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Toward a Comprehensive Policy Vision for Mental Health in Schools

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The process of developing formal policy is political and related to the enactment of laws, regulations, and guidelines. By way of contrast, informal "policies" emerge because of the way people in institutions pursue daily actions. These take the form of routines, customs, rules, and other regularities that determine what is and is not done in a setting, and those that endure over a lengthy period of time can be characterized as the institution's culture (Adelman et al., 1999).

Those who want to enhance mental health (MH) in schools often engage in advocating for policy change and for new policies. However, as the multitude of categorically funded programs in schools and communities demonstrates, advocacy in the absence of a comprehensive and cohesive policy vision tends to produce fragmented agendas. It is such fragmented agendas that produce piecemeal and simplistic approaches to complex, multifaceted concerns. Thus, our focus here is on a comprehensive policy vision that encompasses and reframes MH in schools. Our overarching aim is to highlight a unifying vision for policy and practice around which various policy advocates can coalesce.

Specifically, the presentation covers three matters that those who want to enhance MH in schools should consider if they want to influence school policy in a fundamental way and on a large scale. We begin by highlighting current policy initiatives that shape how MH is addressed in schools and explore basic concerns arising from these initiatives. Then, from a policy perspective, we discuss the need to reframe the argument for MH in schools. Finally, we outline needed policy changes and the importance of connecting efforts to enhance MH in schools with school reform policy.

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CURRENT POLICY AND PRACTICE

Efforts to change policy benefit from understanding the status quo. For our purposes, it will suffice to highlight three matters: (1) how the term *mental health* usually is interpreted in making policy, (2) how school reform policy addresses students who are not succeeding, and (3) how MH in school plays out under current policy.

Mental Health or Mental Illness?

There is a widespread policy trend to use the term *mental health* and to focus only on *mental illness, disorders, or problems*. When this occurs, mental health is *de facto* defined as the absence of problems, and there is a lack of emphasis in practice on promoting positive social and emotional development. This has resulted in an MH field that is primarily focused on problems. This focus has carried over into policy for MH in schools.

A step toward redressing this limited policy perspective is seen in the *Report of the Surgeon General's Conference on Children's Mental Health* (Surgeon General, 2000). Although no formal definition of mental health is given, the vision statement provided at the outset of the report stresses that "both the promotion of mental health in children and the treatment of mental disorders should be major public health goals." This statement uses the term *mental health* in ways that are consistent with definitional efforts to use "health" as a positive concept. For example, the Institute of Medicine (1997) defines health as "a state of well-being and the capability to function in the face of changing circumstances." A similar effort to contrast positive health with problem functioning is seen in SAMHSA's Center for Mental Health Services glossary of children's mental health terms. In that source, *mental health* is defined as "how a person thinks, feels, and acts when faced with life's situations. . . . This includes handling stress, relating to other people, and making decisions." This is contrasted with *mental health problems*. The designation *mental disorders* is described as another term used for mental health problems and the term *mental illness* is reserved for severe mental health problems in adults.

Although some youngsters have serious mental health disorders (or other disabilities) that can interfere with development and learning, it is important for policymakers to recognize that few children are born with such problems. (And despite serious disorders, individuals have assets, strengths, or protective factors that help counter deficits and contribute to success.) The majority of psychosocial and MH problems that youngsters experience arise because of community, family, school, peer, and individual difference factors and are not initially rooted in internal dysfunctions (Adelman & Taylor, 1994; Catalano & Hawkins, 1995). Unfortunately, these problems often are exacerbated as youngsters internalize the frustrations of confronting barriers to development and learning and the debilitating effects of performing poorly at school, at home, and in their neighborhoods (Adelman & Taylor, 1993; Allensworth et al., 1997; Carnegie Council on Adolescent Development, 1989; Dryfoos, 1990; Sarason, 1996; Schorr, 1997). We hasten to add that a perspective that recognizes the nature and scope of external barriers to

development and learning in no way denies the reality that some individuals have true disorders and disabilities. The point is that current policy overemphasizes disorders and disabilities and thus does not adequately address the entire gamut of MH and psychosocial concerns.

School Reform Policy and Students Who Are Not Succeeding

Our analysis of school reform policy indicates that the primary focus is on two major components: (1) enhancing instruction and curriculum and (2) restructuring school governance/management. Increasingly, such efforts are shaped by policy calling for (1) higher standards and expectations, (2) a focus on results, (3) strategies that enhance direct academic support, (4) movement away from a deficiency model to a strengths or resilience-oriented paradigm, and (5) devolving control to school sites.

Beyond these primary considerations, there is a *secondary* focus on students who are not doing well. Here, three types of initiatives have emerged. One line of policy stresses approaches to deal with targeted problems. These "categorical" initiatives generate auxiliary programs, some supported by school district general funds and some underwritten by federal and private sector money. Examples of activities include those related to special and compensatory education; violence reduction; prevention of substance abuse, youth pregnancy, suicide, and dropouts; immunization campaigns; early periodic screening, diagnosis, and treatment; school-based health centers; family and youth resource centers; and so forth.

A second group of overlapping policies includes an emphasis on linking a broad range of community resources to schools. Terms used in conjunction with these initiatives include school-linked services—especially health and social services, full-service schools, school-community partnerships, and community schools. In a few states where such initiatives have been under way for some time, there are discussions of strengthening the linkage between school reforms and efforts to integrate community services and strengthen neighborhoods (e.g., see recent efforts related to Missouri's Caring Communities). Paralleling these efforts is a natural interest in promoting healthy development and productive citizens and workers.

