Lessons Learned From Working With a District’s Mental Health Unit

Although schools are not in the health business, it is evident they must address mental health and psychosocial concerns whenever such matters interfere with students’ learning. From this perspective, mental health in schools is not some extraneous and separate agenda, but rather an integral facet of achieving the educational mission. A comprehensive, multifaceted, and integrated component for addressing barriers to learning and enhancing healthy development (Adelman & Taylor, 1993, 1999; Taylor & Adelman, 1996) is needed that embeds mental health in a continuum of interventions, ranging from systems for positive development and prevention of problems, systems of early intervention to address problems as soon after onset as feasible, and systems of care for those with chronic and severe problems (see p. 261).

Given the need to focus on mental health, the question shifts to how schools and school districts should understand and pursue mental health. This article shares a personal perspective on school mental health through a discussion of the ways that schools currently address mental health, an example of advancing such work through a school district mental health unit, and reflection on some important lessons learned. Our intent is to stimulate thinking about ways to enhance mental health in schools.

Range of Delivery Mechanisms and Formats for Providing Mental Health in Schools

What does providing mental health in schools mean? Ask five people and you will probably get five different answers, based largely on the respondents’ personal experiences. As outlined in the Appendix, analyses of initiatives across the United States suggest that five delivery mechanisms are used to provide mental health programs/services in schools (Policy Leadership Cadre for Mental Health in Schools, 2001). These mechanisms vary in format and differ in focus and comprehensiveness, but they are not necessarily mutually exclusive. The focus may be on treatment of mental health and psychosocial problems, prevention of such problems, or promotion of mental health (e.g., healthy social and emotional development). In terms of comprehensiveness, the emphasis may be mainly on providing clinical treatment and/or providing a referral. Or, the intent may be to develop a full continuum of programs and services to promote positive development, prevent problems, respond as early after onset as is feasible, and offer treatment (Adelman & Taylor, 1998a).

Most school districts employ student support or “pupil services” professionals, such as school psychologists, counselors, and social workers. These personnel perform services connected with mental health and psychosocial problems (including related services designated for special education students). The format usually is a combination of centrally based and school-
based services (Adelman, 1996; Adelman & Taylor, 1997).

Increasingly, schools have developed connections with community agencies. Whether initiated by the community or the school, this delivery mechanism is intended to increase access to mental health services and, in some formats, to enhance coordination among services provided to students and their families (Taylor & Adelman, 2000a).

Most schools include, in some facet of the curriculum, ways to enhance social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems, such as behavior and emotional problems, school violence, and drug abuse. Mental health is incorporated into schools through general instructional processes and special assistance strategies. Teachers who are sensitive to the importance of promoting social and emotional development can integrate such a focus seamlessly into their daily interactions with students.

A few school districts have begun to reconceptualize the fragmented approaches to addressing barriers that interfere with students' learning. They are starting to restructure their student support services, weave them together with community resources, and integrate them with instructional efforts that promote healthy development. By moving toward comprehensive, multifaceted, and cohesive approaches, these initiatives aim at bringing an end to the marginalization of education support programs and services (Adelman & Taylor, 1998b, 1999, 2000a, 2000b; Taylor & Adelman, 2000b).

As discussed in the following section, a few school districts have a multidisciplinary mental health unit providing interventions for students and families and resources for schools. The format for this tends to be centralized clinics that provide outreach, and that offer direct services and consultation for school staff.

**A DISTRICT MENTAL HEALTH UNIT: A RARE AND MAJOR OPPORTUNITY TO ADVANCE MENTAL HEALTH IN SCHOOLS**

Although district mental health units are rare, almost unique, entities, two major examples can be found in Memphis, Tennessee, and in Los Angeles, California.

The unit in the Memphis City School District, in operation since 1969, is staffed primarily by school psychologists and social workers organized into teams. Staff from three satellite centers rotate through each school in the district on a regular basis. The centers offer a variety of clinical and consultation services in support of school programs. Their primary functions are to offer psychological evaluations, counseling and therapy, services for abused/neglected children, school-based alcohol and drug abuse prevention efforts, homemaker services, staff development, parent study groups, and compliance/reporting/record keeping. (See Paaola, Hannah, & Nichol, 1989, for more information about the history and functioning of this unit.)

The mental health unit in the Los Angeles Unified School District (LAUSD) began in 1929, when the district's Assistant Medical Director added mental health professionals to school health centers operated jointly by the Board of Education and the Parent Teacher Association (Sellery, 1973). In 1945, the mental health component was augmented by the school board's creation of child guidance teams at clinic sites funded by the PTA. Currently, the mental health unit offers direct mental health services for any of the district's 720,000 students through school referrals to one of three clinics. These are staffed by psychiatric social workers, clinical psychologists, psychiatric nurses, and child psychiatrists, who work closely with school-based support service staff and with teachers and administrators. Direct services include psychiatric and psychosocial assessments; individual, group, and family counseling and therapy; case management; and crisis intervention. Students are referred by district staff (teachers, support services, administrators). While no direct fees are charged, some cases involve third-party reimbursements. (Through an interagency contract, the unit is reimbursed for Medicaid eligible clients as a MediCal certified child psychiatry outpatient clinic and a Los Angeles County Department of Mental Health contract provider.)

