
Our Community, Our Schools: A Case Study of Program Design for School-Based Mental Health Services

Gordon Capp

Schools face increasing demands to support the mental health needs of students and families; some estimate that 80 percent of students receive mental health services at school. Thus, schools face two daunting challenges: (1) to provide effective mental health support to students and (2) to address how mental health needs affect other students, teachers, and academic priorities. This article presents a case study of collaborative program design and implementation with the intent to improve clinicians' ability to provide mental health services in a school setting, and to expand the role of clinicians to support school staff and others in the school community. Staff from a community mental health clinic collaborated with school personnel (teachers, counselors, and administrators) to design a school-based program that would enhance the provision of mental health services and help to promote a mentally healthy school community. School-based therapists provided direct services regardless of clients' ability to pay or insurance coverage and reported that school personnel were interested in and supportive of ongoing consultation and collaboration regarding the mental health needs of students and families.

KEY WORDS: *mental health services; program design; school-based mental health*

Schools face increasing demands regarding the mental health needs of their students (Adelman & Taylor, 2012; Lean & Colucci, 2010; Weist & Evans, 2005). Approximately 20 percent of youths in schools have a diagnosable mental disorder, and 75 percent of those students do not receive treatment or receive inadequate treatment (Lean & Colucci, 2010). Furthermore, students with mental health challenges typically experience academic deficits and are also less likely to graduate than students with other disabilities (Hurwitz & Weston, 2010). Many advocate school as an appropriate, and important, place to focus on mental health intervention (Graham, Phelps, Maddison, & Fitzgerald, 2011; Lean & Colucci, 2010; Paternite, 2005). This is supported by evidence that mental health and social and emotional outcomes are closely tied to academic success (for example, Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Franklin, Kim, Ryan, Kelly, & Montgomery, 2012). In addition, in a school context, students do not experience mental health symptoms in isolation or without affecting others around them. Other students, teachers, and school administration are regularly affected by the

mental health needs on a school campus (Adelman & Taylor, 2012; Lean & Colucci, 2010).

The delivery of mental health interventions at schools is sometimes described as school mental health or school-based mental health (SBMH). However, there are many different ways that schools or mental health agencies might conceptualize and operationalize services in school settings. Expanded school mental health (ESMH) reflects the need to increase the capacity and breadth of services available for all students, and ESMH interventions are often characterized by mental health promotion and intervention efforts that focus on partnerships between schools and community programs or agencies (for example, Paternite, 2005; Weist, 2005; Weist & Evans, 2005). Furthermore, support is growing for collaborative models that integrate school and mental health personnel to meet the mental health needs of those in school communities (Cappella et al., 2012; Paternite & Johnston, 2005; Weist et al., 2012).

Given the intense need for mental health services, and despite inherent challenges in services provision, school and mental health staff diligently work to provide support and treatment for students with mental

health diagnoses (Adelman & Taylor, 2012; Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). In an effort to improve existing SBMH services and meet complex mental health needs within schools, a pilot program called Our Community, Our Schools (OCOS) was implemented in the 2012–2013 school year in two schools within the service area of a community mental health clinic in Southern California. This article presents a case study in the design and implementation of OCOS to address mental health needs on a school campus. Rather than providing a framework for a sustainable program, it is hoped that this article serves as an example of the possibilities that come from pushing existing constraints around services provision to address common barriers to services, including transportation, insurance, and stigma (Weist, Paternite, Wheatley-Rowe, & Gall, 2009), and the benefit of working within local communities to generate partnerships and solutions.

AGENCY BACKGROUND

This program was developed at a nonprofit community mental health clinic in Southern California. At the time, this agency employed approximately 65 therapists, case managers, and other staff. Funding for mental health services was mostly provided through a county contract using state Medicaid funds. SBMH services consisted of individual therapists being assigned to a particular school site to see clients with qualifying insurance and who met clinical criteria for services. Therapists generally spent one half or one whole day per week at their assigned schools to see clients.

Several concerns regarding the agency's provision of school-based services spurred the desire to make changes and improvements to the existing program. First, the number of referrals from schools was decreasing. Second, clinicians were frustrated with the difficulties involved in building connections and relationships with local schools and building caseloads at those schools. Two problems were especially evident in the agency's model of services provision. Therapists who had only limited time at school sites had difficulty creating relationships with staff and building consistent caseloads. This affected their ability to fill available appointments, and often led to the therapist being recalled from the school to fill their time with clients in other settings to meet billing requirements.

