Addressing Barriers to Learning

New ways to think . . .

Better ways to link

Volume 9, Number 1
Winter, 2004

Integrating Agendas for Mental Health in Schools into the Recommendations of the President's New Freedom Commission on Mental Health

Note: This issue of the newsletter is devoted entirely to presenting the first draft of a brief prepared by the staff of two national centers: the *Center for Mental Health in Schools* at UCLA (co-directed by Howard Adelman and Linda Taylor) and the *Center for School Mental Health Assistance* at the University of Maryland, Baltimore (directed by Mark Weist). We need your feedback as a basis for preparing the final draft (see insert).

As the *President's New Freedom Commission on Mental Health* recognizes, any effort to enhance interventions for children's mental health must involve schools. Indeed, school involvement is key to the transformation of how mental health interventions are delivered in the U.S.A. Fortunately, schools already provide a wide range of programs and services for all students who are not succeeding, and many of these interventions are relevant to mental health and psychosocial concerns. However, schools could and will need to do much more if the mandates of the *No Child Left Behind Act* and the *Individuals with Disabilities Education Act* are to produce the benefits the public desires.

In 1959, NIMH published a seminal document highlighting the importance of mental health in schools. Building on the following 35 years of work, a federal initiative to enhance mental health in schools was initiated in 1995 by the U.S. Department of Health and Human Services. This initiative is helping clarify agendas for intervention research, policy, training, and technical assistance that are essential to improving children's mental health.

The following brief was prepared by the staff of the two national centers the DHHS initiative created to advance mental health in schools. The overview incorporates the research, training, and technical assistance activity of both centers. It also incorporates the goals of *Healthy People 2010,* and the ideas set forth in *Bright Futures, Mental Health.* Moreover, it reflects input from the wide range of stakeholders across the country with whom the centers work. As a result, the brief draws on what has been learned over many years, in many contexts, and from many sources.

The specific intent here is to apply the extant body of knowledge related to mental health in schools in ways that will contribute to operationalizing the recommendations of the President's New Freedom Commission on Mental Health. The underlying message is that efforts to transform how mental health interventions are delivered can and should capitalize on the needs of and opportunities presented by schools. Three topics are covered from the perspectives of enhancing mental health in schools:

- Why Mental Health in Schools is an Imperative
- What Needs to be Done to Meet the Imperative
- Where All This Fits into the New Freedom Commission's Recommendations

Why is Mental Health in Schools an Imperative?

For the most part, the usual answer to this question focuses on either or both of the following points:

(1) accessing students (and their families) who need mental health services is facilitated by contact through and at schools

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

Implied in both answers is the hope of enhancing the nature and scope of mental health interventions to fill gaps, enhance effectiveness, address problems early, and reduce stigma.

Point 1 typically reflects the perspective and agendas of agencies and advocates whose mission is to improve mental health services. The second point reflects the perspective and agendas of student support professionals and some leaders for school improvement.

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

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

Given all this, as a general rationale for making mental health in schools an imperative, it is useful 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.*

Mental Health in Schools: Meeting the Imperative

It is one thing to provide a rationale that stresses mental health in schools is an imperative; it is quite another thing to frame how the imperative should be met. From the perspective of the mission of schools, it is insufficient to frame the work only in terms of (a) screening and diagnosing psychopathology, (b) providing clinical services, and (c) connecting community mental health providers to schools. These, indeed, are all fundamental to improving mental health, but the framework for making the case that mental health *in schools* is an *imperative* must be more comprehensive.

Conceiving mental health *as part of* essential student supports that enable students to learn makes it an imperative for schools as they strive to achieve their mission.

From this perspective, the recommendations of the President's New Freedom Commission can coalesce with school improvement policy, especially (a) the aims of the *No Child Left Behind Act* (particularly the goals of closing the achievement gap and addressing dangerous schools) and (b) the changes that will be forthcoming as a result of the upcoming reauthorization of the *Individuals with Disabilities Education Act.*

Making the case requires proceeding in ways that

- *define mental health broadly* – i.e., encompass the agenda for mental health *in schools* within the broad context of the psychosocial and mental health concerns encountered each day at schools – including an emphasis on strengths as well as deficits; also include an emphasis on the mental health of students' families and school staff

- *enhance partnerships among schools, communities, and the home* – e.g., focus on coalescing and enhancing the roles of schools/communities/homes in addressing emotional, behavioral, and learning problems

- *confront equity considerations* – e.g., stress the role mental health in schools can play in ensuring all students have an equal opportunity to succeed at school

- *address the related problems of marginalization, fragmentation, and counterproductive competition for sparse resources* – i.e., focus on coalescing policy, agencies, organizations, and daily practice

- *address the challenges of evidence-based strategies and achieving results* – e.g., stress ways to build on current in-school practices using a science-base (see Exhibit 1)

Exhibit 1

A Note About Building on Current In-School Practices

It is, of course, not a new insight that psychosocial 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 such 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.

