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School Based Mental Health as it relates to Student Outcomes

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SCHOOL-BASED MENTAL HEALTH AS IT RELATES TO STUDENT OUTCOMES

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School systems are not responsible for
meeting every need of their students.
But when the need directly affects
learning the school must meet the challenge
-Carnegie Task Force on Education

Introduction

Throughout the United States education teams regularly meet to review data related to students' academic achievement. They look at assessment scores, attendance rates, discipline referrals, curriculum, and instructional strategies. When the trend lines are not moving in the right direction, education teams review intervention strategies. In many of these teams, members will tell a familiar story about challenges faced by students.

The familiar story involves a student who is not achieving academically, has some behavioral concerns and may have some adverse childhood experiences. The details typically involve an assortment of the following terms: distracted student behavior, non-compliance, unprepared, unmotivated, disrespectful, disruptive, checked-out, withdrawn, explosive or destructive. Their families are often described as broken, disadvantaged, overwhelmed, not trusting, and not invested in the education process. In this context, the story is used partly to explain the dismal data and also to vent the frustration of dedicated educators who feel as though they are expected to be superheroes and fix a broken system without the tools necessary to do so.

The Every Student Succeeds Act (ESSA), which is the successor to No Child Left Behind, provides opportunities for schools to put the appropriate tools in place to foster safe and healthy students. ESSA recognizes the need for supporting

the mental and behavioral health of students and encourages states to adopt policies that specifically address the needs of their students.

Statement of the Problem

What these stories are telling us is that our communities' needs are not being met by existing educational practices and policies. Current policies and practices do not adequately address the mental health needs of children and youth. There are a number of statistics that illustrate the need to improve on the identification and support for mental health among our youth. Over twenty percent of youth have a major mental illness (Adelman & Taylor,2006; Bains, & Diallo, 2015; CDC, 2013;NAMI,2015; Stagman & Cooper, 2010). Approximately one-third of these children receive

treatment and the average lag between onset of symptoms and intervention can be as long as eight to ten years (CDC 2013; NAMI, 2015). Seventy percent of youth in state and local juvenile systems have a mental illness (NAMI, 2015). Between 37 percent and 44 percent of students age 14 or older, who are living with a mental illness, drop-out of school (NAMI, 2015; Wagner , 2005).

Typical measures for student achievement include attendance, discipline, grades, and graduation rates. Students with mental illness on average perform lower than typical peers on all these measures. As stated by Blackorby, Cohorst and Guzman in their 2003 work, students with mental health needs miss up to 22 days of school or approximately up to 12% of a typical

school year. Suspension and expulsion rates are three times higher for youth with mental health needs. Academic grades of primarily D's and F's are received by up to 14% of youth with mental health problems. (Blackorby et al, 2003).

In order to change the story our districts and schools need to adopt policies and practices for addressing the mental health of all learners by incorporating school-based mental health practices and treatment into the educational system. Mental health well-being is a fundamental component to academic achievement and the disparity in achievement for students with mental health problems can best be addressed through coordination of a multi-system approach. This multi-system approach should include awareness, education and treatment for the high-incidence of mental illness among students living in poverty and trauma. It should also incorporate partnerships between universities and schools, among educators, health professionals, social workers and community agencies.

Focus On Mental Health

Many of our students struggle with social and emotional learning deficits, mental health concerns, chronic poverty and trauma. Issues which significantly impact their ability to learn. As Eric Jensen (2009) noted in his book 'Teaching with Poverty in Mind', there is often a relationship between mental health and chronic poverty and exposure to trauma. As Jensen notes in his work, the data on the impact

of poverty on learning shows that 40 percent of children and adolescents are at-risk for poor educational outcomes. The connection between generational poverty and mental health concerns clearly points to a systemic problem that impedes student learning.

