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Expanded School-Based Health: The Mental Health and School Connection

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Expanded School-Based Health: The Mental Health and School Connection

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Abstract

Research suggests that expanded school-based mental health (ESMH) programs can offer benefits and hope for children and their families. Such programs are part of a national progressive movement involving collaborative relationships between schools and community mental health agencies. The purpose of this article is to highlight the constructs and details of ESMH programs, as well as counselor training possibilities.

Statistics suggest that at least 20% of children demonstrate symptoms of behavioral or emotional problems severe enough to warrant treatment and intervention (Weist, Goldstein, Morris, & Bryant, 2003). Less than one-fifth of those children are receiving the mental health services that they need. In response to these alarming figures, coordinated and collaborative efforts have been made to address the mental health needs of children and youth (Dryfoos, 1994). Partnerships between schools and community mental health agencies have resulted in the development of expanded school mental health (ESMH) programs. Such programs offer mental health counseling services that have been transferred from community mental health centers to schools.

The purpose of this article is to highlight the initiatives and details behind ESMH programs. More specifically, the rationale, purpose, collaboration strategies, research, and challenges of ESMH programs will be addressed. Further, ways in which to educate counselor trainees about this initiative will be outlined.

Expanded School Mental Health (ESMH) Programs: What are They?

Weist (1997) defines ESMH programs as a combination of four elements. These elements include the following: (a) partnerships between schools and community agencies and programs, (b) full continuum of mental health promotion and intervention strategies, (c) offered to youth in general and in special education, and (d) complements or augments the work of school-hired mental health professionals. ESMH programs represent the joining of major child-service systems, schools, and families (Weist, Ambrose, & Lewis, 2006). More specifically, these programs also involve school counselors, psychologists, professional counselors, and social workers from community health departments and other social services (Weist & Christodulu, 2000). Other participants of this collaborative may include education and school-related staff, the community, parents, and students (Armbruster, Gerstein, & Fallon, 1997; Dryfoos, 1994; Evans, 1999; Shaw & Replogle, 1996).

The design of most school-based mental

health services are comparable to the design of community mental health clinics (Flaherty, Weist, & Warner, 1996). Services provided may include comprehensive assessment, treatment, and preventive services for youth in both regular and special education and their families (Waxman, Weist, & Benson, 1999). Individual, group, and family therapies may be available. Preventive services may encompass a range of measures including mental health education, schoolwide interventions, support groups for those in transitional situations, case management, and medication for youth with severe disorders.

School-based mental health programs serve to improve the social adjustment of students and to help them deal with family and personal crisis (Dryfoos, 1994). They are meant to help students maintain attendance, increase achievement, and optimize their health, mental health, and overall quality for life (Weist et al., 2006). The ultimate luxury of having mental health services in schools is that services can equate and go beyond services located in community mental health clinics. These programs may include in depth resources such as mental health evaluations, diagnostic interviews, screening for emotional and behavioral problems, and classroom behavioral observations (Waxman et al., 1999). School-based mental health programs in cities such as Denver, New Haven, New York, and Memphis also have focused on specific school-related preventative issues such as integrating support groups for students in transition (Flaherty et al., 1996).

The Rationale of School-Based Mental Health Programs

The development of ESMH programs has been due in part to the development of school-based health centers (SBHCs) (Weist & Christodulu, 2000). SBHCs were developed for several reasons. For example, SBHCs provide a "single system" that touches all school-aged children while maximizing the chances of identifying and serving a host of health and emotional problems (Shaw & Replogle, 1996). These centers also provide a great deal of permeability among school personnel, community members, families, and students (Erwin, 1996). This allows for the most comprehensive care of children, as well as increased community involvement and the expanded use of school facilities (Adler & Gardner, 1995). As SBHCs began to surface across the United States, the need for independent mental health programs that were originally encapsulated within SBHC centers became evident. In fact, one of the most frequent reasons for students seeking services at SBHCs was because of mental health needs. Due to other factors such as cost efficiency, effectiveness, and the seeming need of mental health services within schools, ESMH programs have been developed and continue to thrive (Flaherty & Weist, 1999).

