems of care varies greatly from state to state. Evaluation findings are somewhat mixed, but overall suggest promising outcomes.

Federal law requires states to provide an array of services and the federal Center for Mental Health Services (CMHS) requires an annual plan for services to children and adults in order to receive federal block grant funding. Funding must target community-based services, not residential or institutional services, for both adults and children. However, these funds must be used by states to serve adults with severe mental illness and children with severe emotional disturbances.

Mental health block grants comprise a small portion of most state mental health agencies’ budgets. Moreover, this funding carries no mandates, like those in federal child welfare laws that require the state to meet the needs of all children in its custody. Most state mental health services are delivered by county or regional community mental health centers that are governed by boards responsible for the fiscal viability of the organization. Most regional, county or local mental health boards are private, not-for-profit corporations. In order to maintain operations, these centers must work within their budgetary constraints. They cannot run a deficit and stay in business very long. Because there is no federal mandate, public mental health providers must limit both the types and amounts of services available to the general population.

Two other funding issues factor into the provision of public mental health services. First, since their inception, the federal children’s mental health initiatives that began with CASSP have focused services solely on those children and youth with severe emotional disturbances (SED) and their families. Following the lead (and, more importantly, the funding) of the federal government, most state mental health agencies concentrate on addressing the needs of this population.
The other major funding issue in most states is that Medicaid is a major, if not the chief, source of funding of children’s mental health services. Whether under Medicaid managed care, the rehabilitation option or any other Medicaid program, service funding is linked to a determination of “medical necessity” criteria for that individual child or youth. This requirement makes positive child and youth development programs, including parenting and formal programs that teach social and problem-solving skills; problem prevention programs and activities; and, some early intervention services, difficult to fund under Medicaid.

In a number of states, the public mental health agency partners with other state agencies to win federal and foundation grants for mental health-related issues, such as school safety, prevention initiatives of the Bureau of Maternal and Child Health, and other programs that require collaborative efforts among child serving agencies. Other states have designed collaborative service models that utilize federal CMHS children’s mental health funds for children and youth with SED, while also participating in more comprehensive programming that includes prevention and early intervention efforts.

Schools and Mental Health Services

Orientation and Organization

Over the years, schools have been required to assume more and different responsibilities for children and youth, along with increased accountability for high achievement of all students. In order to ensure academic achievement, schools must also attend to students’ health, well being and behavioral concerns. Deficits in social/ emotional health and well being present serious barriers to learning for many children and must be addressed. At the same time, education personnel recognize that they alone are unable to meet all the needs of all their students.

Two of the most popular delivery methods are school-linked delivery and school-based delivery of services. There are many variations in configurations of multiple agency collaboration that provide and improve access to health services, specifically mental health services. They operate on a continuum of coordination, collaboration and integration. School-linked include various types of formal and informal arrangements across agencies and schools designed to meet mutual goals. School-Based services are located in a school or on school grounds and are designed to provide onsite preventive and direct services.

“…..comprehensive systems-change initiatives are designed to create a seamless web of supports and services that “wrap around” children and families and to bring an end to the current fragmentation and categorical separation of school agency-directed programs.”


Twenty-second annual report to Congress on the implementation of the Individuals with Disabilities Education Act, p. III-9.
Multiple agencies have invested and provided technical assistance to develop relationships among family, agencies and schools. The United States Department of Education, Office Of Special Education Programs (OSEP) follows a research-to-practice paradigm that supports the effective translation of research into improved practice. This paradigm has guided investment in Research, Technology, Training, Technical Assistance, Parent Training and Information Centers, Evaluation and State Improvement Grants. Mental health investments can be found in each of these areas including investments in specific topics such as positive behavioral interventions and supports, safe schools, effective mental health practices, school mental – health collaboration, and delinquency prevention and individuals with disabilities in the juvenile justice system.

The school board, superintendents, principals and other top administrators at the local level are the key decision-makers for schools. While there are varying levels of state and local oversight, local school districts have a great deal of autonomy. As a result, school districts’ approaches and emphases, and even definitions of mental health programs and services, differ widely.

Depending on the resources of the school district, these interventions may be delivered by school staff, including school psychologists, counselors, social workers, nurses and special educators. School personnel are involved in promoting healthy social and emotional development and applying strategies and staff training for ensuring a safe and healthy school climate (including addressing discipline problems). They also work with students identified with severe emotional or behavioral problems. Some school districts contract with outside mental health providers for school-based or linked outpatient mental health services.

Local education agencies are able to seek information and assistance in effective school mental health planning through several national organizations, including the Council for Chief State School Officers, the National Association of State Boards of Education, the National Association of State Directors of Special Education and many other groups.

**Mandates and Funding**

Over the past 30 years, support for the provision of mental health services in schools has waxed and waned and currently is in a period of resurgence. In 1975, the passage of Public Law 94-142, now called the Individuals with Disabilities Education Act (IDEA), mandated services for students identified under 13 disability categories, each with specific identification criteria. It is commonly recognized that the sources of funding have not kept pace with request for services. This discrepancy has been a source of increasing tension between education, mental health agencies, and families and within the education establishment itself.

