Exploring Patient and Stakeholder Perspectives on School Behavioral Health

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Monograph submitted to the Patient-Centered Outcomes Research Institute (PCORI)
October 31, 2017

Acknowledgments. The authors gratefully thank the Patient Centered Outcomes Research Institute which supported this research (EAIN-2874) and our program officer, Lia Hotchkiss, for providing insight and guidance throughout the project. We thank Lee Fletcher for coordinating forums during Year 1 and Josh Bradley, Samantha Hartley, and Hannah Hunsaker for transcribing forum recordings. Additionally, we thank Jefferson Bass, Gabriela Becerra, Marget Booth, Astrid Dejesus, Kayla Delooze, Jesica Guerrero, Kayla McGuire, and Jamie Millif for their help reviewing and preparing findings from previous literature and Linden Atelsek for analyzing and preparing the report on school behavioral health for juvenile justice involved youth.

History and Introduction

In 2012, the South Carolina (SC) School Behavioral Health Community (SSBHC) was established to promote coherence and scaling up of effective school behavioral health (SBH) programs in the state. As reviewed below, the term SBH is used to refer to expanded school mental health (see Weist, 1997) programs joining with systems of Positive Behavioral Interventions and Supports (PBIS, Sugai & Horner, 2006) toward depth and quality in programs that seek to improve social, health, emotional, behavioral, and academic (SHEBA) functioning of students in schools. Further, SBH should operate within effective multi-tiered systems of support (MTSS), involving Tier 1 – school-wide promotion and prevention, Tier 2 – early identification and intervention, and Tier 3 – intervention for students presenting more serious problems. The SSBHC reached out to systems leaders education and all relevant youth serving systems (e.g., mental health, child welfare, juvenile justice, disabilities, primary health care and allied healthcare services, family and youth advocacy) from all 46 SC counties to invite them in participating in the development of the community and holding of the first interdisciplinary and cross-system SBH conference in SC, which was then held in Columbia in 2014 with 300 participants. The SCBHC, co-developed by the University of South Carolina (USC) SBH Team (in the Department of Psychology), and the SC Association for Positive Behavior Support (SCAPBS) began to gain momentum; for example, establishing a website, beginning to develop a listserv exceeding 2000 people, and held a second SBH conference in Charleston in 2015. During this conference a forum was held with the above diverse stakeholder groups and including students and families receiving services for emotional/behavioral (EB) problems, and five critical themes for the advancement of SBH in the state were identified: 1) Building partnerships between education, families, mental health and other youth-serving systems, 2) developing effective school-wide approaches, 3) promoting cultural responsiveness and humility, 4) improving the quality of services and increasing the use of evidence-based practices (EBPs), and 5) improving implementation support for EBPs (Weist & Stevens, 2017).

In 2015, leads for the SCBHC applied for and received a Eugene Washington Engagement Award from the Patient-Outcomes Research Institute (PCORI) to further advance the SCSBHC by significantly enhancing family and other stakeholder engagement and leadership of this agenda and to hold a research pre-conference to enhance a stakeholder guided strategy for research, training and dissemination. In addition, PCORI project officers recommended the community expand to a southeastern regional focus, and the Southeastern School Behavioral Health Community (SSBHC) was established, with the work of the SCBHC remaining central and the annual conference based in SC going forward. Associated with the third conference held in Myrtle Beach in the spring of 2016, a pre-conference was held with more than 40 diverse stakeholders and patients, and ideas for refining and researching the five above themes were developed. It was decided to hold five research forums on each of these themes during 2016 in different regions of SC and these were conducted. The PCORI award also assisted in further developing the SSBHC, for example, in expanding the listserv (to currently more than 15,000 stakeholders), improving the community's website (see www.schoolbehavioralhealth.org) and developing outreach strategies to six states in the coastal southeast (Virginia, North Carolina, Georgia and Florida) and including Kentucky and Tennessee. In the spring of 2017 in Myrtle Beach a second research pre-conference was held through the support of PCORI and again with

a diverse stakeholder and patient group of around 40 participants. At this meeting, participants reacted to and provided ideas from preliminary themes identified from the five research forums, and also recommended that forums be conducted on advancing SBH for three priority populations: youth in the child welfare system, those with connections to the juvenile justice system, and youth from military families, and these forums were conducted in 2017.

Formal qualitative analysis have been conducted on all eight of these research forums (five critical themes, three priority populations), and summary findings from these forums are presented in this monograph. Please note, we plan on developing a free downloadable e-book in the public domain, including an introductory chapter, chapters on each of the eight forums, and a concluding chapter on implications and recommendations for improving research, practice, and policy from findings. In this monograph, we first provide a focused literature review and background on SBH, then provide brief background for each of the eight themes and preliminary findings from qualitative analyses.

Focused Literature Review and Background

Emotional/Behavioral Problems in Children and Youth

Around one in five children and youth contend with emotional/behavioral (EB) problems (Brauner & Stephens, 2006) that impact their psychosocial functioning in home, school and neighborhood environments (Anderson, Sabatelli, & Kosutic, 2007); however, less than half receive mental health (MH) services (Burns et al., 1995). The EB problems facing these youth increase the risk of school withdrawal and academic failure (Appleton, Christenson, Kim, & Reschly, 2006). Students in special education for EB reasons have the highest rate of drop out (51%) compared to students in any other category of disability (U.S. Department of Education, 2001) and if they graduate from high school, they often experience a poor transition to continued education or employment (Newman, 2005). Many of these youth only receive services in the education system (Lyon et al., 2013), or they interact with multiple service systems that are neither coordinated nor effective for addressing their needs (Greenbaum et al., 1996). In addition, prevention and early intervention efforts are limited, associated with missed opportunities as EB problems begin to intensify around age 14 (Kessler et al., 2005).

Expanded School Mental Health (SMH)

There is increasing recognition that many barriers get in the way of children and youth receiving services in traditional settings like community mental health centers (CMHCs) or local hospitals. In recognition of these barriers there is a significant national movement toward moving community-based MH services to youth *where they are*, in the schools (Evans et al., 2007; Weist, Lever, Bradshaw, & Owens, 2014). These expanded school mental health (SMH) services have been shown to significantly improve access to care and early identification and intervention (Catron, Harris, & Weiss, 1998; Atkins et al., 2006), and when done well are associated with positive outcomes for students (Weist et al., 2014). However, SMH services lack a delivery structure (such as provided through PBIS) and as a result are implemented in a variable, ad hoc manner in many school districts, operating in isolation of other teams, not using data for decision making, and lacking support for the implementation, refinement and improvement of evidence-based practices (Barrett, et al., 2013).

Positive Behavioral Interventions and Supports (PBIS)

Positive Behavioral Intervention and Support (PBIS) is a holistic, multi-tiered, evidence-based approach for preventing and reducing acting out and other problem behavior in school through the implementation of universal prevention (Tier 1) for all children, targeted intervention (Tier 2) for children at risk or showing early signs of problems, and intensive interventions (Tier 3) for children and youth with significant problems (Sugai & Horner, 2006). A growing evidence base supports PBIS as a foundation for effective academic instruction (McIntosh, Chard, Boland, & Horner, 2006). Increases in parent involvement (Ballard-Krishnan et al., 2003), decreases in student discipline referrals (Anderson & Kincaid, 2005), decreases in suspension rates (Frey, Lingo & Nelson, 2008), and improvements in student academic performance (Kincaid, Knoster, Harrower, Shannon, & Bustamante, 2002) have all been documented, along with benefits to schools and staff such as reduction in staff turnover, improved organizational efficiency, increased perception of teacher efficacy and improved quality of life for students (Kincaid et al., 2002). However, in most school districts, PBIS programs at Tiers 2 and 3 are very limited, and PBIS emphasizes *behavior* and may pay little attention to other EB challenges in students such as "internalizing" challenges like depression, anxiety and trauma (Barrett, Eber, & Weist, 2013; Weist et al., in press).