The clinics also work closely with school psychologists to assess eligibility for special education programs of students who may be designated as emotionally disturbed. This process involves a review of the school's assessment and an interview done by a psychiatrist, leading to a report that guides eligibility decisions and helps in formulating the Individualized Education Plan (IEP). Other unit functions include administrative responsibility for the training and operation of all district level crisis intervention teams and involvement in program development and demonstrations projects. Recently, the clinics have participated as sites for research designed to move empirically supported treatments from the laboratory to working clinics.

Through our work with the LAUSD School Mental Health Unit over the past 15 years, we have learned a great deal about more effectively providing mental health to students. We see such a unit as playing a key role in advancing the agenda for mental health in schools by improving delivery of mental health services, including response to crises; enhancing prevention and early intervention; and stimulating major program development and systemic change. Although the context for this presentation is a district-wide unit, it should be apparent that most of what is discussed can be applied to the work of any group of mental health-oriented school professionals and their community partners.
Improving Delivery of Mental Health Services and Responding to Crises

While programs and services in a school district tend to expand and contract due to budget constraints, administrative vision, and new initiatives, the LAUSD mental health unit maintains a stable core of activity in providing child guidance services. The majority of counseling referrals are for elementary school-age boys, and are related to mild emotional, learning, and behavior problems. Special education students usually see therapists privately through their health plans, and/or they receive counseling at school as part of their IEP.

The advantage of providing counseling services at district-owned clinics and at school sites is the increased likelihood that a greater number of families will follow through on referrals (especially when services are offered free). Referral to LAUSD mental health clinics begins with school-initiated referral forms mailed to the clinics, after which appointments are offered to families (by mail, with phone follow-up). Despite varying intake procedures (e.g., individual intake, group orientation intake), the follow-through rate is fairly consistent: about 50 percent of referred families come for at least one appointment. This is a respectable rate of follow-through compared to referrals to community clinics. At the same time, we must recognize the widely known fact that in school districts offering mental health services the number of referrals for mental health counseling far exceeds the resources available. Efforts to deal with this problem and maximize cost-effectiveness (e.g., offering group therapy for students and families, limiting services to brief therapy sessions, referring students with severe problems to more appropriate agencies) only underscore schools’ inability to meet the needs of the many.

The concern about meeting the needs of the many dramatically rises in relation to crises and disasters—for example, earthquakes, civil unrest/riots, and school violence. The district’s mental health unit plays a leadership role in forming a centralized crisis team; it trains and supports school-based teams (consisting of support service personnel, teachers, and administrators) to ensure quick response, needs assessment, and follow-through. What has become evident is that relatively few students need individual counseling following a crisis. What the majority need, and what constitutes the least disruptive intervention, are school-based support programs. These intervention programs are, in most cases, the appropriate response, enabling students to recover and refocus on learning quickly and effectively.

Enhancing Prevention and Early Intervention

Over the years, many families referred to the LAUSD clinics have expressed reservations about their child’s need for mental health services and their frustration with the focus on the child, rather than on how the school can address problems in better ways. Parents often are convinced, as are many staff, that greater attention should be paid to prevention, and to early intervention after the onset of problems, in order to minimize problems and stem the tide of referrals for clinical counseling.

The pressure to meet the needs of the many, the similarity of problems for which students are referred, and the limited effectiveness of individual counseling all underscore the importance of establishing school-based prevention and pre-referral interventions. Toward these ends, some mental health unit staff have tried to develop a strong feedback link to the referrers (including teachers and principals), using each specific case as a way to stimulate the school’s attention to prevention and early intervention (e.g., more structured playground programs, more resources in classrooms to assist students and teachers, implementing a welcome program for new students and families, etc.). School personnel also need instruction on how to reallocate existing resources to underwrite such activities (e.g., shifting the focus of case-oriented teams from individuals to programs that can prevent common problems; using Title I funds to hire staff for pre-referral interventions).

Program Development and System Change

Having a within-district mental health unit provides a pool of experts who can readily work with district decision-makers and planners to help conceive and develop programs. When mental health personnel are part of the planning, they ensure that new programs include appropriate mental health facets and staff. LAUSD has followed this procedure with mainstream programs such as children’s centers, early behavioral interventions, at-risk student interventions, the early mental health initiative, and the Immigrant Assistance Center. In partnership with special education, the mental health unit was able to expand delivery of school-based counseling services prescribed in IEPs, and to include mental health staff in emerging preschool assessment and intervention programs. An organized mental health presence can have a powerful impact by integrating a focus on promoting healthy development and addressing barriers to learning into a school district’s instructional and management components.

