Mental Health in Schools: A Shared Agenda

by Howard S. Adelman and Linda Taylor*

Background and Guiding Principle

Although schools are not in the mental health business, it has long been acknowledged that psychosocial and mental health concerns must be addressed if schools are to function satisfactorily and students are to learn and perform effectively. Capturing this reality, the Carnegie Council Task Force on Education of Young Adolescents (1989) cogently states that: "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."

This notion is reflected in the aims of the No Child Left Behind Act and the Individuals with Disabilities Education Act, and it is consonant with the goals and recommendations of the President's New Freedom Commission on Mental Health. Indeed, these initiatives share a common agenda. For that agenda to be achieved, however, the initiatives must coalesce in school improvement policies and do so in ways that more wisely invest and use sparse resources.

The Federal Program for Mental Health in Schools. A decade ago, the U.S. Department of Health and Human Services recognized the need for an increased stimulus to encourage pursuit of mental health in schools. In 1995, a federal program for mental health in schools was established. The emphasis of that program is on increasing the capacity of policy makers, administrators, school personnel, primary care health providers, mental health specialists, agency staff, consumers, and other stakeholders so that they can enhance the ways in which schools and their communities address psychosocial and mental health concerns. Particular attention is given to prevention and to early response following the onset of problems—critical facets in reducing the prevalence of problems.

Two National Centers. The seminal and catalytic role currently played by this program is carried out through two national technical assistance and training centers: the Center for Mental Health in Schools at UCLA (*http://smhp.psych.ucla.edu*) and the Center for School Mental Health Assistance at the University of Maryland, Baltimore (*http://csmha.umaryland.edu*). This initiative is helping clarify the nature and scope of school-related intervention research, policy, training, and technical assistance essential to improving children's mental health. The guiding principles and frameworks for the work emphasize ensuring that:

- Mental health is understood in terms of psychosocial problems as well as disorders, and in terms of strengths as well as deficits;
- The roles of schools/communities/homes are enhanced and pursued jointly;
- Equity considerations are confronted;
- The marginalization and fragmentation of policy, organizations, and daily practice are countered; and
- The challenges of evidence-based strategies and achieving results are addressed.

These principles encompass an appreciation of the importance of addressing the varying needs of locales and of accommodating diversity among the populations served and those trained to serve them. With all this in mind, training and technical assistance are designed not only to improve practitioners' competence, but to foster changes in the systems with which they work.

A Shared Agenda Stresses a Broad Focus on Mental Health in Schools

From the perspective of initiatives to enhance mental health in schools, efforts to advance a shared agenda must be broadly conceived. Fundamentally, this means contextualizing mental health in schools as:

- Part of essential student support systems that enable students to learn so that schools can achieve their mission; and
- An essential facet of the initiative to transform the mental health system.

Conceiving mental health *as part of* the essential student supports that enable students to learn makes it an imperative for schools as they strive to achieve their mission. It also facilitates deploying and redeploying resources in ways that enhance equity with respect to availability, access, and effectiveness. More specifically, a broad emphasis stresses:

- Promoting social-emotional development, preventing mental health and psychosocial problems, and enhancing resiliency and protective buffers;
- Intervening as early after the onset of emotional, behavior, and learning problems as is feasible and addressing severe and chronic problems;
- Addressing systemic matters at schools that affect student and staff well-being, such as conditions leading to bullying, alienation, and student disengagement from classroom learning;
- Establishing guidelines, standards, and accountability for mental health in schools in ways that confront equity considerations;
- Building the capacity of all school staff to address emotional, behavioral, and learning problems and promote healthy social-emotional development; and
- Drawing on all empirical evidence as an aid in developing a comprehensive, multifaceted, and cohesive continuum of school-community interventions to address emotional, behavioral, and learning problems (see Figure 1).

See AGENDA, next page

"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."

Howard Adelman and Linda Taylor are codirectors of the School Mental Health Project at the University of California in Los Angeles and the UCLA Center for Mental Health in Schools.

