Frequently Asked Questions About Mental Health in Schools

I. What are the mental health needs of youth?

II. Why is it essential for schools to address these needs?

III. How are schools doing it currently?

IV. What's good about what schools are doing
& what needs to change?

V. What can/should policy makers do to support schools
in meeting the mental health needs of youth?

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I. *WHAT ARE THE MENTAL HEALTH NEEDS OF YOUTH?*

A. What are "mental health needs?"

At the onset, it is essential to stress that the field of "mental health" is concerned with more than "mental illness." Mental health should always be understood as including

- ***strengths*** (e.g., positive social and emotional development and intrinsic motivation) and
- ***deficits*** – which encompass psychosocial problems as well as mental disorders

Given this, mental health needs are best understood along a continuum ranging from efforts to

> promote healthy social and emotional development and prevent problems for everyone
> respond to psychosocial and mental health problems as soon after onset as is feasible
> provide intensive care for severe, pervasive, and chronic problems

B. How many young people have behavior and emotional problems?

Focusing mainly on those who have been diagnosed, it is widely estimated that *12% to 22% of youngsters under age 18 need services for mental, emotional or behavioral problems.*

In discussing how many youngsters have diagnosable mental disorders, the Surgeon General's 1999 report on *Mental Health* provides one prominent example of efforts to highlight available data.*

Referring to ages 9 to 17, that document states that 21% or "one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year" – with 11% of all children experiencing significant impairment and about 5 percent experiencing "extreme functional impairment." Of the 5 percent with extreme problems, estimates suggest that 13% have anxiety disorders, 10% have disruptive disorders, 6% have mood disorders, 2% have substance abuse disorders; some have multiple diagnoses. (Using the 2000 data that indicate 70.4 million children 17 or younger in the U.S.A., the 21% estimate translates into about 14 million who show "the signs and symptoms of a DSM-IV disorder during the course of a year.")

Note: The picture worsens when one expands the focus beyond the limited perspective on diagnosable mental disorders to the number of young people experiencing psychosocial problems and who Joy Dryfoos cautions are "at risk of not maturing into responsible adults." For general purposes, it can be stressed that the number of such youngsters in many schools serving low-income populations has climbed over the 50% mark, and few public schools have less than 20%. The Center for Demographic Policy has estimated 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. All current policy discussions 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.

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*As cautioned in the Center report *Youngsters' Mental Health and Psychosocial Problems: What are the Data?* (http://smhp.psych.ucla.edu/pdfdocs/prevalence/youthMH.pdf), "Data on youngsters mental health and psychosocial problems have the power to influence life-shaping decisions for better and for worse. At this stage in the development of the field, the best available data are still rather limited. They provide snapshots, but the pictures are for the most part fuzzy."

C. How many receive help for their problems?

About 1.3 million children under the age of 18 – or one out of 50 – received mental health services in the U.S. (according to data from the 1997 Client/Patient Sample Survey conducted by the U.S. Department of Health and Human Services)

A RAND report, drawing on research published in 2001, highlights the following:*

On average, 5% to 7% of all young people receive mental health care each year.

- Adolescents (ages 12–17) are the biggest users of these services.

Hispanic children are less likely than white or African American children to receive mental health care.

- About 4% of Hispanic children receive care, compared with
- About 5% of African American children and
- About 6% of white children.

The estimated annual cost of treating troubled youth is $12 billion.

- Privately insured youth account for nearly half of total mental health expenditures.
- Medicaid recipients generate only about a quarter of the costs.

The nature of mental health care for young people has changed considerably.

- Sixty percent of care is now given on an outpatient basis, much of it from school-based programs.
- Use of psychotropic medication has grown dramatically.
- More than $1 billion was spent in 1998 on psychotropic medication to treat, on average, 4% of all youth, predominantly ages 6–17.
- Stimulants and antidepressants accounted for nearly three-fourths of the bill.

