



*From the Center's Clearinghouse ...**

An Introductory packet

About Mental Health in Schools
(Revised 2015)

<http://smhp.psych.ucla.edu/pdfdocs/aboutmh/aboutmhinschools.pdf>

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Mental Health in Schools: An Overview

Why mental health in schools?

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. 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 counseling, psychological, and social service programs schools provide.

Adding to what school education support staff do, there has been renewed emphasis over the past 20 years in the health and social services arenas on increasing linkages between schools and community service agencies to enhance the well-being of young people and their families. This “school-linked services” agenda has added impetus to advocacy for mental health in schools.

More recently, the efforts of some advocates for school-linked services has merged with forces working to enhance initiatives for community schools, youth development, and the preparation of healthy and productive citizens and workers. The merger has expanded interest in social-emotional learning and protective factors as avenues to increase students’ assets and resiliency and reduce risk factors.

Thus, varied policies and initiatives have emerged relevant to efforts to enhance mental health in schools. Some directly support school programs and personnel; others connect community programs and personnel with schools. As a result, most schools have some programs to address a range of mental health and psychosocial concerns (e.g., school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, delinquency, violence.)

*Advancing
mental health
in schools*

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. And, available research suggests that for some youngsters schools are the main providers of mental health services. As Burns and her colleagues report from the study of children's utilization of MH services in western North Carolina, "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."

Clearly, mental health activity is going on in schools. Equally evident, there is a great deal to be done to improve what is taking place. The current norm related to efforts to advance mental health policy is for a vast sea of advocates to compete for the same dwindling resources. This includes advocates representing different professional practitioner groups. Naturally, all such 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 make some sense. But in the long-run, it may be counterproductive in that it fosters piecemeal, fragmented, and redundant policies and practices. 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 redundancy, inappropriate competition, and inadequate results.

One response to this state of affairs is seen in the calls for realigning policy and practice around a cohesive framework based on well-conceived models and the best available scholarship. With specific respect to mental health in schools, it has been stressed that initiatives must connect in major ways with the mission of schools and integrate with a restructured system of education support programs and services.

From our perspective, it is time to take a close look at all the pieces. 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, policymakers and practitioners are deprived of information that is essential in determining equity and enhancing system effectiveness. The challenge for those focused on mental health in schools is not only to understand the basic concerns hampering the field, but to function on the cutting edge of change so that the concerns are effectively addressed.

Systemic changes must weave school owned resources and community owned resources together to develop comprehensive, multifaceted, and integrated approaches for addressing barriers to learning and enhancing healthy development. Moreover, pursuit of such changes also must address complications stemming from the scale of public education in the U.S.A. Currently, there are about 90,000 public schools in about 15,000 districts. Thus, efforts to advance mental health in schools also must adopt effective models and procedures for replication and “scale-up.”

Although efforts to advance mental health in schools often are hampered by competing initiatives and agendas, the diversity of initiatives has laid a foundation that can be built upon. There is a need, however, for increased emphasis on *strategic* approaches for enhancing policy and practice. Such strategic approaches can be fostered through efforts to unify thinking about mental health in schools, adoption of well-conceived guiding frameworks, and by support for development of focused networking. To these ends, the Center for Mental Health in Schools at UCLA (1) highlights the need for a broad perspective in thinking about and justifying “mental health” in schools, (2) promotes a working draft of comprehensive and multifaceted guidelines that provide a basis for operationally defining mental health in schools, (3) proposes an integrated framework for promoting healthy development and addressing barriers to learning at a school site in ways that can expand the impact of mental health in schools, and (4) pursues a wide variety of strategies designed to advance the field.

*Needed:
Strategic
approaches &
comprehensive
frameworks
to enhance
policy &
practice*

*Ending the
marginalization*

Clearly, enhancing mental health in schools in comprehensive ways is not an easy task. Indeed, it is likely to remain an insurmountable task until school reformers accept the reality that such activity is essential and does not represent an agenda separate from a school's instructional mission. For this to happen, we must encourage them to view the difficulty of raising achievement test scores through the complementary lenses of addressing barriers to learning and promoting healthy development. When this is done, it is more likely that mental health in schools will be understood as essential to addressing barriers to learning and not as an agenda separate from a school's instructional mission.

Then, we must show how all policy, practice, and research related to mental health in schools, including the many categorical programs funded to deal with designated problems, can be woven into a cohesive continuum of interventions and integrated thoroughly with school reform efforts. In the process, we will need to stress the importance of school-community-home collaborations in weaving together the resources for comprehensive, multifaceted approaches.

In sum, advancing mental health in schools is about much more than expanding services and creating full service schools. It is about establishing comprehensive, multifaceted approaches that help ensure schools are caring and supportive places that maximize learning and well-being and strengthen students, families, schools, and neighborhoods.

A BROAD AGENDA FOR MENTAL HEALTH IN SCHOOLS

Interest in advancing mental health in schools is growing. However, considerably different agenda are being pursued.

Over the years, we have pursued an agenda for advancing mental health in schools through (1) embedding the efforts into every school's broader need for addressing barriers to learning and teaching and promoting healthy development and (2) working to fully integrate this broad agenda into school improvement policy and practice. It should be stressed at the outset that such a broad agenda encompasses enhancing greater family and community involvement in education. And, it requires a fundamental shift in thinking about what motivates students, staff, and other school stakeholders.

This work has led us to understand that there are four fundamental and interrelated concerns school decision makers and planners must confront if schools are to be more effective in ensuring that every student has an equal opportunity to succeed at school and in life. Namely:

- 1) Policy for school (and community) improvement must be expanded to end the marginalization of interventions for addressing barriers to learning and teaching;
- 2) Current student/learning supports must be reframed into a unifying, comprehensive system of intervention;
- 3) The organizational and operational infrastructure for schools, feeder patterns, districts, and for school-community collaboration must be reworked to facilitate the development of the system;
- 4) New approaches must be adopted for planning essential system changes and for sustaining and replicating them to scale.

Without broadening the agenda, mental health in schools gets defined mainly as mental illness and the form of intervention tends to be case-oriented and clinical – providing services for a relatively few of the many students who need some form of intervention (but not necessarily clinical services). And, for the most part, efforts to promote social and emotional health and prevent problems are given short shrift. Policy makers and planners tend to approach all this in fragmented and piecemeal ways that contribute to a counterproductive competition for sparse funds. All this contributes to maintaining the long-standing marginalization of such efforts.

It is with a broad agenda in mind that we strive to advance mental health in schools by working for policy and practices to develop *a comprehensive system of learning supports*. The focus is on establishing an Enabling (often called a Learning Supports) Component at every school. Such a component is designed to enable schools to be more effective in (1) addressing barriers to learning and (2) engaging and re-engaging students so that they are successful at school and are building a solid foundation for well-being after graduation.

From an educational and a public health perspective, the need is for a full continuum of interventions conceived as an integrated set of systems that braids together the resources of schools and communities.

Mental Health in Schools: Why Focus on School Policy?

Because schools are a portal for enhancing access to young people and their families, the tendency is for many researchers and practitioners with specific, yet different agenda to come to the school door seeking entry. Taken individually, each agenda appears imminently reasonable. Taken as a whole, they call for substantial access to students and teachers, additions to the curriculum, introduction of specialized interventions, changes in student support staff roles and functions, capacity building, resource allocation, and more. Thus, the various agenda raise fundamental policy questions about priorities and redeployment of sparse resources. Given this state of affairs, an appreciation of the mission of schools and current school improvement policy is essential for those who want schools to play a major role in addressing mental health and psychosocial concerns.

Two realities are evident when school mission and policy are understood: (1) addressing mental health and psychosocial problems are not *primary* facets of a school's mission and (2) current school improvement policy and practice *marginalizes* interventions related to such matters. That is, schools are first and foremost accountable for educating the young. So, it is one thing to assert the desirability and importance of a proposed agenda for addressing mental health and psychosocial problems; it is quite another to make the case that what is proposed should be adopted as a high priority by schools.