Support for this work comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with cofunding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of U.S. Department of Health and Human Services. *Correspondence may be addressed to Howard S. Adelman, Department of Psychology, UCLA, Box 951563, Los Angeles CA 90095-1563; email: adelman@psych.ucla.edu.*

AGENDA, from page 59

Evidence supporting mental health in schools comes from a variety of sources. Some of the science base is synthesized in published lists of empirically supported, evidence-based interventions for school-aged children and adolescents (an annotated summary of these lists is available online at *http://smhp.psych.ucla.edu/pdfdocs/aboutmh/annotatedlist.pdf*). Another synthesis has been compiled by the Center for Mental Health in Schools at UCLA and is summarized in a Center Brief entitled *Addressing Barriers to Student Learning & Promoting Healthy Development: A Usable Research-Base* (available online at *http://smhp.psych.ucla.edu/pdfdocs/briefs/BarriersBrief.pdf*).

New Freedom Commission and Schools

The final report of the President's New Freedom Commission on Mental Health (available online at *http://www.mentalhealthcommission.gov/reports/reports.htm*) recognizes that any effort to enhance interventions for children's mental health must involve schools. Fortunately, schools provide a wide range of programs and services for all students who are not succeeding, and many of these interventions are relevant to mental health and psychosocial concerns. However, schools could and will need to do much more if the Commission's vision of a transformed mental health system is to become a reality.

In the fall of 2003, the two national centers that focus specifically on mental health in schools undertook the challenge of (1) delineating more fully where mental health in schools fits into the Commission's goals and recommendations and (2) reviewing the nature and scope of readily accessible resources relevant to integrating the various agendas for mental health in schools into the recommendations. The intent is to aid those who have the task of operationalizing the Commission's work.

To these ends, by January 2004, the two Centers had prepared a brief entitled *Integrating Agendas for Mental Health in Schools into the Recommendations of the President's New Freedom Commission on Mental Health* (online at *http://smhp.psych.ucla.edu/*). This document stresses that school involvement is an important focus for any effort directed toward transforming the way in which mental health interventions are delivered in the United States and that such efforts can and should capitalize on the needs of and opportunities presented by schools. In the brief, the Centers draw on the extant body of knowledge related to mental health in schools to formulate suggestions about the ways in which the Commission's six goals and 19 recommendations apply to mental health in schools (see Table 1).

Understanding that mental health is essential to overall health is fundamental for establishing a health system that treats mental illnesses with the same urgency as it treats physical illnesses.

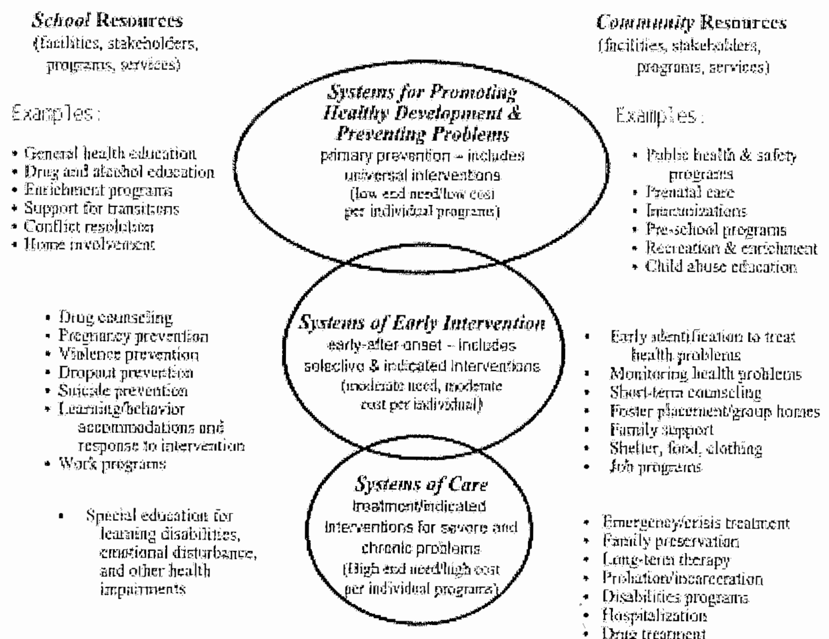
About Goal 1: Americans Understand That Mental Health Is Essential to Overall Health

