

Developing Principles for Best Practice in Expanded School Mental Health

Mark D. Weist,¹ Mark A. Sander,² Christine Walrath,³ Benjamin Link,¹ Laura Nabors,⁴
Steve Adelsheim,⁵ Elizabeth Moore,¹ Jenni Jennings,⁶ and Kristine Carrillo⁵

Received July 7, 2004; accepted August 31, 2004

On the basis of activities of a federally funded national center for school mental health, review of literature on principles for best practice in child and adolescent mental health and school health, and consultation with national experts and family members, a set of 10 principles for best practice in school mental health was developed. A survey was developed enabling 1–6 point Likert ratings (“clearly unimportant” to “clearly important”) for each of the 10 principles. With an original sample of 426 people involved in education, school health or mental health, all 10 principles were strongly endorsed, receiving mean ratings ranging between 5.10 and 5.75. On the basis of qualitative feedback from this survey and interactive forums, language for 9 of the 10 principles was revised and a survey reflecting these changes was developed and administered to a validation sample of 86 respondents. As with the original sample, endorsements of the principles were strong, with mean ratings ranging between 5.45 and 5.79. Findings are discussed in relation to advancing interconnected agendas related to quality assessment and improvement and empirically supported practice in school mental health.

KEY WORDS: empirical; expanded school mental health; Likert rating.

As documented by other papers in this special issue, the school mental health field is undergoing progressive growth and improvement. Since the 1990s, our work in this field has been anchored by a framework termed “expanded school mental health,” which captures core elements of effective programs; that is, close collaboration between families, schools, and community agencies (e.g., mental health centers and health departments) to develop a full array of effective mental health promotion and intervention to youth in both special and general education in schools (Weist, 1997). As almost all schools have some

level of mental health services, ESMH programs should be viewed as augmenting services provided by school-hired mental health professionals such as school counselors, psychologists, social workers, and pupil services staff (Pavola *et al.*, 1996; Waxman *et al.*, 1999).

Contributing to the progressive growth of ESMH programs are data supporting that they are indeed reaching youth who are unlikely to receive services in traditional sites, such as African-American youth and students with internalizing problems like depression and anxiety (Weist, *et al.*, 1999; see Diala *et al.*, 2002). Further, related to significantly enhanced access, many more youth can be seen in ESMH programs than in traditional settings (Flaherty and Weist, 1999; Jennings *et al.*, 2000), and evaluation findings supporting the positive impacts of the programs are increasingly being documented (Armbruster *et al.*, 1997; Nabors and Reynolds, 2000).

Among the most important programmatic and research areas in the emerging ESMH field is quality assessment and improvement (QAI). Within this area, the academic and research base is beginning to develop, as indicated by: (a) broad literature reviews on the background,

¹University of Maryland School of Medicine, Baltimore, Maryland. To whom correspondence should be addressed at the Center for School Mental Health Assistance, Division of Child and Adolescent Psychiatry, University of Maryland School of Medicine, 737 West Lombard Street, 4th Floor, Baltimore, Maryland 21201; e-mail: mweist@psych.umaryland.edu.

²Hennepin County, Department of Children, Families and Adult Services, Minneapolis, Minnesota.

³ORC, Macro, New York, New York.

⁴University of Cincinnati, Cincinnati, Ohio.

⁵New Mexico Department of Health, Santa Fe, New Mexico.

⁶Dallas Independent School District, Dallas, Texas.

presenting challenges and critical issues in the field (e.g., Adelman *et al.*, 1999; Adelman and Taylor, 1997; Evans, 1999; Weist, 1997); (b) literature reviews and conceptual articles specifically focused on QAI and evaluation (e.g., Ambrose *et al.*, 2000); (c) articles reviewing and making recommendations for interdisciplinary collaboration and effective practice in the schools (e.g., Flaherty *et al.*, 1998; Pavola *et al.*, 1996; Rosenblum *et al.*, 1995); and (e) studies focusing on specific dimensions of QAI, such as conducting focus groups and other forms of qualitative evaluation (e.g., Nabors *et al.*, 2000).