Several major public laws signed into law in the mid-nineties have added support to the movement to provide mental health services in schools. The Improving Americas’ Schools Act and the Goals 2000: Educate America Act enacted in 1994 mandated development of a more comprehensive approach to meeting the needs of low achieving students. In 1997, the IDEA Amendments (P.L. 105-17) were enacted. Among other important provisions, IDEA 97 provides increased support for improvement grants through state education departments and for prevention and early intervention programming. It calls for functional behavioral assessments and behavioral intervention supports for students with disabilities experiencing behavioral and disciplinary problems. 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.
The recently enacted “No Child Left Behind Act of 2001” reauthorizes and amends the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.). One section, “Subpart 14—Grants to Improve the Mental Health of Children, “Sec. 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”. This subpart appears to hold promise for developing collaboration between schools and mental health agencies at the local level.

**NO CHILD LEFT BEHIND ACT OF 2001**

Subpart 14—Grants to Improve the Mental Health of Children, 
SEC. 5541. GRANTS FOR THE INTEGRATION OF SCHOOLS AND MENTAL HEALTH SYSTEMS

(c) USE OF FUNDS.—A State educational agency, local educational agency, or Indian tribe that receives a grant, contract, or cooperative agreement under this section shall use amounts made available through such grant, contract, or cooperative agreement 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 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, and make recommendations to the Secretary about sustainability of the program.
Public funding from a variety of sources currently support research and training centers that enhance school mental health services. Two of these centers, the Center for School Mental Health Assistance at the University of Maryland Baltimore, and the Center for Mental Health in Schools at the University of California Los Angeles, have the broad-based enhancement of mental health in schools as their mission.

Federal investments are breaking new ground in cross-agency work. Increasingly, there are opportunities for state and local cross-agency collaboration drawing on the research and technical assistance provided by federal investments.

**Families and Youth**

For purposes of this paper, the family and youth component of the shared agenda refers broadly to groups or organizations made up of youth, parents and family members of children and youth who are in schools and who are concerned with enhancing systems for mental health. Family and youth organizations continue to have an ever-increasing impact on the public human service sector. This component consists of a diverse confederation of organizations, advocacy groups or associations. Organizations of this type should be considered equal partners with schools and other agencies in defining the shared agenda. Unless families and youth, through their organizations, are at the table in meaningful ways, any attempt to form an effective shared agenda will be severely compromised.

Families are defined broadly here. A family consists of minor children or youth, and their parents, primary caregivers, and others either legally or informally bound to one another. In addition to biological parents, family members may include foster parents, adoptive parents, grandparents, other relatives or friends who assume the parental, custodial, or other supportive role. In other words, the family defines its members by function rather than merely by birthright.

**Orientation and Organization**

Families and youth make up the largest stakeholder group—the consumers of, and advocates for, mental health programs and services. It is their collective voice that must be heard in formulating the vision for a single collaborative and coordinated system that meets the social-emotional, well being and mental health concerns of all youngsters.

Successful interagency partnerships make every effort to include family members in the decisions and actions that affect their own children. Parents and other family members are the experts on their own children, and, insofar as possible, they must be allowed, encouraged and supported to participate actively in every aspect of decisionmaking regarding their children. Many families also participate in decisionmaking around policy development or system and program planning, implementation and evaluation. Family leaders who have the trust and the support of other families in an organized group are empowered to speak and act on behalf of many families when important decisions are made.

Family and youth organizations certainly are not systems in the same sense that mental health and education are. Unlike state agencies, families and youth and their advocacy groups reflect widely varying missions and goals. Family organizations are often focused on specific aspects of child welfare, or specific conditions such as autism or Tourette's syndrome. Often, in order to have an impact on the larger system, family and youth organizations participate in larger state coalitions around broader issues of children's social and emotional well being.
MANDATES AND FUNDING

Most family support and advocacy groups do not enjoy the relatively stable public funding provided to public agencies. They are often dependent on federal, state, local or private grants, and on the voluntary participation of their members, many of whom are already coping with family challenges and stresses.

Few family and youth organizations that focus on children's mental health have a strong statewide voice; their issues and concerns are more often local and specific, and often their influence does not span the whole state as do state agencies. Their relationships to the various state agencies are often quite complex. As advocates for more and better services, they sometimes are supportive of, and are sometimes adversarial to, the agencies that serve children and youth—depending on the issue at hand. Being consumers of services, as well as advocates and partners with policymakers and providers, creates a unique tension that all involved must become adept at addressing and balancing.