Currently, there are about 90,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted policies and programs designed with a range of mental health and psychosocial concerns in mind. Some directly support school counseling, psychological, and social service programs and personnel; others connect community programs and personnel with schools. As a result, most schools have some programs to address a range of mental health and psychosocial concerns, such as school adjustment and attendance problems, substance abuse, emotional problems, relationship difficulties, violence, physical and sexual abuse, delinquency, and dropouts. And, there is a large body of research supporting the promise of much of this activity.[1]

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

School districts use a variety of their own *personnel* to address student support concerns. These may include "pupil services" or "support services" specialists such as psychologists, counselors, social workers, psychiatrists, and nurses, as well as a variety of related therapists. Such specialists tend to focus on students seen as problems or as having problems. Their many *functions* can be grouped into: (1) direct services and instruction, (2) coordination, development, and leadership related to programs, services, resources, and systems, and (3) enhancement of connections with community resources. In keeping with this last function, the focus often is on linking and collaborating with community agencies and programs to enhance resources and improve access, availability, and outcomes. Despite the range of activity, it remains the case that too little is being done in most schools, and prevailing approaches are poorly conceived and are implemented in fragmented ways.

[1]For relevant references, go to

(1) http://smhp.psych.ucla.edu/qf/references.htm
(2) http://smhp.psych.ucla.edu/pdfdocs/briefs/BarriersBrief.pdf
(3) http://smhp.psych.ucla.edu/pdfdocs/aboutmh/annotatedlist.pdf
(4) http://csmha.umaryland.edu/

Exhibit 1 (cont) Delivery Mechanisms and Formats for MH in Schools

The five mechanisms and related formats are:

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

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

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

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

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

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

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

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

Examples of ways to meet the imperative – The New Freedom Commission's recommendations can be operationalized to emphasize how schools can

- promote social-emotional development, prevent mental health and psychosocial problems, and enhance resiliency and protective buffers
- intervene as early after the onset of emotional, behavior, and learning problems as is feasible and to address severe and chronic problems
- address systemic matters at schools that affect student and staff well-being, such as practices that engender bullying, alienation, and student disengagement from classroom learning
- establish guidelines, standards, and accountability for mental health in schools (see Exhibit 2)
- build the capacity of all school staff to address emotional, behavioral, and learning problems and promote healthy social-emotional development
- draw on all empirical evidence as an aid in developing a comprehensive, multifaceted, and cohesive continuum of school-community interventions to address emotional, behavioral, and learning problems (see Figure 1)

Where All This Fits into the New Freedom Commission's Recommendations

There are about 90,000 public schools in the U.S.A. In a real sense, schools are primary care and public health settings, and thus, school staff are primary care providers and agents for public health, albeit they usually don't identify as such. Moreover, our society calls on schools to serve all students without regard to disorder, disability, ethnicity, economic status, gender identity, and so forth. As a result, efforts to transform how mental health is delivered in this country need to include a specific emphasis on enhancing the focus on mental health in schools. To this end, the following section highlights ways in which the Commission's recommendations apply to mental health in schools.

Commission Goal 1 - Understanding that mental health is essential to overall health[1]

Rec. 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

- *Schools are key venues for campaigns and prevention programs.* An enhanced focus on mental health in schools provides both natural opportunities and formal avenues to promote efforts to reduce stigma and prevent not only suicide but a range of other related mental health and psychosocial problems. Natural opportunities occur each day at school as students interact with each other and staff. Formal avenues occur through integration into both regular and special education curricula, including prevention programs, specialized interventions for problems, and as part of courses for social and emotional development and mental health education. Schools also provide a conduit to families and community stakeholders for enhancing understanding about mental health.

Rec. 1.2 Addressing mental health with the same urgency as physical health.