In spite of these developments, our literature review failed to identify any studies involving the development of a comprehensive framework for QAI in expanded school mental health, which was the purpose of the study reviewed in this article. This research builds on the experiences of the Center for School Mental Health Assistance (CSMHA), a federally funded technical assistance, training and resource center at the University of Maryland, working collaboratively with a center in Los Angeles (UCLA Center for Mental Health in Schools) to advance school mental health in the United States. It also builds on the experiences of well established school mental health programs in Baltimore, Cincinnati, Dallas, and New Mexico; as well as interdisciplinary networks sponsored by the CSMHA and national school health organizations such as the American School Health Association, and the National Assembly on School-Based Health Care.

Through this broad collaboration, beginning in 1997, planning meetings were held on strategies to advance the quality agenda in expanded school mental health. In 1999, a consensus decision was reached that the best approach would be for the emerging field to be able to agree on a set of principles for best practice to drive QAI programming. These principles would serve a number of purposes, including: (1) Providing an anchoring point for the development of QAI programs in ESMH (e.g., promoting the development, action planning, and monitoring of quality indicators related to the principles), (2) advancing a critical training agenda in school mental health on QAI, as each principle and associated quality indicators connect to important knowledge bases related to effective programs, (3) raising awareness in the field of factors associated with best practice in school mental health, and providing information and tools useful to advocates and policy makers, (4) promoting some level of standardization in services across programs (i.e., as programs pursue common principles and indicators), and (5) facilitating the measurement of ESMH program functioning in relation to the principles, thus promoting research through quantification of the independent variable of school-based services.

Related to points 4 and 5 in the above, we believe the principles provide a framework for QAI efforts and to enhance *services research* in school mental health. This is in contrast to much of the research that has focused to a great extent on narrow interventions focused on narrow problems (e.g., individual disorders; see Rones and Hoagwood, 2000), or alternatively on broad-scale prevention interventions (see Botvin, 2000; Durlak, 1995). Support for this broader focus on services is supported by recent studies that have documented the importance of program adherence to system of care principles in promoting improved behavioral outcomes in children (Stephen *et al.*, 2002).

A key factor is establishing effective QAI in mental health and education organizations involves careful attention to the organizational climate. Glisson and Hemmelgarn (1998), in a groundbreaking study of interorganizational service coordination in child welfare agencies, found that organizational climate (e.g., low conflict, cooperation, and role clarity) was *the primary predictor* of improvements in child psychosocial functioning and a significant predictor of service quality. However, this study is a rare example since overall, research on organizational climate in child and adolescent mental health has been very limited (Glisson and James, 2002). Guiding prevention and practice in ESMH based on a comprehensive set of principles and quality indicators should plausibly influence organizational climate and advance research in this vital area.

Effective QAI is based on a set of guiding principles that directs the QAI process and defines an endpoint. In order to develop a set of principles we completed three procedures. First, we drafted an initial set of principles from a focused literature review on principles for best practice. Two previously developed sets of principles were found to be most relevant to ESMH: (1) Principles from the Child and Adolescent Service System Program (CASSP), a federally sponsored initiative that has promoted systems development, collaborative approaches, and quality care for youth with more serious emotional/behavioral disorders (Lourie, 2003; Stroul, 1996); and (2) Principles and Goals for School-Based Health Centers (National Assembly on School-Based Health Care, 2000). In addition, we reviewed ethical guidelines for child and adolescent mental health disciplines of psychology, psychiatry, and social work. On the basis of the review of principles and ethical guidelines a preliminary set of 10 principles reflecting best practice in ESMH was developed. The second procedure involved the collection of quantitative and qualitative feedback on these principles through written surveys and interactive forums from a national sample of professionals and family members associated with or working in

Table I. Original and Revised Principles for Best Practice in Expanded School Mental Health

