UNIT 1

ADDRESSING CHILD AND ADOLESCENT MENTAL HEALTH DISORDERS IN SCHOOLS

CHAPTER 1

Child and Adolescent Mental Health

LEARNING OBJECTIVES

- Gain an understanding of the current status of child and adolescent mental health.
- Describe current stress-related events that may impact a child's mental health.
- Discuss the need for school-based mental health services.
- Discuss the role of school psychologists in the provision of mental health services.
- Compare the use of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) in diagnosing mental health disorders in medical/clinical settings and the Individuals with Disabilities Education Improvement Act (IDEA) in identifying disability categories in schools.

INTRODUCTION

Mental Health in Children and Adolescents

Social–emotional development provides a child with the skills needed to interact socially with others and to express their feelings in appropriate ways. Children who are mentally healthy have effective coping skills, view themselves positively, interact appropriately in social situations, and are able to regulate their emotions. However, some children struggle in managing their emotions and behaviors and may become overwhelmed in social situations. They may begin to exhibit behavioral outbursts, or "meltdowns," because they cannot manage their emotions and begin to socially isolate themselves because it is too overwhelming to be around others. In the United States, concern about the mental health status of infants, children, and adolescents has been growing for over 20 years and was even considered a public health crisis two decades ago (U.S. Department of Health and Human Services, 2000). Specific concerns included inaccurate diagnoses, limited availability of research-based treatments and services, limited access to available services, and unidentified/untreated mental health problems in youth. In response to the need for a call to action, the U.S. Surgeon General held a conference in 2000 titled "Children's Mental Health: Developing a National Action Agenda" (U.S. Department of Health and Human Services, 2000). Although that conference took place over 20 years ago, the same concerns about children's mental health persist today.

According to the American Psychological Association (n.d.), it is estimated that approximately 15 million children and adolescents have diagnosable mental health disorders. Although this number is alarming, it is equally, if not more concerning that only 7% of children who are in need of psychological services actually receive therapeutic services from a mental health provider. Scholars have examined the impact of adverse childhood experiences (ACEs) on a child's mental and physical health. This type of experience is one that is stressful and potentially traumatic and includes events such as abuse or living in environments that may be emotionally or physically harmful (Boullier & Blair, 2018). It is estimated that almost 35 million children in the United States have experienced at least one ACE (Child and Adolescent Health Measurement Initiative, 2013). Children in our country today face several psychosocial challenges that can perhaps be viewed as ACEs that affect their lives on a daily basis. These stress-related challenges include poverty, racial stress, school violence, and social media and cyberbullying.

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Poverty

The Children's Defense Fund *State of America's Children 2021* report indicated that children in the United States are the "poorest age group in America, with children of color and young children suffering the highest poverty rates" (2021, p. 10). The report found that one in seven children, or 10.5 million children, live in poverty. The findings of the report also indicated that approximately 71% of children living in poverty were children of color and almost one in six children under the age of 6 were poor, with approximately half of the children living in extreme poverty (Children's Defense Fund, 2021).

Scholars have reported that children living in poverty experience difficulties in self-regulation (regulating one's emotions and behaviors), executive functioning (cognitive skills such as working memory and planning), impulsivity, inattention, poor peer relationships, and defiance (American Academy of Pediatrics [AAP], 2016). These types of problems render a child vulnerable to the onset of mental health disorders such as attention deficit hyperactivity disorder (ADHD). The AAP (2016) reports that stress associated with poverty, such as inadequate food, energy, housing, and transportation, can influence parenting. Poverty is also associated with poor developmental and psychosocial outcomes (AAP, 2016).