The impact of successful comprehensive school health programs has helped to further continuous development and enhancement of mental health programs (Flaherty et al., 1996). With the development of refined school-based health centers, particular attention has been paid to the mental health needs of school children and adolescents. Funding, fragmentation of services, legal mandates, lack of accessibility to traditional mental health sites, and the stigma associated with mental health has contributed to the need of school-based mental health programs (Armbruster et al., 1997; Bickman, Pizarro, Warner, Rosenthal, & Weist, 1998; Ramualdi & Sandoval, 1995). In addition, growing numbers of adolescent and youth sexually transmitted diseases, suicides, discipline problems, school failures, adolescent pregnancies, and adolescent parents have influenced the need for school-based mental health programs (Flaherty et al., 1996; Lindahl, 2000). Further, increased attention on screening and identifying suicidal youth over the recent years has provided rationale

for ESMH centers (U.S. Public Heath Service, 2000).

Services from ESMHs centers are geared towards improving the probability that students who need services will actually receive them (Evans, 1999). Research has found that there is a significantly greater percentage of families who will initiate counseling services offered within the school setting rather than in a community counseling agency (Catron, Harris, & Weiss, 1998). For example, Kaplan, Calonge, Guernsey, and Hanrahan (1998) found that adolescents are 10 times more likely to receive mental health or substance abuse counseling than those who did not have insurance or access to an ESMH center. Similarly, students are often overlooked for community mental health services but are more likely to be detected and treated through ESMH programs (Hunter, 2001; Weist, Myers, Hastings, Ghuman, & Han, 1999). In essence, school-based mental health programs may serve as a place where students can go for different kinds of remediation and support (Dryfoos, 1994).

The Collaborative Connection between Community Mental Health and Schools

Collaborative efforts among education staff, school and community stakeholders, and mental health staff are at the heart of EMSH programs (Waxman et al., 1999; Weist et al., 2006). Disciplines from various helping professions must work together within in a non-hierarchical structure. School and clinical social workers and counselors, counseling psychologists, nurses, and child and adolescent psychiatrists must work together across professional disciplines to create a unified vision of the EMSH program goals (Weist, Proescher, Prodente, Ambrose, & Waxman, 2001). In addition, professionals from each of these disciplines must work from a team approach when interacting with education staff, youth and their families.

Successful Collaborative Efforts within SBMH Centers

Literature suggests particular characteristics of successful comprehensive collaboration and/or the implementation of school-based mental health centers. According to Marx and Wooley (1998), a strategic framework designed to be enforced by the staff of school-based mental health programs might include: (a) mapping and analyzing resources and needs, (b) coordinating resources; (c) balancing multi-professional perspectives, and (d) integrating activities to address barriers to the reform at hand. The first step, mapping resources, may include identifying what resources exist at the school site and a need assessment of students, their families, and staff. Through mapping and analyzing, findings can elicit information regarding priorities and redesign interventions that schools will need to address (Marx & Wooley, 1998).

Careful management and efficient mapping of resources can elicit multiple funding streams. In fact, Tourse and Mooney (1999) suggest that when support comes from multiple funders, the sustainability of the program is enhanced. Funding may exist through a combination of education and health dollars (Sullivan & Sugarman, 1996). Funding resources may originate from boards of education, health agencies, community-based agencies, government contracting departments, support brought by other collaborating organization user fees and also includes address funding concerns (Tourse & Mooney, 1999). Additional means of funding can be through education reserves, grants, legislature, and Medicaid.

In Baltimore City for example, school-based mental health services are funded through several mechanisms and models (Flaherty & Weist, 1996). Mechanisms of funding included: (a) Medicaid dollars from special education services, (b) school budget, (c) state and federal grants, (d) City Mayor's Office and Office of Employment Development (e) foundation grants, and (f) Mental Health Lead Agencies in using surplus dollars. Examples of other funding

resources have been utilized by the Board of Education - Children's Aid Society model (Tourse & Mooney, 1999). Collaborating with federal and state institutions has resulted in financial provisions. Such institutions have included Medicaid funding, federal and state departments, state and municipal authorities, and managed-care programs.

A second strategy characteristic of successful comprehensive collaboration includes coordinating and enhancing resources. This strategy can proceed through a team effort, which would include all school/education and mental health staff, community members, families, and students. Particular efforts of the team might include conducting resource mapping and analysis and ensuring that effective systems for referral, case management, and quality assurance are in place. This team would also be responsible for establishing appropriate procedures for program management and communication, as well as, suggesting ways to reallocate and enhance resources (Marx & Wooley, 1998).