<i>Original Principle 1: All youth and families are able to access care regardless of their ability to pay.</i>
Revised: All youth and families are able to access <i>appropriate</i> care regardless of their ability to pay.
<i>Original Principle 2: Programs are implemented to address school and community needs and assets.</i>
Revised: Programs are implemented to address <i>needs and strengthen assets for students, families, schools, and communities.</i>
<i>Original Principle 3: Programs and services are user-friendly, empirically supported, and based on strengthening assets in young people and in their environments.</i>
Revised: Programs and services <i>focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact.</i>
<i>Original Principle 4: All stakeholders are involved in the program's development, oversight, evaluation, and continuous improvement.</i>
Revised: <i>Students, families, teachers and other important groups</i> are actively involved in the program's development, oversight, evaluation, and continuous improvement.
<i>Original Principle 5: Quality assessment and improvement activities guide the program.</i>
Revised: Quality assessment and improvement activities <i>continually</i> guide and <i>provide feedback</i> to the program.
<i>Original Principle 6: A continuum of care is provided, including mental health promotion, early intervention, and treatment.</i>
Revised: A continuum of care is provided, including <i>school-wide</i> mental health promotion, early intervention, and treatment.
<i>Original Principle 7: Staff hold to high ethical standards, are committed to children and adolescents, and display an energetic, flexible, responsive and proactive style in delivering services.</i>
Revised: Staff hold to high ethical standards, are committed to children, adolescents, <i>and families</i> , and display an energetic, flexible, responsive, and proactive style in delivering services.
<i>Original Principle 8: Staff are respectful of, and competently address developmental, cultural, and personal differences among students, families and staff.</i>
Unchanged.
<i>Original Principle 9: Staff build and maintain strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes care.</i>
Revised: Staff build and maintain strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes <i>all efforts</i> .
<i>Original Principle 10: Mental health programs in the school are coordinated together and with related programs in other community settings.</i>
Revised: Mental health programs in the school <i>are coordinated with</i> related programs in other community settings.

ESMH. Finally, based on findings from the first phase of data collection, we revised the principles and reassessed their importance with a second validation sample of school health professionals.

METHOD

Table I lists the original 10 principles developed from the review of the literature and consultation with other experts in the field, and the revised principles based on processes reviewed below. To collect data on the importance of these principles a survey was developed, enabling the rating of each principle on a 1–6 Likert scale, with 1 representing “clearly unimportant” and 6 representing “clearly important.” The survey, which also enabled qualitative feedback on language and general recommendations, was initially completed by 428 people with some involvement in school mental health from diverse backgrounds (e.g., mental health, education, school mental health, and family members). All of these surveys were collected at or shortly after school health conferences, including meetings of the American School Health Association (ASHA), the School Health Interdisciplinary Program (SHIP) of the CSMHA, and the National Assembly on School-Based Health Care

(NASBHC). In addition, forums on the principles were held at the NASBHC meeting held in the spring of 2001, and at the ASHA meeting in the fall of 2001.

In the spring of 2002, some of the language of the principles was changed based on the qualitative feedback (i.e., written comments on surveys) and the forums. In June 2002, another forum on the revised principles was held at the NASBHC meeting. In July 2002, a survey of the revised principles was conducted in conjunction with the SHIP conference and completed by 86 people (representing a validation sample). The original sample of 428 respondents represented 10 different stakeholder groups (e.g., mental health clinician, family member, administrator, researcher, and medical provider) from 39 United States. The sample of 86 people providing feedback on the revised principles represented 8 stakeholder groups from 3 states.

RESULTS

First, descriptive analyses were performed on both the original and revised survey samples to understand their composition in terms of respondent discipline (e.g., social work and psychology), gender, and years involved

in school mental health, position (e.g., clinician and administrator), as well as characteristics of their work setting including geographic area, number of schools, and type of schools. Second, independent *t*-tests were performed to assess the difference in average endorsements between the two samples.

Finally, a multivariate analysis of variance (MANOVA) using the demographic characteristics as independent variables and the 10 principle endorsement ratings as dependent variables was conducted with each sample. All seven demographic characteristics were included in the MANOVA for the original sample; however, due to the unbalanced cell size associated with gender it was not included as an independent variable in the MANOVA for the revised survey sample (male $n = 5$ vs. female $n = 76$). The MANOVAs were used to investigate if the set of principles were endorsed differently as a function of the descriptive characteristics within each sample. If the Wilks' Lambda for a descriptive characteristic reached statistical significance, the Bonferroni corrected univariate analyses of variance (ANOVA) associated with that characteristic was examined for each of the 10 principles.

Descriptive Characteristics of the Two Samples

As indicated in Table II, while the majority of respondents in the original survey sample ($n = 428$) were female and worked in either a mental health or school health discipline, they were diverse with regard to the number of years they had provided school mental health service, the positions held, the number and types of school in which they worked, and the geographic setting in which they worked. Similar to the original survey sample, the majority of respondents in the revised survey sample ($n = 86$) were also female and worked in a mental or school health discipline, and were diverse with regard to their other characteristics.

