

MENTAL HEALTH IN SCHOOLS:

EXPANDED OPPORTUNITIES FOR SCHOOL NURSES

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Introduction

There is a simple truth that every professional working in schools knows: social, emotional, and phys-

ical 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 (Dry-

foos, 1994; Tyack, 1992). 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 (see Table 1). While all students can benefit from such efforts, it is essential for those students manifesting severe and pervasive problems.

Emerging trends are reshaping the work of school nurses and other school service personnel. With respect to direct service and consultation, school nurses increasingly are called upon to deal with psychosocial and mental health problems. Beyond that, school nurses must continue to actuate their roles as advocates, catalysts, brokers, and facilitators of the type of reforms that can effectively address barriers to student learning and promote healthy development.

Continuing education is seen as key to enabling school nurses to build capacity for such roles and functions. The newly formed Center for Mental Health in Schools at the University of California, Los Angeles (UCLA) hopes to be of assistance in this respect. This presentation highlights the Center's orientation to mental health in schools and offers a draft outline for related continuing education.

Extent of Problem

Data suggest that from 12% to 22% of all children suffer from mental, emotional or behavioral disorders, and relatively few receive mental health services (Costello, 1989; Hoagwood, 1995). The picture is even bleaker when one includes those Joy Dryfoos defines as being "at risk of not maturing into responsible adults" — all those young people experiencing psychosocial problems (see Dryfoos,

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Table 1.

Nature and Scope of Student Needs that Must be Addressed **Barriers to Learning/Parenting/Teaching (beyond medical/dental needs)**

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| <p>A. Deficiencies in basic living resources and opportunities for development</p> <ul style="list-style-type: none"> • dearth of food in the home • inadequate clothing • substandard housing (incl. being homeless) • lack of transportation • income at or below the poverty level (e.g., due to unemployment or welfare status) • inadequate conditions for schooling • lack of after-school supervision for child • immigration-related concerns (e.g., limited English proficiency, legal status) <p>B. Observable problems</p> <ul style="list-style-type: none"> • school adjustment problems (incl. truancy, and dropouts) • relationship difficulties (incl. dysfunctional family situations, insensitivity to others) • language difficulties • abuse by others (physical, sexual, emotional) • substance abuse • emotional upset • delinquency (incl. gang-related problems and community violence) • psychosocial concerns stemming from sexual activity (e.g., pregnancy or STDs) • psychopathology | <p>C. General stressors and underlying psychological problems associated with</p> <ul style="list-style-type: none"> • external stressors (objective and perceived) and deficits in support systems • competence deficits (low self-efficacy/self-esteem, skill deficits) • threats to self-determination/autonomy/control • feeling unrelated to others or perceiving threats to valued relationships • personality disorders or psychopathology <p>D. Crises and emergencies</p> <ul style="list-style-type: none"> • personal/familial (incl. home violence) • subgroup (e.g., death of a classmate or close colleague) • school-wide (e.g., earthquake, floods, shooting on school grounds) <p>E. Difficult transitions</p> <ul style="list-style-type: none"> • associated with stages of schooling (e.g., entry, leaving) • associated with stages of life (e.g., puberty, job and career concerns) • associated with changes in life circumstances (e.g., moving, death in the family) |
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Note: The problems listed, of course, vary in their degree of severity (mild-moderate-severe) and pervasiveness (narrow-pervasive).

Areas of Focus in Enhancing Healthy Psychosocial Development

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| <p>A. Responsibility and integrity
(e.g., understanding and valuing of societal expectations and moral courses of action)</p> <p>B. Self-esteem
(e.g., feelings of competence, self-determination, and being connected to others)</p> <p>C. Social and working relationships
(e.g., social awareness, empathy, respect, communication, interpersonal cooperation and problem solving, critical thinking, judgement, and decision making)</p> <p>D. Self-evaluation and self-direction/regulation
(e.g., understanding of self and impact on others, development of personal goals, initiative, and functional autonomy)</p> <p>E. Temperament
(e.g., emotional stability and responsiveness)</p> | <p>F. Personal safety and safe behavior
(e.g., understanding and valuing of ways to maintain safety, avoid violence, resist drug abuse, and prevent sexual abuse)</p> <p>G. Health maintenance
(e.g., understanding and valuing of ways to maintain physical and mental health)</p> <p>H. Effective physical functioning
(e.g., understanding and valuing of how to develop and maintain physical fitness)</p> <p>I. Careers and life roles
(e.g., awareness of vocational options, changing nature of sex roles, stress management)</p> <p>J. Creativity
(e.g., artistic and intellectual inventiveness)</p> |
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1990, for estimates of prevalence by sex, age, race/ethnicity, SES, etc.; also, see Knitzer, Steinberg, & Fleisch, 1990).