A third set of initiatives is designed to promote a narrower focus on coordination and collaboration among *governmental* departments and their service agencies to foster integrated services with an emphasis on greater local control, increased involvement of parents, and locating services at schools when feasible. The federal government has offered various forms of support to foster this policy direction (e.g., Title XI of the Improving America's Schools Act of 1994 administered by the U.S. Department of Education, which was intended to foster service coordination for students and their families; a similar provision in the 1997 reauthorization of the Individuals with Disabilities Education Act; the Centers for Disease Control and Prevention's grants to foster Coordinated School Health Programs by establishing an infrastructure between state departments of health and education). Also, to encourage organizational changes, local, state, and federal intra- and interagency committees have been established, legislative bodies are rethinking their

committee structures, and some states have gone so far as to create new executive branch structures (e.g., combining all agencies and services for children and families under one cabinet-level department). In their most ambitious forms, these efforts are evolving into comprehensive community initiatives with an emphasis on community building.

All of the initiatives are relevant to addressing *some* students who are not succeeding at school. Obviously, it is important to understand what these initiatives accomplish, but the key to improving policy is understanding what more they could accomplish with respect to addressing MH and psychosocial concerns.

Current School Practices

Currently, there are almost 91,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted programs designed with a range of MH and psychosocial concerns in mind. There is a large body of research supporting the promise of much of this activity (e.g., see Center for Mental Health in Schools, 2000).

School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in either regular or special education classrooms or as "pull-out" programs and may be designed for an entire class, groups, or individuals. With specific respect to MH, the full range of topics arise—including matters related to promoting MH, minimizing the impact of psychosocial problems, managing psychotropic medication, and participating in systems of care. Well-developed systems include mechanisms for case coordination, ongoing consultation, program development, advocacy, and quality assurance. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth—though relatively few resources usually are allocated for such activity.

School districts use a variety of *personnel* to address MH concerns. These may include "pupil services" or "support services" specialists such as psychologists, counselors, social workers, psychiatrists, and psychiatric nurses, as well as a variety of related therapists (e.g., art, dance, music, occupational, physical, speech, language-hearing, and recreation therapists). Such specialists tend to focus on students seen as problems or as having problems. As outlined in Table 1, their many *functions* can be grouped into three categories: (1) direct services and instruction; (2) coordination, development, and leadership related to programs, services, resources, and systems; and (3) enhancement of connections with community resources (Adelman & Taylor, 1993, 1997; Center for Mental Health in Schools, 2001; Taylor & Adelman, 1996). In addition to responding to crises, prevailing direct intervention approaches encompass identification of the needs of targeted individuals, prescription of one or more interventions, brief consultation, and gatekeeping procedures (such as referral for assessment, corrective services,

Table 1. Types of Interveners and Functions

I. Interveners Who May Play Primary or Secondary Roles in Carrying Out Functions Relevant to Mental Health and Psychosocial Concerns	
Instructional professionals (e.g., regular classroom teachers, special education staff, health educators, classroom resource staff, and consultants) Administrative staff (e.g., principals, assistant principals, deans) Health office professionals (e.g., nurses, physicians, health educators, consultants) Counseling, psychological, and social work professionals (e.g., counselors, health educators, psychologists, psychiatrists, psychiatric nurses, social workers, consultants)	Itinerant therapists (e.g., art, dance, music, occupational, physical, speech–language–hearing, and recreation therapists; psychodramatists) Personnel-in-training Others <ul style="list-style-type: none"> • Aides • Classified staff (e.g., clerical and cafeteria staff, custodians, bus drivers) • Paraprofessionals • Peers (e.g., peer/cross-age counselors and tutors, mutual support and self-help groups) • Recreation personnel • Volunteers (professional/paraprofessional/nonprofessional—including parents)
II. Functions Related to Addressing Mental Health and Psychosocial Needs at the School and District Level	
Direct services and instruction (Based on prevailing standards of practice and informed by research) <ul style="list-style-type: none"> • Crisis intervention and emergency assistance (e.g., psychological first aid and follow-up; suicide prevention; emergency services, such as food, clothing, transportation) • Assessment (individuals, groups, classroom, school, and home environments) • Treatment, remediation, rehabilitation (incl. secondary prevention) • Accommodations to allow for differences and disabilities • Transition and follow-up (e.g., orientations, social support for newcomers, follow-through) • Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness (e.g., guidance counseling; contributing to development and implementation of health and violence reduction curricula; placement assistance; advocacy; liaison between school and home; gang, delinquency, and safe-school programs; conflict resolution) • Multidisciplinary teamwork, consultation, training, and supervision to increase the amount of direct service impact 	Coordination, development, and leadership related to programs, services, resources, and systems <ul style="list-style-type: none"> • Needs assessment, gatekeeping, referral, triage, and case monitoring/management (e.g., participating on student study/assistance teams; facilitating communication among all concerned parties) • Coordinating activities (across disciplines and components; with regular, special, and compensatory education; in and out of school) • Mapping and enhancing resources and systems • Developing new approaches (incl. facilitating systemic changes) • Monitoring and evaluating intervention for quality improvement, cost–benefit accountability, research • Advocacy for programs and services and for standards of care in the schools • Pursuing strategies for public relations and for enhancing financial resources Enhancing connections with community resources <ul style="list-style-type: none"> • Strategies to increase responsiveness to referrals from the school • Strategies to create formal linkages among programs and services

triage, and diagnosis). In some situations, however, resources are so limited that specialists can do little more than assess for special education eligibility, offer brief consultations, and make referrals to special education and/or community resources.