*The report is online at – http://www.rand.org/congress/health/0602/kids/kids.pdf ; it draws from:

Ringel J.S., Sturm R. (2001). National Estimates of Mental Health Utilization and Expenditures for Children in 1998. *Journal of Behavioral Health Services Research, 28,* 319–333.

Stein B., Sturm R., Kapur K., Ringel J.S. (2001). Psychotropic Medication Costs Among Youth with Private Insurance. *Psychiatric Services,* 52, 152.

In relation to all this, it is essential to ensure that (1) equity and related policy considerations are confronted, (2) the challenges of evidence-based strategies and achieving results are addressed, and (3) the varying needs of locales and the problems of accommodating diversity among interveners and among populations served are met.

II. *WHY IS IT ESSENTIAL FOR SCHOOLS TO ADDRESS THESE NEEDS?*

It has long been acknowledged that a variety of psychosocial and health problems affect learning and performance in profound ways and must be addressed if schools are to function satisfactorily and students are to succeed at school. Moreover, such problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure.

So, to achieve their mission of educating all students, schools must address barriers to learning and promote healthy development. This is especially the case for schools designated as "in need of improvement." As the Carnegie Task Force on Education has pointedly stressed:

> *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.*

Not doing so reduces the likelihood that *all* students will have an equal opportunity to succeed at school and guarantees that too many students will be left behind.

Available Data Underscore the Necessity for Schools to Meet the Challenge

- National findings related to high school graduation indicate that nearly one-third of all public high school students fail to graduate.
- Findings indicate that one-quarter to one-half of all beginning teachers leave teaching within four years and many do so because of the lack of an adequate system of learning supports
- In most states, a significant proportion of schools are designated as "High Priority" (previously Low Performing) Schools
- Evidence is growing that when test score gains are achieved, they mainly occur for young students, are related to noncomplex skills, and tend to plateau after a district shows modest gains over a three year period (http://www.nctimes.net/news/2002/20020830/90153.html; http://www.wcboe.k12.md.us/downloads/NewsReleases/050702anews.htm; http://edreform.com/press/naeptrends.htm)

Other reasons given in advocating for mental health (MH) in schools:

- to increase *access* to kids and their families for purposes of providing MH services
- to increase *availability* of MH interventions
  (a) through expanded use of school resources
  (b) through co-locating community resources on school campuses
  (c) through finding ways to combine school and community resources.
- to encourage schools to adopt/enhance specific programs and approaches
  (a) for treating specific individuals
  (b) for addressing specific types of problems in targeted ways
  (c) for addressing problems through school-wide, "universal interventions"
  (d) for promoting healthy social and emotional development.
- to improve specific processes and interventions related to MH in schools
  (e.g., improve systems for identifying and referring problems and for case management, enhancing "prereferral" and early intervention programs, enhancing communication, coordination, and integration of services)

It also should be recognized, however, that there are advocates for reducing school involvement in MH programs and services (e.g., to avoid competition for sparse instructional resources, to focus more on youth development, to keep the school out of areas where family values are involved).

III. *HOW ARE SCHOOLS DOING IT CURRENTLY?*

Varied policies and initiatives have emerged relevant to efforts to enhance mental health in schools. Some are generated by school owned resources, and others stem from the community.

A. School Owned Student/Learning Supports

Some current efforts directly support school programs and personnel. School policy makers, have a lengthy (albeit somewhat reluctant) history of trying to assist teachers in dealing with problems that interfere with schooling. Prominent examples are seen in the range of counseling, psychological, and social service programs schools provide.

B. Community Owned, School-Based or Linked

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. These school-based or linked services have added impetus to advocacy for mental health in schools.

More recently, the efforts of some advocates for basing or linking community services have 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.

