Leadership Training:
Continuing Education for Change

Addressing Barriers to Learning:
A Comprehensive Approach to Mental Health in Schools

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Preface

There is a simple truth that every professional working in schools knows: social, emotional, and physical health deficits and other persistent barriers to learning must be addressed if students are to learn effectively and schools are to accomplish their educational mission. It would be wonderful if the process of addressing such barriers could be handled solely by families or public and private community agencies. Unfortunately, these agencies are unable to do the job alone. Thus, if school reform is to be effective, schools must play a major role in easing problems, increasing opportunities, and enhancing the well-being of students and families.

Recognizing the crisis related to young people's well-being, the Duke Endowment awarded a grant to the Eastern Area Health Education Center (AHEC) in North Carolina for a project to increase the availability of school-based mental health intervention through enhanced training for school staff. We were asked by the Eastern AHEC to participate in this endeavor. Their plan was to create an eleven part School Mental Health Training Series under the umbrella of the concept of Addressing Barriers to Learning. A key aspect of our involvement was development of this introductory module. The module incorporates what we have learned over many years of working on matters related to students’ learning, behavior, and emotional problems and what schools need to do about such problems.

As is the case with the all our resource materials, many staff and graduate and undergraduate students have contributed to the effort. The material represents a timely and progressive approach to the topic. At the same time, the content, like the field itself, is seen as in a state of continuous evolution. Thus, we are extremely interested in receiving your feedback as a basis for improving the module.

Howard Adelman & Linda Taylor  
Co-Directors, School Mental Health Project/  
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*Two national training and technical assistance centers for mental health in schools were established in 1995 by the Health Resources and Services Administration, Bureau of Maternal and Child Health, Office of Adolescent Health. One center is at UCLA and the other at the University of Maryland at Baltimore. These represent a major initiative established by the U.S. Department of Health and Human Services to enhance the ability of schools to meet the needs of students and their families.
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainers’ Guide</td>
<td>vi</td>
</tr>
<tr>
<td>Pretest/Postest</td>
<td>xiv</td>
</tr>
<tr>
<td><strong>I. Introductory Concepts</strong></td>
<td></td>
</tr>
<tr>
<td>A. Mental Health in Schools</td>
<td>2</td>
</tr>
<tr>
<td>B. For a Few or For the Many?</td>
<td>12</td>
</tr>
<tr>
<td>C. Multifaceted Focus: Addressing Barriers, Enhancing Protections,</td>
<td>15</td>
</tr>
<tr>
<td>Promoting Development</td>
<td></td>
</tr>
<tr>
<td>D. Comprehensive Continuum of Interventions Systems</td>
<td>23</td>
</tr>
<tr>
<td>Brief follow up reading – <em>Advancing Mental Health in Schools</em></td>
<td>27</td>
</tr>
<tr>
<td><strong>II. Policy Considerations</strong></td>
<td></td>
</tr>
<tr>
<td>A. Fragmentation, Marginalization, and Counterproductive Competition</td>
<td>33</td>
</tr>
<tr>
<td>for Sparse Resources</td>
<td></td>
</tr>
<tr>
<td>B. Moving from a two to a three component policy framework</td>
<td>38</td>
</tr>
<tr>
<td>Group Reflection and Discussion:</td>
<td>42</td>
</tr>
<tr>
<td><em>Key Insights About Mental Health in Schools</em></td>
<td></td>
</tr>
<tr>
<td>Brief Follow-up Reading:</td>
<td>43</td>
</tr>
<tr>
<td><em>Why New Directions for Student Support?</em></td>
<td></td>
</tr>
<tr>
<td>**III. Reframing How Schools Address Barriers to Learning –</td>
<td>51</td>
</tr>
<tr>
<td>including Mental Health Concerns</td>
<td></td>
</tr>
<tr>
<td>A. A School-Wide Enabling Component</td>
<td>53</td>
</tr>
<tr>
<td>B. Special Assistance in Keeping with the Principle of Least Intervention Needed</td>
<td>63</td>
</tr>
<tr>
<td>C. Mental Health Services and Instruction</td>
<td>75</td>
</tr>
<tr>
<td>Group Activity:</td>
<td>95</td>
</tr>
<tr>
<td><em>Using a mapping matrix to review the scope and content of a school’s component for addressing barriers to learning</em></td>
<td></td>
</tr>
<tr>
<td>Brief Follow-up Readings:</td>
<td>97</td>
</tr>
<tr>
<td><em>About Addressing Behavior Problems</em></td>
<td></td>
</tr>
</tbody>
</table>
IV. Rethinking Infrastructure 105
   A. Overview 106
   B. A School-Based Resource Coordinating Team 109
   C. Refining the School Infrastructure 115
   D. Infrastructure for a Family of Schools 121

Group Activity:
   Mapping and analyses of infrastructure mechanisms and related resources at school, complex, and district levels 126

Brief Follow up Reading:
   New Directions for Learning Support at a School Site: Establishing a School-wide Enabling Component 127

V. The Systemic Change Problem: Moving Schools Forward in Addressing Barriers to Learning 145
   A. The Role of Standards and Accountability Indicators 147
   B. Frameworks for Understanding Key Facets of Systemic Change 152
   C. Change Agent and Catalytic Facets of Leadership Roles 158

Group Reflection and Discussion:
   Moving Schools Forward: What will it Take to Make it Happen? 159

Brief Follow up Reading:
   New Initiatives: Considerations related to planning, implementing, sustaining, and going-to-scale 160

Concluding Comments 179

Brief Follow up Reading – New Directions: Where’s it Happening? 181

Reference List 187

Internet Sites for a Sampling of Major Agencies and Organizations 189

Addressing Barriers to Learning: Some Published Works and Resources from the Center for Mental Health in Schools at UCLA 193

Answers to Pre/Posttest 200
### Tables

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Types of Interveners and Functions</td>
<td>8</td>
</tr>
<tr>
<td>2.</td>
<td>Delivery Mechanisms and Formats</td>
<td>10</td>
</tr>
<tr>
<td>3.</td>
<td>Barriers to Development and Learning</td>
<td>19</td>
</tr>
<tr>
<td>4.</td>
<td>Examples of Barriers to Learning/Development, Protective Buffers, &amp; Promoting Full Development</td>
<td>22</td>
</tr>
<tr>
<td>5.</td>
<td>From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs to Address Barriers to Learning and Enhance Healthy Development</td>
<td>26</td>
</tr>
<tr>
<td>6.</td>
<td>Special Assistance</td>
<td>66</td>
</tr>
<tr>
<td>7.</td>
<td>Accommodations</td>
<td>68</td>
</tr>
<tr>
<td>8.</td>
<td>504 Accommodation Checklist</td>
<td>69</td>
</tr>
</tbody>
</table>

### Exhibits

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Many are in Need</td>
<td>13</td>
</tr>
<tr>
<td>2.</td>
<td>Guidelines for Mental Health in School</td>
<td>29</td>
</tr>
<tr>
<td>3.</td>
<td>A Range of Community Resources that Could be Part of a Collaboration</td>
<td>37</td>
</tr>
<tr>
<td>4.</td>
<td>Principle of Least Intervention Needed</td>
<td>73</td>
</tr>
<tr>
<td>5.</td>
<td>Annotated “Lists” of Empirically Supported/Evidence Based Interventions for School-Aged Children and Adolescents</td>
<td>92</td>
</tr>
<tr>
<td>6.</td>
<td>What is a Resource Coordinating Team?</td>
<td>114</td>
</tr>
<tr>
<td>7.</td>
<td>Site Administrative Lead for a Component to Address Barriers to Learning</td>
<td>119</td>
</tr>
<tr>
<td>8.</td>
<td>Phasing in Teams and Councils</td>
<td>124</td>
</tr>
</tbody>
</table>
## Figures

1. Range of Learners 14
2. Interconnected Systems for Meeting the Needs of All Youngsters 25
3. Talk About Fragmented 34
4. Moving from a Two- to a Three- Component Model for Reform & Restructuring 38
5a. The Prevailing Two Component Model for School Reform & Restructuring 40
5b. A Three Component Model for School Reform & Restructuring 41
6. An Enabling Component to Address Barriers to Learning and Enhance Healthy Development at a School Site 54
7. Sequence and Hierarchy of Special Assistance 74
8. A Framework for Thinking About Specific Functions and Tasks Related To Mental Health Services and Instruction at a School 76
10. An Example of an Integrated Infrastructure at a School Site 117
11. Infrastructure Linking a Family of Schools Together and with the District and Community 121
12. Expanding the Framework for School Accountability 150
13. Developing a Logic Model for Interventions to Strengthen Young People, Schools, Families, & Neighborhoods 154
14. New Initiatives: Considerations Related to Planning, Implementing, Sustaining, and Going-to-Scale 155
15. Prototype Implementation and Scale-up: Phases and Major Tasks 157
Trainers’ Guide

This module is designed as a direct aid for training leaders and staff and as a resource that can be used by them to train others. While accounting for individual case-oriented approaches, the emphasis is on a systems approach to enhancing mental health in schools. In particular, the focus is on pursuing the need for better mental health interventions within the context of moving toward a comprehensive, integrated approach to addressing barriers to student learning and promoting healthy development. A comprehensive approach encompasses (a) promotion of healthy development, (b) prevention and prereferral interventions for mild problems, (c) high visibility programs for high-frequency psychosocial problems, and (d) strategies to assist with severe and pervasive problems. And, a comprehensive approach recognizes the role school, home, and community life play in creating and correcting young people's problems, especially those who are under-served and hard-to-reach.

