

## Child and Adolescent MH Therapy and Schools: Annotated Outline Focused on Key Concerns

The outline that follows is designed as a starting point for individuals and groups just beginning to think about a presentation on the topic of providing interactive mental health therapy at schools.

After defining the nature of interactive therapy for minors and highlighting some of the major challenges schools need to understand in identifying and treating children and adolescents, the focus is on:

- What are the advantages of offering mental health services on school campuses?
- When is advocacy for expanding mental health services at schools counterproductive to unifying and developing a comprehensive system for addressing learning, behavior, and emotional problems?

\*The information presented here was culled from a variety of resources (see reference list) and drafted by Joyce Chen as part of her work with the national Center for Mental Health in Schools at UCLA.

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## ***I. What is the nature of interactive mental health therapy for minors?***

### **A. Psychotherapy Defined Differently for Adults and Youngsters**

In an introduction to evidence-based psychotherapies for children and adolescents, Kazdin and Weisz (2003) highlight two definitions for psychotherapy:

>For adults, psychotherapy is defined as:

“a special interaction between two (or more) individuals in which one person (the patient or client) has sought help for a particular problem and in which another person (the therapist) provides conditions to alleviate the person’s distress and to improve functioning in everyday life.” [Kazdin & Weisz cite Carfield, 1980; Walrond-Skinner, 1986].

>For children and adolescents, psychotherapy is defined as:

“any interaction that is designed to alleviate distress, reduce maladaptive behavior, or enhance adaptive functioning and that uses means that include counseling and structured or planned interventions” [Kazdin & Weisz cite Weisz, Weiss, Han, Granger, & Morton, 1995].

Based on the above definitions, adult therapy and child therapy can be seen as having similar general aims: to reduce distress and interfering factors and enhance functioning. Moreover, they are similar in that interactive therapy

- may be offered individually or in groups
- often is crisis-driven
- should be modified to account for developmental and diversity considerations.

### **B. Adults and Youngsters: Differences in Choice and Control**

What the definitions do not highlight is that:

Adult therapy usually is focused on a self-presented problem (e.g., phobia, anxiety, depression) and is provided individually with client consent, as well as informed control over confidential information and major decisions.

While adult therapy sometimes is mandated by others (e.g., judges), child and adolescent therapy commonly is the result of a third-party referral (e.g., parents, teachers, judges) with the youngster a reluctant participant and control and confidentiality in the hands of legal caretakers. Moreover, the interaction may be mostly concerned with enhancing socialization and environmental adaptation.

### C. Therapy Goals for Children and Adolescents

In discussing child and adolescent therapy, Brems (2002) specifies three primary sets of goals:

- (1) *Resolve present problems* -- After identifying specific problems, therapist formulates measurable and observable objectives. These objectives are used to monitor progress and determine timing of termination.
- (2) *Strengthen psychological and emotional adjustment* -- These broader theory-driven goals go beyond specific problems to focus on overall well-being. Because this set of goals is more abstract, they are difficult to measure and progress is harder to monitor.
- (3) *Return to healthy point in the developmental* -- Here the focus is on whole-child development (e.g., cognitive, social, emotional, moral) with the aim of helping the youngster achieve a sense of maturity and capability that is age and developmentally appropriate.

Note that these goals encompass concerns not only about problems but healthy development. (See below.)

#### What is Mental Health?

In the past mental health often was defined as “the absence of problems,” or more specifically, the absence of diagnosable symptoms.

However, the absence of problems does not necessarily mean that *positive* thoughts, feelings, and behaviors are present.

Contemporary definitions of mental health emphasize the positive. Institute of Medicine (1997) stresses that health is “a state of well-being and the capability to function in the face of changing circumstances.”

World Health Organization (WHO) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2011).

With respect to treatment, the Substance Abuse and Mental Health Services Administration (SAMHSA) defines “recovery” from mental disorder and substance abuse as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012).

