The Federal Role in School-Based Behavioral Health Services

Moving Toward Public Health Promotion

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Abstract

All aspects of behavioral health for every child needs to be mandated in publicly funded schools and provided by trained, qualified providers. The Centers for Disease Control and Prevention (CDC) recognizes behavioral health as a broad term that encompasses both mental health (including mental illnesses) and substance use [SAMHSA (Substance Abuse and Mental Health Services Administration), 2014]. Children and teachers should feel safe at school no matter what their zip code. Classroom management, school-wide discipline practices that create safe spaces, and knowing what behavioral supports to provide based on a child's presentation don't appear to be intuitive for school leaders (Lohrmann et al., 2008). Ongoing crises in schools highlight the importance of understanding the federal role in facilitating and funding school-based behavioral health services (Adamson & Peacock, 2007).

Through comprehensive frameworks, federal policies, equity considerations, and the adoption of a public health promotion model, there's potential to make significant strides in promoting the behavioral health and well-being of students in schools. School leadership focuses on academics but changes are needed and must be mandated and funded so that every child can be educated in a system that is safe, both physcially and mentally.

Keywords: interdisciplinary collaboration, prevention, federal policies, behavioral health, equity, public health

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Introduction

The increasing recognition of the importance of behavioral health in children's academic success and overall well-being has prompted significant discussion on the federal role in school-based behavioral health services (Adelman & Taylor, 2000; Atkins, et al., 2010; Bradshaw, et al., 2014; Greenberg et al., 2003; Merikangas, et al., 2010). The federal role in school-based behavioral health services and a move toward a public health promotion model has become an increasingly important area of research and practice, especially considering the rising rates of behavioral health challenges among youth.

As defined by the Centers for Disease Control and Prevention (CDC), "[m]ental health affects how we think, feel, and act. Mental Health is important at every stage of life, from childhood and adolescence through adulthood" (CDC - YRBSS - Youth Risk Behavior Surveillance System - Adolescent and School Health, n.d.; Briesch, et al., 2020). Behavioral health services in schools are crucial not only for addressing immediate mental health needs but also for setting a foundation for lifelong well-being. The federal role in these services and the growing emphasis on public health promotion necessitates an integrative review.

Teaching and learning in many schools may be disrupted by antisocial behaviors like harassment, aggression, social withdrawal, and insubordination (Walker et al., 2003). The demands for safer schools have intensified as public awareness and concerns about discipline, drug use, and violence have increased (Sugai & Horner, 2002). To increase their capacity to address antisocial behaviors adequately, school districts have implemented zero-tolerance policies and strengthened sanctions for rule violations (Burke et al., 2004). While applying these policies and sanctions, well-intentioned, reactive, and punitive responses by misinformed school

leadership have proven ineffective in changing student behavior or outcomes (Burke et al., 2004; Horner et al., 2001).

For example, many students with severe behavioral difficulties or emotional disorders do not experience positive educational outcomes (Loe & Feldman, 2007). According to Feinstein (2003), many students with problem behaviors have lower reading and mathematics scores and graduation rates. These students experience higher criminal activity, mental health issues, and dependence on the welfare system (Kutash et al., 2002). Despite this knowledge, public education does not fund nor require trained behavioral health professionals, such as a school psychologist in leadership positions. School leaders must know how to do things right and do the right thing. Schools need leaders to know how to support students with behavioral health needs in K-12 education, such as school psychologists.

Consequently**,** the behavioral health of students, the lack of knowing what to do and who should do it, is a growing public health crisis (Adelman & Taylor, 2021). Differences exist in resources, organization, delivery, and funding of school behavioral health services across the country and policymakers continue to approach behavioral health in an ad hoc manner (Slade, 2023; Adelman & Taylor, 2021). Public Policy has not responded as quickly and thoroughly as needed, both nationally and at state levels. Efforts related to staffing, services, and disparities in access to behavioral health care must be unified, comprehensive, and equitable, with increased federal funding to change the outcomes for the most vulnerable children in the United States. These efforts must be fully embedded in the school improvement policies and within school practices.

Literature Review

Expansion and accessibility, prevention and early intervention, interdisciplinary collaboration, equity and cultural competence, professional development by qualified providers, and the integration of behavioral health into curriculum are emerging themes in the literature related to the federal role in school-based behavioral health services and the movement toward a public health promotion model (Atkins et al., 2006; Atkins et al., 2010; Dwyer, 2000; Anyon, 2016). Education, behavioral health, and public policy need swift integration for schools to move from a reactive to a proactive stance that is fiscally sustainable.

Expansion and Accessibility

Policy benchmarks from the National Institute of Mental Health (NIMH) began in 1964 and 1972, with many more initiatives and agendas to follow. The U.S. Department of Health and Human Services in the mid-1990s established the Mental Health in Schools Program, which created two national centers in the U.S. to inform policymakers, administrators, school personnel, primary health care providers, and other stakeholders. Various agencies and other activities emerged, i.e., the Substance Abuse and Mental Health Services Administration (SAMHSA) and various CDC divisions. Despite the long history of identified need, with two national centers in the U.S., behavioral and mental health challenges among youth continue to rise. This contradiction has only grown the consensus that school-based behavioral health services need to be expanded to reach more students (Mills, et al., 2006). The federal role is pivotal in providing funding, policy guidance, and frameworks to ensure these services are accessible to all students regardless of where they live.

Differences also exist in resources, organization, delivery, and funding of school mental health services across the country (Slade, 2003). The 2004 amended Individuals with Disabilities Education Act of 1997 (IDEA) addresses the issue of behavioral support for some students with

disabilities such as emotional disturbance (Individuals with Disabilities Education Improvement Act, 2004; Azizoglu, 2019). The behavioral provision of the IDEA of 2004 states that "The Individual Education Plan team shall, in the case of a child whose behavior impedes his or her learning or that of others, consider, when appropriate, strategies including positive behavioral interventions and strategies and supports to address that behavior" (IDEA, 2004). Federal law mandates that a team create or revise a behavioral intervention plan that includes positive behavioral support for students with behavioral issues as part of their Individualized Education Plan (IDEA, 2004). However, not all students need special education, leaving most students without the appropriate mandates to get the help they need.

Prevention and Early Intervention

The public health model emphasizes prevention (Hung, et al., 2007). Schools are seen as ideal settings for early identification of behavioral health issues, ensuring timely intervention before problems become more severe or chronic (Bruns, et al., 2016). However, schools have inadequate internal leaders, and community resources are limited. If services are splintered and students are marginalized, resources become sparse. Schools do provide various prevention and early intervention programs; however, they are primarily aimed at drug and alcohol abuse (Karol, 2002). Social-emotional learning and mild mental health prevention and early intervention programs are limited, nor are they funded or mandated in a cohesive, public health model.