In 2012, an opportunity arose to develop programs that would be supported through private fund-

ing instead of contract funding, allowing substantial freedom in program design and services provision. This unique circumstance, in conjunction with a need to improve our school-based program, led to efforts to reformulate our approach to SBMH services. Several ideas guided our initial discussion, and our program goals were as follows:

- To serve the entire school community
- To be integrated into the school community, rather than being a “guest” on a school campus
- To provide easy access to mental health services for students and their families, including access for those without insurance
- To create a holistic program that would provide support to students, families, and school staff and promote mental health as well as treat mental health problems.

PROGRAM FRAMEWORK

One common approach to providing mental health support in schools is a public health approach, often conceptualizing a pyramid of interventions (Cappella et al., 2012; Domitrovich et al., 2010; Weist, 2005). The agency's plans for interventions were rooted in such a three-tier model of services provision that considers the needs of all students in a school and provides for the intensive mental health services used by a small portion of those students (Adelman & Taylor, 2012; Kutash, Duchnowski, & Lynn, 2006; Sugai & Horner, 2002). The first tier of services in this model is preventive in nature and geared toward all students in a school. The second tier includes specialized programs designed for students with at-risk behaviors. The final tier serves the smallest number of students with high-risk behaviors through intensive and specialized services (Sugai & Horner, 2002). The typical mental health services at our agency included group, family, and individual therapy, categorized as second- and third-tier services. During the pilot program and in following years, therapists assigned to the school site would coordinate with school staff to support implementation of primary prevention activities. Secondary prevention and specialized services would account for most of the therapist's clinical work, and other programmatic resources at our agency were able to support the needs of high-risk students.

The OCOS program plan acknowledged the unique cultural aspects of schools, in general, and specific campuses. Connections and support from

school staff at two schools in a local school district were necessary to ensure that our assumptions and expectations were reasonable. In addition to a pyramid framework of interventions, our beliefs about the importance of understanding and working with the whole school community are reflected in other theoretical frameworks. For example, [Benbenishty and Astor \(2005\)](#) presented a theory about school environments that, in hindsight, helps explain our efforts to integrate into a school environment. Their model echoes an ecological or person-in-environment perspective with the school, rather than the individual, being understood as the center of the ecological influences. Influences from the school's external context include the surrounding culture, neighborhood characteristics, and family characteristics. All of these factors interact with characteristics intrinsic to the school, including teacher attitudes, policies, and social support. Also important to note is that the school itself has an influence, and the school's influence might mediate an external contextual influence (for example, social support in the school might alter the effects of neighborhood crime on interactions within the school). The hope was that OCOS would be able to incorporate and contribute to contextual influence for our school communities.

OCOS PROGRAM DEVELOPMENT

Program Goals

Our initial program structure was divided into two aspects of proposed activities within a school. First, we would provide mental health services regardless of clients' ability to pay, and would see anyone who needed services (for example families, parents, couples, or individuals). Part of this was influenced by frustration from restrictions regarding services provision under our contract requirements, and partly influenced by our goal to support the school community. In addition, one of the barriers presented by our school partners was the difficulty in finding support for students without insurance. We also decided to see clients on a larger spectrum of severity. At the clinic, clients had to meet diagnostic criteria characterized as "medical necessity." One frequent scenario encountered by previous school-based therapists involved referrals or direct requests from students who often had less severe problems but would likely benefit from at least brief treatment, or perhaps group support. The OCOS model would allow flexibility in determining courses of

treatment. In addition, we wanted to increase our ability to prevent problems from escalating.

