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Why Population-Based Services Are Essential for School Mental Health, and How to Make Them Happen in Your School

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The national discussion of school mental health that emerged during the 2002 Multisite Conference on the Future of School Psychology (Harrison et al., 2004) was both remarkable and exciting, in part because of the very rich conceptual framework that was used to describe mental health and its relevance to schooling. Within this framework, every school is a community, composed of students, their teachers, staff in the building, and the parents who send their

children to the school. The principle mission of the school is to provide students with the knowledge and skills necessary to lead productive and successful lives. This mission is not the sole responsibility of schools; it is shared with other important societal entities such as families, churches, the legal system, and social services. Moreover, this mission cannot be narrowly defined as an “instructional” mission. Life success is a product of social and emotional competence and personal ambition as much as academic achievement and literacy. Most important, the attempts of schools to promote instructional success are always constrained by their students’ developmental competence. Simply stated, students do not grow into literate adults without also developing social, emotional, and personal competence. Ergo, school mental health goals of promoting psychological wellness are not ancillary to students’ academic success, but integral to it.

There was ample evidence prior to the Futures Conference that mental health is critical to academic success (Hoagwood & Johnson, 2003; Meyers, Parsons, & Martin, 1979). In their influential book, Adelman and Taylor (2006) have pointed out that schools cannot provide high-quality instruction without attending to their students’ participation in learning. Leading developmental psychologists, including Ann Masten (Masten et al., 2005) and Kathryn Wentzel (Wentzel, 2002; Wentzel & Watkins, 2002), have repeatedly demonstrated that children’s school success is integral to and not independent of other facets of developmental competence. The U.S. Department of Education has sponsored a high-powered effort to promote positive behavior supports in schools because these are essential to students’ academic achievement (National Technical Assistance Center on Positive Behavioral Interventions and Supports, 2006). More recently, the National Association of School Psychologists’ Blueprint III (Ysseldyke et al., 2006) underscores the critical contributions of school psychologists to the mental health of learners, and the central importance of mental health for learners’ success.

This book extends the thesis that mental health is essential to schooling by arguing that when school mental health services are framed around population-based strategies, they can be more fully integrated into the core activities of schools. This introductory chapter first describes population-based services and contrasts them with traditional service delivery models. Next, the chapter describes existing knowledge bases that can inform efforts to implement a population-based service model. Finally, it describes the remaining chapters within the framework presented here.

What Are Population-Based School Mental Health Services?

Population-based school mental health services are services that have been carefully designed to meet the mental health needs of all students enrolled in a school. Their premise is that psychological wellness is a precondition for students' success in school and that, as teachers are responsible for teaching all children to read, school mental health providers are responsible for insuring that all students have the psychological competence needed for learning. Within the population-based model, decisions about which mental health interventions to provide and which students will receive interventions are intentional decisions based on carefully collected information about the mental health status of all students in the school. Students can still be referred to the school mental health team within population-based models, but traditional interventions for these individual students are embedded within a larger plan that recognizes and plans for the mental health of referred and nonreferred students alike. Population-based models do not presuppose that all interventions will be delivered school-wide. Instead, the mental health interventions that are implemented may be individual, classwide, school-wide, or district-wide, depending on the needs of the school's students. Similarly, within a population-based model, mental health interventions may be preventive or remedial, depending on evidence of the risk and disorder present within the school's students. Decisions about the kinds of interventions to provide will depend on the urgency of student needs and the importance of anticipated outcomes.

Ideally, population-based mental health services have at least four goals: (a) to promote the psychological well-being of all students so that they can achieve developmental competence; (b) to promote caretaking environments that nurture students and allow them to overcome minor risks and challenges; (c) to provide protective support to students at high risk for developmental failures; and (d) to remediate social, emotional, or behavioral disturbances so that students can develop competence.