The Interconnected Systems Framework (ISF) for SMH and PBIS

Related to the above limitations, for more than a decade, professor Weist and colleagues have been developing the Interconnected Systems Framework (ISF) to address limitations of SMH and PBIS operating separately. The ISF provides specific guidance on their systematic interconnection, including dimensions of effective interdisciplinary collaboration, the positive functioning of teams, improving data-based decision making, and improving the selection and implementation of evidence-based practices to better prevent and assist students contending with EB problems. The ISF capitalizes on PBIS' strong implementation infrastructure and universal prevention strategies, as well as enhanced depth in services in Tiers 2 and 3 through SMH to provide a comprehensive continuum of evidence-based prevention, early intervention and treatment. Since 2007, Weist, and federally funded centers for PBIS (www.pbis.org) and SMH (http://csmh.umaryland.edu) have been working to develop the ISF, and it is currently featured prominently by both national centers. The ISF has been the focus of more than 50 training events (and a current national webinar series), numerous academic publications, as well as a Comprehensive School Safety grant funded by the National Institute of Justice in 2016.

General Method, Summary Findings, and Brief Discussion Related to the Five Critical Themes

All eight research forums reflected focus groups with 10 to 20 participants with focus group questions developed by the first and second author and feedback on questions provided by different stakeholders connected to the SSBHC. All focus groups were audio-recorded and research assistants also took notes to help in matching focus group responses to particular

stakeholder groups. The qualitative analysis program, NVivo Version 10, was used to organize and formally analyze focus group themes and recommendations.

Theme 1: Building Partnerships between Families, Schools, Mental Health and other Youth-Serving Systems

Background/Method. Collaboration between schools, parents, and mental health clinicians is increasingly recognized as an important component of intervention in schools (Lynn, McKay, & Atkins, 2003; Rones & Hoagwood, 2000; Weist et al., 2012). There have been systematic efforts to involve family members in SBH services (see Atkins, Graczyk, Frazier, & Abdul-Adil, 2003), but in general, these efforts have been limited, related to challenges to implementing truly collaborative approaches (Ouellette, Briscoe, & Tyson, 2004). This research forum brought together ten various stakeholders to discuss ways to promote family-school-mental health and other systems partnerships. Stakeholders for this forum included one university professor, two policy members from state agencies, five youth serving agency members, and two patients (one parent and one youth). Further, five of these participants are also parents. The following discussion questions were used to guide this focus group focused on enhanced partnerships:

1. In your experience, how have youth and families, schools, mental health and other youth-serving systems collaborated to advance SBH in SC?
2. What barriers prevent such collaboration?
3. How can these barriers be overcome?
4. Are there examples of middle and high school students helping to lead SBH efforts? If so, please describe.
5. What has limited student involvement in guiding SBH in SC and how can these factors be changed?
6. Are there examples of family members helping to lead SBH efforts? If so, please describe.
7. What has limited family involvement in guiding SBH in SC and how can these factors be changed?
8. What are the most important strategies for students, families, and youth-serving systems leaders and staff to truly collaborate in advancing SBH in SC?
9. What research ideas would help us better understand and advance this theme of improving collaboration in SBH?
10. What other recommendations do you have to move this work forward?

Findings/Discussion. Several participants in the research forum brought up concerns about parents' reticence to discuss behavioral health concerns facing their children because of feeling unwelcomed and intimidated by the school setting. Specifically, participants voiced that parents are concerned that they may be blamed for their child's behavior, which prevents effective collaboration between them and school staff. One participant described experiencing this lack of receptiveness by school personnel when she tried to express concerns about the services her son was receiving. Another participant recounted meeting a colleague at a

conference who seemed to place blame on parents for negative student outcomes. These experiences and concerns are not exclusive to the participants in the forum; similar parent concerns (Olvera & Olvera, 2012; Ouellette et al., 2004) have been reported to negatively impact collaboration between parents and schools.

Participants also discussed experiencing a lack of communication and collaboration from schools when behavioral issues arise. One parent participant described receiving a call from the school resource officer within the first two weeks of school and rather than have a discussion about the incident, the resource officer labeled their child as "a problem student". Another participant added that sometimes students are given labels (including formal diagnoses and more colloquial terms) by school personnel, but are not connected with services that would be helpful for the student. A number of participants expressed that schools inform parents of "warning signs" or even symptoms of a developing mental or behavioral health problem, but at times this was not followed up with information on what would be helpful. Participants expressed a desire to have more recognition of warning signs or symptoms as well as earlier treatment for students with developing concerns before they become serious problems (see Angold, Costello, Farmer, Burns, & Erkanli, 1999).

Concerns with labels extend to twice-exceptional students –students who are academically gifted but also have developmental and/or behavioral health concerns; in this situation, school staff may focus more on their deficits than their strengths (Missett, Azano, Callahan, & Landrum, 2016; Pfeiffer, 2015). Participants conveyed that they want to see more recognition of twice-exceptional students' positive labels to help support their strengths. Participants proceeded to say that an understanding of twice-exceptional students' individual needs and concerns could also prevent these students from being removed from programs or not given services because of these multiple labels. While concerns about negative labeling of students have been emphasized (Harper, Sargent, & Fernando, 2014; Missett et al, 2016; Shute, 2016), work to reduce this labeling remains limited (Lauchlan & Boyle, 2007).

Participants expressed the need for more advocacy for parents and students. Although they acknowledged the efforts of some community organizations and family advocacy groups, they felt that advocacy for parents and students could be incorporated to work within the schools (as opposed to external organizations). Participants also felt that more work should focus on teaching students to be self-advocates for their mental health care which would include mental health education efforts with the goal of reducing the stigma of seeking services.

Participants had a few suggestions for moving collaboration efforts between families and schools forward. First, school personnel (specifically teachers) should have more training in early identification of mental health concerns. Second, there should be interdisciplinary meetings that include all important figures in a child's life to take a holistic, family-systems approach to address every aspect of a child's life, including promotion of physical health. In addition, schools should work towards eliminating barriers (e.g., transportation, language barriers, intimidation, etc.) that make parental involvement difficult. One participant suggested that holding meetings outside of the school (e.g., in local libraries, youth centers, businesses) could address some of these barriers. Finally, participants indicated a specific need to improve communication mechanisms between families, schools, mental health and other youth serving systems. VICTORIA ELABORATE

Theme 2: Developing Effective School-Wide Approaches

Background/Method. The school milieu requires students to learn and apply emotional, cognitive, and social skills by working with adults and fellow students (Paulus, Ohmann, & Popow 2016). Despite the demands of the school environment and the growing mandate for the academic success of all students (e.g., the No Child Left Behind [NCLB] act, 2001), there are still gaps in children's accessibility to mental health services (Cummings, Wen, & Druss, 2013). Approximately 20% of students in the United States experience academic difficulties due to mental health concerns (Kelleher, McInerny, Gardner, Childs, & Wasserman, 2000). The growing awareness of mental health concerns as a barrier to academic success, along with the mandates of NCLB (2001), have prompted a greater focus on school-wide approaches within the SBH field (Smith, Molina, Massetti, Waschbusch, & Pelham, 2007). Fourteen diverse stakeholders assembled to provide ideas on this theme. Members of this group included four university staff and faculty members, six members from youth and family servicing agencies, three K-12 school staff, and one student. Five of these stakeholders held dual roles and are also parents. The following questions were used to guide discussion on school wide approaches:

1. In your experiences at a school, what factors are most important for building high quality school behavioral health (SBH) programs? What factors are most important at the District level?
2. What have your experiences been with Positive Behavioral Interventions and Supports (PBIS)?
3. How should PBIS efforts be strengthened?
4. What should we do to improve school-wide approaches, that is for all students and focusing on promotion and prevention?
5. What strategies can be employed to increase advocacy with the SC Departments of Education, Mental Health and Health and Human Services for growing PBIS in schools?
6. What are the key resource needs in SC schools to effectively implement SBH? How do these needs vary based on school classification (e.g., rural, urban, suburban, higher vs. moderate vs. lower SES)?
7. If resources are limited, how can school-based SBH stakeholders work smarter?
8. What has limited family involvement in guiding SBH in your school/district and how can these limiting factors be changed?
9. What are the most important strategies for effectively engaging school administrators as leaders of SBH in schools?
10. What other recommendations do you have to advance SBH in SC schools?