We have a philosophy about educating the 'whole child,' yet for various reasons we do not have a comprehensive plan or policies to directly address the mental health barriers to learning. Over the past several years, schools and community agencies have attempted to partner to address the behavioral health needs of learners and their families. What often transpires is fragmented treatment that is not comprehensive enough to affect systemic change. This model operates in silos and does not offer a coherent framework to address the need of our communities (Azzi-Lessing, 2010, Scott, 2011).

As previously stated, many of our youth are challenged by mental health concerns, which impedes their ability to learn. Approximately five students in a typical classroom of twenty-five students (see Figure 1) or eighty in a school of four hundred will be affected by mental health concerns (Adelman & Taylor,2006; Bains, & Diallo, 2015; CDC, 2013;NAMI,2015; Stagman & Cooper, 2010).
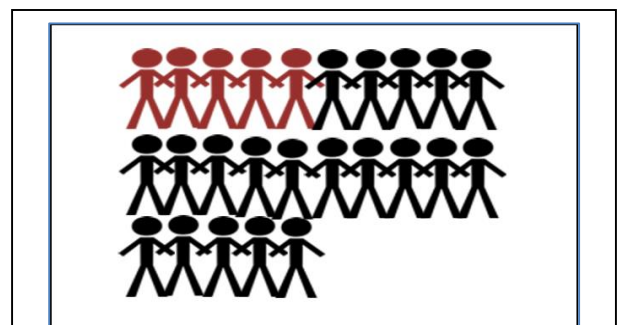

Figure 1: Prevalence of mental health concerns in children. In a typical classroom of 25 students, on average five students struggle with a mental illness.

Source: Adapted from *Prevalence of Mental Illness*. National Alliance for Mental Illness (NAMI) 2015,.

When these concerns are compounded by poverty and its related stressors, we see students with 'acting out' behaviors. Schools often react to these behaviors because they do not have the understanding or the tools necessary to address what is driving the behavior. For example, the norm for schools is to use discipline rather than restorative justice approaches. This reactive approach continues to be a problem because we have not addressed this barrier to learning on an individual basis nor on the global landscape of how this impacts classroom instruction and student learning for all students in our classrooms.

Research illustrates the negative effects that mental health concerns have on educational outcomes. Our communities need a comprehensive policy to address youth mental health and social emotional learning that includes school-based mental health, prevention, and awareness (Puddy, Roberts, Vernberg, Hambrick, 2011; Weist, Youngstrom, Stephan, Lever, Fowler, Taylor, McDaniel, Chappelle, Paggeot, Hoagwood, 2014). Based upon these reports, without such policies and programs in place, we will continue to see school failure and lost opportunities.

In addition to the human impact, there is also the economic burden that must be addressed. A recent report issued in March, 2015 by Margarita Algeria on 'The Disparities in Child and Adolescent Mental Health Services' highlighted the following financial impacts.

Federal spending on children's behavioral services for the 9.6% of children who received Medicaid support accounted for 38% of the spending, while employee insurance plans also saw hospital-based mental health and substance abuse costs increase by 24% and psychiatric drug use by children increase by 10% between 2007 and 2010 (Algeria, 2015). A study released by the U.S. Centers for Disease Control and Prevention in 2013 estimated that the costs to families and the society at large linked children's mental healthcare, such as the treatment, special education, juvenile justice and decreased productivity could be as high as $247 billion a year (CDC, 2013). Based upon these reports, without a change in current policies, total spending on mental health concerns will likely continue to increase.