Racial Stress

Scholars have examined the impact of racism on the social–emotional well-being of minority youth. Evidence in the literature indicates that continued racial discrimination against Black adolescents results in increased symptoms of anxiety, depression, and trauma (Priest et al., 2013). Graham and colleagues (2017) have noted that boys of color may experience at least five ACEs prior to their 18th birthday. Other scholars have found that, on average, Black adolescents experience race-related acts five times per day (English et al., 2020). Examples of race-related acts included being teased because of one's race or being told an offensive joke. Community violence against youth of color has been found to be associated with symptoms of posttraumatic stress (Deane et al., 2020). The social–emotional well-being of youth of color can be negatively influenced by community violence (Lanier et al., 2017), and some scholars contend that the impact of this violence may be intensified by racial stress (Saleem et al., 2020). Over time, race-related acts can have a cumulative effect on a child or adolescent that makes them sensitive to situations in which a threat might be experienced (National Child Traumatic Stress Network [NCTSN], Justice Consortium, Schools Committee, and Culture Consortium, 2017). Racial stress may be exhibited as anxiety, depression, and hypervigilance as well as maladaptive behaviors such as aggression (NCTSN, Justice Consortium, Schools Committee, and Culture Consortium, 2017). According to some scholars, race-related events can be perceived as chronic violence that can make a young child or adolescent of color vulnerable emotionally and at risk for posttraumatic stress disorder (PTSD; Tynes et al., 2019). It is important to keep in mind that media coverage of high-profile cases involving violent acts against an ethnic group may be traumatic triggers for a child (Proctor et al., 2020).

School Violence

School violence, unfortunately, is not a new occurrence. In fact, scholars consider it a public health concern (Janosz et al., 2008). The Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey (2019) reports that one in five high school students acknowledges being bullied at school, and about 8% of high school students have been in a fight at school. A study conducted by Flannery et al. (2004) examined exposure of violence to children in grades 3 through 12. Approximately 56% of children had witnessed another child being beaten up, and 87% watched someone else being slapped or hit (Flannery et al., 2004). The study also revealed that about 44% of students had been threatened when they were at school. The authors found that students with exposure to

high levels of violence at school tended to experience more clinical levels of trauma than students exposed to low levels of violence at school (Flannery et al., 2004). Other scholars have found that school violence victimization was positively linked to depressive symptoms (Estévez et al., 2005) and observing violence at school was a better predictor of subsequent externalizing behaviors than actual victimization (Janosz et al., 2008). Based on the results of the CDC's Youth Risk Behavior Survey (2019), more than 7% of high school students surveyed indicated that they had been threatened or harmed with a weapon at school and approximately 9% of students had not attended school because they felt that they would not be safe while at school. Mental health outcomes of youth exposed to mass shootings include depression, anxiety, traumatic stress, suicide, and substance abuse (Cimolai et al., 2021). One concerning line of research proposes that the internet could provide a support group for male shooters if they decide to shoot peers at their school (Markward et al., 2001).

Social Media and Cyberbullying

Although social media may serve as a way for people to connect and maintain friendships, its use as a tool to cyberbully others can have a concerning impact on the social–emotional and behavioral well-being of youths. For example, Richards and colleagues (2015) reviewed studies to examine the impact of cyberbullying on the health of children and adolescents. The findings revealed the greatest impact was on their mental health. Specifically, the findings indicated an association between social media use and self-esteem and body image. The authors emphasize that cause and effect is difficult to determine and suggest that more research is needed. Other studies have found that cyberbullying was associated with an increase in depression. Some scholars have conducted longitudinal studies to examine the relationship between cyberbullying and symptoms of depression and anxiety. Rose and Tynes (2015) followed a sample of youth between grades 6 and 12. The study was done over a 3-year period. The results of the study revealed a reciprocal relationship between cyber-victimization and depression and cyber-victimization and anxiety (Rose & Tynes, 2015). Overall, these findings revealed that cyberbullying may have adverse impacts on the mental well-being of children and adolescents.

Prevalence

As noted earlier, concern has been expressed by professionals about the number of youth with mental health problems. The CDC (n.d.-a) reports data from the National Survey of Student Health on the prevalence of mental health disorders. According to the CDC (n.d.-b), approximately 13% to 20% (one out of five) have a mental health condition. Among externalizing behaviors, ADHD occurred most frequently, whereas anxiety disorders occurred more often than other internalizing disorders.

Externalizing Disorders: Attention Deficit Hyperactivity Disorder and Behavioral Problems

ADHD occurs more frequently than other disorders. Among children between the ages of two and 17, approximately 9.4%, or 6.1 million, are diagnosed with ADHD (CDC, n.d.-a). With regard to emotional–behavioral types of referrals, most school psychologists are likely to get more referrals regarding issues related to ADHD than any other disorder. Among children between three and 17, disruptive behaviors are diagnosed in about 7.4% of children in this age range, which is about 4.5 million children (CDC, n.d.-a). It should be noted that boys are more likely to be diagnosed with ADHD than are girls (CDC, n.d.-b). In addition, behavior problems are reportedly more common in children between the ages of six and 11 compared to either younger or older children (CDC, n.d.-a).

