Mental Health and Social Services: Results From the School Health Policies and Programs Study 2006

Nancy D. Brener, PhD[a]
Mark Weist, PhD[b]
Howard Adelman, PhD[c]
Linda Taylor, PhD[d]
Mary Vernon-Smiley, MD, MPH[e]

ABSTRACT

BACKGROUND: Schools are in a unique position not only to identify mental health problems among children and adolescents but also to provide links to appropriate services. This article describes the characteristics of school mental health and social services in the United States, including state- and district-level policies and school practices.

METHODS: The Centers for Disease Control and Prevention conducts the School Health Policies and Programs Study (SHPPS) every 6 years. In 2006, computer-assisted telephone interviews or self-administered mail questionnaires were completed by state education agency personnel in all 50 states and the District of Columbia and among a nationally representative sample of school districts (n = 445). Computer-assisted personal interviews were conducted with personnel in a nationally representative sample of elementary, middle, and high schools (n = 873).

RESULTS: Although states and districts generally had not adopted policies stating that schools will have mental health and social services staff, 77.9% of schools had at least a part-time counselor who provided services to students. Fewer schools had school psychologists or social workers. Consequently, counseling services were more common in schools than were psychological or social services. Few schools delivered mental health and social services through school-based health centers. Arrangements with providers not located on school property were more common.

CONCLUSIONS: SHPPS 2006 reveals that linkages with the community need to continue and grow to meet the mental health needs of students. Efforts must be made to build systematic state agendas for school-based mental health, emphasizing a shared responsibility among families, schools, and other community systems.

Keywords: mental health services; counseling; schools; school policy; surveys.

Citation: Brener ND, Weist M, Adelman H, Taylor L, Vernon-Smiley M. Mental health and social services: results from the School Health Policies and Programs Study 2006. J Sch Health. 2007; 77: 486-499.

[a]Health Scientist, (nad1@cdc.gov), Division of Adolescent and School Health, Centers for Disease Control and Prevention, 4770 Buford Highway, NE, Mailstop K-33, Atlanta, GA 30341.

[b]Professor and Director, (mweist@psych.umaryland.edu), Center for School Mental Health, Department of Psychiatry, University of Maryland-Baltimore, 737 W Lombard St, 4th Floor, Baltimore, MD 21201.

[c]Professor and Co-director, (adelman@psych.ucla.edu), School Mental Health Project/Center for Mental Health in Schools, Department of Psychology, University of California at Los Angeles, PO Box 951563, Los Angeles, CA 90095-1563.

[d]Co-director, (ltaylor@ucla.edu), School Mental Health Project/Center for Mental Health in Schools, Department of Psychology, University of California at Los Angeles, PO Box 951563, Los Angeles, CA 90095-1563.

[e]Senior Medical Officer, (mev0@cdc.gov), Division of Adolescent and School Health, Centers for Disease Control and Prevention, 4770 Buford Highway, NE, Mailstop K-29, Atlanta, GA 30341.

Address correspondence to: Nancy D. Brener, Health Scientist (nad1@cdc.gov), Division of Adolescent and School Health, Centers for Disease Control and Prevention, 4770 Buford Highway, NE, Mailstop K-33, Atlanta, GA 30341.

According to the 1999 Surgeon General's Report on Mental Health[1] and the 2000 Report of the Surgeon General's Conference on Children's Mental Health,[2] 1 in 5 children and adolescents have emotional or behavioral problems sufficient to warrant a mental health diagnosis. In addition to those with diagnosable disorders, many young people, especially those living in urban areas, also experience psychosocial problems as a result of the difficult living conditions associated with poverty.[3,4] Because emotional, behavioral, and psychosocial problems can disrupt function at home, in school, and in the community, mental health has become an important public health concern.[5]

The gap between the mental health needs of children and adolescents in the United States and the services available to them is a widely recognized problem. Most children and adolescents with mental health problems do not receive mental health care.[1,6,7] There is increasing recognition that ''specialty'' mental health services, such as those provided through community centers, hospitals, and private offices, are unlikely to be accessed by most youth and families. Barriers to use of these services include limited knowledge of their availability, stigma, transportation, and financial constraints.[8] Even when staff in schools or primary care sites refer youth for specialty mental health services, the youth usually do not receive these services.[9] Further, schools often lack the resources to handle the full range of mental health conditions presented by students. This situation may lead to a marginalization of mental health issues by the education system, partly related to fear of assuming responsibility for what can be highly labor-intensive and costly challenges presented by students.[10,11]

In response to the gap between mental health problems and services, the President's New Freedom Commission on Mental Health was created in 2002 to study the mental health service delivery system and make recommendations that would enable both children and adults with mental health problems to live, work, learn, and participate fully in their communities. In their final report, the Commission recognized the important role that schools can play in meeting the mental health needs of children and adolescents.[12] Because more than 97% of 5- to 17-year olds are enrolled in school,[13] schools are in a unique position not only to identify mental health problems but also to provide links to appropriate services. Further, because students' mental health is essential to learning as well as to social and emotional development, schools must play a role in meeting the mental health needs of students.[12] Schools are a natural setting for mental health services in that children and adolescents spend a large portion of their time there, and schools provide an avenue to reach parents and teachers, who can assist in the maintenance of improved cognitive, behavioral, and emotional functioning.[14]

The New Freedom Commission's recommendation to improve and expand school mental health programs (Recommendation 4.2) is reflected in the policy statements and guidelines of other organizations and agencies. For example, in 2004, the American Academy of Pediatrics (AAP) issued a policy statement on school-based mental health services that outlined the advantages of basing mental health services at school and provided recommendations to help health care professionals, educators, and mental health specialists work together to develop and implement effective school-based mental health services.[15] In 2005, the AAP and the National Association of School Nurses, with funding from the Maternal and Child Health Bureau of the Health Resources and Services Administration, published *Health, Mental Health, and Safety Guidelines for Schools*,[16] which includes detailed guidance to help schools implement quality mental health programs. Guidelines for school mental health and social services also have been developed by the Policy Leadership Cadre for Mental Health in Schools.[17] Other professional associations, such as the American School Counselor Association, the National Association of School Psychologists, and the National Association of School Social Workers, also have guidelines and standards that support school-based mental health.[11,18-21]

Despite all these guidelines and standards, no 1 ''best practice'' model exists for school-based mental health programs.[22] Instead, most school districts offer a range of programs and services oriented to student needs and problems. Some are provided throughout a school district, others are carried out at or linked to specific schools. Some are owned and operated by schools and implemented by school counselors, psychologists, social workers, and other student support staff, with additional support provided by community agencies. The interventions may be for all students in a school, for those in specified grades, for those identified as ''at risk,'' or for those in need of special education. Viewed as a whole, a considerable amount of activity is taking place and substantial resources are being expended. However, planning, implementation, and evaluation are highly fragmented, and the work is marginalized in school policy and practice.[23,24]

To counter this marginalization and fragmentation, 1 model, described by Adelman and Taylor, treats existing mental health programs as the foundation for effective learning. This model proposes a comprehensive, multifaceted approach in which mental health and social services are fully integrated into each school.[25,26]

Weist and colleagues use the term ''expanded school mental health'' to describe core elements of

effective school mental health programs. These programs provide a range of services, including assessment, case management, therapy, and prevention to all students through partnerships between schools and community agencies.[8,21]

Mental health and social services also are provided through school-based health centers (SBHCs), which provide a range of primary health care services within schools.[27] Most SBHCs offer mental health services in addition to physical health services.[27,28] Indeed, mental health problems are a primary reason for referrals to SBHCs.[29,30] An additional way to deliver mental health and social services to students is through arrangements with a community provider to deliver services off-site (ie, not on school property). This is sometimes called a school-linked approach or an ''independent school-based mental health program.''[28] All these arrangements reflect the imbalance between the mental health needs of students and the ability of schools to meet those needs. School staff are unlikely to be able to meet students' needs without at least some help from the community.

