Kurt D. Michael
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Editors

Handbook of Rural School Mental Health

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Foreword

Escalating the Advancement of Rural School Mental Health

As documented in a growing number of books (see Adelman & Taylor, 2010; Clauss-Ehlers, Serpell, & Weist, 2013; Dikel, 2014; Doll & Cummings, 2008; Evans, Weist, & Serpell, 2007; Kern, George, & Weist, 2016; Kutcher, Wei, & Weist, 2015; Robinson, 2004; Weist, Evans & Lever, 2003; Weist, Lever, Bradshaw, & Owens, 2014), proliferating research and journal articles (see newer journals *School Mental Health* published by Springer, and *Advances in School Mental Health Promotion* published by Routledge), and increasing federal support (President's New Freedom Commission, 2003; United States (U.S.) Public Health Service, 2000; U.S. White House, 2013), the school mental health (SMH) field is gaining momentum in the U.S. and around the world (Rowling & Weist, 2004; Weare, 2000; Weist, Short, McDaniel, & Bode, 2016). The field, as represented in this literature and in this critically important book edited by leaders Kurt Michael and John Paul Jameson, reflects an interdisciplinary and cross-system approach involving a range of relevant community agencies and stakeholders (e.g., mental health, juvenile justice, child welfare, family/youth advocacy, disabilities, primary health care) working collaboratively with schools, school-employed mental health professionals, educators, and other school staff to move toward greater depth and quality in multitiered systems of support involving promotion/prevention, early intervention, and treatment (also see the highly related literature on Positive Behavior Support—e.g., Sailor, Dunlap, Sugai, & Horner, 2009; and evolving work to link it with SMH—e.g., Barrett, Eber, & Weist, 2013). Indeed, it can be argued that there is no agenda within a community that is more important, as SMH is focused on assisting children and youth; promoting their positive social, emotional, and behavioral functioning; reducing and removing barriers to their learning; and increasing the likelihood of their successful matriculation, graduation, and positive contributions to society.

The SMH field is based on several fundamental recognitions. First, in general, children, adolescents, and families have difficulty connecting to and subsequently do not regularly attend specialty mental health appointments (see Atkins et al. 1998; Catron, Harris, & Weiss, 1998). Second, although schools represent a universal setting, significant for almost all youth, they are under-resourced to meet the mental health needs of students (see Foster et al., 2005). Third, there are

many advantages to augmenting existing school staff efforts to improve student mental health by partnering with community mental health and other agencies to move toward an "expanded" school mental health approach (Weist, 1997). As the field is gaining momentum in interconnected research, practice, and policy, a range of benefits for students, schools, and community are being documented (see Stallard, Simpson, Anderson, Hibbert, & Osborn, 2007; Suldo, Gormley, DuPaul, & Anderson-Butcher, 2014; Wilson & Lipsey, 2007), which are in turn fueling further advances and fostering the building of capacity.

Notably, there is evidence that SMH is particularly important for rural children, youth, and families, given the higher rates of death by suicide in remote regions (Fontanella et al., 2015), prevalent substance abuse including opioid addiction and overdose (Lambert, Gale, & Hartley, 2008), and increased barriers to receiving effective care (Hefflinger et al., 2015). Thus, there is a critical need for innovative and empirically supported mental health services for rural youth and families (see Jameson, Chambless, & Blank, 2009) with emphasis on school-based approaches to increase the likelihood that they will actually connect to these services (see Michael et al., 2013). This is the gap that this Handbook fulfills. Editors Kurt Michael and John Paul Jameson have assembled a comprehensive collection of superbly written chapters that covers the full range of issues relevant to further building the SMH agenda for rural youth and families. As above, chapters focus on advancements in research, practice, and policy, as well as interconnecting progress across these realms in key theme areas including Development and Implementation, Clinical and Cultural Conditions, Addressing Challenges, and Program Evaluation and Sustainability. Per the interdisciplinary, cross-agency, and diverse nature of the SMH field, contributing authors reflect this diversity, with senior researchers and policy leaders, younger faculty and program managers, multiple disciplines and stakeholder groups represented. Chapters provide relevant background and important hands-on guidance for making progress. It is a privilege to participate in this groundbreaking work.