The second set of program goals centered on collaboration and consultation. Though our desire to integrate our services with a school is supported in the literature ([Adelman & Taylor, 2012](#); [Lean & Colucci, 2010](#)), we also recognized that this would be a process of relationship repairing and building. Past experiences indicated that in those places where therapists were not well connected with school personnel we had more difficulty building and maintaining caseloads. Agency therapists needed to integrate into the school culture and school community as a predictable member. This would allow us to respond to incidents or more general concerns at the school, and would also allow us to target prevention and early intervention efforts in an effective manner. Another aspect of our goal to integrate was to provide support for teachers. Teachers are not primarily mental health workers, but teachers are faced with students with mental health needs every day in their classrooms ([Adelman & Taylor, 2012](#); [Lean & Colucci, 2010](#)). Subsequently, we hoped that we would be able to support teachers through classroom observations, consultations regarding student needs and behaviors, and psychoeducation. This would require a consistent presence on campus to become credible partners at school.

Meetings with Stakeholders

Meetings were arranged with administrative staff in a local school district, at one elementary school and one combined middle/high school. Both of these schools and some of the staff were familiar as our agency provided mental health services at both sites. These meetings were clearly identified as fact-finding conversations as our goal was to present our ideas and gather feedback from school personnel about interest in such a program and their opinions regarding the feasibility of the program. The [Appendix](#) presents the informational flyer created to share with schools and other stakeholders. Of particular importance were the schools' responses to our desire to collaborate and integrate with their school communities. Without their investment in this process, our program would not work. Beyond that, if they did not place equivalent value on the relationship-building aspect of the program, it might indicate that our program design did not match the needs of these schools.

Both schools responded enthusiastically and provided helpful feedback about logistical considerations and nuances related to services provision on a school campus. Administrators and teachers from the middle/high school campus described seeing an increased need for social and emotional support for students, and even noted that teachers are increasingly feeling like parents (personal communication with M. Eeles, assistant principal, Mayfair High School, Bellflower, CA, March 16, 2011). At the elementary school, the principal stated her belief that students need to be socially and emotionally healthy to be successful at school. Both schools also expressed a ready willingness to be pilot sites for the project.

Funding Flexibility

During the time that OCOS was developed, our agency was also working to expand our ability to provide mental health services. Funding from a private foundation was available to supplement programs, including OCOS. This funding allowed two critical aspects of our program to develop. First, it allowed us to remove the stipulation that clients have insurance and allowed therapists to offer mental health services to anyone affiliated with the school community rather than just students and their families. Second, it created the flexibility to have staff dedicated to collaboration, consultation, and outreach activities. These were unbillable activities in our typical business model and, therefore, difficult for therapists to fit into schedules dictated by requirements for caseloads and billable hours. Though consultation with others regarding cases is generally billable, we consulted regularly with people about students who were not currently on a therapist's caseload. Although this particular element of our program may not be replicable, we hope that our experiences might help encourage others to seek opportunities to increase programmatic flexibility to meet client needs in new ways.

Job Structure and Staffing

Several facets of our planned program required that our understanding of an OCOS employee be different than other outpatient therapists. An initial sketch of the OCOS job description represented two categories of responsibilities, both approximating 50 percent of the therapist's workload. The first half was to provide mental health treatment. A clear

need existed for treatment, and our partnership with schools needed to include this service.

It would have been easy to maximize our capacity for treatment and to see as many clients as possible in the course of a week. However, when therapists are secured in a therapy session, they are unavailable for conversations with staff, consultation with teachers, or outreach with students and parents. As an initial solution to this problem, it was decided that the other 50 percent of an OCOS therapist's time would be dedicated to consultation and collaboration. Because of this division, we also had to revamp our job evaluation requirements.

Initial program designs included three full-time therapists and a part-time case manager for the pilot year. One therapist would be assigned to the elementary site. Two therapists would be assigned to the middle/high school site. One therapist would focus entirely on providing therapy, and the other would split her or his time to provide therapy and focus on collaboration with school staff. A case manager would support both of these school sites, as well as some other programs at the agency. During the final budget process, it was decided that only one therapist could be assigned to the middle/high school campus. This information also influenced our choice to focus collaborative efforts on the middle school. During the pilot year, OCOS staff would focus on integration with the middle school staff, though support would be available for high school staff at their request.

School Information

OCOS staff gathered limited demographic and descriptive data on the two schools consulted about the program. The elementary school is located in a suburban area surrounded by residential and retail structures, with an enrollment in 2012 of 850 students. The middle/high school campus is surrounded by mostly residential neighborhoods. Its enrollment in 2012 was approximately 3,400 students, with about 1,200 of those in middle school. We also had information from the California Healthy Kids Survey (WestEd, 2015) specifically about the middle/high school campus, indicating that around 30 percent of their students reported sad and hopeless feelings for a two-week period in the last year. This information demonstrated urgency for providing treatment, but was also troubling given the implication that roughly 1,000 students might need screening and treatment for depression.