A third strategy found within collaborative efforts is the development of a team focused on the balancing of a generalist perspective (Marx & Wooley, 1998). Team members might work at redistributing resources and coming to a commonly shared commitment to one perspective (Adelman & Taylor, 1997). Marx and Wooley (1998) suggest a final scheme in moving towards a comprehensive, coordinated approach. This strategy addresses interventions in working with potential barriers of learning through instruction and school management reforms. Interventions responding to particular barriers might include: the enhancement of classroom-based efforts to enable learning; the provision of prescribed student and family assistance; the respondence to and prevention of crisis; support of transitions; an increase of home involvement in schooling; and a reaching out to develop greater community involvement.

The Collaboration and Restructuring of Professional Staff

Reformations stimulated by school-based mental health collaborative will simultaneously elicit the need for restructuring among all levels (Romualdi & Sandoval, 1995; Waxman et al., 1999). The David and Lucile Packard Foundation (1992) suggests five main components of effective restructuring and change from every level of staff personnel. The first component of restructuring addresses changes in the curriculum and instruction. Secondly, changes in authority and decision making must occur so that decisions can be made at the school site. Thirdly, changes in roles and responsibilities up and down the system must occur. The professional identities of school staff and mental health staff may thus, involve retraining and loss and/or shift of status (Adelman & Taylor, 1997). New roles may be assigned to staff members, community members, and administrators. Romauldi and Sandoval (1995) also suggest that redefining professional roles might provide opportunities for all involved to expand their functions and reshape their professional identity for the better of the whole.

The fourth component of this restructuring framework addresses accountability. Accountability can include the use of proper assessment tools so that the process, results, and goals of collaboration efforts can be measured and evaluated. Finally, restructuring includes going beyond education. This may include linkages created by on-site staff, whether it be teachers and/or counselors, with social service agencies, health service agencies, and the community (Adelman & Taylor, 1997).

Weist et al. (2006) notes several possible outcomes of the effective collaboration of ESMH center professionals. A unified mission allows for the development of prevention, intervention, and mentoring programs for students. Forums and school assemblies can be conducted in order for

professional and education staff, students, and families to dialogue about problems, concerns, knowledge and potential remedies. Under collaborative efforts, professional team members can provide mutual support and encouragement for each other. Finally, procedures can be developed for intervening with students who may need assistance.

Addressing the Challenges within Collaborative Efforts

It would be remiss to not mention the challenges that accompany an interdisciplinary team approach. In order to prevent the ambiguity of professional permeability, extensive roles and guidelines must be established in order for each professional to exercise his or her unique strengths and expected contributions to the effort (Weist et al., 2006). In order to prevent potential "turf wars" among professionals in ESMH centers or individual perceptions of one's job being at risk, continuous discussions among the professionals should occur and should center around professional roles, identity, and expectations.

Research and Practice

There is an increasing focus within psychology and other related fields to support what is being done through empirically supported theory and practice (Proctor, 2004; Weist & Christodulu, 2000). In addition, interventions and treatment that are supported by research may help to ease the challenges of collaboration among different helping professionals. Further, the success of SBMH programs are based upon the consistent evaluation of effectiveness of services provided (Weist et al., 2000).

Several strategies of measuring the success of SBMH intervention and treatment have been suggested in the literature. Donabedian (1980) suggested an evaluation procedure model that includes three dimensions, including structural appraisal, process, and outcome phases. Rosenfield and Gravois (1996) mentioned a similar school-based mental health program evaluation procedure model including three broad areas addressing the evaluation of training, specified outcomes, and the integrity of team implementation.

Another outcome measure or six step evaluation framework of school-based mental health programs has been proposed by Weist et al. (2000). The first step emphasizes that evaluations should be appropriately focused with both quantitative and qualitative measures being considered. Evaluations should directly contribute to positive treatment outcomes (Hayes, Nelson, & Jarrett, 1987). The second step in conducting effective school-based mental health evaluations includes ensuring cultural competence. Weist, Nabors, Myers, and Armbruster (2000) suggest that cultural competent evaluations should include documentations that are developmentally and culturally sensitive. Thirdly, community support for the evaluation should be sought.