From this perspective, we highlight the importance of adopting the unifying concept of addressing barriers to learning as a basis for developing a comprehensive, multifaceted, and cohesive enabling or learning support component at every school. Such a component provides a unifying umbrella under which a school can embrace a comprehensive view of mental health, and, at the same time, fully integrate this focus with other learning supports and with its educational mission. We clarify that developing an enabling or learning support component requires systemic changes that weave together available learning support resources at a school and enhance use of such resources through collaboration among a family of schools and with community and family stakeholders. Such systemic changes include

- expanding policy
- pursuing comprehensive intervention frameworks
- redesigning infrastructure.

Exhibited on the next two pages is an overview of the Module.
Module Overview*

Title:

Addressing Barriers to Learning: A Comprehensive Approach to Mental Health in Schools (6 hrs)

Purpose:

This module is designed as a direct aid for training leaders and staff and as a resource that can be used by them to train others. While accounting for individual case-oriented approaches, the emphasis is on a systems approach to enhancing mental health in schools. From this perspective, we highlight the importance of adopting the unifying concept of addressing barriers to learning as a basis for developing a comprehensive, multifaceted, and cohesive enabling or learning support component at every school. We clarify that developing such a component requires systemic changes that weave together available learning support resources at a school and enhance use of such resources through collaboration among a family of schools and with community and family stakeholders. Such systemic changes include:

1. Expanding policy
2. Pursuing comprehensive intervention frameworks
3. Redesigning infrastructure.

Objectives:

Module users can learn about:

1) fundamental concepts essential to developing a comprehensive approach to addressing barriers to learning
2) how current policy marginalizes promotion of mental health and other learning supports and what needs to be done to integrate such activity into school reform
3) basic frameworks designed to expand current thinking about policy, research, and practice related to addressing barriers to learning
4) how current school and community infrastructure need to be modified to ensure a comprehensive approach is developed and maintained
5) how schools, districts, and states around the country are operationalizing such frameworks in daily practice and dealing with systemic change concerns.

*This module was prepared for the Addressing Barriers to Learning: School Mental Health Training Series developed by the Eastern Area Health Education Center: School Mental Health Project.

(cont.)
Module Overview (cont.)

**Recommended Presenter Requirements:**

- C Personal experience and knowledge related to the matters covered in this module
- C Familiarity with the specific content and format of the module
- C Effective teaching skills

**Suggested Materials:**

The module incorporates a variety of special materials prepared by the Center for Mental Health in Schools at UCLA and provides references to other relevant resources.

**Suggested Equipment:**

Overhead projector and screen; easels, chart paper, and markers for group work.

**Focusing Questions:**

Specific orienting questions are presented in a module pretest and at the beginning of each section of the module. Group activity is designed to consolidate understanding of answers to the focusing questions.

**Module Pre-test:**

At the beginning of the module is a pretest covering knowledge, self-awareness, and self-efficacy.

**Instructional Processes:**

Pretesting; focusing questions; presentations; handouts; question and answer periods; structured small group reflection, discussion, and activity; post-testing; and follow up readings.

**Suggested Handouts and Overheads:**

All handouts used for instructional purposes are designed as overheads and are included with the module for use by participants when they train others

**Post-test**

The pretest is repeated for purposes of post-testing.
Alternative Delivery Systems

The material in this module can be incorporated into various formats:

(1) a self-study tutorial

(2) a guided study group

(3) presentations/workshops (a partial or full day continuing education workshop; a sequence of district-wide inservice workshops)

(4) media and computer courses (instructional television -- live, and if feasible, interactive; video or audiotaped courses; computer courses, an internet offering)

(5) a professional journal offering a continuing education series.

The content is designed as an evolving set of five units. Each unit consists of several parts that generally can stand alone. Thus, the total set can be used and taught in a straight forward sequence, or one or more units and parts can be combined into a personalized course. This design also allows learners to approach the material as they would use an internet website (i.e., exploring specific topics of immediate interest and then going over the rest in any order that feels comfortable). The units are packaged in a sequence that reflects the designers’ preference for starting with a big picture framework for understanding the context and emerging directions for mental health in schools.

If the materials are used in a self-study format, instructors should encourage learners to survey and browse through the material and then read in greater depth. If feasible, learners should be encouraged to establish a study group – preferably one that is instructor-facilitated. Such a group not only can help enhance learning of new ideas, skills, and attitudes, it lays a great foundation for ongoing networking, social support, and team building.

Process Considerations

To facilitate the value of this work as a training aid, included are:

C specific orienting questions in the format of a module pretest and at the beginning of each section.

C group activities to consolidate understanding of basic ideas

C follow up readings for each section

C sets of suggested handouts designed as overheads/slides for use in training others

The module also incorporates a variety of special materials prepared by our national Center for Mental Health in Schools at UCLA and provides references to other relevant resources. Most of these are easily accessed, without fees, from the internet.

For illustrative purposes, an outline for using the module in a 6 hour workshop is exhibited on the following two pages.
Outline for Planning Six Hours of Training

Pretest – sent to participants before the day of the presentation and turned in at registration (or completed as participants enter the room and take their seats -- not part of the 6 hours)

I. Introductory Concepts (60 mins.)

A. Mental Health in Schools
B. For a Few or For the Many?
C. Multifaceted Focus: Addressing Barriers, Enhancing Protections, Promoting Development
D. Comprehensive Continuum of Interventions Systems

>>Brief follow up reading – Advancing Mental Health in Schools

II. Policy Considerations (45 mins)

A. Two major and separate reform movements
B. The problems of fragmentation and marginalization
C. Moving from a two to a three component policy framework

>>Group Reflection and Discussion – Key Insights About Mental Health in Schools

>>Brief follow-up reading – Why New Directions for Student Support?

(Break)

III. Reframing How Schools Address Barriers to Learning – including Mental Health Concerns (1 hour 45 mins.)

A. A School-Wide Enabling Component
B. Special Assistance in Keeping with the Principle of Least Intervention Needed
C. Mental Health Services and Instruction

>>Group activity – Using a mapping matrix to review the scope and content of a school’s component for addressing barriers to learning

>>Brief follow-up readings – About Addressing Behavior Problems

Lunch Break
IV. Rethinking Infrastructure (1 hour 10 mins.)

A. Resource oriented mechanisms
B. Leadership for addressing barriers to learning
C. Connecting infrastructure across levels

>>Group activity – Mapping and analyses of infrastructure mechanisms and related resources at school, complex, and district levels

>>Brief follow up reading – New Directions for Learning Support at a School Site: Establishing a School-wide Enabling Component

(Break)

V. The Systemic Change Problem Moving Schools Forward in Addressing Barriers to Learning (1 hour)

A. The Role of Standards and Accountability Indicators
B. Frameworks for Understanding Key Facets of Systemic Change
C. Change Agent and Catalytic Facets of Leadership Roles

>>Group Reflection and Discussion – Moving Schools Forward: What will it Take to Make it Happen?

>>Brief follow up reading – New Initiatives: Considerations related to planning, implementing, sustaining, and going-to-scale

Concluding Comments, Questions, and Answers (15 mins.)

>>Brief follow up reading – New Directions: Where’s it Happening?

Highlighting of Resources Included at End of the Module (5 mins.)