Selected Federal Support and Related Research

Federal initiatives have helped facilitate the growth of school-based mental health programs and services in recent years.[22,31] Funding for school-based mental health services comes from multiple streams, which helps explain why such programs are fragmented and marginalized.[14,32] For example, Public Law 94-142, the Education for All Handicapped Children Act of 1975, was amended in 1990 and 1997 to become the Individuals with Disabilities Education Act and then reauthorized in 2004.[33] This law requires schools to screen, assess, and plan treatments for students with emotional and behavioral disorders.[34] The Safe and Drug-Free Schools and Communities Act provides states with funding to implement plans for drug abuse and violence prevention, which might include mental health and social services.[34] In addition, many school districts rely on Medicaid as a funding source for mental health services.[14,35]

Recent research on school-based mental health and social services has taken several forms. One line of research has demonstrated the advantages and, in some cases, the effectiveness of school-based mental health services. For example, Slade[36] showed that when mental health services were available at school, students were more likely to have seen a counselor in the previous year, even after controlling for potential confounders such as mental health status and health insurance coverage. In a review of research on school-based mental health programs, Rones and Hoagwood[37] identified a robust group of programs that showed evidence of a positive impact on a range of emotional and behavioral problems. A study in 1 urban school district demonstrated that students receiving mental health services had improved academic outcomes, such as decreased absences, failures, and disciplinary referrals.[38]

Other studies have sought to describe the characteristics of school-based mental health programs. For example, the School Health Policies and Programs Study (SHPPS) 2000 described mental health services provided in schools by counselors, psychologists, and social workers.[39] More recently, the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration conducted a survey of school-based mental health services in the United States during the 2002-2003 school year.[35] That study described mental health services among a nationally representative sample of public schools and their associated school districts and included some information not collected in SHPPS 2000, such as the types of mental health problems encountered in schools and issues related to funding at the district level, but it did not include any state-level data.

This article describes for the first time findings from SHPPS 2006 about state- and district-level policies related to school mental health and social services in the following areas: staffing and staff development, required services, SBHCs and services provided at other sites, professional preparation, collaboration, and evaluation. At the school level, this article describes staffing and facilities, services provided, SBHCs and services provided at other sites, professional preparation, staff development, collaboration, and mental health and social services coordinators. In addition, the article describes changes in key mental health and social services policies and programs from 2000 to 2006. While this article is primarily descriptive in nature, the Centers for Disease Control and Prevention intends to conduct more detailed analyses and encourages others to conduct their own analyses using the questionnaires and public-use data sets available at www.cdc.gov/shpps.

METHODS

Detailed information about SHPPS 2006 methods is provided in ''Methods: School Health Policies and Programs Study 2006'' elsewhere in this issue of the *Journal of School Health.* The following section provides a brief overview of SHPPS 2006 methods specific to the mental health and social services component of the study.

SHPPS 2006 assessed mental health and social services at the state, district, and school levels. State-level data were collected from education agencies in all 50 states and the District of Columbia. District-level data were collected from a nationally representative

sample of public school districts. School-level data were collected from a nationally representative sample of public and private elementary schools, middle schools, and high schools.

Questionnaires

The state- and district-level questionnaires assessed policies on school mental health and social services for grades K-12. Both questionnaires assessed requirements for provision of services; collaboration between school mental health and social services staff and other agency and organization staff; evaluation of school mental health and social services; required staffing; credentials required for school counselors, psychologists, and social workers; SBHC services; services not provided on school property; and the educational background and credentials of the person who oversees or coordinates school mental health and social services for the state or district. The district-level questionnaire also assessed the promotion of school mental health and social services among families of students.

The school-level mental health and social services questionnaire assessed staffing characteristics in elementary, middle, and high schools; collaboration between school mental health and social services staff and other school and community personnel; promotion of mental health and social services among families of students; facilities and equipment; provision of services; SBHC services; services not provided on school property; staff development; and the educational background and credentials of the person who oversees or coordinates mental health and social services at the school.

Data Collection and Respondents

State- and district-level data were collected by computer-assisted telephone interviews or self-administered mail questionnaires. Designated respondents for each of 7 school health program components (ie, health education, physical education and activity, health services, mental health and social services, nutrition services, healthy and safe school environment, and faculty and staff health promotion) completed the interviews or questionnaires. At the state level, the state-level contact designated a single respondent for each component. At the district level, the district-level contact could designate a different respondent for each questionnaire or questionnaire module. A single district-level respondent was designated to respond to the mental health and social services questionnaire since it was not divided into modules. All designated respondents had primary responsibility for, or were the most knowledgeable about, the policies and programs addressed in the particular questionnaire or module.

After a state- or district-level contact identified respondents, each respondent was sent a letter of invitation and packet of study-related materials. Each packet contained a paper copy of the questionnaire(s) so that respondents could prepare for the interview and provided a toll-free number and access code that respondents could use to initiate the interview. Respondents were told that the questionnaire(s) could be used in preparation for their telephone interview or completed and returned if self-administration was preferred. One week after packets were mailed to respondents, trained interviewers from a call center placed calls to them to schedule and conduct telephone interviews. In April 2006, telephone interviewing ceased and most of the remaining state- and district-level data collection occurred via a mail survey. All remaining respondents were mailed paper questionnaires and return envelopes; however, interviewers remained available for respondents who chose to contact the call center.

At the end of the data collection period (October 2006), 82% of state-level mental health and social services questionnaires had been completed via telephone interviews and 18% as paper questionnaires. The completed district-level questionnaires were completed via telephone interviews 47% of the time.

School-level data were collected by computer-assisted personal interviews. During recruitment, the principal or another school-level contact designated a faculty or staff respondent for each questionnaire or module, who had primary responsibility for or the most knowledge about the particular component. For the mental health and social services interview, the most common respondents were school counselors, school social workers, and school psychologists.

Response Rates

One hundred percent (n = 51) of the state education agencies completed the state-level mental health and social services questionnaire. At the district level, 702 districts were eligible for the mental health and social services interview; 63% (n = 445) completed the interview. At the school level, 1315 schools were eligible for the mental health and social services interview; 66% (n = 873) completed the interview.

Data Analysis

Data from state-level questionnaires are based on a census and are not weighted. District- and school-level data are based on representative samples and are weighted to produce national estimates.

Because of missing data, the denominators for each estimate vary slightly. Figures 9 and 10 in

Appendix 1 of this issue of the *Journal of School Health* show the estimated standard error associated with an observed percentage from the district- and school-level mental health and social services questionnaires.

To analyze the changes between SHPPS 2000 and SHPPS 2006, many variables from SHPPS 2000 were recalculated so that the denominators used for both years of data were defined identically. In most cases, this denominator included all states, districts, or schools, rather than a subset of states, districts, or schools. As a result of this recalculation, percentages previously reported for SHPPS 2000[39] might differ from those reported in this article. Only estimates from 2000 and 2006 that are based on this same denominator should be compared.