The number "at risk" in many schools serving low-income populations has climbed over the 50% mark. Harold Hodgkinson (1993), director of the Center for Demographic Policy, estimates 40% of students nationwide

are in "very bad educational shape" and "at risk of failing to fulfill their physical and mental promise." Because so many live in inner cities and impoverished rural areas, or are recently arrived immigrants, he attributes their school problems mainly to conditions they bring with them when they enter school, conditions associated with poverty, difficult and

extremely diverse family circumstances, lack of English language skills, violent neighborhoods, physical and emotional problems, and lack of health care.

One impact of all this is that nationally, at least 12% fail to complete high school. In some large cities, 40% drop out. This leads to extensive negative consequences for them, their families,

and society (National Educational Goals Panel, 1994). There is growing consensus about the crisis nature of the situation. And it is widely recognized that failure to address the problems of children and schools can only exacerbate the health and economic consequences for society.

Project Background

Recognizing the crisis, the U.S. Department of Health and Human Services has launched a variety of initiatives aimed at enhancing the ability of schools to meet the needs of students and their families. One such effort focuses on mental health in schools. As part of this endeavor, two national training and technical assistance centers for mental health in schools were recently established 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. In the spring of 1996, Beverly Bradley and Keeta DeStefano Lewis, representing the National Association of School Nurses, proposed that the UCLA Center prepare materials for continuing education of school nurses. The Center agreed to do so. The purpose of this article is to highlight the type of orientation to mental health in schools that the Center intends to incorporate into all its continuing education modules.

Mental Health Intervention as Part of the Whole

An extensive literature review reports positive outcomes for children resulting from a variety of health and psychosocial interventions available to schools. This research can be characterized as promising, albeit restricted in scope. It provides a menu of "best practices" (e.g., see Bond & Compas, 1989; Brindis, Morales, McCarter, Dobrin, & Wolfe, 1993; Christopher, Kurtz, & Howing, 1989; Cohen & Fish, 1993; Dryfoos, 1990; Kirby, et al., 1994; Larson, 1994; Lewis, 1995; Lewis & Thomson, 1987; Mitchell, Seligson, & Marx, 1989; Newton, 1989; Orr, 1987; Schonfeld, 1996; Schorr, 1988; Slavin, Karweit, & Wasik, 1994; Thomas & Grimes, 1995;

Weissberg, Caplan, & Harwood, 1991; Weisz & Weiss, 1993).

Many of the reports are from narrowly focused, brief demonstrations that by their very nature could produce only limited outcomes. Still, a significant number of appropriately developed and implemented programs have demonstrated benefits both for schools (e.g., improved health, better student functioning, increased attendance, less teacher frustration), and for society (e.g., reduced costs related to welfare, unemployment, and use of emergency and adult services). Thus, the demonstrations are encouraging, and the search continues for better practices that can be widely implemented and that reflect the diverse demographics and conditions of a changing society.

Under the auspices of the School Mental Health Project, the Center for Mental Health in Schools at UCLA pursues the need for better mental health interventions in the context of moving toward a comprehensive, integrated approach to addressing barriers to learning. A comprehensive approach would encompass (a) prevention and prereferral interventions for mild problems, (b) high-visibility programs for high-frequency psychosocial problems, and (c) strategies to assist with severe and pervasive mental health problems. A comprehensive approach recognizes the roles school, home, and community life play in creating and correcting young people's problems, espe-

cially those who are under-served and hard-to-reach. From such a perspective, schools must provide interventions that address individual problems and system changes. At the same time, schools must continue to explore formal and informal ways to link with public and private community agencies.

Even more fundamentally, school and community policy must start to reflect the reality that there are three primary and essential components to be addressed in systematic reform and restructuring. As illustrated in Figure 1, these are the Instructional, Enabling, and Management components. Activities to address health and psychosocial problems are central to the Enabling Component. School-owned enabling activity — such as pupil services and the multi-components of a school health program — must be coordinated and integrated with each other and with community-owned resources. And the overlapping Enabling, Instructional, and Management components must be carried out as a cohesive whole (Adelman, 1996; Adelman & Taylor, 1994, 1997).

It is clear that there is a long way to go before a comprehensive, integrated approach to addressing barriers to learning and promoting healthy development is commonplace. Nevertheless, it seems wise to work within a context that has promise for truly meeting the needs of society rather than continuing to pursue fragmented strategies.