The difference between population-based services and traditional referral-based models of school mental health is analogous to the difference between nurturing a single tree showing signs of failing health and maintaining the vitality of a forest. In both cases, the trees require adequate light, space, water, nutrients, and temperature. Either a single tree or a forest can be threatened by disease or maladies, especially if stressed by an absence of necessary nutrients. To care for a single

tree, a gifted gardener can inject fertilizer in its roots, soak the surrounding soil with ample water, prune it, and control for any infections that emerge. However, groundskeepers who are caring for a forest must use different and more efficient strategies for assessing the condition of their trees, providing the proper nourishment and conditions for growth, and treating diseases. Of course, the tree analogy falls apart once we consider the value of the individual. While a few trees might be sacrificed for the health of the forest, the same is not true for children. Every student in a school is a valued member of the community, and school mental health interventions must be planned so that no child is sacrificed for the good of the whole. This is the special challenge of population-based services—to balance the needs of individual students with those of the school’s community of students.

The intentionality of mental health service planning is central to the provision of population-based services, and so this book uses the following problem-solving cycle to frame their description:

Assess → Identify Resources → Plan → Intervene → Assess

Planning begins with an understanding of the nature of developmental competence and threats to that competence, as derived from the rich developmental research describing children’s social, emotional, cognitive, and personal growth. Given what is known about children’s developmental competence in general, information is gathered to describe the mental health needs of all students enrolled in a particular school. Based on that data-based portrait, resources with the potential to address these needs are identified within and outside of the school setting. Collaborative partnerships that extend throughout the community and school can create infrastructures that integrate related interventions into comprehensive systems of care and that dismantle programmatic silos—narrowly construed interventions that address a single risk factor or disturbance without regard for students’ other risks or needs. Given the identified mental health needs and resources, a plan is constructed that prioritizes the needs of the school’s students and allocates mental health resources to interventions that are frequently needed and those that will have high impact on the students’ psychological wellness. Periodic reassessment of students’ mental health needs allows school mental health providers to evaluate the school’s progress and update its mental health plan. Interventions that emerge out of this problem-solving cycle do not need to focus solely on students. They can also focus on the forests, or schools. Indeed, when population-based assessments suggest that large numbers of children are faltering, an immediate possibility is that something is wrong with the school as an environment for learning or development.

Clearly, this cycle will require that school mental health providers have a description of their building's mental health needs that is both accurate and thorough. Consequently, population-based services must be predicated on data-based portraits of the students' mental health needs (Baker, chapter 3; Short & Strein, chapter 2, this volume). Data can include deliberately collected information about students' mental health and psychological disturbance, as might be acquired through a school-wide administration of a risky behavior survey. Alternatively, existing school data might be used to support a plan's development, including data about student attendance, work completion, or behavior problems. Finally, population-based assessment strategies can be used to screen the full student population of a school and identify those children with a demonstrable need for socioemotional support (Doll & Haack, 2005). Data used to support a school's mental health plan might be variously aggregated across all students in a school, aggregated across subgroups of students (e.g., by grade, gender, or risk factors), or used to identify specific children at high risk. Patterns and trends in that data can be used to suggest particular sources of risk, describe the nature of mental health interventions that are required, or make the case for additional interventions from within or outside the educational system.

One of the dilemmas that school mental health providers face is the very profound discrepancy between the number of youth with significant needs for mental health interventions and the very limited resources available for child and adolescent mental health. It is clear that neither school nor community mental health resources are adequate to meet the needs of the one-in-five school-aged children who meet the criteria for at least one psychiatric diagnosis (Doll, 1996; Nastasi, 2004; Strein, Hoagwood, & Cohn, 2003; U.S. Department of Health and Human Services, 1999). Even more children without diagnoses are at risk for significant developmental failure. Needs of this magnitude demand that a school's mental health plan include interventions provided through public or private agencies or through multi-agency agreements, in addition to interventions provided by school-employed mental health providers. Moreover, needs this diverse require a continuum of mental health services extending from individual interventions for children with special needs, much like traditional clinical interventions, to community-wide interventions that address prevalent problems and promote developmental competence (Nastasi, 2004; Nastasi, Moore, & Varjas, 2004).