In general, schools are most receptive to proposals that frame agenda for addressing student problems in the context of school improvement policy and embed the work under a unifying concept that fits the educational mission.

Multifaceted Problems, Piecemeal Solutions

Anyone who works with young people is all too familiar with the litany of barriers to learning and teaching (e.g., inadequate school readiness; violence; youth subcultures that promote criminal acts, bullying, sexual harassment, interracial conflict, vandalism; frequent school changes; and a host of problems confronting immigrants and poverty laden families). And, while some barriers are the result of significant disabilities and disorders, external factors are responsible for the majority of learning, behavior, and emotional problems.

Moreover, students who only have one type of problem are rare. For example, an adolescent referred for misbehaving or using drugs is often truant, has poor grades, and is at risk of dropping out. Misbehavior is associated with learning and emotional difficulties; learning and behavior problems become overlaid with emotional reactions; emotional problems can lead to and exacerbate behavior and/or learning problems.

When problems arise, the trend is to refer students directly for assessment in hopes of referral for special assistance, perhaps even assignment to alternative programs. In some schools and classrooms, the number of referrals is dramatic. In a few cases where problems are severe, pervasive, and/or chronic, students are referred for a possible special education diagnosis (e.g., most often learning disabilities and attention deficit hyperactivity disorder).

Where schools intervene to address student problems, the interventions usually have been developed, organized, and function in relative isolation of each other. Practitioners mostly spend their time working directly with specific interventions and targeted problems and give little thought or time to developing comprehensive and cohesive approaches. Furthermore, the need to label students in order to obtain special, categorical funding and/or reimbursement from public/private insurance often skews practices toward narrow and unintegrated intervention

approaches. One result is that a student identified as having multiple problems may be involved in programs with several professionals working independently of each other. Similarly, a youngster identified and helped in elementary school who still requires special support may cease to receive appropriate help upon entering middle school.

Pursuit of grant money also leads districts and schools to reshape their practices to meet a funder's requirements. Innovators/researchers also bring special projects to schools. All this can have pernicious results by diverting attention from system building. And when funding and projects end – usually within a period of a couple of years – little of the work remains. (The failure to sustain in such cases has been labeled “projectitis.”)

In general, student and learning supports are fragmented, overspecialized, counterproductively competitive, unsustainable, and fundamentally marginalized in policy and practice. The result is a set of interventions that does not and cannot meet the needs of any school where large numbers of students are experiencing problems.

Most of the time, teachers make requests for help to teams set up to deal with moderate behavior, learning, and emotional problems. The list of such referrals grows as the year proceeds. In many schools, the number of students experiencing problems is staggering. The longer the list, the longer the lag time for review – often to the point that, by the end of the school year, the team has reviewed just a small percentage of those referred. *And, no matter how many are reviewed, there are always more referrals than can be served.*

The solution is not found in efforts to convince policy makers to fund more special programs and services at schools. Even if the policy climate favored more special programs, such interventions alone are insufficient. More services to treat problems, certainly are needed. But so are programs for prevention and early-after-problem onset that can reduce the number of students sent to review teams and special interventions at schools. It is time to face the fact that *multifaceted problems usually require comprehensive, cohesive solutions applied concurrently and over time.* And, the entire constellation of barriers to learning calls for schools, families, and communities working together to develop a systemic approach rather than continuing to address each problem as a special agenda and in a piecemeal manner.

A Note About Youth Subcultures and Diversity in Addressing Problems

Given the multifaceted problems that arise at schools, those who are concerned about and have responsibility for gangs, safe schools, violence prevention, bullying, interracial conflict, substance abuse, vandalism, truancy, and school climate need to work collaboratively. The *immediate objectives* are to (1) educate others about motivational and behavioral factors associated with a particular subgroup and individual difference within subgroups, (2) counter the trend in policy and practice to focus on each subgroup in too fragmented a manner, and (3) facilitate opportunities on campus for youth subgroups to engage positively in subcultural activity and connect with effective peer supports (see page 15 for the link to the Center's youth subculture series).

Toward these ends, schools must reach out to the community and establish a collaborative mechanism where those with specialized knowledge not only bring that knowledge to the table, but also build a comprehensive system of student/learning supports to address pressing barriers to learning, teaching, parenting, and development. Those with specialized knowledge, of course, include youth themselves.

With these concerns in mind, let's look at implications for policy and implementation.

Needed: A Policy Shift

Our analysis of prevailing policies for improving schools indicates that the primary focus is on two major components: (1) enhancing instruction and curriculum and (2) restructuring school governance/management. The implementation of such efforts is shaped by demands for every school to adopt high standards and expectations and be accountable mainly for academic results, as measured by standardized achievement tests. Toward these ends, policy has emphasized enhancing direct academic support and moving away from a “deficit” model by adopting a strengths or resilience-oriented paradigm. As noted above, problems that cannot be ignored – school violence, drugs on campus, dropouts, teen pregnancy, delinquency, and so forth – continue to be addressed in a piecemeal manner. The result at schools is a variety of “categorical” initiatives which generate auxiliary programs, some supported by school district general funds and some underwritten by federal and private sector money.

Overlapping the efforts of schools are initiatives from the community to link their resources to schools. Terms used in conjunction with these initiatives include school-linked services (especially health and social services), full-service schools, school-community partnerships, and community schools.

A third and narrower set of initiatives is designed to promote coordination and collaboration among *governmental* departments and their service agencies. The intent is to foster integrated services, with an emphasis on greater local control, increased involvement of parents, and locating services at schools when feasible. Although the federal government has offered various forms of support to promote this policy direction, few school districts have pursued the opportunity in ways that have resulted in comprehensive approaches to address student problems. To facilitate coordinated planning and organizational change, local, state, and federal intra- and interagency initiatives and councils have been established. Relatedly, legislative bodies have rethought committee structures, and some states created new executive branch structures (e.g., combining education and all agencies and services for children and families under one cabinet level department).

The various initiatives do help *some* students who are not succeeding at school. However, they come nowhere near addressing the scope of need.

Policy makers increasingly are appreciating that funding and operating isolated programs is partially responsible for both the inability to provide for the many individuals in need and the limited results for the relatively few served. This has led to calls for greater coordination to reduce *fragmentation*. However, policy makers have failed to address the underlying problem; namely that interventions for youth problems are *marginalized* in prevailing education and public health policy. In schools, this means that such efforts are pursued as supplementary, auxiliary services and are among the first cut as budgets tighten. As a result, the entire arena is plagued by counterproductive competition for sparse resources, and little attention is paid to developing a comprehensive, systemic approach for addressing student problems.

Increased awareness of school policy deficiencies has stimulated analyses and initiatives to move from the current two- to a three-component policy framework for school improvement. The third component is conceptualized as a component that unifies all school-based and linked interventions designed to address barriers to learning and teaching and re-engage disconnected students. This includes mental health and psychosocial concerns.

Efforts to enhance how schools address student problems will benefit from a policy shift to a three component framework and an expansion of school accountability to drive development of the third component and integrate it fully with instruction and management. The shift will enable an extensive restructuring of all school-owned activity, such as pupil services, safe and drug free school initiatives, and compensatory and special education programs.

See the Exhibit on page 5 for examples of initiatives supportive of a move from a two- to a three-

component blueprint for school improvement policy and practice.

Reworking Operational Infrastructure: Beginning at the School Level

Beyond policy changes, emergence of a cohesive and effective approach to addressing youth problems requires some reworking of *operational* infrastructure so that interventions play out at the school level every day. This calls for conceiving the operational infrastructure from the school outward. That is, first the focus is on mechanisms needed at the school level. Building on this, mechanisms are designed to enable a complex of schools to work together and with neighborhood and home resources to increase efficiency and effectiveness and achieve economies of scale. Finally, system-wide mechanisms can be (re)conceived to provide equitable capacity building in each locality.