Federal and state mandates play a significant role in determining how many pupil services professionals are employed. The School Health Policies and Program Study 2000 conducted by the National Center for Chronic Disease Prevention and Health Promotion sampled 51 state departments of education, 560 school districts, and 950 schools. Findings indicate that 77% of schools have a part- or full-time guidance counselor, 66% have a part- or full-time school psychologist, and 44% have a part- or full-time social worker (<http://www.cdc.gov>). In general, the ratio for school psychologists or school social workers averages 1 to 2500 students; for school counselors, the ratio is about 1 to 1000 (Carlson, Paavola, & Talley, 1995). Given estimates that more than half the students in many schools are encountering major barriers that interfere with their functioning, such ratios inevitably mean that more than narrow-band approaches must be used if the majority are to receive the help they need (Knitzer, Steinberg, & Fleisch, 1990). Nevertheless, the prevailing orientation remains that of focusing on discrete problems and overrelying on specialized services for individuals and small groups.

Because the need is so great, others at a school often are called upon to play a role in addressing MH and psychosocial problems of youth and their families. These include other health professionals (such as school nurses and physicians), instructional professionals (health educators, other classroom teachers, special education staff, resource staff), administrative staff (principals, assistant principals), students (including trained peer counselors), family members, and almost everyone else involved with a school (aides, clerical and cafeteria staff, custodians, bus drivers, paraprofessionals, recreation personnel, volunteers, and professionals-in-training). In addition, some schools are using specialists employed by other public and private agencies, such as health departments, hospitals, and community-based organizations, to provide MH services to students, their families, and school staff.

Because so few resources are allocated, the contexts for the activity often are limited and makeshift. That is, a relatively small proportion of this activity seems to take place in school/clinical offices earmarked specifically for such functions. Health education and skill development interventions may take place in classrooms if they are part of the regular curriculum; otherwise they tend to be assigned space on an *ad hoc* basis. Home visits remain a rarity. Support service personnel such as school psychologists and social workers must rotate among schools as "itinerant" staff. These conditions contribute to the tendency for such personnel to operate in relative isolation of each other and other stakeholders. These conditions clearly are not conducive to effective practice.

As outlined in Table 2, all this activity is provided through five major *delivery mechanisms and formats*. (For more on this, see Policy Leadership Cadre for Mental Health in Schools, 2001.) Despite the range of activity, it is common knowledge that few schools come close to having enough resources to deal with a large number of students with MH and psychosocial problems. Moreover, as is the case with most professionals who come to schools directly from preservice programs, those hired for their mental health expertise still need considerably more training once they

Table 2. Delivery Mechanisms and Formats: Five Mechanisms and Related Formats

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- I. School-financed student support services—Most school districts employ support service 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 for this delivery mechanism usually is a combination of centrally based and school-based services.
 - II. School-district MH unit—A few districts operate specific mental health units that encompass clinic facilities, as well as providing services and consultation to schools. Some others have started financing their own school-based health centers with mental health services as a major element. The format for this mechanism tends to be centralized clinics with the capability for outreach to schools.
 - III. Formal connections with community MH 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 (e.g., “wraparound” 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 partly financed by community health organizations
 - formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or -linked family resource center
 - formal partnerships between a school district and community agencies to establish or expand school-based or -linked facilities that include provision of MH services
 - contracting with community providers to provide needed student services
 - IV. Classroom-based curriculum and special “pull-out” interventions—Most schools include in some facet of their curriculum a focus on enhancing social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. And, of course, special education classrooms always are supposed to have a constant focus on mental health concerns. Three formats have emerged:
 - integrated instruction as part of the regular classroom content and processes
 - specific curriculum or special intervention implemented by personnel specially trained to carry out the processes
 - curriculum approach is part of a multifaceted set of interventions designed to enhance positive development and prevent problems
 - V. Comprehensive, multifaceted, and integrated approaches—A few school districts have begun the process of reconceptualizing their piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. They are starting to restructure their student support services and weave them together with community resources and integrate all this with instructional efforts that effect healthy development. The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early after onset as is feasible, and offer treatment regimens. Mental health and psychosocial concerns are a major focus of the continuum of interventions. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care and the growing movement to create community schools. Three formats are emerging:
 - mechanisms to coordinate and integrate school and community services
 - initiatives to restructure support programs and services and integrate them into school reform agendas
 - community schools
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arrive at a school site. Those school personnel who are called upon to address MH and psychosocial concerns without training related to such matters clearly have even greater needs for capacity building and supervision. Unfortunately, there is little systematic in-service development to follow-up preservice education.

KEY CONCERNS ABOUT POLICY TRENDS

As McDonnell and Elmore (1987) state:

A major challenge for the next generation of policy research will be to apply the lessons of past implementation studies in building a more powerful conceptual framework and in producing more useful information for policymakers Past research provides only limited guidance, because it has tended to focus on relatively narrow categorical programs, rather than programs targeted at all students, and has not addressed the core of schooling. (p. 3)

Viewed from the perspective of what schools do and what they could do related to students who are not succeeding, several concerns are evident. For one, there is no *cohesive* policy vision for addressing factors that interfere with learning and teaching. Relatedly, existing pupil services and school health programs do not have *high* status in the educational hierarchy and in current health and education policy initiatives (Adelman et al., 1999; Adelman & Taylor, 2000; Adler & Gardner, 1994; Center for Mental Health in Schools, 1996, 1997; Dryfoos, 1998; Kirst & McLaughlin, 1990; Knitzer et al., 1990; Kolbe, 1993; Lawson & Briar-Lawson, 1997; Palaich, Whitney, & Paolino, 1991; Tyack, 1992). The continuing trend is for schools and districts to treat such activity, in policy and practice, as desirable but not essential. Since the activity is not seen as essential, the programs and staff are marginalized. Planning of programs, services, and delivery systems tends to be done on an *ad hoc* basis; interventions are referred to as "auxiliary" or "support" services. Specialist personnel almost never are a prominent part of a school's organizational structure. Even worse, pupil services personnel usually are among those deemed dispensable as budgets tighten.