Post-test (completed after the six hours)
Guidelines for Providing the Content of this Module in Ways that Account for All Students

The following guidelines are meant to ensure what is taught accounts for all students, not just those with the most severe problems. The emphasis is on helping staff acquire a broad perspective for understanding the problems they are experiencing and what needs to be done in both the short- and long-run to enable all students to have an equal opportunity to succeed at school.

(1) Covering the Causes of Problems. When discussing the causes of problems, it is essential to counter tendencies to view them too simplistically and in categorical terms. Thus, presentations that discuss causes should be designed with a view to ensuring that staff continue to learn more about:

- the full range of causes for emotional, behavior, and learning problems – contrasting problems caused by external factors from those caused by internal factors from those resulting from both external and internal causes
- how to differentiate commonplace behavior, emotional, and learning problems from true disorders and disabilities
- how often problems are caused by multiple factors
- how often youngsters have multiple problems
- how the same problem behaviors ("symptoms") may arise from different underlying causes and motives
- how different problem behaviors may arise from the same underlying causes and motives.

(2) Exploring Interventions to Address Problems. When discussing how to address problems, it is essential to counter tendencies toward simplistic and categorical solutions to complex problems. Thus, each inservice activity should ensure that discussions are presented (a) from a system’s perspective and (b) with a commitment to personalizing interventions. In all this, there should be an emphasis on ensuring that a caring classroom and school-wide climate and culture emerge from the various intervention efforts.

The system’s perspective should encompass:

- a “big picture” intervention framework – Such a framework should delineate the type of comprehensive, multifaceted continuum of interventions required to effectively address the full range of factors that interfere with school learning and
teaching. That is, the emphasis should be on a continuum that encompasses promotion of healthy development, problem prevention, intervening as early after the onset of problems as is feasible, treatment and follow up support

C how to integrate learning support as a necessary, high level priority in all school improvement planning

C how to enhance teaming and collaboration as a necessary element of a comprehensive approach – in classrooms, school-wide, and with families and others in the community

C how to apply the principle of “least intervention needed” in a sequential manner – focusing first on changes in the classroom and school-wide environment to address environmental causes; then, if necessary, focusing on addressing other needs with increased attention to specialized assistance for those few students and families whose problems remain chronic.

The commitment to personalizing interventions should encompass learning

C how to ensure that motivational differences as well as differences in capability are appropriately accounted for – with a particular focus on intrinsic motivation and the need to address motivation as a readiness, process, and outcome consideration.

The overriding continuing education guideline is: All efforts to enhance staff understanding of student/learning support should have as a major outcome enhanced motivation on the part of school staff to learn more and to use that learning in ways that lead to more success, more often, with more students and their families.*

*There is a great deal of material discussing ways to pursue effective staff development in schools. An organization that is devoted to this arena is the National Staff Development Council (NSDC). It's library of information (see—http://www.nsdc.org/educatorindex.htm) provides guidelines, tools, and access to the Journal of Staff Development. The organization’s emphasis is on a "how-to" format, offering a variety of effective, step-by-step models developed by practitioners who base their methods on research and real-world experiences.
(1) A comprehensive definition of mental health in schools must encompass considerations of the school’s role related to both positive mental health (e.g., promotion of social and emotional development) and mental health problems (psychosocial concerns and mental disorders) of students, their families, and school staff. 
___True ___False

(2) Identify at least one example of a potential barrier to learning related to each of the following categories of external factors
(a) Neighborhood factor ______________________________________
(b) Family factor ____________________________________________
(c) School or peer factor ______________________________________

(3) Integration of school health and social services constitutes a comprehensive, multifaceted and cohesive approach to addressing mental health and psychosocial concerns.
___True ___False

(4) List major systems that constitute a full continuum of interventions for meeting the needs of all youngsters.

(5) Current school improvement policies marginalize efforts to address barriers to learning.
___True ___False

(6) A school-based component to address barriers to learning has been conceived in terms of six intervention arenas. What are the six?

(7) What is the name of the principle reflected in the following statement?

Do not disrupt or restrict a person's opportunity for a normal range of experiences more than is absolutely necessary – but, first and foremost, strive to do what is needed.

(8) Prereferral interventions are intended to speed up referrals for counseling.
___True ___False

(9) Indicate two functions of a resource-oriented team and two functions of a case-oriented team?

(10) Many school staff can and want to be more involved in programs to prevent and correct mental health and psychosocial problems. Which of the following functions that some already are carrying out?
___ (a) mental health education
___ (b) psychosocial guidance and support
___ (c) psychosocial counseling
___ (d) none of the above
___ (e) all of the above

(11) Given that school improvement designs across the country are standard-based and accountability driven, efforts to develop a comprehensive component to address barriers to student learning must be standard-based and accountability driven and must effectively facilitate systemic changes.
___True ___False
I. Introductory Concepts

A. Mental Health in Schools

B. For a Few or For the Many?

C. Multifaceted Focus: Addressing Barriers, Enhancing Protections, Promoting Development

D. Comprehensive Continuum of Intervention Systems

>>Brief follow up reading –

Advancing Mental Health in Schools
I. Introductory Concepts

A. Mental Health in Schools

1. Defining Mental Health

2. Why Mental Health in Schools?

   a. Type of Interveners and Functions
   b. Delivery Mechanisms and Formats

4. Advancing MH in Schools
   a. Needed: Strategic Approaches & Comprehensive Frameworks to Enhance Policy and Practice
   b. Ending the Marginalization

Orienting Questions:

How would you define mental health?

Why should schools be concerned about mental health?

What are the main ways mental health interventions are provided in schools?

What needs to be done to end the marginalization of efforts to address barriers to learning in schools?
I. Introductory Concepts
   A. Mental Health in Schools

1. Defining Mental Health

There are three key concerns that arise around definitions of mental health.

First is the widespread tendency for discussions of mental health to focus only on mental illness, disorders, or problems. When this occurs, mental health is de facto defined as the absence of these problems, and there is a lack of emphasis on the enterprise of promoting positive social and emotional development. Part of the problem is that so much of the mental health field is focused on problems. A step toward redressing this definitional problem is seen in the Report of the Surgeon General’s Conference on Children’s Mental Health (2001). Although no formal definition of mental health is given, the vision statement provided at the outset of the report stresses that “Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals.” This statement uses the term mental health in ways that are consistent with definitional efforts to use “health” as a positive concept. For example, the Institute of Medicine (1997) defines health as “a state of well-being and the capability to function in the face of changing circumstances.” A similar effort to contrast positive health with problem functioning is seen in SAMHSA’s Center for Mental Health Services glossary of children’s mental health terms. In that source, mental health is defined as “how a person thinks, feels, and acts when faced with life’s situations. . . . This includes handling stress, relating to other people, and making decisions.” This is contrasted with mental health problems. The designation mental disorders is described as another term used for mental health problems and the term mental illness is reserved for severe mental health problems in adults.

The second definitional problem is the tendency to designate too many emotional and behavioral problems as disorders (e.g., translating commonplace behavior into “symptoms” and formal psychiatric diagnoses). For children and adolescents, the most frequent problems are psychosocial, and the genesis of the problems for the majority are socio-cultural and economic. This, of course, in no way denies that there are children for whom the primary factor instigating a problem is an internal disorder. The point simply recognizes that, comparatively, these youngsters constitute a relatively small group. Biases in definition overemphasizing this group narrow what is done to classify and assess problems, prevent problems, and intervene after onset. For example, each year a great many parents and teachers identify large numbers of children (e.g., of kindergarten age) soon after the onset of a problem. This “first level screen” bears little fruit because there are so little resources, especially school-based resources, for intervening early after the onset of a problem – unless the problem is severe and pervasive. Currently, few youngsters can readily access help for an emotional, behavioral, or learning problem unless the problem is severe or pervasive enough to warrant diagnosis as a disorder/disability. As long as this is the case,
large numbers of misdiagnoses are inevitable and the response to problems often will be inappropriate and expensive. Furthermore, the amount of misdiagnoses will continue as a major contaminate in research and training. An important way to reduce misdiagnosis and misprescriptions is to place mental illness in perspective with respect to psychosocial problems and broaden the definition of MH to encompass *positive* MH (e.g., the promotion of social and emotional development).