Findings/Discussion. Consistent with the emphasis from the first forum focused on partnerships, participants agreed that there should be more collaboration between mental health professionals, school faculty, and parents. Collaboration between the school and home has been found to be an important factor in effective school based interventions (Paulus et al., 2016). One participant shared the experience of a parent and student discussing the student's mental health concerns at an Individualized Education Plan (IEP) meeting and having those

concerns (particularly the underlying cause of those concerns) ignored by school staff. Participants felt that school administrators may mistakenly blame parents rather than considering other factors contributing to student behavior and limit communications with parents to only problematic student behaviors. Some parents felt it would be helpful to receive updates on their children and to have meetings with faculty outside of the school. Working with community organizations and agencies has been found to mitigate the impact of adverse childhood experiences and could be used to help both educators and parents better understand the needs of their children (Oullette et al., 2004). Collaborative efforts between schools and mental health professionals can positively impact school-based mental health support (Klontz, Bivens, Michels, & DeLeon 2015). Participants agreed that both school faculty and parents need to be involved in training to understand how to help students, consistent with a major emphasis of well-done multi-tiered systems of support (Bruns et al., 2016).

Professional development and training is crucial to effectively enacting school wide change (Bradshaw et al. 2008). Participants asserted that educators need more training about mental health issues as well as PBIS, consistent with other research (Moon, Williford, & Mendenhall, 2017).

Effective implementation of school-wide PBIS is contingent on buy-in from school principals, district administrators, and state department of education leaders; opposition or lack of support of the program can lead to a lower quality or nonexistent level of implementation (McIntosh, Kelm, & Canizal Delabra, 2016). Changes can been enacted at the school level to shift principal and school faculty support, which in turn can have a dramatic effect on the success of implementation (McIntosh et al., 2016). Buy-in from policy makers is particularly crucial, as their leadership position (particularly with regards to budgetary decision making) will enable schools to provide mental health support. Through state wide collaboration and implementation, schools in Maryland had a 72% successful implementation rate (through the usage of an implementation phase inventory) when PBIS was brought into the state (Bradshaw et al. 2012).

With this backdrop in mind participants expressed concerns about the quality of schools' implementation of PBIS. Two participants brought up experiences of working with schools that were implementing PBIS along with standing practices/policies that were counterproductive to maintaining PBIS fidelity. One of the participants also noticed that not all of the teachers they have worked with in PBIS schools were effectively using the PBIS practices, associated with inconsistent implementation and diminished impacts. One participant mentioned that despite receiving PBIS training, staff still had difficulty identifying and responding to student EB problems; for example, reacting only to over externalizing behaviors like non-compliance or aggression. Implementation of PBIS without fidelity mitigates against the potential benefits of the program (Algozzine et al., 2014; Pas & Bradshaw, 2012), which may contribute to a loss in stakeholder buy-in.

Participants gave several suggestions for effectively using school wide approaches. First, they agreed that there needs to be more training about mental health at all levels of the school system. In addition, family members need to be involved when discussing children's behavior and participate actively in training events (see Weist, Garbacz, Lane, & Kincaid, 2017). Participants also expressed that at school and district levels, PBIS is implemented more

effectively when there is a strong statewide system for implementation, along with broad buy-in, including from legislators.

Critical Theme 3: Promoting Cultural Responsiveness and Humility

Background/Method. Of the 50.7 million students projected for the 2017 school year, 26.3 million will belong to a minority group (National Center for Education Statistics). With the growing number of minority students attending school, there is a need for school personnel to practice cultural humility -the process of openness and self-reflection after interacting with individuals from different backgrounds (Foronda, Baptiste, Reinholdt, & Ousman, 2016). Fourteen behavioral health stakeholders (one policy maker from a state agency, four district/school staff members, four members of family and youth serving agencies, two mental health clinic representatives, and three family members) came together to discuss the importance of cultural humility in guiding behavioral health efforts as well as several barriers they perceive and suggestions for advancing cultural humility in schools. The following questions guided the discussion:

1. In your experiences in SC schools, what factors are most important for building high quality school behavioral health (SBH) programs? What factors of SBH programs are most important for improving cultural humility in the school?
2. What have your experiences been with training on disparities in schools with SBH programs?
3. How can PBIS efforts and other SBH initiatives be strengthened to reflect cultural humility and empathy?
4. What should we do to improve school-wide approaches that help all stakeholders recognize personal factors that affect their views and actions about disparities?
5. What emphasis is needed to identify to improve policies and practices that reduce restrictive placement and discipline of minority students?
6. How can we improve SBH initiatives to include families and communities that have been traditionally underserved? How do the family needs of students vary based on school classification (e.g., rural, urban, suburban, higher vs. moderate vs. lower SES)?
7. Due to schools limited resources, how can the role of other community groups and members, such as the faith community and businesses, help in eliminating disparities? How can school-based SBH stakeholders work smarter?
8. Can the SBH initiative stakeholders help in identifying biases? How can the initiative help change these biases?
9. What other recommendations do you have to advance cultural humility in SC schools?

Findings/Discussion. An important theme discussed by participants was how culture is socially perceived. There is no single accepted operational definition to describe the construct of culture. Indeed, Baldwin, Faulkner, and Hecht (2006) devoted a book chapter to the dynamic nature of the construct. Through a historical analysis, they identified many different definitions of culture; beginning with its origin from the Latin word, *colere,* and ending with over twenty

contemporary definitions. Despite the ambiguous nature of the word, Zusho and Clayton (2011) provide a fairly comprehensive definition:

> In short, it is assumed that culture is a way of life that consists of people collectively using all the resources in their environment to achieve; is a part of all human groups; is learned, shared, and regulated by political, legal, and social systems; is socially transmitted; represents both external (observable behaviors) and internal (inferred traits) aspects of an individual; and is an abstraction of people's knowledge and beliefs about themselves, other people, and the world (p. 240).

One participant underscored the importance of within group differences during this discussion by mentioning that two African American mothers will likely have very different experiences and the culture in their homes will be equally diverse. Zusho and Clayton (2011) acknowledge that often culture is used synonymously with race or ethnicity and that by doing so we may be missing a very important part of the individuals' stories. One participant suggested that school personnel attempt to focus on each student as an individual rather than stereotyping students based on perceptions of their culture.

Participants noted that they felt that stigma related to behavioral health is especially true in minority communities. In fact, African American participants conveyed concern that if they were to seek mental health services for their children, they might be labeled and stigmatized by their community (Dempster, Davis, Jones, Keating, & Wildman, 2015). There is related literature that Hispanic-majority communities may have inadequate education, systemic language barriers, and strong cultural stigmas regarding mental health (Gary, 2005; Rastogi, Massey-Hastings, & Wieling, 2012). Although language is a barrier, stigma plays a large role in preventing families from seeking mental health services (Ramos, Cortes, Wilson, Kunik, & Stanley, 2017). The participants in this discussion expressed that stigma must be broken to reach minority communities. They posited that the best way to break the barrier of stigma is to provide education and support to the students and their families, and improve communication and enhance partnerships between families, schools and the mental health system.

Concern was expressed that parents receive calls from administration concerning the behavior of their child, but seldom receive additional support following the initial phone call. Participants expressed that there needs to be additional support staff to guide parents and help them find available resources. In addition, participants would like to see schools move toward utilizing interdisciplinary team meetings in which all people involved in the student's life are present.

Before interdisciplinary teams and collaboration can take place, participants stressed that relationships must be built between families and school personnel. There was concern over the mistrust parents tend to have toward the school. One participant highlighted that many teachers are from middle class families and may not be able to understand the experiences of their minority or low-income students. Fortunately, teachers who spend time with students' parents may experience a decrease in barriers to collaboration and may find new ways to converse with the parents without any sense of bias (Vesely, Brown, & Mehta, 2017). Programs such as Head Start require home visits for their teachers, which one participant noted, provides the teachers with an opportunity to look deeper and individualize experiences

for the students. Another participant recognized grassroots outreach efforts of one school such as having a special event in a neighborhood close to the school that involved the teachers giving out books and snacks to the students and meeting parents.

Inconsistency and disproportionality of expulsions were brought up as a great concern by participating stakeholders and patients. In particular, one participant acknowledged that there are very different laws concerning student expulsion between North and South Carolina. In North Carolina, students cannot be expelled from school if they are 13 years of age or younger (U.S. Department of Education, 2017); whereas, in South Carolina, students of any age can be expelled (U.S. Department of Education, 2017). This is of particular concern because African American, Latino, and American Indian students make up a disproportionate number of discipline referrals in the school setting (Gregory, Skiba, & Noguera, 2010). Participants agreed that more effort needs to be put toward understanding and addressing underlying causes that may be influencing students' problem behavior prior to removing them from schools. It was suggested that students be given the opportunity to work with school staff who demonstrate patience and understanding, qualities that can be lacking in school administrators. Efforts to build relationships with students and their families may play an important role in understanding why students are misbehaving.