Rationale for a Shared Agenda

Family and youth organizations, public education and state mental health systems share key values and goals. All want every child and young person to become a healthy, productive and caring citizen. All want safe and effective schools, homes and communities. All acknowledge the need to improve positive family participation and cultural responsiveness to families. Therefore, one major reason for pursuing a shared agenda is that all three parties already share many common values and goals.

Responsible, strategic use of limited resources demands a shared agenda. A well-planned and implemented agenda can be expected to do better in identifying needs and deploying resources, resulting in more comprehensive, integrated and cost-effective programs and services. A shared agenda also would foster enhanced accountability for public dollars. Particularly at this time of national crisis, we must pool our resources and coordinate our service planning to address the urgent mental health needs of children, youth and school personnel.

The complex and multiple needs of children facing significant mental health challenges cannot be met without a shared agenda. Currently, many children fall through the cracks as a result of too many specialized programs working in isolation. Successful outcomes—especially for children and youth with complex and multiple needs—depend on how well schools, mental health agencies and families work together. A shared agenda will help strengthen working relationships among all the partners, thereby ensuring that these children and youth receive the services and supports they need.

The timing is right to develop a shared agenda. Leaders of family and youth organizations and state education and mental health systems realize that no one system can adequately address the needs of all children. Moreover, the three potential partners all are in the midst of significant changes. More than ever, family voices include a variety of languages and cultural and ethnic backgrounds. At the same time, school and mental health reforms are creating more opportunities for interagency partnerships and integrated programs and services. The intersection of these forces create a push for change and opens the opportunity for developing a shared agenda.
The Outcomes We All Want

Any successful partnership is outcome-driven. For a collaborative effort of this sort to thrive and sustain, it must demonstrate positive outcomes for children and youth. Each of the partners already brings to the table a set of particular desired outcomes for children and youth and for each of their systems. In the very early stages of development of the shared agenda, partners must identify what their distinct sets of outcomes share in common, and build their partnership on this common ground. The ownership that the partners experience over this common set of outcomes nurtures mutual responsibility, a crucial dimension of successful collaboration. Academic achievement becomes not only the responsibility of the schools, but also of mental health agencies and family organizations. Children’s social-emotional and behavioral well-being becomes not only the responsibility of families and mental health agencies, but also of schools. Listed below are typical outcomes that partners might consider. This list is intended to be suggestive, not comprehensive.

**Outcome for Children and Youth**

- Academic achievement for all children and youth
- Improved readiness for learning (i.e., better attendance, grades, decreased discipline referrals, drop-out rates, etc.)
- Improved social and emotional functioning, with peers, teachers and family
- Improved skills for achieving economic self-sufficiency and independent living
- Improved mental wellness (including positive behavior, emotional intelligence and thinking and coping skills)
- Improved satisfaction with school by children and youth
- Greater involvement in decisionmaking

**Outcome for Families**

- Higher participation of families in all aspects of the school’s mental health initiatives—from individual treatment planning to program planning and evaluation
- Enhanced family support
  - From peers
  - From school and mental health personnel
  - From the community
- Improved family satisfaction with school and mental health services
- Increased family access to sources of information
- Increased family access to community-based services
- Increased choices/options available to families
- Increased shared authority and accountability for all decisions affecting children and families
- Improved family relations

**Outcome for Systems**
- Safer and more effective schools as a result of a more supportive school culture and climate
- Better trained workforce with enhanced skills
- Improved personnel competence, job satisfaction and retention
- Improved coordination and compatibility between education and mental health approaches/services
- More efficient use of limited resources
- Cost efficiency: decreased costs, increased productivity and improved outcomes

**Outcome for Communities**
- Healthier and more productive citizens
- Improved quality of life for citizens
- Increased citizen contribution to community’s welfare
- Fewer youth in juvenile justice system
- Decreased need for more intensive health care (e.g., reduced demands in public health facilities, psychiatric hospitals, residential treatment and substance abuse treatment)
- Decreased stigma, more acceptance of mental health services
- Decreased school suspensions and expulsions
- Increased after-school activities/involvement
- Raised awareness about youth mental health, the gap between needs and resources and a sense of urgency to do something about the problem
- Decrease in youth and community violence
- Better attention to people victimized and exposed to physical and other forms of violence
- Improved environment of community information-sharing, problem-solving and idea development that involves all the stakeholders
III. MOVING FORWARD: FORGING NEW PARTNERSHIPS FOR A SHARED AGENDA

Building on Strengths; Dealing with Challenges

Key Assets of Each Partner

Family Organizations bring passion and knowledge based on practical, real-life experience. They understand their children’s strengths and difficulties in coping with the stresses of growing up. Families and youth can provide the child-serving systems critical feedback on the accessibility and effectiveness of services. Not only are parents and other family members the real experts on their own children, they often, of necessity, become experts in navigating the systems. This is true of many youngsters as well.