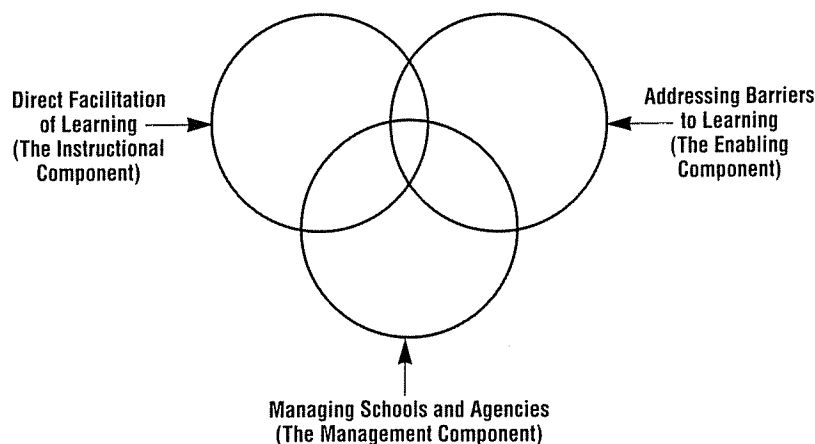


Figure 1: A three-component model for school and community system reform to minimize barriers to learning and healthy development.

Emerging Trends and New Roles

Obviously, school nurses have always played a key role in promoting health and helping students. Now, along with other school professionals, they have the opportunity and the responsibility to play an expanded and essential role in moving schools toward a comprehensive, integrated approach for dealing with barriers to learning and, in the process, enhance efforts to promote healthy development (Igoe & Giordano, 1992; Kolbe, 1993; National Nursing Coalition for School Health Nursing Services, 1995).

Emerging reforms are reshaping the work of all school professionals. Pupil services in schools are expanding and changing rapidly. Pupil service professionals are engaged in an increasingly wide array of activity, including promotion of health, social and emotional development, direct services, outreach to families, and various forms of support for teachers and other school personnel. There is enhanced emphasis on coordination and collaboration within a school and with community agencies to provide the "network of care" necessary to deal with complex problems.

Unfortunately, proliferation of health and psychosocial programs in schools tends to occur with little coordination of planning and implementation. As awareness of this deficiency has increased, major changes have been proposed. Four emerging trends are moves from

- narrowly focused to comprehensive approaches
- fragmentation to coordinated/integrated intervention
- problem specific and discipline-oriented services to less categorical, more cross-disciplinary programs
- viewing mental health programs as "supplementary services" to policy changes that recognize mental health services as an essential element in enabling learning

Each trend has implications for what goes on in schools and for the future of school nurses and other school professionals. New directions call for functions that go beyond direct service and traditional consultation. All

who work in the schools must be prepared not only to provide direct help but also to act as advocates, catalysts, brokers, and facilitators of system-wide reform. Particularly needed are efforts to improve intervention efficacy through integrating physical and mental health and social services. More extensively, the need is for restructuring of all support programs and services into a comprehensive and cohesive set of programs.

Based on analysis of existing resources and emerging trends (Adelman, 1996; Adelman & Taylor, 1997; Taylor & Adelman, 1996), it seems evident that the relatively small number of pupil service personnel available to schools can provide only a minor proportion of the direct services that are needed. The more their expertise is used at the level of program organization, development, and maintenance, the more students they can help. This leads to the view that the range of functions nurses and other pupil service specialists should perform for schools are:

- Direct service activity (e.g., crisis intervention in emergency situations; short-term assessment and treatment, including facilitating referral and case management; prevention through promotion of physical and mental health and enhancing resources through supervising professionals-in-training and volunteers),
- Resource coordination and development (e.g., organizing existing programs; integrating with instruction through inservice mentoring and consultation; interfacing with community agencies to create formal linkages; preparing proposals and developing new programs; acting as an agent of change to create readiness for system reform and facilitating development of mechanisms for collaboration and integration; providing support for maintenance of reforms; participation on school governance and planning bodies),
- Enhancing access to community resources (e.g., identifying community resources; assisting families to connect with services; working with community resources to be

more responsive to the needs of a district's students; community coalition building).

Furthermore, these three areas of function should be given priority so school-based professionals can use their time to produce the broadest impact.

Used properly, pupil service personnel can play an important role in creating a comprehensive, integrated approach to meeting the needs of the young by interweaving what schools can do with what the community offers. With continuing education, school nurses can join other mental health professionals in bringing about specialized understanding of cause (e.g., psychosocial factors and pathology) and intervention (e.g., approaching problem amelioration through attitude and motivation change and system-wide strategies). This knowledge can have many benefits. For instance, mental health perspectives of "best fit" and "least intervention needed" strategies can contribute to reduced referrals and increased efficacy of mainstream and special education programs. With respect to pre- and inservice staff development, such perspectives can expand educators' views of how to help students with everyday upsets as well as with crises and other serious problems, in ways that contribute to positive growth. Specialized mental health understanding also can be translated into programs for targeted problems (e.g., depression, school dropout, drug abuse, gang activity, teen pregnancy).