Internalizing Disorders: Anxiety and Depression

Among internalizing disorders, anxiety disorders occur most frequently in the general population. Based on the data reported by the CDC (n.d.-a), anxiety disorders occur in 7.1% of children between the ages of three and seventeen, or 4.4 million. It occurs more frequently than depression, which is diagnosed in 3.2% of children and adolescents between the ages of three and 17, or 1.9 million children. It should be noted that anxiety and depression become more common with increased age.

Comorbidity

When disorders coexist with each other, this is referred to as *comorbidity,* which is associated with worse outcomes. According to the CDC (n.d.-a), about three in four children (73.8%) with depression between the ages of three and 17 will most likely be diagnosed with anxiety. Also, about one in two children (47.2%) with depression between the ages of three and 17 will be diagnosed with a disruptive behavior disorder. Among children ages three and 17 who are diagnosed with anxiety, more than one in three (37.9%) will also have behavior problems and about one in three (32.3%) will also be diagnosed with depression. With regard to comorbidity among children ages three to 17 with behavior problems, more than one in three (36.6%) will also be diagnosed with an anxiety disorder and approximately one in five (20.3%) will also be diagnosed with depression.

Risk Factors and Protective Factors

Vulnerability to the effects of a mental health disorder is influenced by the presence of risk and protective factors. It is helpful for the school psychologist to have a thorough developmental history and background information on the student to determine whether there are factors that make the child more at risk to the influence of mental health problems or whether there are factors in the background that protect them. According to a report by the U.S. Surgeon General (U.S. Public Health Service et al., 2009), risk factors are linked with a higher chance of developing some negative outcome. For example, risk factors may be biological, resulting from genetics, or familial, such as having a family member with a mental illness. Common risk factors for developing mental health problems include low self-esteem, negative family home environment, stressful events, peer rejection, etc. (U.S. Public Health Service et al., 2009). On the other hand, there are factors known as *protective factors that* help protect the child from the adverse effects of mental illness. Examples of protective factors include having good coping skills, high self-esteem, supportive relationships, and so on (U.S. Public Health Service et al., 2009).

Common risk factors for developing mental health problems include low self-esteem, a negative home environment, stressful events, and peer rejection.

ADDRESSING CHILD AND ADOLESCENT MENTAL HEALTH IN THE SCHOOLS: THE ROLE OF SCHOOL PSYCHOLOGISTS

The Need to Address Child and Adolescent Mental Health in the Schools

In 2004, the Committee on School Health of the American Pediatrics Association published a policy statement on the need for school-based mental health services. The statement noted that, at that time, more than 20% of youth experienced mental health problems. The statement acknowledged the responsibility of the healthcare profession to inform interdisciplinary professionals who work with children and adolescents about the adverse impact that mental health problems may have on children and the need for school-based mental health services. According to the policy, the need for mental health services is evident in the rising number of children struggling with mental health conditions who are seen by pediatricians. In a 20-year span, the percentage of children with psychiatric problems seen in pediatric clinics increased from 7% to 19% (Kelleher et al., 2000, as cited in American Pediatric Association Committee on School Health, 2004). School violence, bullying, and suicides among youth were commonly reported events at that time. Concern was expressed regarding the outcomes of untreated mental health disorders among the young such as increased school dropout rates, juvenile incarceration rates, and family dysfunction. With regard to the types of mental health disorders experienced by youths, it was reported that 13% experienced anxiety, 6.2% had a mood disorder, 10.3% had disruptive behaviors, and 2% experienced substance use (American Pediatric Association Committee on School Health, 2004). The policy also noted barriers that are associated with the provision of mental health services in settings outside the school. These

barriers included financial constraints for services not covered by insurance, transportation issues in getting to facilities, and the stigma associated with mental health problems. Barriers such as these can lead to premature termination of therapeutic services. On the other hand, benefits of school-based mental health programs noted in the policy included identifying mental health problems early, which can lead to children and adolescents obtaining therapeutic services. It is interesting to note that the policy statement strongly advocated for collaboration between school mental health providers and the pediatric community and endorsed the use of a system of service support within schools.