The executive summary for the Commission's report states that:

> In a transformed mental health system, Americans will seek mental health care when they need it—with the same confidence that they seek treatment for other health problems. As a Nation, we will take action to ensure our health and well-being through learning, self-monitoring, and accountability. We will continue to learn how to achieve and sustain our mental health.
>
> The stigma that surrounds mental illnesses and seeking care for mental illnesses will be reduced or eliminated as a barrier. National education initiatives will shatter the misconceptions about mental illnesses, thus helping more Americans understand the facts and making them more willing to seek help for mental health problems. Education campaigns will also target specific audiences, including:

See AGENDA, next page

Figure 1: Interconnected Systems for Meeting the Needs of All Children: Providing a Continuum of School-Community Programs and Services and Ensuring Use of the Least Intervention Needed



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*.

AGENDA, from page 60

- Rural Americans who may have had little exposure to the mental health service system;
- Racial and ethnic minority groups who may hesitate to seek treatment in the current system; and
- People whose primary language is not English.

When people have a personal understanding of the facts, they will be less likely to stigmatize mental illnesses and more likely to seek help for mental health problems. The actions of reducing stigma, increasing awareness, and encouraging treatment will create a positive cycle that leads to a healthier population. As a Nation, we will also understand that good mental health can have a positive impact on the course of other illnesses, such as cancer, heart disease, and diabetes.

Improving services for individuals with mental illnesses will require paying close attention to how mental health care and general medical care systems work together. While mental health and physical health are clearly connected, the transformed system will provide collaborative care to bridge the gap that now exists.

Effective mental health treatments will be more readily available for most common mental disorders and will be better used in primary care settings. Primary care providers will have the necessary time, training, and resources to appropriately treat mental health problems. Informed consumers of mental health service will learn to recognize and identify their symptoms and will seek care without the fear of being disrespected or stigmatized. Older adults, children and adolescents, individuals from ethnic minority groups, and uninsured or low-income patients who are treated in public health care settings will receive care for mental disorders.

Understanding that mental health is essential to overall health is fundamental for establishing a health system that treats mental illnesses with the same urgency as it treats physical illnesses.

The transformed mental health system will rely on multiple sources of financing with the flexibility to pay for effective mental health treatments and services. This is a basic principle for a recovery-oriented system of care.

Recommendation 1.1 then calls for advancing and implementing a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. In this context, we suggest that:

- **Schools are key venues for campaigns and prevention programs.** An enhanced focus on mental health in schools provides both natural opportu-

See AGENDA, next page

Table 1: President's New Freedom Commission's Goals and Recommendations

Goal 1 – Americans Understand That Mental Health Is Essential to Overall Health

Recommendations.

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention

1.2 Address mental health with the same urgency as physical health

Goal 2 – Mental Health Care Is Consumer and Family Driven

Recommendations:

2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance

2.2. Involve consumers and families fully in orienting the mental health system toward recovery

2.3 Align relevant federal programs to improve access and accountability for mental health services

2.4 Create a Comprehensive State Mental Health Plan

2.5 Protect and enhance the rights of people with mental illnesses

Goal 3 – Eliminating Disparities in Mental Health Services

Recommendations:

3.1 Improve access to quality care that is culturally competent.

3.2 Improve access to quality care in rural and geographically remote areas

Goal 4 – Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

Recommendations:

4.1 Promote the mental health of young children.

4.2 Improve and expand school mental health programs.

4.3 Screen for co-occurring mental & substance use disorders & link with integrated treatment strategies.

4.4 Screen for mental disorders in primary health care, across the lifespan, and connect to t reatment and supports

Goal 5 – Delivering Excellent Mental Health Care and Accelerating Research

Recommendations:

5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Goal 6 – Using Technology to Access Mental Health Care and Information

Recommendations:

6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

6.2 Develop and implement integrated electronic health record and personal health information systems.

AGENDA, from page 61

nities and formal avenues to promote efforts to reduce stigma and prevent not only suicide but a range of other related mental health and psychosocial problems. Natural opportunities occur each day at school as students interact with each other and staff. Formal avenues occur through integration into both regular and special education curricula, including prevention programs, specialized interventions for problems, and as part of courses for social and emotional development and mental health education. Schools also provide a conduit to families and community stakeholders for enhancing understanding about mental health.

Recommendation 1.2 calls for addressing mental health with the same urgency as physical health. In this context, we suggest that:

- **Schools play a major role in shaping public attitudes over time.** As a universal socializing institution, schools are a key determiner of future public opinion. Over time, development of a comprehensive, multifaceted approach to mental health in schools not only can increase understanding, but should enhance appreciation of the need to address mental health with equivalent priority as is given to physical health in our society. Some evidence that this will happen comes from the data generated from school-based health centers, where an enhanced appreciation of the need for and value of mental health assistance has been a consistent finding.

About Goal 2: Mental Health Care Is Consumer and Family Driven

The report's executive summary states:

> In a transformed mental health system, a diagnosis of a serious mental illness or a serious emotional disturbance will set in motion a well-planned, coordinated array of services and treatments defined in a single plan of care. This detailed road map—a personalized, highly individualized health management program—will help lead the way to appropriate treatment and supports that are oriented toward recovery and resilience. Consumer, along with service providers, will actively participate in designing and developing the systems of care in which they are involved.
>
> An individualized plan of care will give consumers, families of children with serious emotional disturbances, clinicians, and other providers a valid opportunity to construct and maintain meaningful, productive, and healing relationships. . . .
>
> No longer will parents forgo the mental health services that their children desperately need. No longer will loving, responsible American parents face the dilemma of trading custody for care. Families will remain intact. Issues of custody will be separated from issues of care. . . .
>
> In this transformed system, stigma and discrimination against people with mental illnesses will not have an impact on securing health care. . . .
>
> The hope and the opportunity to regain control of their lives—often vital to recovery—will become real for consumers and families. Consumers will play a significant role in shifting the current system to a recovery-oriented one by participating in planning, evaluation, research, training, and service delivery.

Recommendation 2.1 calls for developing an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance. In this context, we suggest that:

- **Schools need and are in a position to involve consumers in quality individualized planning.** Schools already involve families in Individual Education Plan (IEP) development as part of their compliance with special education mandates. A beginning has been made to transform such planning to conform with the consumer and family driven principles of systems of care. Along with strengthening systems of care efforts, an enhanced focus on mental health in schools can extend systemic recovery and will contribute to the recovery of parents to enable them to support student progress. A key aspect in accomplishing all this will be enhanced partnerships with other interveners and the youngster and his or her family.

Recommendation 2.2 calls for involving consumers and families fully in orienting the mental health system toward recovery. In this context, we suggest that:

- **Schools that enhance their focus on mental health are more likely to work with young consumers and families toward the goal of recovery.** Schools are under tremendous pressure to raise the achievement of all students. This provides a major incentive for them to do more than control externalizing behavior problems. By enhancing mental health in schools, schools will be able to work toward a youngster's approaches to include young consumers and family driven individualized planning for interventions that are implemented early after the onset of a problem.

Recommendation 2.3 calls for aligning relevant federal programs to improve access and accountability for mental health services. In this context, we suggest that:

- **Schools currently can seek waivers to redeploy and braid federal education dollars to coordinate and enhance the impact of student support services.** For example, under Title I of the No Child Left Behind Act, schools can redeploy up to 5% of the federal funds they receive to enhance coordination of services. A similar provision exists in the Individuals with Disabilities Education Act (IDEA). In addition, schools can seek waivers in order to braid together various sources of categorical program funding. As such opportunities also increase for community agencies, school and community resources can be braided. With the enhanced emphasis on coordinating and integrating resources, availability, access, and accountability will increase.