Finally, there is the specific problem of defining mental health in schools. Because of the tendency for discussions of mental health to focus mainly on mental illness, disorders, or problems, the attention of school policy makers has been directed primarily to concerns about emotional disturbance, violence, and substance abuse, with a concomitant deemphasis on the school’s role in the positive development of social and emotional functioning. A comprehensive definition of mental health in schools must encompass considerations of the school’s role related to both positive mental health (e.g., promotion of social and emotional development) and mental health problems (psychosocial concerns and mental disorders) of students, their families, and school staff. (See Guidelines in accompanying reading.)

Addressing mental health of youngsters involves ensuring

- mental illness is understood within the broader perspective of psychosocial and related health problems, in terms of strengths as well as deficits, and as encompassing the well-being of families and staff
- 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.
2. Why Mental Health in Schools?

It’s an appropriate question given that 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.

Given these realities, as a general rationale for MH in schools, it is wise to 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. Because of this, school policy makers, have a lengthy, albeit somewhat reluctant, history of trying to assist teachers in dealing with problems that interfere with schooling.

Varied policies and initiatives have emerged relevant to efforts to enhance mental health in schools. Some directly support school counseling, psychological, and social service programs and personnel; others connect community programs and personnel with schools. As a result, most schools have some programs to address a range of mental health and psychosocial concerns, such as school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, delinquency, and violence. And, there is a large body of research supporting the promise of much of this activity (see Center for Mental Health, 2000).
Mental Health in Schools: It’s About Much More Than Therapy and Counseling

Mental health in schools isn’t just about

• students with diagnosable problems
• therapy and behavior change
• connecting community mental health providers to schools
• what mental health professionals do
• empirically-supported treatments

In addition to all the above, mental health in schools also is about

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

School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs and may be designed for an entire class, groups, or individuals. With specific respect to MH, the full range of topics arise, including matters related to promoting MH, minimizing the impact of psychosocial problems, managing psychotropic medication, and participating in systems of care. Well-developed systems include mechanisms for case coordination, ongoing consultation, program development, advocacy, and quality assurance. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth – though relatively few resources usually are allocated for such activity.

School districts use a variety of personnel to address MH concerns. These may include “pupil services” or “support services” specialists such as psychologists, counselors, social workers, psychiatrists, and psychiatric nurses, as well as a variety of related therapists. Such specialists tend to focus on students seen as problems or as having problems.

As outlined in Table 1, their many functions can be grouped into three categories (1) direct services and instruction, (2) coordination, development, and leadership related to programs, services, resources, and systems, and (3) enhancement of connections with community resources.

In addition to responding to crises, prevailing direct intervention approaches encompass identification of the needs of targeted individuals, prescription of one or more interventions, brief consultation, and gatekeeping procedures (such as referral for assessment, corrective services, triage, and diagnosis). In some situations, however, resources are so limited that specialists can do little more than assess for special education eligibility, offer brief consultations, and make referrals to special education and/or community resources.
Table 1  
Types of Interveners and Functions

I. Interveners Who May Play Primary or Secondary Roles in Carrying Out Functions Relevant to Learning, Behavior, and Emotional Problems

<table>
<thead>
<tr>
<th>Instructional Professionals</th>
<th>Itinerant Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g., regular classroom teachers, special education staff, health educators, classroom resource staff, and consultants)</td>
<td>(e.g., art, dance, music, occupational, physical, speech-language-hearing, and recreation therapists; psychodramatists)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative Staff</th>
<th>Personnels-In-Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g., principals, assistant principals, deans)</td>
<td>Others</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Office Professionals</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g., nurses, physicians, health educators, consultants)</td>
<td>Aides</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Counseling, Psychological, and Social Work Professionals</th>
<th>Paraprofessionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g., counselors, health educators, psychologists, psychiatrists, psychiatric nurses, social workers, consultants)</td>
<td>Peers (e.g., peer/cross-age counselors and tutors, mutual support and self-help groups)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personnel-In-Training</th>
<th>Recreation personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always available -- (nonprofessional -- including parents)</td>
<td>Volunteers (professional/paraprofessional/</td>
</tr>
</tbody>
</table>

II. Functions Related to Addressing Mental Health and Psychosocial Needs at the School and District Level

<table>
<thead>
<tr>
<th>Direct Services and Instruction</th>
<th>Coordination, Development, and Leadership Related to Programs, Services, Resources, and Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>(based on prevailing standards of practice and informed by research)</td>
<td>(e.g., participating on student study/assistance teams; facilitating communication among all concerned parties)</td>
</tr>
</tbody>
</table>

| Crisis intervention and emergency assistance | Coordinating activities (across disciplines and components; with regular, special, and compensatory education; in and out of school) |
| (e.g., psychological first-aid and follow-up; suicide prevention; emergency services, such as food, clothing, transportation) | Mapping and enhancing resources and systems |

| Assessment (individuals, groups, classroom, school, and home environments) | Developing new approaches (incl. facilitating systemic changes) |
| Treatment, remediation, rehabilitation | Monitoring and evaluating intervention for quality improvement, cost-benefit accountability, research |
| (incl. secondary prevention) | Advocacy for programs and services and for standards of care in the schools |

| Accomodations to allow for differences and disabilities | Pursuing strategies for public relations and for enhancing financial resources |
| Transition and follow-up (e.g., orientations, social support for newcomers, follow-thru) | Enhancing Connections with Community Resources |

| Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness (e.g., guidance counseling; contributing to development and implementation of health and violence reduction curricula; placement assistance; advocacy; liaison between school and home; gang, delinquency, and safe-school programs; conflict resolution) | Strategies to increase responsiveness to referrals from the school |
| Multidisciplinary teamwork, consultation, training, and supervision to increase the amount of direct service impact | Strategies to create formal linkages among programs and services |
Because the need is so great, others at a school often are called upon to play a role in addressing MH and psychosocial problems of youth and their families. These include other health professionals (such as school nurses and physicians), instructional professionals (health educators, other classroom teachers, special education staff, resource staff), administrative staff (principals, assistant principals), students (including trained peer counselors), family members, and almost everyone else involved with a school (aides, clerical and cafeteria staff, custodians, bus drivers, para-professionals, recreation personnel, volunteers, and professionals-in-training). In addition, some schools are using specialists employed by other public and private agencies, such as health departments, hospitals, and community-based organizations, to provide MH services to students, their families, and school staff.

As outlined in Table 2, all this activity is provided through five major delivery mechanisms and formats. (For more on this, see the major report prepared in 2001 by the Policy Leadership Cadre for Mental Health in Schools.) Despite the range of 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. Moreover, as is the case with most professionals who come to schools directly from pre-service programs, those hired for their mental health expertise still need considerably more training once they arrive at a school site. Those school personnel who are called upon to address MH and psychosocial concerns without training related to such matters clearly have even greater needs for capacity building and supervision. Unfortunately, there is little systematic in-service development to follow-up pre-service education.
Table 2
Delivery Mechanisms and Formats

The five mechanisms and related formats are:

I. **School-Financed Student Support Services** — Most school districts employ support service or “pupil services professionals,” such as school psychologists, counselors, and social workers. These personnel perform services connected with mental health and psychosocial problems (including related services designated for special education students). The format for this delivery mechanism usually is a combination of centrally-based and school-based services.

II. **School-District Specialized Units** — Some districts operate central units (sometimes including clinics) focusing on specialized student needs and specific problems (e.g., safe and drug free school programs, child abuse, suicide, and mental health). These units often provide outreach services and consultation to schools. They may focus on organizing Family Resource Centers, School-Based Health Centers, and so forth.

III. **Formal Connections with Community MH 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 (e.g., “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 organizations
   - Formal linkages with agencies to enhance access and service coordination for students and families
     at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center
   - Formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of MH services
   - Contracting with community providers to provide needed student services

IV. **Classroom-Based Curriculum and Specialized “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

V. **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 support programs and services and integrate them into school reform agendas
   - Community schools
4. Advancing Mental Health in Schools

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.

Currently, many advocates are competing for the same dwindling resources. Naturally, all want to advance their agenda. And, to do so, the temptation usually is to keep the agenda problem-focused and rather specific and narrow. As a result, 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, counterproductive competition, and inadequate results.

It is time to take a close look at all the pieces. 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.

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, this module (1) highlights the need for a broad perspective in thinking about and justifying “mental health” in schools, (2) promotes the importance 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) suggests a wide variety of strategies designed to advance the field. All this, of course, calls for major systemic changes. These will require weaving 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. That is, strategic efforts to advance mental health in schools also must adopt effective models and procedures for replication and “scale-up.”

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, those concerned with mental health in schools must encourage reformers 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.
I. Introductory Concepts

B. For a Few or For the Many?

Orienting Question:

How would you go about describing the full range of learners found in schools?