The fourth step of this evaluation model includes the development of a conceptual schema for program evaluation. Weist et al. (2000) suggest that this schema may be grouped in the following categories: life stressors and risk factors, protective or resilience factors, emotional/behavioral problems, and life functioning. The fifth step of the evaluation procedure is the usage and identification of specific measurement strategies most appropriate for specific assessment areas. Specific measurement strategies might include the usage of self-reports, reports by parents and teachers, and clinician ratings. Finally, the sixth step in the framework for evaluating school-based mental health programs is the measuring of cost effectiveness.

Challenges and Limitations of SBMH Programs

Although evaluation procedures can allow for the enhancement and improvement of school-based mental health programs, these programs still face numerous setbacks and

barriers. Tensions are prevalent among education staff, mental health staff, and staff from the community at large (Franklin, 2001; Waxman et al., 1999). More specifically, tensions among participants may arise regarding the following: (a) establishing a common mission and readiness for collaboration, (b) maintaining trust among staff, community participants, students, and families, (c) maintaining confidentiality, and (d) communicating about turf related issues (Tourse & Mooney, 1999; Weist et al., 2006).

Other challenges might be related to issues effecting clientele (Bickman et al., 1998). Students using these services may not want family members involved in their treatment. Considering age-appropriateness, this may pose a conflict if potentially volatile family relations and/or abuse issues are brought to therapy. On the other hand, families may be resistant to receiving services from school-based mental health programs even with perceptible advantages. Many families view mental health issues and services with stigma and suspicion. In addition, families and/or parents, especially with troubled children, may feel ineffective, blamed, and/or criticized when interacting with mental health and school professionals.

Finally, challenges to school-based mental health programs may also include a lack of resources such as funding, staffing, and training support (Bickman et al., 1998). Being able to creatively restructure existing and potential resources is a crucial and invaluable component. Unfortunately, integrating creativity also poses a potential challenge for school-based mental health programs (Tourse & Mooney, 1999; Weist et al., 2006).

The Incorporation and Development of SBMH Programs and Collaboratives

A complete illustration of how SBMH programs are developed is not appropriate for this article. However it is helpful to consider at least in abbreviated form what the steps are that are a must in the planning and incorporation of SBMH programs. Tourse and Mooney (1999) suggested a conceptual framework illustrating a school-based mental health collaborative which includes the representation of community health staff, in-school mental health staff, education/school staff (including administrators), an advisory team council, community members, and students and their families. The planning mechanism includes the following components: assessment; problem identification; strategic planning; implementation; discipline-specific action; discipline-specific planning; and ongoing monitoring and evaluation.

The first and second components of this collaboration process, assessment and problem identification, respectfully, may be determined by various criteria. That is, a need for collaboration must present itself through the mapping of various resources possibly initiated by the different members of the community and/or by a state or federal governing body (Marx & Wooley, 1998). The development of an advisory council or team with similar interests, visions, and goals must be formed (Kadel & Routh, 1993; U.S. Department of Education, 1993; Waxman et al., 1999). After a collaborative team is formed, including school and mental health staff, a plan of action must be developed (Adler & Gardner, 1995; Tourse & Mooney, 1999). An important component in developing a plan of action would include a degree of flexibility which may include the shifting of roles and expectations (Adelman & Taylor, 1997; Armbruster et al., 1997; Romauldi & Sandoval, 1995).

After proper assessment has been implemented, the problem has been appropriately identified, and a strategic plan has been formed, implementation of the collaborative can take place. Implementation of the plan might include ongoing staff training, facing and working with barriers and challenges; seeking and maintaining continuous financial support, focusing on outcome and assessment, sharing service

delivery (Marx & Wooley, 1998; Shaw & Replogle, 1996). As mentioned previously in this article, a final step in the development of an ESMH program is the evaluation of effectiveness and outcome measures. Evaluation of present and past outcomes might also summon the potential for future replanning and restructuring.

Counselor Education Training

Since recent literature and research supports the value and effectiveness of SBMH programs, there seems to be incentives for mental health professionals to consider and/or advocate for a SBMH program/center within their respective demographic area. However, Expanded SBMH programs may not seem realistic for many helping professionals. This lack of realism may be related to a deficiency in resources, time, collaborative skills, and/or initiative. Perhaps this lack of realism could be addressed prior to mental health professionals, specifically counselors, actually getting out in the field. That is, counselor educators can start by instilling the importance of such collaborative initiatives in school, mental health, and marriage and family training programs.