Recommendation 2.4 calls for creating a Comprehensive State Mental Health Plan. In this context, we suggest that:

- **For a State Mental Health Plan to be comprehensive, it must encompass a significant role for schools.** Figure 1 (on page 60) illustrates this point.

Recommendation 2.5 calls for protecting and enhancing the rights of people with mental illnesses. In this context, we suggest that:

- **Protecting and enhancing the rights of young people with mental illness requires a coordinated and integrated school and community approach.** Evidence of the need to address schools in this respect is seen in the fact that many school systems currently are out of compliance with special education mandates, especially in terms of meeting mental health needs. An enhanced focus on mental health in schools can help address this system failure.

See AGENDA, page 76

AGENDA, from page 62

About Goal 3: Eliminating Disparities in Mental Health Services

The report's executive summary states:

> In a transformed mental health system, all Americans will share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location. Mental health care will be highly personal, respecting and responding to individual differences and backgrounds. The workforce will include members of ethnic, cultural, and linguistic minorities who are trained and employed as mental health service providers. People who live in rural and remote geographic areas will have access to mental health professionals and other needed resources. Advances in treatments will be available in rural and less populated areas. Research and training will continuously aid clinicians in understanding how to appropriately tailor interventions to the needs of consumers, recognizing factors such as age, gender, race, culture, ethnicity, and locale.

Recommendation 3.1 calls for improving access to quality care that is culturally competent. In this context, we suggest that:

- **School staff are mandated to upgrade their competence continuously.** Increasingly, the emphasis in schools is on enhancing effectiveness with diverse populations. This is a key goal of the focus on disaggregating school accountability indices. Initiatives to enhance mental health in schools all emphasize increasing system and staff capacity to eliminate disparities arising from lack of availability, access, and competence related to human diversity. Still, in the interest of enhancing quality, there are major deficiencies that must be addressed with regard to both the pre-service and in-service training of student support staff and of other mental health professionals who come into schools.

Recommendation 3.2 calls for improving access to quality care in rural and geographically remote areas. In this context, we suggest that:

- **Enhancing mental health in all schools is a key to enhancing availability and access in every community.** Schools serve all communities.

About Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

The Commission states:

> In a transformed mental health system, the early detection of mental health problems in children and adults—through routine and comprehensive testing and screening—will be an expected and typical occurrence. At the first sign of difficulties, preventive interventions will be started to keep problems from escalating. For example, a child whose serious emotional disturbance is identified early will receive care, preventing the potential onset of a co-occurring substance use disorder and breaking a cycle that otherwise can lead to school failure and other problems.

Quality screening and early intervention will occur in both readily accessible, low-stigma settings, such as primary health care facilities and schools, and in settings in which a high level of risk exists for mental health problems, such as criminal justice, juvenile justice, and child welfare systems. Both children and adults will be screened for mental illnesses during their routine physical exams.

> For consumers of all ages, early detection, assessment, and links with treatment and supports will help prevent mental health problems from worsening. Service providers across settings will also routinely screen for co-occurring mental illnesses and substance use disorders. Early intervention and appropriate treatment will also improve outcomes and reduce pain and suffering for children and adults who have or who are at risk for co-occurring mental and addictive disorders. Early detection of mental disorders will result in substantially shorter and less disabling courses of impairment.

Recommendation 4.1 calls for promoting the mental health of young children. In this context, we suggest that:

- **Schools increasingly are focusing on preschoolers and the special needs of students in primary grades.** Head start has always had a mental health focus; all preschools are concerned with promoting social and emotional development. Teachers of young children and other staff at their schools are critical elements in promoting mental health (or contributing to emotional and behavioral problems). They are also essential in early detection and referral. With an enhanced focus on mental health in schools, moreover, more student support programs and services can be available to prevent and address problems early after their onset.