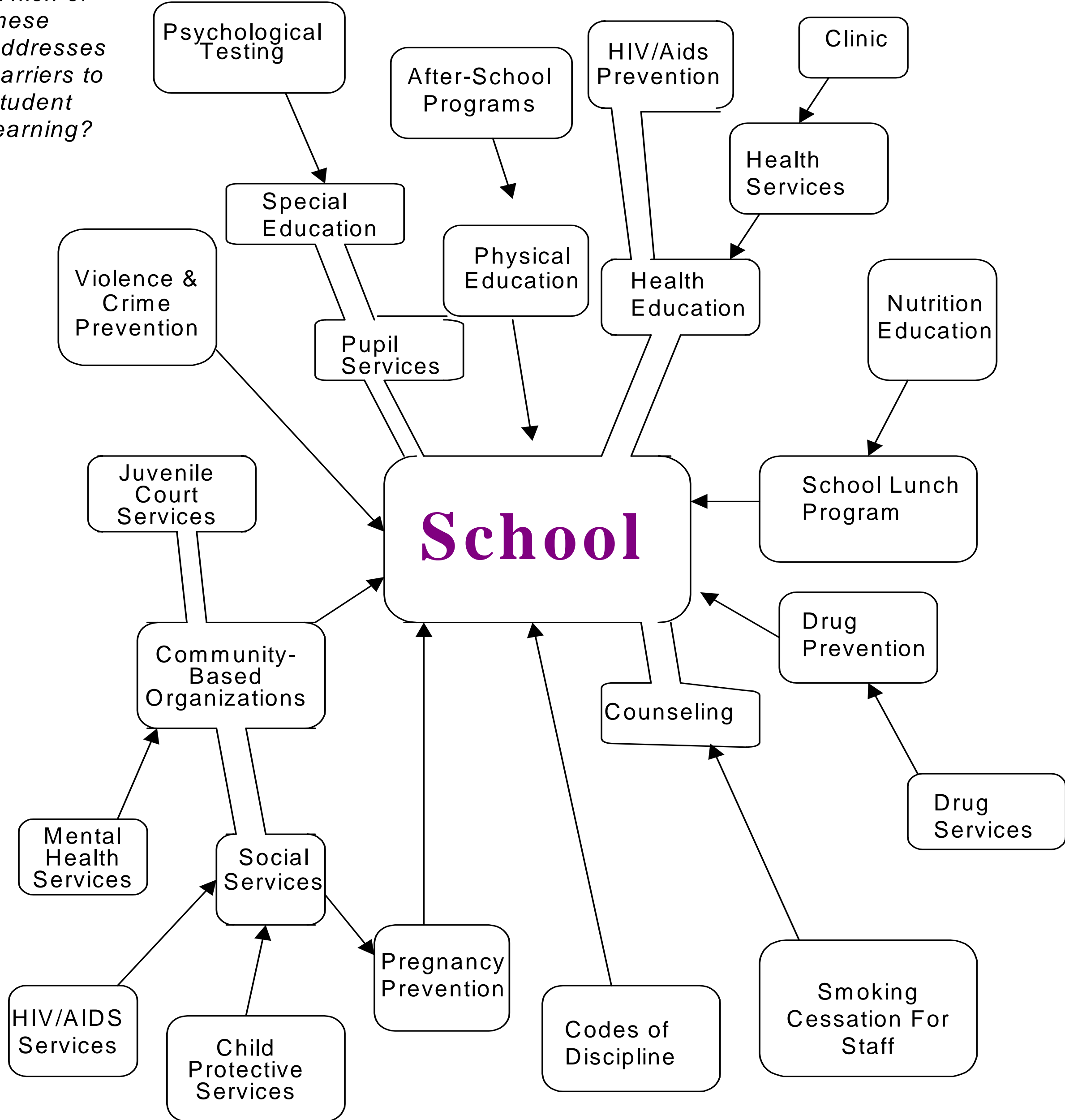
C. As a result . . .

Most schools have some programs to address a range of mental health and psychosocial concerns (e.g., school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, delinquency, violence). Programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development.