Clearly, the focus on operational infrastructure is concerned with more than enhancing coordination. The reworking needs to allow for weaving together what is available at a school, expanding this through integrating school, community, and home resources, and enhancing access to community resources by linking as many as feasible to fill major gaps at a school. Braiding resources is essential for addressing student problems in cohesive, cost-efficient, and equitable ways. Moreover, such an approach is highly supportive of the intent to evolve a comprehensive intervention continuum that plays out effectively in *every locality*. It also addresses issues related to enhancing the functionality of school-community collaboratives.

For more on these topics, see

> *Frameworks for Systemic Transformation of Student and Learning Supports.*

<http://smhp.psych.ucla.edu/pdfdocs/systemic/frameworksfor systemictransformation.pdf>

> *Fostering School, Family, and Community Involvement. Guidebook in series, Safe and Secure: Guides to Creating Safer Schools.*

http://smhp.psych.ucla.edu/publications/44_guide_7_fostering_school_family_and_community_involvement.pdf

Evidence-Based Practices and the Implementation Problem at Schools

Schools require effective interventions for promoting the positive and reducing the negative. Both are integrally related to promoting wellness and fostering a positive school climate.

Increasingly schools are being called on to implement science-based practices. While it is clear that many concerns confronting schools cannot wait for researchers to provide proven prototypes, it is also clear that adopting an existing empirically-supported intervention that effectively meets a priority need is the appropriate course of action. At the same time, just because an evidence-based practice exists is not a sufficient reason for schools to adopt it. At any school, the first question that arises about any new practice is where and how does it fit into the school's priorities.

Given that a new practice is adopted, the multifaceted and complex problems associated with implementation arise. These problems are familiar to anyone who has tried to move prototypes found efficacious under highly controlled conditions into the real world of schools. As the *National Implementation Research Network* has stressed, research to support implementation activities is scarce, and little is known especially about the processes required to effectively implement evidence-based programs to scale (see <http://www.fpg.unc.edu/~nirn/>).

Early research on the implementation problem has focused on concerns about and barriers to matters such as dissemination, readiness for and fidelity of implementation, generalizability, adaptation, sustainability, and replication to scale. All of these matters obviously are important.

However, the tendency has been to analyze and approach the implementation problem with too limited a procedural framework and with too little attention to context. These deficiencies become apparent when the implementation process is viewed from the perspective of the complexities of (1)

diffusing innovations and (2) doing so in the context of organized settings with well-established institutional cultures and infrastructures that must change if effective widespread application is to take place.

Addressing these matters requires drawing on the growing bodies of literature on diffusion of innovations and systemic change. From that perspective, the implementation problem is framed as *a process of diffusing innovation through major systemic change*. For schools, such a process encompasses not only facilitating effective adoption/adaptation of prototypes at a particular site, but the added complications of replication-to-scale

For more on this, see the Center's Quick Find Clearinghouse topic:
Systemic Change – <http://smhp.psych.ucla.edu/qf/systemicchange.html>

Concluding Comments

What unites so many of us is the desire to ensure the well-being of the young. In our work, we stress the need to move beyond specific agenda items in seeking greater attention for addressing mental health and psychosocial concerns in schools. Specifically, we have emphasized expanding policy and practice in ways that can embed such concerns into the type of comprehensive, systemic approach necessary for addressing the complex factors interfering with schools accomplishing their mission. By working collaboratively, schools and communities can integrate fragmented and marginalized initiatives. Over time, this will enable development of a comprehensive system of student and learning supports.

To guide development of a systemic approach, we have suggested a unifying framework for integrating school-community interventions. This includes subsystems for promoting healthy development, preventing problems, intervening early to address problems as soon after onset as is feasible, and addressing chronic and severe problems. There also is a need to fundamentally rework operational infrastructure to ensure leadership and mechanisms for building a comprehensive system at schools and for connecting school and community resources.

It is our view that, only by developing a comprehensive system, will it be feasible to facilitate the *emergence* of a school environment that fosters successful, safe, and healthy students and staff. (It is important to remember that *school climate and culture are emergent qualities* that stem from how schools provide and coalesce on a daily basis the components dedicated to instruction, student and learning supports, and management/governance.)

Ultimately, enhanced intervention access and availability depend on moving the whole enterprise of student and learning supports out of the margins of school improvement policy and practice. In this respect, the impending reauthorization of the *Elementary and Secondary Education Act* (ESEA) represents a golden opportunity for moving to a *three-component framework* for turning around, transforming, and continuously improving schools. However, whether or not the reauthorization incorporates a three-component blueprint, pioneering work across the country is heralding movement in this direction. Properly conceived and implemented, the third component can provide a unifying concept and an umbrella under which schools can weave together all interventions specifically intended to address barriers to learning and teaching and re-engage disconnected students.

The call for ensuring equity and opportunity for all youth demands no less.

Executive Summary:

Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations

What is meant by the term mental health in schools?

Ask five people and you'll probably get five different answers.

That is why so many leaders in the field have called for clarification of what mental health (MH) in schools is and is not. Toward these ends, the *Policy Leadership Cadre for Mental Health in Schools* has developed the resource and reference document summarized here. *The focus of the work is on:

- definitional concerns
- the rationale for mental health in schools
- a set of guidelines to clarify the nature and scope of a comprehensive, multifaceted approach
- the ways in which mental health and psychosocial concerns currently are addressed in schools
- advancing the field.

To embellish the document's value as a resource aid for policy and capacity building, a variety of supportive documents and sources for materials, technical assistance, and training are provided.

Concerns . . .
about definition

As is widely recognized, there is a tendency to discuss mental *health* mainly in terms of mental illness, disorders, or problems. This de facto definition has led school policy makers to focus primarily on concerns about emotional disturbance, violence, and substance abuse and to deemphasize the school's role in the positive development of social and emotional functioning. The guidelines presented in this document are meant to redress this tendency. They stress that the definition of MH in schools should encompass the promotion of social and emotional development (i.e., positive MH) and efforts to address psychosocial and MH problems as major barriers to learning.

and

the place of
MH in schools

Among some segments of the populace, schools are not seen as an appropriate venue for MH interventions. The reasons vary from concern that such activity will take time away from the educational mission to fear that such interventions are another attempt of society to infringe on family rights and values. There also is the long-standing discomfort so many in the general population feel about the subject of mental health because it so often is viewed only in terms of mental illness. And, there is a historical legacy of conflict among various stakeholders stemming from insufficiently funded legislative mandates that have produced administrative, financial, and legal problems for schools and problems of access to entitled services for some students.

Whatever one's position about MH in schools, we all can agree on one simple fact: *schools are not in the mental health 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 about physical and 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.

Rationale Given these realities, as a general rationale for MH in schools, we begin with the view of the Carnegie Council Task Force on Education of Young Adolescents (1989) which states:

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.

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 learn and perform effectively. It has long been acknowledged that a variety of psychological and physical health problems affect learning in profound ways. Moreover, these 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.

Despite some reluctance, school policy makers have a long-history of trying to assist teachers in dealing with problems that interfere with school learning. Prominent examples are seen in the range of counseling, psychological, and social service programs provided by schools. Similarly, policymakers in other arenas have focused on enhancing linkages between schools and community service agencies and other neighborhood resources. Paralleling these efforts is a natural interest in promoting healthy and productive citizens and workers. This is especially evident in initiatives for enhancing students' assets and resiliency and reducing risk factors through an emphasis on social-emotional learning and protective factors.

Guidelines Based on a set of underlying principles and some generic guidelines for designing comprehensive, multifaceted, and cohesive approaches to MH in schools, the following set of guidelines is presented along with rationale statements and references related to each guideline. Clearly, no school currently offers the nature and scope of what is embodied in the outline. In a real sense, the guidelines define a vision for how MH in schools should be defined and implemented.