Policy aimed at students experiencing difficulty with reading and writing mostly calls for improving direct instruction and instituting higher standards and greater accountability. If necessary, students also may be referred for special services. With this in mind, there usually is provision in a school's budget for a few specialized supports. However, because such supports are costly, schools in poor neighborhoods are being encouraged to increase their linkages with community agencies in an effort to expand services and programs. The reality in poor neighborhoods, of course, is that there simply are not enough community agency resources for all services to link with all schools. Thus, the situation becomes either a matter of limiting linkages to the first schools that express an interest or of spreading limited resources (until they are exhausted) as more schools reach out.

Where school-linked services are feasible, some agencies have moved to co-locate staff on a few school campuses. In doing so, they provide a small number of clients better access to health and social services. Given that access is a prerequisite to, if not a guarantee of, effective intervention, this can be beneficial to those who

are served. However, too few are likely to be served, and co-location is not a good model for fostering intervention cohesiveness. In linking with schools, community agencies often operate in parallel to the intervention efforts of school personnel (such as nurses, school psychologists, counselors, and social workers) who perform similar or complementary functions. Furthermore, by approaching school-linked services with a co-location model, outside agencies are creating a fear of job loss among personnel who staff school-owned support services. This sense of threat is growing as school policymakers in various locales explore the possibility of contracting out services. The atmosphere created by such approaches certainly is not conducive to collaboration and interferes with cohesiveness.

Given the relatively low policy priority for education support programs and services, it is not surprising that so little has been done at any administrative level to create the type of vision, leadership, and organizational structure necessary for integrating pupil services into schools in a comprehensive way. At present, specialist personnel rarely are included on governance and planning bodies. Ultimately, realignment of how pupil service personnel are governed and involved in school governance and collective bargaining and efforts to improve cost-effectiveness will play major roles in determining how many personnel address barriers to learning at a school (Hill & Bonan, 1991; Streeter & Franklin, 1993).

Clearly, policy initiatives for specific elements of school health or for coordinated school health programs are negatively affected by the piecemeal and categorical ways in which school-related intervention policies are enacted. Indeed, this is the case for all school-owned and -linked support programs and services. The roots of the problem lie in the marginalized status of such efforts vis-à-vis school reform. The symptoms of this problem are seen in the ensuing fragmentation that usually results in costly redundancy, dysfunctional competition, and limited intervention effectiveness.

To deal with the lack of policy cohesion, there has been a trend toward offering flexibility in using categorical funds, granting temporary waivers from regulatory restrictions, and offering support to encourage development of interagency infrastructure. These moves have helped in specific instances but have not provided the type of impetus for change that is needed if fundamental reforms are to play out at school sites. Direct attention to restructuring and re-forming existing policy with a view toward fostering cohesive intervention is long overdue.

The most fundamental concern, however, is that prevailing intervention approaches are inadequate to the task of effectively addressing barriers to learning, and this lamentable state of affairs will not change as long as such activity is marginalized in policy and practice. This marginalization is seen clearly in how little attention is paid to dealing with the ineffective and inefficient ways resources are used in efforts to address barriers and promote healthy development. In the long run, substantially increasing intervention effectiveness requires changes that transform the nature and scope of how community- and school-owned resources are used; increasing availability and access to essential programs requires a true integration of these resources. None of this is likely to be accomplished as long as the activities involved are treated as tangential to the mission of schools.

In short, the situation is one in which, despite awareness of the many barriers to learning, education reformers continue to concentrate mainly on improving instruction (efforts to directly facilitate learning) and the management and

governance of schools. Then, in the naive belief that a few health and social services will suffice in addressing barriers to learning, education reformers talk of "integrated health and social services." And in doing so, more attention has been given to linking sparse community services to school sites than to restructuring school programs and services designed to support and enable learning.

The previous discussion reflects only a few examples of fundamental policy concerns, but it underscores the point that policymakers and reform leaders have yet come to grips with the realities of students who are not succeeding. For many reasons, policymakers assign a low priority to underwriting efforts to address the needs of such students. The efforts that are made seldom are conceived in comprehensive ways, and little thought or time is given to mechanisms for program development and collaboration. Organizationally and functionally, policymakers' mandate, and planners and developers focus on, specific programs. Practitioners and researchers tend to spend most of their time working directly with specific interventions and samples. Throughout the country and at all levels of political activity, policy, research, and practice initiatives remain marginalized, fragmented, and riddled with serious gaps. As a result, only a small proportion of the many students who are not succeeding are provided with the type of assistance they need, and prevailing intervention approaches tend to be narrowly focused and short term. For too many youngsters, limited intervention efficacy seems inevitable as long as a full continuum of necessary programs is unavailable, and limited cost-effectiveness seems inevitable as long as related interventions are carried out in isolation from one another.

In school districts, fragmentation and marginalization of effort are maintained by the specialized focus and relative autonomy of a district's organizational divisions. That is, the various divisions focusing on curriculum and instruction; student health and other support services; and activity related to integration and compensatory education, special education, language acquisition, parent involvement, intergroup relations, and adult and career education often operate as relatively independent entities. Thus, although these divisions usually must deal with the same common barriers to learning (e.g., poor instruction, lack of parental involvement, violence, unsafe schools, health problems, inadequate support for student transitions), they tend to do so with little in the way of a big picture framework, little or no coordination, and sparse attention to moving toward integrated efforts. Furthermore, in every facet of a school district's operations, unproductive separation is often manifested among the instructional and management components and the multiple activities that constitute efforts to address barriers to learning. This is compounded by the separation among those focusing on students experiencing problems. At the school level, this translates into situations in which teachers simply do not have access to essential supports when they identify students who are having difficulties. Prevailing school reform processes and capacity building (including pre- and in-service staff development) have not dealt effectively with such concerns.