IMPLEMENTATION

In the spring of 2012, OCOS was approved by the agency's board of directors for implementation over the 2012–2013 school year. Ensuing activity included work on budgets, job descriptions, and hiring staff. We also used this time to hone our description of the program and to seek other funding and support for the program. After an initial meeting at the high school, OCOS staff met with a site council group consisting of teachers, students and counselors, and the principal to determine appropriate steps for creating a partnership. Short presentations highlighting the OCOS program were shared with both elementary and middle/high school staff and other relevant stakeholders during the first day of the school year during teacher orientation. The following information was highlighted to make the case for the services, acknowledge the work that teachers do for students, and set the stage for a collaborative experience:

- Fifteen percent to 20 percent of children and youths have diagnosable mental health disorders. Seventy-five percent of those students do not receive treatment, or receive inadequate treatment. Eighty percent of students who receive mental health treatment get those services at school (Lean & Colucci, 2010).
- Students with mental health challenges have academic deficits and are less likely to graduate than students with other disabilities (Hurwitz & Weston, 2010).
- Students with behaviors that interrupt classrooms do not just affect themselves, they also affect other students (Lean & Colucci, 2010).
- School staff members feel they are acting more and more like parents (personal communication with M. Eeles, assistant principal, Mayfair High School, Bellflower, CA, March 16, 2011).
- Schools want to make sure that kids are safe emotionally and physically so they can focus on learning (personal communication with S. Holguin, principal, Ernie Pyle Elementary School, Bellflower, CA, March 29, 2011).
- School mental health promotion is linked to increases in academic achievement, improvements in relationships, and positive changes in school climates (Hurwitz & Weston, 2010).

Both therapists received warm welcomes at their respective schools and were eager to begin work

providing therapy and working with teachers, administrators, and parents. Although both school sites had staff working to connect families to services and provide support to students, neither school (or the district) employed school social workers. The elementary school had a part-time school counselor and a case manager. The middle/high school had full-time school counselors and case managers working to connect students and families to services. Referrals for our therapists primarily came from these existing staff within the schools.

Part of the premise for collaboration was not to replace existing services but to supplement them. For example, our therapist at the elementary school was able to partner with the part-time school counselor to facilitate a multi-session parenting group focused on general topics such as communication with children and supporting academic and social development. Another example of this collaboration came from the referral process at the middle/high school campus. As our therapist worked with school staff to streamline the referral process, it was decided that our therapist would primarily target individuals who were experiencing barriers to treatment. These barriers typically included a lack of transportation (to attend therapy sessions), parent work schedules, funding, and inadequate treatment from other sources. Although this seemed limiting at first, and perhaps slowed the initial filling of available therapy appointments, it was a positive lesson in being able to experiment with our methods of referral to meet the needs of the school community.

It was not surprising that we received feedback that our schools were particularly excited about getting help for students who were previously unable to access it. Often, these were students or families who had ongoing needs for treatment and long-term difficulties engaging in therapy. In many of these cases, our OCOS clinicians were able to initiate assessment and treatment with these individuals and their families. Case managers, school counseling staff, and administrators were all involved in the referral of students; and all were willing to help facilitate treatment for students and families.

Two other programmatic hurdles are worth describing. First, a secure and private physical space is needed for ongoing therapy. We were fortunate that our elementary campus had easily accessible space, and the therapist placed at the elementary school enjoyed a large room in which individuals, families, and even small groups could meet comfortably.

At the middle/high school campus, space was a significant challenge. We had exclusive use of an office on two days of the week, and usually for another half day. On a large and busy campus, it was often difficult for the therapist to see clients while respecting academic schedules and the daily variations inherent in schools. This problem also came with an unexpected benefit. One of the middle school counselors graciously shared her office with our OCOS therapist when the therapy office was unavailable, which allowed our therapist to meet students, staff, and parents, and provide consultations about events (crises and typical school problems) that surfaced daily in the middle school office. This particular solution is not a sustainable one, and there was much deliberation about how to move forward given this particular barrier to providing therapy. This particular struggle may serve as a cautionary example of an element of collaboration that cannot merely be negotiated by willing participants.