Others have also recognized the need for school-based mental health services to address the emotional and behavioral needs in children and adolescents. Davis and colleagues (2006) point out that much attention has been given to documenting prevalence rates of mental health problems in this population, yet in the literature, less attention has been given to provision of school-based mental health services. Davis et al. also note that the problem of untreated mental health problems in youth had, however, been acknowledged at the federal level by the President's New Freedom Commission on Mental Health (2003), which acknowledged that services could be provided in schools to address the mental health needs of youth. Perfect and Morris (2011) note prevalence rates indicate that as many as 20% of youth experience emotional and behavioral problems, including anxiety, obsessive-compulsive disorder, and disruptive behaviors. The authors contend that untreated mental health conditions can lead to school-related problems such as absenteeism, discipline problems, poor grades, grade retention, and juvenile delinquency (Perfect & Morris, 2011). Perfect and Morris (2011) emphasize the need for the provision of school-based mental health services and encourage support for school psychologists as providers of mental health services in schools. Similarly, the National Association of School Psychologists (NASP; 2015) points out the connection between emotional and behavioral wellness and positive gains in achievement and graduation rates, safe school environments, reduced disciplinary actions, and prevention of risk-taking behaviors. In addition, these factors are important to the future lives of students in regard to interpersonal relationships, higher salaries, higher employment stability, and decreased likelihood of being involved in criminal acts (NASP, 2015).

Although these studies support the provision of school-based mental health services, one must also examine the results of studies investigating the effectiveness of such services. Salerno (2016) reviewed research studies investigating mental health awareness interventions that were targeted to improve emotional and behavioral outcomes in K-12 students in the United States. The findings of the study revealed that there was improvement in knowledge about mental health in all studies and most studies revealed improvement in attitudes toward mental health and help-seeking behaviors. The authors concluded improvement existed in regard to mental health, but more research is needed because there were methodological problems in some of the research studies reviewed. O'Connor et al. (2018) also conducted a systematic review of studies that investigated the effectiveness of school-based mental health services. Their analysis revealed three themes of effectiveness related to school-based mental health interventions that include help-seeking and coping, social–emotional well-being, and psychoeducational effectiveness. Overall, the authors concluded that the findings were promising, but more robust research is needed.

National Association of School Psychologists Practice Model and School Psychologists as Mental Health Providers

School psychologists are in a unique position to advocate for provision of mental health services in the school and to deliver school-based mental health services. The role of school psychologists as mental health providers is endorsed by NASP (2020) as evident in its Model for Comprehensive and Integrative School Psychological Services, which is often referred to as the *NASP Practice Model* (NASP, 2021).

The NASP endorses the role of school psychologists as mental health providers in schools.

The model (NASP, 2020) consists of 10 domains: Domain 1: Data-Based Decision-Making; Domain 2: Consultation and Collaboration; Domain 3: Academic Interventions and Instructional

Supports; Domain 4: Mental and Behavioral Health Services and Interventions; Domain 5: School-Wide Practices to Promote Learning; Domain 6: Services to Promote Safe and Supportive Schools; Domain 7: Family, School, and Community Collaboration; Domain 8: Equitable Practices for Diverse Student Populations; Domain 9: Research and Evidence-Based Practices; and Domain 10: Legal, Ethical, and Professional Practice.

Domain 4 of the NASP Practice Model, Mental and Behavioral Health Services and Interventions (NASP, 2020), acknowledges the unique training preparation of school psychologists, their knowledge of factors that influence a child's mental health and behavior, and their understanding of supports needed. NASP encourages school psychologists in their role as mental health providers in the school and in their collaborative work with other school professionals to evaluate student need. NASP states:

> *School psychologists understand the biological, cultural, developmental, and social influences on mental and behavioral health; behavioral and emotional impacts on learning; and evidence-based strategies to promote social-emotional functioning. School psychologists, in collaboration with others, design, implement, and evaluate services that promote resilience and positive behavior, support socialization and adaptive skills, and enhance mental and behavioral health*. (2020, p. 5)

Moreover, comprehensive mental health services should be suitable for the learning environment. School psychologists understand how children's social–emotional and behavioral well-being, learning, and family lives combine to affect behavior in the classroom, as well as how teaching that occurs in the classroom and the context of the school all interact together to guide children's and adolescents' development and well-being (NASP, 2021).