Columbia, SC, USA Mark D. Weist

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Mark D. Weist received a Ph.D. in clinical psychology from Virginia Tech in 1991 after completing his internship at Duke University, and is a Professor in Clinical-Community and School Psychology in the Department of Psychology at the University of South Carolina. He was on the faculty of the University of Maryland for 19 years where he helped to found and direct the Center for School Mental Health (http://csmh.umaryland.edu), providing leadership to the advancement of school mental health (SMH) policies and programs in the United States. He has edited ten books and has published and presented widely in SMH and in the areas of trauma, violence and youth, evidence-based practice, cognitive behavioral therapy, Positive Behavioral Interventions & Supports (PBIS), and on an Interconnected Systems Framework (ISF) for SMH and PBIS. He is currently co-leading a regional conference on school behavioral health (reflecting integrated SMH and PBIS, see http://www.schoolbehavioralhealth.org) and leading a randomized controlled trial on the ISF.

Preface

The idea for this Handbook emerged from a series of conversations that took place in the fall of 2012. JP and I had been deeply involved in the development of school mental health (SMH) initiatives in rural Appalachia for several years. In search of guidance tailored for our remote settings, we consulted the empirical literature on schools, children's mental health, community psychology, implementation science, outcome assessment, school administration, and policy to practice outlets. We also searched for more comprehensive resources in school mental health, child and adolescent behavioral health care, school social work, counseling, nursing, and school psychology. There were certainly some excellent resources already available, including the s econd edition of the *Handbook of School Mental Health* (Springer), yet the issue of rural SMH was not addressed specifically. The closest approximation found were two single chapters in edited books or handbooks, including a chapter in *Rural Mental Health: Issues, Policies, and Best Practices* (Waguespack, Broussard, & Guilfou, 2012) and another single chapter in the *Handbook of Culturally Responsive School Mental Health: Advancing Research, Training, Practice, and Policy* (Owens, Watabe, & Michael, 2013). Though these works are outstanding, it became clear to us that the body of literature on rural issues in SMH was otherwise scant, disjointed, unorganized, and less than user-friendly. Around the same time and coincidentally, Springer Associate Editor, Garth Haller, contacted me to inquire if I had any book ideas. JP and I agreed to meet Garth and his colleague, Senior Editor Judy Jones, in Seattle at the Annual National Association of School Psychologists (NASP) Convention to discuss the idea further. As the conversation deepened, we felt optimistic that there was a sufficient need to assemble an inaugural *Handbook of Rural School Mental Health*. Although it certainly took longer than expected, we are thrilled with the final product.

When we started to organize the content of this book, we approached it as something of a thought experiment. We asked ourselves, "If we could go back in time to when we started this work, what would we want to know to avoid some of the mistakes we made and handle some of the problems we encountered early on?" We quickly realized that this book needed to move well beyond the nuts and bolts of clinical practice in school settings and address the additional issues of development, implementation, process, policy, sustainability, and evaluation. A successful rural SMH program takes a proverbial village, and we decided that we needed a book that spoke to the need of having all parties come together with respect to their unique perspec-

tives and contributions to create effective programs in the service of students. Therefore, the *Handbook of Rural School Mental Health* addresses the concerns of a diverse array of stakeholders involved in all aspects of the functioning of SMH programs in remote and rural settings. And because we hoped that the book would be valuable to researchers, practitioners, policymakers, educators, and advocates alike, as editors we strove to avoid highly technical and abstract models and instead promote the use of illustrative examples to bring important issues and concepts to life for the reader. We also attempted to encourage chapter authors to create bridges between concepts familiar to mental health service providers and those used in education. While we cannot claim that this volume is a universal blueprint for creating, sustaining, and improving SMH programs in rural areas— indeed, we would argue that such an endeavor would be impossible— we do hope that the book provides a thorough treatment of the major issues that rural SMH programs are likely to face.

In addition to this preface, Mark Weist thoughtfully sets the tone for the *Handbook* by providing his expert perspective on the field of school mental health, along with an attempt to persuade the reader of the rationale for a specific resource for stakeholders in rural schools. The contents of the Handbook are separated into four parts: (1) *Development of Rural School Mental Health Initiatives: Rationale, Policies, Ethics, and Competencies*; (2) *Clinical and Cultural Conditions in Rural School Settings*; (3) *Addressing Challenges in Delivering Rural School Mental Health Services*; and (4) *Implementing, Evaluating, and Sustaining Rural School Mental Health Programs*.

