A Center Policy Report . . .

The Current Status of Mental Health in Schools: A Policy and Practice Analysis

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The Center is co-directed by Howard Adelman and Linda Taylor and operates
under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA,

Write: Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563
Phone: (310) 825-3634 Fax: (310) 206-8716 Toll Free: (866) 846-4843
email: smhp@ucla.edu website: http://smhp.psych.ucla.edu

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Preface

As the Surgeon General's national action agenda for children's mental health indicates:

> *Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by the very institutions and systems that were created to take care of them.*
> (Department of Health and Human Services, 2001)

One of those institutions is the school. Around the world, those concerned with advancing mental health in schools are determined to enhance how schools address mental health and psychosocial concerns. And, now is a critical period for doing so.

Some see the field of MH in schools as in its infancy; others think it has grown into adolescence. What it will look like as an adult is unclear; what it should look like is under debate.

In 2001, the *Policy Leadership Cadre for Mental Health in Schools* stressed that, at this stage in the field's development, advancing mental health in schools is about much more than expanding services and creating full service schools. It is about becoming part of comprehensive, multifaceted systemic approach that strengthens students, families, schools, and neighborhoods and does so in ways that maximizes learning, caring, and well-being.

Over the last decade, we have found leaders for MH in schools increasingly emphasizing that efforts to enhance how schools address mental health and psychosocial concerns must be developed around well-conceived models and the best available information and scholarship. They stress that policy must be realigned to create a cohesive framework and must connect in major ways with the mission of schools. Attention must be directed at restructuring the education support programs and services that schools own and operate and weave school owned resources and community owned resources together into comprehensive, integrated approaches for addressing problems and enhancing healthy development. And, in doing all this, the call has been to do more to involve families and to connect the resources of schools, neighborhoods, and institutions of higher education.

Toward enhancing mental health in schools, our Center has clarified the need to fully integrate mental health agenda into school improvement policy and planning. And, we have called upon policy makers to deal with the problems of "scale-up" (e.g., underwriting model development and capacity building for system-wide replication of promising models and institutionalization of systemic changes).

Our intent here is to build on previous reports with a view to further clarifying policy implications for advancing mental health in schools. We begin with a brief reflection on what schools have been and are doing about mental health concerns. Then, we explore emerging trends and end with a discussion of policy implications.

As always, we owe many folks for the contents of this report. In developing this analysis, we drew on various resources. After an initial draft was completed, we sent it to all members of the *Policy Leadership Cadre for Mental Health in Schools* and to others who are knowledgeable about and/or have a vested interest in mental health in schools. The feedback was universally positive, and a few suggestions were offered about what else might be worth including. The present document reflects the feedback we received.

We thank everyone for their contribution, and as always, we take full responsibility for any misinterpretations and errors.

Howard Adelman & Linda Taylor, Co-directors

INTRODUCTION

In many schools, the need for enhancing mental health is a common topic. And, as the final report of the President's New Freedom Commission on Mental Health (2003) recognizes, efforts to enhance interventions for children's mental health must involve schools. Thus, those interested in improving education and those concerned about transforming the mental health system in the U.S.A. all are taking a new look at schools.

However, while mental health in schools is widely discussed in many countries, what's being talked about often differs in fundamental ways. The fact is that various enterprises are being pursued; therefore, there are divergent policy, practice, research, and training agenda. This not only contributes to a degree of confusion, it seems to be a source of increasing conflicts and feeds into the marginalization of the work.

At the outset, the question arises: Why Mental Health *in Schools*?

Why MH in schools?

While there are many societal considerations involved in answering this question, for the most part the usual answers incorporate either or both of the following points:

(1) Accessing and meeting the needs of students (and their families) who require mental health services is facilitated by contact through and at schools.

(2) Addressing psychosocial and mental and physical health concerns is essential to the effective school performance of some students.

Implied in both answers is the hope of enhancing the nature and scope of mental health interventions to fill gaps, enhance effectiveness, address problems early, reduce stigma, and fully imbue clinical and service efforts with public health, general education, and equity orientations.

Point 1 typically reflects the perspective and agenda of agencies and advocates whose mission is to improve mental health services. The second point reflects the perspective and agenda of student support professionals and some leaders for school improvement, as well as providing a supportive rationale for those wanting schools to play a greater role related to addressing young people's health concerns.

Efforts to advance the imperative for mental health in schools must strive to coalesce the various agenda and broaden perspectives of mental health to encompass a full continuum of interventions that integrate school and community resources. To do so, requires an appreciation of the oft-voiced public concern that schools cannot be responsible for meeting every need of their students.

Schools are not in the MH business

Education is the mission of schools, and policymakers responsible for schools are quick to point this out when they are asked to do more, especially when the focus is on mental health. It is not that they disagree with the idea that healthier students learn and perform better. It is simply that prevailing school accountability pressures increasingly have concentrated policy on instructional practices – to the detriment of all matters not seen as *directly* related to raising achievement test scores. Those concerned with enhancing mental health in schools must accept the reality that schools are not in the mental health business.

Then, after developing an understanding of what school leaders currently are doing to achieve the mission of schools, they need to clarify how agenda for mental health in schools help accomplish that mission. This includes matters such as how MH agenda help meet the demands for school improvement, close the achievement gap, and address racial, ethnic, disability, and socio-economic disparities.

Because schools are not in the mental health business, they tend to shy away from the term, especially since it usually is viewed as only about treating mental disorders. They also tend to marginalize all mental health initiatives. Nevertheless, a variety of mental health in school activity is pursued across the country. And, ironically, available research suggests that for some youngsters' schools are the main providers of mental health services. As Burns and her colleagues (1995) found, "the major player in the de facto system of care was the education sector – more than three-fourths of children receiving mental health services were seen in the education sector, and for many this was the sole source of care."

Anyone who has spent time in schools can itemize the multifaceted mental health and psychosocial concerns that warrant attention. The question for all of us is:

How should our society's schools address these matters?

So, how does MH connect with the schools mission?

In answering this question, it is useful to reflect on what schools have been and are doing about mental health concerns. Therefore, this report begins by highlighting a bit of history and outlines the current status of MH in schools. Then, we explore emerging trends and discuss policy implications.

Part I. Past as Prologue

It is, of course, not a new insight that physical and mental health concerns must be addressed if schools are to function satisfactorily and students are to succeed at school. It has long been acknowledged that a variety of psychosocial and health problems affect learning and performance in profound ways. Such problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure.

The Last 50 Years

Because of all this, school policy makers, have a lengthy (albeit somewhat reluctant) history of trying to assist teachers in dealing with problems that interfere with schooling. Prominent examples are seen in the range of health, social service, counseling, and psychological programs schools have provided from the end of the 19th century through today (Baumgartner, 1946; Dryfoos, 1994; Flaherty, Weist, & Warner, 1996; Tyack, 1992).

One interesting policy benchmark appeared in the middle of the 20th century when NIMH increased the focus on mental health in schools by publishing a major monograph on the topic (Lambert, Bower, & Caplan, 1964). Since then, many initiatives and a variety of agenda have emerged – including efforts to expand clinical services in schools, develop new programs for "at risk" groups, and incorporate programs for the prevention of problems and the promotion of social-emotional development (Califano, 1977; Dryfoos, 1994; Knitzer, Steinberg, & Fleisch, 1990; Millstein, 1988; Steiner, 1976; Stroul & Friedman, 1986).

Over the past 20 years, a renewed emphasis in the health and social services sectors on enhancing access to clients has resulted in increased linkages between schools and community service agencies (Center for the Future of Children, 1992; Warren, 2005). This "school-linked services" movement has added impetus to advocacy for mental health in schools. It has promoted school-based health centers, school-based family resource centers, after school programs, and other efforts to connect community resources to the schools. More recently, some advocates for school-linked services have coalesed their efforts with those working to enhance initiatives for youth development, community schools, and the preparation of healthy and productive citizens and workers (Melaville & Blank, 1998). These coalitions have expanded interest in social-emotional learning and protective factors as ways to increase students' assets and resiliency and reduce risk factors (Greenberg, Weissberg, O'Brien, Zins, Fredericks, Resnik, & Elias, 2003; Hawkins & Catalano, 1992). However, the amount of actual mental health activity in schools generated by these efforts remains relatively circumscribed (SAMHSA, 2005).

Federal Support for MH in Schools

In 1995, a direct effort to advance mental health in schools was initiated by the U.S. Department of Health and Human Services through its Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). When this *Mental Health in Schools Program* was renewed in 2000 and again in 2005, HRSA and SAMHSA's Center for Mental Health Services braided resources to co-support the work. The purpose of this program is to enhance the role schools play in mental health for children and adolescents. Specifically, the emphasis is on increasing the

capacity of policy makers, administrators, school personnel, primary care health providers, mental health specialists, agency staff, consumers, and other stakeholders so that they can enhance how schools and their communities address psychosocial and mental health concerns. Particular attention is given to prevention and responding early after the onset of problems as critical facets of reducing the prevalence of problems. The core of the work has been embedded in two national centers. The two which were initially funded in 1995, with a primary emphasis on technical assistance and training, successfully reapplied during the 2000 open competition. A third open competition for a 5 year funding cycle was offered in 2005 with an increasing emphasis on policy and program analyses to inform policy, practice, research, and training. Again, the initially funded Centers applied and were successful in the process. The two Centers are the *Center for Mental Health in Schools* at UCLA and the *Center for School Mental Health Analysis and Action* (formerly the *Center for School Mental Health Assistance*) at the University of Maryland, Baltimore (Anglin, 2003).

Other federal initiatives promote mental health in schools. These include programs supported by (1) the U.S. Department of Education's Office of Safe and Drug Free Schools (including a recently added grants program for the "Integration of Schools and Mental Health Systems"), its Office of Special Education and Rehabilitative Services, and some of the school improvement initiatives under the No Child Left Behind Act, (2) the "Safe Schools/Healthy Students" initiative, which is jointly sponsored by SAMHSA, U.S.D.O.E., and the U.S. Department of Justice, (3) components of the Center for Disease Control and Prevention's "Coordinated School Health Program" and (4) SAMHSA through its "Elimination of Barriers Initiative" and various other programs and projects, as well as its focus on schools in the *Mental Health Transformation State Incentive Grant Program*. A smattering of projects that relate to agenda for MH in schools also are supported by several other federal agencies. The future of all federal programs related to MH in schools is at risk because of budget cuts in 2006.

Another Call for Collaboration

In 2000, the Policymaker Partnership at the National Association of State Directors of Special Education and the National Association of State Mental Health Program Directors met to explore how the two entities could collaborate to promote closer working relations between state mental health and education agencies, schools and family organizations. This led, in 2002, to the concept paper *Mental Health, Schools and Families Working Together for All Children and Youth: Toward a Shared Agenda*. Development of the concept paper was funded by the Office of Special Education Programs for purposes of encouraging state and local family and youth organizations, mental health agencies, education entities and schools across the nation to enter new relationships to achieve positive social, emotional and educational outcomes for every child. The paper focuses on needed policy development and changes to move toward systemic coordination and integration of programs and services. The vision presented is for schools, families, child-serving agencies, and the broader community to work collaboratively to promote opportunities for and to address barriers to healthy social and emotional development and learning. The aim is to align systems and ensure the promise of a comprehensive, highly effective system for children and youth and their families. In stating the need for agencies and schools to work together, the report stresses:

> "While sharing many values and overarching goals, each agency has developed its own organizational culture, which includes a way of looking at the world, a complex set of laws, regulations and policies,exclusive jargon and a confusing list of alphabet-soup acronyms. Funding sources at the federal, state and local levels have traditionally reinforced this separation into "silos." The result is that agencies are almost totally isolated entities, each with its own research and technical assistance components and its own service delivery system, even though they are serving many of the same children. The isolation of each agency, combined with its bureaucratic complexity, requires a long-term commitment of all partners to bridge the gaps between them. Collaborative structures must be based on a shared vision and a set of agreed upon functions designed to enable a shared agenda. Legislative, regulatory or policy mandates may help bring agency representatives to the table, but development of true partnerships and the successful accomplishment of goals depends on participants gaining trust in one another as they pursue a shared agenda."

