Mental Health in Schools and Public Health

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Health policy and practice call for health and mental health parity and for a greater focus on universal interventions to promote, prevent, and intervene as early after problem onset as is feasible. Those in the public health field are uniquely positioned to help promote the mental health of young people and to reshape how the nation thinks about and addresses mental health. And schools are essential partners for doing the work.

YOUNG PEOPLE'S MENTAL HEALTH IS A MAJOR PUBLIC HEALTH CONCERN

The figures usually indicated for diagnosable mental disorders suggest that between 12% and 22% of all youngsters under age 18 are in need of services for mental, emotional, or behavioral problems.[1] The picture worsens when one expands the focus beyond the limited perspective on diagnosable mental disorders to encompass the number of young people experiencing psychosocial problems and those who are at risk of not maturing into responsible adults. The reality for many large urban schools is that well over 50% of their students manifest significant learning, behavior, and emotional problems.[2] For a large proportion of these youngsters, the problems are rooted in the restricted opportunities and difficult living conditions associated with poverty. Almost every current policy discussion stresses the crisis nature of the problem in terms of future health and economic implications for individuals and for society and calls for major systemic reforms.

A growing problem is that more and more youngsters manifesting emotional upset, misbehavior, and learning problems are routinely assigned psychiatric labels denoting severe internal disorders (e.g., attention deficit/hyperactivity disorder, depression, learning disabilities). This trend flies in the face of the reality that the problems of *most* youngsters are not rooted in internal pathology, and many troubling symptoms would not develop if environmental circumstances were appropriately different. Moreover, the trend to diagnosing so many learning, behavior, and emotional problems as disorders leads to large numbers of misdiagnoses and inappropriate and expensive treatments. All of

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this contaminates research, policy, practice, and training. Reducing misdiagnoses and misprescriptions requires placing mental illness in perspective with respect to psychosocial problems and broadly defining mental health to encompass the promotion of social and emotional development and learning.

A CONTINUUM OF INTERVENTIONS

When behavior, emotional, and learning problems are labeled in ways that overemphasize internal pathology, the primary helping strategies used tend to be forms of clinical/remedial intervention. For the most part, such interventions are developed and function in relative isolation of each other. Thus, they represent another instance of using piecemeal and fragmented strategies to address complex problems.

Ameliorating the full continuum of problems generally requires a comprehensive and integrated approach. From this perspective, mental health must be seen as both (*1*) promoting healthy development as one of the keys to preventing psychosocial and mental health problems and (*2*) focusing on comprehensively addressing barriers to development and learning. A public health perspective is needed in both instances. The goals are to:

- Directly facilitate physical, social, and emotional development;
- Minimize psychosocial and mental health problems;
- Identify, correct, or at least minimize problems as early after their onset as is feasible;
- Provide for coordinated treatment of severe and chronic problems; and
- Provide services for severe-chronic psychosocial/mental/physical problems.

Accomplishing all of this requires a continuum of interventions, ranging from systems for promoting healthy development and preventing problems (primary prevention) through those for addressing problems soon after onset, and on to treatments for severe and chronic problems. Moreover, from a schooling perspective, the continuum needs to include (*1*) public health protection, promotion, and maintenance that foster positive development and wellness; (*2*) preschool-age support and assistance to enhance health and psychosocial development; (*3*) early-schooling targeted interventions; (*4*) improvement and augmentation of ongoing regular support; (*5*) other interventions prior to referral for intensive and ongoing targeted treatments; and (*6*) intensive treatments.

The continuum highlights that many problems must be addressed developmentally and with a range of programs—some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. The continuum also underscores the need for concurrent interprogram linkages and for linkages over extended periods. And, consistent with contemporary public health policy and practice, the emphasis throughout is meant to be on:

- Achieving results;
- Involving and mobilizing consumers and enhancing partnerships with those at home, at school, and in the community;
- Confronting equity and human diversity considerations;
- Balancing the focus on addressing problems with an emphasis on promoting health and development of assets; and
- Including evidence-based strategies.

ABOUT PROMOTING MENTAL HEALTH AND PREVENTING PROBLEMS

While screening and diagnosing problems and providing clinical services are fundamental to any mental health system, a public health approach requires much more. Building on the broadest definitions discussed above, a comprehensive approach calls for interventions that assist youngsters and their support systems in preventing problems and addressing those that can't be avoided. And, of course, this includes assuring there are interventions designed for universal application, with access for anyone interested.