In *Part I*, the broad perspectives of national and international school mental health experts, educators, and community mental health leaders are included. The topics range from the initial development and implementation of school mental health programs, the reasons why SMH should be considered, and how implementation can proceed in an empirically informed manner. Sharon A. Hoover and Ashley Mayworm begin the part with *The Benefits of School Mental Health*. They discuss the unique position of SMH programs to facilitate access to care in vulnerable rural settings, address stigma as a barrier to care, provide opportunities for early identification and intervention for mental and behavioral health concerns, facilitate a full continuum of services within the school, and provide care in a young person's natural environment. Hoover and Mayworm make a convincing case for implementation of school mental health programs by highlighting mental and behavioral health outcomes from school mental health interventions. Next, E. Rebekah Siceloff, Christian Barnes-Young, Cameron Massey, Mitch Yell, and Mark Weist describe the process of developing effective policy supports for rural school mental health programs in the chapter *Building Policy Support for School Mental Health in Rural Settings*. Siceloff, Barnes-Young, Massey, Yell, and Weist chronicle important policy considerations and challenges, namely sustainability and funding, to implementing school mental health programs unique to rural settings. They end the chapter with a case study detailing school mental health in South Carolina and the innovative strategies employed to address the challenge of sustainability.

The next two chapters consider practitioner-related aspects of developing rural school mental health programs. Michael Sulkowski considers ethical issues commonly encountered by school mental health practitioners relevant to tight-knit rural communities where mental health providers are scarce and provides a guide for laws that affect school mental health in the chapter *Legal and Ethical Issues Related to Rural School Mental Health*. Sulkowski's guide to navigating legal and ethical issues in rural SMH practice provides valuable information to inform program policies and procedures. In *General and Specific Competencies for School Mental Health in Rural Settings*, Dawn Anderson-Butcher, Jill Hoffman, David Rochman, and Michael Fuller describe the competencies and skills necessary for practitioners in rural school mental health programs. This chapter is especially helpful in developing relevant training competencies for rural school mental health practitioners, considering how being a well-trained mental health service provider translates into the rural school context, and understanding what areas of need are unique to rural school mental health settings.

The final two chapters address the development of school mental health initiatives through consideration of issues related to teachers and school mental health in rural communities. Susan Rodger, Kathy Hibbert, and Michelle Gilpin address the critically important relationship between teachers and school mental health programs in the chapter *Preservice Teacher Education for School Mental Health in a Rural Community*. Rodger, Hibbert, and Gilpin describe important aspects of teacher preservice education that may contribute to rural school mental health and is a helpful resource for a rural school mental health practitioner's understanding of school and teacher functioning. Further addressing school mental health's relevance to rural teachers, Timothy Carey concludes this part with *Why Would Teachers Care? The Value of Rural School Mental Health from an Educator's Standpoint*. Carey attends to educators' values, pointing to the benefits of an increased focus on mental health in rural schools that may improve school functioning for students and teachers.

Part II focuses on supporting SMH practitioners by summarizing the current state of research on assessment and treatment practices for problems commonly seen in school settings and providing practical guidelines for utilizing evidence-based practices in their own programs. This part begins with a piece written by Alex Kirk, Rafaella Sale, and Eric Youngstrom titled, *Rural America and Evidence-Based Assessment: The Potential for a Happy Marriage*. Kirk, Sale, and Youngstrom make a case for contextualizing broadly evidence-based assessment in rural schools as a strategy for reducing costs and improving the efficiency of SMH programs. It is an excellent read for those interested in merging empirically based assessment practices into real world settings. Following this chapter, authors Alex Holdaway, Verenea Serrano, and Julie Sarno Owens outline how best to identify and treat ADHD in rural settings in their chapter titled *Effective Assessment and Intervention for Children with ADHD in Rural Elementary School Settings*. We felt fortunate to have received this contribution, given that the authors (and notably Dr. Owens) have established exceptional reputations for developing and testing ADHD interventions in the lab and successfully adapting them for use in community settings.