Despite these barriers, New York has led the way with the nation's first statute requiring mental health education (Addressing the Youth Mental Health Crisis: The Urgent Need for More Education, Services, and Supports, n.d.; Boulden & Schimmel, 2022). Virginia and Florida were not far behind in requiring several hours dedicated to mental health services at school (Addressing the Youth Mental Health Crisis: The Urgent Need for More Education, Services,

and Supports, n.d.). However, only 14 states have fully expanded health care through Medicaid to cover services for disabled students entitled to special education under IDEA (Addressing the Youth Mental Health Crisis: The Urgent Need for More Education, Services, and Supports, n.d.). Some states have enacted and funded lower ratios to specific mental health professionals in schools but have not mandated the staff to be funded locally in leadership positions. Other states, such as Minnesota and Kansas, have promoted community-based mental health providers within the school setting (Doll, et al., 2017).

Interdisciplinary Collaboration

For school-based services to be effective, there needs to be collaboration between educators, behavioral health professionals, families, and other stakeholders. Services need to include prevention, referral, evaluation, treatment, and case management with cross systems collaboration at the forefront. Research literature suggests that staffing is diverse, professionals vary, and roles and service levels in schools are unequal (Brenner, 2001; Weist et al., 2001).

The School Health Policies and Programs Study (SHPPS) provides data on staffing and support of mental health services in schools (Centers for Disease Control and Prevention, 2000). Professionals vary from school psychologists and nurses to community mental health providers; however, with increased collaboration, these professionals can act as provider teams or involve partnerships between schools and community social services (Brenner, 2001; Weist et al., 2001).

Research also indicates that the delivery model can also vary based on the fiscal arrangements (Policy Leadership Cadre for Mental Health in Schools, 2001; Weist, 1997). These models of delivery for the provision of school mental health services include the following:

- School-financed student support services
- Formal connections with community mental health providers
- District-level mental health units or clinics

- Classroom-based curricula

The variation of staffing and support and the variation of fiscal arrangements validates why the federal government can and should provide guidance and resources to promote interdisciplinary collaboration.

Equity and Cultural Competence

A survey of 62 school administrators found that behavioral health problems worsen as the student matriculates through the system (Weist et al., 2000). Despite resources, students will face access barriers (Nguyen et al., 2016; Ijadi-Maghsoodi et al., 2018). These barriers provoked the increasing recognition that behavioral health services must also be culturally sensitive and equitable (Kiperman, et al., 2023). This means understanding and addressing the diverse needs of students from various backgrounds, including those related to race, ethnicity, socioeconomic status, and more.

Research indicates that student engagement is vital to school behavioral health services, regardless of effective practices, credentialed professionals, and funding streams (Nguyen et al., 2016). In addition, for school personnel to effectively support students' behavioral health in a culturally sensitive and equitable manner, they need training. Focus groups that included 76 middle and high school students at nine school-based health clinics (SBHC) found that teachers are a primary source of support for behavioral health services (Ijadi-Maghsoodi et al., 2018). Federal initiatives can bolster the training of school professionals, ensuring they're equipped to recognize and address behavioral health challenges. Teachers and school staff need awareness of behavioral health issues and increased comfort (Boudreau, 2019).

Antisocial behaviors among school-aged children and youth are a leading concern among educators and the public (Dwyer et al., 1998; Burke et al., 2004). Classrooms are increasingly

culturally and behaviorally diverse as children from all backgrounds, languages, and risk areas are educated together (O'Shaughnessy et al., 2002). Emotional, behavioral, and mental health disorders affect children and families in all our communities. Many students across the nation struggle with emotional and behavioral problems that may lead them to act out in ways that school administrators and teachers might not understand or be prepared to respond to effectively (Read & Lampron, 2012). One in ten children has a mental illness severe enough to impair how they function at home, at school, and with peers (*President's New Freedom Commission on Mental Health: Reports,* 2019). Approximately 70% of children with mental health diagnoses do not receive treatment, and the school district often becomes the de facto mental health provider (Read & Lampron, 2012). Most school district employees lack the training and professional development to address these students' problem behaviors (Kealey et al., 2000). In addition, increased concerns regarding the safety of the nation's schools and accountability standards outlined in the No Child Left Behind (NCLB) Act of 2001 have prompted school officials to seek effective strategies to reduce violence and behavioral issues in their schools (Mettrick et al., 2007).

Consequently, barriers to learning need to be addressed and funded with the correct support. Schools offer some forms of behavioral health support with splintered structures, but a more collective, systemic solution is needed.

Qualified Staff Operating in a Comprehensive Framework

School-based behavioral health staff in schools are not regulated despite public schools being the primary providers of these services for children (Maag & Katsiyannis, 2010; Atkins et al., 2006; Atkins et al., 2010; Flaherty & Osher, 2002; Nastasi, 2004; Foster et al., 2005).

Schools can play a critical role when providing behavioral health services to children if adequately funded and provided by qualified professionals.

Professionals who can coordinate and effectively use data so that the results can inform instruction, improve student, and school outcomes, and enhance accountability and change leadership are needed. In addition to effective use of data, some argue for the integration of behavioral health literacy into the school curriculum, enabling students to understand and manage their emotions, reduce stigma associated with mental health, and seek help when needed (Kutcher, et al., 2016).

School psychologists and other mental health leaders exist in every school nationwide (National Association of School Psychologists, 2021). Psychologists know how to evaluate data and how to coordinate with content lead specialists to ensure that a comprehensive, rigorous curriculum is available to all students, including critical life skills, such as social-emotional learning, self-control, and solid therapeutic components for the emotionally disturbed student (NASP, 2021); however, their role is focused on special education not prevention.

In addition, classroom management can be one of the most significant challenges faced by today's educators (Milner & Tenore, 2010) yet effective classroom management and school-wide discipline practices for establishing safe and effective classrooms and schools have existed in the literature for over 20 years (Dwyer et al., 2000; Mayer, 1995; Metzler et al., 2001; Nelson et al., 1998; Safran & Oswald, 2003; Snead, 2012). School-wide positive behavioral supports (SWPBS) along with behavioral health services have been proven to neutralize or eliminate risk factors, enhancing protective factors to prevent the occurrence of problem behavior, reduce its incidence and prevalence, and improve academic gains yet significant disparities exist based on region, location, and school size (Sugai & Horner, 2006; Slade, 2003).

Comprehensive school-based behavioral health frameworks, such as SWPBS emphasize the importance of integrating and having knowledge of services within the school setting to address behavioral, emotional, and social challenges (Atkins, et al., 2010; Bradshaw, 2013). SWPBS consists of a set of disciplinary practices built on the assumption that behavioral expectations defined, supported, and implemented by the entire school community help to establish a common culture, a culture in which all students are held to the same behavioral standards (Horner et al., 2001; Sugai & Horner, 2002; Sugai et al., 2000; Sugai et al., 2002).

Implementation of SWPBS requires the creation of a school-wide behavior plan led by school leadership that defines behavioral expectations in all school settings, maintains ongoing strategies to acknowledge and reward appropriate behavior, provides opportunities for teaching these expectations to all students, and establishes a continuum of consequences for inappropriate behaviors (Luiselli et al., 2002; Lane et al., 2006; Brading, 2011). Existing literature documents applied behavioral analysis (ABA) as the theoretical foundation of Positive Behavioral Interventions and Supports (PBIS), the foundation of SWPBS (Carr et al., 2002; Carr & Sidener, 2002; Dunlap, 2006; Dunlap et al., 2008). PBIS emerged in the mid-1980s in response to escalating concerns over the use of aversive procedures to address problem behavior (Lavigna & Donnellan, 1986) and the desire to produce more meaningful and sustainable outcomes in complex community settings (Horner et al., 2001; Siddiq, 2019). PBIS grew from the scientific and procedural foundations of ABA, benefiting from functional behavioral assessment and analysis (Dunlap et al., 2008).