The mental health unit also has facilitated efforts related to school-linked services and coordination of resources for children and families. For example, unit staff have gathered and provided information on existing resources, and have discussed ways for community agencies to fill gaps in program availability and type. The unit also has helped work through agreements (memoranda of understanding) with community agen-
cies to clarify matters such as fee and confidentiality guidelines, and has provided a mechanism for troubleshooting. By representing the district in various community efforts to coordinate resources and establish partnerships and collaborations, the unit's staff learns more about other child-serving systems in the area, and provides information to community partners about the wealth of school system resources for counseling and supporting children and families.

Finally, we note that the unit has established very productive relationships with local colleges and universities. Students in professional programs, such as social work, counseling, and school psychology, are able to do clinical internships under the supervision of the unit staff. Intervention researchers are able to test the practical effectiveness of laboratory-developed interventions. In the process, district staff become informed of empirically supported intervention efforts, and university researchers experience the complexities of moving interventions into the broader community.

**Opportunities Taken and Lessons Learned**

Although brief connections with university training and research can be of value, much greater benefits are attained through a sustained district-university partnership, as has been illustrated over the past 15 years through the link between the LAUSD School Mental Health Unit and the School Mental Health Project in the psychology department at the University of California, Los Angeles (UCLA). This connection enabled us to evolve and demonstrate interventions to initiate and sustain systemic changes designed to enhance prevention, early intervention, and treatment.

**Broadening the View of Mental Health in Schools**

The partnership initially focused on two grant-funded, time-limited projects. One was school-based and focused on kindergarten and 1st-grade students already experiencing learning, behavioral, and emotional problems at school. Funded by the U.S. Department of Education for an 8-year period, the 24-school initiative quickly highlighted the need for systemic changes, rather than a few “band-aid” interventions. Thus, we began to focus on learning how to use such a project as a platform from which to restructure the safety net of support services and compensatory education programs at schools across the district (Adelman & Taylor, 1991a). During this same period, school-based health clinics funded by the Robert Wood Johnson Foundation were introduced in the district. We were able to use this as an opportunity to establish a university-based project with a national focus on enhancing the mental health facets of such centers (Adelman & Taylor, 1991b).

In that early project work, we quickly learned that schools have a wealth of personnel, services, and programs for addressing barriers to learning and promoting healthy development. Yet, these personnel and programs are highly fragmented and marginalized, rendering them less effective than they might be and putting them in competition for funding (and vulnerable to termination when funds are tight). Therefore, we steered our efforts toward new directions—reforming and broadening intervention models and frameworks, clarifying policy, and defining infrastructure mechanisms to capitalize on the system’s assets and address problems in ways that enhance intervention effectiveness at school sites (Adelman, 1996; Adelman & Taylor, 1997, 1998a, 1998b, 1999).

**Working for Systemic Change**

One of our first strategies was to develop the concept of a school-based, resource-oriented team, and then train change agents to develop such teams and facilitate related systemic changes (Rosenblum, DiCicco, Taylor, & Adelman, 1995). This action in turn created two major infrastructure mechanisms for working on system-wide changes. By establishing a resource-oriented team at a school, we put in place a key element for mapping, analyzing, setting priorities, redeploying resources, and stimulating program development. The change agent, or “organization facilitator,” provides the school with the capacity to establish and train the team and assist with subsequent systemic changes and program development.

As a catalyst for system-wide change, we decided to use a special commission of community and district leaders to conduct an analysis of education support programs, personnel, and services throughout the district (Blue Ribbon Commission, 1994). In organizing the commission, we worked through the district’s School Mental Health Unit to gain the district superintendent’s endorsement. The commission’s recommendations were instrumental in efforts to restructure education support services. One immediate result was the appointment of a district-wide leader (an association superintendent for health and human services) who was charged with working toward reducing fragmentation of services, and ensuring that programs and services were enhanced at each school. In turn, this led to development of a system-wide restructuring plan (LAUSD, 1995) and establishment of a special school board subcommittee to focus specifically on policy and fiscal matters related to health and human services (Center for Mental Health in Schools, 1998).

The restructuring of student health and social services occurred while the district was reorganizing into complexes (i.e., high school feeder patterns). This provided an opportunity for us to push for scaling up resource-oriented infrastructure mechanisms to en-
hance resource coordination. The district decided to form a Resource Coordinating Council for each complex, which would map and analyze resources that could be shared across schools and reach out in a coordinated way to the community when gaps were identified. These councils were expected to include at least one representative from each school in a neighborhood and from service providers who were linked to those schools. Using the organization facilitator, the district formally created such a staff position and trained a cadre of multidisciplinary support service personnel to assume these positions in each complex. Their functions are to establish the essential infrastructure for improving service coordination, enhancing economies of scale, and moving toward more comprehensive, multifaceted approaches for addressing barriers to student learning and promoting healthy development.