## *II. What are major challenges in identifying and treating children & adolescents?*

Schools need to understand the special challenges that arise in identifying and treating MH problems. These include, but are not limited to, the following:

### **A. Identifying Dysfunction in Light of Common Differences and Diversity**

- (1) Youngsters' behaviors vary widely, and a behavior currently considered dysfunctional for one individual may be normative for another -- now or in the future. Avoiding over-pathologizing differences calls for
  - considering such factors as level of development, motivation, and cultural background in identifying problems that warrant treatment
  - discerning between matters that commonly subside with maturation and problems that are likely to persist.
- (2) Assessment procedures must account for common differences and diversity, elicit information from various sources, and be alert to attributional and cultural biases. That is, they must be designed to
  - accommodate differences in factors such as level of development, motivation, and cultural background (e.g., use stimuli that resonates with the youngster and facilitates response)
  - garner information from multiple sources who frequently interact with the youngster (e.g., parents, siblings, teachers, others with important perspectives), as well as from the youngster
  - clarify differences in actor and observer attributions (e.g., youngsters tendencies to blame others, parent and teacher biases toward "blaming the victim")
  - factor in cultural considerations.

### **B. Deciding on the Focal Point for Intervention**

Children and adolescents are particularly vulnerable to adversities in their environs (e.g., home, school, neighborhood). Moreover, referrals for interventions such as therapy often are made because their behaviors are "disturbing" to those at school, home, etc., rather than a real mental health problem. This raises the challenge of determining when the primary focus of intervention should be on changing the environment that is causing the problems (e.g., working to improve family conditions, school conditions). That is, while the tendency at schools is to focus interventions on the youngster, the emphasis needs to be on deciding whether the focal point of intervention should be the youngster, the environment, or both.

### **C. Enhancing Motivation and Capability for Treatment Participation**

Since youngsters usually do not voluntarily seek treatment, enhancing their motivation to participate is a frequent challenge. In addition, when the family has been told to seek treatment, their motivation for ending therapy prematurely is a concern. Thus, major process objectives in therapy are to

- establish and maintain a good fit with the youngster and parents' initial motivation and capabilities
- enhance motivation and capability for continuing until goals have been met
- address factors that interfere with establishing and maintaining a good fit (e.g., family obstacles; strategies that rely on social control as contrasted with enhancing engagement)

### ***III. What are the advantages of offering MH services on school campuses?***

Schools clearly have a role to play with respect to young people's mental health. When it comes to offering mental health treatment at schools, advocates have stressed the following matters.

#### **A. Data Commonly Cited**

- There are nearly 50 million total enrollments in public elementary and secondary schools (National Center of Education Statistics, 2012). A Surgeon General's report claims that one in every five school-aged (9 to 17) youngsters experienced "the signs and symptoms of a DSM-IV disorder during the course of a year" (Department of Health and Human Services, 1999).
- Half of all lifetime cases of mental disorder show first onset by 14 years old (New Freedom Commission on Mental Health, 2003).
- Attention Deficit Hyperactivity Disorder (ADHD) has been reported as the most commonly diagnosed mental disorder among children, affecting 6.8 percent of children aged 3-17 years, followed by mood disorders (i.e. anxiety and depression) at 5.1 percent (Center for Disease Control and Prevention, 2013).

#### **B. Reasons Offered for Expanding Mental Health Services at Schools**

- Psychopathology (e.g., ADHD, mood disorders) and emotional problems interfere with youngster's academic performance and thus an expanded focus on such matters aligns with a school's mission to maximize academic outcomes.

- Elementary and secondary schools represent a significant portion of a child's life and are therefore effective entry points for MH treatment.
- Early onset psychopathology can be carried into adulthood with increased severity. MH treatment in schools allows for early intervention and secondary and tertiary prevention.
- Schools offer a platform for interventions that go beyond one-therapist-one-client interactions.
- Schools enable therapists to readily and naturally interact with others working with a youngster (e.g., administrator, teachers) to coordinate interventions, gather information, and monitor progress.
- Schools maintain an extensive database on past and current students regarding personal and family profiles, education history, academic performance, health condition, and much more.
- Schools have resources that can be used not only for treatment, but for screening and to enhance referrals.