School Professionals Involved with MH & Psychosocial Concerns

Over the years, the most widespread activity related to mental health in schools has been carried out by school staff described variously as student support staff, pupil personnel professionals, and specialists. These include school counselors, psychologists, social workers, nurses, special education staff, resource teachers, and various other therapists and paraprofessionals.

The numbers have fluctuated up and down over the last 20 years. In the 1990s, it was estimated that professional-to-student ratios for school psychologists or school social workers averaged 1 to 2,500 students; for school counselor, the ratio was about 1 to 1,000 (Carlson, Paavola, & Talley, 1995). In 2000, the *School Health Policies and Program Study* conducted by the National Center for Chronic Disease Prevention and Health Promotion (see http://www.cdc.gov) reported on a sample of 51 state departments of education, 560 school districts, and 950 schools. Findings indicated that 77% of schools had a part or full time guidance counselor, 66% had a part or full time school psychologist, and 44% had a part or full time social worker. Of course, there is considerable variation state-by-state.

Whatever the number, historical accounts stress that schools have used their resources to hire a substantial body of student support professionals. As a result, it is these school staff who have been the core around which programs have emerged.

All the activity over the years is reflected in the burgeoning of organizations and centers that have relevance for the focus of schools on mental health and psychosocial concerns. These include a variety of technical assistance, training, and resource centers.

See Gateway to a World of Resources for Enhancing MH in Schools –
http://smhp.psych.ucla.edu/gateway/gateway_sites.htm

Also, see the sampling of major references related to MH in Schools.
http://smhp.psych.ucla.edu/qf/references.htm

Part II. Where the Field is Now

Data cited on diagnosable mental disorders generally suggest that from 12-22% of all youngsters under age 18 are in need of services for mental, emotional or behavioral problems. These figures are reflected in the Surgeon General's 1999 report on *Mental Health* (U.S. Department of Health and Human Services, 1999). Referring to ages 9 to 17, that document states that 21% or "one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year" – with 11% of all children experiencing significant impairment and about 5 percent experiencing "extreme functional impairment." These data also are reflected in CDC's Youth Risk Behavior Surveys, in a 2004 report from the Annenberg Public Policy Center (See Exhibit 1), and in preliminary data from the 2005 National Health Interview Survey (Simpson, Cohen, Pastor, & Reuben (2006).

The Need from the School's Perspective

The picture worsens when one expands the focus beyond the limited perspective on diagnosable mental disorders to encompass the number of young people experiencing psychosocial problems and who are "at risk of not maturing into responsible adults" (Dryfoos, 1990). Several reports have amply documented the problem (Greenberg, Domitrovich, & Bumbarger, 1999; Institute of Medicine, 1994; NIMH, 1993, 1998). (Also see fact sheets and reports on the websites for SAMHSA's Center for Mental Health Services and USDOE's Safe and Drug Free Schools Program.) An estimate from the Center for Demographic Policy suggests that 40% of young people are in bad educational shape and therefore will fail to fulfill their promise. The reality for many large urban schools is that well-over 50% of their students manifest significant learning, behavior, and emotional problems (Center for Mental Health in Schools, 2003). For a large proportion of these youngsters, the problems are rooted in the restricted opportunities and difficult living conditions associated with poverty. Almost every current policy discussion stresses the crisis nature of the problem in terms of future health and economic implications for individuals and for society; the consistent call is for major systemic reforms.

Related to the above figures is the fact that a growing segment of youngsters manifesting emotional upset, misbehavior, and learning problems routinely are assigned diagnostic labels denoting serious disorders (e.g., attention deficit/hyperactivity disorder, depression, learning disabilities). This trend flies in the face of the reality that the problems of *most* youngsters are not rooted in internal pathology, and many troubling symptoms would not develop if environmental circumstances were appropriately different. Moreover, the trend to diagnosing so many learning, behavior, and emotional problems as disorders leads to large numbers of misdiagnoses and inappropriate and expensive treatments. All this contaminates research and training (Lyon, 2002). Current policy and practice suggest that the way to reduce misdiagnoses and misprescriptions is to place mental illness in perspective with respect to psychosocial problems and to broadly define mental health to encompass the promotion of social and emotional development and learning (Adelman, 1995; Adelman & Taylor, 1994). Schools are being asked to play a major role in all this through strategies such as assessing "response to intervention" prior to diagnosis (see the 2004 reauthorization of IDEA).

Exhibit 1

Some 2004 Data on Students with MH Needs

(Reported by the Annenberg Public Policy Center)

From April 5 to May 28, 2004, the Annenberg Public Policy Center (APPC) as part of the Annenberg Foundation Trust at Sunnylands' Initiative on Adolescent Mental Health surveyed over 1400 public school professionals. The focus of the survey was on how schools provide treatment and counseling for students in need of such services.

The Princeton Survey Research Associates International conducted telephone interviews with 725 high-school and 515 middle-school professionals knowledgeable about the mental health services in their schools.*

Survey findings indicate that the respondents view high school student depression and use of alcohol and illegal drugs as even more serious problems than various forms of violence, including bullying, fighting and use of weapons. More than two thirds (68%) of the high school professionals surveyed identified depression as a great (14%) or moderate (54%) problem in their schools. Similar overall levels of concern were raised about use of alcohol (71%) and illegal drugs (72%). In contrast, 54% of high school professionals identified bullying as a great (11%) or moderate (43%) problem. Even lower levels of concern were expressed about fighting between students (37%) and weapon carrying (6%) at the high school level. Other concerns cited were anxiety disorders (42%), eating disorders (22%), and various forms of self harm such as cutting (26%).

Unlike their counterparts in high schools, middle school professionals are more concerned about interpersonal conflict. Although high proportions of middle school professionals identify depression (57%) and use of alcohol (28%) and illegal drugs (37%) as at least moderate problems, bullying is seen as a problem by 82% of professionals and fighting by 57% of professionals in middle schools. Weapon carrying remains a concern among only 5% of professionals.

Although 66% of the high schools indicated having a process for *referring* students with mental health conditions to appropriate providers of care, only 34% reported having a clearly defined and coordinated process for identifying such students. Comparable findings come from the middle schools; however, 42% of professionals reported having a clearly defined process for identifying students with mental conditions. Only about 3% of the high schools indicated use of universal screening. An additional 5% claim to screen most of their students.

When asked what percentage of their students who might need counseling or treatment actually receive such services, only 7% of high school professionals said that all do and only 31% said that most do. The majority indicated that only half or fewer received the services they need. When asked the same question about receiving services on site at their school, the percentages were even lower: 6% said all do and 22% said most do. Only 24% of school professionals say their high schools have counseling available for students with alcohol or drug dependence problems.

*A minimum of 20 attempts were made to contact a mental health professional at each school. Calls were staggered over different times of day and days of the week to maximize the chance of making contact with potential respondents. Prior to being called, the principal of each school was sent a letter introducing the research and explaining that a mental health professional in the school could expect a call to participate in the study in the coming weeks. In addition, the principals as well as the respondents were told that for their participation a $20,000 charitable donation would be made in the name of all participating schools to an organization that works to improve mental health care among adolescents. The letter also gave an 800 number so that mental health professionals could call in and take the survey at their own convenience. The response rate for the survey was 72%. The sample of schools contained 2,000 public schools drawn from the *Common Core of Data Public Elementary/Secondary School Universe 2002-2003*—a database of virtually all public elementary and secondary schools in the United States produced annually by the National Center for Education Statistics (NCES). The sample was selected to represent all schools that have at least 100 students and that have classes in at least one middle or high school grade. It is estimated that this sample frame represents more than 90% of all adolescent students in the US. The database is compiled from the administrative records provided by state education agencies. The margin of error for the high school component is +/- 3.7% and 4.4% for the middle schools. Results are being included in a forthcoming Oxford University Press book, "A Call for Effective Treatments for Adolescent Mental Health." www.appcpenn.org

Broadening Understanding of the term "Mental Health"

The reality is that when many people hear the term *mental health*, they think mental *illness.* Many people hear *mental health in schools* and they think it's only about therapy and counseling. The reality, of course, is that MH in schools is about much more than providing students with therapy or counseling.

Mental health in schools also means to be about such matters as

- providing programs to (a) promote social-emotional development, (b) prevent mental health and psychosocial problems, and (c) enhance resiliency and protective buffers
- providing programs and services to intervene as early after the onset of learning, behavior, and emotional problems as is feasible
- enhancing the mental health of families and school staff
- building the capacity of all school staff to address barriers to learning and promote healthy development
- addressing systemic matters at schools that affect mental health, such as high stakes testing (including exit exams) and other practices that engender bullying, alienation, and student disengagement from classroom learning
- developing a comprehensive, multifaceted, and cohesive continuum of school-community interventions to address barriers to learning and promote healthy development.

Even more to the point, analyses of the contrasting enterprises being pursued under the banner of MH in schools find seven different agenda with respect to policy, practice, research, and/or training. In Exhibit 2, the agenda are grouped and subdivided in terms of the *primary* vested interests of various parties. Advocates for the first six items would argue for "school-based mental health" as essential to what they want to achieve. However, while some agenda items are complementary, some are not.

Given the diverse agenda, it is not surprising that competing interests come into conflict with each other. For example, those concerned with nurturing positive youth development and mental health and those focusing on the treatment of mental and behavioral disorders often find themselves in counter-productive competition for sparse school time and resources. This contributes to the marginalization (see p. 16) that characterizes MH in schools and to the backlash to efforts to enhance policy and practice.

Exhibit 2

Diverse Agenda for Mental Health in Schools

(1) Efforts to use schools to increase *access* to kids and their families for purposes of
(a) conducting research related to mental health concerns
(b) providing services related to mental health concerns.

(2) Efforts to increase *availability* of mental health interventions
(a) through expanded use of school resources
(b) through co-locating community resources on school campuses
(c) through finding ways to combine school and community resources.

(3) Efforts to get schools to *adopt/enhance specific programs and approaches*
(a) for treating specific individuals
(b) for addressing specific types of problems in targeted ways
(c) for addressing problems through school-wide, "universal interventions
(d) for promoting healthy social and emotional development.

(4) Efforts to *improve specific processes and interventions* related to mental health in schools (e.g., improve systems for identifying and referring problems and for case management, enhancing "prereferral" and early intervention programs)

(5) Efforts to enhance the *economic interests* of various entities (e.g., specific disciplines, guilds, contractors, businesses, organizations) that are
(a) already part of school budgets
(b) seeking to be part of school budgets.

(6) Efforts to *change how student supports are conceived* at schools (e.g., rethink, reframe, reform, restructure) through
(a) enhanced focus on multi-disciplinary team work (e.g. among school staff, with community professionals)
(b) enhanced coordination of interventions (e.g., among school programs and services, with community programs and services)
(c) appropriate integration of interventions (e.g., that schools own, that communities base or link with schools)
(d) modifying the roles and functions of various student support staff
(e) developing a comprehensive, multifaceted, and cohesive component for systematically addressing barriers to student learning at every school.

(7) Efforts to *reduce school involvement* in mental health programs and services (e.g., to maximize the focus on instruction, to use the resources for youth development, to keep the school out of areas where family values are involved).