- *Schools play a major role in shaping public attitudes over time.* As a universal socializing institution, schools are a key determiner of future public opinion. Over time, development of a comprehensive, multifaceted approach to mental health in schools not only can increase understanding, but should enhance appreciation of the need to address mental health with equivalent priority as is given to physical health in our society. Some evidence that this will be the case comes from the data generated from school-based health centers, where an enhanced appreciation of the need for and value of mental health assistance has been a consistent finding.

(text cont. on page 7)

[1]The full report discussing the Commission's goals and recommendations is online at: http://www.mentalhealthcommission.gov/

Exhibit 2. Guidelines, Standards and Accountability for MH in Schools

The following guidelines are based on a set of underlying principles for designing comprehensive, multifaceted, and cohesive approaches to Mental Health in schools (for specific rationale statements and references for each guideline, see http://smhp.psych.ucla.edu/pdfdocs/policymakers/cadreguidelines.pdf). 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 defining and implementing MH in schools. They also provide the basis for developing standards, quality indicators, and accountability measures.

GUIDELINES FOR MENTAL HEALTH IN SCHOOLS

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

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

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

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

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

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

(cont.)

Exhibit 2 (cont.) ***Guidelines For Mental Health in Schools***

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

Note: As stressed above, considerable work is being done around the country related to developing standards, quality indicators, and accountability measures. For example, the State of Hawaii has integrated into its Standards Implementation Design for all schools standards and rubrics for *Quality Student Support* – http://doe.k12.hi.us/standards/sid.pdf Another example is seen the efforts of the Center for School Mental Health Assistance to develop and research a quality assessment and improvement framework (for more information on this effort contact csmha@psych.umaryland.edu).

Commission Goal 2 - Mental health care is consumer and family driven

Rec. 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

- *Schools need and are in a position to involve consumers in quality individualized planning.* Schools already involve families in IEP development as part of their compliance with special education mandates. A beginning has been made to transform such planning to conform with the consumer and family driven principles of systems of care. Along with strengthening systems of care efforts, an enhanced focus on mental health in schools can extend systemic approaches to include young consumers and family driven individualized planning for interventions that are implemented early after the onset of a problem.

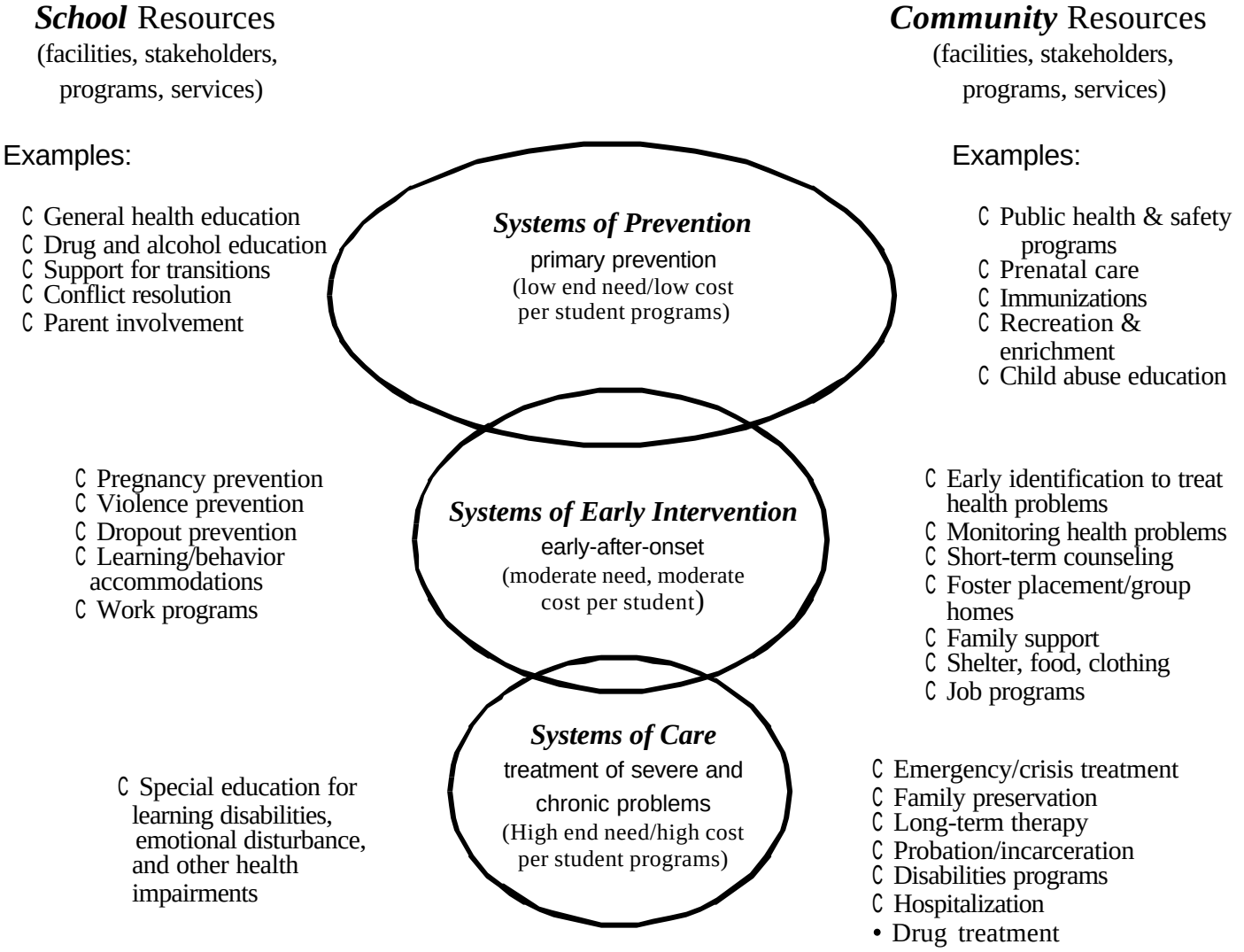
Rec. 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