Participants offered several suggestions for moving forward with culturally responsive SBH. First, they would like to see all school personnel, including school boards, educated on the importance of mental health to encourage buy-in at all levels. Second, school staff need the resources and training to provide a culturally informed school environment. Third, more support should be provided to teachers as often children in lower-income homes and/or non-traditional family structures look to the teachers for more support than their role can afford. Fourth, schools should create outreach efforts to encourage families to come to school board meetings to learn about and weigh-in on school policies. Finally, middle and high schools could offer delinquency prevention and job readiness programs that teach students practical life skills to get a job or pursue a career after school.

Theme 4: Improving the Quality of Services and Increasing Evidence-Based Practices

Background/Method. Effective SBH relies on ongoing support from school leaders and professionals who work in schools including teachers, counselors, psychologists, and others, and ideally students and families should provide guidance on the program (Arora, Connors, George, Lyon, Wolk, & Weist, 2016; Langley, Nadeem, Kataoka, Stien, & Jaycox, 2010; Weist, Garbacz, Lane, & Kincaid, 2017). The quality of SBH may be compromised by very high levels of student need (Langley et al., 2010; Owens et al., 2002) and other factors are influential such as clinician demographics and level of prior training (DeCarlo Santiago, Kataoka, Forness, & Miranda, 2014). Thirteen diverse stakeholders in SBH, including two researchers, four teachers, one family advocate, two medical professionals, two parents, and two others participated in the discussion focused on the most pressing barriers and potential solutions to improving the quality of SBH. The following questions were used to guide the discussion:

1. What are characteristics of high quality school behavioral health (SBH) programs at Tier 1? At Tier 2? At Tier 3?

2. Thinking about your experiences in our schools, what factors are most important for building high quality SBH programs? Which of these factors are frequently missing in our schools? Why?
3. What is the top priority for quality improvement in SBH programs at Tier 1? At Tier 2? At Tier 3?
4. How have schools used data to help make decisions about or improve the quality of SBH services? Provide examples of schools doing this well at Tier 1, 2, and/or 3.
5. For schools who do not use data, what seem to be the barriers to using data to improve SBH quality?
6. There are many research-based EBPs available for schools at Tier 1, Tier 2, and Tier 3. What challenges exist for adopting and implementing these programs in schools? What recommendations do you have for overcoming these challenges?
7. How can students and families be more involved in collaboratively guiding and implementing EBPs in schools?
8. What role do school staff and clinicians have in improving quality of SBH services? What role do parents and students play?
9. How can stakeholders (parents, students, providers, school staff) work together to improve the quality of SBH services?
10. What other recommendations do you have to advance SBH in SC schools?

Findings/Discussion. A major theme that arose from the discussion is that participants expressed that in general, schools do not view behavioral health as a priority. Participants elaborated that schools tend to focus on the immediate and pressing needs of students (e.g., homelessness, food insecurity) and while these are critical, students' emotional/behavioral needs are often neglected. Participants agreed that buy-in from stakeholders at all levels should occur to improve the quality of SBH services. For instance, school administrators should understand that acknowledging student behavioral health problems does not reflect poorly on the quality of the school. Additionally, principals and state-level stakeholders must provide organizational and fiscal support for SBH programs to be successful (McIntosh, Kelm, & Canizal Delabra, 2016).

Participants discussed wanting to see more collaboration between schools, youth-serving community organizations (e.g., places of worship), and students' families. One participant described a parent who had emailed teachers, principals, and even the superintendent and received very few responses even after sending follow-up emails (also noting that some of the administrators' contact information was not up to date online). Another participant expressed her concern that school psychologists, clinicians, and schools are not working with parents to help them develop the skills to work with their child's emotional/behavioral (EB) needs. Specifically, parents would like to see schools provide at least informational (if not training) sessions on dealing with common EB issues in children. Participants agreed that resources for parents are not easy to find and expressed a need for easily accessible resources and handouts that teachers could give students to take home as well as being posted on the school website. One participant suggested that the School Improvement Council should be involved in this resource development and sharing.

Participants recognized that in most cases data-based decision making in schools and in SBH programs is not at appropriate levels. In the participants' experiences, schools often collect and even present the data, but utilizing it to solve problems and make treatment decisions does not occur as frequently. Although data-based decision making in SBH has received much needed research attention in the last decade (Kelly & Lueck, 2011; Kilgus, Reinke, & Jimerson, 2015; Swain-Bradway, Johnson, Eber, Barrett, & Weist, 2015), the participants' concerns illuminate the need for expansion of this emphasis, with adequate infrastructure support to enable optimal data utilization. Participants also recommended strategies for school staff, families, mental health staff and others involved in assisting children to be able to share information, such as through an electronic health-mental health-education record. Participants emphasized that appropriate confidentiality and privacy protections are needed in such data sharing arrangements, and that schools need to be more open about sharing data, versus not sharing it related to concerns about school image.

Youth involvement and self-advocacy was identified by participants as an important part of high quality treatment planning (see Astramovich & Harris, 2007; Friesen, Koroloff, Walker, & Briggs, 2011). Furthermore, participants expressed the need for more emphasis on training students in self-care/life skills. One participant suggested a self-care/life skills course for middle-school students that would help prepare them for high school and beyond, such as the Life Skills Training program and similar programs (Botvin & Griffin, 2004; Chiang, Ni, & Lee, 2017; Tymes, Outlaw, & Hamilton, 2016). A limiting factor to these programs is they are often focused on substance abuse prevention, which could decrease buy-in for some students or other constituent groups.

Another theme was on limitations of typical schools for responding effectively to the needs of students presenting more intensive problems. Counselors with high caseloads often do not have the time necessary to devote to students with elevated needs (Brown, Dahlbeck, & Sparkman-Barnes, 2006). Additionally, students do not consistently work with the same counselor in traditional schools. Participants felt that the traditional school schedule may not allow some students to be successful, and more careful thought was needed on factors such as lunchroom environments and transitions between classes, that may represent stressful environments for some students (e.g., those will elevated social anxiety).

Participants had several suggestions for improving the quality of services available in schools. First, schools should prioritize informing parents about what resources are available to them and their children. Second, all students should be educated on how individuals experiencing EB concerns feel so that students feel more comfortable disclosing their own concerns. Third, schools could use more training on how to effectively use data to address the needs of the students. Finally, there is a need to provide consistency in care such as assigning one counselor to work with a student for the duration of the school year. If a school cannot do this or if the student transfers schools, districts could use Individual Growth Plans with behavioral tracking to facilitate the process of transferring counselors.

Critical Theme 5: Improving Implementation Support for Evidence-Based Practices

Background/Method. Schools are the most common mental health care setting for youth (Substance Abuse and Mental Health Services Administration [SAMSHA], 2009); however,

competing responsibilities, logistics, parental consent, policies regarding mental health, lack of collaboration between public services, lack of access to programs, and administrator and teacher knowledge, support, and perceptions are all barriers to effective school mental health (Langley, Nadeem, Kataoka, Stien, & Jaycox, 2010; Reinke, Stormont, Herman, Puri, & Goel, 2011; Pas, Waasdorp, & Bradshaw, 2015; Stiffman, Stelk, Horwitz, Evans, Outlaw, & Atkins, 2010). Evidence-based assessments are an integral part of implementing and improving SBH services as they allow for SBH professionals to assess if services are addressing student needs (Arora, Connors, George, Lyon, Wolk, & Weist, 2016). Evidence-based assessment also helps to guide collaborative efforts (Arora et al., 2016), which can facilitate the implementation process (Langley et al., 2010). Well done multi-tiered systems of support (MTSS) have been shown to be an effective platform for SBH (Stephan, Sugai, Lever, & Connors, 2015; Stiffman et al., 2010) along with better policies regarding student mental health; stronger linkages between schools, mental health and other youth-serving systems; and systematic screening to improve early identification and intervention efforts (Stiffman et al., 2010). Eleven stakeholders, including three parents, three researchers, two university staff, two teachers, and one family advocate assembled to discuss barriers to and ways to improve implementation support for evidence-based SBH. The following questions were used to guide the discussion on implementation support:

1) What School Behavioral Health (SBH) initiatives are your schools currently implementing?
2) In your mind, what is the quality of implementation of these programs; for example, are programs implemented as intended, with consistency, with strong involvement of school staff and students?
3) What are the factors that help these programs to be implemented well? At Tier 1? At Tier 2? At Tier 3?
4) What are the challenges encountered in implementing these programs well? At Tier 1? At Tier 2? At Tier 3?
5) What recommendations do you have for overcoming these challenges?
6) How can school, family, mental health and partnerships with other community systems help improve the implementation of high quality, evidence-based programs across the three tiers toward effective and high impact school behavioral health?
7) Are you aware of exemplar schools, implementing high quality, evidence-based programs across the three tiers in school behavioral health? What is contributing to the success of these programs?
8) How could we share and publicize the experiences of these programs to promote broader scaling up of effective school behavioral health?
9) Do you think it would be worthwhile to establish a state-wide leadership team that would help to guide and coordinate training and Implementation Support (IS) for effective SBH? Your ideas on how to move this forward?
10) What other recommendations do you have?

Findings/Discussion. A major theme participants discussed was creating partnerships with community and state organizations, which in the broader literature have been found to

improve the implementation of effective services for children and youth (Nastasi, 2000; Power, 2003). One participant discussed the partnerships formed between several school districts and the local mental health centers, which enabled clinicians from the mental health centers to work with students in the schools.

The participants agreed that although there are a few outstanding examples, there is not wide-scale adoption of effective partnerships between families, schools and other youth-serving systems. While some of the programs participants discussed seemed to be helpful, a number of barriers (e.g., stigma, transportation problems, insurance issues) hinder the reach of these programs (see Cummings et al., 2013; Ouellette, Briscoe, & Tyson, 2004). One participant brought up that some families have to drive up to an hour to access programs for their children. Additionally, the participants said that teachers and school administrators are not aware of the programs available to schools or families, which precludes any potential partnership from forming. According to one participant, a district has attempted to solve this problem by hiring an individual to connect and coordinate all of the available services with the schools.

Participants identified a lack of communication between schools, caregivers, and youth behavioral and physical health care providers as a major barrier to effective early intervention and treatment. Specifically, the participants thought that being able to share information across caregivers and providers would improve the coordination of services and in turn the support students receive. In addition to improving support, this collaborative method of support could foster a greater sense of collaboration and mutual respect among school and community members involved in the child's life. This method of treatment coordination would then keep the responsibility of communicating a child's needs and treatment between doctor, clinician, and school from resting solely on the parents' shoulders. Although there are legal barriers to a system of collaborative care (such as communication restrictions associated with the Federal Education Rights Privacy Act, FERPA), one of the participants cited a charter school that has partnered with a local hospital system to establish a flow of information between the school, the hospital, and clinicians involved in SBH services.

Participants recognized insurance problems as another major barrier to students accessing appropriate services, as discussed in the literature (Owens et al., 2002). One district that has addressed a structural barrier by having mental health clinicians deliver services in the schools, still deals with the barrier of cost as uninsured students cannot receive services. In an extreme case, one participant noted that an uninsured student with more severe EB concerns was sent to a residential treatment center because it was the only way of receiving affordable treatment. One school was able to address the cost barrier by acquiring social and fiscal support from the director of counseling at the local department of mental health, who was able to allocate some funding for treatment for uninsured students.

Participants also discussed that parents want help in understanding their child's behavioral health issues, but do not know where they can go to get that help. One school has created a parent academy that focuses on helping parents understand their role in the treatment process and as an advocate for their child. Another school held an agency fair for parents to learn about programs and services available for their families. Some of the participants felt that general education teachers are not receiving enough training in integrating special education students into normal classrooms as many schools are moving towards more inclusive classrooms. This is of particular importance as some evidence suggests that without

some training on interacting with students with disabilities, teachers can focus on the disability rather than the student (Carroll, Forlin, & Jobling, 2003).

Participants had a few suggestions for moving forward with implementation support in schools. First, schools should make resources about programs and services easily available to families and teachers. Second, partnerships between behavioral health care providers and schools should be emphasized to coordinate services for students. Third, more teachers should be trained on understanding adverse childhood experiences. Finally, team meetings should be interdisciplinary when developing treatment plans for students as participants have noticed the greatest impacts for students needing intensive interventions occur when all individuals involved in the student's treatment come together to discuss a comprehensive treatment plan.

Findings Related to the Three Priority Populations

Priority Population 1: Children and Youth in the Child Welfare System

Background/Method. Youth within the child welfare system report a suicidal ideation rate of 27% as opposed to the 16% rate of the general population (Anderson, 2011), highlighting a critical need for effective treatment of youth in this system. This increased risk may be caused by barriers at the macro-level (e.g., organizational capabilities of service systems; Yoo, Brooks, & Patti, 2007), meso-level (e.g., job support and effective training for staff; Van der Geest, Bijleveld, Blokland, Nagin, 2016), and micro-level (e.g., lack of cultural competence by individual providers; Mundy, Neufeld, & Wells, 2016). Related to these barriers and the generally elevated needs of youth in child welfare (Garcia, Circo, DeNard, & Hernandez, 2015), focused attention on developing effective SBH programs for these youth is warranted. Ten diverse stakeholders (six members from state agencies, two university staff, one member from a family serving agency, and one teacher) were brought together to discuss barriers and potential solutions to foster more effective behavioral health treatment for students in the child welfare system. The following questions were used to guide the discussion:

1. What barriers prevent collaboration between child welfare and SBH staff? How can they be overcome?
2. What Child Welfare (CW) organizations (either governmental or non-profit), have you worked with or are aware of that support Behavioral Health (BH) initiatives?
3. What is the existing infrastructure supports for working with CW Agencies? How should the infrastructure and efforts be strengthened?
4. Are there examples of SBH and child welfare staff working effectively together? What are the characteristics of these relationships? Are there SBH programs that could be considered exemplary in this area (name them)?
5. With the identification of exemplary sites, how can we publicize their experiences and promote generalization of successful programming strategies to other CW sites and agencies.
6. What recommendations do you have for collaborative training of SBH and Child Welfare staff? 7. What can be done to improve family involvement in guiding CW activities? Can the factors that prevent or reduce family involvement be changed?

7. Do you think it would be worthwhile to establish a state-wide leadership team that would help to guide and coordinate training and Implementation Support (IS) for effective BH in CW organizations?
8. What strategies can be employed to increase advocacy with the SC CW Agencies for meaningful implementation of BH systems?
9. What other recommendations do you have to move this work forward in our CW systems and agencies?

Findings/Discussion. The participants agreed that one of the most important factors in improving child welfare efforts is collaboration between schools, parents, clinicians, and any other organizations involved in the student's life (e.g., juvenile justice, primary healthcare), to both coordinate and to avoid duplicating services. Some of the participants indicated that collaboration between these organizations is limited by ineffective policies and/or inadequate funding (a commonly found limitation; Garcia et al., 2015), which may result in multiple organizations providing the same services to the child, rather than pooling their resources. Collaboration is also important to ensure students and families are able to effectively navigate youth-serving systems, and families in child welfare often need to navigate multiple additional systems (e.g., special education, juvenile justice). One program has been successful at collaborating with the Solicitor's Office to bring students who are at risk for truancy charges up for pre-judicial court. Since implementing this program, students often do not have to go to truancy court and family court as a result of truancy.

Collaboration between organizations is critically hampered by a lack of communication between them. Some research has examined collaboration and organizational factors within (Yoo et al., 2007) and between (He, 2017; Herlihy, 2016; Lee, Benson, Klein, & Franke, 2015) child welfare organizations, along with specific recommendations to improve collaboration and organizational functioning (e.g., He, Lim, Lecklitner, Olson, & Traube, 2015). Participants said that school personnel are often not aware of what organizations are available and who to contact in those organizations to get collaboration started. Furthermore, if a student is receiving services from multiple organizations (e.g., the school, Department of Mental Health [DMH], Department of Social Services [DSS]), these organizations are often unaware of the other services the student is receiving (unless the parent explicitly communicates this). For example, if a student is receiving services from DMH and DSS, the DSS worker often is not aware of services provided by DMH and as such may waste time seeking additional services. Participants indicated there are often no routes for discussion and case coordination between staff from different agencies.