The next three chapters discuss considerations for preventing suicide and treating anxiety and depression in rural settings. First, Marisa Schorr, Whitney Van Sant, and JP Jameson make the case for schools as a logical starting point for suicide prevention interventions in rural communities in the chapter *Preventing Suicide Among Students in Rural Schools*. Schorr, Van Sant, and Jameson discuss salient suicide risk factors in rural communities and provide an overview of school-based suicide prevention programs, highlighting the characteristics of such programs that are adaptable for rural schools. This section is an excellent starting point for implementing rural school-based suicide prevention and postvention practices and considering strategies for overcoming barriers to implementation. In the chapter *The Identification and Treatment of Anxiety Among Children in Rural Settings*, Sophie Schneider, Suzanne Davies, and Heidi Lyneham provide convincing evidence in support of telehealth as a useful anxiety treatment strategy that can increase the accessibility of mental health treatment in rural communities. Schneider, Davies, and Lyneham provide a thoughtful analysis of anxiety assessment and treatment strategies along with relevant adaptations and challenges for rural contexts. Carissa Orlando, Abby Albright Bode, and Kurt Michael outline depression treatment challenges in rural settings and set up school mental health programs as an innovative approach to addressing these challenges in the chapter *Depression and Rural School Mental Health: Best Practices*. By providing helpful examples of school mental health programs treating depression, Orlando, Albright Bode, and Michael provide a framework for evidence-based assessment and treatment of depression and useful adaptations for treating depression within rural schools.

The following three chapters discuss treatment considerations for other clinical concerns in rural schools. Kristyn Zajac, Arthur Andrews, and Ashli Sheidow provide information about the manifestation of adolescent substance use and conduct problems in rural settings and how limited access to treatment can exacerbate substance and conduct-related concerns in the chapter *Conduct Disorders and Substance Abuse in Rural School Settings*. Zajac, Andrews, and Sheidow provide a compelling case for implementing evidence-based treatments for substance use and conduct problems within the school setting as a potential solution for limited access to mental health treatment while providing thoughtful considerations for future program development. Then, Rafaella Sale, Alex Kirk, and Eric Youngstrom discuss the school as the optimal setting for making gains in early detection and intervention for pediatric bipolar disorder in rural communities in the chapter *What Lies Beneath: Pediatric Bipolar Disorder in the Context of the Rural School*. Sale, Kirk, and Youngstrom advocate for a collaborative approach between educators and mental health professionals in early identification of pediatric bipolar disorder as it presents in the classroom to aid early intervention, which further emphasizes the importance of school mental health programs for rural communities. Last, in the chapter *Supporting Students with Autism Spectrum Disorder in Rural Schools*, Cynthia Anderson, Ryan Martin, and Rocky Haynes provide a framework for supporting students with autism, emphasizing avenues for appropriate assessment, intervention, and monitoring of intervention within schools with scarce resources. Anderson, Martin, and Haynes pay

particular attention to evidence-based interventions that are feasible within the school setting, making this chapter especially useful for educators and mental health professionals interested in increasing school supports for students with autism.

Part II concludes with Robin Kowalski, Gary W. Giumetti, and Susan P. Limber discussing the gap in the literature examining bullying and cyberbullying in rural settings to the detriment of our understanding of these experiences for rural adolescents in the chapter *Bullying and Cyberbullying Among Rural Youth*. Pointing to the differences between rural and urban settings, Kowalski, Giumetti, and Limber discuss the implications for prevention and intervention based on what is known about bullying and cyberbullying among both rural and urban adolescents, and provide guidance for future research endeavors in this understudied area.

Part III addresses common barriers to SMH service delivery in rural areas (e.g., stigma and suspicion of mental health services, mental health service provider shortages, building integrated care systems with limited resources) by presenting innovative practice models that have demonstrated and documented success in rural schools. Beginning this section, Scotty Hargrove, Lisa Curtin, and Brittany Kirschner discuss barriers related to the stereotypes of rural settings themselves that have affected policies related to mental health care and advocate for policy that reflects a greater understanding of diversity in rural settings in the chapter *Ruralism and Regionalism: Myths and Misgivings Regarding the Homogeneity of Rural Populations*. Hargrove, Curtin, and Kirschner describe the rationale for policy support for school mental health programs as a viable method for context-specific provision of mental health care common to all rural communities.