ABA, established in the 1960s, is a science in which learning principles applied systematically produce socially essential changes in behavior (Anderson & Freeman, 2000). PBIS was developed in the late 1980s as a general strategy of intervention and support,

employing concepts and methods from ABA and other disciplines (Dunlap, 2006; Blevins, 2007). Both behavioral approaches focus on enhancing an individual's quality of life and reducing problem behaviors. Most educational leadership programs do not include behavioral theory or applied behavioral analysis training.

PBIS and ABA have several common characteristics (Carr & Sidener, 2002). These include person-centered planning, functional behavioral assessment, positive behavioral intervention strategies, multifaceted interventions, a focus on the environment, meaningful outcomes, and, most likely, a part of a certified school psychologist's training. Effective schools provide access to good instruction and culture that supports engagement, community, and success (Flannery et al., 2010; Sugai & Horner, 2008). Schools must simultaneously develop school-wide systems of constructive social behavior and curricular and instructional practices to promote successful academic achievement for all students (Sugai & Horner, 2008). School psychologists are trained and certified in these practices.

Community Partnerships with Policy, Advocacy, Financing and Sustainability

While the initial investment in school-based behavioral health services might be significant, there's a growing understanding that the long-term societal benefits — in terms of improved academic outcomes, reduced healthcare costs, and enhanced life trajectories — make this investment worthwhile. The federal government plays a key role in providing the needed resources and ensuring the sustainability of these programs.

The diversity of funding streams and the costs in schools make it difficult to collect data (DeKruyf et al., 2013). It is typical for services to be funded through multiple categorical funding streams with varying missions and limitations, such as Medicare. This diversity in funding also contributes to the fragmentation of services.

Funding is crucial to sustaining the requirements to improve the provision of behavioral health services in public education (Foster et al., 2005). Federal, State, and local funding streams through service reimbursement and foundation grants are splintered nationwide. IDEA is one of the primary funding streams. Title I of the Elementary and Secondary Education Act of 1965, Improving Academic Achievement of the Disadvantaged, is also relied upon for behavioral funding. However, the State Children's Health Insurance Program (SCHIP) was rarely reported (2%) as a funding source (Foster et al., 2005). Families report that financial constraints are a severe barrier to accessing behavioral health services (Foster et al., 2005).

Publicly funded behavioral health services have also been provided through community-based systems of care. School-based health centers (SBHC) reduce access barriers to behavioral health (Lai et al., 2016). Managed health care increased the popularity of SBHC (Stroul et al., 1998). In addition, managed care has promulgated briefer, more problem-oriented treatment approaches. However, managed care services have developed systems of care for students who need behavioral health services that are not being linked with managed care initiatives. This lack of coordination and the preauthorization requirements increase fiscal barriers to public health promotion.

Large, urban school districts have attempted to integrate health, behavioral health, and educational services simultaneously. In 2010, the Affordable Care Act (ACA) authorized $200 million to expand integrated health care by increasing the capacity of SBHC nationwide. Fourteen wellness centers provided health, mental health, and other services to underserved ethnic minority students living in poverty. The wellness centers included student advisory boards, student-led health engagement activities, and mental health services (Lai et al., 2016).

Three separate integrated care models emerged: coordinated care, co-located care, and integrated care (Lai et al., 2016). As described by Lai (2016), coordinated care includes health and mental health providers collaborating from a distance in separate facilities. The co-located model includes primary medical and mental health services on the same site but with separate systems, and the integrated care includes a shared treatment plan between medical and behavioral health providers. Sites that provided behavioral health services reported more mental health screenings being conducted (Lai et al., 2016).

Federally designated comprehensive health clinics were contracted for primary care services. (Lai et al., 2016). Interviews revealed differences in provider models with various integrated services (Lai et al., 2016). Staffing, operations, partnerships, and engagement determined the depth of behavioral health integration for students. The types and levels of integration between health and mental health varied, however, the research indicated that the coordination and collaboration efforts were integral to success (Tancred, et al., 2018). Partnerships between providers and school staff were critical to protecting information and delivering services (Lai et al., 2016). When the medical and behavioral health services were combined, the most integration of services occurred.

As SBHC expands, interconnected care systems are vital to improve outcomes for students and families struggling with behavioral health. Behavioral health care for all students must be affordable, non-discriminatory, and include coverage for the most effective and appropriate treatment led by qualified staff (Leithwood et al., 2004).

Research indicates that schools can't address behavioral health in isolation. There's an emphasis on forming partnerships with community organizations, health care providers, and other entities to create a comprehensive network of support for students (Bruns, et al., 2016).

This concept is further supported through the Carnegie Council Task Force on Education of Young Adolescents. This task force recognizes that if behavioral health is a barrier to learning, then as a society, we are responsible for meeting that need.

Inadequate community behavioral health service providers pose another barrier to behavioral health services. Residential and inpatient services are scarce. Schools are the most universal natural setting for children. However, communities face the challenge of developing public health intervention systems for children.

In 1993, the Los Angeles Unified School District entered an interagency contract with the L.A. County Department of Mental Health (Tancred et al., 2018). This collaboration created the first blended funding agreement between the school and community. The contracted services included 60 full-time social workers, psychologists, and psychiatrists serving students and families. Reimbursement dollars were provided through both federal and state sources. School professionals led the way with mental health activity in schools.

Programs across the country have produced a variety of policies and initiatives, some that directly support school programs and others that connect community resources (Adults et al., 2009; Warren et al., 2010). All programs intend to intervene early, prevent crises, provide treatment, and promote positive outcomes (Youth.Gov, 2009). For all these themes to be effectively addressed, there's a need for strong policy and advocacy efforts at the federal level. State policy efforts seeking mental health education requirements started conversations that did not exist 20 years ago (Weist et al., 2000). As Weist notes, the disparities are too vast. States that have empowered youth have made significant changes to service delivery.

Analysis

Four theories were chosen as the theoretical foundation for understanding the emerging themes from a review of the school based behavioral health literature: multi-tiered systems of support, ecological systems, social-cognitive theory, and public health model theory. The pedological, socio-political, and public health perspectives lens will add the necessary viewpoint for proposed action and outcomes.

The pedagogical perspective is multifaceted, focusing on both the intellectual and emotional aspects of teaching and learning. It is shaped by educational theories, the personal beliefs of educators, and the cultural context of the learning environment. This perspective significantly influences the effectiveness of teaching and the overall quality of learning experiences for students (Karisan & Eilks, 2023).

The socio-political perspective refers to an approach that considers the interplay between social and political factors in understanding and analyzing various phenomena. This perspective often examines how societal norms, values, and structures interact with political systems, power dynamics, and policymaking and for this review, especially amid marginalized youth (Marchand, et al., 2020).