Counselor educators might teach counselors-in-training the techniques and skills, as well as provide them with experiences similar to those in a real-life collaborative school/mental health program. For example, within the counseling curriculum, students can be provided with information that explicitly outlines the roles, responsibilities, and perspectives of other related professions. Through required activities, students can collaborate with their colleagues and peers from other mental health training tracks. Finally, through information, in class role-plays, and real life experience, counseling students can brush up and strengthen their skills in defeating the challenges that accompany such needed collaborations within the mental health field.

Provision of Information

Counselor educators can begin their training efforts by educating counseling students in different tracks about their specific roles. For example, an orientation class in the counseling curriculum could be developed for both school and mental health counselors-in-training. Through discussion, dialogue, and information, students will gain an understanding of what their peers will be trained to do during their academic careers. Mental health students might be provided a preview of the school system, policies, and procedures in order to better understand the school community and context from which children interact most of the week. Further, counselor education departments also can sponsor discussion mediums where panels of mental health and school counselors are invited to talk to students about their specific, as well as collaborative roles and responsibilities. These panel members also might discuss specific skills and attitudes necessary for successful collaborative relationships with their counterparts.

Development of Collaborative Skill Base

Counselor education programs can prepare students to collaborate by assigning related projects within the training curriculum. For example, Shoffner and Briggs (2001) suggested an interactive CD-ROM that would pose various client situations requiring students to form collaborative relationships in order to help this client. Varying professionals would be presented as choices for potential collaborative efforts. Through this activity, students learn about their colleagues, as well as experience collaborative relationships. Other collaborative activities between school and mental health students, for example might provide a medium for understanding the best ways of sharing information, respecting "turf," and effective collaborative

communication. Finally, students might be assigned "real life" collaborative relationships in the community. For example, school counseling students might be asked to shadow a Licensed Professional Clinical Counselor at a local agency for a day or two.

Discussion/Conclusion

From the analysis of the literature, it is evident that school-based mental health programs can offer benefits and hope for children and their families. Children and adolescents facing socioeconomic difficulties, transitional issues, behavioral problems, and family problems can benefit from such services. The basis for promoting school-based mental health programs also has been supported through continuous evaluation and assessment measures that have documented the success of such programs. Such documented success has provided interested parties with specific collaborative strategies and further potential for research and assessment. Finally, the author suggests that counselor educators might consider the benefits of ESMH programs and premise of collaboration by instilling such ideas and related skills into counselor training programs.

References

Adelman, H. S., & Taylor, L. (1997). Addressing barriers to learning: Beyond school-linked services and full-service schools. American Journal of Orthopsychiatry, 67(3), 408-421.

Adler, L., & Gardner, S. (1995). The politics of linking schools and social services. Washington DC: The Falmer Press.

Armbruster, P., Gerstein, S. H., & Fallon, T. (1997). Bridging the gap between service need and service utilization: A school-based mental health program. Community Mental Health Journal, 33(3), 199-210.

Bickham, N. L., Pizarro, L. J., Warner, B., Rosenthal, B., & Weist, M. D. (1998).

Family involvement in expanded school mental health. Journal of School Health, 68(10), 425-429.

Catron, T., Harris, V. S., & Weiss, B. (1998). Posttreatment results after two yearsof services in the Vanderbilt School-Based Counseling project. In M. H.

Epstein & K. Kutash (Ed.), Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices (pp. 633-656). Austin, TX: Pro-Ed.

Donabedian, A. (1980). The definition of quality and approaches to its assessment. Ann Arbor: MI: Health Administration Press.

Dryfoos, J. (1994). Full-service schools. San Francisco, CA: Jossey-Bass Publishers.

Erwin, E. (1996). Putting children first. Baltimore, MD: Paul H. Brooks Publishing.

Evans, S. W. (1999). Mental health services in schools: Utilization, effectiveness, and consent. Clinical Psychology Review, 19(2), 165-178.

Flaherty, L. T., & Weist, M. D. (1999). School-based mental health services: TheBaltimore Models. Psychology in the Schools, 36(5), 379-339.

