Mental Health in Schools: 
A Federal Initiative

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In this article, we describe a major initiative entitled Mental Health of School-Age Children and Youth implemented in 1995 by the Maternal and Child Health Bureau's Office of Adolescent Health in the U.S. Department of Health and Human Services. Specifically, we outline the nature of the initiative, describe the two national centers and five state projects, briefly explore models developed by the state projects, and highlight some implications of the initiative.

It has long been recognized that mental health and psychosocial problems must be addressed if schools are to function satisfactorily and students are to learn and perform effectively (see Cowen, Izzo, Miles, et al., 1963; Flaherty, Weist, & Warner, 1996; Lambert, Bower, Caplan, et al., 1964; Tyack, 1992; USOE/NIMH, 1972). In recent years, an increasing number of school-based and school-linked mental health and psychosocial programs have emerged. A growing literature helps clarify the policy and conceptual bases and available data related to mental health in schools, and there is a large body of research supporting the promise of early intervention, treatment, crisis intervention, and prevention approaches implemented in schools. Such programs aim at addressing a wide variety of mental health and psychosocial problems (school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, teen pregnancy, delinquency and violence—including gang activity). They encompass efforts to help students, schools, parents, and communities establish ways to deal with emergency situations and enhance social and emotional well-being, resiliency, self-esteem, intrinsic motivation, empathy, and prosocial skills.

The nature and scope of mental health in schools varies from district to district and site to site. In large school districts, there usually is an extensive range of relevant preventive and corrective activity oriented to students' problems (including a focus on promoting mental health, minimizing the impact of psychosocial problems, managing psychotropic medication, participating in systems of care). Some programs are provided throughout a district and others are carried out at or linked to targeted schools. The efforts may be owned and operated by schools or reflect a contribution of community agencies such as community mental health centers and

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county health and social service agencies. Interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs; they may be designed for individual's, groups, or an entire class. Additional services also may be offered through school-based health centers or family resource centers.

In general, however, few schools come close to having enough resources to meet their needs for dealing with mental health and psychosocial problems. Most schools offer only bare essentials. Moreover, the topic of mental health in schools remains controversial (see Adelman & Taylor, in press-b). In addition to concerns about whether schools should offer mental health counseling programs and services have been criticized because they often are planned and implemented in an unsystematic and ad hoc fashion. As widely discussed, the ensuing fragmented and piecemeal activities are an inefficient use of limited resources (Adelman & Taylor, 1997; Adler & Gardner, 1994; Center for Mental Health in Schools, 1997; Center for the Future of Children staff, 1992; U.S. Department of Education, 1995; U.S. General Accounting Office, 1993).

An even more fundamental concern, however, is the low policy priority placed on the whole enterprise of addressing mental health and psychosocial factors that affect student learning (Adelman, 1996a, 1996b; Adelman & Taylor, in press-a). Existing programs are characterized as supplemental services, treated as a sideshow at school sites, and are among the first programs to go when budgets become tight. Despite all the discussion of problems interfering with student learning and all the emphasis on school reform, school reformers and policymakers at all levels spend little time trying to improve their approaches to addressing barriers to learning. The impact of all this, in policy and in practice, has been to marginalize all efforts related to mental health in schools. From this perspective, it is highly significant that the U.S. Department of Health and Human Services has set in motion an initiative for mental health in schools. This article outlines the nature of the initiative, describes the two national centers and five state projects established in the initial funding cycle, briefly explores key similarities and differences among the state projects, and highlights some implications of the initiative.

THE MATERNAL AND CHILD HEALTH BUREAU'S INITIATIVE

In response to increasing awareness of the need to make mental health services more accessible for the school-age population, a major initiative entitled Mental Health of School-Age Children and Youth was implemented in 1995 by the Maternal and Child Health Bureau's (MCHB) Office of Adolescent Health in the U.S. Department of Health and Human Services (Public Health Service, Health Re-
sources and Services Administration). In pursuing this initiative, the Department noted in its application guidance packet:

Recent studies indicate that approximately one in every five students in the Nation’s schools have significant mental health problems that need attention. Their problems cause pain and emotional distress, and they compromise their chances for fully using learning opportunities and for ultimately succeeding. These problems not only present challenging behaviors such as aggression and disruption, but also can cause internal turmoil through feelings such as anxiety and depression. Enhancing primary mental health resources and services for school-age children and youth will facilitate early attention for such problems and will promote preventive activity designed to reduce their prevalence. (U.S. Department of Health and Human Services, 1995, p. 16)