In general, from the perspective of health promotion and problem prevention, a comprehensive framework for mental health intervention must address risk factors, protective buffers, and the promotion of full development related to youngsters, families, schools, and communities. Promotion of mental health encompasses efforts to enhance knowledge, skills, and attitudes in order to foster social and emotional development, a healthy lifestyle, and personal well-being. Promoting healthy development, well-being, and a value-based life are important ends unto themselves and are keys to preventing psychosocial and mental health problems. Such interventions focus not only on strengthening individuals, but also on enhancing nurturing and supportive conditions at school, at home, and in the neighborhood. All this includes a particular emphasis on increasing opportunities for personal development and empowerment by promoting conditions that foster and strengthen positive attitudes and

behaviors (e.g., enhancing motivation and capability to pursue positive goals, resist negative influences, and overcome barriers).

While prevention encompasses efforts to promote well-being, the primary focus is on interventions to reduce risks and enhance buffers either through programs designed for the general population (often referred to as universal interventions) or for selected groups designated at risk. With respect to risk factors, again the intervention focus is not only on individuals, but on conditions at home, in the neighborhood, and at school. This recognizes that the primary causes for most youngsters' emotional, behavior, and learning problems are external factors (e.g., related to neighborhood, family, school, and/or peer factors such as extreme economic deprivation, community disorganization, high levels of mobility, violence, drugs, poor quality or abusive caretaking, poor quality schools, negative encounters with peers, inappropriate peer models, immigrant status, etc.). At the same time, there is continuing concern about problems stemming from individual disorders and developmental and motivational differences (e.g., medical problems, low birthweight/neurodevelopmental delay, psychophysiological problems, difficult temperament and adjustment problems, etc.).

Public health professionals can encourage youngsters and their families to take advantage of opportunities in the schools and community to prevent problems and enhance protective buffers (e.g., resilience). Examples include enrollment in (*1*) direct instruction designed to enhance specific areas of knowledge, skills, and attitudes on mental health matters; (*2*) enrichment programs and service learning opportunities at school and/or in the community; and (*3*) after-school youth development programs.

In addition, public health professionals have a role to play in initiatives designed to strengthen families and communities. For example, the National Strategy for Suicide Prevention's first goal is to promote awareness that suicide is a public health problem that is preventable. It suggests developing public education campaigns, sponsoring national conferences on suicide prevention, organizing special-issue forums, and disseminating information.

A NOTE ABOUT MENTAL HEALTH SCREENING IN SCHOOLS

Each year parents and teachers identify large numbers of children soon after the onset of a problem identified through their daily interactions. This natural screening can be helpful in initiating supportive accommodations that can be incorporated into regular school and home practice. Then, by assessing the response of these children to such interventions, it can be determined whether more specialized intervention is needed to overcome a problem.

In contrast to natural screening, formal screening to identify students who have problems or who are "at risk" is accomplished through individual or group assessment procedures. Most such procedures are *first-level* screens and are expected to over-identify problems. That is, they identify many students who do not really have significant problems (false positive errors). This certainly is the case for screens used with infants and primary grade children, but false positives are not uncommon when adolescents are screened. Errors should be detected by follow-up assessments. Because of the frequency of false positive errors, serious concerns arise when screening data are used to diagnose students and prescribe remediation and special treatment.

Screening data are primarily meant to sensitize responsible professionals. No one wants to ignore indicators of significant problems. At the same time, there is a need to guard against tendencies to see normal variations in students' development and behavior and other facets of human diversity as problems. First-level screens do not allow for definitive statements about a student's problems and need. At best, such screening procedures provide a preliminary indication that something may be wrong. In considering formal diagnosis and prescriptions for how to correct the problem, one needs data from assessment procedures with greater validity. It is essential to remember that many factors found to be symptoms of problems also are common characteristics of young people, especially in adolescence.

Clearly, extreme caution must be exercised to avoid misidentifying and inappropriately stigmatizing a youngster. It is easy to overestimate the significance of a few indicators. Moreover, many formal screening instruments add little predictive validity to natural screening.

PUBLIC HEALTH PROFESSIONALS NEED TO ENHANCE COLLABORATIVE RELATIONSHIPS WITH SCHOOLS

School staff and public health professionals share goals related to education and socialization of the young. Ultimately, they must collaborate with each other if they are to accomplish their respective missions. As the Carnegie Task Force on Education stressed, "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."[3] And to

meet the challenge, schools and communities must work together.

Promoting well-being, resilience, and protective factors and empowering families, communities, and schools all require multiple and interrelated interventions and the concerted effort of all stakeholders. Leaving no child behind and closing the achievement gap are only feasible through well designed collaborative efforts.

Obviously, true collaboration involves more than meeting and talking. The point is to work together to produce actions that yield important results. For this to happen, steps must be taken to ensure that collaboratives are developed in ways that ensure they can be effective. This includes providing them with the training, time, support, and authority to carry out their roles and functions. It is when such matters are ignored that groups find themselves meeting and meeting, but going nowhere.