Because state-level data are based on a census, statistical tests for differences between 2000 and 2006 are not appropriate. Therefore, this article highlights changes over time meeting at least 1 of 2 criteria: (1) the difference was greater than 10 percentage points or (2) the 2006 estimate increased by at least a factor of 2 or decreased by at least half compared with the 2000 estimate. At the district and school levels, *t* tests were used to compare SHPPS 2000 and SHPPS 2006 prevalence estimates. However, to account for multiple comparisons, this article only highlights changes over time meeting at least 2 of 3 criteria: (1) a p value less than .01 from the *t* test, (2) a difference greater than 10 percentage points, or (3) the 2006 estimate increased by at least a factor of 2 or decreased by at least half compared with the 2000 estimate. A p value less than .01 was used as the sole criterion for reporting on statistically significant differences based on means and medians between 2000 and 2006. Note that not all variables meeting these criteria are presented in this article.

RESULTS

Mental Health and Social Services at the State and District Levels

Staffing and Staff Development. Only 8.9% of states but 49.8% of districts had adopted a policy stating that each school will have someone to oversee or coordinate mental health and social services at the school. States and districts also had adopted policies on school counselors. Nationwide, 21.3% of states and 33.2% of districts had adopted a policy stating that elementary schools will have a full-time counselor. Similarly, 27.7% of states had adopted a policy stating that middle schools will have a full-time counselor, compared to 51.1% of districts, and 38.3% of states had adopted such a policy for high schools, compared to 62.9% of districts.

Nationwide, 80.4% of states and 61.1% of districts had adopted a policy stating that newly hired school mental health or social services staff will earn continuing education credits on mental health or social services topics. Staff development was defined as workshops, conferences, continuing education, graduate courses, or any other kind of in-service. During the 2 years preceding the study, 98.0% of states and 93.2% of districts provided funding for staff development or offered staff development for mental health or social services staff on at least 1 of the topics listed in Table 1. Generally, a larger percentage of states than districts provided funding for staff development or offered staff development during this time period.

Mental Health and Social Services Coordinators. More than three fourths (79.2%) of states and 71.9% of districts had a person who oversees or coordinates school mental health and social services. Unfortunately, the number of these coordinators who served as the respondent to the state- and district-level mental health and social services questionnaires was too small for meaningful analysis of the data about their qualifications.

Required Services. Student assistance programs (SAPs) provide services designed to assist students experiencing personal or social problems that can impact school performance, physical health, or overall well-being. More than half (55.6%) of states and 73.0% of districts had adopted a policy stating that SAPs will be offered to all students. Similarly, 58.3% of states and 73.6% of districts had adopted a policy stating that schools will create and maintain student support teams, defined as teams of school staff who collaborate to provide assistance to students with disabilities or those who are experiencing academic difficulties or behavioral problems.

While 79.6% of states and 89.0% of districts had adopted a policy stating that school mental health or social services staff (eg, school counselors, psychologists, or social workers) will participate in the development of individualized education programs (IEPs) (a document written by school administrators, teachers, and parents that identifies annual goals, strategies, or services provided for a student with special education needs) when indicated, similar policies were less common for 504 plans (which describe a program of instructional services to assist students with special needs who are in a regular education setting). Specifically, 54.2% of states and 78.5% of districts had adopted a policy stating that school mental health or social services staff will participate in the development of 504 plans, when indicated.

Nationwide, 84.1% of states had any schools that served as Medicaid providers by providing mental health or social services to qualified students.

SBHCs and Services Provided at Other Sites. Nationwide, 29.9% of districts had at least 1 SBHC (defined as a health center on school property where

Table 1. **Percentage of All States and Districts That Provided Funding for Staff Development or Offered Staff Development for Mental Health or Social Services Staff on Mental Health or Social Services, Prevention Services, or Methods of Service Delivery,* SHPPS 2006**

	% of All States	% of All Districts
Mental health or social services topic		
After-school programs (eg, day-care or supervised recreation)	76.2	33.0
Alcohol- or other drug-use treatment	89.4	66.2
Child care options for teen mothers	48.8	27.5
Counseling after a natural disaster or other emergency or crisis situation	85.1	63.2
Counseling for emotional or behavioral disorders (eg, anxiety, depression, or ADHD)	80.4	75.2
Crisis intervention for personal problems	83.3	69.2
Eating disorders treatment	52.4	36.4
Emergency preparedness	93.5	70.7
Enrollment in Medicaid or SCHIP	62.5	31.0
Enrollment in WIC or accessing food stamps or food banks	44.7	24.8
HIV counseling, testing, and referral	72.7	26.2
Identification of emotional or behavioral disorders (eg, anxiety, depression, or ADHD)	87.5	74.3
Identification of or referral for physical, sexual, or emotional abuse	83.0	71.5
Identification of or referral for students with family problems	76.6	66.0
Job readiness skills programs	73.9	54.1
Services for gay, lesbian, or bisexual students	46.7	23.2
Stress management	71.8	49.6
Tobacco-use cessation	82.6	51.8
Ways to promote a positive school climate	93.9	76.7
Weight management	53.7	25.1
Prevention services topic		
Alcohol- or other drug-use prevention	93.3	68.1
HIV prevention	93.5	42.1
Injury prevention and safety counseling	67.4	49.0
Nutrition and dietary behavior counseling	58.1	35.0
Physical activity and fitness counseling	71.4	36.4
Pregnancy prevention	76.2	43.5
STD prevention	88.6	45.9
Suicide prevention	91.5	65.7
Tobacco-use prevention	84.4	56.3
Violence prevention	93.9	79.3
Methods of service delivery		
Case management for students with chronic health conditions (eg, asthma or diabetes)	63.4	43.6
Case management for students with emotional or behavioral problems (eg, anxiety, depression, or ADHD)	76.1	62.3
Comprehensive assessment or intake evaluation	51.2	38.4
Family counseling	44.2	36.5
Group counseling	58.7	48.1
Individual counseling	63.0	61.4
Peer counseling or mediation	69.0	56.1
Self-help or support groups	58.1	40.8

ADHD, attention deficit hyperactivity disorder; HIV, human immunodeficiency virus; SCHIP, State Children's Health Insurance Program; STD, sexually transmitted disease; WIC, Special Supplemental Food Program for Women, Infants, and Children.
*During the 2 years preceding the study.

enrolled students could receive mental health and social services, including diagnostic and treatment services) that offered mental health and social services to students. In 10.8% of all districts, at least 1 SBHC served as a Medicaid provider by providing mental health and social services to qualified students.

Mental health and social services also were provided to students by mental health and social services professionals who worked at school-linked health centers or who had a contract, memorandum of agreement, or other similar arrangement with a district or school to provide mental health or social services to students not on school property. These services may or may not have been paid for by the school system. More than one third (35.6%) of states had adopted a policy stating that districts or schools will have these types of arrangements, and 62.2% of districts had such arrangements. One fifth (20.2%) of all districts had at least 1 SBHC and these types of arrangements; 71.9% of districts had either an SBHC or these types of arrangements.

At the district level, the most common arrangements with providers not located on school property were with a local mental health or social services agency, a local health department, a community health clinic, or a local hospital (Table 2). The most common services provided through these arrangements included counseling for emotional or behavioral disorders; crisis intervention for personal problems; identification of emotional or behavioral disorders; identification of or referral for physical, sexual, or emotional abuse; identification of or referral for students with family problems; case management for students with emotional or behavioral problems; and individual counseling (Table 3).