Currently, there are about 90,000 public schools in about 15,000 districts enrolling about 48 million students. Over the years, most (but obviously not all) schools have instituted policies and programs designed with a range of mental health and psychosocial concerns in mind. Some directly support school counseling, psychological, and social service programs and personnel; others connect community programs and personnel with schools. As a result, most schools have some interventions to address a range of mental health and psychosocial concerns, such as school adjustment and attendance problems, substance abuse, emotional problems, relationship difficulties, violence, physical and sexual abuse, delinquency, and dropouts. And, there is a large body of research supporting the promise of much of this activity.*

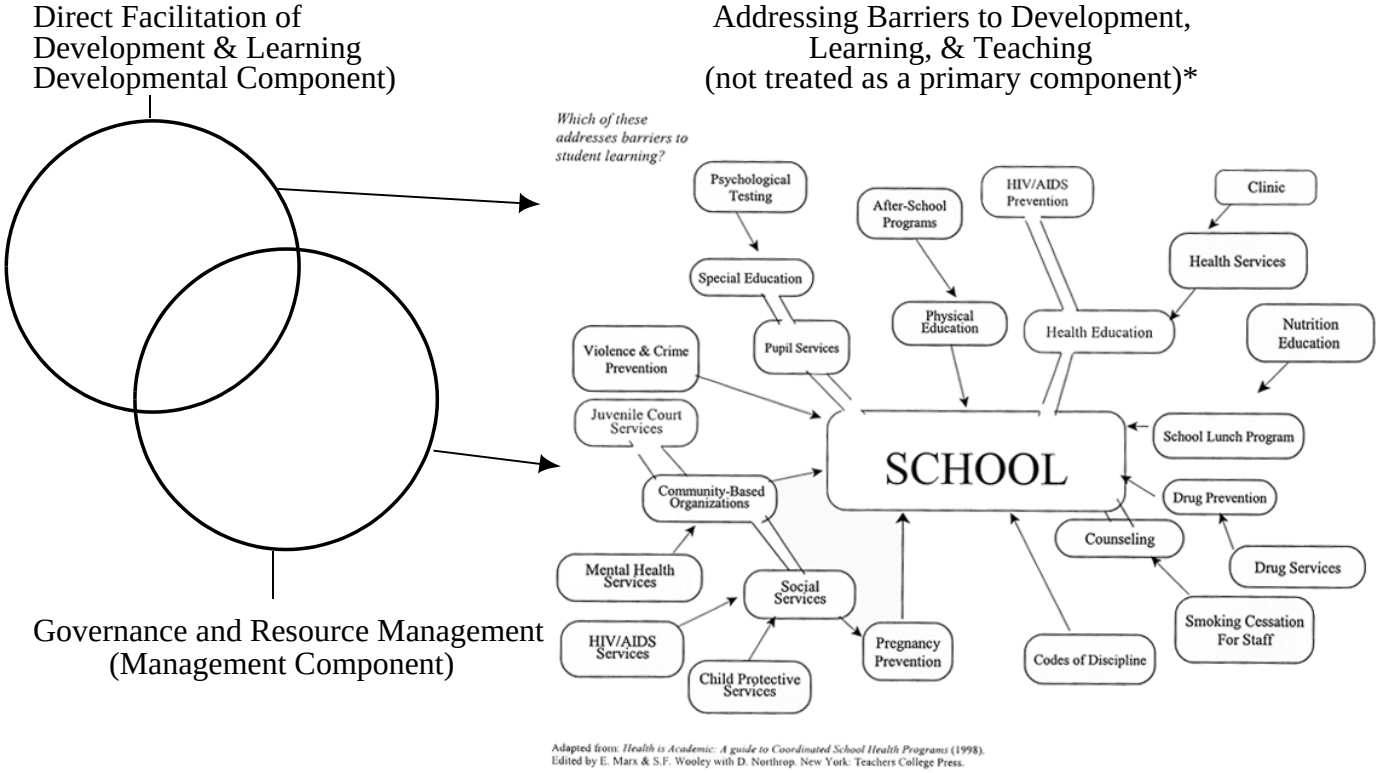
Addressing psychosocial and mental health concerns in schools typically is not assigned a high priority

School-based interventions relevant to mental health encompass a wide variety of practices, an array of resources, and many issues. However, addressing psychosocial and mental health concerns in schools typically is not assigned a high priority. Such matters gain stature for a while whenever a high visibility event occurs – a shooting on campus, a student suicide, an increase in bullying. Because of their usual humble status, efforts continue to be developed in an ad hoc, piecemeal, and highly marginalized way (see Exhibit 3).

*There are too many references to cite here, but a bit of an overview of work that is directly relevant to school-based and linked interventions can be garnered from Adelman and Taylor (2006), Albee and Gullotta (1997), Armbruster & Lichtman (1999), Barrett & Ollendick (2004), Borders and Drury (1992), Carnegie Council on Adolescent Development (1988), Center for Mental Health in Schools (2004a), Catalano & Hawkins (l995), Dryfoos (1994, 1998), Durlak (1995), Duttweiler (1995), Elliott (1998), Franklin, Harris, & Allen-Mears (2006); Goleman (1995), Henggeler (1995), Hoagwood & Erwin, 1997, Karoly, Greenwood, Everingham, et al., 1998, Kazdin (1993), Larson (1994), Robinson (2004), Rones & Hoagwood (2000), Scattergood, Dash, Epstein, & Adler, 1998, Schorr (1988, 1997), Slavin, Karweit, and Wasik (1994), Thomas and Grimes (2002), Zins, Weissberg, Wang, & Walberg (2004), Weist, Evans, & Lever (2003).

Exhibit 3

Mental Health in Schools and All Direct Efforts to Address Barriers to Learning and Development are Marginalized and Fragmented in Policy and Practice



*While not treated as a primary and essential component, every school offers a relatively small amount of school-owned student "support" services – some of which links with community-owned resources. Schools, in particular, have been reaching out to community agencies to add a few more services. All of this, however, remains marginalized and fragmented in policy and practice.

School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as out of classroom programs and may be designed for an entire class, groups, or individuals. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth – though relatively few resources usually are allocated for such activity. Exhibit 4 outlines the five major *delivery mechanisms and formats* used in schools to pursue the various agenda for mental health.

Exhibit 4 Delivery Mechanisms and Formats for MH in Schools

The five mechanisms and related formats are:

1. *School-Financed Student Support Services* – Most school districts employ pupil services professionals such as school psychologists, counselors, school nurses, and social workers to perform services related to mental health and psychosocial problems (including related services designated for special education students). The format for this delivery mechanism tends to be a combination of centrally-based and school-based services.

2. *School-District Mental Health Unit* – A few districts operate specific mental health units that encompass clinic facilities, as well as providing services and consultation to schools. Some others have started financing their own School-Based Health Centers with mental health services as a major element. The format for this mechanism tends to be centralized clinics with the capability for outreach to schools.

3. *Formal Connections with Community Mental Health Services* – Increasingly, schools have developed connections with community agencies, often as the result of the school-based health center movement, school-linked services initiatives (e.g., full service schools, family resource centers), and efforts to develop systems of care ("wrap-around" services for those in special education). Four formats and combinations thereof have emerged:

- co-location of community agency personnel and services at schools – sometimes in the context of School-Based Health Centers partly financed by community health organizations
- formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center
- formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of MH services
- contracting with community providers to provide needed student services

4. *Classroom-Based Curriculum and Special Out of Classroom Interventions* – Most schools include in some facet of their curriculum a focus on enhancing social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. And, of course, special education classrooms always are supposed to have a constant focus on mental health concerns. Three formats have emerged:

- integrated instruction as part of the regular classroom content and processes
- specific curriculum or special intervention implemented by personnel specially trained to carry out the processes
- curriculum approach is part of a multifaceted set of interventions designed to enhance positive development and prevent problems

5. *Comprehensive, Multifaceted, and Integrated Approaches* – A few school districts have begun the process of reconceptualizing their piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. They are starting to restructure their student support services and weave them together with community resources and integrate all this with instructional efforts that effect healthy development. The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment regimens. Mental health and psychosocial concerns are a major focus of the continuum of interventions, as reflected in initiatives designated as expanded school mental health. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care and the growing movement to create community schools. Three formats are emerging:

- mechanisms to coordinate and integrate school and community services
- initiatives to restructure student support programs/services and integrate them into school reform agenda
- community schools

Federal and state mandates tend to determine how many pupil services professionals are employed

As indicated in Part I, school districts use a variety of their own *personnel* to address student support concerns. These may include "pupil services" or "support services" specialists such as psychologists, counselors, social workers, psychiatrists, and nurses, as well as a variety of related therapists. Federal and state mandates tend to determine how many pupil services professionals are employed, and states regulate compliance with mandates. Governance of their work usually is centralized at the district level. In large districts, counselors, psychologists, social workers, and other specialists may be organized into separate units, overlapping regular, compensatory, and special education.

Specialists tend to focus mainly on students seen as problems or as having problems. Their many *functions* can be grouped into: (1) direct services and instruction, (2) coordination, development, and leadership related to programs, services, resources, and systems, and (3) enhancement of connections with community resources. (In keeping with this last function, the focus often is on linking and collaborating with community agencies and programs to enhance resources and improve access, availability, and outcomes.)

Prevailing direct intervention approaches encompass responding to crises, identifying the needs of targeted individuals, prescribing one or more interventions, offering brief consultation, and providing referrals for assessment, corrective services, triage, diagnosis, and various gatekeeping functions. In some situations, however, resources are so limited that specialists can do little more than assess for special education eligibility, offer brief consultations, and make referrals to special education and/or community resources.

It should be stressed that, because the need is so great, across the country a variety of individuals often are called upon to play a role in addressing problems of youth and their families. These may encompass instructional professionals (health educators, other classroom teachers, special education staff, resource staff), administrative staff (principals, assistant principals), students (including trained peer counselors), family members, and almost everyone else involved with a school (aides, clerical and cafeteria staff, custodians, bus drivers, para-professionals, recreation personnel, volunteers, and professionals-in-training). In addition, as noted, some schools are using specialists employed by other public and private agencies, such as health departments, hospitals, social service agencies, and community-based organizations, to provide services to students, their families, and school staff (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003; Romer & McIntosh, 2005).

Exhibit 5 provides a summary of some 2002-2003 data excerpted from the first national survey of school mental health services (Foster, Rollefson, Doksum, Noonan, Robinson, G., & Teich, 2005). The sample was representative of public schools across the U.S., and the data amplify and support previous findings, including those discussed above.

Exhibit 5

Some Base Line Data on School Mental Health Services

(Excerpted from a national survey funded by the
Center for Mental Health Services, SAMHSA, U.S. Dept. of Health and Human Services)

As reported in *School Mental Health Services in the United States, 2002–2003*,* the survey topics included: types of mental health problems encountered in school settings; types of mental health services that schools are delivering; numbers and qualifications of school staff providing mental health services; types of arrangements for delivering mental health services in schools, including collaboration with community-based providers; and major sources of funding for school MH services.

Key Findings as Reported in the Executive Summary

- Nearly three quarters (73 percent) of the schools reported that "social, interpersonal, or family problems" were the most frequent mental health problems for both male and female students.
- For males, aggression or disruptive behavior and behavior problems associated with neurological disorders were the second and third most frequent problems.
- For females, anxiety and adjustment issues were the second and third most frequent problems.
- All students, not just those in special education, were eligible to receive mental health services in the vast majority of schools (87 percent).
- One fifth of students on average received some type of school-supported mental health services in the school year prior to the study.
- Virtually all schools reported having at least one staff member whose responsibilities included providing mental health services to students.
- The most common types of school mental health providers were school counselors, followed by nurses, school psychologists, and social workers. School nurses spent approximately a third of their time providing mental health services.
- More than 80 percent of schools provided assessment for mental health problems, behavior management consultation, and crisis intervention, as well as referrals to specialized programs. A majority also provided individual and group counseling and case management.
- Financial constraints of families and inadequate school mental health resources were the most frequently cited barriers to providing mental health services.
- Almost half of school districts (49 percent) used contracts or other formal agreements with community-based individuals and/or organizations to provide mental health services to students. The most frequently reported community-based provider type was county mental health agencies.
- Districts reported that the most common funding sources for mental health services or interventions were the Individuals with Disabilities Education Act (IDEA), State special education funds, and local funds. In 28 percent of districts, Medicaid was among the top five funding sources for mental health services.
- One third of districts reported that funding for mental health services had decreased since the beginning of the 2000–2001 school year, while over two thirds of districts reported that the need for mental health services increased.
- Sixty percent of districts reported that since the previous year, referrals to community-based providers had increased. One third reported that the availability of outside providers to deliver services to students had decreased.

While survey findings indicate that schools are responding to the mental health needs of their students, they also suggest increasing needs for mental health services and the multiple challenges faced by schools in addressing these needs. Further, more research is needed to explore issues identified by this study, including training of school staff delivering mental health services, adequacy of funding, and effectiveness of specific services delivered in the school setting.

*Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). *School Mental Health Services in the United States, 2002–2003*. DHHS Pub. No. (SMA) 05-4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA05-4068/SMA05-4068.pdf

As things stand, most schools have some interventions to address a range of MH and psychosocial concerns, such as school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, delinquency, and violence. Some are funded by the schools or through extra-mural funds schools seek out; others are the result of linkages with community service and youth development agencies. Some programs are provided throughout a district; others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs and may be designed for an entire class, groups, or individuals.

Funding

Inadequate data are available on how much schools spend to address behavior, emotional, and learning problems. Figures most often gathered and reported focus on pupil service personnel. These data suggest that about 7% of a school district's budget goes to paying the salaries of such personnel.

Inadequate data are available on how much schools spend to address behavior, emotional, and learning problems

In calculating how much schools spend on addressing behavior, emotional, and learning problems, focusing only on pupil service personnel salaries probably is misleading and a major underestimation. This is particularly so for schools receiving special funding. Studies are needed to clarify the entire gamut of resources school sites devote to student problems. Budgets must be broken apart in ways that allow tallying all resources allocated from general funds, support provided for compensatory and special education, and underwriting related to programs for dropout prevention and recovery, safe and drug free schools, pregnancy prevention, teen parents, health services, family literacy, homeless students, and more. In some schools receiving funds from multiple categorical funding streams, some school administrators tell us that as much as 25 to 30 percent of the budget may be expended on problem prevention and correction.

Looking at total education budgets, in 1997 one group of investigators reported that nationally 6.7 percent of school spending (about 16 billion dollars) was used for student support services, such as counseling, psychological services, speech therapy, health services, and diagnostic and related special services for students with disabilities (Monk, Pijanowski, & Hussain, 1997). The amount specifically devoted to behavior, emotional, and learning, problems is unclear (e.g., see Robinson, Barrett, Tunkelrott, & Kim (2000). The figures do not include costs related to time spent on such matters by other school staff, such as teachers and administrators. Also not included are expenditures related to initiatives such as safe and drug free schools programs and arrangements such as alternative and continuation schools and funding for school-based health, family, and parent centers.

Using 2001 as an example and based on U.S. Department of Education estimates of costs, schools spent about $100 billion on special education (of which the federal government funded about $7.5 billion). Estimates in many school districts indicated that about 20% of their budget was consumed by special education. Again, how much was used directly for efforts to address behavior, emotional, and learning problems was unknown, but over 50 percent of those in special education were diagnosed as learning disabled and over 8 percent were labeled emotionally/behaviorally disturbed.

As stressed by the Policy Leadership Cadre for Mental Health in Schools (2001):

> *To date there has been no comprehensive mapping and no overall analysis of the amount of resources used for efforts relevant to mental health in schools or of how they are expended. Without such a "big picture" analysis, policy-makers and practitioners are deprived of information that is essential to determining equity and enhancing system effectiveness.*

Whatever the expenditures, it is common knowledge that few schools come close to having enough resources to deal with a large number of students with behavior, emotional, and learning problems. Moreover, the contexts for intervention often are limited and makeshift because of how current resources are allocated and used. A relatively small proportion of space at schools is ear-marked specifically for programs that address student problems. Many special programs and related efforts to promote health and positive behavior are assigned space on an ad hoc basis. Support service personnel often must rotate among schools as "itinerant" staff. These conditions contribute to the tendency for such personnel to operate in relative isolation of each other and other stakeholders. To make matters worse, little systematic in-service development is provided for new "support" staff when they arrive from their pre-service programs. Obviously, all this is not conducive to effective practice and is wasteful of sparse resources.

The need is great ... the current response is insufficient

Clearly, diverse school and community resources are attempting to address complex and overlapping psychosocial and mental health concerns. The need is great (see Exhibits 1 and 5). The current response is insufficient.

Another perspective on where the field is at this juncture comes from the types of requests for assistance that centers such as ours receive from practitioners. Exhibit 6 provides an indication of what those in the field have been asking about and asking for. This affords a glimpse into the concerns and needs encountered by practitioners in schools across the country. Note that many requests ask about the research/science/knowledge base for practices and for data to make the case for student supports. Other common requests are for resources and strategies to use in daily practice and to facilitate continuing education of school personnel. Practical, ethical, and relationship issues are frequently raised. And, there is increasing interest in school improvement planning as a context for enhancing how schools address mental health and psychosocial concerns.

Marginalization

Despite the range of activity related to mental health and psychosocial problems, the overall enterprise is not assigned a high priority most of the time. This reflects the fact that existing student support services and school health programs do not have high status in the educational hierarchy and in current health and education policy. As noted already, aspects of the enterprise gain stature when a high visibility event such as a shooting on campus occurs. But, the elevated status is brief.

Because of their usual humble status, student supports continue to be developed in an ad hoc, piecemeal, and highly marginalized way. And, the marginalization not only produces fragmented approaches, it contributes to redundancy, counterproductive competition, and inadequate results.

Student supports are developed in an ad hoc, piecemeal, and highly marginalized way

The continuing trend, in policy and practice, is for schools and districts to treat the activity as desirable but not a primary consideration. Since the activity is not seen as essential, the programs and staff are pushed to the margins. Planning of programs, services, and delivery systems tends to be done on an ad hoc basis; interventions are referred to as "auxiliary" or "support" services, and student support personnel almost never are a prominent part of a school's organizational structure. And, such staff usually are among those deemed dispensable as budgets tighten. This, of course, reduces availability and access.

The marginalization spills over to how schools pursue special education mandates and policies related to inclusion. It also shapes how they work with community agencies and initiatives for systems of care, wrap-around services, school-linked services, and other school-community collaborations. And, it negatively effects efforts to adopt evidence-based practices and to implement them with fidelity.

It also spills over into school improvement. Analyses of school improvement planning guides indicate that too little attention is given to how schools do and do not address mental health and psychosocial concerns (Center for Mental Health in Schools, 2005a, b, c).

Exhibit 6

Practitioner's Requests

What's being asked about? What's being asked for?

Assessment Instruments to

- Measure individuals (e.g., self-esteem, mental "health," behavior problems, anger management, psychosocial competence, parenting knowledge and skills, client satisfaction)
- Screen problems (e.g., depression, suicide, at risk kindergarteners)
- Assess violence prevention at school
- Map and analyze systems

Available Research/Science/Knowledge-Base on

- Best/effective practices for schools related to
  - >mental health >providing health and social services
  - >behavioral health >suicide prevention
  - >strengthening community mental health
  - >promoting parent/child communication
  - >anger management for high school students
  - >working with neighborhood vendettas
- Empirically supported therapeutic relationships
- Effects of dress codes on academic achievement and graduation rates
- Effects of exposure to violence on learning
- Cost-effectiveness
- "Huffing" as gateway drug
- Moving students with problems into special settings
- Comparative efficacy of school & community services
- Racial disproportionality in special education
- Most common barriers to learning
- "Knowledge-based Compensation System"
- Connection between bullying and substance abuse
- School based depression screening programs
- Students living in poverty with a single parent
- Homelessness and mental health
- Prevalence and incidence of various problems
- Student use of MH services in schools
- Making the case for MH in schools
  - >need for MH in schools >effectiveness of school MH
  - >impact on school performance >effect on academics
  - >impact on suicide prevention
  - >implications of the "Plateau Effect"
  - >productivity of school-based MH clinicians
- Social marketing
  - >the value of school-based student support
  - >the value of mental health at the school site

Confidentiality and Consent Concerns

- Using email to share info about a student's problems
- Do school mental health staff have to tell the principal if a student is suicidal?
- Is a consent form needed for school counseling?
- Can MH staff see a student under age 12 one time without parent consent?
- Does writing therapy goals in an IEP violate confidentiality?
- Conducting research on school-based MH practice

Evaluation of

- School-based individual interventions
- School-based programs
- MH intervention outcomes in schools
- Parent involvement
- Family functioning before and after interventions
- Systemic changes
- School consultation teams
- 8th grade transition program
- School-community collaboration
- MH workers in schools
- Multiservice family centers

Funding for Doing and Enhancing the Work

- Writing proposals
- Leveraging grant funding
- Coping with budget reductions
- Resources for delivering mental health in schools
- Funding for afterschool counseling
- Strengthening a school-based student/family center

(cont.)

Inservice/CE Topics, Strategies, and Resources

(e.g., teaching teachers, support staff, administrators)
[Note: All of the other categories, of course, contain matters relevant to inservice and continuing education.]

- Info for establishing ways to
  - >orient new support staff
  - >support for new teachers
  - >help teachers and other school staff learn more about school MH, about imparting MH info, and about being sensitive to student MH
  - >provide leadership training on mobilizing staff
  - >tell parents about a teacher's molestation conviction
- Info to help in covering specific topics such as
  - >student transitions
  - >homework as a MH concern and barrier to learning
  - >engaging parents of middle school students
  - >resilience and high school students
  - >suicide prevention and referral guidelines
  - >dealing with the hurricane aftermath
  - >avoiding "triangulation"
- Requests for resource materials
  - >powerpoint presentation for school staff on MH
  - >short but comprehensive MH handbook for teachers
  - >guides for behavioral management systems for schools
  - >protocols on school planning to respond to terrorism
  - >for planning/implementing disaster aftermath efforts
  - >lesson plans for conflict resolution for middle school
  - >curriculum materials on various MH issues
  - >guides for suicide prevention and aftermath
  - >to use with non-English speaking populations
  - >for use by special education assistants and aides
  - >on social-emotional learning
  - >on helping students cope with holiday stressors
  - >on helping students cope with grief and loss
  - >on paraeducator training
- Questions about dealing with the following specific types of student problems
  - >bullying >teen depression >substance abuse
  - >attention problems >fear of talking >grief
  - >won't speak at school >communication disorders
  - >verbally aggressive >cries at school every day
  - >oppositional defiant disorder >suicide >huffing
  - >extreme separation anxiety >bipolar disorders
  - >choking game >cutters >bright, turned off student
  - >those impacted because of family deployment to war
  - >students on medication >exposure to domestic abuse
  - >student who made false abuse accusation
  - >classroom disruptors >residential school students
  - >understand sibling with Asperger's Syndrome
  - >avoidance behavior around homework
  - >disaster victims >obesity as an eating disorder
  - >computer game addiction >children living in poverty

Intervention Approaches (How to do it)

- Mental health in schools "How do I start?"
- Behavior supports
- Dealing with behavioral outbursts
- Guidelines on alternatives to corporal punishment
- Addressing truancy and student attendance
- Alternatives to suspension
- Starting a counseling program at a school
- Group counseling guidelines
- MH interventions for 10-14 year olds
- Helping to transition new students
- Human sexuality curriculum for special populations
- Curriculum for sexual abuse prevention
- Developing a day treatment program
- Promoting MH through classroom curriculum
- Using interactive software (e.g., for MH education)
- Strategies to minimize dependence and enhance independence in students
- Using social-emotional themes in students' reading
- Processes for triage, referral, tracking, session planning, care management, progress evaluation
- Transition programs for ninth grade
- Suicide prevention for 5th grade
- Preventing violence among deaf adolescents
- Resources for crisis response
- Adventure-based counseling in schools
- Strategies to support cultural & linguistic diversity
- Introducing non-English speakers to MH concerns
- Working with troubled kindergarten students
- Working with a gifted but unmotivated student
- Working with students concerned about death of friends/relatives
- Working with families through a student "life map"
- Family Systems Therapy in schools
- Info on juvenile justice for "high risk" youth
- Practices for keeping students out of jail
- Rural school MH and teleconsultation
- Helping grandparents who are raising grandchildren
- Re-engaging disengaged students in learning
- Strategies to keep kids engaged during the summer
- Enhancing "self-discipline" through class projects
- Enhancing student connectedness
- Talking with students about motivation
- Homework as "work at home"
- What to do (and not to do) on the anniversary of a school shooting or other tragedy

Intervention Issues

- Helping vs. socialization
- School-wide screening for depression and suicide
- Continuing counseling at school after graduation
- How to account for diversity
- First grade retention
- Intervening at school vs. in a special setting
- Medication refusal at school
- Why don't classrooms account for emotional problems?
- "Mental health" can be a scary term for students and families: What's a better term?
- Does early drug abuse education increase curiosity about drugs?