Population-based services do not discard the traditional clinical model that focuses on the needs of an individual, but require that schools move beyond it. A similar case has been made within

Blueprint III (Ysseldyke et al., 2006), which argues that school psychologists' focus should not remain at the individual level despite their history of collecting individual assessments of student learning. There is no assurance that drafting a population-wide plan for a continuum of mental health interventions will stretch existing resources to meet the needs of a school's students. However, planning for the full school's enrollment can assure that those decisions made about the allocation of mental health interventions will be deliberate and informed.

This continuum of school mental health interventions is likely to look very much like the three-tiered model of service described by Osher, Dwyer, and Jackson (2004). The continuum must address the *universal* mental health needs of students with system-wide or building-wide interventions to promote psychological wellness and to prevent disturbance. The Center for Mental Health in Schools refers to these universal interventions as "systems for positive youth development" and "systems of prevention" (Center for Mental Health in Schools, 2001). For example, all students could benefit from instruction in social problem-solving strategies (Shure & Spivack, 1982) or from a school-wide bullying prevention plan (Olweus, 1993). Universal interventions are similar to services that were historically called "Primary Prevention," but the updated term recognizes that the purpose of these interventions is not simply to prevent problems but also to promote wellness. Planning for universal interventions can draw on the very rich research in developmental competence that has begun to define factors that predict school learners' social, academic, and behavioral success (Masten et al., 2005; Wentzel, 2002; Wentzel & Watkins, 2002).

The second-tier interventions are *selected* mental health interventions (also called systems of early intervention by the Center for Mental Health in Schools, 2001) that are provided to students with demographic risk (i.e., evidence of poverty, family violence, or other characteristics that predict poor outcomes) or functional risk (i.e., evidence of early or emerging symptoms of disturbances). Selected interventions are more concentrated and more intense than universal interventions, and address needs that are not broadly held by all students in a school. They are similar to secondary prevention interventions, but have the purpose of strengthening competence as well as ameliorating risk. Examples of selected interventions are programs to involve parents more fully in their children's schooling (e.g., Check & Connect) (Sinclair, Christenson, Hurley, & Evelo, 1998) or interventions to prevent substance abuse in high-risk families (e.g., Preparing for the Drug-Free Years) (Kosterman, Hawkins, Spoth, Haggerty, & Zhu, 1997). In the prototypic school, 15 to 20% of the school enrollment will benefit from selected mental health interventions. However, particular

schools may differ strikingly in the prevalence as well as the nature of selected interventions they need. Demographic risk is not evenly distributed across all school communities, but instead tends to concentrate in niches of very high risk such as those characterizing certain inner-city urban schools or very isolated rural communities (Pianta & Walsh, 1996). One function of population-based mental health planning is to identify the nature and extent of a school's need for selected interventions, drawing on the wealth of research on developmental risk and resilience to develop and evaluate selected interventions.

In every school, a subset of students will require more intensive selected interventions. This third tier of *selected* interventions is necessary for students who show evidence of adjustment disturbances so pronounced that they are not able to benefit from schooling without accommodations. In typical schools, these students represent between 1 and 5% of the enrollment, but, once again, the nature and extent of need can differ markedly from one school to the next. Traditionally, indicated interventions have been referred to as "tertiary prevention," "therapy," or "intervention." Examples include "level" programs for students with severe behavior disorders or desensitization procedures for students with major anxiety disorders. Within a population-based model, interventions to support students with significant disturbances could still occur at the classroom or school level, and students identified for these interventions may be served individually or in groups.

This three-tier pyramid emphasizes a structure for children's mental health services that is profoundly different from current services. In deference to this change, Adelman and Taylor (2006) suggest that the pyramid must be firmly grounded in one more level of services—that of infrastructure-building interventions. The purpose of these interventions is to promote the systemic reforms that are necessary for communities' comprehensive system of mental health services to be planned, funded, implemented, and evaluated on a routine basis.

What Do We Already Know?