The public health perspective focuses on the science and art of preventing disease, prolonging life, and promoting health through organized community efforts. It encompasses a broad range of activities and disciplines aimed at improving the health of populations, rather than focusing solely on individual health (Klontz, et al., 2015)

Theory 1: Multi-Tiered Systems of Support (MTSS) Framework

From a pedagogical perspective the MTSS emphasizes proactive strategies for defining, teaching, and supporting appropriate behaviors in schools, leading to positive behavioral

outcomes. MTSS is a framework that promotes the academic and behavioral success of all students. It emphasizes a data-driven, problem-solving approach at multiple levels of intervention, from universal (Tier 1) to intensive individualized interventions (Tier 3) (Sugai & Horner, 2020). School-wide Positive Behavior Support (SWPBS) is a strategy within an MTSS framework that seeks to enhance the school's capacity to prevent disruptive behavior by creating and sustaining primary, secondary, and tertiary support for students (Bradshaw et al., 2010; Kabaka, 2021). SWPBS is a systems approach to establishing the overall social culture and the intensive behavior supports needed to achieve academic and social success for all students (Horner et al., 2009; Jass, 2019). SWPBS is a proactive approach to discipline that promotes appropriate student behavior and increases learning, and it aims to establish a predictable, consistent, and positive school culture for all students and staff (Horner et al., 2001). Behavioral theory and applied behavior analysis are the theoretical and conceptual tenets of SWPBS (Anderson & Freeman, 2000; Carr & Sidener, 2002; Culig et al., 2005; Dunlap, 2006; Dunlap et al., 2008).

From a socio-political perspective, the federal endorsement of MTSS can shift school culture and practices towards preventive behavioral health strategies. Leadership affects learning (Leithwood, Louis, Anderson, & Wahlstrom, 2004). Classroom instruction is the most potent learning indicator; however, leadership is second and often underestimated (Leithwood et al., 2004). Leithwood (2004) found that the effects of leadership are largest where and when needed most, such as a student with an behavioral health needs. Principals directly impact the roles of behavioral health providers in schools (Brock & Ponec, 1998; Janson et al., 2008; MacDonald et al., 2008; Ponec & Brock, 2000; Peabody, 2012). Principals can define leadership roles and

initiatives, such as SWPBS and shift the practices of those within the school community (Amatea & Clark, 2005; Dollarhide et al., 2007).

With its tiered intervention strategy, MTSS can be seen as a public health approach to behavioral health in schools. School leaders that have implemented SWPBS with fidelity have reported a 20%-60% reduction in office discipline referrals, improved school climate, and improved academic performance (Cushing, 2000; Luiselli et al., 2002; Nakasato, 2000; Nelson et al., 1996; Nelson et al., 1998; Nersesian, et al., 2000; Taylor-Greene et al., 1997). School psychologists and school counselors are qualified individuals who work in most school systems throughout the country. They provide tactical advocacy for marginalized students, improve school culture, and are experts in child development (Wingfield et al. 2010, Reiser et al. 2010). However, their roles are pigeonholed due to the mandates that currently regulate what must be done and when (Reiser, 2010). Per IDEA and Chapters 14 and 15 of the State Board Regulations, the Pennsylvania Department of Education (PDE) supervises all public schools, school districts, and other public education agencies to ensure a Free Appropriate Public Education (FAPE) for all students. Mandates within IDEA regulate the timeline of the evaluations that a school psychologist must complete. Pennsylvania Public School Code of 1949 regulates the provision of services that regulate the role of school counselors (Article XI). National associations define best practices for school counselors and psychologists to be effective (NASP, 2020; Walsh, 2007). They are often not in leadership positions but are collective bargaining unit members which can limit their decision-making power and this needs to change.

Theory 2: Ecological Systems Theory

The ecological systems theory, proposed by Urie Bronfenbrenner in 1979, suggests that individual development is influenced by different interconnected environmental systems, from

immediate surroundings like family and school to broader societal contexts. Schools play a pivotal role in the microsystem of students, influencing their behavioral health. Schools can bridge the gap between the systems that are creating barriers for behavioral health access. From the pedagogical perspective connecting individuals and families to a macro level, such as society at large, can have an impact on learning and behavioral health of students.

Addressing behavioral health within schools acknowledges the significant impact that this microsystem can have on student well-being. Federal policies can play a vital role in establishing standards and providing funding for school-based behavioral health services. Education and health departments can collaborate to optimize resources and ensure program efficacy (Merikangas et al., 2011; Stephan, 2015).

Students need adequate and equitable access to a therapeutic and culturally responsive school environment that provides comprehensive psychological services, behavioral health wellness, social-emotional learning, and school-wide practices that reinforce a safe and supporting environment. From a socio-political perspective, federal policies can influence the ecosystems and macrosystems, indirectly impacting school behavioral health services.

Furthermore, an ecological approach understands that public health is not merely individual but extends to larger systemic structures. Every Student Succeeds Act (ESSA), and IDEA ensures maximum federal investments in Title I, II, and IV and is critical for achieving these policy priorities, which include the following:

I. Mandate a more comprehensive role for the school psychologist and school counselor.

II. Replace existing school structures, policies, and procedures to ensure equitable student outcomes.

III. Provide safe and supportive community environments for all students.

IV. Initiate evidence-based, comprehensive school safety and crisis response efforts.

V. Increase access to comprehensive school mental and behavioral health services. (Darling et al., 2016; Federal Policy Platform, 2021)

Theory 3: Social Cognitive Theory

Proposed by Albert Bandura, this theory emphasizes the importance of observing and modeling the behaviors, attitudes, and emotional reactions of others. It posits that learning can be a direct result of observing, rather than doing. In the school context, peers play a significant role in influencing behavior. If antisocial behaviors (e.g., aggression, harassment) are prevalent and unchecked in a school environment, other students may observe and model these behaviors, exacerbating the challenges educators face in managing classroom behavior.

These challenging conditions and the desire to ensure school safety have led to zero-tolerance discipline policies, often punitive, reactive, exclusionary, and largely ineffective in addressing safety issues or preventing problem behaviors (Skiba & Peterson, 1999). The evidence has suggested that these reactive and punitive leadership practices inadvertently reinforce antisocial behavior, increasing the likelihood that the behaviors will continue and escalate (Mayer & Sulzer-Azaroff, 2002; Sugai & Horner, 2002). These policies have led to increased levels of expulsion, disparate application of disciplinary measures to minority populations, and disproportionate reactions to minor student infractions (Heaviside et al.1999; Skiba, 2000).

From a pedagogical perspective, the evidence indicates that inconsistent and punitive management practices fail to allow students to learn and practice social skills and self-

management (Colvin et al., 1994) and that the traditional approaches of leadership that include verbal reprimands, suspensions, and detentions do not bring long term change in behavior (Sprague et al., 2001). Students with the most challenging behavioral problems are the least likely to respond to a hierarchy of consequences, and their problem behavior is expected to increase in frequency and intensity. Failure to address severe behavioral issues harms the student demonstrating the inappropriate behavior and the other students in the classroom because the teachers often break from their lesson plans and routine to address the disruptive behavior (Read & Lampron, 2012).