Contributing Factors

Causes for the mental health concerns include physiological, psychological, and environmental stress. Poverty is a contributing factor that can lead to mental health problems. Poverty is often related to high mobility rates, lower attendance rates, and additional risk factors including emotional and social challenges, chronic stressors, cognitive la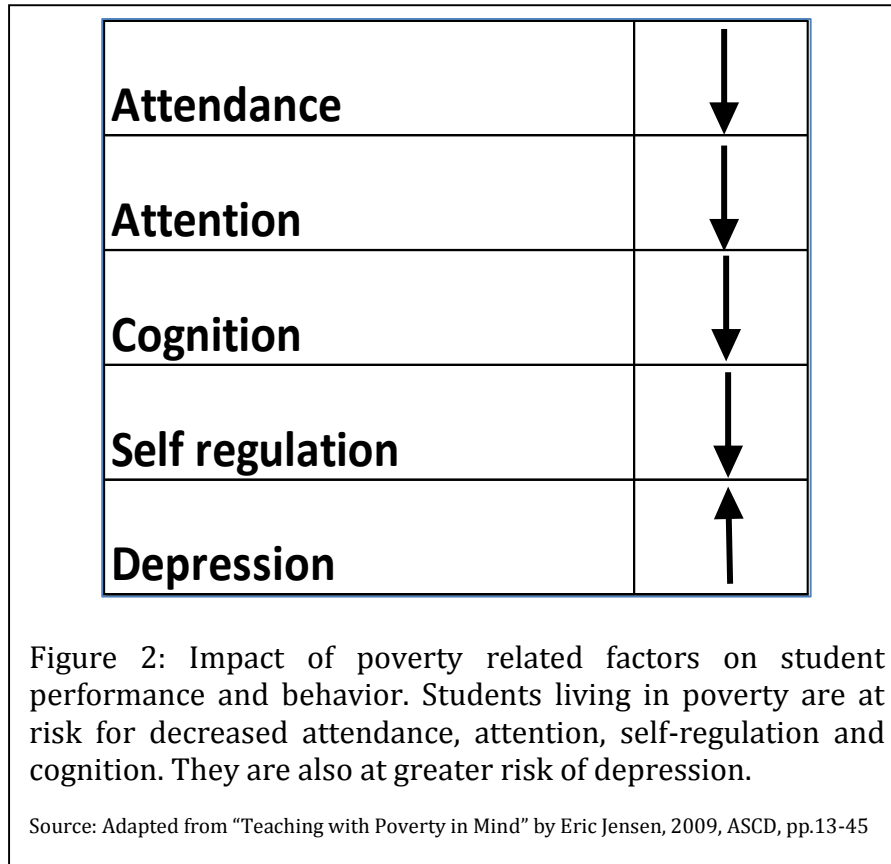gs, as well as health and safety issues (Jensen, 2009). Exposure to traumatic events can also be a contributing factor to mental illness (NAMI, 2015). The relationship and connection among risk factors often leads to a cycle of maladaptive behaviors (Azzi-Lessing 2010). "Poverty is a risk factor for child disability including disability

associated with mental disorders. At the same time, child disability is a risk factor for family poverty" (National Academies of Science, Engineering and Medicine ,2015, p. 7).

Receiving inadequate, or in the worst cases no treatment, for mental health problems is related by a separate set of factors. Many parents do not recognize the symptoms related to mental illness and others are wary of the stigma surrounding an emotional disturbance or mental illness diagnosis and may also have doubts about the effectiveness of treatment (Farmer, 2013). School staff may also lack the training needed to recognize the early signs and symptoms of potential mental health conditions.

Impact on education

The influence of all these contributing factors to mental illness can be seen in the classroom. Students who are experiencing these concerns may have uneven academic growth and struggle with emotional regulation as evidenced by their school performance. Many of these students demonstrate 'acting out' behaviors, impulsivity, and inappropriate emotional responses, which, in turn, yield discipline referrals (Jensen, et al 2009). Referrals typically result in a loss of academic learning time for students, which further impacts the students' overall performance and fails to address the underlying concern.

Attendance	↓
Attention	↓
Cognition	↓
Self regulation	↓
Depression	↑

Figure 2: Impact of poverty related factors on student performance and behavior. Students living in poverty are at risk for decreased attendance, attention, self-regulation and cognition. They are also at greater risk of depression.