Professional Preparation. Most states and districts had minimum education and certification requirements for newly hired mental health and social services staff. For newly hired counselors, 82.2% of states and 71.4% of districts required a master's degree in counseling, and another 15.2% of districts required an undergraduate degree in counseling. In addition, 95.6% of states and 81.7% of districts required newly hired counselors to be licensed or certified by the state. Less than two thirds of states (65.2%) and districts (62.2%) required newly hired school psychologists to have a master's degree in psychology. Another 26.1% of states and 19.7% of districts required other types of undergraduate or graduate degrees. Nearly all states (95.9%) and 73.4% of districts required newly hired psychologists to be licensed or certified by the state. Sixty percent of states and 37.7% of districts required newly hired school social workers to have a master's degree in social work. Another 22.2% of states and 24.1% of districts required an undergraduate degree in social work. Most (91.5%) states and

Table 2. **Percentage of All Districts and Schools That Offered Mental Health and Social Services Through Providers Not on School Property, SHPPS 2006**

Provider	% of All Districts	% of All Schools
Community health clinic	28.7	14.7
Local health department	34.2	12.4
Local hospital	22.9	14.8
Local mental health or social services agency	55.8	35.6
Managed care organization	7.2	5.4
Private counselor	16.2	13.3
Private psychiatrist	12.9	7.3
Private psychologist	19.5	14.3
Private social worker	11.7	10.5
School-linked health center	16.9	8.6
University or medical school	7.2	4.3

56.3% of districts required newly hired school social workers to be licensed or certified by the state.

States and districts can provide assistance to districts and schools by providing model policies. Model policies were defined as an example of what an actual policy on a particular topic or issue might address. The content might be based on scientific evidence, best practices, or state laws or policy. Model policies are provided for districts or schools to consider when they are developing their own policies. They are recommendations, not mandates. During the 2 years preceding the study, 74.5% of states provided model policies or other guidance to districts or schools on providing mental health or social services to students, but only 38.3% of districts provided such guidance to schools during that period.

Collaboration. During the 12 months preceding the study, state and district mental health and social services staff worked on school mental health or social services activities with staff representing other components of the school health program and other agencies and organizations. In 94.0% of states and 59.9% of districts, mental health or social services staff worked with health education staff, and in 85.4% of states and 58.9% of districts, they worked with health services staff. In 69.8% of states and 39.3% of districts, mental health or social services staff worked with nutrition or food service staff, and in 52.2% of states and 41.7% of districts, they worked with physical education staff.

State mental health or social services staff worked with the state health department in 100% of states, with the state mental health or social services agency in 98.0%, with the state child welfare agency in 85.7%, with a state-level school health committee in 85.4%, and with a state-level school counselor, psychologist, or social worker association in 85.4%. In addition, state mental health or social services staff

Table 3. **Percentage of All Districts and Schools That Provided Mental Health and Social Services, Prevention Services, and Methods of Service Delivery Not on School Property, SHPPS 2006**

	% of All Districts	% of All Schools
Mental health or social service		
Alcohol- or other drug-use treatment*	43.0	34.9
Assistance with enrolling in Medicaid or SCHIP	32.3	22.2
Assistance with enrolling in WIC or accessing food stamps or food banks*	32.2	28.5
Counseling after a natural disaster or other emergency or crisis situation	39.5	33.0
Counseling for emotional or behavioral disorders (eg, anxiety, depression, or ADHD)	47.4	37.5
Crisis intervention for personal problems	51.2	36.3
Eating disorders treatment*	23.0	27.3
HIV counseling, testing, and referral*	24.7	27.2
Identification of emotional or behavioral disorders (eg, anxiety, depression, or ADHD)	48.0	34.9
Identification of or referral for physical, sexual, or emotional abuse	51.7	37.1
Identification of or referral for students with family problems	47.9	37.2
Job readiness skills programs*	37.7	25.3
Referrals for after-school programs (eg, day-care or supervised recreation)	28.2	23.9
Referrals for child care for teen mothers*	28.0	29.2
Services for gay, lesbian, or bisexual students*	15.1	22.9
Stress management	28.4	28.1
Tobacco-use cessation*	33.8	26.3
Weight management	15.3	16.9
Prevention service in 1-on-1 or small-group sessions		
Alcohol- or other drug-use prevention	38.7	30.7
HIV prevention*	27.7	26.5
Injury prevention and safety counseling	25.3	21.2
Nutrition and dietary behavior counseling	20.9	18.3
Physical activity and fitness counseling	15.7	15.2
Pregnancy prevention*	28.4	28.9
STD prevention*	28.3	28.1
Suicide prevention	35.0	29.5
Tobacco-use prevention	33.9	24.6
Violence prevention	35.3	30.9
Method of service delivery		
Case management for students with chronic health conditions (eg, asthma or diabetes)	29.4	24.8
Case management for students with emotional or behavioral problems (eg, anxiety, depression, or ADHD)	46.9	33.8
Comprehensive assessment or intake evaluation	40.6	34.7
Family counseling	39.2	32.4
Group counseling	35.7	30.9
Individual counseling	47.4	37.2
Peer counseling or mediation	24.3	20.4
Self-help or support groups	30.0	28.4

ADHD, attention deficit hyperactivity disorder; HIV, human immunodeficiency virus; SCHIP, State Children's Health Insurance Program; STD, sexually transmitted disease; WIC, Special Supplemental Food Program for Women, Infants, and Children.
*Only asked among middle schools and high schools.

worked with the state juvenile justice department in 83.0% of states, with colleges or universities in 78.3%, with a state-level school nurses' association in 68.2%, with a state-level physicians' organization in 54.8%, with a state-level health organization (eg, the American Heart Association or American Red Cross) in 43.8%, and with businesses in 45.2%.

District mental health or social services staff worked with a local mental health or social services agency in 76.1% of districts, with a local child welfare agency in 71.8%, and with a local health department in 59.8%. District mental health or social services staff also worked with a health organization in 39.0% of districts, with a local hospital in 34.7%, with a local college or university in 34.4%, with a local business in 31.4%, and with a local service club (eg, Rotary Club) in 30.4%.

Evaluation. Some states and districts evaluated aspects of their school mental health or social services programs during the 2 years preceding the study. Specifically, 50.0% of states and 53.5% of districts evaluated mental health or social services staff development or in-service programs, 50.0% of states and 42.2% of districts evaluated their school mental health or social services policies, 47.7% of states and 43.8% of districts evaluated student use of mental health or social services, and 40.5% of states and 41.9% of districts evaluated the quality of their mental health or social services program.

Changes Between 2000 and 2006 at the State and District Levels. Between 2000 and 2006, some changes related to staffing for school mental health and social services were detected. The percentage of states that had adopted a policy stating that each school will have someone to oversee or coordinate mental health and social services at the school decreased from 18.8% to 8.9%. However, the percentage of states with a school mental health or social services coordinator increased from 52.0% in 2000 to 79.2% in 2006.

Changes in required services also were detected. Between 2000 and 2006, the percentage of states that had adopted a policy stating that SAPs will be offered to all students increased from 34.0% to 55.6%, and the percentage of districts that had adopted a similar policy increased from 51.2% to 73.0%. The percentage of states that had adopted a policy stating that school mental health or social services staff will participate in the development of IEPs when indicated increased from 62.7% to 79.6%. The percentage of states in which any schools served as a Medicaid provider by providing mental health or social services to qualified students increased from 73.5% to 84.1%.