The work described above has benefited both the school district and the work of the School Mental Health Project (SMHP) at UCLA. The sustained district-university partnership enabled us to demonstrate ways to enhance existing interventions, expand the focus on mental health in schools, help clarify the necessity and potential for integrating such a focus into the fabric of schools, and evolve approaches for systemic change. It also laid the foundation for us to do even more to advance the field.

Moving On: The National Center for Mental Health in Schools at UCLA

In 1995, the SMHP received funding from the U.S. Department of Health and Human Services (Public Health Service, Health Resources and Service Administration, Maternal and Child Health Bureau, Office of Adolescent Health) to become one of two national technical assistance and training centers for mental health in schools. In 2000, the Center was funded for a second five-year cycle (with additional funding from the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services). The goals of the Center are to: 1) enhance availability of and access to resources to improve and advance mental health in schools, 2) increase the capacity of systems/personnel, and 3) expand the role of schools in addressing mental health, psychosocial, and related health concerns.

In addition to providing technical assistance and training related to mental health in schools for professionals across the country, we currently have working relationships with many states and with numerous local school districts and agencies. Some are trying to develop comprehensive system and program models that group mental health and psychosocial concerns under the umbrella of addressing barriers to student learning, and in ways that integrally connect with school reform. We also are providing support for advancing understanding of how to sustain and scale up new approaches. Through face-to-face interactions in locales across the United States, we have learned more about the common problems and barriers facing students, families, and school systems in reaching positive outcomes. We have extracted and shared many more lessons through the Center’s array of activities. In addition, by helping build networks of major organizations and centers, we are encouraging greater policy cohesion and shared use of resources, thereby reducing redundancy and applying sparse resources more efficiently (e.g., to fill existing gaps in technical assistance and training related to mental health in schools). And we have produced a host of resource materials, guidebooks, continuing education modules, and more, and made them and other information readily accessible on the Internet (http://smhp.psych.ucla.edu) and through inexpensive hard copies. These materials are providing school staff, administrators, and community partners with information and resources tailored to their busy schedules and specific needs.

Over time, all of these efforts are designed to help counter marginalization and fragmentation within school districts, at school sites, and in health and social service agencies, and to enhance collaboration between school and community programs. We believe that school reform models will be expanded as more professionals involved in reform understand the key role a comprehensive, multifaceted continuum of programs and services plays in addressing barriers to learning and promoting healthy development. Then, schools finally will be able to fulfill the dream of leaving no child behind.

References

Appendix. Delivery Mechanisms and Formats

The five mechanisms and related formats are:

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

2. **School District Mental Health Unit** — A few districts operate specific mental health units that encompass clinic facilities and that provide services and consultation to schools. Some others have started financing their own school-based health centers featuring mental health services. The format for this mechanism tends to be centralized clinics with the capability for outreach to schools.

3. **Formal Connections With Community Mental Health Services** — Increasingly, schools have developed connections with community agencies, often as the result of the school-based health center movement, school-linked services initiatives (e.g., full-service schools, family resource centers), and efforts to develop systems of care (“wrap-around” services for those in special education). Four formats have emerged:
   - Co-location of community agency personnel and services at schools, sometimes in the context of school-based health centers and partly financed by community health organizations.
   - Formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center.
   - Formal partnerships between schools and community agencies to establish or expand school-based or linked facilities that include provision of mental health services.
   - Contracts with community providers to provide needed student services.

4. **Classroom-Based Curriculum and Special “Pullout” Interventions** — Most schools include a focus on enhancing social and emotional functioning in some facet of their curriculum. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. And, of course, special education classrooms should always be focused on mental health concerns. Three formats have emerged:
   - Integrated instruction, as part of the regular classroom content and processes.
   - Specific curriculum or special intervention implemented by personnel specially trained to carry out the process.
   - Curriculum approach, as part of a multifaceted set of interventions designed to enhance positive development and prevent problems.

5. **Comprehensive, Multifaceted, and Integrated Approaches** — A few school districts have begun the process of reconceptualizing their piecemeal and fragmented approaches to addressing barriers that interfere with students’ academic success. They are starting to restructure their student support services and weave them together with community resources, integrating them with instructional efforts that support healthy development. Doing so provides a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early as onset as is feasible, and offer treatment regimes. Mental health and psychosocial concerns are a major focus of this continuum. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care, as well as by the growing movement to create community schools. Three formats are emerging:
   - Mechanisms to coordinate and integrate school and community services.
   - Initiatives to restructure student support programs and services and integrate them into school reform agendas.
   - Community schools.