The next two chapters examine family-related variables as both assets to overcoming barriers related to rural settings and as barriers themselves. Shannon Holmes, Amanda Witte, and Susan Sheridan consider the unique strengths of rural parents and teachers encompassed in Conjoint Behavioral Consultation as one method for overcoming barriers to mental health treatment in rural communities in the chapter *Conjoint Behavioral Consultation in Rural Schools*. Holmes, Witte, and Sheridan further strengthen their argument for Conjoint Behavioral Consultation as a viable approach for providing acceptable school mental health treatment in rural settings by detailing the results of a randomized controlled trial examining the efficacy of this approach in rural communities. Then, Lisa Curtin, Cameron Massey, and Sue Keefe describe patterns of intergenerational mental health variables in rural communities and how such variables are integral to the understanding of rural students' mental health concerns in their chapter *Intergenerational Patterns of Mental Illness in Rural Settings and Their Relevance for School Mental Health*. By examining the importance of family-related mental health variables to the provision of school mental health services and describing the operation of a school mental health program oriented to these contextual issues, Curtin, Massey, and Keefe provide compelling suggestions for working with both students and their families in rural school mental health programs.

Jeannie Golden, Dorothy Dator, Katherine Gitto, and Christelle Garza conclude this part with the chapter *Contributions of Applied Behavior Analysis to School-Based Mental Health Services*. Golden, Dator, Gitto, and Garza describe the versatile nature and wide applicability of Applied Behavior Analysis (ABA) as a method for increasing widespread access to skill provision at home and in schools for parents, students, and educators in rural schools. Golden, Dator, Gitto, and Garza critically examine the ability of ABA to address many barriers to school mental health care and where ABA may fall short, the authors provide further evidence for the importance of collaboration between parents, educators, and clinicians in overcoming barriers to school-based mental health services.

Part IV focuses on methods for evaluating SMH programs and sustaining successful programs over time. The intended audience for the Handbook is researchers, practitioners, and administrators who would benefit from a comprehensive source of information to further benefit service recipients, trainees, and policy makers. Moreover, the Handbook is essential reading for those who endeavor to develop a rural SMH program. Jackie Belhumeur, Erin Butts, Kurt Michael, Steve Zieglowsky, Dale DeCoteau, Dale Four Bear, Courage Crawford, Roxanne Gourneau, Ernie Bighorn, Kenneth Ryan, and Linda Farmer begin this part with the chapter *Adapting Crisis Intervention Protocols: Rural and Tribal Voices from Montana.* Belhumeur, Butts, Michael, Zieglowsky, DeCoteau, Four Bear, Crawford, Gourneau, Bighorn, Ryan, and Farmer describe efforts to involve rural community agencies and tribal organizations to develop effective crisis intervention protocols in Montana public schools. Moreover, the authors emphasize the importance of youth voice and local champions as central features of effective health promotion and suicide prevention programs. This chapter makes a thoughtful case for facilitating active community engagement in school-based mental health services in rural communities.

The next three chapters examine issues of school mental health program evaluation, implementation, and continued improvement in rural settings. First, Brandon Schultz, Anne Dawson, Clifton Mixon, Craig Spiel, and Steve Evans provide an expert discussion of the challenges associated with rural school mental health program evaluation in the chapter *Evaluating Rural School Mental Health Programs*. With a focus on specific evaluation concerns, Schultz, Dawson, Mixon, Spiel, and Evans detail the benefits of a fundamental change to program evaluation by school mental health professionals. Next, Barbara Sims and Brenda Melcher provide a valuable framework for implementation in the chapter *Active Implementation Frameworks: Their Importance to Implementing and Sustaining Effective Mental Health Programs in Rural Schools*. This handbook benefits from the helpful guide Sims and Melcher provide that is relevant to both educators and clinicians interested in implementing practical and effective school mental health programs in rural settings. Melissa Maras, Paul Flaspohler, Marissa Smith-Millman, and Lindsay Oram conclude this part by discussing the need for innovative frameworks for planning, implementing, and evaluating improvement in effective and efficient rural school mental health programs in the chapter *Planning, Implementing, and Improving Rural School Mental*

Health Programs. Maras, Flaspohler, Smith-Millman, and Oram anchor the entire Handbook by describing the process of improving school mental health programs as essential to program sustainability and provide an excellent and innovative suggestion for building the capacity for effective, practical, and sustainable rural school mental health programs.