Source: Adapted from "Teaching with Poverty in Mind" by Eric Jensen, 2009, ASCD, pp.13-45

Mental Health Professionals

in Schools

Historically, schools have had mental health professionals on staff including a social worker and a school psychologist. The school social worker often help students in need of behavioral or mental health support through group therapy or individual therapy. School psychologists are trained mental health professionals, yet their role is traditionally that of a diagnostician or psychological examiner (Perfect, 2011). The twenty percent of identified students receiving services are often receiving these services without collaboration with

an outside agency or health provider.

The challenge is developing and implementing programs that improve outcomes for children with mental health concerns. Schools represent an obvious entry point for mental health screening and location for service delivery. Benefits for school-based mental health services include the ability for clinicians to see clients in their natural setting, coordination of care across domains, and ease of scheduling and carrying out treatment. An additional benefit to this is a reduction in stigma as treatment becomes part of the natural school day.

As Eric Jensen (2009) has pointed out in his research, living in chronic stress, which may lead to mental illness, adversely affects students' attendance, ability to learn and cope with daily living. Attendance for many students with adverse childhood experiences can be influenced by negative parent attitudes about school, as well as students' lack of connection to their school community. These children are more likely to have increased difficulty with attention and memory due to a hyper-vigilant stress response. The chronic fight-or-flight state also impedes self-regulation skills including impulsivity and the ability to calm oneself along with potentially increasing anxiety and a sense of hopelessness (See Figure 2). Services and supports that address mental health concerns can greatly improve students' ability to achieve academic and social and emotional learning targets.

Policy Background

Currently, there is no specific mandate requiring multi-system mental health services for youth in schools. There have been policies that have moved towards this, yet shifts in the political climate have changed the course for development of a comprehensive policy. The introduction of Medicaid in the 1960's created a mandate for mental health service for children living in poverty. More recently the State Child Health Improvement Program (CHIP) has increased access to include more children. Unfortunately, these programs are optional so some states opt-out. The Individuals with Disabilities Act of 1990 (IDEA) and its earlier predecessor, Education for All Handicapped Children Act of 1975, required all states to provide services to children with disabilities, including emotional disturbance. Most of these services are educationally based and there is not a consistent level of service across districts or states. What we do have is many youth receiving services through special education or juvenile justice system, as they are labeled disabled or delinquent (Lourie & Hernandez, 2003).

In her 1982 report, Jane Knitzer helped establish the concept of a multi-system framework in order to address the needs of youth with mental health concerns and the response to the heightened awareness of the systemic failure. The report found that two-thirds of all children with severe emotional issues were not receiving

appropriate services. Acting on this report Congress approved funds in 1984 for the Child and Adolescent Service System Program (CASSP). CASSP was a national effort with the objective of helping States and communities build comprehensive, community-based systems of care that were both youth and family focused. The goals of CASSP were to create specific child mental health agencies, increase their funding, increase the role of families in the process, and to embed cultural competence within system-of-care interventions. In the 1990's this program was extended to 1999, with the help of funds provided by a congressional act. As managed care became more influential in the United States, mental health policy has become driven by cost reduction (Lourie & Hernandez, 2003).

The CASSP framework has continued to form the foundation for many mental health service delivery programs within communities such as the Comprehensive Community Mental Health Services for Children and Their Families Program, also known as the Children's Mental Health Initiative (CMHI). For example, CMHI has dispersed over 1.6 billion dollars in funds to over 150 communities in all fifty states as of 2011 (Stroul & Friedman, 2011).

Another agency that evolved from the CASSP is the Substance Abuse and Mental Health Services Administration (SAMHSA), which provides funding and services to states to support systems-of-care. The principles of CASSP that these organizations have adopted are child-centered, family focused, community based, multi -system,

culturally competent, least restrictive and least intrusive.