Peer Programs

- Youth council to address MH stigma
- Peers imparting mental health info
- Training 4th-6th graders as peer coaches for coping

(cont.)

Policy Information

- Policy for a student/learning support system
- Policies and procedures around drug testing
- Substance abuse policies for athletes and afterschool
- Policies that affect immigrant students
- District social-emotional policy

School-Agency Relationships & Bureaucratic Concerns

- Difficulties between school staff and school-based community mental health providers
- Reconciling differences in rules and regulations
- Aligning record keeping and teacher consultation
- Working as a case team at school
- School-community collaborative agenda
- Fingerprinting
- Record keeping (e.g., decisions, tracking, review)
- Sample forms (consent, release of info., etc.)
- Computer-generated behavior report to parents

School Climate

- Customer friendly schools
- Student ratings
- Improving school teamwork and climate

School Improvement Planning as Context for Enhancing How Schools Address MH and Psychosocial Concerns

- Opportunities related to Title I
- Opportunities related to IDEA
- Including MH guidelines in School Wellness Plans
- Using a unifying framework to pull together initiatives
- Integrating an “enabling component”
- Support staff playing a role in the school's restructuring
- Formulating a plan for mental health in schools
- Creating readiness for a comprehensive and integrated system of student support
- Planning how to move in more effective new directions
- Winning over district leaders and "fence sitter" staff
- Enhancing learning supports in small schools
- Forming charter school for students with MH problems
- MH in schools: looking to the future – a chance to reshape the No Child Left Behind Act

School Staff Wellness

- Surveying staff overwork and stress
- Resources to support staff well-being
- Providing teacher support groups
- Supporting school staff reeling from accountability pressures

Selecting and Training New Professionals

- Starting a school counseling intern program
- Guidelines needed for supervision of school MH staff for licensing
- Interviewing to select school-based MH staff

Special Education Concerns

- Helping a new teacher in a special ed class
- Difference between a special day class and intensive day treatment
- Who provides what services in private schools?
- Timelines for evaluating and placing a new student who comes in with an IEP
- Backlash to excessive special ed referrals
- Does writing therapy goals into the IEP violate confidentiality?
- Focusing an IEP team on student engagement and positive goals
- Moving beyond a social control agenda
- Next steps for post secondary student with learning problems

Stakeholder Relationships at School

- Administrator-staff
- School-family connections
  >enhancing communication >working with families
- Teams

In sum, analyses show that activities related to mental health in school are developed and function in relative isolation of each other, and they rarely are envisioned in the context of a comprehensive approach to addressing behavior, emotional, and learning problems and promoting healthy development. Organizationally, the tendency is for policy makers to mandate and planners and developers to focus on specific services and programs, with too little thought or time given to mechanisms for program development and collaboration. Functionally, most practitioners spend their time applying specialized interventions to targeted problems, usually involving individual or small groups of students. Consequently, programs to address behavior, emotional, learning, and physical problems rarely are coordinated with each other or with educational programs. Intervention planning and implementation are widely characterized as being fragmented and piecemeal which is an ineffective way for school to deal with the complex sets of problems confronting teachers and other staff. Thus, despite the range of personnel and activity, it remains the case that too little is being done in most schools, and prevailing approaches are marginalized, poorly conceived, and implemented in fragmented ways.

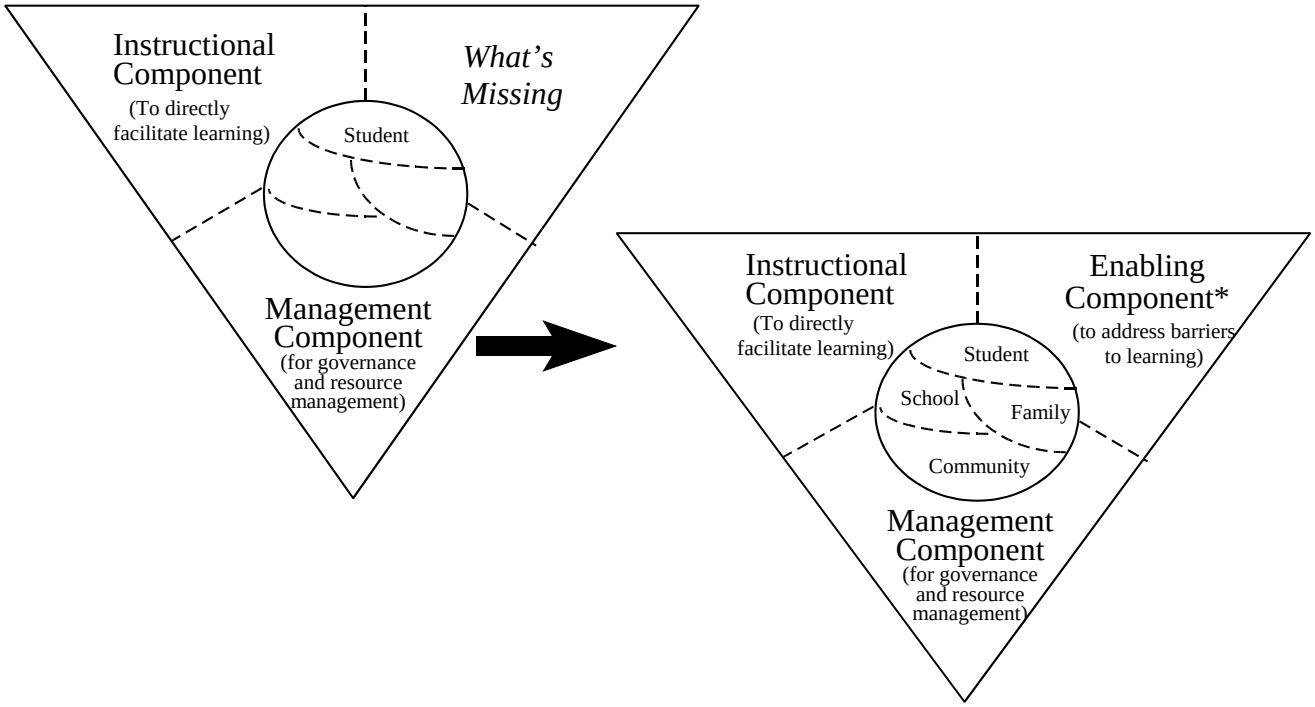
Addressing the Key Policy Problem

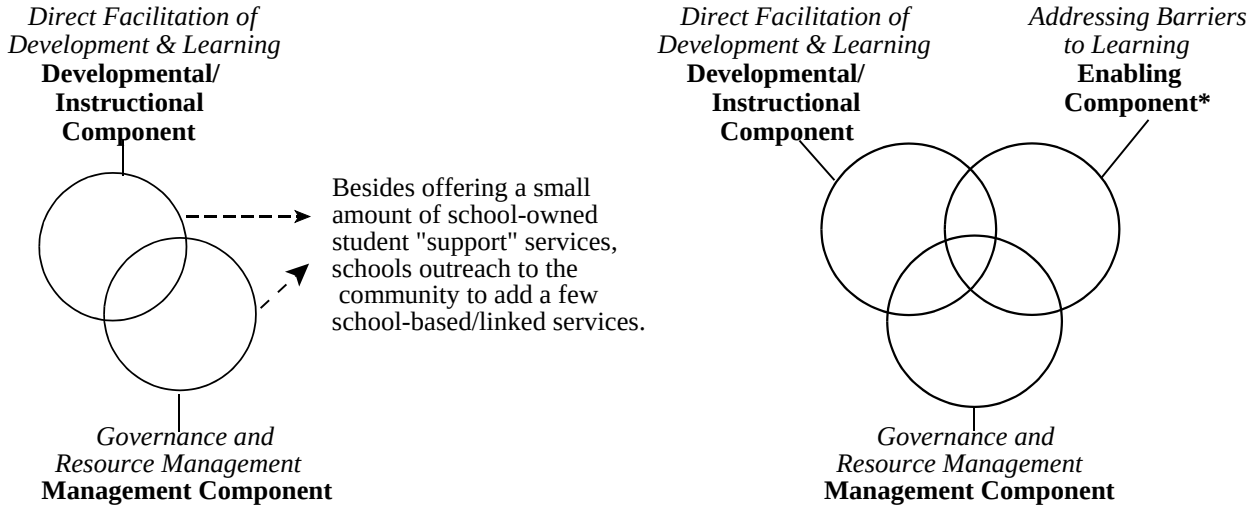
The above state of affairs reflects a fundamental policy weakness, namely: *Efforts to address barriers to learning and teaching are marginalized in current education policy*. This maintains an unsatisfactory status quo related to how schools address learning, behavior, and emotional problems. Analyses indicate that school policy is currently dominated by a two-component systemic model (Adelman, 1995, 1996a, 1996b; Adelman & Taylor, 1994, 1997, 1998; Center for Mental Health in Schools, 1996, 1997). That is, the primary thrust is on improving instruction and school management. While these two facets obviously are essential, ending the marginalization of efforts to effectively address barriers to learning, development, and teaching requires establishing a third component as a fundamental facet of transforming the educational system (see Exhibit 7).

In Exhibit 7, the third component is designated as an Enabling Component to address barriers to learning. In states and localities where pioneering efforts are underway for moving from a two- to a three- component policy framework, the component to address barriers to learning has been denoted by various other terms, such as a Learning Supports Component or a Comprehensive Student Support System (Center for Mental Health in Schools, 2004b). This third component not only is intended to provide a basis for combating marginalization, it establishes a focal point for developing a comprehensive approach in which mental health and psychosocial concerns are embedded and fully integrated with the school's mission. To this end, the pioneering efforts recognize that all three components are essential, complementary, and overlapping. The trail blazing efforts also underscore the political complexities of shifting policy.

Exhibit 7

Moving from a Two- to a Three-component Policy Framework for School Improvement





*The third component (an enabling or learning supports component) is established in policy and practice as primary and essential and is developed into a comprehensive approach by weaving together school and community resources.

Part III. Where is the Field Going?

Prediction is a risky business. When it comes to thinking about the future of MH in schools, a few matters are evident. For one, it is clear that the field is in flux. For another, practitioners in the schools who are most associated with mental health concerns are realizing that changes are needed and are afoot. There is widespread agreement that a great deal needs to be done to improve what is taking place, but no specific perspective or agenda is dominating policy, practice, research, or training.

It is also evident that schools and communities increasingly are being called on to meet the needs of *all* youngsters, especially those experiencing behavior, learning, and emotional problems.

All this provides both an opportunity and challenge to rethink mental health in ways that involve schools and communities working together to develop comprehensive, multifaceted, and cohesive systems for intervention.

Schools and the Transformation of the MH System in the U.S.

One perspective on the future comes from the *New Freedom Initiative's* efforts to follow-up on the work of the *President's New Freedom Commission on Mental Health*. The Commission's recommendations are designed to transform the mental system in the U.S. As we have indicated in a previous policy report, each recommendation can be operationalized into agenda items for mental health in schools (see Appendix A).

As the Commission's report notes, this is a time of sparse resources for public enterprises. With this in mind, the report stresses the importance of "policy and program changes that make the most of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers, coupled with a strong measure of accountability." The aim is to more wisely invest and use sparse resources. One set of relevant resources certainly are those already committed to mental health in schools. However, because of the Commission's limited focus on MH in schools (see Rec. 4.2 in Appendix A), this venue is unlikely to play a major role in immediate efforts to transform the mental health system, never mind enhancing MH in schools.

Emerging View

Approaching MH in schools from a different perspective a variety of stakeholders are pushing to enhance policy and practice in ways that directly connects various mental health agenda with the mission of schools. We see this as an emerging view.