The purpose of this MCHB initiative is to strengthen the capacity of school-based and school-linked health programs to address psychosocial issues and mental health problems by enhancing primary mental health resources and services for school-age children and youth, including those with special health care needs. This encompasses promotion of healthy psychosocial development and primary prevention of a wide range of problems, early problem identification and intervention (including referral and follow-up), and collaboration with ongoing care for serious and chronic mental health disorders. Programs supported by the initiative are meant to assist during developmental and family crises, provide guidance to promote healthy behaviors, and address the psychosocial aspects of physical disabilities and chronic illnesses such as juvenile diabetes. They also are intended to raise levels of awareness regarding behavioral dysfunction and emotional distress, help make the academic environment sensitive and supportive, and assist in responding to challenges confronting students when disturbing events such as an outbreak of violence or a suicide impact on the school community.

Grants priorities were formulated in the request for applications as:

1. Development of infrastructure and resources to build capacity in school-based/linked programs to assure accessibility to primary mental health services for school-age youngsters. To these ends, infrastructure grants were designated as State Level Partnerships for Mental Health in Schools (e.g., partnerships among health, mental health, and education agencies).

2. Development of "state of the art" instructional materials and resources to strengthen the mental health service capacity of primary care providers for school-age children and youth—operationalized as Training and Technical Assistance Centers for Mental Health in Schools.

Stated simply, the initiative aims at enhancing availability and equitable access to mental health programs and services by influencing how schools deal with such
Mental Health in Schools

The process for accomplishing these ends is twofold: (a) state projects to demonstrate ways to foster greater interaction among various state and local agencies with the goal of improving the status of mental health in schools, and (b) national centers to contribute to related capacity building throughout the country. There is a strong emphasis on state projects facilitating comprehensive approaches by fostering coordinated school-based/linked programs that encompass multiple community resources (e.g., public health, mental health, substance abuse prevention and treatment, social service and other relevant systems). Implicit in all this is the initiative's potential to inform and advance mental health policy at all levels.

In 1995, the MCHB multiyear initiative to foster mental health in schools was implemented with five statewide projects and two national training and technical assistance centers. The two national centers are based at universities: One is housed in the Department of Psychology at the University of California at Los Angeles (UCLA) and is called the Center for Mental Health in Schools; the other is in the Department of Psychiatry at the University of Maryland at Baltimore and is called the Center for School Mental Health Assistance. The five state projects are:

- The Integrated Resource in Schools Initiative in Kentucky.
- School-Linked/School-Based Mental Health Services Project in Maine.
- State and Local Partnership for Mental Health in Schools in Minnesota.
- School Mental Health Initiative in New Mexico.
- The MCHB Public-Academic Partnership Program in South Carolina.

**Brief Description of the Two National Centers and Five State Projects**

The two national centers were created with a view to ensuring overlapping and complementary activity. The five state projects reflect a diverse set of approaches. A brief description of each follows.

**Center for Mental Health in Schools**

The UCLA center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Its mission is to improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools. Through extensive collaboration, the center works to (a) enhance practitioner roles, functions and competence; (b) interface with systemic reform movements to strengthen mental health in schools; (c) provide continuing education that fosters integration of mental health in schools; and (d) assist in establishing and maintaining infrastructure at
all policy levels to counter fragmentation, enhance collaboration, and provide training and support. These goals are accomplished through a variety of mechanisms, including (a) a clearinghouse that features specialized resources, materials, and information on mental health in schools; (b) a series of specially prepared introductory, resource, and technical aid packets and samplers on key topics relevant to specific psychosocial problems, programs, processes, and system concerns; (c) a consultation cadre; (d) print and electronic newsletters; (e) national and regional meetings; (f) a website; and (g) a series of guidebooks, including continuing education curricula guides.

Center for School Mental Health Assistance

The center at the University of Maryland at Baltimore provides leadership and technical assistance to advance effective interdisciplinary school-based mental health programs. It strives to support schools and community collaboratives in the development of programs that are accessible, family-centered, culturally sensitive, and responsive to local needs. The center offers training and a forum for exchanging ideas, and it promotes coordinated systems of care that provide a full continuum of services to enhance mental health, development, and learning in youth. The center's five objectives are to (a) provide technical assistance and consultation; (b) conduct national training and education; (c) analyze and promote discussion on critical issues; (d) gather, develop, and disseminate relevant materials; and (e) facilitate networking between programs and individuals involved in or interested in school mental health.