Despite the range of knowledge and skills they bring to a setting, school nurses usually are able to see only a small proportion of the many students, families, and school staff who could benefit from their efforts. This is not surprising given the relatively few nurses many school districts employ and the many roles they are called on to assume in order to accommodate changing models for delivering and financing health care (Proctor, 1993).

This lamentable state of affairs raises several points for discussion. One often discussed idea is that greater dividends (in terms of helping more people) might be forthcoming if

Table 2.

Mental Health in Schools: Outline for a Continuing Education Module for School Nurses

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| <p>I. Mental Health in School:
An Introductory Overview</p> <p>II. The Need</p> <ul style="list-style-type: none"> A. Barriers to Learning — including physical and mental health problems B. Promoting Healthy Development (physical and mental) C. Personal and Systemic Barriers to Learning <ul style="list-style-type: none"> • Psychosocial problems • Psychopathology • Environmental stressors • Student and environment mismatch D. Family Needs for Social/Emotional Support E. Staff Needs for Social/Emotional Support <p>III. Addressing the Needs</p> <ul style="list-style-type: none"> A. Understanding What Causes Different Types of Problems B. Legislative Mandates C. Clinical Approaches in School Sites D. Programmatic Approaches: Going Beyond Clinical Interventions <ul style="list-style-type: none"> • Working with classroom teachers • Systems for student and family assistance • Crises/emergencies: response–prevention • Supporting student and family transitions • Mobilizing parent/home involvement in schooling and health promotion E. Toward a Comprehensive, Integrated Continuum of Interventions <ul style="list-style-type: none"> • Primary prevention of problems (including a major emphasis on promoting opportunities, wellness, and positive physical and mental development) • Early-age interventions for problems (including prereferral interventions) • Early-after-problem onset interventions (including prereferral interventions) • After the problem has become chronic | <p>IV. Roles for the School Nurse:</p> <p>A Multifaceted Focus</p> <ul style="list-style-type: none"> A. Problem Identification, Referral, Triage, and Assistance (including helping to develop referral and triage systems) <ul style="list-style-type: none"> • Assessment • Psychological first aid • Open-enrollment programs • Information-giving and didactic approaches • Counseling • Support and maintenance of students receiving psychotropic medication B. Developing Systems for Case, Resource, and Program Coordination, Monitoring, and Management C. Collaborative Teams D. Community Outreach E. Training Aides, Volunteers, and Peers to Help with Targeted Individuals and Groups F. Providing Inservice Staff Training G. Working for Systemic Changes <p>V. Working Relationships and Cultural, Professional, and Individual Differences</p> <ul style="list-style-type: none"> A. Matching Motivation and Capabilities <ul style="list-style-type: none"> • Building on strengths and resiliency • Minimizing weaknesses, resistance, and reactance • Least intervention needed B. Support, Guidance, Accommodations, and Appropriate Limit Setting <p>Addendum</p> <ul style="list-style-type: none"> A. Getting the Right Support from the School District B. Limitations as Challenges |
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school nurses devoted their skills more to prevention. At an even more fundamental level, it seems likely that larger numbers would benefit if nurses devoted a greater portion of their time to creating a comprehensive, integrated approach for addressing barriers to learning and enhancing healthy development. For this to happen, however, there must be a shift in priorities. Specifically, this involves redeploying time to focus more on functions related to (a) coordination, development, and leadership (for example, developing and maintaining resource integration) and (b) evolving long-lasting collaboration with community resources. Given the opportu-

nity, school nurses can contribute greatly to creation of a comprehensive, integrated approach.

Conclusion

Today's trends are reshaping the work of school nurses. New directions call for going beyond direct service and beyond traditional consultation. All who work in schools must be prepared not only to provide direct help but also to act as advocates, catalysts, brokers, and facilitators of system-wide reform. Particularly needed are efforts to improve intervention outcomes by integrating physical and mental health and social services.

More comprehensively, the need is for reform and restructuring of all education support programs and services to improve the "state of the art" and provide a "safety net" of care.

One essential aspect of all this is continuing education for school professionals. Table 2 presents an initial draft of a working outline developed by the Center for Mental Health in Schools at UCLA for a continuing education module for school nurses. Your suggestions and comments are invited; please send them to: Howard Adelman and Linda Taylor, Department of Psychology, UCLA, 405 Hilgard Avenue, Los Angeles, CA 90095-1563. ●

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