The participants also emphasized the importance of utilizing family and community supports when working with children; a finding echoed in the literature (Conn, Szilagyi, Jee, Blumkin, & Szilagyi, 2015; Lewis, Feely, Seay, Fedoravicis, & Kohl, 2016). One participant mentioned a program that works with local places of worship to provide mentors to students who had been referred by the Department of Juvenile Justice (DJJ) for non-violent offenses. Another program works to prepare foster children for life outside of the foster care system by teaching them about the consequences of impulsivity and also partners with a local car dealership to teach young adults about the process of saving for and purchasing their first vehicle. Participants emphasized that families are essential partners in cross-system

collaboration (Weist et al., 2017), but it can be challenging to get families involved, especially when child welfare systems are involved (Lewis et al., 2016). One concern brought up is that caregivers can feel intimidated by the school environment and may even be worried that the school is going to criticize their parenting without collaboratively offering helpful solutions.

Participants also agreed that it is important to provide support to students and take preventative measures to keep them out of the juvenile justice system; since youth in child welfare are also at elevated risk for DJJ involvement (Van Wert, Mishna, & Malti, 2016). The faith-based community program that was previously mentioned was designed to keep students out of juvenile detention centers and support positive social development. A participant shared that foster parents of children with conduct problems are often at odds with DSS as they wish to keep their children out of the juvenile justice system, but DSS often insists that there should be documented consequences for the child's misconduct. Another participant voiced the documented problem that it is often difficult for young adults to obtain jobs when they have a record (Van der Geest et al., 2016).

Participants had several suggestions for improving child welfare systems. First, a system of communication between various youth organizations is needed to effectively collaborate on treatment. Second, the participants would like to collaborate with the University of South Carolina Children's Law Center to advocate for legislative support for SBH (this is already occurring). Third, the participants want to see a state leadership committee that could identify points of contact for organizations with vested interests in SBH for youth in child welfare, and to also create an information sharing agreement template, which would greatly facilitate the process of collaboration between these organizations. Fourth, participants would like to see more community outreach on behalf of youth serving organizations to inform the public of what services they have available for families. One participant suggested the possibility of creating community blogs which could act as not only repositories of community resources, but a way to crowd-source information about available resources. Another participant suggested having support staff from these organizations present at parent-teacher meetings to talk about what their organization offers. Finally, the participants wished to see more trauma informed training of teachers as many teachers do not understand the trauma that children in the foster care system go through.

Priority Population 2: Children and Youth with Connections to the Juvenile Justice System

Background/Method. A majority of juvenile justice-involved youth, particularly those who have been incarcerated, meet the diagnostic criteria for one or more emotional or behavioral disorders (Teplin, Abram, McLellan, Dulcan & Mericle, 2002; Skowyra & Cocozza, 2006; Burke, Mulvey, & Schubert, 2015). As few as 20% of these youth access mental health services (Burke et al., 2015). Schools, which could provide these services, have instead been trending towards zero-tolerance policies, funneling many juveniles — disproportionately poor and non-white —from education to incarceration (Mallett, 2016). This is particularly concerning because juvenile justice involvement predicts later-life offending, as well as difficulty attaining and maintaining employment (Ou & Reynolds, 2010; van der Geest, Bijleveld, Blokland, & Nagin, 2016). A panel of fifteen stakeholders discussed the unique needs of JJIY, weaknesses in the juvenile justice and education systems, and how to better serve the children

who interact with both. This panel consisted of seven individuals from state agencies, five individuals from a mental health clinic, two individuals involved with foster care (one foster parent), one university staff member, and one school district personnel. The following questions were used to help guide the discussion:

1. What are the unique emotional and behavioral needs of youth with connections to juvenile justice?
2. How well are those needs being met?
3. Are you aware of school-based programs or initiatives focused on improving emotional and behavioral functioning for youth with juvenile justice connections? Please describe these programs. Would any be considered exemplary? How could we share innovative practices from these sites?
4. What are the existing infrastructure or organizational supports for this work? How can this be strengthened?
5. What has limited family involvement in guiding school-based programs for youth with juvenile justice connections, and how can these limiting factors be changed?
6. Do you think it would be worthwhile to establish a state-wide leadership team that would help to guide and coordinate training and implementation support for school behavioral health programs for youth with juvenile justice connections?
7. How can we increase outreach and involvement with policy leaders from correctional systems to explore mechanisms to advance school behavioral health programs for incarcerated youth?
8. How can departments of juvenile justice, mental health, social services, education, and other youth-serving systems work better to develop and improve school behavioral health programs for youth with juvenile justice connections?
9. What other recommendations do you have?

Findings/Discussion. Participants noted several risk factors for DJJ involvement or misbehavior in mainstream classrooms that may lead to alternative school placement. Many youth with connections to DJJ have untreated mental health issues, with 41.7% meeting the diagnostic criteria for ADHD (Abram, Teplin, McClellan, & Dulcan, 2003) and between 10-20% meeting the diagnostic criteria for depression (Teplin et al., 2002). A large percentage of these youth experienced trauma before entering DJJ which is associated with increased aggression (Ford, Chapman, Connor, & Cruise, 2012). On average, DJJ involved youth reported an average of 14.6 past traumas, mostly violent (Rosenberg et al., 2014), and around 70% had experienced family dysfunction (Logan-Greene, Tennyson, Nurius, & Borja, 2017). Participants said that many children had developed maladaptive coping mechanisms to deal with these unaddressed needs, such as self-harm and substance use, with one participant noting that her students would often self-medicate for ADHD with illicit substances. Up to a third of detained youth with EB problems have a comorbid substance use disorder, with half of all detainees meeting the criteria for substance use disorder (Abram et al., 2003). As many as 61% of detained juveniles have a history of self-injury, and the suicide rate in DJJ facilities is 3-18 times that of the general population (Casiano, Katz, Globerman, & Sareen, 2013).

Additionally, there was some concern that juveniles were coming into the classroom with "lagging skills," and particularly poor literacy — in a population with a mean age of 16 or older, the average reading level was only 8th grade (Baltodano, Harris, & Rutherford, 2005). These deficiencies led to frustration as children were asked to perform tasks they were incapable of and teachers found their students failing to meet their expectations. Indeed, youth in DJJ may have special learning needs, since 38.6% of them have learning disabilities (Quinn, Rutherford, Leone, Osher, & Poirier, 2005).

However, the quality of education in special education may be poor, and many students do not graduate (Morgan, Frisco, Farkas, & Hibel, 2010). Additionally, participants noted that in their experience, schools lacked social-emotional learning (SEL) curricula, meaning missed opportunities for training children in coping, self-regulation, and effective interpersonal skills. Combined with poor skills in managing classroom demands, misbehavior due to lack of social competency often leads to special education referral by teachers who simply cannot handle these children in a mainstream classroom (Mallett, 2016). Participants suggested that schools purchase SEL curricula, since there is some indication that SEL programs help to reduce aggression and increase social-emotional competency (Espelage, Low, Polanin, & Brown, 2013; Ashdown & Bernard, 2012). Additionally, participants said that extracurricular activities, which help to teach social competency and act as a protective factor for high-risk children, should be more accessible to children contending with economic disadvantage (Mahoney, Parente, & Lord, 2007; Eisman, Stoddard, Bauermeister, Caldwell, & Zimmerman, 2016). Forum participants said these programs are also often only available to well-behaved children, which removes children who truly need social skills training.

Participants who were educators said that it was difficult to identify children's needs, find adequate resources for them, or provide social skills training due to their own ignorance of clinical practice, a sentiment echoed in a survey of teachers, who admitted that they need supplemental training in mental health to best serve students (Rothí, Leavey, & Best, 2008). According to participants, this issue was compounded by upper administration undervaluing and underfunding EB issues in children and SBH services to address them. This makes it difficult to hire clinical professionals, overloads the clinical professionals who are present, and causes school-wide preventative care to suffer (Kapp, Petr, Robbins, & Choi, 2013). In one case, a participant stated that her school had tried for years to hire a psychologist, and had only succeeded after cutting teachers. This may stem from a difference in philosophies between administrators, who may be more concerned with discipline than mental health, and education and treatment professionals who work directly with children (Kapp et al., 2013).