Social-cognitive theory recognizes the role of social and cultural contexts in shaping behavior. From a social-political perspective, school-based programs must be culturally sensitive and inclusive, acknowledging the diverse backgrounds of students. This includes addressing socio-political issues like inequality, discrimination, and access to resources. Encouraging students to be agents of change in their communities aligns with both social-cognitive theory and a socio-political approach. Schools can facilitate student-led initiatives that address social issues, thereby enhancing students' sense of agency and civic engagement.

From a public health viewpoint, social-cognitive theory supports the development of interventions that promote healthy behaviors and prevent negative outcomes. This includes programs aimed at reducing substance abuse, bullying, and mental health issues. Punitive discipline tends to predominate in proportion to the alternative, which is to take a positive, preventive approach to discipline, in which trained school psychologists know how to implement (Skiba et al., 1997; Skiba & Peterson, 2000).

In 2001, IDEA of 1997 was amended to address the issue of behavioral support for students with disabilities. This federal legislation required that school districts take a systematic

approach to addressing the behavioral needs of students with disabilities by integrating functional behavioral assessment and positive behavior intervention plans (Individuals with Disabilities Education Improvement Act of 2004). However, not all students are special education students. There is a need for evidence-based behavior management approaches that address student behavior issues proactively and positively for all students (Read & Lampron, 2012).

Theory 4: Public Health Model

A significant disparity exists in the accessibility of quality behavioral health services in schools, often correlated with socioeconomic and demographic factors (Baines & Diallo, 2016; Anyon et al., 2016). Addressing these inequities is crucial for a holistic public health approach. Regarding a pedagogical perspective, knowledge alone is insufficient for behavior change; perceptions of risk and benefits play a crucial role in health decision-making among students. Shifting from a purely clinical perspective to a public health promotion model can foster preventive measures, early identification, and interventions. The Public Health Model focuses on prevention and intervention of diseases or issues at a population level. In this case, the emphasis would be on preventing behavioral health issues among school-aged children and intervening early when problems are identified and may assist in understanding and addressing behavioral health in schools. This model recognizes the interconnectedness of physical, behavioral, and social health in promoting student well-being (Greenberg, et al., 2001; Suldo, et al., 2011).

The school-to-home connection is vital to addressing the mental health crisis in schools (Youth.Gov, 2019). Psychologists are leaders in understanding and creating these connections thus increasing the socio-ecological perspective (NASP, 2021). Meeting the student's needs in school and at home requires collaboration and consultation that psychologists can provide if

given the authority (NASP, 2021;Youth.Gov, 2019). Providing rich content in the school environment alone is insufficient for emotionally disturbed students (Youth.Gov, 2019). Students need access to a full range of learning support. Psychologists can lead educators and direct families to identify and remedy barriers to learning, such as disabilities, mental or physical health problems, or social, cultural, language, or family issues impacting education for all students (NASP, 2021).

Teachers need help implementing appropriate academic interventions and promoting evidence-based classroom learning strategies such as SWPBS (Parsonson, 2012). Students need attention, motivation, and problem-solving skills to develop appropriate social-emotional and behavioral regulatory strategies (Teaching Students to Solve Social Problems – Behavior Management Resource Guide, n.d.). These strategies foster student engagement, contribute to a more positive and orderly classroom environment, increase time focused on learning, and increase school attendance and graduation rates thus subsequently promoting a blueprint for public health (Fredricks & Eccles, 2006).

Ethical Implications

Education is a civil right for all Americans (Title VII of the Civil Rights Act of 1964, n.d.). Education should be an equitable right for all Americans, period. It was made clear 66 years ago in the Brown v. Board of Education (Brown v. Board of Education, 1954) decision that separate, and unequal is unconstitutional. From achievement gaps and graduation rates to college attendance, America has made great strides in providing equal opportunities for all (Global Campaign for Education, n.d.). However, we can look in the windows of classrooms across the country and see that our most vulnerable, impoverished students live in crime-ridden or abusive

communities that do not have equality in education (Ferguson, Bovaird, & Mueller, 2007; Engle & Black, 2008).

Teachers and school administrators are neither trained nor prepared to handle trauma, abuse, and the psychological instability associated with poverty (Ferguson et al., 2007; Engle & Black, 2008). Students will be expelled and may turn to crime to survive. They are victims from birth with little fighting chance. The disproportionate data shows that minority students are over-identified for special education and suspensions, a pattern that still exists in schools today, and that is where the school-to-prison begins (U.S. Department of Education [USDE] Office of Civil Rights [OCR], 2014).

School administrators have primarily relied on suspension and expulsion to handle students with behavioral problems despite laws in place to protect these students (Stonemeier, 2017). Inexperienced school leadership depends on the justice system, which is not equipped to handle nonviolent crimes or intervene when students need mental health interventions (Council of State Governments, 2002).

Positive behavioral intervention supports (PBIS) were used for individual interventions, but not systemically until the late 1990s (Stonemeier, 2017). To this day, schools are not required to implement this whole-system approach to change the culture and climate of a school environment. Instead, the disciplinary practices can go unseen and unchanged depending on the school systems' location, leadership, and data monitoring systems (Wallace et al., 2008). This invisibility happens despite knowing effective techniques, ultimately perpetuating the cycle of victimizing children in the emotional support classrooms separated from their typically developing peers (Darensbourg & Perez, 2010; Blomberg, 2003).

As states began adopting these zero-tolerance policies, suspensions and expulsions increased (Brown, 2006). At the same time as zero-tolerance policies for violence were growing, school districts adopted their version of the "broken windows" theory of policing (Brown, 2006). The "broken windows" theory is when minor offenses are targeted more heavily to deter more serious, violent crimes in the future. Schools also started to rely more heavily on the justice system by inviting officers into schools (Brown, 2006). From 1997 to 2007, the number of school resource officers (SROs) increased by nearly a third (Justice Policy Institute, 2011). They made administrators, teachers, students, and parents feel safer, especially after mass shootings like the Columbine High School shooting in 1998 (Addington, 2009). Police were there to protect, not to harm. However, that protection turned into more arrests of students. About 92,000 students were arrested in school during the 2011-2012 school year (USDE OCR, 2014). Most of those were low-level violations. According to a report published by the state courts, 74% of arrests in New York City public schools in 2012 were for misdemeanors or civil violations (New York City School-Justice Partnership Task Force, 2013). These arrests happen far more at schools with officers. A report by the Justice Policy Institute found that even controlling for a school district's poverty level, schools with officers had five times as many arrests for disorderly conduct as schools without them (Justice Policy Institute, 2011).

In education, school psychologists are likely to know that out-of-school suspensions or expulsions do not do anything to improve a student's academic standing, and they do not do anything to monitor behavior or improve safety. Students are victims who need resources, interventions, counseling, and processing of the trauma they are most likely experiencing, not to be removed from school (Kataoka, et al., 2012; Jaycox, et al., 2009). Students and school

systems need trained, knowledgeable behavioral health professionals who can lead effective practices and interventions (Fitzgerald & Cohen, 2012).