Concentrating on matters such as curriculum and pedagogical reform, standard setting, decentralization, professionalization of teaching, shared decision making, and parent partnerships is necessary but certainly not sufficient, given the nature and scope of the barriers that interfere with school learning and performance among a large segment of students (Council of Chief State School Officers, 1992). That is, although higher standards and accountability are necessary ingredients

in the final recipe for school reform, they are insufficient for turning around most schools that are in trouble. At such schools, overreliance on raising the bar and demands for rapid test score increases may even be counterproductive, because they force attention away from addressing the multitude of overlapping factors that interfere with effective learning and teaching. (And, they may be creating and exacerbating MH problems among students, their families, and school staff.) As long as the primary emphasis of those leading the movement to restructure education is limited to reforming the instructional and management components, too many students in too many schools will not benefit from the reforms. Thus, the demand for significant improvements in achievement scores will remain unfulfilled.

Given all this, it is not surprising that many schools are not making much of a dent in improving achievement test score averages. This state of affairs is undermining the move toward higher standards and efforts to minimize grade retention as social promotion is eliminated. For such initiatives to work, every school needs a comprehensive and multifaceted set of interventions not only to prevent and respond to problems early after onset but also to assist students with chronic problems. For this to be the case, however, advocates for children and families cannot pursue narrow and competing policy agendas, interventions cannot be conceived and organized in rigid categorical ways, and professionals cannot narrowly conceive their roles and functions.

Our analyses of current school policies and practices lead us to the view that the argument for MH in schools must be reframed. The new argument must be embedded in a comprehensive policy vision that encompasses an umbrella concept under which various advocates can coalesce.

REFRAMING THE ARGUMENT FOR MENTAL HEALTH IN SCHOOLS

Advocates for MH in schools include (1) those concerned about youngsters who have diagnosable mental disorders, subdiagnostic emotional and behavioral problems, and/or psychosocial problems; (2) those who want to prevent such problems; and (3) those interested in promoting healthy social and emotional development. Some of these advocates work for school districts, and their desire is for school policymakers to expand current commitments related to addressing a variety of barriers to student learning, including preventing problems by promoting healthy development. Some MH advocates who are not employed by the schools focus mainly on ways to expand school involvement in treating MH problems; others call for a greater emphasis on fostering social-emotional learning.

The various advocacy agendas have developed in relative isolation of each other. These have resulted in piecemeal policies and practices and counterproductive competition for sparse resources. Most of the agendas have narrowly framed the argument for MH in schools and have reflected an inadequate understanding of what schools are currently doing and what they can do.

The Usual Arguments for MH in Schools

With specific respect to MH in schools, the tendency of many advocates is to begin by citing the figures related to MH problems. They note, for example, that the Surgeon General's 1999 report on *Mental Health* states that "one in five

children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year"—with about 5% of all children experiencing "extreme functional impairment." And they stress that the picture is even bleaker when one expands the focus beyond the limited perspective on diagnosable mental disorders to the number of young people experiencing psychosocial problems and who are "at risk of not maturing into responsible adults" (Dryfoos, 1990).

The various data on need are then paired with the data on the society's response. For instance, epidemiological studies indicate that, in some communities, two-thirds of children with psychiatric disorders and significant impairment do not receive specialist care (Leaf et al., 1996). And, the Surgeon General's 1999 report on *Mental Health* estimates 6 to 9 million youngsters with serious emotional disturbances are not receiving the help they need—especially those from low-income families. Moreover, the report stresses the inadequacies of the current MH system and warns that the situation will worsen because of swelling demographics that are resulting in more children and adolescents with MH-related concerns.

Given these data, some advocates then suggest that it is self-evident that schools should expand what they do related to mental health. This position echoes the call of many others who have recognized that schools provide an important venue for enhancing the health status of children and adolescents. Such a view is well articulated, for instance, in an Institute of Medicine report (Allensworth et al., 1997) and in initiatives funded by the federal government designed to foster coordinated school health programs and MH in schools (Adelman et al., 1999; Marx, Wooley, & Northrop, 1998; Weist, 1999).

For the most part, however, school policymakers have not been swayed by the argument that schools are a good venue for addressing physical or mental health. Thus, proponents have expanded their position to make the case that a greater focus on health in schools will contribute to healthier students, and healthier students will learn and perform better. On the surface, this seems a stronger argument. However, it too has not had a great influence on school policy.

The problem with the previous arguments arises from one simple fact: *schools are not in the health business*. Education is the mission of schools, and policymakers are quick to point that out whenever schools are asked to do more about physical and mental health. Moreover, the accountability pressures on schools increasingly have focused attention on improving instruction at the expense of all matters not seen as *directly* related to raising achievement test scores. Related to this is the mandate schools have to make certain that *all* students (not just some students) experience an equal opportunity to benefit from the instruction provided.

In addition, it is important to remember that among some segments of the populace schools are not seen as an appropriate venue for MH interventions. The reasons include not only the concern that such activity will take time away from the educational mission but also the fear that such interventions are another attempt of society to infringe on family rights and values. There also is the long-standing discomfort so many in the general populace feel about the subject of mental health because it so often is viewed only in terms of mental illness. And, there is a historical legacy of conflict among various stakeholders stemming from insufficiently funded legislative mandates that have produced administrative, financial, and legal problems for schools and problems of access to entitled services for some students.

Even among those advocating for MH in schools, some argue that the involvement of schools should be restricted to those few students who have diagnosed mental disorders and qualify for special education services. Others want schools to offer a range of counseling and psychotherapeutic services to any student who is manifesting "mental health" symptoms. Still others want classrooms and schools to include a major focus on promoting healthy social and emotional development for all students.