Kentucky

The Integrated Resource in Schools (IRIS) initiative is guided by a statewide team. The group includes 15 state or private agencies, a family representative, and four local community teams. Project goals are to (a) develop necessary groundwork and resources at state and local levels, (b) promote preventive mental health services in existing school-based or school-linked health programs, and (c) create long-term capacity solutions through state and local partnerships that address gaps and barriers to integrated delivery of primary mental health services. Four partner communities are designated as demonstration models for the state.

The project is designed to build on existing efforts of education, health, mental health, and the community to expand Kentucky's vision and skills in promoting partnerships that help children (from birth to age 7) and their families adapt to mental health stresses. To these ends, there is a focus on enhancing state and local partnerships to develop strategies that are innovative, flexible, family-responsive.
comprehensive, and results oriented. To ensure family involvement, family members are invited to take an active part in the decision-making process for their community. In addition, the IRIS initiative provides consistent statewide coordination and local decision making on behalf of Kentucky's families and children. This is done by crossing traditional agency boundaries at state and local levels and providing direction, training, and technical assistance for state agencies and the four local partner communities.

Maine

The overall aim of Maine's School-Linked/School-Based Mental Health Services Project is to develop a state infrastructure to build on and expand school-based or linked efforts to increase mental health and substance abuse services, including prevention programs, identification, early intervention, treatment, and referrals for students. Specific goals are to (a) identify various ways to fund school-based or linked services, (b) develop ways to measure effectiveness of services provided at the local level, (c) assess and improve current training activities provided for youth workers and school personnel, (d) pilot model programs that will demonstrate effective services for children, and (e) increase local implementation of school-based or linked services.

Currently the project works with six communities across the state to develop demonstration sites for school-based or linked mental health and substance abuse services. Each site is implementing a different approach to integrating services at the school—as part of a school-based health center, as part of a student assistance team model, as part of a wrap-around model, as part of a linkage to a local health center, and as part of an in-school alternative program transitioning students with significant risk factors back into the regular classroom. Another major project focus is collaborating with the state Department of Education or the Healthy Learners Initiative, which consists of implementing the Primary Mental Health Project, Inc. for grades pre-K through 3. In addition, project staff serve on various state-level policy groups related to children's mental health services and schools. A work group representing key participants, including parents and family advocacy organizations, meets on a quarterly basis to provide guidance for project implementation. The project reports to the Children's Policy Committee, which is made up of upper level managers of child- and family-serving agencies in state government.

Minnesota

The State and Local Partnership for Mental Health in Schools seeks to support academic achievement by addressing the social, emotional, and mental health needs of
children and youth. The project’s goal is to replicate statewide a framework developed and demonstrated at sites in the Minneapolis Public Schools. The model calls for strengthening the capacity of schools to address psychosocial and mental health concerns through effective implementation of internal systems, enhanced school-based and school-linked services—including interagency and community collaborations, increased funding, enhanced training for teachers, school and student support staff, and greater family involvement. All this is meant to ensure a supportive school environment where essential structures are predictable and integrated and processes are effective and respectful. Specific objectives include fostering (a) a system to establish socially and emotionally supportive school climates for all children; (b) a process to move children experiencing emotional and social stress through an organized and streamlined system of screening, assessment, support, treatment, and follow-up at school or referral; (c) a process for linking children, families, schools, and community institutions to create effective partnerships; and (d) a structure among multiple state agencies to promote positive social and emotional growth. Project staff have used their base of operations within the Minneapolis schools to create interest and develop local partnerships at seven demonstration sites.

New Mexico

The School Mental Health Initiative focuses on breaking down barriers to students’ learning, with an emphasis on meeting mental health needs. The initiative supports linkages among youth, families, schools, communities, and government agencies to create and maintain an environment in which children can learn and thrive. Specific objectives include (a) breaking down barriers to student learning; (b) increasing awareness of children’s social and emotional needs; (c) decreasing stigma around mental health issues; (d) increasing access to quality and timely screening and assessments; (e) linking systems to improve support, resources, advocacy, and assessment; (f) creating school-linked programs that are family-friendly, accessible, integrated, and comprehensive; (g) promoting culturally appropriate approaches that are strength-based; and (h) supporting local strategies that create healthy schools.