The second hurdle was less severe, and this was a reflection of the newness of working in schools for both OCOS therapists. Their adjustment to new work schedules (that is, the school schedule) and a new way of conceptualizing their jobs took time. Their supervisor had experience teaching and providing mental health services in schools, and subsequent support included discussion about navigating school environments. Conversations also involved exploring the possibilities of different kinds of work, given our freedom from funding restrictions and the somewhat nebulous task of collaborating with a school.

Initial Feedback

Preliminary feedback was gathered approximately two months after OCOS was implemented. This information was focused on the collaboration and integration of our therapists. At the middle school level, our therapist had connected with 45 staff members (including teachers, counselors, administrators, and security staff). There was a concentrated group of eight teachers that used four to five observations and consultations each. This seemed to support our collaboration as a worthwhile investment. Also at the middle school, our therapist was invited to a pre-expulsion meeting for a student. During the meeting, it was learned that a history of trauma was likely creating difficulties for the student. School staff were supportive of this student seeking treatment, and the student subsequently began treatment

with our therapist. Her mother also requested services to support her own reactions to the same trauma and to support the student.

At the elementary school site, the OCOS therapist connected with all 38 teachers, observed in classrooms, and consulted at length with 13 teachers. Similar to the middle school, several teachers quickly became frequent users of our services. In addition, both therapists were having conversations with parents and teachers with no direct connection to clients in therapy. This was a positive indication as it suggested that our presence on campus was providing opportunities for mental health staff to engage in outreach with community members.

There were other indicators that our focus on collaboration and integration resulted in positive experiences at both school sites. We worked with school staff to provide parenting workshops, and, at both sites, provided staff training regarding mental health needs of students. Our therapists were available for crisis intervention. In one particular case involving an upset student, support was provided to a teacher and to the rest of the class after a startling incident in the classroom. Therapists at both school sites reported frequent conversations with students and parents not on their official caseloads. These conversations sometimes involved basic questions about mental health services, and sometimes resulted in opening cases. Classroom observations and consultations with teachers happened frequently and were generally focused on concerns about particular student behaviors. We found that the therapists were generally spending 10 percent to 20 percent of their workweek in consultation with school staff.

Future Planning

From the beginning, we knew that building relationships and establishing interventions, especially schoolwide interventions, would take time. The first year was largely dedicated to building relationships, creating awareness, and setting up opportunities for future work. As OCOS staff began planning for our second year, several concerns entered into our discussions. One concern that surfaced was that we would be typecast into certain kinds of activities; this seemed especially likely with individual therapy. The number and consistency of referrals indicated the school's need for this service and on some level an effort to ensure that we had enough business to justify the program. Though we did not want to ignore or minimize the need for individual services,

we also wanted to persevere with our program goals of integrating and collaborating with the school in other ways.

We developed plans to build capacity to provide therapy, and to continue work on school community interventions. Our design for the second year included additional staff for therapy hours, for example, MSW interns from a local university. We also hoped that our efforts to engage the whole school community would help alleviate pressure on the top tier of needs by meeting the needs of larger numbers of children through prevention and early intervention activities.

It is possible that OCOS was understood, at least in this first year, as a supplemental influence. We were likely viewed as a valuable resource, but one that was intended to solve a specific problem, that is, mental health issues for students. More work lies ahead of the therapists at our two OCOS sites to integrate with the school and become part of the school context that helps to affect external influences. As the school has to take in external influences, like OCOS, it makes sense that it would take time for our program to evolve from an external influence to an internal component of the school's system.

CONCLUSION

At the end of the first year, reports from the elementary school site indicated that we had consulted with staff regarding approximately 240 students, more than one-quarter of the school's population. In addition, positive reactions to our presence on campus support the importance of our focus on integration and collaboration. While being respectful of existing school structures and culture, we worked to present alternative ways to conceptualize mental health and mental health services for a school. Moving forward, it is hoped that we will continue to establish our program as an integrated resource at these schools, and eventually be able to expand OCOS to other school sites and school districts. At the time of this writing, both therapists were well into their second year at their schools and were still working with various school staff to enhance mental health services on campus.