Public Health Literature

A roadmap for the design and development of population-based perspectives on school mental health can be found in the annals of the public health professions. Public health professionals in the United States have traditionally focused their interventions on populations, and have emphasized society's shared responsibility for the health of

the population. One of the most concise definitions is, “Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy” (Institute of Medicine, 1988, p. 1). Within medicine, the emphasis on public health first emerged in the 1800s, as communities were threatened by high rates of disease and the proliferation of environmental hazards (Nastasi, 2004; Strein et al., 2003). Early public health efforts focused principally on disease prevention through widespread vaccinations and environmental improvements. In the 1970s, public health systems increasingly emphasized carefully conducted research describing the collective health of populations. More recently, in the 1990s, the attention of public health systems has shifted to include health promotion as well as disease prevention. Policies, practices, and empirical research strategies developed within the public health systems can be adapted to understand the mental health of community populations, and particularly the prevention of psychological disturbance and well-being within a school’s student body. For example, Table 1.1 describes how the Institute of Medicine’s (1988) 10 essential public health services could be applied to school mental health services.

The compelling relevance of public health perspectives to the practice of school psychology has been recognized repeatedly by key leaders in mental health and school psychology (Institute of Medicine, 1994). Hoagwood and Johnson (2003) guest-edited a special issue of the *Journal of School Psychology* that called for this shift in school psychological roles. Nastasi (2004) similarly called for the integration of public health and public education, an essential step toward the national promotion of children’s mental health. Power (2003) emphasized the necessary partnerships between mental health and education that must underlie a public health perspective. Even earlier, Eddy, Reid, and Curry (2002) described a public health perspective on the prevention of antisocial behavior and violence in youth.

Research on Developmental Psychopathology

Ample data in the developmental psychopathology research describes the kinds of mental health interventions that will be needed in many schools. For example, epidemiologic studies have shown that the most prevalent psychosocial disorders in both elementary and secondary schools are anxiety disorders (Doll, 1996). The National Comorbidity Study (Kessler, Berglund, Demler, Jin, & Walters, 2005) has shown that the average age of onset for anxiety disorders is 11 years, or approximately during the sixth grade. Anxiety has not

Table 1.1 Application of the 10 Essential Public Health Services to School Mental Health

<i>10 Essential Public Health Services*</i>	<i>Equivalent School Mental Health Services</i>
1. Monitor health status to identify community health problems	Monitor students' mental health status including their academic, social-emotional, and relational competence
2. Diagnose and investigate health problems and health hazards in the community	Diagnose and investigate psychological disturbance in students
3. Inform, educate, and empower people about health issues	Inform, educate, and empower students and their families about mental health issues
4. Mobilize community partnerships to identify and solve health problems	Mobilize school-family-community partnerships to identify and solve psychological disturbances
5. Develop policies and plans that support individual and community health efforts	Develop policies and plans that support student, family, school, and community mental health efforts
6. Enforce laws and regulations that protect health and ensure safety	Implement policies and practices that protect students' mental health and ensure developmental competence
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable	Link students and their families to universal, selected, and intensive interventions as needed
8. Assure a competent public health and personal health care workforce	Provide appropriate staff training and monitor throughout intervention
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services	Evaluate effectiveness, accessibility, and quality of school mental health services
10. Research new insights and innovative solutions to health problems	Research new insights and innovative approaches to promoting mental health

*Source: Institute of Medicine (1988).

traditionally received a significant proportion of the focus of school mental health providers, despite the evidence that anxiety disorders significantly interfere with learning and personal adjustment. The ubiquity of anxiety disturbances, and their prevalence throughout the

lifespan, suggests that strategies to identify and manage maladaptive anxiety ought to be infused into the curriculum of most schools, regardless of level.

Impulse control disorders have a similarly early average age of onset, and are equally prevalent in elementary and secondary schools. However, the nature of the impulse control disorders shifts as students move into the middle school. In the elementary grades, the incidence of attention deficit disorder with and without hyperactivity (ADD and ADHD) is slightly higher than the incidence of simple conduct disorders and oppositional defiant disorders. Moreover, a significant portion of elementary-aged students struggle with both disorders simultaneously. By the secondary grades, the incidence of ADHD has declined somewhat, although some researchers argue that it is the expression of the disorder that has shifted and not its actual prevalence. However, the incidence of conduct disorders in secondary schools is at least twice that of elementary schools. Impulse control disorders are eminently contextual in origin, and are often moderated by careful manipulation of contingencies and setting events in the school environment.