The initiative was built around three work groups comprised of families, educators, mental health professionals, child advocates, and agency representatives ranging from local providers to state departments. These work groups are as follows:

- The Advocacy, Data, and Evaluation Group, which has developed a proposal for legislative endorsement (i.e., a “Memorial”) to support state-level collaboration for improving school mental health and is also working to increase students’ access to comprehensive, quality screening and assessment.
• The Training Group, which creates assessment tools for schools to use in designing approaches to meet student needs and is also collaborating with the State Pupil Services Alliance to expand support and training for mental health professionals and other staff who work in schools.

• The Family, School, and Community Linkages Group, which emphasizes student accommodations and related training issues; integration of school and community resources; and ways to help families, schools, and communities develop systems that reduce barriers to learning.

At this time, the state has four funded demonstration sites focused on school–community collaboration and behavioral health. It also has four technical assistance sites, one primary care pilot project, eight planning grant sites, and 10 other sites that are receiving technical assistance support.

South Carolina

The MCHB Public-Academic Partnership Program was formed from a collaboration between the South Carolina Departments of Mental Health, Education, and Health and Environmental Control. The aim of the project is to increase opportunities for children and youth to be full participants in education. Specific goals are to (a) improve coordination and access to health and mental health services in school and community settings with an emphasis on coordination in rural areas, (b) develop a process that school districts across the state can use to increase access to mental health and health services, (c) involve minority college students in school health services and encourage more minority representation in school health professions, and (d) demonstrate that enhanced mental health service coordination and access for school-age children will improve other aspects of their lives.

Accomplishment of these ends involves increased coordination of service delivery by the state Departments of Mental Health, Education, and Health Services. In addition, the project is developing demonstration sites in four school districts. Local project coordinators are building community liaisons through local advisory councils that consist of parents, local school district administrators, teachers and other staff, health department staff, mental health center staff, and community leaders. School-based mental health projects are implemented in select schools to provide students with direct access to services. This project also involves college students who provide peer counseling, tutoring, and group leadership.

BRIEF ANALYSIS OF SOME KEY SIMILARITIES AND DIFFERENCES AMONG THE STATE PROJECTS

Each of the five state projects is committed to affecting state and local infrastructures that have relevance for mental health in schools. In pursuing their commit-
ment, each initiative has commonalities, but each also differs in keeping with the particular characteristics of the context in which it is functioning. With respect to major similarities, all five emphasize the importance of a continuum of coordinated and accessible programs and services that go beyond treatment of severe and pervasive disorders to encompass prevention and early intervention. They all are involved with local initiatives and development of model sites that include school—community collaboration and weaving together of resources. They all provide technical assistance and training, and all have drawn on the national centers to build their capacity for doing so. They all aim at enhancing the availability and accessibility of services as an essential facet of improving school achievement and personal well-being over the long run. Finally, they all acknowledge they have a long way to go in meeting their aims, and they point out that they are trying to do so with extremely limited resources.

Some Differences

Given the initiative’s focus on systemic change, it is relevant to note differences in each state with respect to (a) linkages with policymakers and higher education, and (b) the mechanisms used to create demonstrations for advancing the work statewide.

Linkages. Although all are concerned with interagency collaborations and institutionalizing systemic changes, each project is positioned differently for influencing policymakers, and each has different mechanisms available for advancing its agenda. Over time, it will be important to analyze whether any of the differences facilitate or hinder immediate progress and widespread and long-term impact. Examples of differences are outlined in the following with respect to linkages and the types of mechanisms an initiative is using or developing. Note that each initiative is administered by different agencies, and the agencies are at different stages of development with respect to collaboration within and among themselves. The initiatives also differ in terms of their collaboration with institutions of higher education.

From the outset, Kentucky’s initiative was designed to build on its State Interagency Council to improve coordination of services for children with severe emotional disabilities and to partner with programs established by the Kentucky Educational Reform Act (which encompasses school-based health and social service reforms). The initiative for mental health in schools is seen as a first proactive step to focus reforms on primary prevention and young children (ages birth to 7). The project is part of a coordinated effort by the Department of Mental Health and Mental Retardation Service’s Office of Prevention Education and Networking Systems, which includes two other prevention efforts targeting children—the
FIRST Project diversion program and the Governor's Youth Substance Abuse Prevention Process focusing on collaboration among partners and research-based solutions.

Maine's initiative is administered by the state Department of Human Services and is directly linked to the state Children's Policy Committee and Maternal and Child Health Program. Moreover, the initiative is part of current long-term planning being conducted by the Governor's Children's Cabinet. The project has direct ties with the University of Southern Maine and the University of Maine's College of Education.