Endorsements of the 10 Principles by the Two Samples

Overall, the original 10 principles were endorsed as important, with average scores ranging from 5.10 to 5.75 (Table III). Respondents to the original survey provided written feedback on the language of several of the principles, resulting in revision of 9 of the 10 principles. The revised principles, when reviewed by a subsequent sample, were endorsed with significantly higher mean scores that ranged from 5.45 to 5.79 (Table III). Independent *t*-tests indicated significantly higher endorsements by the

Table II. Overall Descriptive Statistics for Original and Revised Survey Samples

Demographic characteristic	Original survey sample ($N = 428$)		Revised survey sample ($N = 86$)	
	<i>N</i>	Percentage ^b	<i>N</i>	Percentage ^b
Discipline				
Mental health	212	50.1	13	15.1
Education	77	18.2	1	1.2
School health	87	20.6	63	73.3
Other	47	11.1	9	10.5
Missing	5	1.2	0	0
Gender				
Male	53	13	5	6.2
Female	355	87	76	93.8
Missing	20	4.7	5	5.8
Years of SMH^a (years)				
≤2	108	30.3	14	19.4
>2 and ≤5	86	24.1	14	19.4
>5 and ≤13	81	22.7	23	31.9
>13	82	23	21	29.2
Missing	71	16.6	14	16.3
Position				
Program administration	63	16.8	11	14.1
Service provider	151	40.4	12	15.4
Both roles	29	7.8	1	1.3
Other	131	35	54	69.2
Missing	54	12.6	8	9.3
Geographic setting				
Urban	165	40.6	17	21.5
Rural	126	31	25	31.6
Suburban	59	14.5	21	26.6
Multiple	56	13.8	16	20.3
Missing	22	5.1	7	8.1
Number of schools				
1	197	51.3	34	45.9
2	70	18.2	18	24.3
3	117	30.5	22	29.7
Missing	44	10.3	12	14
Type of school				
Elementary	95	24.7	19	25.7
Middle	36	9.4	7	9.5
High	66	17.2	8	10.8
Multiple	187	48.7	40	54.1
Missing	44	10.3	12	14

^aSMH = school mental health; number of schools refers to the number of schools in which the respondent worked.

^bPercentages for variables were calculated without missing cases in the denominator, and the percentage of missing data is also reported.

revised survey sample as compared to the original survey sample for principles 2, ($t = -2.32$, $n = 510$, $p = .02$), 4 ($t = -3.27$, $n = 490$, $p = .001$), 5 ($t = -2.76$, $n = 490$, $p = .006$), 9 ($t = -2.07$, $n = 489$, $p = .04$), and 10 ($t = -4.01$, $n = 490$, $p = .001$). All of these principles were among those revised prior to the second survey suggesting that the revisions may have led to improved ratings of importance. It is also reasonable to assume that

Table III. Means and SD of Principles: Original and Revised Surveys

Principle	<i>N</i> ^a	Mean	SD
Principle 1			
Original	423	5.75	0.668
Revised	86	5.78	0.524
Principle 2			
Original	424	5.51	0.753
Revised	86	5.68*	0.599
Principle 3			
Original	424	5.54	0.743
Revised	82	5.56	0.631
Principle 4			
Original	408	5.1	0.921
Revised	82	5.45***	0.688
Principle 5			
Original	408	5.22	0.87
Revised	82	5.50**	0.653
Principle 6			
Original	408	5.68	0.665
Revised	81	5.72	0.454
Principle 7			
Original	407	5.7	0.658
Revised	80	5.79	0.454
Principle 8			
Original	407	5.65	0.684
Revised	81	5.7	0.486
Principle 9			
Original	408	5.54	0.707
Revised	81	5.68*	0.52
Principle 10			
Original	405	5.36	0.841
Revised	81	5.64***	0.508

^aTotal *N* for original survey = 428 and total *N* for revised survey = 86.

*Significant difference between original and revised surveys at $p < 0.05$; **Significant difference between original and revised surveys at $p < 0.01$;

***Significant difference between original and revised surveys at $p < 0.001$.

differences in the samples may have been responsible for the differences.