Impulse control disorders are not only disturbing for the students who evidence them, but also contribute to a climate of interpersonal aggression that can make schools very frightening environments for all students. In particular, Swearer (Swearer, Espelage, Love, & Kingsbury, chapter 8, this volume; Swearer & Cary, 2003) describes patterns of physical, verbal, and relational aggression among students that is frequent, disturbing, and may occur outside the immediate notice of supervising adults in the building. Sugai, Horner, and Gresham's (2002) review of school data suggests that, in many schools, a small proportion of students account for the majority of aggressive and rule-breaking incidents in a building. Thus, information on disruptive disorders suggests that all schools need systematic management plans to address behavioral conduct in positive ways, conflict mediation strategies to help students repair relationships in the face of interpersonal conflicts, and more intense intervention strategies to address the severe behavioral transgressions of the school's few, very disruptive students.

In contrast to anxiety disorders and disruptive disorders, mood disorders are three to four times as prevalent in secondary schools as in elementary schools (Doll, 1996), with as many as 6% of high school students meeting the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition, Text Revision (DSM-IV-TR*, American Psychiatric Association, 2000) criteria for a clinical depression. Moreover, the

National Comorbidity Study (Kessler et al., 2005) suggests that these adolescent cases are just the beginning of an increase in mood disorders, whose average age of onset is approximately 30 years of age. Even in adults, delays in seeking treatment for mood disorders tended to stretch across six or eight years. In addition to the unrecognized pain of students with mood disorders, even moderate mood disorders contribute to substance dependence and impairments of school work or life tasks. Consequently, secondary school mental health plans ought to prepare students to recognize mood disorders, know when to seek treatment, and understand how to cope with a predisposition for significant mood disorders.

Neither the National Comorbidity Study (Kessler et al., 2005) nor the *DSM-IV-TR* formally recognizes disturbances in social relationships including severe social withdrawal, social rejection, social neglect, and social isolation. However, developmental research has clearly established that children with significant social difficulties are much more likely to struggle with adult disturbances, including mental illness, unemployment, financial dependence, and educational failure. School bullying research has shown that children without friends are more likely to be victimized by peer bullying (Song, 2006). In contrast, children with friends and ample social support networks will like school more, and are more likely to finish school, succeed in work, and form healthy adult families. Consequently, all school mental health plans should incorporate strategies for promoting friendships and social interactions among students in the building.

Research on Developmental Risk and Resilience

It is not just the onset of disorders but also the predictors of disorders that inform schools' mental health service plans. Developmental data on psychological risk establish that demographic characteristics of students' families and communities can be as important as their individual characteristics in predicting subsequent development of adult disturbances (Coie et al., 1993; Consortium on the School-Based Promotion of Social Competence, 1994; Doll & Lyon, 1998; Masten & Coatsworth, 1998). In particular, students' exposure to poverty, family violence, parental mental illness, or community violence significantly increases their chances of developing debilitating mental illnesses. Moreover, these risk factors tend to concentrate in high-risk communities. Thus, schools serving students from high-risk communities must plan to address a far greater need for school mental health interventions than schools serving more affluent or less violent communities.

Developmental resilience research offers important insights into the kinds of interventions that will be effective in ameliorating these demographic risks. Specifically, students are more likely to be successful despite the odds when they have access to close peer friendships, high self-efficacy, high levels of engagement in productive activities, access to warm relationships and guidance from adults, or access to responsive schools. Thus, the developmental resilience research provides a roadmap for planning school mental health services that address the academic and social problems of a school's students.

Prevention and Intervention Policy and Research

As the place where children routinely congregate, schools are natural sites for early intervention efforts. In addition, schools as community institutions frequently benefit from successful prevention efforts that lower students' risk and foster their developmental competence. Moreover, some of the strongest conceptual frameworks for population-wide interventions are included within the prevention literature.