Professional preparation expectations for school social workers changed between 2000 and 2006. Specifically, the percentage of states and districts requiring newly hired school social workers to have a master's degrees in social work increased from 38.3% to 60.0% among states and from 25.2% to 37.7% among districts. Similarly, the percentage of states requiring newly hired school social workers to be licensed or certified by a state agency or board increased from 80.0% to 91.5%, and the percentage of districts requiring this increased from 36.3% to 56.3%.

Between 2000 and 2006, there was an increase in the percentage of states providing funding for staff development or offering staff development for mental health or social services staff during the 2 years preceding the study on the following topics: alcohol or other drug use treatment (from 77.8% to 89.4%), identification of emotional or behavioral disorders (from 74.5% to 87.5%), tobacco use cessation (from 70.5% to 82.6%), alcohol or other drug use prevention (from 82.6% to 93.3%), human immunodeficiency virus (HIV) prevention (from 83.3% to 93.5%), and physical activity and fitness counseling (from 54.1% to 71.4%). In contrast, decreases were detected in the percentage of states providing funding for staff development or offering staff development on the following topics: eating disorders treatment (from 65.2% to 52.4%); enrollment in Medicaid or the State Children's Health Insurance Program (from 79.1% to 62.5%); enrollment in the Special Supplemental Food Program for Women, Infants, and Children (WIC) or accessing food stamps or food banks (from 61.5% to 44.7%); comprehensive assessment or intake evaluation (from 75.6% to 51.2%); family counseling (from 63.4% to 44.2%); group counseling (from 69.0% to 58.7%); peer counseling or mediation (from 87.0% to 69.0%); and self-help or support groups (from 69.0% to 58.1%).

In addition, during the 2 years preceding the study, the percentage of districts that provided funding for staff development or offered staff development to mental health or social services staff on the following topics increased: services for gay, lesbian, or bisexual students (from 13.0% to 23.2%); nutrition and dietary behavior counseling (from 22.7% to 35.0%); suicide prevention (from 52.4% to 65.7%); and violence prevention (from 67.8% to 79.3%).

Between 2000 and 2006, some changes were detected in the collaborations that occurred at both the state and the district levels. Specifically, the percentage of states and districts in which mental health and social services staff worked with nutrition services staff on mental health and social services activities increased from 30.2% to 69.8% and from 11.1% to 39.3%, respectively. Similarly, the percentage of states and districts in which mental health and social services staff worked with health education staff on mental health and social services

activities increased from 79.6% to 94.0% and from 45.2% to 59.9%, respectively. In addition, the percentage of states in which mental health and social services staff worked with health services staff increased from 72.9% to 85.4%. However, the percentage of states in which state-level mental health or social services staff worked with a state-level health organization on mental health or social services activities decreased from 60.5% in 2000 to 43.8% in 2006.

The percentage of states and districts evaluating aspects of their mental health or social services program increased between 2000 and 2006. Specifically, the percentage of states evaluating their mental health or social services policies during the 2 years preceding the study increased from 34.9% to 50.0% and the percentage of districts doing the same increased from 31.0% to 42.2%. In addition, the percentage of states evaluating student use of the school mental health or social services program increased from 35.6% to 47.7%, and the percentage of states evaluating the quality of the school mental health or social services program increased from 27.3% to 40.5%. The percentage of districts evaluating staff development or in-service programs for mental health or social services staff increased from 38.6% to 53.5%.

Mental Health and Social Services at the School Level

Standard mental health and social services, which include counseling, psychological services, and social services such as crisis intervention, alcohol or other drug use treatment, or identification of emotional disorders, were defined as services offered at school to all students and usually provided by a school counselor, psychologist, or social worker or by staff from collaborating community agencies. Standard mental health and social services do not include activities by teachers in the classroom or activities by nurses or physicians.

Staffing and Facilities. Nationwide, 76.8% of schools had a person who oversees or coordinates standard mental health and social services at the school. Similarly, 77.9% of schools had at least 1 part-time or full-time counselor who provided mental health or social services to students at the school. Fewer (61.4%) schools had at least 1 part-time or full-time school psychologist who provided services to students at the school. Less than half (41.7%) of schools had a part-time or full-time school social worker who provided services to students.

Using the criterion that a school had a full-time counselor, psychologist, or social worker if one was present in the school for at least 30 hours per week during the 30 days preceding the study, 50.3% of all schools had a full-time counselor, 8.3% of all schools had a full-time psychologist, and 14.3% of all schools had a full-time social worker. Among schools with a part-time counselor (ie, one present less than 30 hours per week during the 30 days preceding the study), that counselor was present an average of 13.1 hours per week. Schools with a part-time psychologist had one present an average of 9.8 hours per week, and schools with a part-time social worker had one present an average of 10.2 hours per week during the 30 days preceding the study. Nationwide, 28.9% of all schools also had backup or after-hours coverage when school mental health or social services staff were not available, such as after school or on weekends.

Nationwide, 92.6% of schools had a private room for counseling students, and 87.4% had locked storage space for files related to the standard mental health or social services provided to students. Half (50.7%) of schools had a dedicated phone line for standard mental health and social services, and 48.6% had an answering machine or voice mail reserved for the same purpose.

Nationwide, 49.3% of schools helped ensure privacy for students receiving standard mental health or social services by having the primary location where students obtained services out of view of the main office. However, in 27.5% of schools, students obtained these services within view of the school's main office, and in 23.2% of schools, students obtained these services in the same office suite as the main office.

Services Provided. Nationwide, 57.4% of schools offered SAPs, 79.6% of schools had student support teams, and 39.0% of schools had a student support team that included staff from collaborating community agencies. In more than three fourths of all schools, mental health or social services staff such as school counselors, psychologists, and social workers provided counseling after a natural disaster or other emergency or crisis situation; counseling for emotional or behavioral disorders; crisis intervention for personal problems; identification of emotional or behavioral disorders; identification of or referral for physical, sexual, or emotional abuse; identification of or referral for students with family problems; and stress management services (Table 4). In addition, more than three fourths of all schools provided suicide prevention and violence prevention in 1-on-1 or small-group sessions, and more than three fourths provided case management for students with emotional or behavioral problems, group counseling, and individual counseling.

Nearly all (96.8%) schools kept records of mental health or social services provided to students, and during the 12 months preceding the study, 70.3% of all schools reviewed these records to identify students with chronic problems or ways to prevent further occurrences of these problems.