GUIDELINES FOR MENTAL HEALTH IN SCHOOLS

1. General Domains for Intervention in Addressing Students' Mental Health

- 1.1 Ensuring academic success and also promoting healthy cognitive, social, and emotional development and resilience (including promoting opportunities to enhance school performance and protective factors; fostering development of assets and general wellness; enhancing responsibility and integrity, self-efficacy, social and working relationships, self-evaluation and self-direction, personal safety and safe behavior, health maintenance, effective physical functioning, careers and life roles, creativity)
- 1.2 Addressing barriers to student learning and performance (including educational and psychosocial problems, external stressors, psychological disorders)
- 1.3 Providing social/emotional support for students, families, and staff

2. Major Areas of Concern Related to Barriers to Student Learning

- 2.1 Addressing common educational and psychosocial problems (e.g., learning problems; language difficulties; attention problems; school adjustment and other life transition problems; attendance problems and dropouts; social, interpersonal, and familial problems; conduct and behavior problems; delinquency and gang-related problems; anxiety problems; affect and mood problems; sexual and/or physical abuse; neglect; substance abuse; psychological reactions to physical status and sexual activity)
- 2.2 Countering external stressors (e.g., reactions to objective or perceived stress/demands/crises/deficits at home, school, and in the neighborhood; inadequate basic resources such as food, clothing, and a sense of security; inadequate support systems; hostile and violent conditions)
- 2.3 Teaching, serving, and accommodating disorders/disabilities (e.g., Learning Disabilities; Attention Deficit Hyperactivity Disorder; School Phobia; Conduct Disorder; Depression; Suicidal or Homicidal Ideation and Behavior; Post Traumatic Stress Disorder; Anorexia and Bulimia; special education designated disorders such as Emotional Disturbance and Developmental Disabilities)

3. Type of Functions Provided related to Individuals, Groups, and Families

- 3.1 Assessment for initial (first level) screening of problems, as well as for diagnosis and intervention planning (including a focus on needs and assets)
- 3.2 Referral, triage, and monitoring/management of care
- 3.3 Direct services and instruction (e.g., primary prevention programs, including enhancement of wellness through instruction, skills development, guidance counseling, advocacy, school-wide programs to foster safe and caring climates, and liaison connections between school and home; crisis intervention and assistance, including psychological first-aid; prereferral interventions; accommodations to allow for differences and disabilities; transition and follow-up programs; short- and longer- term treatment, remediation, and rehabilitation)
- 3.4 Coordination, development, and leadership related to school-owned programs, services, resources, and systems – toward evolving a comprehensive, multifaceted, and integrated continuum of programs and services
- 3.5 Consultation, supervision, and inservice instruction with a transdisciplinary focus
- 3.6 Enhancing connections with and involvement of home and community resources (including but not limited to community agencies)

(cont.)

Guidelines For Mental Health in Schools (cont.)

4. *Timing and Nature of Problem-Oriented Interventions*

- 4.1 Primary prevention
- 4.2 Intervening early after the onset of problems
- 4.3 Interventions for severe, pervasive, and/or chronic problems

5. *Assuring Quality of Intervention*

- 5.1 Systems and interventions are monitored and improved as necessary
- 5.2 Programs and services constitute a comprehensive, multifaceted continuum
- 5.3 Interveners have appropriate knowledge and skills for their roles and functions and provide guidance for continuing professional development
- 5.4 School-owned programs and services are coordinated and integrated
- 5.5 School-owned programs and services are connected to home & community resources
- 5.6 Programs and services are integrated with instructional and governance/management components at schools
- 5.7 Program/services are available, accessible, and attractive
- 5.8 Empirically-supported interventions are used when applicable
- 5.9 Differences among students/families are appropriately accounted for (e.g., diversity, disability, developmental levels, motivational levels, strengths, weaknesses)
- 5.10 Legal considerations are appropriately accounted for (e.g., mandated services; mandated reporting and its consequences)
- 5.11 Ethical issues are appropriately accounted for (e.g., privacy & confidentiality; coercion)
- 5.12 Contexts for intervention are appropriate (e.g., office; clinic; classroom; home)

6. *Outcome Evaluation and Accountability*

- 6.1 Short-term outcome data
- 6.2 Long-term outcome data
- 6.3 Reporting to key stakeholders and using outcome data to enhance intervention quality

What schools are already doing

Currently, there are almost 91,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted programs designed with a range of mental health and psychosocial concerns in mind. And, there is a large body of research supporting the promise of many of the approaches schools are pursuing.

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 (see the next page for an Exhibit highlighting five major *delivery mechanisms and formats*). Despite the range of activity, it remains the case that too little is being done in most schools, and prevailing approaches are poorly conceived and are implemented in fragmented ways.

Delivery Mechanisms and Formats

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, 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 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 orgs.
 - 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 “Pull Out” 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. 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 and services and integrate them into school reform agendas
 - community schools

The document concludes with a discussion of policy-focused ideas related to advancing the field. At present, a low policy priority is assigned to addressing mental health and psychosocial factors that negatively affect youngsters development and learning. In schools, existing programs are characterized as supplemental services and are among the first to go when budgets become tight. In

effect, they are marginalized in policy and practice. For this situation to change, greater attention must be paid to enhancing the policy priority assigned such matters, developing integrated infrastructures including new capacity building mechanisms, enhancing use of available resources, and rethinking the roles, functions, and credentialing of pupil service personnel.

Concluding Comments

In terms of policy, practice, and research, all activity related to MH in schools, including the many categorical programs funded to deal with designated problems, eventually must be seen as embedded in a cohesive continuum of interventions and integrated thoroughly with school reform efforts.

When this is done, MH in schools will be viewed as essential to addressing barriers to learning and not as an agenda separate from a school's instructional mission.

In turn, this will facilitate establishment of school-community-home collaborations and efforts to weave together all activity designed to address mental health problems and other barriers to learning.

All this can contribute to the creation of caring and supportive environments that maximize learning and well-being and strengthen students, families, schools, and neighborhoods.

**Impediments to Enhancing Availability of Mental Health Services in Schools:
*Fragmentation, Overspecialization, Counterproductive
Competition, and Marginalization***

<http://files.eric.ed.gov/fulltext/ED461819.pdf>

Note: This paper introduces a new phase in the NASP-ERIC/CASS Partnership. Each year NASP and ERIC/CASS will commission an outstanding author to prepare an original paper relevant to the theme of the NASP national convention. This paper will be presented to the NASP Executive Council and later made available to NASP members at the ERIC/CASS booth at the convention. In recognition of its special status, the paper will be entered into the ERIC international database as an ERIC/CASS - NASP Premier Partnership Paper. This category will be reserved for papers displaying the highest order of scholarship and devoted to a topic of compelling criticality for school psychology. It will also be posted on the websites of both organizations.

This paper, *Impediments to Enhancing Availability of Mental Health Services in Schools: Fragmentation, Overspecialization, Counterproductive Competition, and Marginalization*, authored by two eminent policy strategists, Howard S. Adelman and Linda Taylor, is an excellent start-up for the series and appropriately compliments the convention theme of Overcoming Barriers, Increasing Access and Serving All Children. It is our joint intent that this paper will highlight the high quality of resources being entered into the ERIC database and also encourage other psychologists to submit their papers to ERIC/CASS.

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Impediments to Enhancing Availability of Mental Health Services in Schools: *Fragmentation, Overspecialization, Counterproductive Competition, and Marginalization*

Howard Adelman & Linda Taylor

Abstract

Concerns about enhancing availability and access to mental health services in schools range from sparse resources to the proliferation of piecemeal and overspecialized interventions arising from categorical funding. This paper discusses such concerns and stresses that they must be addressed from a perspective that fully appreciates the degree to which school policies and practices marginalize student support programs and services. Changing all this is discussed in terms of reframing school reform to fully address barriers to student learning. Finally, a proactive agenda addressing the implications for new directions for pupil personnel professionals is suggested.

Over the years, various legal mandates and awareness of the many barriers to learning have given rise to a variety of school counseling, psychological, and social support programs and to initiatives for school-community collaborations. Paralleling these efforts is a natural interest in promoting healthy development. As a result, a great amount of activity is in play, and a great many concerns have arisen about intervention availability, access, and delivery and about effectiveness and cost-efficiency.