- *Schools that enhance their focus on mental health are more likely to work with young consumers and families toward the goal of recovery.* Schools are under tremendous pressure to raise the achievement of all students. This provides a major incentive for them to do more than control externalizing behavior problems. By enhancing mental health in schools, schools will be able to work towards a youngster's recovery and will

(text cont. on page 9)

Figure 1. Interconnected systems for meeting the needs of all students.

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



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

Such collaboration invloves horizontal and vertical restructuring of programs and services
(a) withing jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters of schools)
(b) between jurisdictiosn, school and comunity agencies, public and privae sectors; among schools; among community agencies

contribute to the recovery of parents to enable them to support student progress. A key aspect in accomplishing all this will be enhanced partnerships with other interveners and the youngster and his or her family.

Rec. 2.3 Align relevant Federal programs to improve access and accountability for mental health services.

- *Schools currently can seek waivers to redeploy and braid federal education dollars to coordinate and enhance the impact of student support services.* For example, under Title I of the No Child Left Behind Act schools can redeploy up to 5% of the federal funds they receive to enhance coordination of services. A similar provision exists in the Individuals with Disabilities Education Act. In addition, schools can seek waivers in order to braid together various sources of categorical program funding. As such opportunities also increase for community agencies, school and community resources can be braided. With the enhanced emphasis on coordinating and integrating resources, availability, access, and accountability will increase.

Rec. 2.4 Create a Comprehensive State Mental Health Plan.

- *For a State Mental Health Plan to be comprehensive, it must encompass a significant role for schools.* See Figure 1.

Rec. 2.5 Protect and enhance the rights of people with mental illnesses.

- *Protecting and enhancing the rights of young people with mental illness requires a coordinated and integrated school and community approach.* Evidence of the need to address schools in this respect is seen in the fact that so many school systems currently are out of compliance with special education mandates, especially in terms of meeting mental health needs. An enhanced focus on mental health in schools can help address this system failure.

Commission Goal 3 - Eliminating disparities in mental health services

Rec. 3.1 Improve access to quality care that is culturally competent.

- *School staff are mandated to upgrade their competence continuously.* Increasingly, the emphasis in schools is on enhancing effectiveness with diverse populations. This is a key goal of the focus on disaggregating school accountability indices. Initiatives to enhance mental health in schools all emphasize increasing system and staff capacity to eliminate disparities arising from lack of availability, access, and competence related to human diversity. Still, there are major deficiencies related to both the pre- and inservice training of student support staff and other mental health professionals who come into schools that must be addressed in the interest of enhancing quality.

Rec. 3.2 Improve access to quality care in rural and geographically remote areas.

- *Enhancing mental health in all schools is a key to enhancing availability and access in every community.* Schools serve all communities.

Commission Goal 4 - Making early mental health screening, assessment, and referral to services common practice

Rec. 4.1 Promote the mental health of young children.