Relationship between Descriptive Characteristics and Endorsement of the Principles

The MANOVA conducted with the original survey sample included 249 respondents who had information on all 10 principles as well as the set of seven demographic characteristics. The only sample characteristic associated with significantly different endorsement ratings of principles was the position held by the respondent (Wilks' Lambda = .83, $p = .02$). The ANOVAs associated with respondent position indicated that Principle 4

(i.e., *All stakeholders are involved in the program's development, oversight, evaluation, and continuous improvement*) was the only principle on which respondents of different position groups provided significantly different endorsements ($F[3, 231] = 3.02$, $p = .03$). The least significant difference post-hoc comparisons indicated that respondents who had dual positions (i.e., administrators and providers) and those that were in the 'other' position category had significantly higher endorsements of Principle 4 than those who served solely as program administrators. However, it should be noted that endorsements remained in the "important range" across all of these groups.

The MANOVA conducted with the revised survey sample included the 52 respondents with information on the set of 10 principles as well as 6 demographic characteristics (gender was excluded). Based on this analysis there were no demographic differences in endorsement ratings across the set of 10 principles in the revised survey sample.

DISCUSSION

A significant problem in child and adolescent mental health, and school-based mental health is the tremendous variability in practice, which no doubt contributes to the failure to document that standard therapies result in positive outcomes for youth and families (see Weisz and Jensen, 2002; Weisz *et al.*, 1998). Within school mental health, the fact that there are no standardly accepted principles for best practice contributes to this variability. The current study, based on planning processes beginning in 1997, and research beginning in 1999, attempted to fill this critical void for the rapidly developing ESMH field. Through review of other principles for best practice and ethical guidelines, and discussions with national leaders and stakeholders, a set of 10 principles for best practice in ESMH and a corresponding survey was developed.

In general, the 10 principles in the original and revised samples were rated positively and similarly by groups varying on demographic characteristics such as discipline, years in school mental health, position, geographic location, and school level. This provides support for the global relevance and importance of the principles to the range of people involved in school mental health. The only demographic difference found was in the original sample ($n = 428$) for Principle 4, "*All stakeholders are involved in the program's development, oversight, evaluation, and continuous improvement.*" On this principle administrators who were also providers, and those in the "other" category (including family members and

advocates) rated the principle higher than administrators (who were not also providers). While this could be a reflection of administrators prioritizing stakeholder involvement less than providers, parents, and advocates; it is important to not over-interpret this difference since both groups rated the principle in the “very important” range.

As mentioned earlier, the literature on QAI in ESMH is beginning to develop, yet systematic research remains limited. We are beginning a program of federally funded research involving systematic training in QAI based on these 10 principles for ESMH staff and programs. For each of the 10 principles, quality indicators have been developed. For example, for Principle 4 (regarding stakeholder involvement), quality indicators include: (a) *Have you helped your school develop an advisory board (including youth, families, administrators, teachers, school health staff, and community leaders) for its mental health programs?* (b) *Do you participate in activities (e.g., meetings, focus groups, and surveys) to obtain feedback on an ongoing basis from students, families, teachers, and other important groups on how the program is functioning?* Ongoing training, supervision, and technical assistance will be used to ensure that staff receiving the QAI intervention are consistently pursuing quality indicators associated with best practice in school mental health.

Importantly, the agenda to advance QAI in school mental health should be viewed as an agenda that will increase the likelihood of evidence-based practice on multiple levels. First, the 10 principles are based on literature and research supporting their importance to positive outcomes for youth and families (e.g., Anglin *et al.*, 1999; Domitrovich and Greenberg, 2000; Nabors and Reynolds, 2000; Stroul, 1996; Weist *et al.*, 1999). Second, many of the principles involve assuring that the ESMH program is well accepted and integrated into the school, and that clinicians have the personal qualities and experience, and are trained to do well negotiating the unique demands of school mental health. These factors should be viewed as foundational to the success of any prevention or intervention effort, as supported by emerging literature on strategies for the successful implementation of evidence-based prevention programs (Graczyk *et al.*, 2003). Third, some of the principles and associated quality indicators explicitly focus on empirically supported practice. For example, under Principle 3, one of the quality indicators states, *are you actively using the evidence base of what works in child and adolescent mental health to guide your preventive and clinical interventions?*