Families and youth know what works and what does not work. Many organizations provide a strong family and youth voice. Thus, they are in a unique position to teach policymakers and providers about cultural competence and system responsiveness. They can also play a potent role in teaching practitioners about how to make their systems and services more family-friendly. In addition, they provide an invaluable base of support and assistance when families and young people are in crisis related to mental health or other concerns. Just as importantly, they provide advocacy training and leadership development for their members. Family members gain knowledge of the systems with which they are dealing and skills to participate productively in discussions of policy and practice.

Education agencies and schools represent a system of universal access for every child. In their responsibility to ensure high standards of achievement for every child, schools are exploring reforms leading toward creating learning environments that are responsive to a wider array of student learning needs. The field of education has discovered effective research-based structures and practices that offer behavioral supports and interventions to build school climates favorable to learning. These approaches encompass positive child and youth development, prevention of problems and early intervention strategies as well as addressing school climate and discipline. Many school administrators across the country have embraced a number of whole school approaches to build a healthy, safe and nurturing school environment and a positive school climate. Such approaches dramatically decrease disciplinary actions, visits to the principal’s office, absences and tardiness and increase academic performance and positive interactions among students, teachers and between students and teachers. Additional funding
and support for preventing school violence has also provided schools with new and exciting resources that address proactive mental health promotion and early identification of at-risk children and youth and students who need assistance. Public schools, by their very nature, provide the most natural environment in which to offer students of all ages and abilities these kinds of assistance.

The state public mental health agencies in most states have made great progress in improving children's mental health services in the past fifteen years. Under CASSP, the system of care for children and youth with severe emotional disturbances emphasizes the importance of strength-based interventions, interagency collaboration, serving children in the least restrictive settings, family involvement, cultural competence and other key principles. For most states, a major incentive for developing a community-based system of care is to reduce the large number of unnecessary placements of children in hospitals and other large institutions. As this approach evolves, many state mental health authorities and public community mental health centers are learning how to work closely with other agencies and to involve family members in meaningful and important ways. Today there are more community-based services for children, youth and their families than ever before, including therapeutic foster care, day treatment, crisis stabilization, respite care and other non-traditional programs and interventions. Appropriate services and supports are “wrapped around” children and youth through service coordination (case management) and service teams for each child.

Not every state has adopted a system of care approach. It is sometimes not available statewide even in those states that have embraced the strategy. Nevertheless, the initiative has developed a rich research literature and technical assistance component. What we have learned about collaboration, family involvement, cultural competence and other aspects of mental health services for children reinforces and complements the work that the education system is doing in these areas. The public mental health system’s strong emphasis on serving children and youth with severe emotional disturbances and their families is an important area for collaboration with schools.

Challenges to Developing a Shared Agenda

Policymakers from mental health and education agencies and family organizations face a number of major challenges in developing a shared agenda. These challenges, however, are not insurmountable. Most of them stem from, or reflect, the significant differences among the partners.

Mental Health And Education. While sharing many values and overarching goals, each agency has developed its own organizational culture, which includes a way of looking at the world, a complex set of laws, regulations and policies, exclusive jargon and a confusing list of alphabet-soup acronyms. Funding sources at the federal, state and local levels have traditionally reinforced this separation into “silos.” The result is that agencies are almost totally isolated entities, each with its own research and technical assistance components and its own service delivery system, even though they are serving many of the same children.

The isolation of each agency, combined with its bureaucratic complexity, requires a long-term commitment of all partners to bridge the gaps between them. Collaborative structures must be based on a shared vision and a set of agreed upon functions designed to enable a shared agenda. Legislative, regulatory or policy mandates may help bring agency representa-
tives to the table, but development of true partnerships and the successful accomplishment of goals depends on participants gaining trust in one another as they pursue a shared agenda.

Family And Youth Organizations. Barriers to family involvement are well documented and require little elaboration here. Examples include professionals who view the family as the cause of the child’s problem (parent blaming), who relegate parents and other family members to the subordinate role of client or hold the view that professionals always know best, or who are insensitive to family work schedules and other difficulties related to working as partners. With respect to family and youth organizations, probably the major barrier is the difficulty they have in speaking with a unified voice. As indicated earlier, family organizations are not a “system” in the same sense as are state mental health and education systems. However, to have major influence, family and youth organizations often need to coalesce. In successful partnerships, family organizations usually form coalitions with different associations and groups to enhance and represent their views.