Nation et al. (2003) conducted a systematic analysis of the most effective preventive interventions from which they distilled a cogent description of key program characteristics. First, effective programs are comprehensive in that they incorporate multiple interventions and are implemented across school, home, community, and peer settings. Second, the most effective programs use varied and interactive teaching methods that actively engage participants in developing specific skills. Third, "dosage" of the best programs was matched to the severity of the problem. More severe problems require interventions that are more intense and of longer duration. Too often interventions are based on past experience and what appears logical. However, the fourth characteristic the researchers found was that programs are most effective when they are theory driven, taking into account the etiology of the problem and drawing from an empirical evidence base. Theory-driven programs "focus on the best methods for changing the etiological risks" (Nation et al., 2003, p. 453). Finally, all effective programs promote strong, positive relationships between parents and children, teachers and children, and children and peers.

Skilled selection and implementation of preventive interventions is critical to their effectiveness (Nation et al., 2003). Interventions may miss the mark if they are delivered too early or too late. Traditional special education referral is a good example of waiting to intervene until failure is evident, when earlier and systematic steps might have avoided the failure altogether. As another example of the power of

timing, HIV/AIDS programs have proved to be effective for adolescents before they become sexually active, but ineffective for those who are already sexually active. Skilled intervention planning will also select interventions that are consistent with local sociocultural norms as well as cultural beliefs and attitudes. When implementing population-based interventions, one size does not necessarily fit all communities. Skilled prevention programs also embed evaluation into the intervention planning from the start. Useful evaluation is formative or ongoing and informs continuous improvement in the intervention during implementation. The most effective evaluation is systematic, with methodologically rigorous designs, and not antidotal or limited to a single case study. Finally, a well-trained staff is essential to effective interventions. Skilled interventionists will deliver a program with greater fidelity. Table 1.2 refines the Nation et al. (2003) analysis into 10 critical questions that guide the development and implementation of preventive interventions.

Table 1.2 Questions to Consider When Planning and Implementing Prevention Programs

<p>Is the intervention comprehensive? Does it include multiple interventions and settings?</p> <p>Are varied teaching methods used that promote specific skills? Are participants actively learning as opposed to passively listening?</p> <p>Does the dosage of the intervention match the severity of the need or problem? Are booster sessions needed to increase the longevity of the intervention effects?</p> <p>Does the intervention address the etiological basis of the problem? Does the intervention have an evidence base indicating its effectiveness?</p> <p>Does the intervention promote positive relationships across teachers, parents, and students?</p> <p>Is the intervention appropriately timed relative to the developmental status of the targeted population?</p> <p>Is the intervention socioculturally relevant in terms of community norms as well as cultural attitudes and practices?</p> <p>Is the evaluation an integral part of the implementation plan and designed to provide formative feedback at various stages of the intervention?</p> <p>Is the staff well prepared and monitored to promote intervention fidelity during the implementation?</p>

Source: Adapted from Nation et al. (2003).

Evidence-Based Practice

An important recent trend in applied psychology has been to focus on the evidence underlying interventions (Chambless & Hollon, 1998; Chambless et al., 1996; Kratochwill & Stoiber, 2002; U.S. Department of Health and Human Services, 1999). The standards governing demonstrations of empirical support for treatments have been described at length by Chambless et al. (1996), Hayes, Barlow, and Nelson-Gray (1999), Lonigan, Elbert, and Bennett-Johnson (1998), Hughes (2000), and most recently, Kratochwill and Stoiber (2002). The work of these and other groups in documenting a range of efficacious psychological treatments was acknowledged in the Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999). Some of the most rigorous standards assert that, to be proven effective, a treatment must have been subjected to at least two well-designed group studies conducted by unrelated research teams or by a series of well-conducted single-subject studies. Participants in the studies should be randomly assigned to different treatment groups and comparisons should be made between groups of subjects, one of which is provided with no treatment, others with competing treatments, and one with the treatment of interest. Finally, results should indicate that improvements in symptoms occur, are not due to chance, are due to the treatment of interest, represent an improvement over no treatment at all, and are at least as strong as those produced by existing treatments.