Table 4. **Percentage of All Schools That Provided Mental Health and Social Services, Prevention Services, and Methods of Service Delivery, SHPPS 2006**

	% of All Schools
Mental health or social service*	
Alcohol- or other drug-use treatment†	53.8
Assistance with enrolling in Medicaid or SCHIP	46.1
Assistance with enrolling in WIC or accessing food stamps or food banks†	49.9
Counseling after a natural disaster or other emergency or crisis situation	94.2
Counseling for emotional or behavioral disorders (eg, anxiety, depression, or ADHD)	86.2
Crisis intervention for personal problems	95.4
Eating disorders treatment†	46.2
HIV counseling, testing, and referral†	40.7
Identification of emotional or behavioral disorders (eg, anxiety, depression, or ADHD)	81.7
Identification of or referral for physical, sexual, or emotional abuse	93.8
Identification of or referral for students with family problems	94.0
Job readiness skills programs†	56.8
Referrals for after-school programs (eg, day-care or supervised recreation)	60.0
Referrals for child care for teen mothers†	57.6
Services for gay, lesbian, or bisexual students†	59.0
Stress management	83.6
Tobacco-use cessation†	60.2
Weight management	34.5
Prevention service in 1-on-1 or small-group sessions*	
Alcohol- or other drug-use prevention	73.0
HIV prevention†	54.4
Injury prevention and safety counseling	60.9
Nutrition and dietary behavior counseling	42.9
Physical activity and fitness counseling	35.7
Pregnancy prevention†	60.4
STD prevention†	55.6
Suicide prevention	82.6
Tobacco-use prevention	64.1
Violence prevention	90.7
Method of service delivery*	
Case management for students with chronic health conditions (eg, asthma or diabetes)	40.3
Case management for students with emotional or behavioral problems (eg, anxiety, depression, or ADHD)	83.7
Comprehensive assessment or intake evaluation	65.1
Family counseling	49.7
Group counseling	78.6
Individual counseling	92.9
Peer counseling or mediation	67.9
Self-help or support groups	64.4

ADHD, attention deficit hyperactivity disorder; HIV, human immunodeficiency virus; SCHIP, State Children's Health Insurance Program; STD, sexually transmitted disease; WIC, Special Supplemental Food Program for Women, Infants, and Children.
*Services provided by mental health and social services staff such as counselors, psychologists, and social workers. Did not include activities by teachers in the classroom or activities by nurses or physicians.
†Only asked among middle schools and high schools.

Mental health and social services staff also were involved in developing plans for students with special needs, when their participation was indicated. Specifically, in 82.9% of schools, someone from the mental health or social services staff participated in the development of IEPs, and in 79.9% of schools, mental health or social services staff participated in the development of 504 plans. In contrast, mental health or social services staff participated in the development of individualized health plans in only 47.2% of schools.

SBHCs and Services Provided at Other Sites. Nationwide, only 13.6% of schools had an SBHC that offered mental health or social services to students, whereas 44.8% of schools had a contract, memorandum of agreement, or other similar arrangement with organizations or professionals to provide mental health or social services to students at sites not located on school property. Few (8.6%) schools had both an SBHC and arrangements with providers not located on school property; 49.8% had either an SBHC or such arrangements. Among all schools, the most common arrangements were with a local mental health or social services agency (Table 2). The most common services provided through these arrangements were counseling after a natural disaster or other emergency or crisis situation; counseling for emotional or behavioral disorders; crisis intervention for personal problems; identification of emotional or behavioral disorders; identification of or referral for physical, sexual, or emotional abuse; identification of or referral for students with family problems; case management for students with emotional or behavioral problems; comprehensive assessment or intake evaluation; and individual counseling.

Professional Preparation. Most schools had a minimum education requirement for newly hired mental health and social services staff. Specifically, 75.4% of schools required newly hired school counselors to have a master's degree in counseling, 11.0% required an undergraduate degree in counseling, and 11.1% required another type of degree. For newly hired school psychologists, 78.8% of schools required a master's degree in psychology, 9.1% required a doctoral degree in psychology, and 10.3% required another type of degree. For newly hired school social workers, 63.9% of schools required a master's degree in social work, 28.7% required an undergraduate degree in social work, and 4.7% required another type of degree. Most schools also required state licensure for newly hired mental health and social services staff. Nationwide, 84.1% of schools required newly hired school counselors to be licensed or certified by a state agency or board, 94.8% required newly hired school psychologists to be licensed or certified by a state agency or board, and 87.6% required newly hired school social workers to be licensed or certified by a state agency or board.

Staff Development. Nationwide, 82.5% of schools required newly hired mental health or social services

staff to earn continuing education credits on mental health and social services topics. During the 2 years preceding the study, 98.7% of school mental health and social services coordinators received staff development on at least 1 of the topics listed in Table 5. Specifically, more than three fourths of school mental health and social services coordinators received staff development on counseling after a natural disaster or other emergency or crisis situation; counseling for emotional or behavioral disorders; crisis intervention for personal problems; emergency preparedness; identification of emotional or behavioral disorders; identification of or referral for physical, sexual, or emotional abuse; ways to promote a positive school climate; and violence prevention (Table 5). More than 40% of coordinators indicated that they wanted to receive staff development on counseling for emotional or behavioral disorders, violence prevention, and case management for students with emotional or behavioral problems.

Mental Health and Social Services Coordinators. Among the 76.8% of schools with a school mental health or social services coordinator, 81.6% had that person serve as the respondent to the school mental

Table 5. **Percentage of School Mental Health and Social Services Coordinators* Who Received Staff Development† and Who Wanted Staff Development on Mental Health and Social Services, Prevention Services, and Methods of Service Delivery, SHPPS 2006**

	% Who Received Staff Development	% Who Wanted Staff Development
Mental health or social service topic		
After-school programs (eg, day-care or supervised recreation)	21.9	14.6
Alcohol- or other drug-use treatment	56.7	19.6
Child care for teen mothers	13.1	12.3
Counseling after a natural disaster or other emergency or crisis situation	79.1	29.6
Counseling for emotional or behavioral disorders (eg, anxiety, depression, or ADHD)	78.0	40.5
Crisis intervention for personal problems	77.9	35.4
Eating disorders treatment	31.7	27.8
Emergency preparedness	75.4	22.5
Enrollment in Medicaid or SCHIP	13.8	14.7
Enrollment in WIC or accessing food stamps or food banks	10.2	15.3
HIV counseling, testing, and referral	18.2	15.9
Identification of emotional or behavioral disorders (eg, anxiety, depression, or ADHD)	82.5	33.8
Identification of or referral for physical, sexual, or emotional abuse	78.9	19.1
Job readiness skills programs	33.5	18.4
Services for gay, lesbian, or bisexual students	24.2	26.5
Stress management	59.8	33.1
Tobacco-use cessation	32.1	13.8
Ways to promote a positive school climate	86.0	32.3
Weight management	11.1	19.7
Prevention service topic		
Alcohol- or other drug-use prevention	54.9	26.7
HIV prevention	25.3	16.5
Injury prevention and safety counseling	47.9	21.9
Nutrition and dietary behavior counseling	18.7	31.9
Physical activity and fitness counseling	20.6	26.6
Pregnancy prevention	20.2	18.6
STD prevention	25.5	17.4
Suicide prevention	65.4	37.7
Tobacco-use prevention	37.1	16.3
Violence prevention	87.6	45.5
Method of service delivery topic		
Case management for students with chronic health conditions (eg, asthma or diabetes)	27.0	27.9
Case management for students with emotional or behavioral problems (eg, anxiety, depression, or ADHD)	58.9	41.1
Comprehensive assessment or intake evaluation	38.8	23.5
Family counseling	37.3	34.9
Group counseling	50.9	34.2
Individual counseling	65.2	30.7
Peer counseling or mediation	47.4	35.3
Self-help or support groups	42.6	31.2

ADHD, attention deficit hyperactivity disorder; HIV, human immunodeficiency virus; SCHIP, State Children's Health Insurance Program; STD, sexually transmitted disease; WIC, Special Supplemental Food Program for Women, Infants, and Children.

*Among the 62.7% of schools that had a school mental health or social services coordinator who served as the respondent to the school mental health and social services questionnaire.