Collaboratives are about building relationships. It is important to understand that the aim is to build potent, synergistic, *working* relationships, not simply to establish positive personal connections. Collaboratives built mainly on personal connections are vulnerable to the mobility that characterizes many such groups. Establishing stable and sustainable working relationships requires clear roles, responsibilities, and an institutionalized infrastructure, including effective mechanisms for performing tasks, solving problems, and mediating conflict. Through well designed collaboration with schools, public health professionals can help build the continuum of interventions needed to make a significant impact in addressing the safety, health, learning, and general well-being of all youngsters.

MENTAL HEALTH IN SCHOOLS: WHERE IS THE FIELD GOING?

Prediction is a risky business. A few matters are evident. For one, it is clear that the fields of mental health and public health are both in flux. For another, practitioners in the schools who are most associated with mental health concerns are realizing that changes are needed and are afoot. There is widespread agreement that a great deal needs to be done to improve what is taking place. And, at this point in time, no specific perspective or agenda is dominating policy, practice, research, or training.

However, we are detecting an emerging view related to mental health in schools. That view is calling for much more than expanded services and full service schools. It is focused on enhancing strategic collaborations to develop comprehensive approaches that strengthen students, families, schools, and neighborhoods and doing so in ways that maximize learning, caring, and well-being. And, it involves the full integration of mental health concerns into a school's efforts to provide students with learning supports. This means connecting various mental health agenda in major ways with the mission of schools and integrating with the full range of student learning supports designed to address barriers to learning. Moreover, given the current state of school resources, the work must be accomplished by rethinking and redeploying existing resources and by taking advantage of the natural opportunities at schools for countering psychosocial and mental health problems and promoting personal and social growth.

The emerging view recognizes that schools are not in the mental health business. Indeed, it fully recognizes that many school stakeholders are leery of mental health, especially when the focus is presented in ways that equate the term only with mental disorders. Such stakeholders are quick to stress that the mission of schools is to educate all students. In response, advocates of the emerging view stress that when students are not doing well at school, mental health concerns and the school's mission usually overlap because the school cannot achieve its mission for such students without addressing factors interfering with progress. This is especially the case in schools where students not doing well outnumber those who are. In such instances, an enhanced focus on addressing barriers to learning and teaching provides a context for pursuing a needed range of mental health and psychosocial concerns within the stated mission of schools.

The emerging view, of course, requires major systemic changes. Such changes will require weaving school-owned and community-owned resources together to develop comprehensive and cohesive approaches. Efforts to advance mental health in schools also must adopt effective models and procedures for helping every school in a district. This means addressing the complications stemming from the scale of public education in the United States.

The emerging view also focuses on promoting the well-being of teachers and other school staff members so they can do more to promote the well-being of students. Like students, school personnel require supports that enhance protective buffers, reduce risks, and promote well-being. Every school needs to commit to fostering staff and student resilience and creating an atmosphere that encourages mutual support, caring, and sense of community. Staff and students must feel good about themselves if they are to cope with challenges proactively and effectively.

For any school, a welcoming induction and ongoing support are critical elements both in creating a positive sense of community and in facilitating staff and student school adjustment and performance. School-wide strategies for welcoming and supporting staff, students, and families at school every day are part of creating a mentally healthy school—one where staff, students, and families interact positively with each other and identify with the school and its goals. The ideal is to create an atmosphere that fosters smooth transitions, positive informal encounters, and social interactions; facilitates social support; provides opportunities for ready access to information and for learning how to function effectively in the school culture; and encourages involvement in decision making. Clearly, for such an ambitious picture to become a reality will require the combined creativity and energy of many school, public health, and mental health professionals.

In sum, any effort to enhance public health interventions to improve children's mental health must involve schools, and the aims of mental health in schools are best accomplished through the involvement of public health professionals. Schools already provide a wide range of programs and services relevant to public health and mental health. And schools can and need to do much more if the mandates of the No Child Left Behind Act and the Individuals with Disabilities Education Act, the recommendations of the President's New Freedom Commission on Mental Health, and the goals of Healthy People 2010 are to be achieved.

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REFERENCES

1. Department of Health and Human Services (US). Mental health: a report of the Surgeon General. Rockville (MD): DHHS; 1999. Also available from: URL: http://www.surgeongeneral.gov/library/mentalhealth/home.html [cited 2006 Jan 20].
2. Center for Mental Health in Schools. Youngsters' mental health and psychosocial problems: what are the data? Los Angeles: University of California at Los Angeles; 2003.
3. Carnegie Council on Adolescent Development. Turning points: preparing American youth for the 21st century. New York: Carnegie Corporation; 1989.