Participants suggested that forming a leadership team containing treatment and education professionals might help to build a cohesive mental-health-based administrative philosophy. To make substantial changes, it might be necessary to seek out sympathetic officials — case studies of organizational change in DJJ systems have found that a cooperative administration was vital to the success of their programs (Elwyn, Esaki, & Smith, 2017; Rocque, Welsh, Greenwood, & King, 2014). Sometimes legislators must be directly educated on the necessity of behavioral health programming in order to get funding without going through school administrators (Rocque et al., 2014).

Perhaps due to funding issues and inadequate personnel, participants agreed that the care that youth in DJJ received before, during, and after their time with DJJ was fragmented at

best. Unsupervised transitions are common, like teacher and grade transitions in middle and high school; school-home transitions at all levels of schooling; and mainstream-special education transitions. This inconsistency in support was compounded by system failures like lack of teacher education and diversion of children with behavioral problems into non-mainstream classrooms, where behavioral management systems and mental health supports are likely to be inadequate (Mallett, 2016; Wagner et al., 2006). Participants did not believe that services could be integrated until the breakdown points had been addressed and the question of what integrated services would look like had been answered. To do this, they suggested a series of open forums to design support systems and discuss service integration, involving youth and their families as well as a continuum-wide team of professionals like school psychologists, teachers, and probation officers. They also suggested that community partnerships, which are significantly related to implementation of best practices in DJJ settings, could be used to bridge the gaps between services (Farrell, Young, & Taxman, 2011). One participant's school formed community-based partnerships with local businesses and childcare systems to provide support — supplying juveniles with medication and structured recreation, as well as supplying the school with information that allowed them to target interventions.

Participants felt that taking into account adverse childhood experiences, family structure, and social factors were key to providing culturally competent mental health support to youth with DJJ involvement. Particularly, they noted that intervention must take into account the profound effects of race on a child's DJJ interaction. Additionally, successful DJJ interventions must be trauma-informed, and truly effective trauma-informed interventions must take into account special populations who may have different service needs (Branson et al., 2017). Participants also agreed that parents should be more involved, as parental involvement makes interventions more effective (Dowell & Ogles, 2010). However, in their view, parents were often not literate with regards to behavioral health, which made communication difficult and instilled a sense of "helplessness" on the part of the parents. They noted the importance of considering barriers to collaboration with parents, such as demanding work schedules or lack of access to transportation, since the most successful interventions take steps to be more accessible (Lee et al., 2014). In the case of youth in DJJ, it might not be adequate to seek out parental support, as many have parents who are not the main custodial figure. Other familial supports, like grandparents, whose charges may be up to three times as likely to require mental health services, may need more education (Campbell, Hu, & Oberle, 2006).

Re-entry to the community presents a new set of challenges, such as recidivism. Participants believed that deviancy training was one major cause of re-offense, since residential facilities that group offending youth together have higher recidivism rates (Shapiro, Smith, Malone, & Collaro, 2010). Participants also believed that some crime was need-based — since previously-detained youth are less likely to be employed — and thereby potentially solvable with increased educational and vocational training (van der Geest et al., 2016). While vocational training only consistently improves chances of employment if job experience is included in the training, there is a clear need for better education in DJJ facilities, as many released youth are behind their peers in reading and math (Altschuler & Brash, 2004; Baltodano et al., 2005). One participant noticed that mindfulness-based SEL training had reduced recidivism at her workplace, and there is evidence that it is effective at reducing violence,

recidivism, and substance use (Hoogsteder et al., 2014; Himelstein, Saul, Garcia-Romeu, & Pinedo, 2014).

Released youth also face a dearth of transition support. In some cases, records may not be transferred from the detainment facility to their schools for months, and there may be no behavior or learning plans in place for them once they re-enter mainstream classrooms (Goldkind, 2011). Participants felt that a transition specialist who would follow up with these youth after their release would help correct for the lack of reliable behavioral support that results from rapid, frequent institutionalization and de-institutionalization. Goldkind (2011) suggested that social workers could potentially be used to fill this role.

Participants had a number of suggestions for improving behavioral health outcomes for these youth. First, providing some job or vocational training while still under DJJ supervision may increase the likelihood that they will be able to get jobs upon release. Second, teaching these youth effective social-emotional skills (whether in the school or DJJ system) will help them cope with antisocial impulses and prevent recidivism. Third, creating a leadership team that includes diverse stakeholders –from researchers to professionals who work directly with DJJ involved youth– to advocate for district administration, county-level and state-level legislative buy-in for proactive initiatives and funding. Fourth, the participants would like to see a greater level of cultural competency training for school personnel and clinicians as racial and ethnic disparities in the DJJ system are real and significant. Finally, youth and family input should be included when designing support systems, meeting about service integration, and when assembling support teams of diverse stakeholders to provide comprehensive care to these youth.

Priority Population 3: Children and Youth from Military Families

Background/Methods. Children of parents in the military deal with a unique set of challenges (e.g., parental deployment, permanent change of station, parental behavioral health concerns) that can have a dramatic impact on their life (Cammack, Brandt, Slade, Lever, & Stephan, 2014). Approximately one in three children of deployed military personnel experience psychosocial problems (Flake, Davis, Johnson, & Middleton, 2009). Older military children have also been found to experience problems at school, with their family, and with their peers when they have a parent deployed (Chandra et al., 2010), and military-connected adolescents are at a higher risk for suicidal ideation and attempts than their non-military peers (Gilreath et al., 2016). To discuss these pressing issues, a forum was held inviting thirteen diverse stakeholders in military family behavioral health. The stakeholders consisted of five university staff and faculty members, two active duty service members, three military spouses, two school liaisons, and one school-based clinician. Five of these participants were also parents of military children. The following questions were used to guide the conversation:

1. What organizations (either governmental or non-profit), have you worked with or are aware of that support Behavioral Health (BH) initiatives with military families?
2. What are some of the unique needs for military families in this work? In what ways should the infrastructure and efforts be strengthened?

3. What has limited family involvement in guiding BH for military families in local schools? How can these limiting factors be changed?
4. Do you think it would be worthwhile to establish a state-wide leadership team that would help to guide and coordinate training and Implementation Support (IS) for effective SBH for military families?
5. How can we increase outreach and involvement with policy leaders from our military systems to explore mechanisms to build the SBH workforce?
6. Are you aware of any schools that are effectively implementing true system-wide SBH for military families? Is it being done at all tiers? Can these facilities be named "Exemplar?"
7. With the identification of exemplary sites, how can we publicize their experiences and promote generalization of successful programming strategies to other sites with large military populations?
8. What strategies can be employed to increase advocacy within military communities?
9. If resources are limited, how can military SBH stakeholders work smarter?
10. What other recommendations do you have to move this work forward in schools that's serve military families?

Findings/Discussion. One of the major problems participants identified was a lack of programs and services available to military children (particularly those living off-base). Although there are programs for some branches and bases, there is no unified, easy-to-access system of treatment for military families. For instance, the Marine Corps has a behavioral health branch but they cannot treat students in schools, so if a child needs counseling a parent must take them out of school to the appointment. Participants cited a myriad of other programs (e.g., FOCUS; Lester, Nash, Green, Pynoos, Beardslee, 2011; Strong Bonds; Strong Bonds, 2017) which are helpful for adults and families, but none of these programs specifically provide therapeutic services to children. This paucity of behavioral health support for military children has only been recently identified in the literature (Rossiter et al., 2016). Participants noted that the one program that does work with children is the Military and Family Life Counselor (MFLC) Program. Participants expressed their appreciation for this program but also stated that this program predominantly focuses on deployment and permanent change of station which doesn't encompass all of the behavioral health needs of military children.