"Data shows that more than half of all U.S. children have experienced some kind of trauma in the form of abuse, neglect, violence, or challenging household circumstances—and 35 percent of children have experienced more than one type of traumatic event, according to the Centers for Disease Control and Prevention" (Minera, 2017, p .2). Behavioral health services need to be embedded in school change, school improvement plans, and barriers need to access need to be identified and remedied (Kataoka, et al., 2012). The Academy of Pediatrics (AAP) has declared mental health a national emergency since COVID-19 [AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health. (n.d.)]. Rates of suicide and mental health concerns in children steadily rose between 2010 and 2020 [AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health. (n.d.)]. This declaration from the Academy of Pediatrics states that the safety and stability of families are at risk and that the impact is so widespread that policymakers at all levels of government and advocates for children need to advocate for the following to improve outcomes for students:

- Increase federal funding from infancy through adolescence to ensure access to evidence-based mental health screening, diagnosis, and treatments with emphasis on the under-resourced populations.
- Improve access to technology and telemedicine and address the regulatory challenges creating barriers.
- Increase sustainable funding of effective models of school-based mental health care.

- Accelerate the adoption of effective and financially sustainable integrated care systems for vulnerable students.
- Strengthen prevention programs to reduce the risk of mental health crises in school-based settings and ensure a model of appropriate funding.
- Address the ongoing challenges for children, such as acute care settings and access to emergency care, by expanding step-down programs from inpatient units to community-based response teams.
- Fully fund comprehensive, community-based systems of care that connect families to evidence-based interventions in school settings.
- Advance policies ensuring compliance with and enforcing mental health parity laws.

Providing clarity around rules and standards needed to implement a change to behavioral health services is vital to enforcement, such as mandating a school psychologist to be in a position of authority within school systems. However, the detailed procedures related to rulemaking are only sometimes efficient. Regardless, norms that have the actual force of law or serve to inform are produced.

In 2017, the United States Supreme Court issued an opinion on free appropriate public education (FAPE) requirements in the Individuals with Disabilities Education Act (IDEA) (Couvillon, Yell, & Katsiyannis, 2018). The case was used to demonstrate the scope of the interpretation. The ruling was issued because it overturned a lower Court ruling that the educational services provided to a student with autism were not "merely more than de minimis" benefit. Through this ruling, the United States Department of Education provided more

information on the educational benefit that a child with a disability must be afforded based on the implementation of IDEA.

The ruling changed the scope of practice of IDEA's free and appropriate public education (FAPE) practices which promulgated the Department's Office of Special Education and Rehabilitative Services (OSERS) interest in receiving public comment to develop implementation questions and best practices. Various attorneys provided various interpretations and helped individual entities understand what the ruling meant and did not mean (Prince et al. 2018; Bueso, 2019). Prior to this ruling, courts relied on landmark cases; they did not establish any one test for determining educational benefit (Martin, et al., 1996).

This ruling changed that standard. "De minimis" in Latin means too trivial. Previous rulings did not establish a particular measure for education benefits, which left the lower courts disagreeing on interpreting educational benefits. Different substantive standards were applied, and the previous standards were no longer considered good law. State and local entities reviewed policies, procedures, and practices to provide the appropriate guidance to school districts and IEP teams. Although many districts were already implementing this standard, it was an opportunity to ensure that all children with disabilities were afforded high-standard educational opportunities.

Critical issues were quickly identified, and stakeholder groups within education began interpreting and applying this critical decision (Yell, 2019). Special education directors and superintendents across the state panicked, and the meeting frenzy began (Bueso, 2019). What did this rule mean for the day-to-day operations of our services? What needed to change immediately? What safety nets needed to be put in place? How much was this going to cost? The centerpiece to a child's education was just challenged, and entitlements were redefined. Districts needed to respond as soon as possible. Disabled children were entitled to have a chance to meet

challenging objectives, something that most educational entities strive for but, in some circumstances, is hard to achieve due to the nature of a disability (Couvillon et al., 2018; Yell, 2019; Bueso, 2019). The concerns about behavioral health best practices also need this type of critical decision making and scrutiny.

Current best practices in education depend upon the leadership of "whole school" approaches, which create a single, unified, and efficient service delivery model for all students, disabled and non-disabled, living in a community (Adelman, 2021). This practice is predicated on the belief that students are more alike than different from other students and that integrating programs and resources improves student outcomes for all. The culture, climate, and daily environment that is expected, understood, and led by school administration can create nurturing, positive, and safe environments that can change a child's perspective and life trajectory. However, we should not rely on the hope that administrators will implement these interventions based on priority or resources. These expectations should be demanded, required, and implemented with fidelity. Leading students cannot only be to rely on the juvenile justice system. Our society must recognize the need to keep them present inside the school system, not at home, on the streets, or in our criminal justice system (Christle et al., 2005).

Qualified behavioral health leaders can change student outcomes by redesigning discipline policies that demand more family engagement, embracing and using local resources and social service agencies, and requiring a social and emotional core curriculum. Schools need leaders who know supportive procedures to address the underlying causes of misbehavior, such as trauma, substance abuse, mental health issues, academic deficiencies, and poverty. Leaders need to possess strong moral convictions but not overzealous ones, which can be far more dangerous. Ethics and effectiveness need to converge. Leadership requires a mix of confidence

and humility. Leaders need to know the limitations of their knowledge and their perspective. A good leader is confident enough to ask for help, admit they are wrong, and know when they need additional training or support.

School leadership must know, align, and safeguard evidence-based practices for vulnerable youth. For example, research indicates that schools with SWPBS provide students with a school environment that is predictable, positive, safe, and consistent (Horner & Sugai, 2002). SWPBS has common behavioral expectations that are taught to all students using a common language. A critical component of SWPBS is fidelity of implementation in which all adults monitor student behavior and reward appropriate behavior (Horner & Sugai, 2009). All adults should have similar behavioral expectations of their students and leadership needs to ensure alignment. Inconsistent management practices fail to allow students to learn and practice social skills and self-management (Colvin, Kame'enui, & Sugai, 1994) and that the traditional approaches of verbal reprimands, suspensions, and detentions do not bring long-term change in behavior (Sprague et al., 2001). Reactive and punitive responses have proven ineffective in changing student behavior or outcomes (Burke et al., 2004; Horner et al., 2001) yet suspension and expulsion rates even in preschool increase (Zeng et al., 2019). Discipline decisions are made by leadership and leadership needs mandated, qualified professionals to guide those decisions.

Policy Recommendations

School-based behavioral health services are not regulated even though public schools are the primary providers of behavioral health services for children (Foster, Rollefson, Doksum, Noonan, Robinson, & Teich, J., 2005). Classroom management demands for safer schools and significant disparities in the provision of behavioral health services vary drastically across the nation (Slade, 2003). Federal laws, such as IDEA, address the behavioral support required by law

for the most vulnerable students, students with disabilities but not all students. Years of research have identified effective strategies, such as SWPBS, PBIS, and the use of ABA principles (Dwyer et al., 2000; Mayer, 1995; Metzler et al., 2001; Nelson et al., 1998; Safran & Oswald, 2003). School leaders must be trained and certified in evidence-based research practices (Maag & Katsiyannis, 2010). School psychologists, school counselors, and other behavioral health providers are qualified individuals who work in most school systems nationwide, but their duties and functions vary (Wingfield et al., 2010; Reiser et al., 2010).