- *Schools increasingly are focusing on pre-schoolers and the special needs of students in primary grades.* Head start has always had a mental health focus; all pre-schools are concerned with promoting social and emotional development. Teachers of young children and other staff at their schools are critical elements in promoting mental health (or contributing to emotional and behavioral problems). They also are essential to early detection and referral. And, with an enhanced focus on mental health in schools, more student support programs and services can be available to prevent and address problems early after their onset.

Rec. 4.2 Improve and expand school mental health programs.

- *Continue and expand the federal Mental Health in Schools Program.*
- *Expand the federal mental health research agenda to enhance the focus on mental health in schools.* A strong research agenda is needed related to the interface between school and mental health policy, research, training, and practice.

- *Coalesce mental health-related federal categorical programs in schools.* The Safe Schools/Healthy Students initiative has pioneered an interagency approach that braids funds from three federal departments in ways that have improved and expanded mental health programs. A broader initiative is now needed to address the problems of so-called "silo" funding to schools within and across federal agencies. (Also, see school-related recommendation for 2.3 above.)

Rec. 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

- *Substance abuse is a major concern in schools.* Because of this, schools provide an invaluable venue for addressing co-occurring MH and substance problems. Next to parents, teachers and student support staff are in a strategic position to detect problems early. And, by definition, an integrated intervention approach requires the involvement of school staff.

Rec. 4.4 Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports.

- *School nurses, other student support staff, and the staff of school-based health centers should be viewed as providing primary health care.* Such personnel do and can play an even greater role in early detection and referral of mental health problems and in coordinating and integrating interventions at school and with community providers.

Commission Goal 5 - Delivering excellent mental health care and accelerating research

Rec. 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

- *Expand the federal mental health research agenda to accelerate the focus on mental health in schools.* There are many areas in need of extensive research. For example: research on resilience and protective buffers related to schools is still in its earliest stages; research on the outcomes of special education programs for emotional and behavioral problems has yet to identify approaches that have a high degree of lasting effectiveness; research is needed related to replication and school districts scale-up of science-based prevention programs.

Rec. 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

- *Schools increasingly are being called upon to use evidence-based MH practices.* In doing so, they have developed demonstration projects and various dissemination strategies. The next step is to focus on sustainability, replication, and scale-up strategies. Lessons learned from the current federal initiative for diffusing Comprehensive School Reform models will be instructive with respect to creating public-private partnerships. Also useful will be what has been learned from the extensive work across the country focused on developing school-community collaboratives.

Rec. 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

- *Build the capacity of student support staff and other mental health professionals who come into schools for incorporating science-based activity.* The current federal Mental Health in Schools Program has begun this process through the two national training and technical assistance centers it established. Obviously, such capacity building is a long-term concern, and one that must be institutionalized into pre- and in-service programs across the country.

Rec. 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

- *Schools must play a role in each of these areas.* School involvement is indispensible both as contexts and sources for child and adolescent samples. With an enhanced focus on mental health in schools, some of the barriers to conducting such research can be reduced.

Commission Goal 6 - Using technology to access mental health care and information

Rec 6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

- *Schools already are involved in pioneering use of health technology and telehealth.* The next step is to evolve and sustain the demonstrations and develop replication and scale-up strategies.

Rec. 6.2 Develop and implement integrated electronic health record and personal health information systems.

- *Schools currently are in the process of revamping and computerizing their information management systems.* In response to the accountability demands of the No Child Left Behind Act (and the protections required by Family Educational Rights and Privacy Act [FERPA] and Health Insurance Portability and Accountability Act [HIPAA]), school districts across the country are redesigning and computerizing their information management systems. The opportunity exists to influence the type of health data included and improve system connectivity with health and other agencies.

Concluding Comments

As the Commission noted, this is a time of sparse resources for public enterprises. Therefore, their report stresses the importance of "policy and program changes that make the most of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers, coupled with a strong measure of accountability." The aim is to more wisely invest and use sparse resources. The focus in this brief on mental health in schools is consistent with this aim.

Schools currently expend significant resources on student support programs and services that address behavioral and emotional problems. Such resources are deployed through piecemeal policies and are implemented in a fragmented manner. One focus of the federal Mental Health in Schools Program has been to address these problems so that resources are deployed and redeployed in ways that enhance equity with respect to availability, access, and effectiveness.

As the New Freedom Commission's recommendations are operationalized, the opportunity arises to further the agendas for schools to play a comprehensive role in transforming mental health in the U.S.A. There are many stakeholders ready to help make this a reality.

Now, if you have feedback to offer and/or would like to receive a copy of the final version of this report, please fill out and send back the enclosed insert.