As potential partners beginning to forge a shared agenda, agencies and organizations need to assess what each brings to the table and learn to build on each other’s strengths and deal with the challenges of working together. Over time, it will help to identify such strengths and challenges in an organized way. To illustrate the point, some key examples of current strengths and challenges are offered below. They are organized with reference to specific arenas of activity that are relevant to fashioning a shared agenda. These include values, policy, funding and infrastructure as well as legal matters, advocacy, leadership and capacity building.
Creating a Shared Agenda: Current Strengths and Challenges

Values, Policy, Funding and Infrastructure

Some major strengths:

- All potential partners share some core values and goals:
  - strong family participation in their children’s schools and other agencies that serve them;
  - effective cultural responsiveness, better and more productive lives for children, youth and families; and
  - stronger and safer communities and schools.
- A number of federal agencies are offering grants that require interagency collaboration.
- Federal child-serving agencies are partnering to offer grants on areas of mutual concern. The Mental Health “System of Care” philosophy and framework over the years have generated research and technical assistance in how to accomplish successful interagency collaboration.
- IDEA and the Elementary and Secondary Education Act (ESEA) support collaborative efforts among all agencies on behalf of all children, including infants, toddlers, preschoolers and youth. Both laws encourage early identification and intervention.
- State mental health and education agencies often control or have access to significant funding streams, such as general and special education grant initiatives, Medicaid, state general revenues, federal mental health block grant and other grant programs. Carefully planned and coordinated utilization of these multiple funding streams could help improve the whole child-serving system.
- Many states and communities have policies in place that establish interagency groups at the state and local levels.
- Some states have statutes that support or mandate interagency collaboration and joint or interagency funding to develop a shared agenda among child-serving agencies and families.

Some major challenges:

- Oftentimes, because each system is so invested in its own mission, there is little attention or value placed on the difficult work of building a shared agenda with other agencies or organizations.
- In spite of improvements, there is still a lack of data and information on what we are doing, how much it costs, and the outcomes of interagency collaboration.
Different federal agencies with common missions and goals often have not examined their respective authority and alignment. This often results in fragmented efforts at the state and local levels. Strict categorical funding often creates barriers to partnering creatively.

Many state and local agency policies do not support interagency collaboration.

Policy at some state and local levels is practiced inconsistently and the infrastructure for developing a shared agenda is weak.

Even when collaborative policies are in place, turnover of key players and stakeholders can threaten the infrastructure.

Services to infants, toddlers, and preschool children are often not linked to the full range of prevention and intervention services.

Provision of services to young children is often not well coordinated with provision of services to older children.

**Legal matters**

**Some major strengths:**

- Proactive legal analysis and sharing of information can help in developing a shared agenda.

- Client confidentiality has been successfully addressed in many interagency partnerships; it need not be a barrier to working together.

- Litigation often can be avoided when all partners are working together on behalf of children and youth; however, when necessary, litigation helps to affirm the rights of people and to develop resources so that agencies can carry out their duties to the intended beneficiaries.

**A major challenge:**

- Fear of liability and litigation can interfere with risk-taking and making positive changes.

**Advocacy**

**Some major strengths:**

- Effective family advocacy for services and supports for children, youth and families can move and change systems, empower families and inform and support good policy and practices. Legislators are more responsive to their constituents than to agency bureaucrats.

- Self-advocacy is a right that is increasingly claimed by youth and families. Effective partnerships can provide a forum to resolve difficulties around self-advocacy and reduce costly and antagonistic litigation.
SOME MAJOR CHALLENGES:

- Advocacy can be counterproductive to build a shared agenda if it is based only on narrowly conceived self-interest.
- Strong competition among special-interest groups and organizations can be divisive and counterproductive to developing a comprehensive shared agenda. Indeed, an unintended result of advocacy from special interest groups may help perpetuate categorical funding (“silos”) of programs within service-delivery systems, which often inhibits the development of a shared agenda.

Leadership

SOME MAJOR STRENGTHS:

- Together, committed and skilled agency and family leaders with vision, passion and relationship-building skills can create a shared agenda. Moreover, they influence and model effective collaboration for their own agencies or organizations.
- Strong leadership in the advocacy community can promote and support an effective shared agenda.

SOME MAJOR CHALLENGES:

- Leaders of key agencies or organizations who are uncommitted to the partnership, or who lack leadership skills, can seriously inhibit effective partnering. Their lack of commitment adversely affects collaborations at all the organizational levels below them.
- Bureaucracies often encourage risk-avoidance behavior.

Capacity Building

SOME MAJOR STRENGTHS:

- A number of federally funded projects have developed excellent curricula and training programs for cross-training personnel from multiple agencies on whole school approaches to meeting the social-emotional and mental health needs of all children.
- Institutions of higher education can become valuable resources in developing and implementing a shared agenda, through ongoing research and training.

SOME MAJOR CHALLENGES:

- Schools and mental health agencies face serious difficulties recruiting and retaining enough qualified and well-trained staff, especially in rural areas.
- Colleges and universities do not provide enough state-of-the art training and education to educators, mental health workers and other service providers on meeting the social-emotional and mental health needs of children, youth and families.
- Institutions of higher learning still do not sufficiently address interagency collaboration as a research interest.
Building a Common Conceptual Framework

Common frameworks help shape policy in consistent, congruent and cohesive ways. Successful intervention partnerships need to adopt a common conceptual framework for meeting the complex needs of all children, youth and their families. A conceptual framework provides the basis for clearly articulated policy and should drive the implementation of a shared agenda in ways that yield a comprehensive, multifaceted and cohesive continuum of interventions.