In providing comprehensive school-based mental health services, there are specific roles that school psychologists can have to ensure the social–emotional and behavioral well-being of the children with whom they work. NASP (2021) has identified school psychologists as being leaders in the implementation of Multi-Tiered Systems of Support (MTSS) in schools. MTSS typically consist of three tiers that are used to deliver supports and services of increasing intensity to meet the needs of students. The first tier provides universal social–emotional wellness and behavioral supports to all students. The second tier provides services that are targeted for students identified as needing additional social–emotional and/or behavioral services beyond those provided in Tier 1 that could be provided in a small group. The third tier provides more intensive mental health supports and interventions to individual students (NASP, 2016). Through the use of a framework, such as MTSS, that provides academic, social–emotional, and behavioral supports, children's mental health needs can be identified and addressed before they fully manifest (as in the case of universal prevention), worsen, or become long-lasting. MTSS can also provide services that are data driven and increasingly intensive for individual children (NASP, 2021). NASP (2021) has proposed a continuum of comprehensive school-based mental and behavioral services that consists of the following levels: (a) universal wellness promotion and prevention services such as social–emotional learning programs and universal screening for all students, (b) early identification of and support for mental and behavioral health concerns which could include services such as trauma-informed services, (c) targeted school mental and behavioral interventions such as group counseling and functional behavioral assessments, (d) intensive school interventions such as direct therapeutic interventions for individual students, and (e) intensive community services such as psychiatric services or family counseling.

NASP (2016) has aligned this comprehensive school-based mental health model with federal legislation, the Every Student Succeeds Act (ESSA), which recognizes the importance of comprehensive and integrative mental and behavioral health services. ESSA acknowledges school psychologists are qualified mental health professionals and specialized instructional support personnel who are instrumental in (a) school and district assessment and accountability, (b) provision of supports that are targeted toward school improvement, (c) efforts to enhance school climate and school safety, and (d) ensuring access to high-quality comprehensive learning and mental-health–related supports (Every Student Succeeds Act, 2015). NASP (2016) contends that, in addition to providing direct services to children and adolescents, school psychologists can be instrumental in (a) establishing and delivering system-wide prevention supports delivered in MTSS; (b) understanding and interpreting data for program-planning purposes; (c) creating and monitoring program services; (d) consulting with professionals

at the system-wide, classroom, and individual case levels; (e) creating crisis prevention and response protocols; as well as (f) planning and coordinating services with community providers (NASP, 2016). Moreover, NASP (2016) contends that school psychologists can effectively support decision-making across levels that will lead to improved MTSS services.

The framework for the comprehensive school-based mental health services proposed by NASP (2021) includes a continuum of school and community services. Community services that some children may need may go beyond the capability of the school. Hence, community resources and support may become involved in the tiered system at the point when the intensity of the support increases. Integrating both school and community services requires much planning and coordination between school and community professionals. School psychologists could be involved in these efforts and effectively guide them by establishing partnerships with community sources such as mental health clinics or agencies that can provide more intensive services. In order to reduce an overlap or redundancy in services and to avoid creating stress for the family, clear communication between the school and community agency regarding the contribution of each group is essential. Each group must understand what its role will be in this partnership. As part of this partnership, school psychologists would play a pivotal role as a liaison between the school and community mental health providers (NASP, 2021).

IDENTIFICATION OF MENTAL HEALTH PROBLEMS IN SCHOOLS: *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* VERSUS INDIVIDUALS WITH DISABILITIES EDUCATION IMPROVEMENT ACT

As mental health providers in schools, it is important for school psychologists to understand the classification system used by the community resources or agencies providing more intensive mental health services as well as the classification system used in the schools to identify a child as having a disability. Knowledge of *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) disorders provides school psychologists with an understanding of symptoms associated with a particular disorder and how symptoms may manifest in the classroom and impact the child or adolescent in the school setting. Differences in the medical and educational models are described in the next section.