Much has been made of categorical funding as related to the problems of availability and access and the proliferation of piecemeal and overspecialized interventions. Concomitantly, problems constantly arise because of turf battles among pupil service personnel and between such personnel and community providers offering school-linked services. Such concerns clearly are significant and related. However, they need to be addressed from a perspective that fully appreciates the degree to which programs and services for addressing barriers to student learning are marginalized in school policy and practice. This paper discusses such concerns and the need to reframe school reform and the roles of pupil personnel professionals in order to deal with them.

Fragmentation, Overspecialization, and Competition

Problems of fragmentation, overspecialization, and counterproductive competition arise from several sources. For purposes of this discussion, it will suffice to highlight matters in terms of efforts related to (a) school-owned programs and (b) initiatives designed to enhance school and community agency connections.

School-Owned Programs

Looked at as a whole, one finds in many school districts a range of preventive and corrective activity oriented to students' needs and problems. Some programs are provided throughout a school district, others are carried out at or linked to targeted schools. (Most are owned and operated by schools; some are owned by community agencies.) The interventions may be offered to all students in a school, to those in specified grades, to those identified as "at risk," and/or to those in need of compensatory education. The activities may be implemented in regular or special education classrooms and may be geared to an entire class, groups, or individuals; or they may be designed as "pull out" programs for designated students. They encompass ecological, curricular, and clinically oriented activities designed

to reduce problems such as substance abuse, violence, teen pregnancy, school dropouts, and delinquency (Adelman, 1996a).

It is common knowledge, however, that few schools come close to having enough resources when confronted with a large number of students experiencing a wide range of psychosocial barriers that interfere with learning and performance. Most schools offer only bare essentials. Too many schools cannot even meet basic needs. Primary prevention often is only a dream.

While schools can use a variety of persons to help students, most school-owned and operated services are offered as part of what are called pupil personnel services or support services. Federal and state mandates tend to determine how many pupil service professionals are employed, and states regulate compliance with mandates. Governance of daily practice usually is centralized at the school district level. In large districts, psychologists, counselors, social workers, and other specialists may be organized into separate units. Such units overlap regular, special, and compensatory education. Analyses of the situation find that the result is programs and services that have a specialized focus and relative autonomy. Thus, although they usually must deal with the same common barriers to learning (e.g., poor instruction, lack of parent involvement, violence and unsafe schools, inadequate support for student transitions), the programs and services generally are planned, implemented, and evaluated in a fragmented and piecemeal manner. Consequently, student support staff at schools tend to function in relative isolation of each other and other stakeholders, with a great deal of the work oriented to discrete problems and with an overreliance on specialized services for individuals and small groups. In some schools, a student identified as at risk for grade retention, dropout, and substance abuse may be assigned to three counseling programs operating independently of each other. Such fragmentation not only is costly, it works against developing cohesiveness and maximizing results, and it leads to counterproductive competition for sparse resources - all of which works against enhancing availability (Adelman, 1996a; Adelman & Taylor, 1997, 1999).

Furthermore, in every facet of a school district's operations, an undesirable separation usually is manifested among the instructional and management components and the various activities that constitute efforts to address barriers to learning. At the school level, this translates into situations where teachers simply do not have the supports they need when they identify students who are having difficulties. Clearly, prevailing school reform processes and capacity building (including pre and in service staff development) have not dealt effectively with such concerns.

School-Community Collaborations

As another way to provide more support for schools, students, and families, there has been increasing interest in school-community collaborations. This interest is bolstered by the renewed policy concern about countering widespread fragmentation of and enhancing availability and access to community health and social services and by the various initiatives for school reform, youth development, and community development. In response to growing interest and concern, various forms of school-community collaborations are being tested, including state-wide initiatives in many states (e.g., California, Florida, Kentucky, Missouri, New Jersey, Ohio, and Oregon). This movement has fostered such concepts as school linked services, coordinated services, wrap-around services, one-stop shopping, full service schools, and community schools (Dryfoos, 1994). The growing youth development movement adds concepts such as promoting protective factors, asset-building, wellness, and empowerment.

In building school-community collaborations, the tendency has been to limit thinking about communities by focusing only on agencies. This is unfortunate because the range of resources in a community is much greater than the service agencies and community-based organizations that often are invited to the table (Kretzmann & McKnight, 1993).

Not surprisingly, early findings primarily indicate how challenging it is to establish collaborations (Knapp, 1995; Melaville & Blank, 1998; SRI, 1996; White & Whelage, 1995). Still, a reasonable inference from available data is that school-community collaborations can be successful and cost effective over the long-run. For example, by placing staff at schools, community agencies increase the amount of assistance available and make access easier for students and families, especially those who usually are underserved and hard to reach. Such efforts not only provide services, they seem to encourage schools to open their doors in ways that enhance recreational, enrichment, and remedial opportunities, and lead to greater family involvement (Center for Mental Health in Schools, 1996, 1997; Day & Roberts, 1991; Dryfoos, 1994, 1998; Knapp, 1995; Lawson & Briar-Lawson, 1997; Melaville & Blank, 1998; Schorr, 1997; Taylor & Adelman, 2000; U.S. Department of Education, 1995; U.S. General Accounting Office, 1993).

Marginalization

Policy makers have come to appreciate the relationship between limited intervention effectiveness and the widespread tendency for complementary programs in school and community to operate in isolation. Limited results do seem inevitable as long as interventions are carried out in a piecemeal and inappropriately competitive fashion and with little follow through.

The call for "integrated services" clearly is motivated by the desire to reduce redundancy, waste, and ineffectiveness resulting from fragmentation, while also increasing availability and access (Adler & Gardner, 1994; Merseth, Schoor, & Elmore, 2000). Special attention is given to the many piecemeal, categorically funded approaches, such as those created to reduce learning and behavior problems, substance abuse, violence, school dropouts, delinquency, and teen pregnancy. However, by focusing primarily on fragmentation, policy makers fail to deal with the overriding issue, namely that addressing barriers to development and learning remains a marginalized aspect of policy and practice. Fragmentation stems from the marginalization, but concern about such marginalization is not even on the radar screen of most policy makers.

Stated simply, the majority of school programs, services, and special projects designed to address barriers to student learning are viewed as supplementary (often referred to as auxiliary services) and operate on an ad hoc basis. The degree to which marginalization is the case is seen in the lack of attention given to such school activity in consolidated plans and certification reviews and the lack of efforts to map, analyze, and rethink how resources are allocated. Educational reformers virtually have ignored the need to reframe and restructure the work of school professionals who carry out psychosocial and health programs. As long as this remains the case, reforms to reduce fragmentation and increase availability and access are seriously hampered. More to the point, the desired impact for large numbers of children and adolescents will not be achieved.

At most schools, community involvement also is a marginal concern, and the trend toward fragmentation is compounded by most school-linked services' initiatives. This happens because such initiatives focus primarily on coordinating community services and linking them to schools, with an emphasis on co-locating rather than integrating such services with the ongoing efforts of school staff. Fragmentation is worsened by the failure of policy makers at all levels to recognize these problems (Adelman & Taylor, 2000). Reformers mainly talk about "school-linked integrated services" – apparently in the belief that a few health and social services are a sufficient response. Such talk has led some policy makers to the mistaken impression that community resources alone can effectively meet the needs of schools in addressing barriers to learning. In turn, this has led some legislators to view linking community services to schools as a way to free the dollars underwriting school-owned services. The reality is that even when one adds together community and school

assets, the total set of services in impoverished locales is woefully inadequate. In situation after situation, it has become evident that as soon as the first few sites demonstrating school-community collaboration are in place, community agencies find they have stretched their resources to the limit. Another problem is that the overemphasis on school-linked services is exacerbating rising tensions between school district service personnel and their counterparts in community-based organizations. As "outside" professionals offer services at schools, school specialists often view the trend as discounting their skills and threatening their jobs. At the same time, the "outsiders" often feel unappreciated and may be rather naive about the culture of schools. Turf conflicts arise over use of space, confidentiality, and liability. Thus, a counterproductive competition rather than a substantive commitment to collaboration is the norm.