The Foundation of a Shared Agenda: A Common Conceptual Framework

The multi-tiered framework described below is based on a public health model. It provides a comprehensive foundation upon which to build a shared agenda among family organizations and state mental health and education agencies.

A number of initiatives within different federal agencies have adopted the core aspects of this particular public health model. These initiatives use somewhat different language in describing the three major tiers or levels of intervention or activities, but all of them agree on the notion of a continuum of services or systems that is necessary in meeting the social, emotional and mental health needs of all children and youth.

The framework below differentiates three basic levels of intervention: (1) positive child, youth, and family development and prevention of problems; (2) early intervention; and (3) intensive interventions and supports. Descriptions of the three levels follow.

The Multi-Tiered Framework
POSITIVE CHILD, YOUTH AND FAMILY DEVELOPMENT AND PROBLEM PREVENTION

Promoting Positive Development. All systems that support children and youth must be con-
cerned with promoting social-emotional development and learning. This includes parenting
and formal programs that teach social and problem-solving skills. It encompasses enrichment
and recreation programs, both during school and before and after school. It involves training
teachers and staff on how to support positive school and classroom behavior.

Creating and sustaining a supportive environment for children and youth is a community-
wide responsibility. The school is a critical part of that environment. Activities that create a
sense of community through personal relationships and connections help create safe and sup-
portive environments. School and service agency personnel can model appropriate behaviors,
create a climate of emotional support and demonstrate commitment to working with all
youngsters. Equally important, personnel must be provided with support and assistance in
sustaining a healthy school and service agency climate.

Problem Prevention. Preventing foreseeable and recurring problems include promoting
healthy development and safe environments. It also includes creating systems of prevention
for all children and families.

Examples of programs to promote positive development and prevent problems are: welcom-
ing and social support programs for new students and their families, values-based alcohol and
drug education and support for transitions and child abuse education.

In some schools and communities, the majority of students will require no more than this
first level of intervention.

EARLY INTERVENTION

This level involves addressing emotional and behavior problems children experience at an
early age and intervening as soon as a problem occurs, no matter what the age of the child.
Examples include small group activities, behavioral support plans, after school programs and
dropout re-entry programs.

INTENSIVE INTERVENTIONS AND SUPPORTS

This level includes more intense and sustained services and supports for children who experi-
ence severe, persistent, or chronic emotional or behavioral disabilities (about 3-5 percent of all
children). These children and youth and their families usually require individualized multidis-
ciplinary and multi-agency service plans to access a coordinated system of care. Examples of
strategies within a service plan include intensive home-based services, respite care, individual,
group, and family therapy, therapeutic foster care, crisis intervention, intensive after-school
programs and in-school aides, all of which are linked through service coordination.

This multi-tiered framework is a helpful way to conceptualize the continuum of services and
interventions, and to recognize them as a coherent system. Arguing over whether a particular
intervention fits into one level or another is counterproductive. For instance, whether any
school-wide activity is “prevention” or “positive youth development” for purposes of our discus-
sion is not as important as understanding that all systems must conceptualize and build a con-
tinuum of interventions as complete as possible, from the least intensive and restrictive to the
most intensive and restrictive.
SOME FEDERALLY SUPPORTED INITIATIVES THAT ARE GROUNDED IN THE MULTI-TIERED FRAMEWORK

The multi-tiered framework described is the foundation for a number of federally supported systems change initiatives and programs.

EDUCATION

- “Safeguarding our Children,” 2000, Departments of Education and Justice
- The Technical Assistance Center on Positive Behavioral Interventions and Supports (PBIS)
- The National Center on Education, Disability, and Juvenile Justice (EDJJ)
- The Center for Effective Collaboration and Practice (CECP)

MENTAL HEALTH

- “Building Bridges of Support: One Community at a Time,” a five-year grant to parts of Appalachian Kentucky under the Comprehensive Community Mental Health Services for Children and Their Families Program, funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration
- Policy Leadership Cadre for Mental Health in the Schools, “Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations,” 2000

The Promise of a Conceptual Framework

The multi-tiered framework provides a foundation for mapping policy and program development. It is a commonsense approach that can apply to all programs and services. The framework represents a conceptual shift and grounds a shared vision of systemic interventions that drive the planning and implementation of services directed toward the well being of all children. Moreover, if positive child and youth development, problem prevention and early intervention strategies are in place, and students receive the kind of help they need earlier, fewer children will need intensive interventions.

Using a common and comprehensive framework, mental health and school staff can appreciate and pursue a more integrated role in comprehensive school-wide efforts to meet the social-emotional needs of all students. Mental health workers practice what they know best—conducting psychological evaluations, or individual and group therapy—and too often see little opportunity to address the environment in which they are working. As “insiders,” these mental health workers can become knowledgeable about how the school is organized and works, be co-trained with school personnel on school-wide approaches and integrate all their efforts into the school’s culture. They will work with the schools to identify and seek intensive mental health services for those students who need them, but they will do so as a part of a school’s comprehensive, multi-faceted, and integrated approach for all students.