##########

Want resources? Need technical assistance?

Contact us at: E-mail: **smhp@ucla.edu** Ph: **(310) 825-3634** Toll Free Ph: **(866) 846-4843**

Write: Center for Mental Health in Schools, Department of Psychology, UCLA, Los Angeles, CA 90095-1563

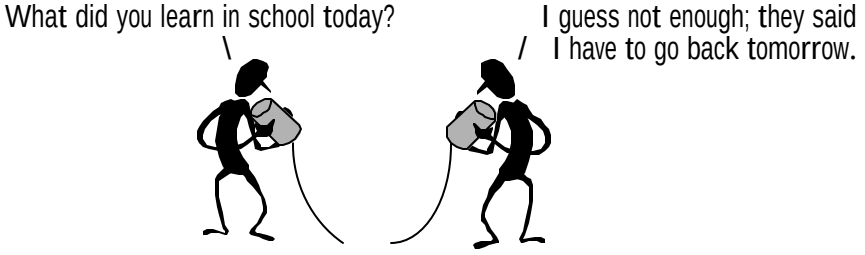
Or use our website: **http://smhp.psych.ucla.edu**

If you're not receiving our monthly electronic newsletter (ENEWS), send an E-mail request to: **smhp@ucla.edu** or subscribe online @ – http://lists.ucla.edu/cgi-bin/mailman/listinfo/mentalhealth-L

FOR THOSE WITHOUT INTERNET ACCESS, ALL RESOURCES ARE AVAILABLE BY CONTACTING THE CENTER.

Exchange info on MH practices in school and network with colleagues across the country by joining (1) the **Weekly Listserv for School MH Practitioners** and/or (2) **the Center's Consultation Cadre**. Sign up by email at smhp@ucla.edu or by phone (toll Free (866) 846-4843)

##########



Center Staff:
Howard Adelman, Co-Director
Linda Taylor, Co-Director
Perry Nelson, Coordinator
. . . and a host of graduate and undergraduate students

Center News

*****NEW RESOURCES**

Youngsters' Mental Health And Psychosocial Problems: What Are the Data?

http://smhp.psych.ucla.edu/pdfdocs/prevalence/youthMH.pdf

A common request to Centers such as ours is for information about the prevalence and incidence of youngsters' problems. The intent of this report is to provide a synthesis of the best data and to clarify the limitations of what has been gathered so far. Contents Include:

I. How many young people are affected
II. How are the Data Commonly Reported?
III. Increasing Rates?
IV. Are they Served?
Concluding Comments
References
Appendices
A. Mental Health Data
B. Special Education Data
C. Psychosocial Problems Data
D. Related Cultural Concerns Data

Recent Journal Publication by Center staff:

"On Sustainability of Project Innovations as Systemic Change" Journal of Educational and Psychological Consultation, 14(1) 1-25.

Summits Initiative:
New Directions for Student Support

CA will be the third state to hold a state-wide summit (in mid-February). At this juncture, indications of interest in having a state-wide summit have come from Indiana, Rhode Island, Texas, Tennessee, Kansas, Iowa, Ohio, and Washington.

We also are receiving direct calls from districts asking how we can help them move forward.

If you want a statewide Summit on *New Directions for Student Support* or if your district wants to explore moving in new directions, contact our Center (see contact info on page 11 of this newsletter).

A featured presentation on the Summits Initiative is planned for the April conference of NASP (the National Association of School Psychologists) and in June, a meeting is planned to engage NASP's policy leadership group in the new directions' work.

For more information on the Summits Initiative, go to the homepage of the Center website and click on the green button labeled Summits on New Directions.

As for the future, our task is not to foresee it,but to enable it.

Antoine de Saint-Exupery

Use the enclosed response form to give us feedback.
And, please send us information, ideas, and materials for the Clearinghouse.

School Mental Health Project/
Center for Mental Health in Schools
Department of Psychology, UCLA
Los Angeles, CA 90095-1563
PX-11

NON-PROFIT
ORGANIZATION
U.S. POSTAGE
PAID
UCLA

U.S. Department of Health and Human Services
HRSA Health Resources and Services Administration
Maternal and Child Health Bureau

CMHS Center for Mental Health Services
SAMHSA Substance Abuse & Mental Health Services Administration

he Center for Mental Health in Schools is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project in the Dept. of Psychology ,UCLA. Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration. Co-funding comes from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
Both HRSA and SAMHSA are agencies of the U.S. Dept. of Health and Human Services.