A Rationale that Connects with the Mission of Schools

Given the previously described state of affairs, the case for MH in schools probably is best made by not presenting so many separate agendas. Our approach to framing a policy rationale for MH in schools begins with the conclusion arrived at by the Carnegie Council Task Force on Education of Young Adolescents (1989). In their report, they stress: "School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge." It is evident that a variety of psychological and physical health problems affect learning in profound ways. Moreover, the problems are exacerbated as youngsters internalize the frustrations of confronting barriers (external and internal) to learning, experience the debilitating effects of performing poorly at school, and are punished for the misbehavior that often accompanies school failure.

While suburban areas are not exempt, the litany of barriers to development and learning is especially familiar to anyone who lives or works in urban or rural settings where families struggle with low income. In such locales, insufficient school and community resources often deprive youngsters of basic opportunities (not to mention enrichment activities) found in higher-income communities. Furthermore, the resources are inadequate for dealing with threats to well-being and learning such as drugs, gangs, and violence. As recent widely reported incidents underscore, violence is a specter hanging over all schools. Although the guns and killings that capture media attention fortunately are not pandemic, other forms of violence affect and debilitate youngsters at every school. Those who study the many faces of violence report that large numbers of students are caught up in cycles where they are the recipient or perpetrator (and sometimes both) of physical and sexual harassment ranging from excessive teasing and bullying to mayhem and major criminal acts. Moreover, any student may suffer the effects of severe anxiety or depression, and the rate of suicide among the young remains a constant concern. In many school settings, additional barriers to student learning and family involvement in schooling are created by inadequate attention to health problems, difficult and culturally diverse family circumstances, lack of English-language skills, and high rates of student mobility (Dryfoos, 1990; Knitzer et al., 1990; Schorr, 1997). Such conditions are breeding grounds for frustration, apathy, alienation, and hopelessness—all of which interfere with learning. In many large urban schools, the proportion of students experiencing behavior, learning, and emotional problems has climbed to over 50%, and few public schools experience less than 20%.

A strong rationale for MH in schools must be built first and foremost on the widespread need to enable more students to succeed at school. We stress that the strategy is to *build on* what school policymakers already are doing to achieve their

mission. That is, those interested in enhancing the focus on MH and psychosocial concerns must recognize that such matters already are a facet of the agenda schools have for addressing barriers to learning (i.e., a variety of existing school policies and practices combine to establish a *de facto* commitment to MH). Most evident is the multifaceted enterprise that has developed to serve those students whose emotional, behavioral, and learning problems interfere with school performance and thus qualify them for special education. Also prominent are a range of counseling, psychological, and social service programs provided by schools for targeted problems related to violence, drugs, pregnancy, dropout, and so forth. Many of these programs take the form of enhancing students' assets and resiliency and reducing risk factors through an emphasis on social-emotional learning and protective factors. Clearly, school policymakers have demonstrated that they understand they must do something to assist teachers in dealing with problems that interfere with school learning.

From this perspective, we suggest that efforts to enhance and expand the *de facto* commitment to MH and psychosocial concerns are best pursued under the umbrella concept of *addressing barriers to student learning*. When this broad concept is used as a lens through which to view current policy and practices, it is quite clear that schools need to do much more and that their current efforts require considerable rethinking. Moreover, it becomes evident how low a policy priority presently is placed on the whole enterprise of addressing the factors that interfere with youngsters succeeding at school. Such awareness is a prerequisite to addressing the problems of marginalization, fragmentation, and unproductive competition.

CONNECTING WITH AND EXPANDING SCHOOL REFORM POLICY

By embedding our focus on enhancing MH in schools into the concept of addressing barriers to learning, development, and teaching, we have come to appreciate the need for shifts in policy. There is a major policy void, for example, surrounding the topic of *restructuring school-operated interventions* that are relevant to addressing barriers to learning and teaching. This is incompatible with efforts to develop truly comprehensive and multifaceted approaches to ameliorating problems and improving educational results.

Developing a Comprehensive, Multifaceted, and Cohesive Approach

Ultimately, the problems of students who are not succeeding must be approached from a societal perspective and with fundamental systemic reforms. As we have stressed elsewhere, the reforms must lead to development of a comprehensive continuum of programs (e.g., Adelman & Taylor, 1997, 1998, 2000). Such a continuum must be multifaceted and woven into three overlapping and integrated school-community systems: systems to promote healthy development and prevent problems, early intervention to address problems as soon after onset as feasible, and care for those with chronic and severe problems (see Fig. 1).

The three systems highlighted in Fig. 1 must encompass an array of effective programmatic activities that (1) enhance regular classroom strategies to improve instruction for students with mild-to-moderate behavior and learning problems,

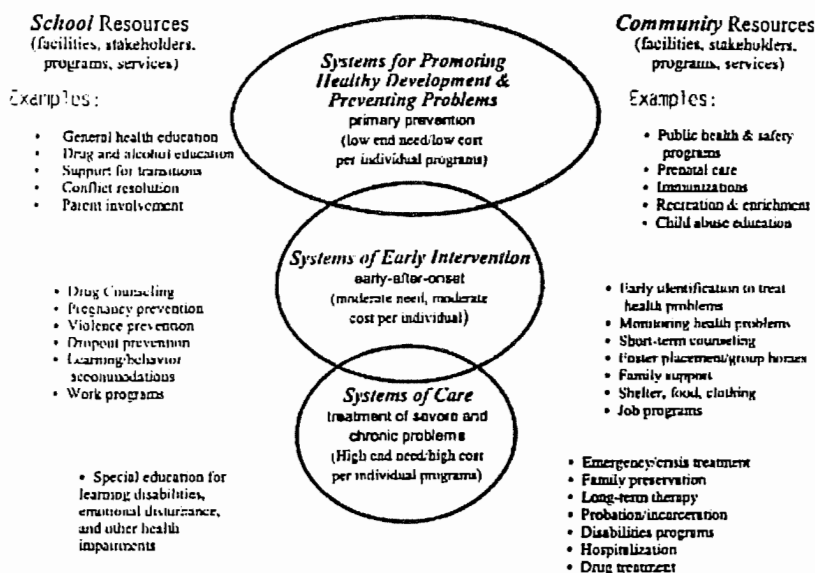


Figure 1. Interconnected systems for meeting the needs of all students. Systemic collaboration is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among systems of prevention, systems of early intervention, and systems of care. Such collaboration involves horizontal and vertical restructuring of programs and services (1) within jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters of schools) and (2) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies. Adapted from various public domain documents authored by H. S. Adelman & L. Taylor and circulated through the Center for Mental Health in Schools at UCLA.