Education, mental health systems, families and youth can join together. They already are doing so in communities around the nation. Through shared initiatives, they are addressing barriers to learning and improving the lives of all young people. It is time to move to action in every community and school.
Aligning Policy and Practice to Facilitate Effective Partnerships for a Shared Agenda

Policies and practices are key factors in the effectiveness of partnerships. It is important to recognize the different but related interests of each organization.

Education policy focuses the school’s critical role in promoting the mental wellness of all students and the role in promoting healthy school climate and improving educational outcomes.

Mental health policy stresses the importance of integrating child and youth development, 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. This emphasis on prevention and early intervention can enhance community-wide mental wellness and reduce costs by reducing the numbers who need the much more expensive interventions required for treating severe emotional disturbances.

In general, state agencies might seek to align policies within an agency and among agencies through review teams composed of local and state professionals, family members and community partners. While resulting polices and practices will not be identical, they may become more consistent with the agencies’ values and principles.

Among the first steps that education and mental health agencies might take to align policies that will eventually support practice are:

- **Identify common values and goals**: Agencies should strive to ensure that the social-emotional and mental health needs of all children and youth are met with the least intrusive activities and interventions, in the least restrictive setting, at the earliest possible time. A strong emphasis should be placed on practices that build on the strengths and competencies of all children, staff, families and other community stakeholders.

- **Commit to family-centeredness**: Reinforce the responsibilities of child-serving entities to:
  - Support the integrity and unity of the family
  - Provide mechanisms to ensure family-centered services
  - Acknowledge and utilize the family’s cultural strengths
  - Design and implement systems that empower the participation, planning and decision-making by families

- **Design integrated training**: Facilitate the joint development and implementation of comprehensive and coordinated curricula for all partners. These curricula should include core competencies for all and specialized skills for each of the components of the multi-tiered framework. Cross-train all partners in core competencies as much as possible.
Pursue shared accountability: Ensure a joint accountability system that identifies and measures desired outcomes, tracks costs, and improves effectiveness and efficiency of the collaborative efforts. Facilitate the sharing of individual, aggregate and system information across systems, while assuring appropriate confidentiality for children, youth and their families.

Coordinate funding and budgeting: Enable the development of a coordinated budgeting process that ensures that partners maximize all funding sources and eliminate waste and duplication of effort.

Create flexibility that supports local initiatives: Through waivers and other means, make efforts to allow for local agency creativity in designing and implementing best practices.

Note: The collaborative approach and the multi-tiered framework promoted in this Concept Paper are intended to include all state and local child-serving partners. In addition to education and mental health agencies and family organizations, it is directed toward public health services, child welfare, juvenile justice, family resource and youth service centers, faith-based organizations, private service and recreational organizations, and other interested groups. This Concept Paper focuses on the relationships among families and youth and public mental health and education systems. This does not mean to imply that these partners are the only possible ones. Depending on the current political, fiscal and other circumstances in a particular state, any number of key agencies or organizations can begin the kind of work needed to realize this vision.
IV. RECOMMENDATIONS FOR IMMEDIATE ACTION

The following recommendations are formulated in terms of action steps that will be initiated through NASMHPD and NASDSE. These two national organizations represent individuals who have the influence and authority within states to introduce change. Through their interaction in The Policymaker Partnership, these two groups can shape national discussions while forging action initiatives and engaging other important stakeholders at the state level. Collectively, their efforts may allow states to reconceptualize their relationship with the individuals and families that are the consumers of their service. As well, their efforts should enable a shared agenda across agencies. Toward this end, the advisors to this document recommend that NASMHPD and NASDSE work through the Policymaker Partnership and the IDEA Partnerships to:

A. Initiate the process for implementing the recommendations: Establish and maintain a national cross-sector advisory body.
   After a planned national dissemination of this document, NASMHPD and NASDSE should maintain communication among the members of the Concept Paper task force for the purpose of advising states and national organizations as requested.

B. Identify and convene teams from interested states.
   NASMHPD and NASDSE should convene cross-sector teams from states that wish to pursue the vision presented in this document. These teams will become a work group focused on these issues. Their work will inform each other and the national organizations and agencies in their related fields. Each state will identify the ways in which the cross-sector teams will work to support this vision within their state framework.

   NASMHPD and NASDSE should support states in:
   - Identifying ways in blending and braiding resources in support of a shared agenda. Blending of funds imply that funds are mixed for a common purpose and lose their categorical identity. Braiding implies that resources dedicated to address similar concerns are woven together to strengthen each other’s efforts.
   - Developing of a “change agent” mindset throughout the cross-sector teams.
   - “Bridge building” strategies that link the state agencies with the local agencies in actualizing a shared agenda.
Creating durable partnerships, including alignment of missions, policies and practices across agencies, shared accountability, resource mapping, redeployment of existing resources, and action planning.