Antisocial behaviors are one of the several challenges that schools face in educating all students, and schools become de facto behavioral health providers (Read & Lampron, 2012). These challenging conditions have led to the implementation of discipline policies that must be more effective and research based (Skiba & Peterson, 2000).

Teachers and school administrators need help. Education and behavioral health integration will build a solid foundation that will help (National Association of School Psychologists, 2021). However, educational reform and a change in the fundamental funding framework within school behavioral health are needed (Adelman & Taylor, 2021). This change needs a new set of priorities, the inclusion of integrated models, and attention to improving outcomes for all students with federal funds to support a strong research agenda (Adelman & Taylor, 2021).

Moving Toward a Public Health Promotion

The federal government should play a critical role in funding school-based behavioral health services. Federal guidelines can shape the priorities of school-based services. A public health model can be a place to start. Comprehensive frameworks are needed so that strategies can target individuals and integrate communities. Policies need to be more impactful, lead to a more

holistic approach with the intention to drive national conversations and increase public awareness, ultimately changing the perceptions and beliefs about behavioral health.

Drawing from PBIS and the public health model, a shift towards preventive measures can be more effective than merely intervening after behavioral health issues arise. Public health promotion should account for diverse student populations, recognizing unique challenges and cultural beliefs. The integration of these theories from various perspectives can provide a comprehensive understanding of school-based behavioral health services and their promotion. A federal role that is informed by such an integrative perspective can lead to better outcomes for students and communities.

Physical education is required in schools, but what about behavioral health services? The diversity of funding streams makes it challenging to collect data (Read & Lampron, 2012; Weist et al., 2000). Current funding sources for school behavioral health services are idiosyncratic, unsystematic, and undependable (Darlington et al., 2016). Fiscal solutions to support behavioral health programs are incredibly diverse nationwide (Read & Lampron, 2012; Weist et al., 2000). Funding changes quickly over time (Foster et al., 2005) and will require the development of different models of behavioral health financing, including those that reduce tax competition and conflict over scarce resources. Studies assessing the relative costs and effectiveness of different delivery models, such as colocation, coordination, and on-site versus off-site delivery, would be instrumental in formulating more robust fiscal policies (Council of Chief State School Offices, n.d.).

Behavioral health and educational outcomes are intertwined, but educational policy and behavioral health operate with different paradigms. How do we begin to bridge the gaps? One strategy includes the students receiving the service. The National Institute of Mental

Health shares that empowered youth have changed behavioral health service delivery in certain states. Research also tells us what behavioral health services in schools should focus on: social-emotional development, preventing mental health and psychosocial problems, enhancing resiliency, early intervention, and developing a unified, comprehensive, and equitable system of interventions, including the capacity of school personnel (Adelman et al., 2021). Federal funding that increases investment in student support services can remove many obstacles.

Formal connections with community behavioral health providers laid the foundation for school services (Brenner et al., 2001; Weist et al., 2001). Community-based care systems are the current platform for funding behavioral health services (Adelman et al., 2021). Schools can enlist community providers to spend more time on school campuses and to structure billing for those services. School-based health clinics in large, urban school districts have reduced access barriers to behavioral health (Lai et al., 2016).

Policy and funding need to be leveraged for behavioral health outcomes to improve [Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs. (n.d.)]. Behavioral health in school policies need to be reviewed to support an integrated approach. Several states have expanded the use of their federal dollars, but more is needed to impact the nation significantly. Federal funds such as IDEA, Social Security, Children's Mental Health Services Program, Medicaid, and formula grants, such as IDEA, are the first step. Recent funds made available for pandemic recovery include the Elementary and Secondary School Emergency Relief (ESSR) and the American Rescue Plan (ARP). Although not a constant, these funds can be leveraged to build a solid behavioral health foundation. Staff can be hired, and coordinated implementation plans can be matched.

Preventive evidenced-based programs, such as SWPBS and ABA can reduce time, cost, and effort (Bradshaw et al., 2010; Maag & Katsiyannis, 2010; Adelman, et al., 2021). Early identification in schools can reduce long-term psychiatric services (SAMHSA, 2020). Financing strategies that support expanded behavioral health services in schools, significant policy initiatives, and communities of practice exist; however, the disparities across the nation must be addressed. Sharing success stories with policymakers and innovative approaches can influence more supportive, equitable policies to increase needed funding.

Significant policy reviews are needed to support the integrated system of behavioral health services for students to move forward. Funds need to be leveraged to provide the necessary personnel and programs. Appropriations that Congress controls related to behavioral health services include the following with recommended dollars to move forward (Appropriations Committee Approves Fiscal Year 2022 Labor, Health and Human Services, Education, and Related Agencies Funding Bill, 2021, July 15):

Every Student Succeeds Act (ESEA):

- Title I-A (ESSA) Education for the Disadvantaged. Minimum $36.7B.
- Title II-A (ESSA) Supporting Effective Instruction. Minimum$2.3B.
- Title IV-A (ESSA) Student Support and Academic Enrichment Grants. Minimum $2.0B.

Office of Special Education and Rehabilitative Services (OSERS):

- Individuals with Disabilities Education Act Part B, Grants to States. Minimum $15.5B.
- IDEA Part B Preschool Grants. Minimum $598M.

- Individuals with Disabilities Education Act Part C, Infants and Toddlers with Disabilities, $732.2M.
- State Personnel Development. Minimum of $42M.
- Personnel Development to Improve Services and Results for Children with Disabilities: $300M.

Not only do the qualifications of the behavioral health provider matter, but the federal agencies administering the service matter. The agencies overseeing and guiding the delivery of behavioral health services are splintered. The rulemaking powers of IDEA and ESSA are essential. However, their rulemaking related to students' behavioral health needs must be more specific.

A review of the literature indicates that comprehensive frameworks, federal policies, equity considerations, and the adoption of a public health promotion related to the promotion of school behavioral health services are desperately needed.

Summary

School-based behavioral health services lack regulation, and despite public schools being primary providers of these services for children, there's a shortfall in funding and a shortfall of mandated qualified professionals (Keeton, et al., 2012). Classroom management challenges, due to issues like harassment, aggression, and social withdrawal, hinder teaching, and learning (Walker et al., 2003). Students exhibiting problem behaviors often face negative educational outcomes, including reduced academic scores and increased involvement in criminal activities (Loe & Feldman, 2007). Unfortunately, public education doesn't necessitate the inclusion of trained behavioral health professionals in leadership roles (Leithwood, Louis, Anderson, & Wahlstrom, 2004). In attempts to curb these antisocial behaviors, schools have adopted zero-

tolerance policies, yet many such reactive measures don't effectively improve student behavior or outcomes (Burke et al., 2004; Brown, 2006)

Behavioral health service provision in schools varies widely based on factors like location and school size, and while research has consistently shown the benefits of strategies like SWPBS, they aren't mandatory in leadership training programs (Leithwood, Louis, Anderson, & Wahlstrom, 2004). On a regulatory note, the 2004 amendment of the Individuals with Disabilities Education Act (IDEA) does highlight the importance of behavioral support for students with emotional disturbances and other disabilities. However, despite this federal mandate, there's still a piecemeal approach to behavioral health by policymakers. The ongoing behavioral health crisis among students, exacerbated by global events like the pandemic, necessitates a robust response. Policymakers must ensure unified, comprehensive, and equitable behavioral health efforts, emphasizing increased federal funding to better serve the nation's most vulnerable children.