These standards, as articulated, are clearly aspirational rather than absolute. Few mental health interventions meet these criteria, and those that do have typically been examined within the context of a single cultural or socioeconomic group. Still, educational leaders clearly and firmly support the principles underlying evidence-based intervention, and school mental health plans will need to incorporate those interventions with the strongest empirical evidence of effectiveness.

How This Book Will Help

The purpose of this book is to provide a roadmap to the provision of population-based school mental health interventions. Its emphasis is on strategies that are available now, can be put into practice immediately, and have evidence supporting their utility. In the book's first section, school-wide assessment, screening, and monitoring are described as strategies to identify and prioritize the mental health needs of a school's enrollment and use in service planning. In particular, Short and Strein provide an invaluable description of epidemiologic assessment as it

applies to the identification of population-wide psychological disorders in schools. Then, Baker explains how an array of formal and informal assessment strategies can be used to detect and describe risk and protective factors in a school's student body.

The second section of the book explains what schools can do to promote the healthy and competent psychological development of all students and to prevent mental illness. The chapters in this section explain how intervention strategies lend themselves to population-based services and the characteristics of these practices that strengthen their impact on students' lives. First, Christenson, Whitehouse, and VanGetson describe the critical role that families play in schools' mental health services, and the school practices that foster highly effective partnerships with families. Because behavioral competence is an important developmental task for all students, Bear explains the school-wide strategies that promote behavioral discipline and prevention behavior problems. Academic success is an equally important developmental task, and Martínez and Nellis describe response-to-intervention strategies that apply data-based problem-solving strategies to academic monitoring and intervention. In deference to the similarly important place of social and emotional competence for students' psychological well-being, Merrell, Gueldner, and Tran explain how school practices can promote students' friendships and social development. School bullying, intimidation, and violence are particularly recognized as common and very destructive aspects of students' peer interactions, and the chapter by Swearer, Espelage, Love, and Kingsbury explains how bullying prevention activities can be integrated into school routines. Finally, as an example of how a traditional mental disorder can be addressed through population-based strategies, Mazza and Reynolds describe school-wide approaches for addressing depression and suicidal behaviors in schools.

It is clear that reframing school mental health services around a population-based perspective is an instance of systemic change. The new perspective articulates a purpose and organization for school mental health services that is more connected to a school's core responsibilities, but it is also quite distinct from the traditional roles that school mental health providers have played within schools. Consequently, the third section of the book describes the fit between population-based services and school and district policies, procedures, practices, and resources. In particular, Nastasi and Hitchcock describe the essential purpose of program evaluation in guiding and propelling the shift from traditional to population-based models of school mental health. Next, Adelman and Taylor discuss ways to enhance the interface between school improvement efforts and new

directions for addressing mental health and psychosocial concerns in schools. In this context, they outline ways to reframe student support interventions so that all students have an equal opportunity to succeed at school. They also illustrate how the school's infrastructure can be reworked to facilitate the development of a comprehensive, multifaceted, and cohesive system of learning supports at every school.

The concluding chapter integrates these authors' very comprehensive descriptions of population-based services with the role and mission of school psychology, as defined by the 2002 Multisite Conference on the Future of School Psychology and the National Association of School Psychologists. The transition to a population-based perspective is both necessary and inevitable for school mental health professionals, and this chapter explains how it can happen in your school and your time.

Discussion Questions

1. Given what you already know about children's social and emotional development, what are likely to be the most urgent mental health needs in your community?
2. How are population-based school mental health services similar to the services familiar to your community? How are they different?
3. What is the fit between population-based services and your school district's policies, procedures, practices, and resources?
4. If a school decided to implement a population-based service model in your community, what are some likely barriers to the transformation? What might facilitate the transformation in your community?
5. What ethical dilemmas might arise in your community if school mental health services were reframed around the collective needs of children?

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