Unlike the other four, the Minnesota initiative is administered as a joint effort between a major school district (the Minneapolis Public Schools' Health Related Services Program) and the State's Department of Health. This local demonstration is designed to inform state level policy regarding ways to restructure systems and build linkages between school and community resources to increase the capacity of schools for addressing students' social, emotional, and mental health needs.

New Mexico's initiative is administered by the Office of School Health in the Department of Health's Public Health Division and has established links with the state's Department of Education, Children, Youth, and Families Department, Juvenile Justice, as well as with the infrastructure grant for comprehensive school health funded by the Center for Disease Prevention and Control. Other state collaborative partners are Parents for Behaviorally Different Children, State Pupil Service Alliance, and New Mexico's universities. Noteworthy is the fact that the initiative is well coordinated with the Department of Education's Safe and Drug Free Schools Program. Also of great relevance is the fact that the legislature incorporated school mental health into its State Children's Health Insurance Plan. In 1998, the project generated support for a state Senate proposal enabling the Department of Health to take the lead in studying the need for and best methods of providing a statewide program for mental health in the schools.

In South Carolina, the State Department of Mental Health administers the initiative and maintains formal linkages with the Department of Education and Health and Environmental Control. The project directly assists local communities in their efforts to access funding through collaborations with business and grants from local, county, and state government (e.g., related to safe and drug-free schools, violence prevention, law enforcement). Students from postsecondary institutions play roles in all this as a result of the project's close ties to Benedict College and South Carolina State University and other 2- and 4-year colleges. The project also has links with the University of South Carolina for training, technical assistance, consultation, research, and evaluation.

Mechanisms. Each project has taken a different approach with respect to mechanisms for creating demonstrations and building capacity to sustain and repli-
cate the initiative throughout its state. Kentucky is using the mechanism of Family Resource Centers as a focal point for creating a state and local partnership to address gaps and barriers to integrated, school-based, or linked delivery of primary and preventive mental health services. Such a mechanism is seen as facilitating grassroots decision making with the family and community as the engine for system design and delivery. At the state level, the State Interagency Council’s System Change Work Group is the key mechanism for recommendations and work plans related to capacity building for the demonstrations and subsequent statewide replication. The work group aims to promote quality mental health among young children through integrated collaborative systems for prevention and early intervention. To date, the group has stressed the need to foster primary prevention and early intervention through (a) enhancing a local decision-making model that includes families, caregivers, businesses, workers, and others across the community in making decisions about services for children, families, or both; (b) stronger emphasis on state agencies as specialized support and technical assistance bodies to help local communities achieve agreed on outcomes; (c) reallocating dollars so “front line” agency personnel can pursue such activities to achieve mental health outcomes for children and families; (d) offering demographically based services that permit front line staff to serve families and children regardless of ability to pay or meet eligibility criteria; (e) blending roles and responsibilities and promoting enhanced communication among top agency personnel to encourage greater local flexibility in using existing funds; (f) drafting policy and regulations for rewards and incentives to encourage state and local agency collaboration in working for children and their families.

Initially, the Maine project staff established statewide teams as mechanisms to clarify needs and recommend actions. Then, six communities were designated as places to develop demonstrations of different approaches to enhancing mental health services. Project staff assist each community’s efforts, and a work group made up of representatives of key participating groups (designated as stakeholders) meets quarterly to provide guidance. Project staff report to the Children’s Policy Committee, which is made up of upper level managers of child- and family-serving agencies in state government. Project staff also serve on state-level policy groups that include a focus on mental health services and schools.

In Minnesota, project staff have embedded their efforts for addressing social and emotional concerns into the school district’s agenda by adopting an approach called School Engagement: Building Assets and Addressing Barriers to Learning. This approach focuses on school reform and includes direct links to several ongoing initiatives that have mechanisms in place, such as the project for coordinated school health. To pave the way for state-level use of the demonstrations, project staff who work for the state’s Department of Health are collaborating with other state-level agencies to create interest and identify existing mechanisms that may be of use in developing state-level support for widespread replication.
To support and guide their efforts, New Mexico’s project staff created state work groups focusing on advocacy; training; and family, school, and community linkages. Using recommendations and ideas developed by a statewide planning forum on safe schools, the school mental health initiative offered support for innovative and accessible school-based programs (schools and communities working collaboratively). These programs were seen as demonstrating a mechanism for addressing behavioral health needs of children as part of the school and community’s overall goals of reducing barriers to learning. Funded sites have advisory councils to ensure input from children, youth, parents, teachers, school administrators, and community participants. With a view to enhancing resources to sustain and expand the initiative, project staff work directly with the state’s elected officials (the Governor’s office and the legislature) and are pursuing strategies to garner a share of existing funding streams (e.g., Medicaid managed care, federal block grants, juvenile justice grants, the Children’s Health Insurance Program). They also intend to enhance coordination with special education, systems of care initiatives, statewide “accommodation” programs (related to Section 504 of the Rehabilitation Act of 1974), initiatives for safe and drug-free schools, school-based health centers, coordinated school health programs, and so forth. A major priority has been statewide training (e.g., on school health, substance abuse, student accommodations, grant writing).