Missouri

School-based mental health has been recognized as a critical component to addressing child mental health (Kutash, Duchnowski, Lynn, 2006; Powers, Edwards, Blackman, Wegmann, 2013; Reddy, Newman, DeThomas, Chun, 2008; Weist, 2005). For example, a 2003 Executive Summary detailing findings of Missouri Focus Group discussions outlined maximizing resources and coordinating services to best promote mental health for children in schools (Mental Health, Schools and Families Working Together, 2003). Additionally, this work toward a shared agenda identified the need to provide pre-service and in-service educators training on recognizing and dealing

with mental health problems among youth (Mental Health, Schools and Families Working Together, 2003).

The Missouri Council of Administrators of Special Education (MO-CASE) has identified a multi-tier system of supports (MTSS) as an effective program to improve outcomes for all students. The MTSS model mirrors the response to intervention model (RtI) and the Positive Behavior Intervention Supports (PBIS), two school-based approaches which are grounded in data collection and on the progress of implementation of evidence-based practices. MTSS uses the review of data to inform decisions about more individualized interventions that are provided in tiers of supports. This model provides access to support for all students not just those that meet the

eligibility criteria of a specific program. Interventions are provided for both academic and behavioral needs (MO CASE, 2015). MO-CASE also recommends that school psychologists practice and treat students in schools, which is a shift from their frequently limited role as psychological examiners and educational diagnosticians (MO-CASE 2015). Seven hundred ninety schools in Missouri currently use the PBIS framework, which aligns with the Multi-tiered System of Supports. This collaboration allows for Interconnected Schools Framework and provides the foundation to scale up and build capacity throughout the state (SW-PBIS MO, 2015).

In the St. Louis area, several school districts are accessing St. Louis County's Children's Services Fund to partner with community

health agencies. In fact, St. Louis County Children's Services Fund allocated $3.10 million on school-based mental health in 2014. Youth In Need, Great Circle, and Lutheran Services are among the agencies involved in providing services to identified youth in the school communities. This is a promising start to build upon as there are continued areas of need within these communities and throughout the state. There are of course, a number of obstacles to this idea. For starters, there is a shortage of qualified therapists who could assist schools in this effort. There also limited funding streams. Additionally, many schools lack a dedicated space for these types of services (SSD PBIS, 2015). In addition, when schools plan for special services it is primarily for

intellectual and developmental disabilities, but not for mental health issues including preventative, episodic, or chronic.

Mental Illness and Schools

Numerous studies have shown that there is a significant need to improve on the identification and support for mental health problems among our youth population (Adelamn & Tyalor, 2006; Alegria et al, 2015, Anakwenze & Zuberi, 2013; Azzi-Lessing, 2010; Gonzalez, 2005; Husky et al, 2011; Weist et al, 2014). With the National Institute for Health reporting that twenty percent of our youth being impacted by mental health concerns and only thirty-three percent of those identified receiving treatment, there is an urgent need to address this public health concern (NIH, 2015).

Additionally, half of adolescents with a mental illness drop out of school, which is the highest drop-out rate among all disabilities (NAMI, 2015). The National Institute for Mental Health reports that seventy-five percent of girls and sixty-five percent of boys who are incarcerated juveniles have at least one diagnosed mental illness. Many of our youth with unmet mental health needs do not receive treatment for a variety of reasons such as the lack of identification, difficulty accessing treatment, and stigmatization of mental illness. For many families, just navigating the complex systems of healthcare, insurance, and treatment is a daunting task that prevents students from receiving the help they desperately need. Schools are the front line in this, as they are

the primary source for mental health interventions.

Researchers have identified screening, collaboration and funding as potential obstacles to effective school-based mental health programs(Adelman & Taylor, 2006; Anakwenze & Zuberi2013,; Husky, Kaplan, McGuire, Flynn, Chrostowski, Olfson, 2011; Puddy et al, 2011, Weist et al 2014). Formal screenings can lead to over-identification of elementary aged children and under-identification of adolescents. The false-positives and false-negative results underscore the need to create age-appropriate valid screening tools (Adelman & Taylor, 2006). Studies suggest that a school-based screening tool detects an increased number of youth-in-need in comparison to the traditional referral systems (Husky et al, 2011).