We were truly honored and blessed to receive so many exemplary contributions from the entire group of 73 esteemed authors. Editing this volume has certainly expanded the breadth and depth of our knowledge, and we have taken many lessons from these chapters that have helped us improve our own programs. We hope that the *Handbook of Rural School Mental Health* is as informative to your work, regardless of your role in providing or supporting access to mental health in the schools.

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Part I

Development of Rural School Mental Health Initiatives: Rationale, Policies, Ethics, and Competencies

1 The Benefits of School Mental Health

Sharon A. Hoover and Ashley M. Mayworm

In recent decades, student mental health services and supports have increasingly been integrated into education systems across the nation. In many districts, schools and communities have partnered in their efforts to both promote student wellness and social emotional competence and identify and address mental health problems as they arise. These school-community partnerships reflect a growing movement toward "comprehensive school mental health systems" (CSMHSs), or partnerships between school systems and community programs that provide a full array of evidence-based, tiered services (universal mental health promotion, selective prevention, and indicated early intervention). The integration of mental health into education offers the potential to enhance the wellness and reduce the mental illness of children across the United States, particularly in the most vulnerable communities with limited access to quality mental health care, including those in rural settings.

It has been established that there is a high incidence of children and adolescents with unmet mental health needs. According to data from the National Comorbidity Study—Adolescent Supplement (NCS-A), 46.3% of 13–18-year-olds currently or at some point in their life will have a mental health disorder (Merikangas et al., 2010). In younger children (ages 8–15 years), the National Health and Nutrition Examination Survey (NHANES) suggests that approximately 13% of children had a diagnosable mental disorder in the previous year (National Institutes of Health, n.d.). However, of those adolescents with a mental health disorder, approximately only 36% receive mental health treatment (Merikangas et al., 2011), and only 50% of 8–15-year-olds with a diagnosable mental health disorder received treatment in the past year (Grief Green et al., 2013). Other studies estimate that as many as 79% of 6–17-year-olds have unmet mental health needs (The National Survey of American Families; Kataoka, Zhang, & Wells, 2002). Furthermore, school principals indicate that mental health is one of the greatest unmet needs in their students (Iachini, Pitner, Morgan, & Rhodes, 2015).

Rural areas face unique mental health challenges, including more significant impairment among youth and difficulties providing adequate care to those in need. Even after controlling for socioeconomic factors, youth suicide mortality rates are significantly higher in rural areas as compared to urban areas, with this gap becoming larger in recent decades (Singh, Azuine, Siahpush, & Kogan, 2013). Further, access to care is difficult, with 1.9 million children in the United States experiencing mental health

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problems but living in rural areas with little to no mental health care resources. In rural areas, four out of five children who could benefit from mental health services live in a county without a community mental health center (Moore et al., 2005). Although children and families report receiving the majority of mental health care in school settings, rural schools indicate limited capacity to address the mental health needs of their students. In a survey of teachers, administrators, school psychologists, counselors, and social workers working in rural schools within the United States, participants reported that while learning, attention, conduct, and autism-related needs tend to be met in their schools, issues related to family, anxiety, depression, and trauma have higher rates of unmet need. Additionally, services for prevention, promotion, and mentorship were reported as lacking (Lee, Lohmeier, Niileksela, & Oeth, 2009).