Everyday we hear the mantras of school reformers:

All students can learn.

No child left behind.

Easy phrases to say, but the sad truth is that in every school students are being left behind academically, socially, and emotionally (see Exhibit 1). Moreover, the focus on the achievement gap highlights how much this is a function of societal inequities.

Any discussion of addressing students behavior, emotional, and learning problems must recognize the full range of factors that cause such problems, and any approach to mental health in schools must address all (not just some) students.

The causes of negative feelings, thoughts, and behaviors range from environmental/system deficits and minor group/individual vulnerabilities to major biological disabilities. It is the full range of causes that account for the large number of children and adolescents who are reported as having mental health, psychosocial, or developmental problems.

With the movement toward schools and communities working collaboratively, difficulties often arise because participants are talking about different missions and agendas. One result is that some are concerned mainly about the needs of subgroups of students and their families, while others are focused on all children and families. For example, representatives of mental health agencies usually are concerned with connecting to schools to increase access to clinical services for those with significant emotional problems. While student support staff from a school are concerned about students with emotional problems, they also have to focus on every student who has a learning, behavior, and emotional problem and on ensuring that all students have an equal opportunity to succeed at school. The mission and agenda of community mental health agencies can be met by serving some young people; schools must serve all students. Mental health in schools must focus on the many and not just think in terms of providing greater access to clinical services for a few. Moreover, mental health in schools is about helping to engage and re-engage students as classroom learners.

To emphasize the point, Figure 1 highlights the range of learners grouped in terms of their response to academic instruction.
Exhibit 1: Many are in Need

Because of the inadequacies of current data gathering, we must rely on best estimates of mental health (MH) problems in schools, primary health care systems, and juvenile justice systems (e.g., Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1996). Over the last part of the century, data on diagnosable mental disorders (based on community samples) suggest that from 12% to 22% of all youngsters under age 18 are in need of services for mental, emotional or behavioral problems (Costello, 1989). From 3-5% of school children are considered to have serious behavioral or emotional disabilities, with less than 2% receiving MH services (Hoagwood & Erwin, 1997). Epidemiological studies indicate that, in some communities, two-thirds of children with psychiatric disorders and significant impairment do not receive specialist care (Leaf et al., 1996). Another report (Kelleher et al., 1997) indicates that, of all pediatric visits in the period from 1979 to 1996, the prevalence of psychological problems among children 4 to 15 years of age increased from 7% to 18%. In the Surgeon General’s Call to Action to Prevent Suicide 1999, the rate of suicide among those 10-14 years of age is reported as having increased by 100% from 1980-1996, with a 14% increase for those 15-19. (In this latter age group, suicide is reported as the fourth leading cause of death.) Among African-American males in the 15-19 year age group, the rate of increase was 105%. And, of course, these figures don’t include all those deaths classified as homicides or accidents that were in fact suicides.

All this is further amplified in the Surgeon General’s 1999 report on Mental Health. That document states that “one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year” – with about 5 percent of all children experiencing “extreme functional impairment.” It also states that an estimated 6 to 9 million youngsters with serious emotional disturbances are not receiving the help they need – especially those from low-income families. And, it underscores that "an alarming number of children and adults with mental illness are in the criminal justice system inappropriately." The report warns of the inadequacies of the current MH system and that the situation will worsen because of swelling demographics that are resulting in more older Americans and children and adolescents with MH-related concerns.

The picture is even bleaker when one expands the focus beyond the limited perspective on diagnosable mental disorders to the number of young people experiencing psychosocial problems and who are "at risk of not maturing into responsible adults" (Dryfoos, 1990). There is no reason to repeat all the statistics here. Dryfoos (1990) provides estimates of prevalence by sex, age, race/ethnicity, and other relevant factors. And, other reports have amply documented the problem (IOM, 1994; Greenberg, Domitrovich, & Bumbarger, 1999; NIMH, 1993, 1998; also see fact sheets and reports on the websites for the SAMHSA’s Center for Mental Health Services and the USDOE’s Safe and Drug Free Schools Program). For our purposes here, it is sufficient to note the number of such youngsters in many schools serving low-income populations has climbed over the 50% mark, and few public schools have fewer than 20% who are at risk. An estimate from the Center for Demographic Policy suggests that 40% of young people are in bad educational shape and therefore will fail to fulfill their promise. The reality for many large urban schools is that well-over 50% of their students manifest significant learning, behavior, and emotional problems. For a large proportion of these youngsters, the problems are rooted in the restricted opportunities and difficult living conditions associated with poverty.

It also is relevant to note that a major objective of Healthy People 2000 was to reduce the prevalence of child and adolescent mental health disorders from a 1992 estimate of 20% to less than 17%. This included reducing suicides to no more than 8.2 per 100,000 (in the age bracket 15-19) and the incidence of injurious adolescent suicide attempts to 1.8%. And, the report on leading health indicators for Healthy People 2010 stresses the problem of high rates of failure to graduate high school as strongly associated with poverty and a variety of health problems, and therefore enhancing high school graduation rates is seen as an essential focus. Finally, we note that all current policy discussions in this area stress the crisis nature of the problem in terms of future health and economic implications for individuals and for society and call for major systemic reforms.
Figure 1. Range of Learners (categorized in terms of response to academic instruction)

I = Motivationally ready and able*

II = Not very motivated/
     Lacking prerequisite knowledge & skills/
     Different learning rates and styles/
     Minor vulnerabilities**

III = Avoidant/
     Very deficient in current capabilities/
     Has a disability
     Major health problems

* Few youngsters start out with internal problems that interfere with learning what schools teach. There can be little doubt that external factors are primarily responsible for the majority of learning, behavior, and emotional problems encountered in schools.

** All learners have assets/strengths/protective factors that can contribute to success; all have differences that require some degree of personalization by instructional systems; any may internalize negative experiences that interfere with learning at school.
I. Introductory Concepts

C. Multifaceted Focus: Addressing Barriers, Enhancing Protections, Promoting Development

1. Learning, Behavior, and Emotional Problems: Common Phenomena

2. Schools and Barriers to Learning

3. Aligning Barriers (Risk Factors), Protective Buffers, & Promoting Full Development

**Orienting Questions:**

What are some common barriers to learning?

Is a focus on risk factors incompatible with a focus on resiliency and promoting positive development?
1. Learning, Behavior, and Emotional Problems: Common Phenomena

*Many well-known adolescent difficulties are not intrinsic to the teenage years but are related to the mismatch between adolescents’ developmental needs and the kinds of experiences most junior high and high schools provide.*

Linda Darling-Hammond (1997)

... consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one high school crisis is followed by another, we concentrate on the particular people involved – their values, their character, their personal failings – rather than asking whether something about the system in which these students find themselves might also need to be addressed.

Alfie Kohn (1999)

Poverty is a correlate, not the cause

Given that learning, development, and performance are functions of the transactions between the individual and the environment, it is understandable that certain groups would have higher rates of problems. One such group consists of those individuals living in poverty. Poverty is a correlate, not the cause. As Moos (2002) stresses, guided by transactional thinking...

... we have progressed from a static model in which structural factors, such as poverty level, were linked to indices of community pathology, to a dynamic model of neighborhood processes and experiences, focusing on characteristics such as social integration, value consensus, and community resources and services.

It is important to understand the factors that lead many who grow up in poverty to manifest problems. It is equally important, as we discuss later, to understand what enables those who overcome the negative impact of such conditions.

For some time, official data have indicated that youngsters under age 18 were the age group with the greatest percentage (16.2 percent) living in poverty in the United States (U.S. Census Bureau, 2000). It is acknowledged widely that poverty is highly correlated with school failure, high school drop out, delinquency, teenage pregnancy, and other problems.

In comparison to students coming from middle or higher income families, many young children residing in poverty have less opportunity to develop the initial capabilities and attitudes most elementary school programs require for success. Most poverty families simply do not have the resources to provide the same preparatory experiences for their children as those who are better off financially. Moreover, those in urban ghettos reside in the type of hostile environment that can generate so much stress as to make school adjustment and learning excessively difficult.
Thus, it is not surprising that so many youngsters from poor families enter kindergarten and over the years come to school each day less than ready to meet the demands made of them. The mismatch may be particularly bad for individuals who have recently migrated from a different culture, do not speak English, or both.