Medical Model: The Use of the *DSM-5* Classification

In medical or clinical settings, such as a child psychiatric outpatient clinic or a community-based mental health agency, mental health disorders are diagnosed using the *DSM-5* (American Psychiatric Association, 2013). The first version of the *DSM* was published in 1844 as a "statistical classification of institutionalized mental patients" (American Psychiatric Association, 2013, p. 6). Its purpose was to enhance communication about the various types of clients served in hospital settings. As noted by the American Psychiatric Association (2013), the *DSM* underwent major revisions to evolve into a system that allowed psychiatrists, clinical psychologists, and other mental health professions to use a common language to describe the primary features of a mental disorder. In the current edition, *DSM-5* (American Psychiatric Association, 2013), diagnostic criteria are presented and based on these, the mental health professional determines whether diagnostic criteria are met for a particular disorder. The *DSM-5* indicates that it is designed to help guide medical and clinical practitioners in decisions regarding treatment and management of disorders. Within the *DSM-5*, disorders are classified by major groups that share a common characteristic. For example, neurodevelopmental disorders, such as an intellectual disability, ADHD, or autism spectrum disorder (ASD), all have a neurodevelopmental basis. There were major revisions from the previous version that are described in the manual (American Psychiatric Association, 2013). (For those who would like more information about these changes, please see American Psychiatric Association, 2013.)

In the medical or clinical setting, a child or adolescent may be referred to a clinical or medical professional who evaluates the child to determine whether a mental disorder is present. Although comprehensive psychiatric or psychological evaluations may differ, they share some common

elements. During this evaluation, the practitioner will ask the parent and child (if developmentally appropriate) to describe the symptoms or behaviors that the child or adolescent is experiencing (John Hopkins, n.d.). Questions will attempt to ascertain when the behavior began, the duration of the behavior, how often it occurs, the types of conditions in which it occurs, and so on. The evaluation also attempts to determine the effect that the behaviors have had on the child (John Hopkins, n.d.). A criterion for many disorders within the *DSM-5* is whether the symptoms have had a significant impact on the child's or adolescent's functioning. For example, a medical or clinical professional evaluating a child for suspected ADHD will ask questions that are related to symptoms of inattentiveness and hyperactivity/impulsivity and how the child's behavior has affected school functioning, such as whether there are indications that the child has a difficulty time staying seated, listening to the teacher, organizing material, and so forth. Information is gathered regarding whether these types of behaviors have impacted the child's functioning, such as a decline in grades or disciplinary action for disruptive behaviors. There may be other components to the evaluation depending on the professional conducting the evaluation. For example, a licensed clinical psychologist may also do a psychological assessment using norm-referenced standardized tests, whereas a psychiatrist, who is a medical doctor, may assess the need for medication to manage the presenting symptoms. Following the evaluation, the clinical or medical professional will determine whether the child or adolescent meets the criteria for a *DSM-5* diagnosis. Based on all of the information gathered during the evaluation, a treatment plan will be developed if applicable.

Educational Model: The Use of the IDEA Disability Classification

In school, the classification of disabilities is based on the Individuals with Disabilities Education Improvement Act (IDEA) of 2004. This federal legislation originated from the Education for All Handicapped Children Act (Public Law 94-142), which stipulated that students with disabilities have the right to a free, appropriate public education (FAPE; Salvia et al., 2016). This law also stipulated that students with disabilities must be educated in the least restrictive environment possible, have an Individual Education Program (IEP), and be assessed with instruments and practices that are fair and unbiased. It also indicates that parents of students with disabilities have the right to inspect their child's school record and to challenge changes in the child's placement. In 1986, amendments were made to the law to ensure that the law extended to preschoolers with disabilities and that every school district "conduct a multidisciplinary assessment and develop an individualized family service plan for every preschooler with a disability" (Salvia et al., 2016, p. 26). Four years later, the law was reauthorized in 1990 and became known as *IDEA* (U.S. Department of Education, n.d.). IDEA was reauthorized again in 1997 and in 2004. IDEA of 2004 includes 13 disability categories. These are Autism, Deaf-Blindness, Developmental Delay, Emotional Disturbance, Hearing Impairment, Intellectual Disability, Multiple Disabilities, Orthopedic Impairment, Other Health Impairment, Specific Learning Disability, Speech–Language Impairment, Traumatic Brain Injury, and Visual Impairment (U.S. Department of Education, n.d.). Each of the 13 disability categories has a set of eligibility criteria that must be met.