In children and adolescents who do access care, rates of attrition are high. Approximately 40–60% of children, adolescents, and families who begin mental health treatment drop out prematurely (Kazdin, 1996; Kazdin, Holland, & Crowley, 1997). Moreover, more than half of families do not return by the fourth session (McKay, Lynn, & Bannon, 2005). Several factors predict treatment dropout, including family stressors, perception of lack of relevancy of treatment to child's needs, and poor therapist–client relationship. Even when these factors are minimized, families must navigate a multitude of obstacles in order to receive mental health services in traditional outpatient and specialty clinic settings including structural barriers (lack of availability of providers, uninsured, transportation difficulties, inconvenient appointment times, long wait lists) and concerns about the mental health system (limited trust of providers, privacy concerns, stigma; Owens et al., 2002; Weist, Lever, Bradshaw, & Sarno Owens, 2014). Many of these barriers are particularly pronounced in rural communities, where structural barriers are more prominent due to scarcity and geographic distance of specialty providers, as well as greater perceived threat to privacy and anonymity. The limitations of our traditional mental health system to adequately reach and serve children and families have led many communities to consider the potential of schools as a venue for providing a full continuum of student mental health supports.

Benefits of SMH

Integration of mental health into the education sector offers tremendous promise for addressing gaps in mental health care, as well as a mechanism for boosting student academic success. In addition to facilitating access to care, providing mental health services and supports directly in the school building offers a host of benefits including greater follow-through with initiated care, ability to see students in their natural environment (school) and generalize skills to that setting, ability to engage key socialization agents (teachers, parents), opportunities for screening and early identification of mental health concerns, and opportunities to offer mental health promotion activities as well as more intensive mental health intervention as needed. Each of these benefits is discussed below, with particular attention to their relevance in rural settings.

Access to Care

Schools offer a natural access point to students who need, but may not otherwise receive, mental health services. Children and adolescents spend a great deal of their time in the school setting (approximately 15,000 h), and in addition to parents, teachers and other school staff are often the first people to identify a potential mental health problem in children (Loades & Mastroyannopoulou, 2010). Indeed, current estimates suggest that over 70% of youths who receive mental health services do so in school and education settings (Rones & Hoagwood, 2000; Teich, Robinson, & Weist, 2008). As Weist (1997) explains, "By placing services in them [schools], we are reaching youth 'where they are,' eliminating many of the barriers that

exist for traditional child mental health services (e.g., as provided in community mental health centers and private offices)" (pp. 319–320). As compared to youth who receive services in community mental health settings, youth who receive services in schools are less likely to have received prior mental health counseling (Weist, Myers, Hastings, Ghuman, & Han, 1999). This is particularly true for students with internalizing issues such as depression and anxiety, and suggests that youth may be identified earlier in schools and/or that schools are reaching youth who may not otherwise receive care. For instance, in a rural high school with suicide attempts double the national average, the vast majority of the 42 students assessed for suicidal or homicidal threat (79%) had never received mental health services prior to the crisis. This on-site school mental health effort resulted in 23 of these students receiving formal mental health intervention support (14 in school, 9 in the community) and 19 being matched to an adult assigned to "check in" to monitor wellness and safety (Michael et al., 2015).

The presence of comprehensive school wellness centers is associated with much greater use of mental health care among students in both urban and rural settings, pointing to the value of placing mental health services on-site in schools (Gue, Wade, & Keller, 2008). Beyond initial access, students are also more likely to follow through with mental health services when they are offered in schools as compared to other community mental health settings, where high no-show rates are the norm (Catron et al., 1998). Although schools offer unmatched access to mental health care for youth, some findings suggest that students are more likely to access services when their schools are located in urban settings than in rural settings, suggesting that some of the other factors impeding care in rural settings (stigma, privacy concerns) may still be prominent in schools (Grief Green et al., 2013). That being said, given the relative lack of community mental health clinics and specialty psychiatric services in rural settings, schools are well positioned to narrow the access gap among rural youth with mental health problems.

Comfort/Stigma

Stigma around mental illness is one of the barriers to children and families accessing and remaining in mental health treatment. Stigma can impact the help-seeking behaviors and openness to mental health treatment of both the parent and the child directly. In a review of the literature on stigma and child mental health disorders, Mukolo, Heflinger, and Wallston (2010) concluded that stigma of children with mental illness may be as "unforgiving" as the public stigma that exists for adults. The general public tends to view mental health problems in children as related to propensity for violence and to support legally mandating that parents of children with mental illness place their children in treatment (Pescosolido, Fettes, Martin, Monahan, & McLeod, 2007). Furthermore, when adults were shown vignettes of children with emotions and behaviors that the adults viewed as dangerous or an indication of mental illness, they were more likely to respond punitively and negatively to the hypothetical situation and child (Pescosolido et al., 2007). Pescosolido et al. (2007) suggest that these attitudes reflect general societal stigma around child mental health problems and judgment of parents of children with mental health disorders. Similarly, children view individuals with mental illness less favorably than other groups (Wahl, 2002). Related to these perceptions of mental illness, adults and children alike may experience fear or embarrassment about help seeking for mental health problems.