There is a poignant irony in all this. Children of poverty often have developed a range of other cultural, subcultural, and language abilities that middle class-oriented schools are unprepared to accommodate, never mind capitalize upon. As a result, many of these youngsters struggle to survive without access to their strengths. It should surprise no one that a high percentage of these youngsters soon are seen as having problems, and may end up diagnosed as having learning disabilities, ADHD, and/or other disorders.

Of course, a youngster does not have to live in poverty to be deprived of the opportunity to develop the initial capabilities and attitudes to succeed in elementary-school programs. There are youngsters who in the preschool years develop a bit slower than their peers. Their learning potential in the long-run need not be affected by this fact. However, if early school demands do not accommodate a wide range of differences, the youngsters are vulnerable. Given what we know about the normal range of developmental variations, it is no surprise that many of these youngsters end up having not only learning, but behavioral and emotional problems.

When students have trouble learning at school, they frequently manifest behavior problems. This is a common reaction to learning problems. And, of course, behavior problems can get in the way of learning. Furthermore, both sets of problems may appear simultaneously and stem from the same or separate causes. It is important to remember that an individual can have more than one problem. That is, a person may manifest high levels of activity, lack of attention, and problem learning in class. This sometimes leads to a dual diagnosis (e.g., ADHD and LD). Given all this, it is not surprising that there is considerable confusion about the relationship between learning and behavior problems.
2. Schools and Barriers to Learning

From the perspective of schools, an essential way to discuss why children have problems learning and behaving at school is to think in terms of barriers to learning and what the role of schools should be in addressing such factors. Such a perspective blends well with a transactional view of the causes of human behavior because it emphasizes that, for a great many students, external not internal factors often are the ones that should be the primary focus of attention.

Implicit in democratic ideals is the intent of ensuring that all students succeed at school and that “no child is left behind.” If all students came ready and able to profit from “high standards” curricula, then there would be little problem. But all encompasses those who are experiencing external and/or internal barriers that interfere with benefitting from what the teacher is offering. Thus, providing all students an equal opportunity to succeed requires more than higher standards and greater accountability for instruction, better teaching, increased discipline, reduced school violence, and an end to social promotion. It also requires addressing barriers to development, learning, and teaching (see Table 3).

The terrible fact is that too many youngsters are growing up and going to school in situations that not only fail to promote healthy development, but are antithetical to the process. Some also bring with them intrinsic conditions that make learning and performing difficult. At one time or another, most students bring problems with them to school that affect their learning and perhaps interfere with the teacher’s efforts to teach. As a result, some youngsters at every grade level come to school unready to meet the setting’s demands effectively. As long as school reforms fail to address such barriers in comprehensive and multifaceted ways, especially in schools where large proportions of students are not doing well, it is unlikely that achievement test score averages can be meaningfully raised.

In some geographic areas, many youngsters bring a wide range of problems stemming from restricted opportunities associated with poverty and low income, difficult and diverse family circumstances, high rates of mobility, lack of English language skills, violent neighborhoods, problems related to substance abuse, inadequate health care, and lack of enrichment opportunities. Such problems are exacerbated as youngsters internalize the frustrations of confronting barriers and the debilitating effects of performing poorly at school. In some locales, the reality often is that over 50% of
students manifest forms of learning, behavior, and emotional problems. And, in most schools in these locales, teachers are ill-prepared to address the problems in a potent manner.

Table 3
Barriers to Development and Learning

Based on a review of over 30 years of research, Hawkins and Catalano (1992) identify common risk factors that reliably predict such problems as youth delinquency, violence, substance abuse, teen pregnancy, and school dropout. These factors also are associated with such mental health concerns as school adjustment problems, relationship difficulties, physical and sexual abuse, neglect, and severe emotional disturbance. The majority of factors identified by Hawkins and Catalano are external barriers to healthy development and learning. Such factors are not excuses for anyone not doing their best; they are, however, rather obvious impediments, and ones to which no good parent would willingly submit his or her child. Below is our effort to synthesize various analyses of external and internal barriers.

<table>
<thead>
<tr>
<th>External Factors*</th>
<th>Internal Factors (biological and psychological)</th>
</tr>
</thead>
</table>

**Community**
- Availability of drugs
- Availability of firearms
- Community laws and norms favorable toward drug use, firearms, and crime
- Media portrayals of violence
- Transitions and mobility
- Low neighborhood attachment and community disorganization
- Extreme economic deprivation

**Family**
- Family history of the problem behavior
- Family management problems
- Family conflict
- Favorable parental attitudes and involvement in the problem behavior

**School**
- Academic failure beginning in late elementary school

**Peer**
- Friends who engage in the problem behavior
- Favorable attitudes toward the problem behavior

*Other examples of external factors include exposure to crisis events in the community, home, and school; lack of availability and access to good school readiness programs; lack of home involvement in schooling; lack of peer support, positive role models, and mentoring; lack of access and availability of good recreational opportunities; lack of access and availability to good community housing, health and social services, transportation, law enforcement, sanitation; lack of access and availability to good school support programs; sparsity of high quality schools.
I. Introductory Concepts  
C. Multifaceted Focus: Addressing Barriers, Enhancing Protections, Promoting Development

3. Aligning Barriers (Risk Factors), Protective Buffers, & Promoting Full Development

Schools tend to address barriers to learning as a last resort. This is not surprising since their assigned mission is to educate, and school staff are under increasing pressure both to “leave no child behind” and avoid discussing matters that may sound like excuses for not doing so. The irony, of course, is that most school staff are painfully aware of barriers that must be addressed. Moreover, the widespread emphasis on high stakes testing not only underscores how many students are not performing well, but the degree to which such testing is adding another barrier that keeps some students from having an equal opportunity to succeed at school.

All this leads to concerns about what the role of schools is and should be in handling such problems. Critics point out that the tendency is for schools to be reactive – waiting until problems become rather severe and pervasive. At the same time, because schools have been accused of having a deficit orientation toward many youngsters, they have increasingly tried to avoid terms denoting risks and barriers or an overemphasis on remediation.

It is well that schools realize that a focus solely on fixing problems is too limited and may be counterproductive. Overemphasis on remediation can diminish efforts to promote healthy development, limit opportunity, and can be motivationally debilitating to all involved. And undermining motivation works against resiliency in responding to adversity. One important outcome of the reaction to overemphasizing risks and problems is that increasing attention is being given to strengths, assets, resilience, and protective factors. Among the benefits of this focus is greater understanding of how some youngsters born into poverty overcome this potential barrier to success.

However, as Scales and Leffert (1999) indicate in their work on developmental assets, focusing just on enhancing assets is an insufficient approach.

“Young people also need adequate food, shelter, clothing, caregivers who at the minimum are not abusive or neglectful, families with adequate incomes, schools where both children and teachers feel safe, and economically and culturally vibrant neighborhoods – not ones beset with drugs, violent crime, and infrastructural decay. For example, young people who are disadvantaged by living in poor neighborhoods are consistently more likely to engage in risky behavior at higher rates than their affluent peers, and they show consistently lower rates of positive outcomes (Brooks-Gunn & Duncan, 1997). Moreover, young people who live in abusive homes or in neighborhoods with high levels of violence are more likely to become both victims and perpetrators of violence (Garbarino, 1995).”

As advocates have argued the merits of their respective positions about risks vs. assets and as terms such as resilience and protective factors are popularized, confusion and controversy have arisen. The following distinctions are offered in support of the position that the need is to address barriers, establish protective buffers, and promote full development.
One way to think about risks is in terms of potential external and internal barriers to development and learning. Research indicates that the primary causes for most youngsters’ learning, behavior, and emotional problems are external factors (related to neighborhood, family, school, and/or peers). For a few, problems stem from individual disorders and differences. An appreciation of the research on the role played by external and internal factors makes a focus on such matters a major part of any comprehensive, multifaceted approach for addressing barriers to learning, development, and teaching.

Protective factors are conditions that buffer against the impact of barriers (risk factors). Such conditions may prevent or counter risk producing conditions by promoting development of neighborhood, family, school, peer, and individual strengths, assets, and coping mechanisms through special assistance and accommodations. The term resilience usually refers to an individual’s ability to cope in ways that buffer. Research on protective buffers also guides efforts to address barriers.