In short, policies shaping agendas for school and community reform are seriously flawed. Although fragmentation and access are significant problems, marginalization is of greater concern. It is unlikely that the problems associated with education support services will be appropriately resolved in the absence of concerted attention in policy and practice to ending the marginalized status of efforts to address factors interfering with development, learning, parenting, and teaching.

Reframing School Reform to Fully Address Barriers to Student Learning

Keys to ending marginalization include expanding comprehensiveness and ensuring that school reform initiatives fully integrate education support activity. Presently, there are several windows of opportunity for moving in this direction.

Windows of Opportunity for Systemic Change and Renewal

Among the most prominent opportunities are the major reform initiatives related to schools and welfare and health services. These initiatives are shifting the ways in which children and their families interface with school and community. For example, among other things, school reform aims to close the achievement gap, eliminate social promotion, enhance school safety, and minimize misidentification and maximize inclusion of exceptional learners in regular programs (Center for Mental Health in Schools, 2001a; Lipsky & Gartner, 1996). If such changes are to benefit the targeted students, current implementation strategies must be thoroughly overhauled, and well-designed interventions for prevention and early-after-onset correction of problems are essential. To these ends, all school personnel concerned with these matters must find their way to leadership tables so that effective system-wide changes are designed and implemented.

Similar opportunities arise around welfare reform. As the pool of working parents is increased, there is an expanding need for quality day care and preschool programs and programs to fill nonschool hours for all youngsters. Health reforms also are beginning to bring more services to schools (e.g., school-based health centers, family resource centers) and are stimulating renewed interest in primary and secondary prevention. As local schools and neighborhoods wrestle with the implications of all this, the result can be further fragmentation and marginalization of programs, or steps can be taken to weave changes into comprehensive approaches for addressing barriers to development and learning. Student support staff have not yet emerged as key participants in these arenas, but the opportunity for assuming a leadership role is there.

Another window of opportunity comes from the rapid expansion of technology. In the next few years, technology will provide major avenues for improving how school staff function. Now is the time to take the lead in planning how technology will be used in working with students and their families and in building capacity for more effective, less costly interventions. Tools already are available for empowering student choice and self-sufficiency and system capacity building.

Improved computer programs are emerging that systematically support many intervention activities, and the Internet enables increased access to information and resources, enhances collaborative efforts including consultation and networking, and provides personalized continuing education and distance learning (Center for Mental Health in Schools, 2000). Resources contained in ERIC and the ERIC/CASS Virtual Libraries can be highly contributive to the efforts to reframe school reform and address barriers to student learning (<http://ericcass.uncg.edu>).

Toward Comprehensive, Multifaceted Approaches

Prevailing initiatives and windows of opportunity provide a context for formulating next steps and new directions. Building on what has gone before, we submit the following propositions. First, we suggest that many specific problems are best pursued as an integrated part of a comprehensive, multifaceted continuum of interventions designed to address barriers to learning and promote healthy development. For another, we submit that comprehensive, multifaceted approaches are only feasible if the resources of schools, families, and communities are woven together. A corollary of this is that the committed involvement of school, family, and community is essential in maximizing intervention implementation and effectiveness. The following discussion is designed to clarify these propositions.

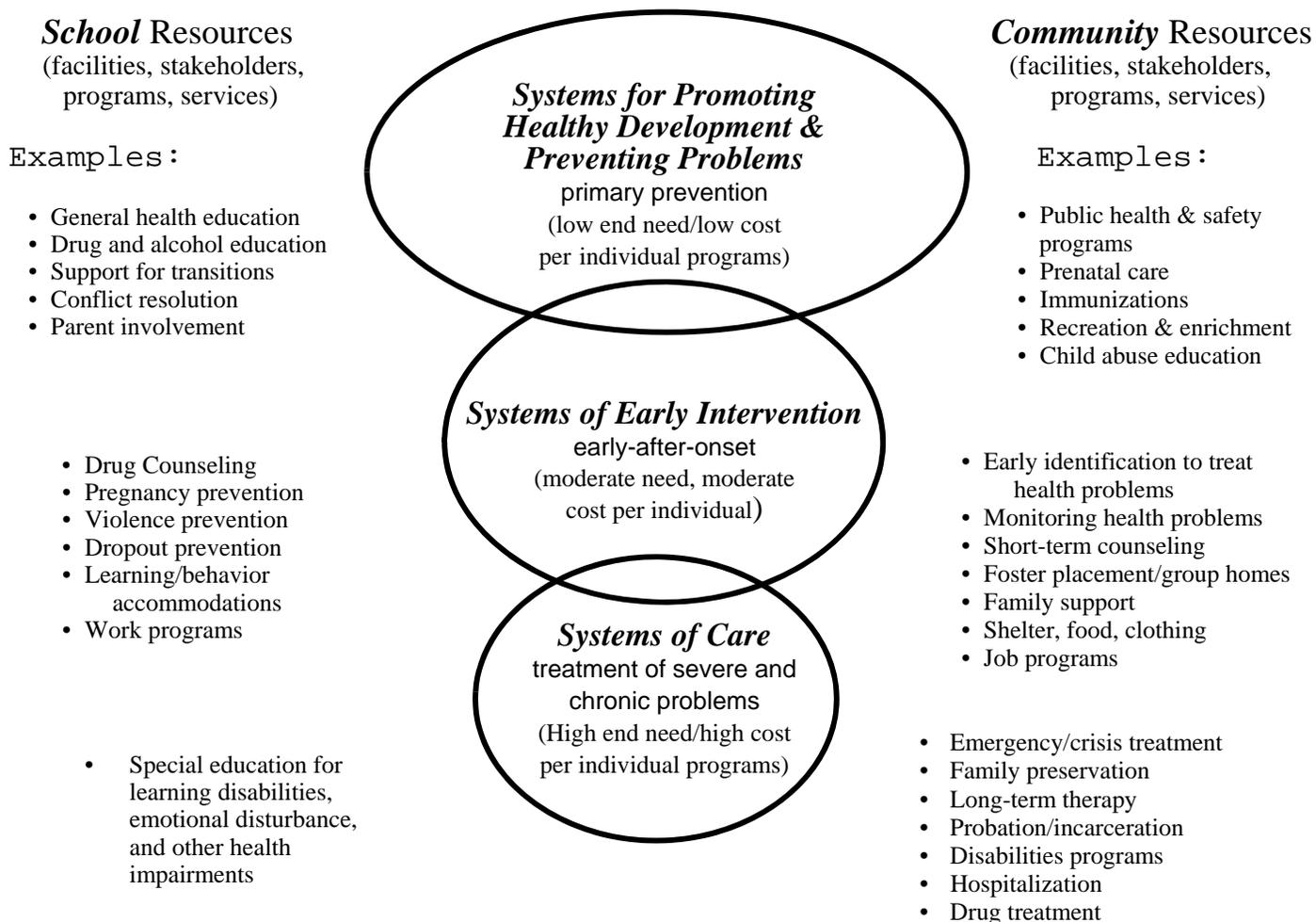
A comprehensive and multifaceted continuum of braided interventions. Problems experienced by students generally are complex in terms of cause and needed intervention. This means interventions must be comprehensive and multifaceted.

How comprehensive and multifaceted? The desired interventions can be conceived as a continuum ranging from a broad-based emphasis on promoting healthy development and preventing problems (both of which include a focus on wellness or competence enhancement) through approaches for responding to problems early-after-onset, and extending on to narrowly focused treatments for severe/chronic problems (see Figure). Not only does the continuum span the concepts of primary, secondary, and tertiary prevention, it can incorporate a holistic and developmental emphasis that envelops individuals, families, and the contexts in which they live, work, and play. The continuum also provides a framework for adhering to the principle of using the least restrictive and nonintrusive forms of intervention required to appropriately respond to problems and accommodate diversity.