South Carolina uses a State Advisory Council to coordinate a plan for collaboration and implementation of the demonstrations in four school districts. Special attention is given to improving coordination between the state’s Departments of Health, Mental Health, and Education with respect to school-based mental health and health services for school-age children and their families. This mechanism has identified barriers to services and ways to overcome these barriers at state and local levels. Among the matters identified and addressed are policy and procedural concerns raised by collaborative ventures—including concerns about providing adequate information to consumers, appropriate consent forms, sharing of essential information, maintaining confidentiality where necessary, and so forth. The Council also has been instrumental in providing training for project sites. Local project coordinators for demonstration sites are establishing collaborative mechanisms to enhance coordinated services. This includes forming service teams with school support service staff and ensuring stakeholder input by creating advisory teams. Project staff have developed contracts with historically Black colleges and universities and other local colleges to involve student interns as tutors, mentors, role models, and interveners who provide recreational activities, presentations, and special assistance. Project staff also help develop access to previously unavailable community resources such as Boys and Girls Clubs, recreation centers, health care, after-school and summer enrichment programs, and youth enterprise development.
THE COMPLEMENTARY ACTIVITY OF THE TWO NATIONAL CENTERS

From their inception, the two national centers were designed as complementary and overlapping entities. Each is committed to providing training, technical assistance, and other activity related to advancing the state of the art with respect to mental health in schools. To aid knowledge diffusion, the centers gather and develop resources and are creating mechanisms for widespread distribution of information and materials. Among the currently available resources are (a) documents that provide basic facts and information, references, and samples of materials; (b) center-developed resource and technical aids, guidebooks, and continuing education modules; and (c) reports on key topics generated by expert panels. The centers have created a range of mechanisms to foster communication, networking, and support. These include clearinghouses, consultation cadres, websites, print newsletters, electronic news reports, and national and regional conferences and workshops. To foster distribution and use of resources and to enhance training and technical assistance, formal linkages have been developed with other centers and clearinghouses and a host of organizations, especially associations connected with school nurses, school psychologists, and other personnel working in schools. In addition, both centers are directly involved with school-based programs, reform initiatives, and organizations and projects that pursue agendas relevant to school mental health and psychosocial concerns. This work has led to a variety of conceptual and empirical publications aimed at advancing the status and quality of mental health activity in schools.

Examples of how the centers complement each other are seen in the ways they convene professionals. The center at the University of Maryland at Baltimore has created a major annual national conference dedicated to advancing school mental health. The center at UCLA initiates and collaborates with other organizations on regional and national invitational meetings designed to advance strategic objectives. These objectives include developing and implementing strategies for advancing policy and practice: restructuring education support programs and student support services; and developing comprehensive, multifaceted, and integrated approaches to address barriers to learning and enhance healthy development.

Another example of complementary activity is seen with respect to needs assessment and resource mapping. The Baltimore-based center focuses on clarifying the mental health needs of students and identifies the services schools provide for meeting needs. These data are circulated through reports and articles designed to foster the concept of expanded school mental health services. The center at UCLA focuses on clarifying policy considerations that result in fragmented and marginalized approaches to mental health in schools. This includes identifying policies that interfere with intra- and interagency collaboration and school-comm
Community partnerships, clarifying gaps in current policy, and highlighting the need for policy cohesion.

CURRENT STATUS OF THE INITIATIVE

On March 7, 1998, a summit was held in Washington, DC, to review initial progress of the MCHB initiative for mental health in schools, explore lessons learned, and do some problem solving and planning for the future (Center for Mental Health in Schools, 1998). In attendance were professionals from each of the five states involved in the initiative, the directors of the two national centers, and representatives from national organizations with interest in the work.

Immediate Contributions

Four areas were discussed related to strengthening the capacity of school-based and school-linked programs to address psychosocial issues and mental health problems: (a) development of a leadership pool, (b) the role of the demonstration models, (c) policy analysis, and (d) resource development. Some key examples of progress are highlighted briefly in the following sections.