But, the current norm related to mental health in schools 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 makes some sense. In the long-run, however, it is counter-productive in that it perpetuates piecemeal and fragmented policies and practices. The impact of all this is seen in the deployment of diverse school and community resources in ways that are highly fragmented (see Figure). This continues the current trends toward redundancy, inappropriate competition, marginalization, and inadequate results.

And, this means that only a relatively small
percentage of students' who need it are helped.

Talk about fragmented!!!



Adapted from: *Health is Academic: A guide to Coordinated School Health Programs* (1998). Edited by E. Marx & S.F. Wooley with D. Northrop. New York: Teachers College Press.

IV. *WHAT'S GOOD ABOUT WHAT SCHOOLS ARE DOING & WHAT NEEDS TO CHANGE?*

Clearly, mental health activity is going on in schools. Available research suggests that for some youngsters schools are the main providers of mental health services. As Burns and her colleagues report from the study of children's utilization of MH services in western North Carolina,

> "the major player in the de facto system of care was the education sector — more than three-fourths of children receiving mental health services were seen in the education sector, and for many this was the sole source of care."

A. What's good?

- Schools already know a good deal about addressing barriers to student learning.
- Schools are trying to work with communities to enhance how they do this.
- Schools are helping some students who have mental health problems.
- A foundation has been laid for essential changes in policy and practice.

B. Major Systemic Changes are Needed

Systemic changes must focus on ensuring that the available, sparse resources are used in ways that serve a much larger proportion of students. For this to happen, it is essential to end the fragmentation, marginalization, counter-productive competition, and costly redundancy that characterizes what schools and communities do to address barriers to student learning.

- The aim must be to weave school owned and community owned resources together to develop comprehensive, multifaceted, and integrated approaches for addressing barriers to learning and enhancing healthy development.
- The process must stress the importance of school-community-home collaborations.
- And, the work must connect in major ways with the mission of schools and integrate with a restructured system of education support programs and services.
- Moreover, pursuit of such changes also must address complications stemming from the scale of public education. That is, efforts to advance mental health in schools must adopt effective models and procedures for replication and "scale-up."

> Advancing mental health in schools is about much more than expanding services and creating full service schools. It requires comprehensive, multi-faceted approaches that help ensure schools are caring and supportive places that maximize learning and well-being and strengthen students, families, schools, and neighborhoods.
>
> Howard Adelman & Linda Taylor (2006). The School Leader's Guide to Student Learning Supports: New Directions for Addressing Barriers to Learning. Corwin Press.

V. *WHAT CAN/SHOULD POLICY MAKERS DO TO SUPPORT SCHOOLS IN MEETING THE MENTAL HEALTH NEEDS OF YOUTH?*

It is a given that government will continue to invest sparingly in advancing the role schools play in mental health for children and adolescents. Therefore, it is essential for policy makers to take a close look at all the pieces that already are in place related to mental health in schools. 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.

Available evidence makes it clear that policy for mental health in schools must address the fragmentation, marginalization, counter-productive competition, and costly redundancy resulting from current policy and practices. Minimally, this means (1) reversing the trend of piecemeal and fragmented initiatives, (2) promoting efforts to develop comprehensive, multifaceted, and integrated approaches for addressing barriers to learning, including mental health concerns, and (3) ensuring the work is fully integrated into the mission of schools and can be replicated and "scaled-up."

In the process, policy makers should help

- ensure that mental health is understood in terms of psychosocial problems as well as disorders and in terms of strengths as well as deficits,
- enhance the capacity and facilitate ways for schools, communities, and families to work together to braid existing school owned and community owned resources,
- pay special attention to reducing the prevalence of problems by promoting development of systems for prevention and responding early after the onset of problems,
- ensure that equity considerations, the varying needs of locales, the problems of accommodating diversity among interveners and among populations served, and the challenges of evidence-based strategies and achieving results are all addressed.