Teachers make many of the referrals for an evaluation, although parents may request an evaluation. Prior to getting a referral, students will have received supports or interventions to address any social–emotional, behavioral, or learning problems that were evident in the classroom. Students who fail to respond to these supports or interventions may be referred for an evaluation to determine eligibility for special education services. Once parental consent is obtained, hearing and vision tests are conducted by the school nurse. The school psychologists and other members of the multidisciplinary team will have 60 days to conduct an evaluation (U.S. Department of Education, n.d.). Once the evaluation is completed, a multidisciplinary team reviews all of the assessment data collected from multiple sources and determines whether the child is considered a student with a disability under IDEA. To be determined to be a student with a disability, eligibility criteria for one of the 13 disability categories must be met and a need demonstrated for special education services and/or related services for the child to be successful in the classroom (Salvia et al., 2016). Hence, the child's disability is found to have an adverse impact on the child's classroom performance. If a child is found to be eligible for special education services, the team has 30 days to develop an IEP, which is a legal written plan that identifies the specific special education services the child will receive (Salvia et al., 2016).

If the multidisciplinary team determines that the child is not in need of special education services, consideration may be given to developing a 504 plan, which determines accommodations needed for the child to succeed. This plan is provided through Section 504 of the Rehabilitation Act of 1973, which is civil rights legislation. It provides students with any type of disability equal access to services if their disability limits an area of daily life functioning.

CONCLUDING REMARKS

As future school psychologists, the services that you provide to the school will play a major role in the decisions made about the children's education. These decisions can influence their time spent in the educational system and affect their future career/vocational choices.

SUMMARY POINTS

- The prevalence of mental health disorders in children and adolescents is high.
- School-based mental health services are needed to address the social–emotional and behavioral needs of youth.
- Domain 4 of the NASP Practice Model applies to the role of school psychologists in regard to the provision of school-based mental health services.
- While IDEA classification of disabilities is used in schools to identify children in need of special education services, the *DSM-5* classification of mental health disorders is used to make a medical diagnosis.

TEST YOUR KNOWLEDGE

1. Which of the following domains of the NASP Practice Model supports the role of school psychologists as mental health providers?
   a. Domain 2
   b. Domain 3
   c. Domain 4
   d. Domain 5

2. Protective factors help protect, or decrease the likelihood of, the child developing a mental health condition.
   a. True
   b. False

3. The *DSM-5* is the classification system used to identify disability categories for special education services.
   a. True
   b. False

4. Common risk factors for developing mental health problems include low self-esteem, a negative home environment, stressful events, and peer rejection.
   a. True
   b. False

5. Which of the following disorders is the most common among children and adolescents?
   a. ADHD
   b. Anxiety disorders
   c. Depressive disorder
   d. Disruptive behavior problems

Answers: (1) c, (2) a, (3) b, (4) a, (5) a.

DISCUSSION QUESTIONS

1. Describe the differences between the medical model used to classify disorders with the *DSM-5* and the education model, which uses IDEA disability categories.

2. Identify three risk factors and three protective factors that are associated with mental health problems.

3. Discuss how racial stress can impact a child's mental health.

4. Discuss the need for school-based mental health services.

5. Discuss the role of school psychologists as providers of mental health services in schools.

CHAPTER RESOURCES

National Association of School Psychologists *Comprehensive School-Based Mental and Behavioral Health Services and School Psychologists*: www.nasponline.org/resources-and-publications/resources-and-podcasts/mental-health/school-psychology-and-mental-health/comprehensive-school-based-mental-and-behavioral-health-services-and-school-psychologists

National Association of School Psychologists *Practice Model: Improving Outcomes for Students and Schools*: www.nasponline.org/standards-and-certification/nasp-practice-model

National Association of School Psychologists *Position Statement: Ensuring High-Quality, Comprehensive, and Integrated Student Supports*: http://www.nasponline.org/research-and-policy/policy-priorities/position-statements

National Association of School Psychologists *The Professional Standards of the National Association of School Psychologists*: www.nasponline.org/standards-and-certification/nasp-2020-professional-standards-adopted

KEY REFERENCES

Only the key references appear in the print version. The full reference list follows.

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