Development of a leadership pool. A key element in the ultimate success of the MCHB initiative for mental health in schools is development of a strong cadre of leaders who are knowledgeable about effective models for pursuing mental health in schools and about how to effect systemic changes that involve schools. Such leaders are needed to provide guidance and support at all levels of policymaking and program planning, implementation, and evaluation.

By implementing the initiative for mental health in schools, MCHB has brought together a core of leadership to whom the Bureau, the Department of Health and Human Services, and others across the country can turn for policy guidance, technical assistance, and training related to enhancing school-based or linked mental health activity. Currently, each state initiative is providing on-the-job leadership training for groups of individuals who can play a leadership role in and outside their states. Both national centers also are carrying out training and providing technical assistance designed to build leadership capacity. In addition, they have begun the process of identifying and increasing the visibility of a large cadre of individuals with relevant expertise and are helping to build networks among many key individuals and organizations across the nation who want to enhance mental health in schools.
Models that can inform and act as catalysts. At each step of the way, the MCHB state initiatives are learning from each other and from others around the country. The state initiatives and the national centers are clarifying models for policy, infrastructure, operational prototypes, and specific practices that can guide others. The work also is playing a catalytic role in creating readiness and expanding perceptions of how school mental health connects with other initiatives.

Many entities already have drawn on the work. These include policymakers and practitioners involved in (a) federal and state efforts related to school-based health centers, coordinated school health programs, safe and drug-free school planning, and behavioral initiatives; and (b) school districts and specific school sites. The work also has found its way into the continuing education efforts of national and state professional associations and guilds, including the American Psychological Association’s (APA) program for psychology in the schools, the National Association of School Psychologists, and the National Association of School Nurses. If the current pattern continues, the state projects and national centers are likely to expand their involvements at an exponential rate.

Policy analysis. The experiences in each of the five states and in other sites around the country are providing invaluable data for understanding policy associated with mental health in schools. Thus, this MCHB initiative is creating a unique opportunity to analyze and clarify the status of policy at federal, state, and local levels. Policy analyses so far suggest that initiatives for mental health in schools are hampered because (a) prevailing policy assigns a low priority to efforts to address health and social concerns in schools; (b) there is no explicit policy framework supporting establishment of comprehensive, multifaceted, and integrated approaches for addressing barriers to development and learning; and (c) there is a lack of cohesion in existing policies that results in categorical funding and piecemeal programs and services.

Resource development. As noted earlier, the state projects provide training, technical assistance, and resource development within their respective states. In response to needs identified by the state projects and other school mental health initiatives, the two national centers continuously gather and develop a variety of resources and provide training and technical assistance and knowledge diffusion across the country.3

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3For the UCLA Center, see their website (http://smhp.psych.ucla.edu); for assistance, use e-mail smhp@psych.ucla.edu or call (310) 825-3634. The Center for School Mental Health Assistance maintains a toll-free telephone number for assistance, (888) 706-0980 and a website (http://csma.ab.umd.edu). For updates on the Maine project, see its website (http://www.muskie.edu/smhp).
Lessons Learned to Date

Most of the fundamental lessons learned to date are those commonly cited in the systemic change literature. Chief among these are that progress is dependent on developing a critical mass of supporters (including families and students), intensive and continuing capacity building, and prototype demonstrations that show results. Of course, there are also the perennial concerns about funding. The projects continue to find that support for mental health is extremely limited and mainly budgeted for the most severe and pervasive problems. This maintains the type of categorical emphasis that makes it difficult to reduce service fragmentation and marginalization and yields few incentives for creating prevention and early identification programming.

Building a critical mass of support for the initiative. Because efforts to pursue mental health concerns are fragmented and marginalized, initiatives to enhance mental health in schools must use sophisticated strategies to enlist support from a critical mass of stakeholders—including key policymakers. This is especially important given the many concerns associated with mental health and psychosocial problems and interventions and how such matters relate to the mission of schools. Once attained, policy support must be communicated widely in a highly visible manner. Strategies must be built around the view that the initiative can play a major role in helping schools be more effective in achieving their educational mission.