Facilitating communication, coordination, problem solving, and sharing of lessons learned.

Initiating capacity building efforts, including cross-training, that have potential to move the shared agenda beyond demonstration sites and develop efforts at scale across the states.

Adopting strategies that develop leadership across systems at all levels.

C. Engage and involve the researchers and technical assistance providers in education, special education and mental health.

Each agency makes research investments that provide information that is essential in guiding system decisions. Each agency also supports a network of providers that assist state systems in making and sustaining change. In each organization family groups are active in bringing information to the consumers. It is important to involve these researchers, providers and family groups as they play key roles in system change efforts at the national, regional, state and local levels.
V. CONCLUDING STATEMENT

For over a decade policymakers, educators, mental health personnel and families have recognized that both academic and non-academic barriers threaten school achievement and community participation. Education and well being are interrelated. Healthy families support school performance. Likewise, school success helps families and supports the goals they and their children have set. Today’s families are challenged by a number of complex problems. They have a variety of needs. Today’s schools share an interest in seeing that those needs are met. For these reasons, policy in education, health and mental health have encouraged co-operation, collaboration, cost sharing and, in some cases, consolidation of services.

Beginning with a commonly accepted, multi-tiered framework, partners can forge a shared agenda to which they will commit their work and their resources. Achieving the promises of this shared agenda requires true commitment. Partners must believe that the payoff in better outcomes for children, youth and their families is worth the investment of time, energy and money.

A number of highly successful state and community initiatives demonstrate that such investments are indeed worthwhile. Given the promise of enhanced partnerships, it is time to align policy and practice across agencies and move forward together.
References


APPENDICES

A. The Development of the Concept Paper
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      Contact List (10/4/01)
   2. Additional Technical Readers

B. Resources for Mental Health in Schools
   1. Selected Literary Resources
   2. Other Selected Resources

C. The Dimensions of an Accountability Framework
Appendix A. Development of the Concept Paper

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Appendix B. Resources for Mental Health in Schools

B-1. Selected Literary Resources


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Appendix B. **Resources for Mental Health in Schools**

**B-2. Other Selected Resources**

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Center for the Study and Prevention of Violence, Institute for Behavioral Sciences, University of Colorado-Boulder Campus, Box 442, Boulder, CO 80309-0442; 303-492-1032; fax: 303-492-3927; http://www.ccbsd.net


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Appendix C.  The Dimensions of an Accountability Framework  

As developed by the Mental Health Workgroup (in rank order)

All potential partners in a shared agenda for children, youth and their families must be concerned about accountability for resources and outcomes. Education and mental health agencies and family organizations should develop a shared accountability framework. Here are some key dimensions of an accountability framework that should be addressed:

1. Move toward aligned missions and shared outcomes.
   Within this dimension, building consensus on outcomes meaningful to all stakeholders is an important aspect. Additionally, understanding the interconnectedness of outcomes (e.g., improved academic outcomes are connected to improved emotional functioning) is vital. Without acknowledgement of this interdependency, all systems fail to reach desired outcomes. A leadership summit could begin this process and actions, agreements and mechanisms across systems could be developed through such a process.

2. Develop a mechanism for children, youth and families and ensure that it is inclusive of all systems.
   A mechanism or team should be established to help guide all child-serving agencies, including children, youth and families, to develop shared outcomes and to monitor their achievement on an on-going basis.

3. Improve communication and problem-solving mechanisms across systems.
   Enhanced communication between and among key stakeholders (including state policymakers, children, youth and families, local policymakers and community leaders, university personnel) is critical to a functional accountability framework. Without establishing such communication mechanisms, systemic change will not be achieved at all levels.

4. Ensure compatibility in accountability mechanisms across systems and connect resources to performance.
   The promotion of common and shared indicators is important both to a shared vision across systems and to achieving desired outcomes. Growth and progress toward identifying and then achieving positive indicators should be linked to providing additional resources to programs and initiatives that assist in achieving these outcomes.
5. **Align and/or develop resources to achieve outcomes identified through the accountability mechanisms.**

While coordinating services, explore mechanisms for braiding funds, resources and staff that allow agencies and programs to maintain integrity while pursuing common indicators. These mechanisms will help personnel maintain unique roles and skills while joining forces to achieve common outcomes.

6. **Ensure that accountability mechanisms are unbiased and influential.**

Integrity of the accountability framework is essential for its effectiveness. Quality assurance mechanisms must be in place to promote productive and valid team decisionmaking. State leadership in all systems should be kept apprised of all emerging themes, activities and accomplishments of the collaborative efforts.

7. **Publicize and market the work and outcomes of the accountability framework. Increase public participation in and awareness of improved outcomes brought about by systems change.**

Use all potential media outlets, including public dialogue, newsletters and reports, to publicize cross-systems accomplishments and outcomes.
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