Recommendation 4.2 calls for improving and expanding school mental health programs. In this context, we suggest that we should:

- **Continue and expand the federal Mental Health in Schools Program.**
- **Expand the federal mental health research agenda to enhance the focus on mental health in schools.** A strong research agenda is needed with respect to the interface between school and mental health policy, research, training, and practice.
- **Coalesce mental health-related federal categorical programs in schools.** The Safe Schools/Healthy Students initiative has pioneered an interagency approach that braids funds from three federal departments in ways that have improved and expanded mental health programs. A broader initiative is now needed to address the problems of so-called "silo" funding to schools within and across federal agencies. This should include integrating the Center for Disease Control and Prevention's Coordinated School Health Program with a specific emphasis on enhancing school climate in ways that promote healthy physical and mental development. (Also, see school-related recommendation for 2.3 above).

Recommendation 4.3 calls for screening for co-occurring mental and substance use disorders and linking with integrated treatment strategies. In this context, we suggest that:

- **Substance abuse is a major concern in schools.** Because of this, schools provide an invaluable venue for addressing co-occurring mental health and substance problems. Next to parents, teachers and student support staff are in a strategic position to detect problems early. And, by definition, an integrated intervention approach requires the involvement of school staff.

Recommendation 4.4 calls for screening for mental disorders in primary health care, across the lifespan, and connecting to treatment and supports. In this context, we suggest that:

- **School nurses, other student support staff, and the staff of school-based health centers should be viewed as providing primary health care.** Such per-

See AGENDA, next page

AGENDA from page 76

sonnel do and can play an even greater role in early detection and referral of mental health problems and in coordinating and integrating interventions at school and with community providers.

About Goal 5: Delivering Excellent Mental Health Care and Accelerating Research

The Commission states:

In a transformed mental health system, consistent use of evidence-based, state-of-the-art medications and psychotherapies will be standard practice throughont the mental health system. Science will inform the provision of services and the experience of service providers will guide future research. Every time any American—whether a child or an adult, a member of a majority or a minority, from an urban or rural area—comes into contact with the mental health system, he or she will receive excellent care that is consistent with our scientific understanding of what works. That care will be delivered according to the consumer's individualized plan. . . .

Also benefiting from these developments, the workforce will be trained to use the most advanced tools for diagnosis and treatments. Translating research into practice will include adequate training for front-line providers and professionals, resulting in a workforce that is equipped to use the latest breakthroughs in modern medicine. Research discoveries will become routinely available at the community level. To realize the possibilities of advances in treatment, and ultimately in prevention or a cure, the Nation will continue to invest in research at all levels.

Recommendation 5.1 calls for accelerating research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses. In this context, we suggest that we should:

- **Expand the federal mental health research agenda to accelerate the focus on mental health in schools.** There are many areas in need of extensive research. For example, research on resilience and protective buffers related to schools is still in its earliest stages; research on the outcomes of special education programs for emotional and behavioral problems has yet to identify approaches that have a high degree of lasting effectiveness; research is needed with respect to replication and school districts' scale-up of science-based prevention programs.

Recommendation 5.2 calls for advancing evidence-based practices using dissemination and demonstration projects and creating a public-private partnership to guide their implementation. In this context, we suggest that:

- **Schools increasingly are being called upon to use evidence-based mental health practices.** In doing so, they have developed demonstration projects and various dissemination strategies. The next step is to focus on sustainability, replication, and scale-up strategies. Lessons learned from the current federal initiative for diffusing comprehensive school reform models will be instructive with respect to creating public-private partnerships. Also useful will be the lessons learned from the extensive work across the country on developing school-community collaboratives.

Recommendation 5.3 calls for improving and expanding the workforce providing evidence-based mental health services and supports. In this context, we suggest that we:

- **Build the capacity of student support staff and other mental health professionals who come into schools for incorporating science-based activity.** The current federal Mental Health in Schools program has begun this process through its two national training and technical assistance centers. Such capacity building is a long-term concern, and one that must be institutionalized into pre-service and in-service programs across the country.