Leadership that has time and commitment and is accountable. Because of their complexity, any initiative for mental health in schools requires a sufficient cadre of leaders who are committed to its adoption and can devote full time to pursuing systemic change in a relentless manner. They must be equipped and ready to counter the stigma-related fears and the denial that so often are associated with mental health and psychosocial problems. They must also be able to make the case for how school-based programs to deal with such problems are essential to schools fulfilling their educational mission. At the same time, policymakers must ensure that such leaders are not impaired by timetables that are unrealistic and judgments of progress that use accountability criteria that are unreasonable.

Appropriate support for capacity building. Because of the complexity of systemic change, progress is hindered significantly by insufficient support for capacity building of the leaders and those they enlist in planning, implementing, and evaluating the initiative.
Prototype demonstrations and evidence of positive impact. Initial progress is slow when capacity-building activity cannot draw on prototype models and evaluation to clarify effective processes and concretely show positive impact. Subsequent replication depends on an initiative's ability to establish compelling and effective demonstrations and use them in ways that enhance stakeholder interest and commitment.

MOVING FORWARD

Taken as a whole, the MCHB initiative for mental health in schools is building a foundation that should yield a variety of long-term benefits. It is expanding the pool of leaders and resources and establishing models that can inform and catalyze. It also is providing a new focal point and a catalytic opportunity to enhance mental health in schools by linking various initiatives in which states and localities are engaged. For example, a component for mental health is encompassed in the efforts by the Centers for Disease Control and Prevention (CDC) to establish coordinated school programs in every state (Marx, Wooley, & Northrop, 1998). Several states involved in the MCHB initiative for mental health in schools have infrastructure grants related to CDC's initiative. Some of these states are proposing steps to integrate these overlapping initiatives (perhaps starting with a national summit at which all the CDC infrastructure states meet with representatives of state departments of mental health for a strategic planning session). As another example, the Department of Health and Human Services has established partnerships with several professional associations including the APA. Such partnerships provide formal mechanisms for exploring ways to link APA's various initiatives for psychology in schools with those of the Department and with those pursued by other associations.

In a similar vein, special education's move toward inclusion provides many opportunities at the federal, state, and local levels for integrating overlapping initiatives and enhancing linkages among the agencies shaping how mental health activity plays out in schools. For instance, such concerns are part of efforts at all levels of policy and practice aimed at developing systems of care in ways that embrace schools, and the complementary moves to improve strategies for appropriately including more special education students in regular classrooms. States such as New York have passed legislation for local school-community collaboration to maintain children in the least restrictive educational placement and develop preventive mental health services designed by families, school staff, and community leaders. New York's state education and mental health partnership reflects the public policy concern with reducing the high cost of neglecting problems until they require expensive, often ineffective treatment. Each of the MCHB projects for mental health in schools provides opportunities to work with community men-
tal health centers and other agencies involved with systems of care to foster an emphasis on systems of prevention and early intervention.

Mental health also is a major concern in the more than 1,000 school-based health centers around the country and, relatedly, is part of the Robert Wood Johnson Foundation’s Making the Grade program, which works with states to promote the increased availability of school-based health services. More basically, every school in every state continues to draw on various resources to address mental health and psychosocial concerns such as school avoidance, school violence, substance abuse, physical and sexual abuse, intrapersonal and relationship problems, dropouts, and so forth. Clearly, the time has come for enhancing the ways such concerns are addressed, and the MCHB initiative’s broad focus on school-based and school-linked programs provides a context for doing so.

At this stage of development the federal initiative for mental health in schools not only requires a great deal of nurturing, it needs to function within a cohesive policy context. For example, within the U.S. Department of Health and Human Services, the initiative would benefit from enhanced coordination among all those trying to involve schools in addressing health and psychosocial agendas. A good starting place would be to explore opportunities for linking related initiatives such as this MCHB initiative for mental health in schools, CDC’s initiative for coordinated school health programs, the work of the Center for Mental Health Services, and that of the new Center for School-Based Health Care.

Finally, anticipating positive evaluation data on the efficacy of the demonstrations, MCHB needs to start the process of formulating a scale-up initiative to foster widespread adoption of mental health in schools. In doing so, it will be important to review the status of policies related to children’s mental health to identify where limited funding can pay the greatest dividends. It also will be essential to capitalize on the lessons learned from the many other efforts to replicate widespread systemic changes in schools. Ultimately, the long-term value of the current initiative rests with a successful scale-up strategy.

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For more information on state actions related to mental health in schools, see Adolescent Health Issues: State Actions, published each year by the National Conference of State Legislators, 1560 Broadway, Suite 700, Denver, CO 80202. This resource provides a summary of every act that was passed during a particular year related to mental health, school health, and school-based health services.
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