As often is stressed, being problem-free is not the same as being well-developed. Efforts to reduce risks and enhance protection can help minimize problems but are insufficient for promoting full development, well-being, and a value-based life. Those concerned with establishing systems for promoting healthy development recognize the need for direct efforts to promote development and empowerment, including the mobilization of individuals for self-pursuit. In many cases, interventions to create buffers and promote full development are identical, and the pay-off is the cultivation of developmental strengths and assets. However, promoting healthy development is not limited to countering risks and engendering protective factors. Efforts to promote full development represent ends which are valued in and of themselves and to which most of us aspire.

Considerable bodies of research and theory have identified major correlates that are useful guideposts in designing relevant interventions (see Table 4). And, as the examples illustrate, there is a significant overlap in conceptualizing the various factors. Some risk factors (barriers) and protective buffers are mirror images; others are distinct. Many protective buffers are natural by-products of efforts to engender full development. From this perspective, addressing barriers to learning and development and promoting healthy development are two sides of the same coin. And, the best way to engender resilient behavior, individual assets, and healthy behavior in children and adolescents probably is to focus intervention on both sides of the coin.
### Table 4
Examples of Barriers to Learning/Development, Protective Buffers, & Promoting Full Development*

#### I. Barriers to Development and Learning (Risk producing conditions)

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Family</th>
<th>School and Peers</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>extreme economic deprivation</td>
<td>chronic poverty</td>
<td>poor quality school</td>
<td>medical problems</td>
</tr>
<tr>
<td>community disorganization, including high levels of mobility</td>
<td>conflict/disruptions/violence</td>
<td>negative encounters with teachers</td>
<td>low birth weight/neurodevelopmental delay</td>
</tr>
<tr>
<td>violence, drugs, etc.</td>
<td>substance abuse</td>
<td>negative encounters with peers &amp;/or inappropriate peer models</td>
<td>psychophysiological problems</td>
</tr>
<tr>
<td>minority and/or immigrant status</td>
<td>models problem behavior</td>
<td></td>
<td>difficult temperament &amp; adjustment problems</td>
</tr>
<tr>
<td>chronic poverty</td>
<td>abusive caretaking</td>
<td>inadequate provision for quality child care</td>
<td></td>
</tr>
<tr>
<td>conflict/disruptions/violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>substance abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>models problem behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>abusive caretaking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inadequate provision for quality child care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### II. Protective Buffers (Conditions that prevent or counter risk producing conditions – strengths, assets, corrective interventions, coping mechanisms, special assistance and accommodations)

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Family</th>
<th>School and Peers</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>strong economic conditions/ emerging economic opportunities</td>
<td>adequate financial resources</td>
<td>success at school</td>
<td>higher cognitive functioning</td>
</tr>
<tr>
<td>safe and stable communities</td>
<td>nurturing supportive family members who are positive models</td>
<td>positive relationships with one or more teachers</td>
<td>psychophysiological health</td>
</tr>
<tr>
<td>available &amp; accessible services</td>
<td>safe and stable (organized and predictable) home environment</td>
<td>positive relationships with peers and appropriate peer models</td>
<td>easy temperament, outgoing personality, and positive behavior</td>
</tr>
<tr>
<td>strong bond with positive other(s)</td>
<td>family literacy</td>
<td>strong bond with positive other(s)</td>
<td>strong abilities for involvement and problem solving</td>
</tr>
<tr>
<td>appropriate expectations and standards</td>
<td>provision of high quality child care</td>
<td></td>
<td>sense of purpose and future</td>
</tr>
<tr>
<td>opportunities to successfully participate, contribute, and be recognized</td>
<td>secure attachments – early and ongoing</td>
<td></td>
<td>gender (girls less apt to develop certain problems)</td>
</tr>
</tbody>
</table>

#### III. Promoting Full Development (Conditions, over and beyond those that create protective buffers, that enhance healthy development, well-being, and a value-based life)

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Family</th>
<th>School and Peers</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>nurturing &amp; supportive conditions</td>
<td>conditions that foster positive physical &amp; mental health among all family members</td>
<td>nurturing &amp; supportive climate school-wide and in classrooms</td>
<td>pursues opportunities for personal development and empowerment</td>
</tr>
<tr>
<td>policy and practice promotes healthy development &amp; sense of community</td>
<td></td>
<td>conditions that foster feelings of competence, self-determination, and connectedness</td>
<td>intrinsically motivated to pursue full development, well-being, and a value-based life</td>
</tr>
</tbody>
</table>

*For more on these matters, see:


**A reciprocal determinist view of behavior recognizes the interplay of environment and person variables.
D. Comprehensive Continuum of Intervention Systems

Orientation Question:
What is encompassed by the term comprehensive continuum of intervention?

In many schools, when students are not doing well, the trend is to refer them directly for assessment in hopes of referral for special assistance, perhaps even assignment to special education. In some schools and classrooms, the number of referrals is dramatic. Where special teams exist to review students for whom teachers request help, the list grows as the year proceeds. 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.

One solution might be to convince policy makers to fund more special programs and services at schools. However, even if the policy climate favored more special programs, such interventions alone are not a comprehensive approach for addressing barriers to learning. 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 teachers send to review teams. That is, a full continuum of interventions is needed.

Development of a full continuum involves the efforts of school and community. Such a continuum must be comprehensive, multifaceted, and integrated and woven into three overlapping systems: systems for positive development and prevention of problems, systems of early intervention to address problems as soon after their onset as feasible, and systems of care for those with chronic and severe problems (see Figure 2). Accomplishing all this requires that society’s policy makers work toward fundamental systemic reforms that will enable redeployment of how current resources are used.

The three systems highlighted in Figure 2 encompass an array of effective programmatic activities along the continuum. For example, moving through the continuum, the emphasis is on (1) public health protection, promotion, and maintenance that foster positive development and wellness, (2) preschool-age support and assistance to enhance health and psychosocial development, (3) early-schooling targeted interventions, (4) improvement and augmentation of ongoing regular support, (5) other interventions prior to referral for intensive and ongoing targeted treatments, and (6) intensive treatments. Examples of each are listed in Table 5.
The continuum framed in the Figure and Table encompasses a holistic and developmental emphasis. The focus is on individuals, families, and the contexts in which they live, learn, work, and play. A basic assumption underlying the application of any of the interventions is that the least restrictive and nonintrusive forms of intervention required to address problems and accommodate diversity should be used initially. Another assumption is that problems are not discrete, and therefore, interventions that address root causes should be used.

When the outlined framework is used to analyze a school’s programs and those in the surrounding community, it usually becomes evident that both the school and its surrounding community have some related, but separate initiatives. Such an analysis highlights the degree of fragmentation (and marginalization) that characterizes efforts to address barriers to development and learning. More importantly, it suggests the need for systemic collaboration to braid resources and establish interprogram connections on a daily basis and over time. This involves horizontal and vertical restructuring of programs and services within and between jurisdictions (e.g., among departments, divisions, units, schools, clusters of schools, districts, community agencies, public and private sectors). Such connections are essential to counter tendencies to develop separate programs in different venues for every observed problem.
Figure 2. Interconnected systems for meeting the needs of all youngsters.

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

Examples:
- Enrichment & recreation
- General health education
- Promotion of social and emotional development
- Drug and alcohol education
- Support for transitions
- Conflict resolution
- Parent involvement
- Pregnancy prevention
- Violence prevention
- Dropout prevention
- Learning/behavior accommodations
- Work programs
- Special education for learning disabilities, emotional disturbance, and other health impairments

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

Examples:
- Youth development programs
- Public health & safety programs
- Prenatal care
- Immunizations
- Recreation & enrichment
- Child abuse education
- Early identification to treat health problems
- Monitoring health problems
- Short-term counseling
- Foster placement/group homes
- Family support
- Shelter, food, clothing
- Job programs
- Emergency/crisis treatment
- Family preservation
- Long-term therapy
- Probation/incarceration
- Disabilities programs
- Hospitalization

**Systems for Positive Development & Systems of Prevention**
primary prevention
(low end need/low cost per student programs)

**Systems of Early Intervention**
early-after-onset
(moderate need, moderate cost per student)

**Systems of Care**
treatment of severe and chronic problems
(High end need/high cost per student programs)
Table 5. From primary prevention to treatment of serious problems: A continuum of community-school programs to address barriers to learning and enhance healthy development

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

Few doubt that psychosocial and health problems affect learning and performance. Because of this, school decision makers have supported, to a degree, various ways 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, such as school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, delinquency, and violence.

There are about 91,000 public schools in about 16,000 districts. Over the years, most, but obviously not all, schools have instituted programs designed with a range of MH and psychosocial concerns in mind.