Moreover, given the likelihood that many problems are not discrete, the continuum can be designed to address root causes, thereby minimizing tendencies to develop separate programs for each observed problem. In turn, this enables increased coordination and integration of resources which can increase impact and cost-effectiveness. Ultimately, the continuum can evolve into integrated systems by enhancing the way the interventions are connected. Such connections may involve horizontal and vertical restructuring of programs and services (a) within jurisdictions, school districts, and community agencies (e.g., among divisions, units) and (b) between jurisdictions, school and community agencies, public and private sectors, among clusters of schools, and among a wide range of community resources.

Integrating with school reform. It is one thing to stress the desirability of developing a full continuum of interventions; it is quite another to propose that schools should be involved in doing so. In the long run, the success of such proposals probably depends on anchoring them in the mission of schools. That is, the recommendations must be rooted in the reality that

Figure. Interconnected systems for meeting the needs of all students.



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.*

- *Such collaboration involves horizontal and vertical restructuring of programs and services
- within jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters of schools)
 - between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies

Adapted from various public domain documents authored by H. S. Adelman & L. Taylor and circulated through the Center for Mental Health in Schools at UCLA.

schools are first and foremost accountable for educating the young. In particular, such proposals must reflect an appreciation that schools tend to become concerned about addressing a problem when it clearly is a barrier to student learning. Moreover, it is the entire constellation of external and internal barriers to learning that argues for schools, families, and communities working together to develop a cohesive, comprehensive, multifaceted approach. Indeed, to achieve their educational mission, schools need to address barriers to learning and to do so with more than school-linked, integrated health and human services. Addressing barriers involves comprehensive, multifaceted strategies that can only be achieved through strong school-community connections. (School-community connections are particularly important in poverty areas where schools often are the largest piece of public real estate in the community and also may be the single largest employer.)

As stressed above, however, the current situation is one where schools marginalize everything except direct efforts to improve teaching and enhance the way schools are managed. Therefore, we suggest that policy makers must move beyond what fundamentally is a two-component model dominating school reform. They must recognize that for teachers to teach effectively there must not only be effective instruction and well-managed schools; there also must be a component to address barriers in a comprehensive way.

Enabling Learning by Addressing Barriers

Our work points to the need for a three-component framework for reform that views all three components as complementary and overlapping (Adelman, 1996a; 1996b; Adelman & Taylor, 1994, 1997, 1998; Center for Mental Health in Schools, 1996, 1997, 1998). The third component is conceived as a comprehensive, multifaceted approach to enable learning by addressing barriers. Thus, we call it an enabling component. (Enabling is defined as "providing with the means or opportunity; making possible, practical, or easy.") Of even greater importance, we have stressed that adoption of a three-component model must be done in a way that elevates efforts to address barriers to development, learning, and teaching to the level of a fundamental and essential facet of education reform and school and community agency restructuring.

By calling for reforms that fully integrate a focus on addressing barriers to learning, the concept of an enabling component provides a unifying frame of reference for responding to a wide range of psychosocial factors interfering with effective schooling. In policy and practice, all categorical programs, such as Title I, safe and drug free school programs, and special education, can be integrated into such a comprehensive component. Moreover, when current policy and practice are viewed through the lens of this third component, it becomes evident how much is missing in prevailing efforts to enable learning, development, and teaching. Adoption of such an inclusive unifying concept is seen as pivotal in convincing policy makers to recognize the essential nature of activity to enable learning. That is, the third component is seen as providing both a basis for combating marginalization and a focal point for developing a comprehensive framework for policy and practice. When such a component is elevated to a high policy level, it finally will be feasible to unify disparate approaches to preventing and ameliorating psychosocial problems and promoting wellness, thereby reducing fragmentation. That is, we see this form of expanded school reform as a foundation upon which to mesh resources for minimizing risk factors and fostering healthy development and as a catalyst for rethinking community resources and how they can best be connected with schools.

Implications for New Directions for Pupil Personnel Professionals: A Proactive Agenda

Our analyses envision schools and communities weaving their resources together to develop a comprehensive continuum of programs and services designed to address barriers to development, learning, parenting, and teaching. From a decentralized perspective, the primary focus in designing such an approach is on systemic changes at the school and neighborhood level. Then, based on understanding what is needed to facilitate and enhance local efforts, changes must be made for families of schools and wider communities. Finally, with clarity about what is needed to facilitate school and community-based efforts and school-community partnerships, appropriate centralized restructuring can be pursued.

Whether or not what we envision turns out to be the case, pupil service personnel must be proactive in shaping their future. In doing so, they must understand and take advantage of the windows of opportunity that are currently open as a result of major reform initiatives and the rapid advances in technology. We also think they need to adopt an expanded vision of their roles and functions (Policy Leadership Cadre for Mental Health in Schools, 2001). Politically, they must integrate themselves fully into school reform at all levels and especially at the school.

For some time, policy and practice changes have suggested the need for restructuring personnel roles and functions and systemic mechanisms (at schools, in central offices, and by school boards). Some thoughts about this are offered in the next section.

Rethinking Roles and Functions

As the preceding discussion indicates, many influences are reshaping and will continue to alter the work of pupil personnel staff. Besides changes called for by the growing knowledge base in various disciplines and fields of practice, initiatives to restructure education and community health and human services are creating new roles and functions. Clearly, pupil service personnel will continue to be needed to provide targeted direct assistance and support. At the same time, their roles as advocates, catalysts, brokers, leaders, and facilitators of systemic reform will expand. As a result, they will engage in an increasingly wide array of activity to promote academic achievement and healthy development and address barriers to student learning. In doing so, they must be prepared to improve intervention outcomes by enhancing coordination and collaboration within a school and with community agencies in order to provide the type of cohesive approaches necessary to deal with the complex concerns confronting schools (Adelman, 1996a, 1996b; Center for Mental Health in Schools, 2001b, 2001c; Freeman & Pennekamp, 1988; Gysbers & Henderson, 2000, 2001; Lapan, 2001; Marx, Wooley, & Northrop, 1998; Reschly & Ysseldyke, 1995).

Consistent with current systemic changes is a trend toward less emphasis on intervention ownership and specialization and more attention to accomplishing desired outcomes through flexible and expanded roles and functions. This trend recognizes underlying commonalities among a variety of school concerns and intervention strategies and is fostering increased interest in cross-disciplinary training and interprofessional education (Carnegie Council on Adolescent Development, 1995; Lawson & Hooper-Briar, 1994).

Clearly, all this has major implications for changing pupil personnel professionals' roles, functions, preparation, and credentialing. Efforts to capture key implications are discussed in a recent report from the Center for Mental Health in Schools (2001d) entitled: *Framing New Directions for School Counselors, Psychologists, & Social Workers*.

New Mechanisms

With specific respect to improving how problems are prevented and ameliorated, all school personnel designated as student support staff need to lead the way in establishing well-redesigned organizational and operational mechanisms that can provide the means for schools to (a) arrive at wise decisions about resource allocation; (b) maximize systematic and integrated planning, implementation, maintenance, and evaluation of enabling activity; (c) outreach to create formal working relationships with community resources to bring some to a school and establish special linkages with others; and (d) upgrade and modernize interventions to reflect the best models and use of technology. As discussed above, implied in all this are new roles and functions. Also implied is redeployment of existing resources as well as finding new ones (Center for Mental Health in Schools, 2001b).

Concluding Comments

Over the next decade, initiatives to restructure education and community health and human services will reshape the work of school professionals who provide student support. Although some current roles and functions will continue, many will disappear, and others will emerge. Opportunities will arise not only to provide direct assistance but to play increasing roles as advocates, catalysts,

brokers, and facilitators of reform and to provide various forms of consultation and inservice training. And, it should be emphasized that these additional duties include participation on school and district governance, planning, and evaluation bodies. All who work to address barriers to student learning must participate in capacity building activity that allows them to carry out new roles and functions effectively. This will require ending their marginalized status through full participation on school and district governance, planning, and evaluation bodies.