†During the 2 years preceding the study.

health and social services questionnaire. Nearly two thirds (65.3%) of these coordinators were employed by the school district, with 45.8% working for a specific school. Few (6.4%) worked for a local mental health or social services agency. Most (91.9%) had a graduate degree, with 56.1% of those degrees being in counseling, 22.2% in social work, 19.8% in education, and 13.9% in psychology. Moreover, 76.0% of these coordinators were licensed or certified by a state agency or board to provide school mental health or social services.

Collaboration. School mental health and social services staff collaborated with staff from other components of the school health program in several ways during the 12 months preceding the study. A school counselor, psychologist, or social worker taught students as part of a health education unit or lesson in 56.1% of elementary schools and a physical education unit or class in 11.6% of elementary schools. School mental health or social services staff taught a health education class in 36.4% of middle or high schools, a biology or other science class in 10.7% of middle or high schools, and a physical education class in 9.0% of middle or high schools. School mental health or social services staff worked on school mental health or social services activities with health services staff in 60.3% of schools, with health education staff in 56.2% of schools, with physical education staff in 37.7% of schools, and with nutrition or food service staff in 21.8% of schools.

School mental health and social services staff also worked on mental health and social services activities with outside agencies and organizations. These staff worked with a local mental health or social services agency in 72.0% of schools, with a local child welfare agency in 67.5%, with a local health department in 41.0%, with a local college or university in 39.0%, with a local service club in 35.2%, with a local business in 33.5%, with a local hospital in 31.1%, and with a health organization in 26.1%.

Changes Between 2000 and 2006 at the School Level. Two changes were detected between 2000 and 2006 that showed an increase in access to mental health and social services in schools. The percentage of schools with a dedicated phone line for mental health and social services increased from 37.5% to 50.7%, and the percentage of schools with an answering machine reserved for mental health and social services increased from 26.0% to 48.6%.

Between 2000 and 2006, the percentage of schools providing HIV counseling, testing, and referrals increased from 23.3% to 40.7%. However, the percentage of schools providing family counseling decreased from 60.8% to 49.7%.

Professional preparation expectations increased for social workers. The percentage of schools requiring a newly hired school social worker to be licensed or certified by a state agency or board increased from 76.9% to 87.6%. However, between 2000 and 2006, a decrease was detected in the percentage of school-level mental health or social services coordinators who received staff development on the following topics during the 2 years preceding the study: alcohol- or other drug-use prevention (from 68.2% to 54.9%), alcohol- or other drug-use treatment (from 71.3% to 56.7%), case management for students with emotional or behavioral problems (from 73.2% to 58.9%), family counseling (from 49.6% to 37.3%), and peer counseling (from 61.9% to 47.4%). In addition, the percentage of mental health or social services coordinators who wanted to receive staff development on eating disorders treatment decreased from 38.1% to 27.8%, and the percentage who wanted to receive staff development on identification of or referral for physical, sexual, or emotional abuse decreased from 31.9% to 19.1%.

Finally, between 2000 and 2006, the percentage of schools in which mental health and social services staff worked with a local health department decreased from 51.3% to 41.0%.

DISCUSSION

Although states and districts generally had not adopted policies stating that schools will have mental health and social services staff, more than three fourths of schools had at least a part-time counselor who provided services to students. Other mental health and social services staff were less common, with less than two thirds of schools having a school psychologist and less than half having a school social worker. The percentage of schools with each type of mental health or social services staff has remained stable since 2000 and also is similar to the findings of another recent national survey by Foster et al. of school-based mental health programs.[35]

The percentage of schools providing particular services to students reflects the available staffing. That is, schools were more likely to have counselors than psychologists or social workers, and so counseling services such as counseling for emotional or behavioral disorders were more common than psychological services, such as comprehensive assessments or intake evaluations, or social services, such as assistance with enrolling in WIC or accessing food stamps or food banks. With just 2 exceptions, the percentage of schools providing each type of service has remained stable since 2000.

Relatively few schools delivered mental health and social services through SBHCs. Arrangements with providers not located on school property were more common. SHPPS 2006 found that slightly less than half of schools reported such arrangements, as did Foster et al. in their recent study.[35] Both studies

also found that local mental health or social services agencies were the most common community-based providers. Because schools are not able to meet the mental health and social services needs of all students, such linkages with the community need to continue and to grow.

The percentage of states with a mental health and social services coordinator has increased since 2000, as has the level of collaboration on mental health and social services activities at the state and district levels. Despite these and other improvements such as increased requirements for SAPs, state- and district-level policies supporting broad school mental health and social services are far from universal. This lack of policy support may create unsystematic planning and implementation of mental health programs and services, as well as fragmented and piecemeal activities at the school level, an inefficient use of limited resources.[25] The delivery of school mental health and social services would improve if policies were in place to frame a system of learning supports rather than separate programs or services.[32]

More than three fourths of the states provided funding for staff development or offered staff development on nearly 20 topics during the 2 years preceding the study. In addition, while more than three fourths of school mental health and social services coordinators received staff development on 8 important topics during this period, training on several other topics was much less common. Research is needed to better understand the staff development needs of school mental health and social service providers, because sufficient training of key staff is critical to improving school-based mental health and social services.[40]

Collaboration between school mental health and social services staff and other staff working in schools and in the community also is critical to the success of school-based mental health programs.[41] Although some collaboration is occurring, most frequently with school health services staff and with local mental health or social services agencies and local child welfare agencies, room for improved collaboration exists.

SHPPS 2006 results can determine the extent to which school mental health and social services programs in the United States are meeting various guidelines for schools. For example, according to the *Health, Mental Health, and Safety Guidelines for Schools*,[16] schools should have student support teams. SHPPS 2006 found that nearly 80% do. Those guidelines also state that schools should maintain a system to recognize and report child abuse and neglect. Nationwide, 94% of schools provide identification of and referral for physical, sexual, or emotional abuse. The AAP recommends that ''private, confidential, and comfortable physical space should be provided at the school site'' for the delivery of mental health and social services,[15] but only about half of schools delivered services out of view of the school's main office. Similarly, only about half of schools had a dedicated phone line for mental health and social services or an answering machine or voice mail reserved for these staff. While this represents an improvement since 2000, more schools need to improve mental health and social service facilities to ensure student privacy and confidentiality. Further analyses of SHPPS 2006 data can determine the extent to which other guidelines are being met.

Comparing results from SHPPS 2000 and 2006 reveals that some positive improvements in mental health and social services have been made at the state and district level during this period. These include increases in the percentage of states and districts with education and certification requirements for school social workers, increases in the percentage of states and districts that had adopted a policy stating that SAPs will be offered to all students, and increases in the percentage of states that had adopted a policy stating that mental health or social services staff will participate in the development of IEPs. At the school level, however, few changes were detected, indicating that room for improvement exists. Specifically, insufficient numbers of mental health and, especially, social services providers are employed by schools, and connections between schools and related community systems such as mental health, juvenile services, and child welfare need to be strengthened.

To improve school mental health and social services, efforts must be made to build systematic state agendas for school-based mental health, emphasizing a shared responsibility among families, schools, and other community systems. The mental health needs of children and adolescents must be addressed collaboratively by education agencies, mental health agencies, and public health agencies. SHPPS 2006 and other related data can be used for program and policy analyses to drive national improvement in school-based mental health programs, meeting the challenges set forth by the US Surgeon General[1,2] and the New Freedom Commission.[12] As recently stated by Adelman and Taylor, ''Schools can and need to do much more if ... the recommendations of the President's New Freedom Commission on Mental Health ... are to be achieved.''[3]

REFERENCES

1. US Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, Md: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; 1999.