In addition, policy makers must support the development of better systems for gathering quality and generalizable prevalence and incidence data on the problems experienced by children and adolescents. Such data systems are fundamental to improving policy and practice. A beginning has been made related to some problem arenas. But policy is needed that focuses on building a comprehensive system for gathering a full set of indicators that can be used, with critical care, to guide efforts to understand the nature and scope of youngsters' problems and as an accountability "report card" on the well-being of children.

In moving forward, it will be essential to change (e.g., rethink, reframe, reform, restructure) the way student supports are conceived at schools and to proceed *strategically.* Three specific concerns will be (a) infrastructure changes, (b) enhancing leadership, and (c) facilitating bridging within and across agencies and the braiding of resources. Moreover, there must be appropriate training, incentives, and safeguards for those who are expected to facilitate systemic change.

A. Infrastructure. It is rare to find an infrastructure that supports comprehensive, school-based approaches encompassing mental health. In most situations, infrastructure mechanisms must be modified so that improved policy directions are translated into appropriate daily operations. Well-designed mechanisms ensure local ownership, a critical mass of committed stakeholders, processes that overcome barriers to working together effectively, and strategies that mobilize and maintain

proactive change. Such mechanisms cover functions for (1) governance, (2) leadership, (3) planning/implementation of organizational and program objectives, (4) coordination and integration for cohesion, (5) management of communication and information, (6) capacity building, and (7) quality improvement and accountability.

Beyond the school, links among a "family of schools" (e.g., a feeder pattern of schools) focus on maximizing use of resources. When schools in a geographic area collaborate, they can share programs and personnel in many cost-effective ways, including achieving economies of scale by assigning staff and implementing staff development across linked schools. To these ends, the illustrated infrastructure needs to be paralleled for a family of schools. And, it also must connect effectively at the district level and with relevant facets of community and government infrastructure at all levels.

In redesigning mechanisms to address these matters, new collaborative arrangements must be established, and authority (power) redistributed (easy to say, extremely hard to accomplish). Obviously all this requires ensuring that those who operate essential mechanisms have adequate resources and support, initially and over time.

B. Leadership. Research on leadership in education and agencies has shifted from a focus on personal characteristics of *leaders* to an emphasis on what is involved in providing effective *leadership*. In such settings, the systemic change literature suggests that leadership entails the ability to catalyze, advocate, influence, create readiness, guide, support, facilitate, maintain the "big picture vision," and create renewal. This includes the ability to play a role in

- > conveying a full understanding and appreciation of the big picture and its various facets
- > developing and maintaining effective shared governance
- > braiding and prioritizing allocation of resources
- > ensuring effective daily operations
- > accomplishing systemic changes
- > ensuring ongoing capacity building for the entire system
- > ensuring aggregation and disaggregation of appropriate data for formative and summative evaluation and for accountability and social marketing purposes
- > ensuring periodic revision of strategic plans

C. Bridging and braiding. It is widely acknowledged that policy and practice are highly fragmented. Such fragmentation not only is costly in terms of redundancy and counter-productive competition, it works against developing cohesive approaches and maximizing results. Government efforts need to promote policy that bridges the "silos" and facilitates braiding of resources. Accomplishing this requires operating with guiding frameworks that encompass the entire range of learning, behavior, and emotional problems seen in schools.

> Given the complexity and range of problems that must be addressed, it seems clear that advancing the field requires adopting a unifying, comprehensive, multifaceted., and cohesive *intervention framework*. Evolving such a comprehensive, systemic approach at a school and throughout a district requires *rethinking infrastructure* and *policy* and using a sophisticated framework and strategies to facilitate major *systemic changes*. With respect to all this, there also is a need to incorporate the invaluable understanding of human motivation that *intrinsic* motivation scholars have developed over the last 40 to 50 years.
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> Howard Adelman & Linda Taylor (2006). The School Leader's Guide to Student Learning Supports: New Directions for Addressing Barriers to Learning. Corwin Press.