***IV. When is advocacy for expanding MH services at schools counterproductive to unifying and developing a comprehensive system for addressing learning, behavior, and emotional problems?***

In contrast to those advocating for expanding MH services in schools, our Center and others have cautioned that the advocacy of such an initiative can be counterproductive for a wider agenda for mental health in schools and for the role of mental health in addressing learning, behavior, and emotional problems. The concerns raised include:

**A. Perpetuating Policy Marginalization and Increasing Fragmented Approaches**

- Advocacy specifically for expanding mental health services on school campuses contributes to the continuous advocacy for many other special initiatives. Such special initiatives always are marginalized in school policy and practice.
- Ongoing marginalization contributes to the well-recognized problem of fragmented and often redundant efforts to address barriers to learning and teaching and re-engage disconnected students.
- Fragmentation often is further compounded when community-based mental health professionals are co-located on a campus and operate in relative isolation from others at the school.

## **B. Contributing to the Tendency to Limit the term *Mental Health* to *Mental Illness***

As noted, the term mental health often, paradoxically, is perceived as referring to mental illness (i.e., diagnosable disorders).

- Advocacy for expanding mental health services on school campuses overemphasizes a focus on psychopathology and tends to push the focus for mental health in schools toward mental illness and away from promoting mental health (e.g., social and emotional development) and preventing problems.
- The overemphasis on psychopathology tends to narrow the focus to students who manifest severe and chronic problems and to diagnosable symptoms rather than root causes of problems.

## **C. Contributing to Misdiagnoses and Stereotypic Labeling**

Overemphasis on pathology leads to

- tendencies by professionals at school to attribute student problems (e.g., learning problems, conduct problems) to “stable personal dispositions” of students when many of these problems are caused by external factors (e.g., the school and/or home environment)
- tendencies by students and parents to accept (and sometime seek) misdiagnoses in order to take advantage of special academic accommodations (e.g., extra attention from instructors, extended test-taking time, additional services)

## **D. Expanding Counterproductive Competition for Sparse Resources**

Collaboration is essential to embedding a whole-person approach to mental health into schools through development of a unified and comprehensive system of student and learning supports (see Appendices A and B). Advocacy for special initiatives works against collaboration and generates counterproductive competition.

- Advocacy for mental health services on campus contributes to maintaining the overspecialization of key staff roles and functions.
- Overspecialization results in each group at a school (e.g., school psychologists, counselors, social workers, etc.) fighting for a larger share of sparse resources. The problem often is compounded when community-based mental health professionals are co-located on school campuses to provide services.
- Overspecialization works against developing the type of operational infrastructure needed to unify and develop a comprehensive system of student and learning supports).

## **E. Providing for a Small Proportion Rather than All Students**

Clearly students manifesting emotional problems need help and schools can play a role in referral and care. At the same time, many students experience factors that interfere with learning at school that do not warrant interactive mental health treatment.

- Schools must play a role in addressing a wide range of barriers to learning and teaching and do so in ways that provide for all who are affected and not just some students.
- Given the limited resource (e.g., money, space, personnel) in schools, one-on-one and even small group treatment is costly and usually draws resources away for other needs.

### **References**

**Much of the material in this outline was derived from the following major sources:**

Adelman, H.S. & Taylor, L. (2010). *Mental health in schools: Engaging learners, preventing problems, and improving schools*. Thousand Oaks, CA: Corwin Press.

Brems, C. (1993). *A comprehensive guide to child psychotherapy*. Boston: Allyn and Bacon.

Christner, R. W., & Mennuti, R. B. (Eds.) (2009). *School-based mental health: A practitioner's guide to comparative practices*. New York: Routledge.

Kazdin, A. E., & Weisz, J. R. (Eds.) (2003). *Evidence-based psychotherapies for children and adolescents*. New York: Guilford Press.

**Additional resources for specific points:**

Centers for Disease Control and Prevention (2013). Mental health surveillance among children — United States 2005–2011. *MMWR*, 62, 1-35. <http://www.cdc.gov/features/childrensmentalhealth/>

Center for Mental Health in Schools, *Schools and the challenge of LD and ADHD misdiagnoses*, Los Angeles: Author at UCLA. <http://smhp.psych.ucla.edu/pdfdocs/ldmisdiagnoses.pdf>

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## Appendix A

### **Embedding Mental Health into a Unified and Comprehensive System of Learning Supports**

Excerpt from: *Embedding Mental Health into a Learning Supports Component: An Essential Step for the Field to Take Now (Policy Alert, Center for Mental Health in Schools at UCLA)*  
<http://smhp.psych.ucla.edu/pdfdocs/embeddingmh.pdf>

The time has come for ending the counterproductive competition that arises from efforts that push separate, narrow agenda for mental health in schools. No single program or service can address the range of factors interfering with equity of opportunity to succeed at school for the large number of students affected. And the competition for resources resulting from separate advocacy for such programs and services is contributing to the continuing marginalization and resultant fragmentation of such endeavors and the fact that they reach only a small proportion of the many students who should be beneficiaries.