(2) assist students and families as they negotiate the many school-related transitions, (3) increase home and community involvement with schools, (4) respond to and prevent crises, and (5) facilitate student and family access to specialized services when necessary. Although schools cannot do everything needed, they must play a much greater role in developing the programs and systems that are essential if all students are to benefit from higher standards and improved instruction. They can, for example, do much more to welcome and provide social supports for new students and their families. They can work closely with those in the community to develop programs for recruiting, training, and deploying volunteers in ways that improve and augment ongoing social and academic supports and recreational and enrichment opportunities as well as other facets of school operation. They can work with those responsible for adult education to bring classes to school sites and facilitate enrollment of family members who want to improve their literacy, learn English, and develop job skills. And, they can play a role in ensuring that students with MH problems receive the services they need.

Establishment of comprehensive, multifaceted approaches to address barriers and promote healthy development requires cohesive policy that facilitates the blending of resources. In schools, this includes restructuring to combine parallel efforts supported by general funds, compensatory and special education entitlements, safe and drug-free school grants, and specially funded projects. With

proper policy support, a comprehensive approach can be woven into the fabric of every school, and neighboring schools can be linked to share limited resources and achieve economies of scale. This scope of activity underscores the need to develop formal mechanisms for essential and long-lasting interprogram connections (collaboration in the form of information sharing, cooperation, coordination, and integration) on a daily basis and over time.

Efforts to braid and blend resources are fundamental to developing potent school-community partnerships. And, such partnerships are fundamental if we are to strengthen students and their schools, homes, and neighborhoods by creating caring and supportive environments that maximize learning and well-being.

To accomplish these goals, cohesive policy and practice seem essential. That is, policies must be realigned so that the diverse practices aimed at addressing barriers are unified. This requires moving from fragmented to cohesive policy and implies moving from narrowly focused, problem-specific, and specialist-oriented services to comprehensive general programmatic approaches. As used here, general approaches include a focus on enhancing healthy development as a key facet of prevention and encompass procedures for adding specialized services as necessary. It is time for reform advocates to expand their emphasis on improving instruction and school management to include a comprehensive component for addressing barriers to learning. To this end, we have introduced the concept of an enabling component to generate a three-component model as a framework to guide restructuring of policy and practice (see Adelman, 1996; Adelman & Taylor, 1994, 1997, 1998). And, we argue that in moving beyond the current tendency to concentrate mainly on instruction and management, school policy must elevate this third component to the same level of priority given the other two. That is, such an enabling (or learner support) component for addressing barriers to learning must be a primary and essential facet of school reform. School reformers like to say their aim is to ensure that all children succeed. We think that this third component is the key to making *all* more than the rhetoric of reform.

The Policy Leadership Cadre for Mental Health in Schools (2001) has developed a set of guidelines that are consistent with the previously described conceptual framework and reflect a comprehensive policy vision for MH in schools. The basic outline for these guidelines is presented in Table 3.

GOOD POLICY REQUIRES ADEQUATE UNDERWRITING OF SYSTEMIC CHANGE AND ESSENTIAL CAPACITY BUILDING

As discussed previously, our analyses suggest that current policy trends designed to ensure that *all* students have an equal opportunity to succeed at school generally add only a bit more of what already is being done. Moreover, in reaction to the narrow focus on categorical approaches and the related widespread fragmentation of activity, reformers are prematurely fixated on service coordination and integration. This has been especially the case with school health policy. As a result, policy is not contributing much to development of the type of comprehensive, multifaceted, and cohesive approaches that are needed to address the full range of students who are not succeeding. The type of expanded policy vision we have outlined is clearly needed.