Collaboration among school and community professionals is identified as a key component to effective school-based mental health programs (Weist et al 2014; Adelman & Taylor, 2006; Puddy et al, 2011). Puddy suggests that high-quality service coordination has the potential to improve adaptive behavior of students with significant serious emotional disturbance (Puddy et al, 2011). The positive outcomes to beneficial service and supports are illustrated in Figure 3, which shows improved attendance, increased mental health awareness, improved emotional regulation, decreased mental illness concerns, reduction in school drop-out rates and decreased out-of-school suspensions (Jensen, 2009).

Attendance	↑
Mental health awareness	↑
Emotional regulation	↕
Mental health concerns	↕
Drop-out rate	↓
Out-of-school suspension	↕

Figure 3: Impact of school- based mental health on students. The table above illustrates the positive benefits of school based mental health interventions.

Source: Adapted from Teaching with Poverty in Mind: What being Poor Does to Kids' Brains and What Schools Can Do About It by Eric Jensen, 2009, Alexandria, VA: ASCD.

Studies on the impact of school-based mental health suggest that these programs can improve outcomes for at-risk students. A review of 154 published studies correlating behavioral health promotion and interventions with student outcomes identified 28 empirical studies based on the following criteria: published in a peer-reviewed journal, experimental or quasi-experimental design, more than 100 participants, an evaluation report on a mental health prevention or promotion program, and a change measured in at least one academic area. The twenty - eight studies showed improved

academic outcomes for standardized test scores, school grades, grade point average, and teacher-rated academic performance. Other related improvements include on-task behavior, time management, goal setting, problem-solving skills, decrease absenteeism, and decreased aggression. Additional findings of note are increased academic motivation, self-efficacy, and commitment to school (The Impact of School-Connected Beahvioral and Emotional Health Interventions on Student Academic Performance, 2014).

One of the benefits identified in one study has been an increase in mental health literacy and an increase in academic achievement and behavioral functioning (Montanez, Berger-Jenkins, Rodriguez, McCord, 2015). Another study that examined outcomes reported increase in student attendance and decrease in out-of-school suspension (Kang-Yi, Madell, Hadley, 2013). Interestingly, the study suggested that the reduction of out-of-school suspensions could be attributed to a school-wide policy that encouraged students staying in school. Evaluations of existing school-based mental health programs are promising and support continued research and education of school administrators, faculty, staff and students and their families.

Model Programs

Some schools and community agencies are partnering to address the gap between those who need services and those who receive them. They partner to

implement multi-tiered supports that include screenings and interventions to target preventative programs as well as ongoing treatment for those with more intensive needs. For example, implementing systems to increase protective factors for all students, screen for wellness, and provide individualized support for identified students is a model approach that many states are now adopting (PBIS ISF, 2015).

There are a few established models to consider when looking at evidence-based frameworks. UCLA has a Youth and Mental Health Initiative that provides information on embedding mental health into learning supports. The state of Minnesota has shown evidence of positive student outcomes with the model it has adopted. The states of Illinois, Maryland, Montana, New York, Pennsylvania, and South Carolina have also piloted a program based upon an Interconnected Systems Framework (ISF), which coordinates the tiered-interventions of PBIS with School Mental Health. Additional resources to consider include the National Registry of Effective Programs and Practices (NREPP) and the Substance Abuse and Mental Health Services Administration.

Connecting with Care

In partnership with the Robert Wood Johnson Foundation, area mental health agencies, Boston Children's Hospital, Blue Cross and Blue Shield of Massachusetts, the Dorchester and Roxbury public schools and the Alliance for

Inclusion and Prevention developed and implemented Connecting with Care, a project to support the mental health needs of children in Dorchester and Roxbury schools. Before establishing Connecting with Care, social workers at an area middle school reported that they were only able to arrange treatment for one-fifth of the identified children in need of services, thereby demonstrating a need to change existing models. Results of the Connecting with Care implementation include a financial model for covering treatment costs, a school-based model for trauma therapy, and improved social-emotional results for program participants. Connecting with Care offers a model framework that offers economic, systemic, and community guidelines for other school-based

mental health initiatives (Connecting with Care, 2012).