In addition to the lack of services available, participants felt that they were uninformed about services and programs available near them. One participant mentioned that at a previous base, their family was able to attend a meet and greet with other military families which allowed them to ask questions and make friends, whereas at their current base no such effort was made. Some of the participants felt the largest barrier to accessing behavioral health services for their children was the lack of information about services or resources available which is different for every base; a that does not receive much attention in the literature (Becker, Swenson, Esposito-Smythers, Cataldo, & Spirito, 2014). One participant noted that the only family oriented service they were informed of were spouse dinners hosted by the on-base church. Another participant added that when their partner was deployed, there was no outreach from base personnel to provide resources to their family. Although the participants agreed the resources and outreach efforts vary base to base, they would still like to see a more

unified effort to inform military families of the services available, regardless of the branch or base.

A few participants identified one school-based clinician that made a huge positive impact on their families' experiences with parental deployment and changing schools. This clinician works in a public, non-Department of Defense (DoD) funded school and their position is focused on fostering personal relationships with military students and families. The clinician is also able to create programs geared specifically toward meeting the needs of military children; for example, they created a lunch time group for students with parents who are deployed to give the students and opportunity to connect with other students in similar situations. One participant even mentioned that they may not have enrolled their child at one particular school (due to lower ratings) had it not been for this school-based clinician. This participant also felt that if there were more military family focused school clinicians, fewer families would travel long distances to enroll their children in schools with higher ratings. Unfortunately, not all schools serving military communities have the ability to employ a full-time school-based clinician that can attend to the unique needs of military children and families.

Throughout the discussion, the need for school behavioral health service expansion for off-base (i.e., public) schools serving military communities came up many times. The participants agreed that effective policy change requires buy-in from district administrators and state legislators. This notion is strongly supported by previous initiatives in school behavioral health (Bradshaw et al., 2012; Faran et al., 2015; Cammack et al., 2014; Mendenhall, Iachini, & Anderson-Butcher, 2013). This prompted the suggestion of creating a state-wide leadership team to help guide SBH initiatives to support military families. The participants suggested several areas the state leadership team could work in to improve school behavioral health.

One suggested area the state leadership team could work to improve is to educate key stakeholders (e.g., policy makers, school-boards, superintendents) on the unique needs of military children (*see* Bradshaw, Sudhinaraset, Mmari, & Blum, 2010). These educational efforts could then be focused on teachers and school staff who serve military communities. One participant mentioned that they have noticed that veteran teachers at schools in military communities have grown to understand the unique needs of military children, but often the newer teachers are much less aware of these students' needs; large scale education efforts could help to address these disparities.

While the participants felt that educating non-military teachers of the unique needs of military children is a good start, they felt that teachers still cannot quite understand exactly what the students are experiencing. To provide a more comprehensive support system, the participants suggested that the state-wide leadership team could advocate for school-based clinicians in schools with a high military population throughout the state. The participants acknowledged that some schools would not be able to hire a clinician due to funding, but could recruit military spouses to volunteer to receive some behavioral health training and serve in a similar role. One participant suggested that since military personnel tend to move around frequently, having a non-military community health worker guide training for the military spouses could maintain the consistency of care and act as a liaison between the military and the community. Previous research supports the role of relationships between clients and professionals (who represent institutions) as a way to build trust and expand resource knowledge accessibility for clients (Barker & Thomson, 2015). These collaborative relationships

can also create stronger bonds among and between military families and schools which helps these families cope with the challenges of military family life (Mmari, Bradshaw, Sudhinaraset, & Blum, 2010).

The discussion on the potential role of military spouses brought forth the question of whether an associate's degree for community mental health workers has been established in South Carolina (post-hoc searches did not uncover an associate's program like this in SC). The participants suggested that the state-wide leadership team could collaborate with the USC Social work department and potentially other community colleges to create a program that could serve this role. Participants felt that a 2-year community mental health program was an exciting idea that could be very useful to military spouses. A tuition assistance program called My CAA (2017) exists that military spouses could potentially use to help pay for the program. Several of the participants thought that an associate's program like this could be very popular among military spouses who may already be involved with community behavioral health efforts as they could transfer these skills (and potentially a formal position) as they moved from base to base.

The participants also suggested that the state-wide leadership team could facilitate collaborations between school districts with high military populations and the Department of Defense (DoD). The DoD could provide an MFLC as a point of contact for the school district and community mental health workers. This would create a line of contact between the school and the military so parents are not solely responsible for discovering all of the possible services and programs available to them. One of the participants noted that there is a literature on using "lay health advisors" to connect a community to a formal system (*see* Eng & Young, 1992; Rhodes, Foley, Zometa, & Bloom, 2007), and that this model could be used with military spouses (perhaps in conjunction with the previously mentioned associate's program) to connect military bases to school districts.

In addition to facilitating collaborative community efforts for SBH, the participants recommended that the state-wide leadership team could also conduct much needed research on more effective strategies for behavioral health for military children. One participant identified that there may be a gap in the SBH literature on the needs of military children compared to non-military children. This research should focus on the effects of deployment and other stressful experiences for military children (e.g., temporary duty assignment, a parent who has experienced severe trauma). While some of the current literature does consider the military child's experience holistically (Bradshaw et al., 2010; Harrison & Vannest, 2008; Mmari et al., 2010), more work is needed on providing support within the school to military children experiencing these stressors (Cammak et al., 2010).

Beyond the suggestions for the state-wide leadership team, the participants had several other suggestions to further SBH efforts for military families. First, the participants would like to see behavioral health prioritized and they would like to do this by gaining political and social traction. They suggested that military family behavioral health stakeholders need to attend town halls, writing letters to policy makers and editors, and advocate for expanded behavioral health initiatives. One participant said: "In communities where they get organized around supporting one another, great stuff started happening." Second, the participants believe that there needs to be more district support for military children and families as they feel that there currently is little to none. Third, non-military educators, administrators, and legislators should

be educated about the issues military families face in order to get buy-in from all levels. Fourth, the participants would like for Tricare (military insurance) to cover telemental health and telepsychiatry in more regions; telemental health has found to be fiscally efficient in rural areas (Lambert, Gale, Hartley, Croll, & Hansent, 2016) and has been used by military personnel previously (Luxton, Pruitt, O'Brien, & Kramer, 2015). A final note from one participant was that as behavioral health initiatives are moving forward, the "paper trail" may make some military personnel shy away (i.e., the note on their record that they received behavioral health services). The stigmatization of receiving mental health services is a documented problem (Greene-Shortridge, Britt, & Castro, 2007), and the participants would like to find better ways of providing confidentiality to military personnel and their families receiving behavioral health services.

Conclusion and Next Steps

Through this PCORI Eugene Washington Engagement Award, in 2016, our team was able to conduct research forums across South Carolina on five critical themes identified by diverse stakeholders including patients, clinicians, researchers and other stakeholders as necessary for the SBH field to advance: 1) Building partnerships between education, families, mental health and other youth-serving systems, 2) developing effective school-wide approaches, 3) promoting cultural responsiveness and humility, 4) improving the quality of services and increasing the use of evidence-based practices (EBPs), and 5) improving implementation support for EBPs (Weist & Stevens, 2017). This group of diverse stakeholders then recommended that forums be conducted on advancing SBH for three priority populations: youth in the child welfare system, those with connections to the juvenile justice system, and youth from military families, and these forums were conducted in 2017. The rich ideas and recommendations offered by stakeholders in these eight research forums are actively being included in discussions of the 12-state, Southeastern School Behavioral Health Community (SSBHC), established in 2016 with the support of this award. Barriers, ideas for overcoming them, and other recommendations are forging new avenues for research, practice and policy as well as ideas for interconnecting progress across realms. At present, we are pursuing the development of an e-book with each of the eight themes reviewed in this monograph reviewed in detail within its own chapter and to include and introductory and concluding chapter. Our plans for this monograph and the e-book are for them to be free downloadable resources to help school staff, collaborating community agency staff, families, youth, advocates, researchers, government officials and others to make purposeful strides in improving and building capacity for effective SBH programs in schools, districts and southeastern states. Through the SSBHC, a community of practice approach (Cashman et al., 2014) is being taken promoting progressively deeper relationships among stakeholder groups, including an annual conference, the website (www.schoolbehavioralhealth.org), a repository of relevant information on the website (e.g., this monograph, PowerPoints from presentations, research briefs, white papers), ongoing discussion forums and other activities to strengthen stakeholder partnerships and escalate the pace of positive change. We extend our considerable appreciation to PCORI for this significant support and look forward to joining with others in the U.S. in taking school behavioral health to a new level of effectiveness and impact in the years to come.

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