By defining mental health in schools as encompassing a full continuum of interventions and embedding the work into a comprehensive system of student/learning supports, policy makers can

- avoid the unrealistic and often inappropriate call for more and more one-on-one direct services
- counter the mistaken view that collocating community services on school campuses can ever be a sufficient approach to filling critical intervention gaps at schools and for enhancing community and home engagement
- better address classroom, school wide, and community interventions that can reduce the need for one-on-one services
- facilitate the weaving together of school, home, and community resources to gain economic benefits and enhance outcomes
- enhance coordination and cohesion of all resources (school, community, family) intended to support young people.

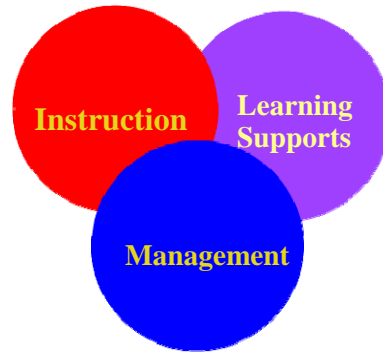
By embedding mental health into a student and learning supports umbrella concept, public education, public health, and the community at large can reduce nonproductive competition for sparse resources and do more for more students and their families

## Appendix B

### What Is a Unified and Comprehensive System of Learning Supports?\*

To enable all students to have an equal opportunity to succeed at school, schools need to be able to directly address barriers to learning and teaching. This requires elevating such efforts so that they are a third primary and essential component for school improvement.

As indicated below, the third component is called a learning supports component.



Learning supports are the resources, strategies, and practices that provide the physical, social, emotional, and intellectual supports that directly address barriers to learning and teaching, and that re-engage disconnected students.

To be most effective, learning supports are unified and then developed into a comprehensive system that provides supportive interventions in classrooms and school-wide and is fully integrated with efforts to improve instruction and management at a school.

The learning supports intervention framework combines both an integrated and systemic continuum of school and community interventions and a multifaceted and cohesive set of six content areas. The continuum is designed to

- promote positive development and prevent problems
- intervene as early after the onset of problems as is feasible
- provide special assistance for severe and chronic problems.

The continuum is embedded into the following six content areas:

- *Classroom-based approaches to enable learning* (e.g., ensuring classrooms have necessary supports and create and maintain a positive climate)
- *Support for transitions* (e.g., assisting students and families as they negotiate hurdles to enrollment, adjust to school, grade, and program changes, make daily transitions before, during, and after school, access and effectively use supports and extended learning opportunities, and so forth)
- *Home involvement and engagement in schooling* (e.g., increasing and strengthening the home and its connections with school)

- *Community engagement with schools* (e.g., outreach to develop a greater community support from a wide range of entities. This includes agency collaborations and use of volunteers to extend learning opportunities and help students-in-need.)
- *Crises assistance and prevention* (including ensuring immediate assistance in emergencies, providing follow-up care as necessary, developing prevention programs, creating a caring and safe learning environment and countering the impact of out-of-school traumatic events)
- *Student and family assistance* (facilitating student and family access to effective services and special assistance on campus and in the community as needed).

Combining the continuum with the six areas provides a matrix framework to represent a unified and comprehensive system of learning supports (see below).

**Combined Continuum and Content Arenas:  
Framework for a Unified and Comprehensive System of Learning Supports**

		Levels of Intervention		
		Systems for Promoting Healthy Development & Preventing Problems	Systems for Early Intervention (Early after problem onset)	Systems of Care
<b>Learning Supports Content Areas</b>	Classroom-based approaches to enable learning			
	Crisis assistance & prevention			
	Support for transitions			
	Home Involvement & Engagement in Schooling			
	Community Engagement with Schools			
	Student and Family Assistance			

\*For other *Brief Overviews*, see Section A of the Center’s System Change Toolkit online at <http://smhp.psych.ucla.edu/toolkit1.htm> .

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