Potential Obstacles

There are no simple solutions to these complex problems and it is easy to get distracted by the details. The stigma of mental illness prevents many from taking a realistic look at the fallout from not addressing these concerns, which ultimately impact everybody. Additionally, there are many who believe that school is in the business of education and school-based mental health programs does not fit with their traditional view of what school looks like. Some may argue that school-based mental health will be undermining the rights of parents, but a review of all programs indicates that family involvement is a critical component for successful

outcomes. It will take a public awareness campaign to overcome these obstacles.

Any policy decisions that are made and implemented will ultimately come down to funding. Building capacity of strong and effective school-based mental health will require investing in human capital. It is important for policymakers to also consider the cost of not addressing the impact of mental health concerns on student learning. These costs are well documented in generational poverty, child abuse, MSIP data, incarceration rates and in the stories at the team meeting. A number of studies have attempted to quantify the financial impact. For example, annual costs directly linked to child abuse and neglect was estimated to be in the order of

$103.8 billion in 2007 (Wang & Holton, 2007).

Key Stakeholders

Providing school-based mental health services is a key recommendation of many researchers studying mental health and poverty (Adelman, 2006; Anakwenze & Zuberi 2013; Barrett, Eber, Weist, 2013; Atkins,Graczyk , Frazier, Abdul-Adill 2003; Jensen, 2009; Kataoka, Rowan, Hoagwood, 2012). Research reports that systemic failure of current practice results in too many youth being incarcerated or locked in a cycle of poverty and mental illness. The formulation and implementation of school-based mental-health policy requires a coordinated effort among a diverse group of community members in order for policy to

become practice. Anakwenze and Zuberi's report on "Mental Health and Poverty in the Inner City" from the *Journal of Health & Social Work* (2013) suggests a community of practice involving social workers, parents, teachers, police officers, coaches, pastors and mental health professionals. For this to happen in Missouri, additional collaborative members would include the Missouri Department of Elementary and Secondary Education, The Missouri Department of Health, and the Missouri Department of Justice.

Summary

Through the examination of research and literature associated with mental health needs of youth and school-based mental health programs it is clear that as a society we need to change our current model of identification and treatment. Misunderstanding the manifestation of mental illness and not providing accessible pathways to treatment are greatly impacting our youth and their families. For many, this lack of action maintains their status of poverty and for others it ensures missed opportunities. Screening, coordinating care, providing services for students, educating school communities about mental health, and guiding families can support prevention and treatment of mental health.

The treatment of mental illness can be costly, but the related cost of not addressing this public health concern is a potentially a much greater financial burden. The literature has shown that there is a direct impact of mental illness on student achievement and outcomes.

Educating our communities about mental illness can help improve understanding, identification, and reduce the stigma associated with it. By aligning systems in an interconnected framework the expense to communities can be reduced and outcomes for youth improved.

There has been a significant amount of data on the prevalence of mental illness and the connections to cycles of poverty,. The data on specific, comprehensive school-based mental health programs has started to be reported as the programs have become more established and expand. The data from current implementations should be considered as it becomes available. This literature information will help guide recommendations on youth mental

health policy changes when revising policies for the State of Missouri Department of Education and the State of Missouri Department of Health.

Recommendations

In December 2015, President Obama signed into law the Every Student Succeeds Act (ESSA), which is the successor to No Child Left Behind. Included in this new education law are provisions that specifically address the social and emotional learning of students with recommendations for activities to support safe and healthy students by providing mentoring and school counseling to all students and implementation of school-wide positive behavioral interventions and supports. Also included are allowances for specialized

instructional support personnel in supporting the mental and behavioral health of students. Missouri now has the opportunity through ESSA funding, which has yet to be determined, to improve educational outcomes for all students by implementing multi-system school-based mental health services in communities-in-need through the social and emotional learning provisions within ESSA.