School-wide Positive Behavior Support (SWPBS)

School-wide Positive Behavior Support (SWPBS) is a proactive strategy designed to foster a conducive learning environment by emphasizing primary, secondary, and tertiary student support structures (Bradshaw et al., 2010; Kabaka, 2021). Rooted in behavioral theory and applied behavior analysis, SWPBS promotes a disciplined yet positive academic setting (Horner et al., 2009; Jass, 2019). By defining and consistently applying behavioral expectations, the entire school community collaborates to create a unified culture wherein all students adhere to the same behavioral standards (Sugai & Horner, 2006). Successful implementation necessitates a holistic behavioral plan that elucidates expectations across various school scenarios, reinforces positive behavior, instructs students on these standards, and establishes consistent repercussions

for behavioral lapses. However, SWPBS remains optional in many U.S. schools, with educational leadership programs often omitting training on its foundational concepts.

The Role of Leadership

Leadership plays a pivotal role in academic environments (Amatea & Clark, 2005; Dollarhide et al., 2007). While classroom instruction holds the highest influence on learning, leadership follows closely, especially in contexts where challenges such as emotional disturbances among students arise. Principals shape the role of behavioral health professionals in schools and can direct initiatives like SWPBS. Nonetheless, if principals lack understanding in areas like applied behavioral analysis, they might struggle to address students' behavioral and mental health needs effectively. Successful SWPBS adoption has reaped substantial rewards, including reduced disciplinary actions and improved academic outcomes (Cushing, 2000; Luiselli et al., 2002; Nakasato, 2000; Nelson et al., 1996; Nelson et al., 1998; Nersesian, et al., 2000; Taylor-Greene et al., 1997; Sugai & Horner, 2006).

Expertise in Schools and Legislative Mandates

School psychologists and counselors, with their specialized training, play vital roles in most American educational systems (Sugai & Horner, 2008). These experts advocate for marginalized students, promote positive school cultures, and offer deep insights into child development. However, regulatory mandates can sometimes limit their roles and impact (IDEA, 2004). For instance, the Pennsylvania Department of Education sets specific regulations, and national associations provide guidelines for best practices. While these professionals possess expertise in areas like PBIS, ABA, and direct psychological services, their influence can be restricted, given their typical positions outside of leadership and decision-making circles (Wingfield et al., 2010; Reiser et al., 2010).

Public schools play a significant role as behavioral health service providers for children (Ijadi-Maghsoodi et al., 2018). However, there is a lack of regulation in these services, leading to stark disparities across the nation. While there are federal laws like IDEA addressing behavioral support, schools still heavily rely on classroom management and safety protocols. There's ample research on effective strategies like SWPBS, PBIS, and ABA principles. School psychologists and counselors are present in most schools, but their roles aren't uniform across the country.

Challenges, Policies, and the Need for a Holistic Approach

Educational institutions grapple with diverse challenges, from antisocial behaviors to the complexity arising from increasingly heterogeneous student populations (Dwyer et al , 1998; Burke et al., 2004). Amidst these challenges, schools are often the default behavioral health providers, despite many staff lacking the necessary training to address students' behavioral issues. The desire for safe learning environments has led to zero-tolerance disciplinary policies, which, although well-intentioned, can be punitive and ineffective (Skiba & Peterson, 1999). Such approaches can inadvertently exacerbate antisocial behaviors, disproportionately affect minority populations, and often result in overreactions to minor student misbehaviors. It underscores the need for comprehensive, evidence-based approaches like SWPBS that prioritize both discipline and support.

Antisocial behaviors present challenges in schools, making them default mental health providers (Read & Lampron, 2012). This has led to a shift in discipline policies, leaning towards more effective and research-based approaches. The need for a comprehensive integration of education and mental health has never been more evident, with a push for reform in school mental health funding and the establishment of new priorities. States like New York, Virginia, and Florida have recognized the importance of mental health by making it a mandatory subject in

schools. However, funding remains a major challenge (Addressing the Youth Mental Health Crisis: The Urgent Need for More Education, Services, and Supports, n.d.; Boulden & Schimmel, 2022). The diverse nature of funding streams and the idiosyncratic nature of current sources make it hard to sustain and manage (Read & Lampron, 2012; Weist et al., 2000). Strategies are needed to address these fiscal challenges, including exploring various delivery models and removing restrictions in Medicaid reimbursement for non-office-based care.

Intertwining Education and Behavior Health Outcomes

Educational and mental health outcomes are deeply connected, yet they operate on different paradigms. Bridging this gap involves focusing on social-emotional development, prevention, early intervention, and capacity building. This calls for advocacy, federal funding, and strategies to align different paradigms and ensure consistent delivery. Moreover, community mental health providers' role is crucial, and formal connections with them can enhance school services. Also, the role of federal funds in K-12 education, community-based care systems, and other avenues like the ACA in supporting mental health cannot be overlooked.

There's a pressing need for clearer policies and funding mechanisms to improve mental health outcomes in schools. Evidence-based preventive programs can help reduce long-term psychiatric services, but the disparities in service provisions across the nation remain a concern. While many administrators are unaware of funding requirements for comprehensive behavioral health needs, splintered funding from varied sources leads to gaps in service delivery. To move forward, there's a need for significant policy reviews, prohibition of ineffective disciplinary practices, and appropriate allocation of funds for services and programs to benefit the students.

Policies mandating the alignment of psychological and counseling services are missing, which need to change. School psychologists are qualified to lead PBIS, initiate strong ABA

practices, and can provide direct psychological services to students. Psychologists can lead school teams to understand mental health screeners, suicide risk assessments, threat assessments, and individual counseling. Psychologists, by training, know effective academic interventions, the academic structure of the school, and relevant components to the culture and climate of the school environment. They are well-positioned to consult, coordinate, and lead their educational colleagues to improve behavioral and mental health supports for all students. Furthermore, they can lead and direct the appropriate mental health and child development systems to improve school-wide practices and policies to ensure students receive needed services (NASP, 2021). Reading, writing, and arithmetic need another partner in schools today: federally funded behavioral health leadership.

Schools currently tend to respond to behavioral health challenges as they arise, often leading to short-term solutions that may not be financially sustainable in the long run. To address this, there's a pressing need for a more comprehensive framework that combines education, behavioral health, and public policy. This integration should aim to proactively address issues before they become critical, which requires a strategic alignment of educational goals, behavioral health support, and policy frameworks. By doing so, schools can adopt a forward-thinking approach that not only anticipates future challenges but also manages resources more effectively, leading to solutions that are both effective in meeting students' needs and sustainable in terms of fiscal management. Federal funding that mandates qualified behavioral health professionals in school leadership can facilitate the necessary shift from a reactive to a proactive stance. Collaborative efforts among educators, behavioral health professionals, and policymakers, are needed to expand, prevent, and ensure equitable access to services so students and staff are safe at school.

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