Recommendation 5.4 calls for developing the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care. In this context, we suggest that:

- **Schools must play a role in each of these areas.** School involvement is indispensable both in terms of contexts and as sources for child and adolescent samples. With an enhanced focus on mental health in schools, some of the barriers to conducting such research can be reduced.

About Goal 6: Using Technology to Access Mental Health Care and Information

The Commission states:

In a transformed mental health system, advanced communication and information technology will empower consumers and families and will be a tool for providers to deliver the best care. Consumers and families will be able to regularly communicate with the agencies and personnel that deliver treatment and support services and that are accountable for achieving the goals outlined in the individual plan of care. Information about illnesses, effective treatment, and the services in their community will be readily available to consumers and families. . . .

An integrated information technology and communications infrastructure will be critical to achieving the five preceding goals and transforming mental health care in America. To address this technological need in the mental health care system, this goal envisions two critical technological components:

- A robust telehealth system to improve access to care; and
- An integrated health records system and a personal health information system for providers and patients.

Recommendation 6.1 calls for using health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations. In this context, we suggest that:

- **Schools already are involved in pioneering use of health technology and telehealth.** The next step is to evolve and sustain the demonstrations and develop replication and scale-up strategies.

Recommendation 6.2 calls for developing and implementing integrated electronic health record and personal health information systems. In this context, we suggest that:

- **Schools currently are in the process of revamping and computerizing their information management systems.** In response to the accountability demands of the No Child Left Behind Act (and the protections required by the Family Educational Rights and Privacy Act and Health Insurance Portability and Accountability Act), school districts across the country are redesigning and computerizing their information management systems. The opportunity exists to influence the type of health data included and to improve system connectivity with health and other agencies.

Concluding Comments

It is one thing to provide a rationale stressing that mental health in schools is an imper-

See AGENDA, next page

EDITOR'S CORNER, from page 58

not just from the perspective of treatments delivered in clinical settings, but from the vantage point and awareness of the larger societal forces that play a role in successful child development and mental health. For example, consider the following: For those of us who consider ourselves child advocates, to what extent do we/should we advocate for child mental health treatment interventions per se, or for programs that are less directly but nonetheless linked to child (and family) mental health but which we do not normally consider part of the mental health domain—e.g., parental health, employment, and housing, prenatal and early childhood nutrition, pollution control, even seat belts and bicycle helmets? To the extent that any of these factors are linked to improved overall family well-being, to children's social-emotional health, and/or to brain development, one might conclude that addressing such factors will reduce the overall burden of behavioral and emotional disorders (Costello & White, 2001).

Although the overall focus of *EBDY* is not on prevention/early intervention per se, it is critical that we not lose sight of the importance of these factors. Seeing differences in rates of various risk factors across other countries and contexts, as well as differences in how well countries address these factors, helps us to double-check our assumptions and make sure that we are not missing the bigger picture. For my part, it is a humbling experience to see how much we have to learn from our like-minded colleagues in other countries.

—Peter S. Jensen, M.D.

Seeing differences in rates of various risk factors across other countries and contexts, as well as differences in how well countries address these factors, helps us to double-check our assumptions and make sure that we are not missing the bigger picture.

References

Costello, A., & White, H. (2001). Reducing global inequalities in child health. *Archives of Disease in Childhood, 84(2)*, 98–102.

Duarte, C., Hoven, C., Berganza, C., Bordin, I., Bird, H., & Miranda, C.T. (2003). Child mental health in Latin America: Present and future epidemiologic research. *International Journal of Psychiatry in Medicine, 33(3)*, 203–222.

Fewtrell, L.J., Pruss-Ustun, A., Landrigan, P., & Ayuso-Mateos, J.L. (2004). Estimating the global burden of disease of mild mental retardation and cardiovascular diseases from environmental lead exposure. *Environmental Research, 94(2)*, 120–133.