It is recommended for the state of Missouri to develop social emotional learning standards. Missouri should also mandate school districts to develop policy addressing the mental health needs of the communities they serve. School districts should be mandated to develop action plans to specifically address mental health needs resulting from mental illness,

toxic stress, and trauma. Plans should incorporate collaboration between schools districts and community based agencies.

Youth mental health is multi-faceted and requires a multi-system approach that utilizes CASSP's guiding principles of being child-centered, family focused, community-based, integrated, culturally competent, and least restrictive. The continuing advances in science have increased our understanding of, not only the pathology and treatment options for specific mental illness, but also our understanding of how poverty and trauma affect child development. This multi-system approach requires coordination of resources and an understanding of the inherent cultural complexities

Schools are a vital component in the solution to improve mental health of youth. By coordinating multiple systems of care more students will have access to mental health preventions and more prescriptive treatment if needed. A crucial component will be to incorporate trauma-informed education and mental health awareness for pre-service teachers and all school staff who have contact with students. Community experts, such as pediatric psychiatrists and psychologists, social workers, and behavior consultants can provide training on the effects of trauma and mental health challenges faced by students. Additionally, they can help train teachers on how to engage students who have adverse childhood experiences.

When educators and community agencies work together using universal screeners for social and emotional competencies, problem-solving frameworks, and wraparound services in data-driven decision making there is an increased potential to prevent mental illness while promoting school climate and academic achievement. The Every Child Succeeds Act bolsters expanding the opportunities for school-based mental health systems and, thereby, reduce many of the barriers to prevention and support.

Glossary of terms

Mental Health

Mental health generally refers to the emotional well-being of individuals. It is defined as how a person thinks, feels, and acts in life. This incorporates how an individual manages daily stress, interacts with others and their ability to make decisions. The World Health Organization defines it as "a state of well-being in which the individual realizes his or her abilities, can cope with normal stressors of life, can work productively and fruitfully, and is able to make a contribution to his or her community." (WHO, 2015) The Center for Disease Control identifies emotional well-being, psychological well-being and social well-being as three indicators in assessing mental health. (CDC, 2015)

Mental Illness

The term mental illness is used for more significant mental health problems. Mental illness impacts an individual's behavior, ability to think, and mood regulation. The most common mental health disorders among children in the Unites States are ADHD, mood disorders, depression, conduct disorders, and anxiety.

Protective Factors

Protective factors are those characteristics that lower the likelihood of negative outcomes. Protective factors can offset risk factors and can be internal and/or external. The domains that impact these conditions for children are individual, school, and community or cultural factors. Some of these factors can be addressed and improved such as low birth weight

babies, and other factors could change over time such as increasing the supply of safe housing in low-income neighborhoods.

Trauma

Trauma refers to an emotionally painful and/or distressing experience. The American Psychological Association explains potential reactions to trauma may include uneven emotions, difficult relationships as well as physical symptoms. Chronic exposure to trauma is often described as toxic stress. (APA, 2015)

Trauma–informed

This term refers to a professional practice of being trained on how trauma may manifest in an individual's behavior and also best practices to utilize in order to support an individual's growth while preventing re-traumatization. Staff

in schools, for example, can receive professional development on trauma-informed practice.

Post -Traumatic Stress Disorder

Events that are deeply traumatic may result in post -traumatic stress disorder (PTSD), which is extreme anxiety that is disruptive to daily functioning. Individuals with PTSD relive the events via memories, flashbacks and or nightmares. (APA, 2015) The Center for Disease Control reports that panic attacks, depression and suicidal thoughts and feelings are potential results of PTSD. A study of potential risk factors for PTSD in children indicates that disordered thinking, blaming others and distracted behavior are strong indicators of PTSD. (Trickey, 2012)

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