As illustrated in Exhibit 8, this emerging view calls for developing, over time, a full continuum of systemically interconnected school and community interventions that encompasses a

> *system* for promoting healthy development and preventing problems

> *system* for responding to problems as soon after onset as is feasible

> *system* for providing intensive care

Exhibit 8

Interconnected Systems for Meeting the Needs of All Students

Providing a *Continuum of School-community Programs & Services*
Ensuring use of the *Least Intervention Needed*

School **Resources**
(facilities, stakeholders, programs, services)

Examples:

- General health education
- Drug and alcohol education
- Enrichment programs
- Support for transitions
- Conflict resolution
- Home involvement

- Drug counseling
- Pregnancy Prevention
- Violence prevention
- Dropout prevention
- Suicide Prevention
- Learning/behavior accommodations and response to intervention
- Work Programs

- Special education for learning disabilities, emotional disturbance, and other health impairments

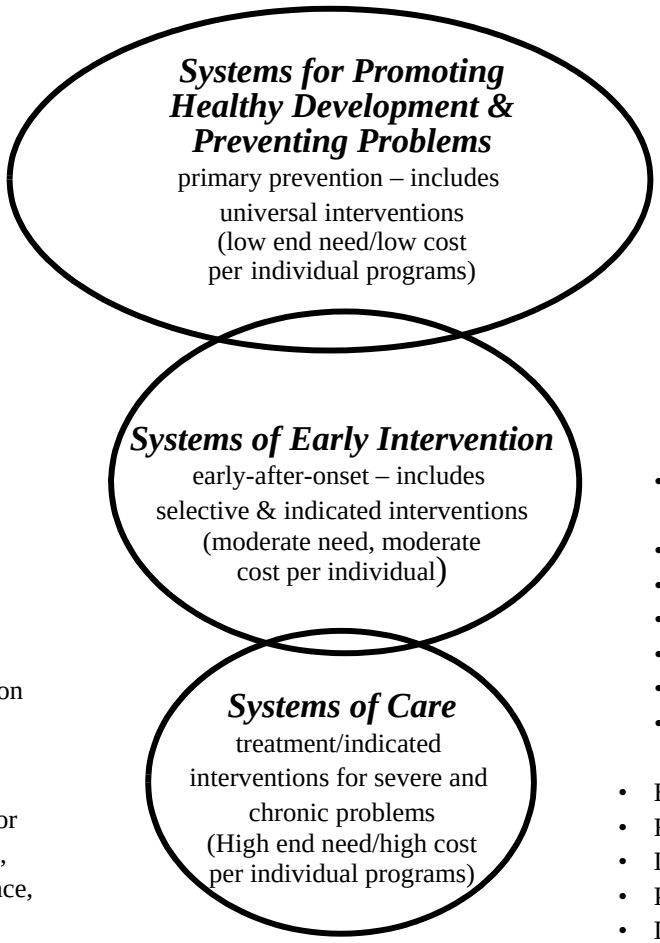
Community **Resources**
(facilities, stakeholders, programs, services)

Examples:

- Public health & safety programs
- Prenatal care
- Immunizations
- Pre-school programs
- Recreation & enrichment
- Child abuse education

- Early identification to treat health problems
- Monitoring health problems
- Short-term counseling
- Foster placement/group homes
- Family support
- Shelter, food, clothing
- Job programs

- Emergency/crisis treatment
- Family preservation
- Long-term therapy
- Probation/incarceration
- Disabilities programs
- Hospitalization
- Drug treatment



Systemic collaboration* is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among *systems of prevention*, *systems of early intervention*, and *systems of care*.

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*Such collaboration involves horizontal and vertical restructuring of program sand services

(a) within jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters of schools)

(b) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies

In most discussions, the continuum is conceived as encompassing a holistic and developmental emphasis. The focus is on individuals, families, and the contexts in which they live, learn, work, and play. And, a basic assumption underlying intervention application is that the least restrictive and nonintrusive forms of intervention required to address problems and accommodate diversity would be used initially. Another assumption is that problems are not discrete, and therefore, interventions that address root causes whenever feasible.

An array of interconnected programs

For further emphasis, we have transcribed the interconnected systems in Exhibits 8 and 9 into an array of programmatic examples. Moving through the continuum, the emphasis is on (1) public health protection, promotion, and maintenance that foster positive development and wellness, (2) preschool-age support and assistance to enhance health and psychosocial development, (3) early-schooling targeted interventions, (4) improvement and augmentation of ongoing regular support, (5) other interventions prior to referral for intensive and ongoing targeted treatments, and (6) intensive treatments.

What's the outcome data?

In support of specific types of programs exemplified, a little bit of data can be gleaned from various facets of the research literature, most often project evaluations and dissertations. Most *formal* studies have focused on specific interventions. This literature reports positive outcomes (for school and society) associated with a wide range of practices. Because of the fragmented nature of available research, the findings are best appreciated in terms of the whole being greater than the sum of the parts, and implications are best derived from the total theoretical and empirical picture. When such a broad perspective is adopted, schools have a large research-base to draw upon in addressing barriers to learning and enhancing healthy development. Examples of how to organize and use this research-base have been developed by our Center (Adelman & Taylor, 2006; Center for Mental Health in Schools, 2004a). Additional data will be forthcoming from efforts to implement and validate the effectiveness of prototypes (Adelman & Taylor, 2003; Elias, Zins, Graczyk, & Weissberg, 2003).

Research on comprehensive approaches is still in its infancy. For obvious reasons, no study has ever looked at the impact of implementing the full continuum in any one geographic catchment area. However, inferences can be made from the daily evidence of what takes place in every wealthy and most upper middle income communities. These natural "experiments"clearly show that families who have financial resources, or who can avail themselves of such resources when necessary, will purchase any of the interventions listed in Exhibits 8 and 9 to ensure their children's well-being. In a real sense, this represents empirical support for the value of such interventions that cannot be ignored.(As one wag put it*: The range of interventions is supported by a new form of validation – market validity!*) Moreover, this body of evidence dramatically underscores the promise of ensuring all youngsters have access to a comprehensive, multifaceted continuum of interventions.

Exhibit 9 From Primary Prevention to Treatment of Serious Problems: a Continuum of Community-School Programs to Address Barriers to Learning and Enhance Healthy Development

Intervention Continuum	***Examples of Focus and Types of Intervention*** (Programs and services aimed at system changes and individual needs)
Systems for Health Promotion & Primary prevention	*1. Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness* • economic enhancement of those living in poverty (e.g., work/welfare programs) • safety (e.g., instruction, regulations, lead abatement programs) • physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)
Systems for Early-after-problem onset intervention	*2. Preschool-age support and assistance to enhance health and psychosocial development* • systems' enhancement through multidisciplinary team work, consultation, and staff development • education and social support for parents of preschoolers • quality day care • quality early education • appropriate screening and amelioration of physical and mental health and psychosocial problems *3. Early-schooling targeted interventions* • orientations, welcoming and transition support into school and community life for students and their families (especially immigrants) • support and guidance to ameliorate school adjustment problems • personalized instruction in the primary grades • additional support to address specific learning problems • parent involvement in problem solving • comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment) *4. Improvement and augmentation of ongoing regular support* • enhance systems through multidisciplinary team work, consultation, and staff development • preparation and support for school and life transitions • teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support) • parent involvement in problem solving • resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth) • comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth) • Academic guidance and assistance • Emergency and crisis prevention and response mechanisms *5. Other interventions prior to referral for intensive, ongoing targeted treatments* • enhance systems through multidisciplinary team work, consultation, and staff development • short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)
Systems for Treatment for severe/chronic problems	*6. Intensive treatments* • referral, triage, placement guidance and assistance, case management, and resource coordination • family preservation programs and services • special education and rehabilitation • dropout recovery and follow-up support • services for severe-chronic psychosocial/mental/physical health problems

What are the gaps?

Although schools cannot do everything, the frameworks outlined in Exhibits 8 and 9 provide a reasonable basis for beginning to map and conduct a variety of analyses of what is currently being done by and with schools. The focus of such mapping is on how well the current state of the art approximates the ideal of having a comprehensive, multifaceted, and cohesive approach for addressing barriers to learning. Appendix B provides a more extensive framework for such mapping and analyses.

To date, society's policy makers have not committed to establishing the interconnected set of systems outlined in Exhibits 8 and 9. However, as discussed in the preceding section, work is underway to establish the type of policy and practice shift that can institutionalize such a comprehensive, multifaceted, and integrated approach in schools.

Two parables help differentiate the old and emerging views of mental health in schools. The old *view* fits the *starfish* metaphor.

> The day after a great storm had washed up all sorts of sea life far up onto the beach, a youngster set out to throw back as many of the still-living starfish as he could. After watching him toss one after the other into the ocean, an old man approached him and said: *It's no use your doing that, there are too many, You're not going to make any difference.*
>
> The boy looked at him in surprise, then bent over, picked up another starfish, threw it in, and then replied: *It made a difference to that one!*

This parable, of course, reflects all the important clinical efforts undertaken by staff alone and when they meet together to work on specific cases.

The emerging view is captured by what can be called the *bridge* parable.

> In a small town, one weekend a group of school staff went fishing together down at the river. Not long after they got there, a child came floating down the rapids calling for help. One of the group on the shore quickly dived in and pulled the child out. Minutes later another, then another, and then many more children were coming down the river. Soon every one was diving in and dragging children to the shore and then jumping back in to save as many as they could. In the midst of all this frenzy, one of the group was seen walking away. Her colleagues were irate. How could she leave when there were so many children to save? After long hours, to everyone's relief, the flow of children stopped, and the group could finally catch their breath. At that moment, their colleague came back. They turned on her and angrily shouted: *How could you walk off when we needed everyone here to save the children?*
>
> She replied: *It occurred to me that someone ought to go upstream and find out why so many kids were falling into the river. What I found is that the old wooden bridge had several planks missing, and when some children tried to jump over the gap, they couldn't make it and fell through into the river. So I got someone to fix the bridge.*

Fixing and building better bridges is a good way to think about what the emerging view adds to previous thinking about MH in schools. It underscores the importance of taking time to improve and enhance resources, programs, and systems in schools.

All – not just some students

Both metaphors are embedded in the emerging view of MH in schools. This view recognizes that schools must be concerned with all, not just some students and with preventing problems and promoting development.

In keeping with a commitment to all students, emerging trends are to

- *define mental health broadly* – i.e., encompass the agenda for mental health *in schools* within the broad context of the psychosocial and mental health concerns encountered each day at schools – including an emphasis on strengths as well as deficits and on the MH of students' families and school staff
- *enhance partnerships among schools, communities, and the home* – e.g., coalesce and enhance the roles of schools/communities/homes in addressing emotional, behavioral, and learning problems
- *confront equity considerations* – e.g., stress the role mental health in schools can play in ensuring all students have an equal opportunity to succeed at school
- *address the related problems of marginalization, fragmentation, and counterproductive competition for sparse resources* – i.e., work to coalesce policy, agencies, organizations, and daily practice
- *address the challenges of evidence-based strategies and achieving results* – e.g., stress ways to build on current in-school practices using a science-base

Relatedly, there is growing recognition of the drawbacks to framing MH in schools only in terms of (a) screening and diagnosing problems, (b) providing clinical services, and (c) connecting community mental health providers to schools to expand and integrate, school-linked services. These, indeed, are all fundamental to improving MH, but they don't connect well enough to a school's mission to make the case that MH *in schools* is an *imperative*.

The emerging view stresses connecting MH agenda with the mission of schools

The emerging view emphasizes connecting various MH agenda in major ways with the mission of schools and integrating with the full range of student learning supports designed to address barriers to learning. It also emphasizes the importance of taking advantage of the natural opportunities at schools for countering psychosocial and mental health problems and promoting personal and social growth that arise each day, over the school year, during every transition, and as soon as a student is identified as having problems (see Appendix C).

The Policy Leadership Cadre for Mental Health in Schools (2001) has translated the emerging view into the first-ever set of guidelines for mental health in schools (see Appendix D). The type of comprehensive approach reflected in the guidelines, of course, requires unifying frameworks and major systemic changes. Such changes involve strategic collaborations focused on weaving school owned and community owned resources together to develop *comprehensive, multifaceted, and integrated* systems for addressing barriers to learning and enhancing healthy development.