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. There is a large body of research supporting the promise of much of this activity (see Center for Mental Health, 2000). And, the available research also suggests that for some youngsters schools are the main providers of MH services. As Burns and her colleagues (1995) 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, counterproductive 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. This theme permeates this module.

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.

It also is necessary to 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 (a) woven into a cohesive continuum of interventions and (b) integrated thoroughly with school reform efforts. In the process, the importance of school-community-home collaborations in weaving together the resources for comprehensive, multifaceted approaches can be stressed.

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 strengthen students, families, schools, and neighborhoods and do so in ways that maximize learning, caring, and well-being.
On the following two pages is an outline of a set of field defining guidelines. They represent a framework for designing comprehensive, multi-faceted, and cohesive approaches to MH in schools. These first-ever guidelines were developed in 2001 by the Policy Leadership Cadre for Mental Health in Schools. (See the Cadre document for 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 Mental Health in schools should be defined and implemented.

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**Exhibit**

**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)

   (cont.)
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)

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
The above guidelines are a work in progress. Feedback is welcome and, indeed, is essential to advancing the field. What the guidelines do is provide a focal point for clarifying the nature and scope of MH in schools. Moreover, they do so in a way that is a good match with the mission of schools. They do not suggest that schools should be in the mental health business, but rather indicate the many ways that a MH focus supports the school’s mission. The shared intent is to ensure that every student has an equal opportunity to succeed at school by maximizing learning and well-being. More than good instruction is needed if this is to be achieved. Also required is development of comprehensive, multifaceted, and cohesive approaches that address MH and psychosocial concerns. Such approaches encompass efforts to weave together all activity dealing with MH and other barriers to learning, including initiatives for promoting and enhancing healthy development.

Those who mean to advance MH in schools must work to ensure their agenda is not seen as separate from a school’s educational mission. That is, in terms of policy, practice, and research, all activity related to MH in schools, including the many categorical programs for designated problems, eventually must be embedded fully into school reform initiatives. This is the key to having the efforts viewed as essential to the learning and teaching agenda. It is also the key to ending the marginalization and fragmentation that currently characterizes most endeavors for addressing barriers to learning at schools.4

Endnotes

1. Center for Mental Health in Schools (2000). Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning. Los Angeles: Author at UCLA.


3. Policy Leadership Cadre for Mental Health in Schools (2001). Mental health in schools: guidelines, models, resources & policy considerations. Los Angeles: Center for Mental Health in Schools at UCLA. This document can be downloaded at http://smhp.psych.ucla.edu or a hardcopy can be ordered from the Center. Send feedback to the Center.

4. For more information, references, and resources related to mental health in schools, see the Center for Mental Health in Schools, which operates under the auspices of the School Mental Health Project at UCLA. The Center’s website is: http://smhp.psych.ucla.edu
Materials for use as
Handouts/Overheads/Slides
in Presenting
Part I
I. Introductory Concepts

A. Mental Health in Schools

B. For a Few or For the Many?

C. Multifaceted Focus: Addressing Barriers, Enhancing Protections, Promoting Development

D. Comprehensive Continuum of Intervention Systems

>>Brief follow up reading –

About Mental Health in Schools: An Introduction
Addressing mental health of youngsters involves ensuring

C mental illness is understood within the broader perspective of psychosocial and related health problems, in terms of strengths as well as deficits, and as encompassing the well-being of families and staff

C the roles of schools/communities/homes are enhanced and pursued jointly

C equity considerations are confronted

C the marginalization and fragmentation of policy, organizations, and daily practice are countered

C the challenges of evidence-based strategies and achieving results are addressed.
Mental Health in Schools: It’s About Much More Than Therapy and Counseling

Mental health in schools isn’t just about

C students with diagnosable problems
C therapy and behavior change
C connecting community mental health providers to schools
C what mental health professionals do
C empirically-supported treatments

In addition to all the above, mental health in schools also is about

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

I. *Interveners* Who May Play Primary or Secondary Roles in Carrying Out Functions Relevant to Learning, Behavior, and Emotional Problems

- Instructional Professionals
- Administrative Staff
- Health Office Professionals
- Counseling, Psychological, & Social Work Staff
- Itinerant Therapists
- Personnel-In-Training

II. *Functions* Related to Addressing Mental Health and Psychosocial Needs at the School and District Level

- Direct Services and Instruction
- Coordination, Development, and Leadership Related to Programs, Services, Resources, and Systems
- Enhancing Connections with Community Resources
Current Practices

Delivery Mechanisms and Formats

I. School-Financed Student Support Services
   (e.g., pupil services/student support personnel)

II. School-District Specialized Units
   (i.e., district-wide units – sometimes with clinics)

III. Formal Connections with Community Mental Health Services
   - Co-location of agency at schools
   - Formal linkages with agencies to enhance access and service coordination
   - Formal partnerships between a school district and community agencies for school-based/linked facilities
   - Contracting with community providers

IV. Classroom-Based Curriculum and Specialized “Pull Out” Interventions
   - Integrated into regular classroom instruction
   - Specific curriculum or special intervention implemented by specially trained personnel
   - Curriculum approach is part of a multifaceted set of interventions for positive development and prevention

V. Comprehensive, Multifaceted, Integrated Approaches
   - Mechanisms to coordinate and integrate services
   - Initiatives to restructure student support programs and integrate them into school reform agendas
   - Community schools
Advancing MH in Schools

C Needed: Strategic Approaches & Comprehensive Frameworks to Enhance Policy and Practice

C Ending Marginalization
Range of Learners
(categorized in terms of their response to academic instruction)

I  =  Motivationally ready and able*

II  =  Not very motivated/
Lacking prerequisite knowledge & skills/
Different learning rates and styles/
Minor vulnerabilities**

III  =  Avoidant/
Very deficient in current capabilities/
Has a disability
Major health problems

* Few youngsters start out with internal problems that interfere with learning what schools teach. There can be little doubt that external factors are primarily responsible for the majority of learning, behavior, and emotional problems encountered in schools.

** All learners have assets/strengths/protective factors that can contribute to success; all have differences that require some degree of personalization by instructional systems; any may internalize negative experiences that interfere with learning at school.
# Multifaceted Focus

## Examples of Barriers to Learning/Development, Protective Buffers, & Promoting Full Development*

<table>
<thead>
<tr>
<th>Environmental Conditions**</th>
<th>Person Factors**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighborhood</td>
<td>Family</td>
</tr>
<tr>
<td>School and Peers</td>
<td>Individual</td>
</tr>
</tbody>
</table>

### I. Barriers to Development & Learning

Risk producing conditions

### II. Protective Buffers

Conditions that prevent or counter risk producing conditions – strengths, assets, corrective interventions, coping mechanisms, special assistance and accommodations

### III. Promoting Full Development

Conditions, over and beyond those that create protective buffers, that enhance healthy development, well-being, and a value-based life

*For more on these matters, see:


**A reciprocal determinist view of behavior recognizes the interplay of environment and person variables.
Comprehensive Continuum of Intervention Systems

Interconnected systems for meeting the needs of all youngsters.

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

Examples:

- Enrichment & recreation
- General health education
- Promotion of social and emotional development
- Drug and alcohol education
- Support for transitions
- Conflict resolution
- Parent involvement
- Pregnancy prevention
- Violence prevention
- Dropout prevention
- Learning/behavior accommodations
- Work programs

**Systems for Positive Development**  
&  
**Systems of Prevention**  
(primary prevention  
(low end need/low cost per student programs))

**Systems of Early Intervention**  
(early-after-onset  
(moderate need, moderate cost per student))

**Systems of Care**  
(treatment of severe and chronic problems  
(High end need/high cost per student programs))

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

Examples:

- Youth development programs
- Public health & safety programs
- Prenatal care
- Immunizations
- Recreation & enrichment
- Child abuse education
- Early identification to treat health problems
- Monitoring health problems
- Short-term counseling
- Foster placement/group homes
- Family support
- Shelter, food, clothing
- Job programs
- Emergency/crisis treatment
- Family preservation
- Long-term therapy
- Probation/incarceration
- Disabilities programs
- Hospitalization
Comprehensive Continuum of Intervention Systems

From primary prevention to treatment of serious problems: A continuum of community-school programs to address barriers to learning and enhance healthy development

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

It’s not about turning schools into health & social service agencies

Obviously:

School systems are not responsible for meeting every need of their students.

But as the Carnegie Task Force on Education concluded:

When the need directly affects learning, the school must meet the challenge.