Schools may be uniquely suited to addressing stigma as a barrier to treatment, in that they offer a more familiar and less threatening environment in which to seek care. Several studies have documented the positive therapeutic alliance between school-based providers and students and families (Lazicki, Vernberg, Roberts, & Benson, 2008; Nabors, Weist, Reynolds, Tashman, & Jackson, 1999). Students and caregivers also consistently report feelings of comfort and high satisfaction in school mental health services (Nabors and Reynods, 2000). Further, schools offer natural opportunities to provide training and education to teachers and parents on mental health literacy

and help seeking, in order to lower stigma and normalize mental illness and treatment. Despite the potential for reducing stigma and increasing comfort, some students might not feel comfortable seeking mental health care in the school setting. A recent qualitative study by Huggins et al. (2016) found that adolescents in high school often have a negative opinion of seeking mental health counseling at school, due to a fear of being embarrassed or negatively stereotyped. This may be particularly concerning for adolescents who are driven by peer approval and the need to "fit in," thereby suggesting the need for consideration of developmentally tailored strategies to reduce stigma and promote comfort among students seeking school mental health services.

Stigma may be particularly impactful on mental health help seeking in rural settings in part due to the perception of a lack of anonymity in small communities. Although research on stigma related to child mental illness in rural areas is limited, adults in rural areas view mental illness with more negativity than their urban counterparts, resulting in less help-seeking behavior (Rost, Smith, & Taylor, 1993). Polaha, Williams, Heflinger, and Studts (2015) found that in a sample of 347 caregivers of children with psychosocial concerns living in rural areas, higher perceptions of stigma around mental health services for children were related to lower rates of willingness to seek out services. Schools may offer a safe, familiar environment that parents and students already know and attend, possibly buffering the impact of stigma on mental health treatment use.

Early Identification and Intervention

Integrating mental health into schools offers the opportunity to identify and address mental and behavioral health problems early on. This is critical because mental health problems in children are often underidentified (Flett & Hewitt, 2013). In particular, young people with internalizing disorders (e.g., depression, anxiety) are less likely to be identified as having a mental health problem and receive treatment than those with externalizing disorders (e.g., conduct problems, hyperactivity); approximately 18–38% of youth meet the criteria for an anxiety or a mood disorder, but only 17–37% of those youth receive treatment, whereas approximately 15% of youth meet the criteria for a behavior disorder with 45–60% of those youths receiving treatment (Merikangas et al., 2010; Merikangas et al., 2011). A first step in the process of providing appropriate prevention and early intervention services to children is understanding and identifying the mental health needs of the population through systematic, evidence-based measurement. Schools are uniquely suited to early identification, as they have access to a large population of young people. Universal screening in schools, or the voluntary assessment of mental health needs and strengths across the entire student population (Dowdy et al., 2015), allows schools and community partners to identify areas of mental health need in their student population, identify students who may benefit from various prevention and intervention efforts, and monitor changes in these mental health needs over time. These data can be aggregated or disaggregated as needed, to inform resource utilization and programming prioritization (Dowdy, Ritchey, & Kamphaus, 2010); data are also useful measures for evaluating program effectiveness. As Dowdy and her colleagues (Dowdy et al., 2010) note: "By systematically engaging in periodic mental health screening of all children in schools (Hill et al., 2004), school-based mental health professionals can shift their focus away from solely providing indicated services to providing more population-based, ultimately preventive, services" (p. 169). Recent federal and state efforts to support teacher training in mental health have recognized the value of integrating teachers into the process of early identification of mental health problems. Teachers have the advantage of viewing a large sample of same-aged children (as compared to parents, for example), and therefore are well positioned to nominate those students who may be presenting in a manner that falls outside of the typical "curve" of development and behavior.

Early identification of mental and behavioral health problems is related to treatment engagement, as parents are more likely to seek out treatment once a mental health problem has