Flaherty, L. T., Weist, M. D., & Warner, B. S. (1996). School-based mental health services in the United States: History, current models and needs. Community Mental Health Journal, 32(4), 341-352.

Franklin, C. (2001). Establishing successful relationships with expanded school mental health professionals. Children & Schools, 23(4), 194-197.

Hayes, S. C., Nelson, R. O., & Jarrett, R. B. (1987). The treatment utility of assessment: A functional approach to evaluating assessment quality. American Psychologist, 42, 963-974.

Hunter, L. (2001, Spring). The value of school-based mental health programs. Report on Emotional and Behavioral

Disorders in Youth, 1, p. 27-28, 46.

Kadel, S., & Routh, D. (1993). Implementing collaborative services: new challenges for practitioners and experts in reform. In L. Adler & S.

Gardner (Eds.), The Politics of Linking Schools and Social Services (pp.121-132). Washington DC: The Falmer Press.

Kaplan, D. W., Calonge, B. N. Guernsey, B. P., & Hanrahan, M. B. (1998).

Managed care and school-based health centers: Use of health services. Archives of Pediatric Adolescent Medicine, 152, 25-33.

Lindahl, C. W. (2000). Counseling: The missing link. Education Week, pp. 37, 41.

Marx, E., & Wooley, S. (1998). Health is academic. New York, NY: TeachersCollege Press.

Proctor, E. K. (2004). Leverage points for the implementation of evidence-based practice. Brief Treatment and Crisis Intervention, 4, 227-242.

Romualdi, V., & Sandoval, J. (1995). Comprehensive school-linked services: Implications for school psychologists. Psychology in the Schools, 32, 306-315.

Rosenfield, S., & Gravois, T. (1996). Instructional consultation teams. New York,NY: The Guilford Press.

Shoffner, M. F., & Briggs, M. K. (2001). An interactive approach for developing interprofessional collaboration: Preparing school counselors. Counselor Education and Supervision, 40(3), 193-200.

Shaw, K. M., & Replogle, E. (1996). Challenges in evaluating school-linked services. Evaluation Review, 20(4), 424-469.

Sullivan, C. J., & Sugarman, J. M. (1996). State policies affecting school-linked integrated services. Remedial and Special Education, 17(5), 284-292.

The David and Lucile Packard Foundation. (1992). The future of children. Los Altos, CA: Center for the Future of Children, the David and Lucile Packard Foundation.

Tourse, R., & Mooney, J. (1999). Collaborative practice. Westport, CT: Praeger Publishers.

U.S. Department of Education. (1993). Together we can. Chevy Chase, MD: PrismDAE.

Waxman, R. P., Weist, M. D., & Benson, D. M. (1999). Toward collaboration in the growing education-mental health interface. Clinical Psychology Review, 19(2), 239-253.

Weist, M. D. (1997). Expanded school mental health services: A national movement in progress. In T. H. Ollendick & R.J. Prinz (Ed.), Advances in clinical child psychology, Volume 19 (pp. 319-352). New York: Plenum Press.

Weist, M. D., Ambrose, M. G., & Lewis, C. P. (2006). Expanded school mental health: A collaborative community - school example. Children & Schools, 28(10), 45-50.

Weist, M. D., & Christodulu, K. V. (2000). Better mental health care helps heal kids. Journal of School Health, 70, 195-200.

Weist, M. D., Goldstein, A., Morris, L., & Bryant, T. (2003). Integrating expanded school mental health programs and school-based health centers. Psychology in the Schools, 40(3), 297-308.

Weist, M. D., Myers, C. P., Hastings, E., Ghuman, H., & Han, Y. L. (1999). Psychosocial functioning of youth receiving mental health services in the schools versus community mental health centers. Community Mental Health Journal, 35, 69-81.

Weist, M. D., Nabors, L. A., Myers, C. P., & Armbruster, P. (2000). Evaluation of expanded school mental health programs. Community Mental Health Journal, 36(4), 395-411.

Weist, M. D., Proescher, E., Prodente, C., Ambrose, M. G., & Waxman, R. P. (2001). Mental health, health, and education staff working together inschools. Child and Adolescent Psychiatric Clinics of North America, 10, 33-43.