It is worth repeating that the program described in this article provides an example for what may be possible when certain fiscal and agency constraints are relaxed. This program also reflects grassroots collaborative efforts between a mental health agency and two schools to change the way mental health services are

conceptualized and delivered to local communities. The hope is that lessons learned through efforts to collaboratively design and implement a program might encourage others to seek opportunities within their existing systems to shape or change the experiences of those seeking and providing services. **CS**

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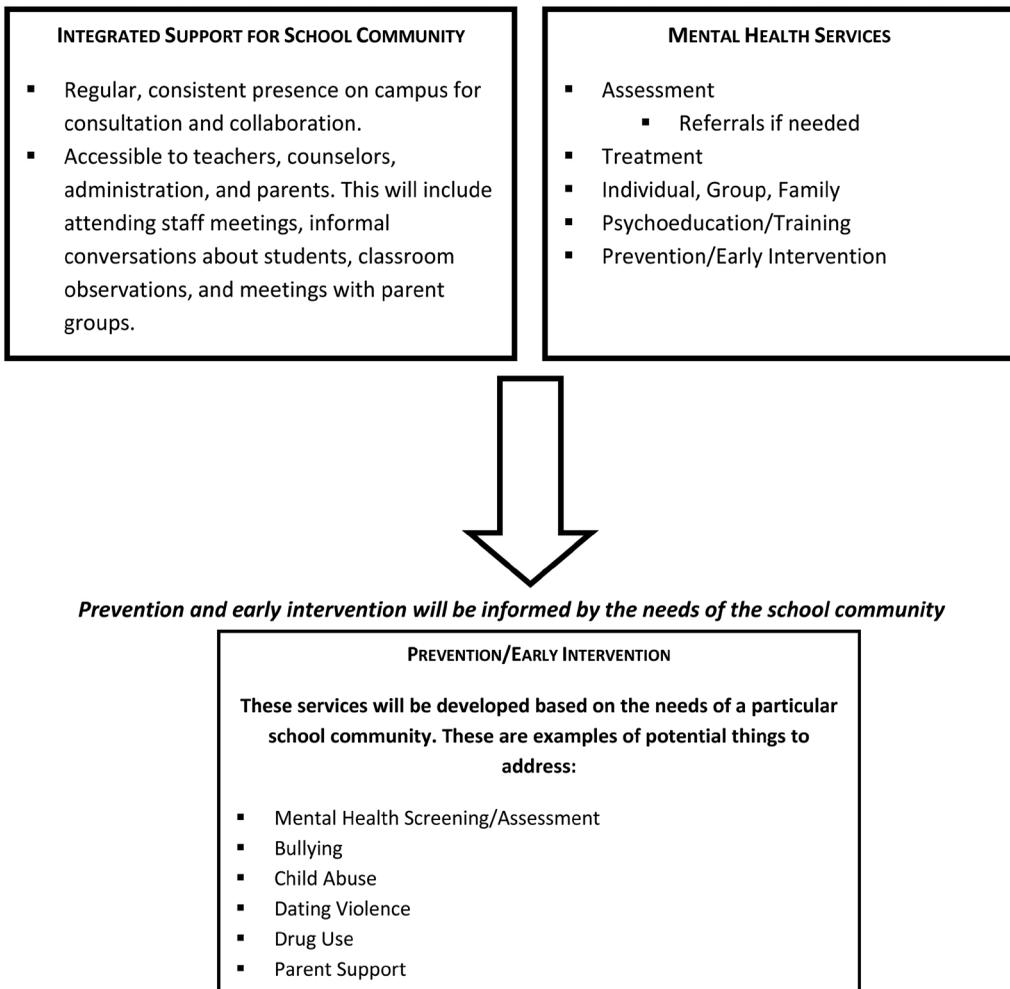
APPENDIX

Our Community, Our Schools

Purpose: Alleviate mental health issues that affect school performance and social development.

To accomplish this, we propose the following:

- Our mental health staff will be on site to be *integrated* with the school community. We want to learn about and join the community so that we can be responsive to concerns and problems, work to prevent future problems, and prevent escalation of existing problems.
- Our staff will treat mental health needs, and our goal is to serve students and families regardless of insurance/financial status.



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