In sum, the emerging view recognizes that schools are not in the mental health business. Indeed, it acknowledges that the mission of schools is to educate all students and that many school stakeholders are leery of MH, especially when the focus is presented in ways that equate the term only with mental disorders. At the same time, advocates of the emerging view stress that when students are not doing well at school, MH concerns and the school's mission usually overlap because the school cannot achieve its mission for such students without addressing factors interfering with progress. This is especially the case in schools where the number of students not doing well outnumbers those who are. Thus, the emerging view takes the position that school improvement planning must encompass a comprehensive system of interventions that includes a focus on MH and psychosocial concerns (Center for Mental Health in Schools, 2005a and b). In that context, mental health in schools can be conceived both as (a) *part of* essential learning supports systems that enable students to learn so that schools can achieve their mission and (b) a fundamental facet of the initiative to transform the mental health system. Moreover, existing resources can be deployed and redeployed in ways that enhance equity with respect to availability, access, and effectiveness.

About Connecting with School Improvement Planning

Before leaving discussion of where the field is going, we want to highlight the following as some of the basic considerations that will arise if the field moves toward connecting with school improvement planning.

The field must be ready to propose how schools should

- promote social-emotional development, preventing mental health and psychosocial problems, and enhancing resiliency and protective buffers

- intervene as early after the onset of emotional, behavior, and learning problems as is feasible and to address severe and chronic problems

- address systemic matters at schools that affect student and staff well-being, such as practices that engender bullying, alienation, and student disengagement from classroom learning

- establish guidelines, standards, and accountability for mental health in schools in ways that confront equity considerations

- build the infrastructure for and the capacity of all school staff to address emotional, behavioral, and learning problems and promote healthy social-emotional development

- draw on all empirical evidence as an aid in developing a comprehensive, multifaceted, and cohesive continuum of school-community interventions to address emotional, behavioral, and learning problems

- implement and validate prototypes of systems for addressing barriers to learning and teaching.

Creating a mentally healthy school climate requires addressing the MH of school staff

Finally, as suggested above, efforts to enhance mental health in schools should encompass a focus on promoting the well-being of teachers and other school staff so that they can do more to promote the well-being of students. Teachers, principals, student support personnel, office staff, bus drivers all impact learning outcomes at a school. How staff work together and support each other makes a crucial difference. As is the case for students, staff need supports that enhance protective buffers, reduce risks, and promote well-being. From this perspective, the field needs to be ready to specify how every school can foster staff and student resilience and create a school climate that encourages mutual support, caring, and sense of community (see Exhibit 10). In a real sense, concerns about school climate focus us not just on mental health in schools, but on the mental health *of* schools.

Exhibit 10

About Enhancing a Positive School Climate

The concept of *climate* plays a major role in shaping the quality of school life, learning, and the mental health of all who are involved. (School/classroom climate sometimes is referred to as the learning environment, as well as by terms such as atmosphere, ambience, ecology, and milieu.) The advocated ideal is to create an atmosphere that fosters smooth transitions, positive informal encounters, and social interactions; facilitates social support; provides opportunities for ready access to information and for learning how to function effectively in the school culture; and encourages involvement in decision making.

Research indicates a range of strategies for enhancing a positive climate (Adelman & Taylor, 2006; Fraser, 1998; Freiberg, 1999; Moos, 1979). School climate is not created through a few direct strategies (e.g., through morale building activities); rather, it is a quality that emerges from the general psychological reactions stakeholders have to classroom and school-wide interventions, including those designed to enhance a positive work culture. All who work in schools have a role to play in ensuring that such strategies are in place. Proactive efforts to develop a positive school climate require careful attention to (1) enhancing the quality of life at school and especially in the classroom for students and staff, (2) pursuing a curriculum that promotes not only academic, but also social, and emotional learning, (3) enabling teachers and other staff to be effective with a wide range of students, and (4) fostering intrinsic motivation for learning and teaching. With respect to all this, the literature advocates

- a welcoming, caring, and hopeful atmosphere
- social support mechanisms for students and staff
- an array of options for pursuing goals
- meaningful participation by students and staff in decision making
- transforming the classroom infrastructure from a big classroom into a set of smaller units organized to maximize intrinsic motivation for learning and not based on ability or problem-oriented grouping
- providing instruction and responding to problems in a personalized way
- use of a variety of strategies for preventing and addressing problems as soon as they arise
- a healthy and attractive physical environment that is conducive to learning and teaching.

For any school, a welcoming induction and ongoing support are critical elements both in creating a positive sense of community and in facilitating staff and student school adjustment and performance. School-wide strategies for welcoming and supporting staff, students, and families at school *every day* are part of creating a mentally healthy school – one where staff, students, and families interact positively with each other and identify with the school and its goals.

Part IV. Policy Implications

Based on the background and analyses set forth in this report, we suggest that the most fundamental policy concern at this time is to end the marginalization of mental health in schools. To do so, policymaker should consider embedding the school focus on mental health and psychosocial concerns in policy for learning supports.

At the same time, to address the complexities of implementing innovative changes in schools, policy must specifically focus on the complications of systemic change, including rethinking and redeploying use of existing resources and phasing-in changes over time.

End the Marginalization by *Embedding MH in Policy for Learning Supports*

In arguing for ending the marginalization of mental health in schools, a good starting place is the statement of the Carnegie Council Task Force on Education of Young Adolescents. In their 1989 report they stress:

> *School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.*

Furthermore, given that many schools currently are not meeting the challenge in a significant manner, the case can be made that this is a major reason why they are so unsuccessful in enhancing student progress and closing the achievement gap. Analyses of school improvement processes and capacity building (including pre and inservice staff development) indicate short shrift has been given to efforts to address barriers to learning and teaching (including mental health and psychosocial concerns). The simple psychometric reality is that in schools where a large proportion of students encounter major barriers to learning, test score averages are unlikely to increase much until such programs are rethought and redesigned.

With these points made, it can be argued that meeting the challenge requires a policy shift. Policy is needed to ensure that every school improvement effort includes a focus on development, implementation, and validation of a comprehensive system to address barriers to learning and teaching.

The policy shift outlined in Part II of this report, the emerging view described in Part III, and the work outlined in Appendices B, C, and D indicate the type of changes that can end the marginalization of mental health in schools. The focus is on development, implementation, and validation of a comprehensive, multifaceted system of interventions, built using a unifying umbrella concept that fits school improvement needs and embedding concerns about mental health. As discussed, one way to designate such a system is as a component for addressing barriers to learning.

Appendix E provides examples of policy statements and legislation for comprehensive systems of learning support to address barriers to learning and teaching. Each reflects a fundamental commitment to MH and psychosocial concerns.

Address Systemic Change

Meeting the challenge, of course, also means addressing complications stemming from the scale of public education. That is, those who set out to enhance mental health in schools across a district are confronted with two enormous tasks. The first is to develop, implement, and validate prototypes; the second involves large-scale replication. One without the other is insufficient. Current school improvement efforts generally do not address the systemic change considerations involved in both these matters. Thus, the need for policy attention.

Policy for school improvement tends to give short shrift to the process of systemic change

Elsewhere, we have explored in some detail a basic framework highlighting how key elements involved in designing major school improvements (such as enhancing the focus on mental health and psychosocial concerns) are logically connected to considerations about designing systemic change (Center for Mental Health in Schools, 2005c). Exhibit 11 outlines the framework.

As can be seen, the same elements can be used to frame key design concerns related to school improvement and accomplishing systemic changes, and each is intimately linked to the other. The elements are conceived as encompassing

- the vision, aims, and underlying rationale for the work
- the resources needed to do the work
- the general functions, major tasks, activities, and phases that must be pursued
- the infrastructure and strategies needed to carry out the functions, tasks, and activities
- the positive and negative results that emerge.

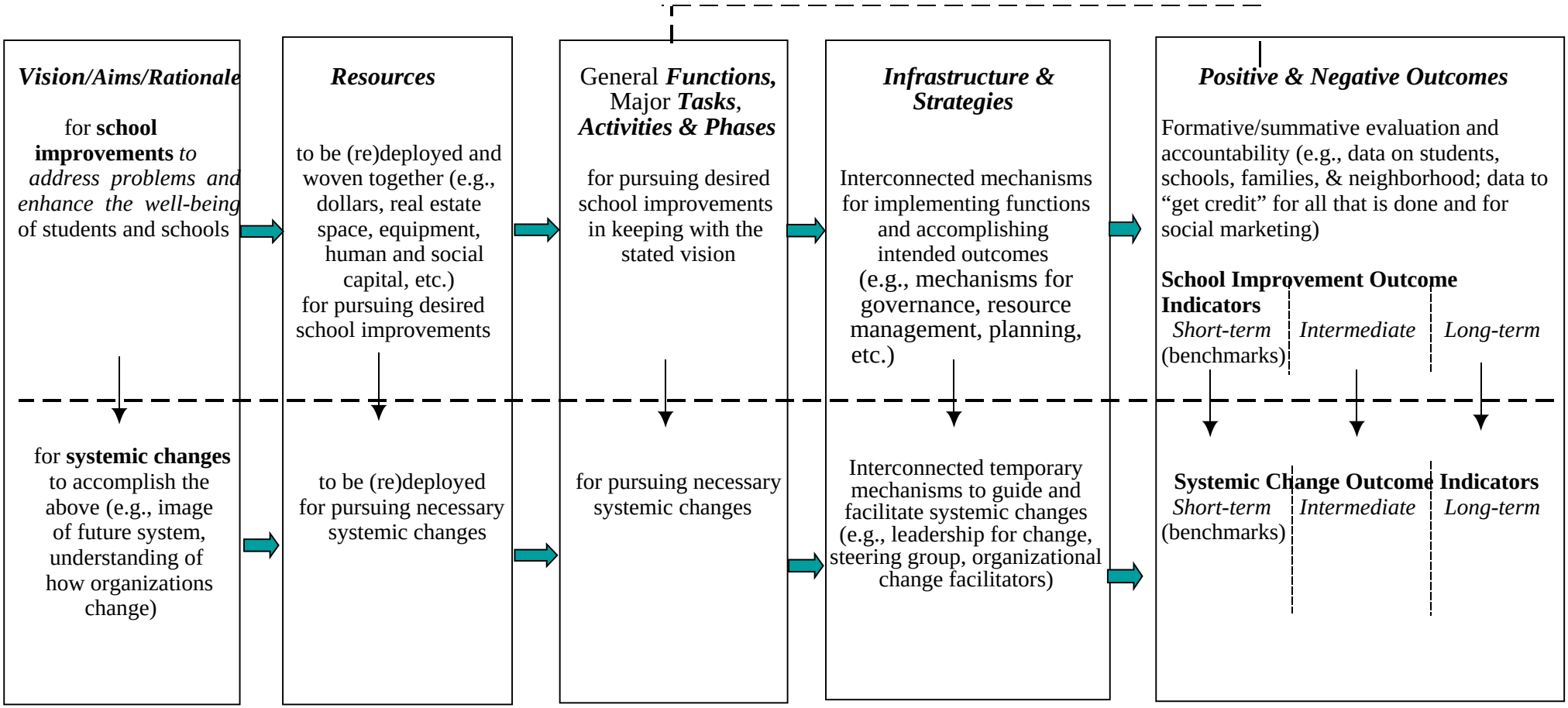
Policy is needed to ensure that strategic planning for school improvement accounts for each of the elements outlined with respect to (1) prototypes for ensuring that all students have an equal opportunity to succeed in school and (2) how the school will accomplish and validate essential changes.

At the district level, the need is for policy ensuring strategic planning for how the district will facilitate replication and scale-up of prototype practices.

Exhibit 11 Linking Logic Models for Designing School Improvement and Systemic Change

Key considerations with respect to both (a) desired school improvements and (b) "getting from here to there" (e.g., systemic changes):

>What is the vision, long-term aims, and underlying rationale?
>What are the existing resources that might be (re)deployed and woven together to make good progress toward the vision?
>What general functions, major tasks, activities, and phases need to be implemented?
>What infrastructure and strategies are needed to carry out the functions, tasks, and activities?
>What short-term indicators will be used as process benchmarks, what intermediate outcomes will indicate progress toward long-range aims, and how will negative outcomes be identified?