2. US Public Health Service. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services; 2000.
3. Adelman H, Taylor L. Mental health in schools and public health. *Public Health Rep*. 2006;121:294-298.
4. Atkins MS, Frazier SL, Adil JA, Talbott E. School-based mental health services in urban communities. In: Weist M, Evans S, Tashman N, eds. *Handbook of School Mental Health: Advancing Practice and Research*. New York, NY: Kluwer Academic/Plenum Publishers; 2003:165-178.
5. Zins JE, Weissberg RP, Wang ML, Walberg E, eds. *Building Academic Success on Social and Emotional Learning: What Does the Research Say?* New York, NY: Teachers College, Columbia University Press; 2004.
6. Burns BJ, Costello EJ, Angold A, et al. Children's mental health service use across service sectors. *Health Aff (Millwood)*. 1995;14:147-159.
7. Leaf PJ, Alegria M, Cohen P, et al. Mental health service use in the community and schools: results from the four-community MECA Study. Methods for Epidemiology of Child and Adolescent Mental Disorders Study. *J Am Acad Child Adolesc Psychiatry*. 1996;35:889-897.
8. Weist MD. Expanded school mental health services: a national movement in progress. In: Ollendick TH, Prinz RJ, eds. *Advances in Clinical Child Psychology*. Vol. 19. New York, NY: Plenum Press; 1997:319-352.
9. Catron T, Harris V, Weiss B. Posttreatment results after 2 years of services in the Vanderbilt school-based counseling project. In: Epstein M, Kutash K, eds. *Outcomes for Children and Youth with Emotional and Behavioral Disorders and Their Families: Programs and Evaluation Best Practices*. Austin, Tex: Pro-Ed, Inc; 1998:633-656.
10. Lever NA, Adelsheim S, Prodente C, et al. System, agency and stakeholder collaboration to advance mental health programs in schools. In: Weist MD, Evans SW, Lever NA, eds. *Handbook of School Mental Health: Advancing Practice and Research*. New York, NY: Kluwer Academic/Plenum Publishers; 2003: 149-162.
11. Robinson K, ed. *Advances in School-Based Mental Health Interventions*. Kingston, NJ: Civic Research Institute; 2004.
12. New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. Rockville, Md: Department of Health and Human Services; 2003. DHHS Publication SMA-03-3832.
13. US Census Bureau. Current population survey, October 2005. Available at: http://www.census.gov/population/socdemo/school/cps2005/tab01-01.xls. Accessed June 22, 2007.
14. Evans SW. Mental health services in schools: utilization, effectiveness, and consent. *Clin Psychol Rev*. 1999;19(2):165-178.
15. Committee on School Health. Policy statement: school-based mental health services. *Pediatrics*. 2004;113:1839-1845.
16. Taras H, Duncan P, Luckenbill D, Robinson J, Wheeler L, Wooley S, eds. *Health, Mental Health, and Safety Guidelines for Schools*. Elk Grove Village, Ill: American Academy of Pediatrics; 2004.
17. Policy Leadership Cadre for Mental Health in Schools. *Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations*. Los Angeles, Calif: Center for Mental Health in Schools; 2001.
18. American School Counselor Association. Ethical standards for school counselors. Available at: http://www.schoolcounselor.org/content.asp?contentid=173. Accessed April 9, 2007.
19. National Association of School Psychologists. Guidelines for the provision of school psychological services. Available at: http://www.nasponline.org/standards/ProfessionalCond.pdf. Accessed April 9, 2007.
20. National Association of School Social Workers. NASW Standards for School Social Work Services. Available at: http://www.naswdc.org/practice/standards/NASW_SSWS.pdf. Accessed April 9, 2007.
21. Weist MD, Evans SW, Lever NA, eds. *Handbook of School Mental Health: Advancing Practice and Research*. New York, NY: Kluwer Academic/Plenum Publishers; 2003.
22. Paternite CE. School-based mental health programs and services: overview and introduction to the special issue. *J Abnorm Child Psychol*. 2005;33:657-663.
23. Adelman H. School counseling, psychological, and social services. In: Marx E, Wooley SF, Northrop D, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York, NY: Teachers College Press; 1998:142-168.
24. Center for Mental Health in Schools. *The Current Status of Mental Health in Schools: A Policy and Practice Analysis*. Available at: http://smhp.psych.ucla.edu/currentstatusmh.htm. Accessed June 22, 2007.
25. Adelman H, Taylor L. Promoting mental health in schools in the midst of school reform. *J Sch Health*. 2000;70:171-178.
26. Adelman H, Taylor L. *The School Leader's Guide to Student Learning Supports: New Directions for Addressing Barriers to Learning*. Thousand Oaks, Calif: Corwin Press; 2005.
27. National Assembly on School-Based Health Care 2004-2005 Census. National Assembly on School-Based Health Care, 2007. Available at: http://www.nasbhc.org/EQ/EQ_National_Data1.htm. Accessed June 22, 2007.
28. Armbruster P. The administration of school-based mental health services. *Administrative Psychiatry* 2002;11:23-41.
29. Anglin TM, Naylor KE, Kaplan DW. Comprehensive, school-based health care: high school students' use of medical, mental health, and substance abuse services. *Pediatrics*. 1996;97: 318-330.
30. Weist MD, Goldstein A, Morris L, Bryant T. Integrating expanded school mental health and school-based health centers. *Psychol Sch*. 2003;15:297-308.
31. Anglin T. Mental health in schools: programs of the Federal government. In: Weist MD, Evans SW, Lever NA, eds. *Handbook of School Mental Health Programs: Advancing Practice and Research*. New York, NY: Kluwer Academic/Plenum Publishers; 2003:89-106.
32. Adelman H, Taylor L. *Mental Health in Schools: Reflections on the Past, Present, and Future*. Los Angeles, Calif: Center for Mental Health in Schools; 2004.
33. Individual with Disabilities Education Act, *20* USCA §§1400-1491 (2005).
34. Safe and Drug-Free Schools and Communities Act, *20* USCA §§7111-7116 (2005).
35. Foster S, Rollefson M, Doksum T, Noonan D, Robinson G, Teich J. *School Mental Health Services in the United States, 2002-2003*. Rockville, Md: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2005. DHHS Publication SMA 05-4068.
36. Slade EP. Effects of school-based mental health programs on mental health service use by adolescents at school and in the community. *Ment Health Serv Res*. 2002;4:151-166.
37. Rones M, Hoagwood K. School-based mental health services: a review. *Clin Child Fam Psychol Rev*. 2000;3:223-241.
38. Jennings J, Pearson G, Harris M. Implementing and maintaining school-based mental health services in a large, urban school district. *J Sch Health*. 2000;70:201-205.
39. Brener ND, Martindale J, Weist MD. Mental health and social services: results from the School Health Policies and Programs Study 2006. *J Sch Health*. 2001;71:305-312.
40. Weist MD. Fulfilling the promise of school-based mental health: moving toward a public mental health promotion approach. *J Abnorm Child Psychol*. 2005;33:735-741.
41. Weist MD, Proescher E, Prodente C, Ambrose MG, Waxman R. Mental health, health, and education staff working together in schools. *Child Adolesc Psychiatr Clin N Am*. 2001;10:33-43.