The next 20 years will mark a turning point for how schools and communities address the problems of children and youth. Currently being determined is: In what direction should schools go? And who should decide this? Where student support staff are not yet shaping the answers to these questions, they need to find a place at the relevant tables. Their expertise is needed in shaping policy, leadership, and mechanisms for developing school-wide and classroom programs to address barriers to learning and promote healthy development. There is much work to be done as the field redefines itself to play a key role in schools of the future.

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A Sampling of References
(from the Center's Quick Find Collection)

Go to <http://smhp.psych.ucla.edu/qf/references.htm>

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Executive Summary



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

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 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.

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

How should our society’s schools address these matters?

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.

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. School policy makers have a lengthy (albeit somewhat reluctant) history of trying to assist teachers in dealing with factors 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.

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. And, ongoing efforts to enhance access to clients in health and social services sectors has resulted in increased linkages between schools and community service agencies.

Over the years, the most widespread activity related to MH in schools has been carried out by school staff described variously as student support staff, pupil personnel professionals, and specialists. Schools have used their resources to hire a substantial body of these professionals. As a result, it is these school staff who have been the core around which programs have emerged.

And, in support of MH in schools, various federal initiatives have been developed. Besides those emanating from the U.S. Department of Health and Human Services, significant initiatives have been generated by the U.S. Department of Education and through special interagency collaborative projects.

Where the Field is Now

Most schools have some interventions to address a range of MH and psychosocial concerns, such as school adjustment and attendance problems, bullying, violence, relationship difficulties, emotional upset, physical and sexual abuse, substance abuse, dropouts, and delinquency. Some are funded by the schools or through extra-mural funding; others are the result of linkages with community service and youth development agencies. Some programs and services are found 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." Overlapping problems may be targeted and dealt with in isolation of each other through separate, categorical programs or may be addressed as part of other school-wide and classroom programs. 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.

Despite the range of personnel and activity, it is common knowledge that few schools come close to having enough resources to deal with a large number of students with MH and psychosocial problems. And, schools do report having many children and adolescents in need of assistance; for some, the numbers have risen to over half those enrolled.

Given this state of affairs, it is poignant to see how low a priority schools assign in both policy and practice to addressing psychosocial and mental health concerns. Indeed, this arena of activity is extremely marginalized.

As a result, interventions 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, efforts 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 schools to deal with the complex sets of problems confronting teachers and other school staff. The fragmentation has been well documented, and a variety of federal, state, and local initiatives have offered models for enhancing coordination.

Analyses indicate that there is a fundamental policy weakness that maintains the unsatisfactory status quo related to how schools address learning, behavior, and emotional problems. School policy and school improvement planning are currently dominated by a two-component systemic model. 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.

In states and localities where pioneering efforts are underway to move from a two- to a three- component policy framework, the component to address barriers to learning is denoted by various terms, such as an Enabling Component, a Learning Supports Component, a Comprehensive Student Support System. 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 MH 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.

Where is the Field Going?

It is clear that the field of mental health in schools is in flux. 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.

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 stated aim in the Commission's report is to more wisely invest and use sparse resources. One set of relevant resources certainly are those already committed to MH in schools. However, because of the Commission's limited focus on MH in schools, this venue is unlikely to play a major role in immediate efforts to transform the mental health system, never mind enhancing MH in schools.

Approaching MH in schools from a different perspective, a variety of stakeholders are pushing to enhance policy and practice in ways that directly connect various mental health agenda with the mission of schools. This emerging view is calling for much more than expanded services and full service schools. It is focused on enhancing strategic collaborations to develop comprehensive approaches that strengthen students, families, schools, and neighborhoods and doing so in ways that maximize learning, caring, and well-being. Moreover, advocates of the emerging view stress that when students are not doing well at school, mental health 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.

The specific emphasis of the emerging view is on developing, over time, a full continuum of systemically interconnected school and community interventions that encompasses (a) a *system* for promoting healthy development and preventing problems, (b) a *system* for responding to problems as soon after onset as is feasible, and (c) a *system* for providing intensive care. This encompasses the full integration of mental health concerns into a school's efforts to provide students with learning supports by connecting in major ways with the mission of schools.

Policy Implications

- *Ending the Marginalization of MH in Schools.* Based on the background and analyses set forth in this report, it is concluded that the most fundamental policy concern at this time is to end the *marginalization* of mental health in schools. To achieve this goal, it is suggested that a policy shift 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. Moreover, it is suggested that such a system needs to be built using a unifying umbrella concept that fits school improvement needs and embeds concerns about mental health. The report includes specific examples of policy that incorporate this perspective.
- *Addressing the Complications of Systemic Change.* 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. 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. The report provides a framework highlighting key elements of and the linkages between these tasks. Policy is needed to ensure that strategic planning for school improvement accounts for each of the highlighted elements 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. And, 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

Concluding Comments

At present, mental health activity is going on in schools with competing agenda vying for the same dwindling resources. Diverse school and community stakeholders 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.

Enhancing MH 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.

The present state of affairs calls for realigning policy and practice around a unifying and cohesive framework based on well-conceived models and the best available scholarship. Initiatives for MH in schools must be connected in major ways with the mission of schools and integrated into a restructured system of education support programs and services. This means braiding resources and interventions with a view to ensuring there is a *system of learning supports*, rather than separate programs and services. Coordinated efforts naturally are part of this, but the key is development of a system of learning supports that meets overlapping needs and does so by fully integrating mental health agenda into school improvement planning at school and district levels. The implications for policy and practice seem clear:

Policy and practice must end the marginalization of mental health in schools. To do less is to leave too many children behind.

School systems are not responsible for meeting
every need of their students.
But when the need directly affects learning,
the school must meet the challenge.
Carnegie Council Task Force on Education of Young Adolescents (1989)

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A Brief Overview About the Center for Mental Health in Schools at UCLA

In an effort to advance the field, the School Mental Health Project was established in 1986 in the Department of Psychology at UCLA to pursue theory, research, practice, and training related to addressing mental health and psychosocial concerns through school-based interventions. Under the auspices of the Project, the national Center for Mental Health in Schools was funded in 1995 to 2011. The Center's goals are to enhance *in strategic ways* (1) availability of and access to resources to improve and advance MH in schools, (2) the capacity of systems/personnel, and (3) the role of schools in addressing MH, psychosocial, and related health concerns.

From the perspective of the guiding frameworks described in various works generated by the project/center staff, addressing MH of youngsters involves ensuring

- mental *illness* is understood within the broader perspective of psychosocial and related health problems and in terms of strengths as well as deficits
- the roles of schools/communities/homes are enhanced and pursued jointly
- equity considerations are confronted
- the marginalization and fragmentation of policy, organizations, and daily practice are countered
- the challenges of evidence-based strategies and achieving results are addressed.

Thus, the Center's work aims not only at improving practitioners' competence, but at fostering changes in the systems with which they work. Such activity also addresses the varying needs of locales and the problems of accommodating diversity among those trained and among populations served.

Given the number of schools across the country, resource centers such as ours must work in well-conceived strategic ways. Thus, our emphasis is on expanding programmatic efforts that enable all student to have an equal opportunity to succeed at school and on accomplishing essential systemic changes for sustainability and scale-up through (a) enhancing resource availability and the systems for delivering resources, (b) building state and local capacity, (c) improving policy, and (d) developing leadership.

The strategies for accomplishing all this include

- connecting with major initiatives of foundations, federal government & policy bodies, and national associations;
- connecting with major initiatives of state departments and policy bodies, counties, and school districts;
- collaborating and network building for program expansion and systemic change;
- providing catalytic training to stimulate interest in program expansion and systemic change;
- catalytic use of technical assistance, internet, publications, resource materials, and regional meetings to stimulate interest in program expansion and systemic change.

Because we know that schools are not in the mental health business, all our work strives to approach mental health and psychosocial concerns in ways that integrally connect with school reform. We do this by integrating health and related concerns into the broad perspective of addressing barriers to learning and promoting healthy development. We stress the need to restructure current policy and practice to enable development of a comprehensive and cohesive approach that is an essential and primary component of school reform, without which many students cannot benefit from instructional reforms and thus achievement scores will not rise in the way current accountability pressures demand.