Fombonne, E. (1994). The Chartres Study: I. Prevalence of psychiatric disorders among French school-age children. *British Journal of Psychiatry, 164(1)*, 69–79.

Ford, T., Goodman, R., & Meltzer, H. (2003). The British Child and Adolescent Mental Health Survey 1999: The prevalence of DSM-IV disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 42(10)*, 1203–1211.

Levi, F., La Vecchia, C., Lucchini, F., Negri, E., Saxena, S., Maulik, P.K., & Saraceno, B. (2003). Trends in mortality from suicide, 1965–99. *ACTA Psychiatrica Scandinavica, 108(5)*, 341–349.

Sawyer, M.G., Arney, F.M., Baghurst, P.A., Clark, J.J., Graetz, B.W., Kosky, R.J., Nurcombe, B., Patton, G.C., Prior, M.R., Raphael, B., Rey, J.M., Whaites, L.C., & Znbrick, S.R. (2001). The mental health of young people in Australia: Key findings from the child and adolescent component of the national survey of mental health and well-being. *Australian and New Zealand Journal of Psychiatry, 35(6)*, 806–814.

Sentes, K., & Kipp, W. (2003). Global burden of disease: Huge inequities in the health status in developing and developed countries. *Healthcare Management Forum, 16(3)*, 27–29.

Tadesse, B., Kebede, D., Tegegne, T., & Alem, A. (1999). Childhood behavioural disorders in Ambo district, western Ethiopia. I. Prevalence estimates. *ACTA Psychiatrica Scandinavica Supplement, 397*, 92–97.

Valent, F., Little, D., Bertollini, R., Nemer, L.E., Barbone, F., & Tamburlini, G. (2004). Burden of disease attributable to selected environmental factors and injury among children and adolescents in Europe. *Lancet, 363(9426)*, 2032–2039. ■

AGENDA, from page 77

ative; it is quite another thing to frame the way in which that imperative should be met. From the perspective of the schools' mission, it is insufficient to frame the work only in terms of (1) screening and diagnosing psychopathology, (2) providing clinical services, and (3) connecting community mental health providers to schools. Although these are all fundamental to improving mental health, the framework for making the case that mental health *in schools* is an *imperative* must be more comprehensive. Making that case requires proceeding in ways that:

- **Define mental health broadly:** that is, they encompass the agenda for mental health *in schools* within the broad context of the psychosocial and mental health concerns encountered each day at schools—including an emphasis on strengths as well as deficits; they also include an emphasis on the mental health of students' families and school staff;
- **Enhance partnerships among schools, communities, and the home:** that is, they focus on coalescing and enhancing the roles of schools/communities/homes in addressing emotional, behavioral, and learning problems;
- **Confront equity considerations:** that is, stress the role mental health in schools can play in ensuring all students have an equal opportunity to succeed at school;
- **Address the related problems of marginalization, fragmentation, and counterproductive competition for sparse resources:** that is, they focus on coalescing policy, agencies, organizations, and daily practice;
- **Address the challenges of evidence-based strategies and achieving results:** that is, they stress ways to build on current in-school practices using a science base.

As the New Freedom Commission recognizes, this is a time of sparse resources for public enterprises. Their report therefore stresses the importance of "policy and program changes that make the most of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers, coupled with a strong measure of accountability." The aim is to more wisely invest and use sparse resources. The focus in this brief on mental health in schools is consistent with this aim.

Schools currently expend significant resources on student support programs and services that address behavioral and emotional problems. Such resources are deployed through piecemeal policies and fragmented efforts. One focus of the federal Mental Health in Schools Program has been to address these problems so that resources are deployed and redeployed in ways that enhance equity with respect to availability, access, and effectiveness.

As the New Freedom Commission's recommendations are operationalized, the opportunity arises to further the agendas for schools to play a comprehensive role in transforming mental health in the United States. There are many stakeholders ready to help make this a reality. ■