Encouraging Policy Action by Emphasizing Benefits, Feasibility, and Prudence

To encourage policy makers to move on the above matters, it will help to emphasize benefits, feasibility, and prudence with respect to (a) cost-benefits and (b) systemic change considerations. The following are points that can be stressed in making the case and could be translated into guidelines accompanying enacted policy.

(a) *Cost-benefits*. Given the current state of public resources, the economics of the proposed policies must be underscored. This includes not only the costs and benefits arising from what is proposed, but the costs related to not taking action.

Exhibit 12 highlights major financial benefits that can be reaped and some of the economic costs of maintaining the status quo. Other financial benefits arise from increased efficiencies and effectiveness of systemic improvements for addressing barriers to learning and teaching, from enhanced capability in sustaining innovations, and from maintaining teachers who currently are leaving in large numbers because they do not have essential supports.

As to the costs of implementing the new policies, it can be emphasized that much of the work involves rethinking and redeploying existing resources. The feasibility of doing so is found in sections of the *No Child Left Behind Act* and the *Individuals with Disabilities Education Act* (see Appendix F). And, the work is consonant with the goals and recommendations of the *President's New Freedom Commission on MH*.

All these policy initiatives agree that there are ways to more wisely invest and use existing resources. In this respect, it can be stressed that the agenda items they share argue for guidelines that enable extensive braiding of resources to accomplish their overlapping goals.

Furthermore, such redeployment and braiding of resources can be a sound way to entice others (e.g., public and private agencies and foundations) to weave in some of what they invest in enhancing the well-being of children and adolescents.

And, the resultant pool of dedicated resources can be used to leverage additional support.

Exhibit 12

Financial Costs and Benefits of Addressing Barriers to Learning and Teaching

On October 24 and 25, 2005 Teachers College, Columbia University sponsored a symposium on the "Social Costs of Inadequate Education." Major presentations were given by a group of distinguished researchers. See
http://www.tc.columbia.edu/centers/EquityCampaign/symposium/resource.asp

Below are a few major points from the presentations:

>In 2005, it is estimated that close to one trillion dollars was spent on education in the U.S. This approaches 10% of the overall economy.

>What are the benefits or return on this investment? Estimates depend on whether we are talking only in terms of immediate increases in test scores or are including longer-term economic, social, health, and cultural benefits. From strictly an economic perspective, symposium presenters estimated that the U.S. could recoup nearly $200 billion a year in economic losses by raising the quality of schooling, investing more money and other resources in education, and lowering dropout rates.

Some Other Data from the Symposium Papers

A high school dropout earns about $260,000 less over a lifetime than a high school graduate and pays about $60,000 less in taxes. Annual losses exceed $50 billion in federal and state income taxes for all 23 million of the nation's high school dropouts ages 18 to 67.

The United States loses $192 billion– 1.6% of its current gross domestic product – in combined income and tax-revenue losses with each cohort of 18-year-olds who never complete high school. Increasing the educational attainment of that cohort by one year would recoup nearly half those losses.

Health-related losses for the estimated 600,000 high school dropouts in 2004 totaled at least $58 billion, or nearly $100,000 per student. High school dropouts have a life expectancy that is 9.2 years shorter than that of graduates.

Increasing the high school completion rate by 1% for men ages 20 to 60 could save the U.S. up to $1.4 billion a year in reduced costs from crime. A one-year increase in average years of schooling for dropouts correlates with reductions of almost 30 % in murder and assault, 20% in car theft, 13% in arson, and 6% in burglary and larceny.

The country will have a shortfall of 7 million college-educated workers by 2012, compared with the projected need.

Participation in excellent preschool programs has been shown to boost academic achievement and reduce dropout rates, among other benefits. The economic benefits of such programs range as high as $7 for each dollar spent (although savings and positive results are not linked to preschools that lack adequate funding and strong teaching).

Rethinking and Redeploying Resources

(b) *Systemic change considerations*. Major systemic changes, of course, must be made strategically. With this in mind, the following can be outlined in discussing the feasibility of the proposed changes and can be incorporated into facilitative guidelines accompanying policy. The emphasis throughout is on realistically phasing-in changes (See Exhibit 13).

To develop a comprehensive, multifaceted, and cohesive component for addressing barriers to learning and teaching at every school, there must be a focus on doing the following over time

(1) *weaving resources into a cohesive and integrated continuum of interventions*. Specifically, school staff responsible for the component must collaborate with families and community stakeholders to evolve systems for (a) promoting healthy development and preventing problems, (b) intervening early to address problems as soon after onset as feasible, and (c) assisting those with chronic and severe problems.

(2) *restructuring* at every school and district-wide with respect to

- redefining administrative roles and functions to ensure there is dedicated administrative leadership that is authorized and has the capability to facilitate, guide, and support the systemic changes for ongoing development of such a component at every school
- reframing the roles and functions of pupil services personnel and other student support staff to ensure development of the component
- redesigning the infrastructure to establish a team at every school and district-wide that plans, implements, and evaluates how resources are used to build the component's capacity

(3) *expanding standards and accountability indicators* for schools to ensure the systemic changes are fully integrated with the instructional component at a school and are pursued with equal effort in policy and practice.

In addition, it will be useful to guide boards of education toward establishing a standing subcommittee focused specifically on ensuring effective implementation of the enacted policies (Center for Mental Health in Schools, 2004c).

It also will be important to move pre- and in-service programs for school personnel toward including a substantial focus on the concept of an enabling or learning supports component and how to operationalize it at a school in ways that fully integrate with instruction.

Exhibit 13

About the Phases of Systemic Change

Any approach to significantly enhancing mental health in schools requires substantive organizational and programmatic transformation (Adelman & Taylor, 2003; Elias, et al., 2003; Taylor, Nelson, & Adelman, 1999). Whether the focus is on establishing a prototype at one site or replicating it at many, the systemic changes can be conceived in terms of four overlapping phases: (1) *creating readiness* – increasing a climate/culture for change through enhancing the motivation and capability of a critical mass of stakeholders, (2) *initial implementation* – change is carried out in stages using a well-designed infrastructure to provide guidance and support, (3) *institutionalization* – accomplished by ensuring there is an infrastructure to maintain and enhance productive changes, and (4) *ongoing evolution* – through use of mechanisms to improve quality and provide continuing support in ways that enable stakeholders to become a community of learners and facilitates periodic creative renewal.

Key stakeholders and their leadership must understand and commit to the changes. And, the commitment must be reflected in policy statements and creation of an organizational structure at all levels that ensures effective leadership and resources for systemic change (including well-trained change agents).

With respect to development of a comprehensive, multifaceted, and cohesive system to address barriers to learning and teaching at every school, the first phases require special attention to:

(1) building interest and consensus for establishing the new system
(2) introducing basic concepts to relevant groups of stakeholders
(3) establishing a policy framework that recognizes such a system is a primary and essential facet of the institution's activity
(4) ensuring appointment of high level leaders (at school and district levels) to ensure commitments are carried out related to this component

Because of various pressures, it is not uncommon for insufficient time and attention to be spent on creating readiness by enhancing a climate/culture for change. This may account for the frequency with which changes end up being superficial rather than substantial.

In general, for significant prototype development, implementation, and validation and systemic change to occur, policy and program commitments must be demonstrated through effective allocation and redeployment of resources to facilitate organizational and operational changes. That is, finances, personnel, time, space, equipment, and other essential resources must be made available, organized, and used in ways that adequately operationalize policy and promising practices. This includes ensuring sufficient resources to develop an effective structural foundation for prototype development, systemic changes, sustainability, and ongoing capacity building. To do less is to undermine substantive systemic change and perpetuate an unsatisfactory status quo.

There is much work to be done as public schools across the country strive to leave no child behind.

In sum, the next decade must mark a turning point in how schools and communities address the problems of children and youth. With respect to policy, there must be a focus on reforming and restructuring how schools work to prevent and ameliorate the many learning, behavior, and emotional problems experienced by students.

Concluding Comments

Any effort to enhance interventions for children's mental health must involve schools. Schools already provide a wide range of programs and services for all students who are not succeeding, many of which are relevant to mental health and psychosocial concerns. And, schools can and need to do much more if the mandates of the *No Child Left Behind Act* and the *Individuals with Disabilities Education Act* and the recommendations of the *President's New Freedom Commission on Mental Health* are to be achieved.

Educational inequity is first and foremost an issue of justice and fairness, but the research findings ... show that it is also an issue that affects all of us in our daily lives – and will affect our children even more so.
Henry Levin

At present, mental health activity is going on in schools with competing agenda vying for the same dwindling resources. Diverse school and community resources are attempting to address complex, multifaceted, and overlapping psychosocial and mental health concerns in highly fragmented and marginalized ways. This has led to inappropriate competition for sparse resources and inadequate results.

Naturally, all advocates want to advance their agenda. And, to do so, the temptation usually is to keep the agenda problem-focused and rather specific and narrow. Politically, this makes some sense. But in the long-run, it may be counterproductive since it fosters piecemeal, fragmented, and redundant policies and practices.

One response to this state of affairs are the calls for realigning policy and practice around a cohesive framework based on well-conceived models and the best available scholarship. In particular, it is stressed that initiatives for MH in schools must connect in major ways with the mission of schools and integrate with a restructured system of education support programs and services. This means braiding resources and interventions with a view to ensuring there is a cohesive component, rather than separate programs and services. Coordinated efforts naturally are part of this, but the key is developing an integrated whole that meets overlapping needs in ways that fully integrate mental health agenda into a school "learning supports" component.

From this perspective, those concerned with enhancing mental health in schools must:

- *not lose sight of the larger context which legitimizes mental health in schools.* Advancing mental health in schools is about much more than expanding services and creating full service schools. It is about becoming part of a comprehensive, multifaceted system that strengthens students, families, schools, and neighborhoods and does so in ways that maximizes learning, caring, and well-being.

- *approach the matter with an understanding that they are part of a larger enterprise and one that meshes with the basic mission of schools.* That enterprise is one of providing essential support systems that enable students to learn in ways that assure schools achieve their mandates;

- *encourage reformers to view the difficulty of raising achievement test scores through the complementary lenses of addressing barriers to learning and promoting healthy development.*

The school is the client

In a real sense, enhancing mental health in schools requires accepting the idea that the school is the client. This does not mean the needs of individuals are ignored. Rather, it recognizes that the goal is not just responding to a few specific students with problems; the aim is to ensure that all students engage and re-engage in classroom learning and that schools become healthier and health promoting places for all concerned. And, all this, of course, involves major systemic changes that address complications stemming from the scale of public education in the U.S.A.

Five major themes have emerged so far to guide systemic changes involving schools. These themes emphasize moving

(1) from serving the few to ensuring an equal opportunity to succeed for the many

(2) from fragmented practices to integrated approaches

(3) from narrowly focused, discrete, problem specific, and specialist-oriented services to comprehensive, multifaceted, cohesive systemic approaches

(4) from an efficacy research-base toward effectiveness research as the base for student support interventions, with articulated standards that are reflected in an expanded approach to school accountability

(5) from projects and pilot demonstrations toward sustainable initiatives that are designed to go to scale

These themes have major implications for theory, policy, research, practice, and training. For example, they point to the need for an increasing focus on:

- framing intervention comprehensively and systemically and in ways that bridge school and community

- policy shifts that move student support from the margins into the mainstream of school improvement and *transform* efforts to enhance and connect systems of intervention (e.g., school and community systems for promoting healthy development, preventing problems, responding early after problem onset, treating severe/ pervasive/chronic problems)

- systemic infrastructure considerations that ensure systems of intervention are enhanced and connected appropriately and effectively

- systemic change frameworks that enhance replicability, sustainability, and scale-up with appropriate fidelity

Enhancing mental health in schools clearly is not an easy task. The bottom line is that limited efficacy seems inevitable as long as the full continuum of necessary programs is unavailable and staff development remains deficient; limited cost effectiveness seems inevitable as long as related interventions are carried out in isolation of each other; limited systemic change is likely as long as the entire enterprise is marginalized in policy and practice.

And, mental health in schools is likely to remain marginalized as long as its advocates do not embed their agenda under a unifying concept that is an integral component of school improvement. When this is done, the likelihood is enhanced that mental health in schools will be understood as essential to the aim of leaving no child behind.