Table 3. Guidelines for Mental Health in Schools

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- I. General Domains for Intervention in Addressing Students' Mental Health
 1. Ensuring academic success and also promoting healthy cognitive, social, and emotional development and resilience (including promoting opportunities to enhance school performance and protective factors; fostering development of assets and general wellness; enhancing responsibility and integrity, self-efficacy, social and working relationships, self-evaluation and self-direction, personal safety and safe behavior, health maintenance, effective physical functioning, careers and life roles, creativity)
 2. Addressing barriers to student learning and performance (including educational and psychosocial problems, external stressors, psychological disorders)
 3. Providing social/emotional support for students, families, and staff
 - II. Major Areas of Concern Related to Barriers to Student Learning
 1. Addressing common educational and psychosocial problems (e.g., learning problems; language difficulties; attention problems; school adjustment and other life-transition problems; attendance problems and dropouts; social, interpersonal, and familial problems; conduct and behavior problems; delinquency and gang-related problems; anxiety problems; affect and mood problems; sexual and/or physical abuse; neglect; substance abuse; psychological reactions to physical status and sexual activity)
 2. Countering external stressors (e.g., reactions to objective or perceived stress/demands/crises/deficits at home, school, and in the neighborhood; inadequate basic resources such as food, clothing, and a sense of security; inadequate support systems; hostile and violent conditions)
 3. Teaching, serving, and accommodating disorders/disabilities (e.g., learning disabilities; attention deficit hyperactivity disorder; school phobia; conduct disorder; depression; suicidal or homicidal ideation and behavior; posttraumatic stress disorder; anorexia and bulimia; special education designated disorders such as emotional disturbance and developmental disabilities)
 - III. Type of Functions Provided Related to Individuals, Groups, and Families
 1. Assessment for initial (first level) screening of problems, as well as for diagnosis and intervention planning (including a focus on needs and assets)
 2. Referral, triage, and monitoring/management of care
 3. Direct services and instruction (e.g., primary prevention programs, including enhancement of wellness through instruction, skills development, guidance counseling, advocacy, schoolwide programs to foster safe and caring climates, and liaison connections between school and home; crisis intervention and assistance, including psychological first aid; prereferral interventions; accommodations to allow for differences and disabilities; transition and follow-up programs; short- and longer-term treatment, remediation, and rehabilitation)
 4. Coordination, development, and leadership related to school-owned programs, services, resources, and systems—toward evolving a comprehensive, multifaceted, and integrated continuum of programs and services
 5. Consultation, supervision, and in-service instruction with a transdisciplinary focus
 6. Enhancing connections with and involvement of home and community resources (including but not limited to community agencies)
 - IV. Timing and Nature of Problem-Oriented Interventions
 1. Primary prevention
 2. Intervening early after the onset of problems
 3. Interventions for severe, pervasive, and/or chronic problems
 - V. Assuring Quality of Intervention
 1. Systems and interventions are monitored and improved as necessary
 2. Programs and services constitute a comprehensive, multifaceted continuum
 3. Interveners have appropriate knowledge and skills for their roles and functions and provide guidance for continuing professional development
 4. School-owned programs and services are coordinated and integrated
 5. School-owned programs and services are connected to home and community resources
 6. Programs and services are integrated with instructional and governance/management components at schools

(Continued)

Table 3. (Continued)

V. Assuring Quality of Intervention
7. Programs/services are available, accessible, and attractive
8. Empirically supported interventions are used when applicable
9. Differences among students/families are appropriately accounted for (e.g., diversity, disability, developmental levels, motivational levels, strengths, weaknesses)
10. Legal considerations are appropriately accounted for (e.g., mandated services, mandated reporting and its consequences)
11. Ethical issues are appropriately accounted for (e.g., privacy and confidentiality, coercion)
12. Contexts for intervention are appropriate (e.g., office, clinic, classroom, home)
VI. Outcome Evaluation and Accountability
1. Short-term outcome data
2. Long-term outcome data
3. Reporting to key stakeholders and using outcome data to enhance intervention quality

At the same time, we hasten to stress that while a new policy and practice framework is necessary, it will only lay the foundation. For significant systemic change to occur, policy commitments must be demonstrated through allocation and redeployment of resources (e.g., finances, personnel, time, space, and equipment) that can adequately operationalize policy and promising practices. In particular, there must be sufficient resources to develop an effective structural foundation for systemic changes. Existing infrastructure mechanisms must be modified in ways that guarantee that new policy directions are translated into appropriate daily practices. Well-designed infrastructure mechanisms ensure there is local ownership, a critical mass of committed stakeholders, effective capacity building, processes that can overcome barriers to stakeholders' working together effectively, and strategies that can mobilize and maintain proactive effort so that changes are implemented and renewed over time.

Institutionalizing comprehensive approaches requires redesigning mechanisms for governance, capacity building, planning and implementation, coordination, daily leadership, communication, information management, and so forth. In reforming mechanisms, new collaborative arrangements must be established, and authority and power must be redistributed. All of this obviously requires that those who operate the mechanisms are adequately supported and provided with essential resources, such as time, space, materials, and equipment—not just initially but over time. And, there must be appropriate incentives and safeguards for those undertaking the risks involved in making major changes.

CONCLUDING COMMENTS

Leaders for MH in schools suggest that the well-being of young people can be substantially enhanced by addressing key policy concerns in this arena. In this respect, they recognize that policy must be developed around well-conceived models and the best available information. Policy must be realigned to create a cohesive framework and must connect in major ways with the mission of schools (Policy Leadership Cadre for Mental Health in Schools, 2001). From our perspective, we think this can be accomplished through a basic policy shift that reorganizes efforts to reform education and restructure community resources around

three fundamental and essential overlapping components:

- a component encompassing all efforts to directly facilitate development and learning,
- a component encompassing all efforts to address barriers to development and learning,
- a component encompassing all efforts to manage and govern school resources and practices and school-community partnerships.

Reorganizing around three major components promises to reduce fragmentation and redundancy; enhance existing programs; increase the range of programs and services; and facilitate development of comprehensive, multifaceted, and integrated approaches. With specific respect to school health policy, the three-component model can help end the marginalized status of health initiatives in schools. To accomplish this, the focus for the immediate future must be on fully embedding school health initiatives into a component for addressing barriers to learning and advocating for inclusion of such a component as a primary facet of school reform policy.

Then, attention must be directed at restructuring the education support programs and services that schools own and operate and weave school-owned resources and community-owned resources together to provide the resources necessary for transforming the nature and scope of intervention efforts so that comprehensive, multifaceted, and integrated approaches are developed to address problems and enhance healthy development. Policymakers also must deal with the problems of creating necessary infrastructure and providing for effective capacity building to ensure appropriate implementation of comprehensive approaches and allocating the resources necessary for implementing widespread "scale-up" (e.g., underwriting model development and capacity building for systemwide replication of promising models and institutionalization of systemic changes). And, in doing all this, more must be done to involve families and to connect the resources of schools, neighborhoods, and institutions of higher education. Inadequate policy support related to any of these matters decreases the likelihood of enhancing intervention effectiveness on a large scale.

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