It is important to emphasize that the 10 principles developed through this study provide general guidance on areas of importance in efforts to develop and improve school mental health programs. However, each principle

may not be applicable to all programs. For example, Principle 1, states that “All youth and families are able to access appropriate care regardless of their ability to pay.” While this is a principle that most in the field would support (per results of this study), it may not be possible to operationalize it in a program totally dependent on fee-for-service revenue. But knowledge of the principle, even for a program like this, could engender efforts to develop other funding mechanisms (e.g., grants and contracts) to make progress toward achieving it. Similarly, not all ESMH programs are currently able to do much in the prevention realm, but Principle 6 (on developing a full continuum of promotion, early intervention, and treatment) may serve as a stimulus for beginning action in this area.

In addition, it is not possible to cover the realm of all areas relative to effective ESMH in one set of 10 principles. A key concern here is training and supervision, which could justifiably be a principle of its own. However, training and supervision could be viewed as relating to all the other principles, is embedded implicitly in many of them, and in our QAI training program, a number of indicators directly relate to it. Alternatively, some issues like appropriately handling consent and confidentiality issues were discussed as potential principles, but in our development process were viewed as too focused to be principles, and instead are quality indicators in our QAI training program.

We should comment on a few limitations to the present study. First, sample sizes for the original and revised survey samples were not large, and were predominantly female. However, the very strong and consistent endorsements of the principles by these two samples suggest that differences in findings with larger sample sizes would be unlikely. In addition, the disciplines surveyed in the current study (e.g., child and adolescent mental health, school mental health, and education) are predominantly staffed by females, so survey findings are reflective of this gender-related demographic. A second limitation is that the samples could have been more diverse; in particular, more input from youth and family members would have been beneficial.

In spite of these limitations, the study provides a set of principles for best practice in expanded school mental health that can serve as guidance for program development and improvement, and the development of a critically needed agenda in QAI.

ACKNOWLEDGMENTS

Supported by cooperative agreement U93 MC 00174 from the Office of Adolescent Health, Maternal and Child

Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, with co-funding by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Also supported by project R03 HS 09542 from the Agency for Healthcare Research and Quality. We express our appreciation to Melissa Ambrose, Jennifer Axelrod, Nancy Bearss, Tanya Bryant, Steve Evans, Phyllis Hazel, Anthony Lehman, Linda Kinney, Nancy Lever, and John Schlitt for ideas and assistance in conducting this study.

REFERENCES

- Adelman, H. S., and Taylor, L. (1997). System reform to address barriers to learning: Beyond school-linked services and full service schools. *Am. J. Orthopsychiatry* 67(3): 408–421.
- Adelman, H. S., Taylor, L., Weist, M. D., Adelsheim, S., Freeman, B., Kapp, L., Lahti, M., and Mawn, D. (1999). Mental health in schools: A federal initiative. *Children's Services Social Policy, Research, and Practice* 2(2): 95–115.
- Ambrose, M. G., Weist, M. D., Schaeffer, C., Nabors, L. A., and Hill, S. (2002). Evaluation and quality improvement in school mental health. In Ghuman H. S., Weist M. D., and Sarles R. M. (eds.), *Providing Mental Health Services to Youth Where They Are: School and Community-Based Approaches*. Brunner-Routledge, New York, pp. 95–112.
- Anglin, T. M., Naylor, K. E., and Kaplan, D. W. (1999). Comprehensive, school-based health care: High school students' use of medical, mental health, and substance abuse services. *Pediatrics* 97(3): 318–330.
- Armbruster, P., Gerstein, S. H., and Fallon, T. (1997). Bridging the gap between need and service utilization: A school-based mental health program. *Community Ment. Health J.* 33: 199–211.
- Botvin, G. J. (2000). *Life Skills Training: Promoting Health and Personal Development: Teacher's Manual I*. Health Press, Princeton, NJ.
- Diala, C. C., Muntaner, C., Walrath, C., Nickerson, K., LaVeist, T., and Leaf, P. (2002). Racial/ethnic differences in attitudes toward seeking professional mental health services. *Am. J. Public Health* 91(5): 805–807.
- Domitrovich, C. E., and Greenberg, M. T. (2000). The study of implementation: Current findings from effective programs that prevent mental disorders in school-aged children. *J. Educ. Psychol. Consult.* 11(2): 193–221.
- Durlak, J. A. (1995). *School-Based Prevention Programs for Children and Adolescents*. Sage Publications, Thousand Oaks, CA.
- Evans, S. W. (1999). Mental health services in schools: Utilization, effectiveness, and consent. *Clini. Psychol. Rev.* 19(2): 165–178.
- Flaherty, L. T., Garrison, E., Waxman, R., Uris, P., Keyes, S., Siegel, M. G., and Weist, M. D. (1998). Optimizing the roles of school mental health professionals. *J. School Health*, 68(10): 420–424.
- Flaherty, L. T., and Weist, M. D. (1999). School-based mental health services: The Baltimore models. *Psychol. Sch.* 36(5): 379–389.
- Glisson, C., and Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse Negl.* 22(5): 401–421.
- Glisson, C., and James, L. R. (2002). The cross-level effects of culture and climate in human service teams. *J. Organizational Behav.* 23: 767–794.
- Graczyk, P. A., Domitrovich, C. E., and Zins, J. E. (2003). Facilitating the implementation of evidence-based prevention and mental health promotion efforts on schools. In Weist M. D., Evans S. W., and Lever N. A. (eds.), *Handbook of School Mental Health Programs: Advancing Practice and Research*. Kluwer Academic/Plenum Publisher, New York, pp. 301–318.
- Jennings, J., Pearson, G., and Harris, M. (2000). Implementing and maintaining school-based mental health services in a large urban school district. *J. Sch. Health*70(5): 201–296.
- Lourie, I. S. (2003). A history of community child mental health. In Pumariega A., and Winters N. C. (eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry*. Jossey-Bass, San Francisco, pp. 1–16.
- Nabors, L. A., and Reynolds, M. W. (2000). Program evaluation activities: Outcomes related to treatment for adolescents receiving school-based mental health services. *Child. Ser. Soc. Policy Res. Pract.* 3(3): 175–189.
- Nabors, L. A., Reynolds, M. W., and Weist, M. D. (2000). Qualitative evaluation of a high school mental health program. *J. Youth Adolesc.* 29(1): 1–14.
- National Assembly on School-Based Health Care: Center for Advocacy and Public Policy (2003). Principles and Goals for School-Based Health Care. Retrieved September 23, 2003, from <http://www.nasbhc.org/>
- Pavola, J. C., Carey, K., and Cobb, C. (1996). Interdisciplinary school practice: Implications of the service integration movement for psychologists. *Prof. Psychol. Res. Pract.* 27: 34–40.
- Rones, M., and Hoagwood, K. (2000). School-based mental health services: A research review. *Clin. Child Family Psychol. Rev.* 3(4): 223–241.
- Rosenblum, L., DiCecco, M. B., Taylor, L., and Adelman, H. S. (1995). Upgrading school support programs through collaboration: Resource coordinating teams. *Soc. Work Educ.* 17: 117–124.
- Stephen, R. L., Holden, E. W., and Hernandez, M. (2004). System-of-care practice review scores as predictors of behavioral symptomatology and functional impairment. *J. Child Fam. Studies* 13(2): 179–191.
- Stroul, B. (ed.), (1996). *Children's Mental Health: Creating Systems of Care in a Changing Society*. Paul H. Brookes, Baltimore.
- Waxman, R. P., Weist, M. D., and Benson, D. M. (1999). Toward collaboration in the growing education-mental health interface. *Clin. Psychol. Rev.* 19: 239–253.
- Weist, M. D. (1997). Expanded school mental health services: A national movement in progress. *Adv. Clin. Child Psychol.* 19: 319–352.
- Weist, M. D., Myers, C. P., Hastings, E., Ghuman, H., and Han, Y. (1999). Psychosocial functioning of youth receiving mental health services in the schools vs. community mental health centers. *Community Ment. Health J.* 35(5): 69–81.
- Weisz, J. R., Huey, S. J., and Weersing, V. R. (1998). Psychotherapy outcome research with children and adolescents: The state of the art. *Adv. Clin. Child Psychol.* 20: 49–91.
- Weisz, J. R., and Jensen, A. L. (2002). Child and adolescent psychotherapy in research and practice contexts: Review of the evidence and suggestions for improving the field. *Eur. Child Adolesc. Psychiatry* 10(Suppl. 1): 12–18.