Chapter 2

Advancing Mental Health in Schools—Guiding Frameworks and Strategic Approaches

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INTRODUCTION

It is, of course, not a new insight that physical and mental health concerns must be addressed if schools are to function satisfactorily and students are to succeed at

school. It has long been acknowledged that a variety of psychosocial and health problems affect learning and performance in profound ways (see Bremmer, 1971; Council for Chief State School Officers, 1992; Tyack, 1992). Such problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure. Because of all this, school policy makers, have a lengthy (albeit somewhat reluctant) history of trying to assist teachers in dealing with problems that interfere with schooling. Prominent examples are seen in the range of counseling, psychological, and social service programs that schools provide (Adelman, 1998).

Adding to what school education support staff do, there has been renewed emphasis over the past twenty years in the health and social services arenas on increasing linkages between schools and community service agencies to enhance the well-being of young people and their families (Dryfoos 1994; 1998; Surgeon General, 2000). This "school-linked services" agenda has added impetus to advocacy for mental health in schools.

More recently, the efforts of some advocates for school-linked services have merged with forces working to enhance initiatives for community schools, youth development, and the preparation of healthy and productive citizens and workers (see Merseth, Schorr, & Elmore, 2000). The merger has expanded interest in social-emotional learning and protective factors as avenues to increase students' assets and resiliency and reduce risk factors (Elias et al., 1997).

Thus, varied policies and initiatives have emerged relevant to efforts to enhance mental health in schools. Some directly support school programs and personnel; others connect community programs and personnel with schools. As a result, most schools have some programs to address a range of mental health and psychosocial concerns (e.g., school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upsets, delinquency, and violence.) 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. And, available research suggests that for some youngsters schools are the main providers of mental health services. As Burns and her colleagues (Burns et al., 1995) report from the study of children's utilization of mental health services in western North Carolina, "the major player in the de facto system of care was the education sector—more than three-fourths of children receiving mental health services were seen in the education section, and for many this was the sole source of care" (p. 155).

Clearly, mental health activity is going on in schools. Equally evident, there is a great deal to be done to improve what is taking place. For reasons discussed elsewhere, the current state of affairs is that these diverse school and community resources are attempting to address complex, multifaceted, and overlapping psychosocial and mental health concerns in highly fragmented and marginalized ways. (Adelman & Taylor, 1998, 1997a, 2000a, 2000b, 2000c). This has led to redundancy, inappropriate competition, and inadequate results.

One response to this state of affairs is seen in the calls for realigning policy and practice around a cohesive framework based on well-conceived models and the best available scholarship (Adelman & Taylor, 1998, 2000a; 2000b; 2000c; Franklin & Streeter, 1995; Knitzer, Steinberg, & Fleisch, 1990; Leaf et al., 1996; Taylor &

Adelman, 2000a). With specific respect to mental health in schools, it has been stressed that initiatives must connect in major ways with the mission of schools and integrate with a restructured system of education support programs and services (Adelman, 1996; Adelman & Taylor, 1997a; Institute of Medicine, 1997; Policy Leadership Cadre for Mental Health in Schools, 2001).

From our perspective, systemic changes must weave school-owned resources and community-owned resources together to develop comprehensive, multifaceted, and integrated approaches for addressing barriers to learning and enhancing healthy development (Adelman & Taylor, 2002). Moreover, pursuit of such changes must also address complications stemming from the scale of public education in the United States. Currently, there are about 90,000 public schools in about 15,000 districts. Thus, efforts to advance mental health in schools must also adopt effective models and procedures for replication and "scale-up" (Adelman & Taylor, 1997b; Motes et al., 1996; Taylor, Nelson, & Adelman, 1999).

Although efforts to advance mental health in schools often are hampered by competing initiatives and agendas, the diversity of initiatives has laid a foundation that can be built upon. There is a need, however, for increased emphasis on strategic approaches for enhancing policy and practice. Such strategic approaches can be fostered through efforts to unify thinking about mental health in schools, adoption of well-conceived guiding frameworks, and by support for development of focused networking. To these ends, this chapter: (1) highlights the need for a broad perspective in thinking about and justifying "mental health" in schools; (2) offers a working draft of comprehensive and multifaceted guidelines that provide a basis for operationally defining mental health in schools; (3) proposes an integrated framework for promoting healthy development and addressing barriers to learning at a school site in ways that can expand the impact of mental health in schools; and (4) describes strategies that the national Center for Mental Health in Schools at UCLA currently pursues to advance the field.

MENTAL HEALTH IN SCHOOLS—WHAT ARE WE TALKING ABOUT?

Ask five people what is meant by the term "mental health in schools" and you'll probably get five different answers. At schools, as in the general community, there is a widespread policy trend to use the term mental health as if it were synonymous with mental illness, disorders, or problems. Because of this, mental health tends to be defined de facto 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 a mental health field that is primarily focused on problems. This focus has carried over into policy and practice for mental health in schools.

A step toward redressing this limited perspective is seen in the *Report of the Surgeon General's Conference on Children's Mental Health* (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" (p. 3). 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" (p. 16). 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" (*http://www.mentalhealth.org/publications/allpubs/ca-0005*). This is contrasted with *mental health problems*. The designation 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 policy makers 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 mental health 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; Hawkins, Catalano, & Miller, 1992). Moreover, as noted already, these problems are often worsened by the psychological impact of confronting barriers to development and learning and the debilitating effects of performing poorly at school, at home, and in the neighborhood (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 mental health and psychosocial concerns—including concern for promoting positive mental health.

The overemphasis on disorders and disabilities contributes to a tendency to view students as having internal problems when they are not doing well in class and to increasing numbers of referrals for counseling or for assessment in hopes of referral for special help. In some schools and classrooms, the number of referrals is so dramatic as to be alarming. Where special teams have been established to review teacher requests for help, the list grows as the year proceeds. The longer the list, the longer the lag time for review—often to the point that, by the end of the school year, the team has only reviewed a small percentage of those on the list. And, no matter how many are reviewed, there are always more referrals than can be served (Taylor & Adelman, 1996).

One solution might be to convince policy makers to fund more services. However, even if the policy climate favored expanding public services, more health and social services alone are not a comprehensive approach for addressing barriers to learning. More services to treat problems are certainly needed. But so are prevention and early-after-onset programs that can reduce the number of students teachers refer for special assistance.

Delivery Mechanisms and Formats

Our analysis suggests that five delivery mechanisms are being used to provide programs and services in schools (Table 2.1). The mechanisms take on varying oper-

Table 2.1
Mental Health in Schools: Delivery Mechanisms and Formats

The five mechanisms and related formats are:

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., "wrap-around" services for those in special education). Four formats have emerged:

- co-location of community agency personnel and services at schools—sometimes in the context of School-Based Health Centers 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

From: Policy Leadership Cadre for Mental Health in Schools (2001). *Mental health in schools: Guidelines, models, resources & policy considerations.* Los Angeles: Center for Mental in Schools at UCLA.

ational formats and differ in terms of focus and comprehensiveness, but for the most part they are not mutually exclusive. Some focus primarily on the treatment of mental health problems; others include a focus on prevention of such problems; and some encompass a concern for promoting positive mental health (e.g., healthy social and emotional development). In terms of comprehensiveness, some are essentially mechanisms to provide and/or refer to clinical treatment. Others aspire to developing a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as soon after onset as is feasible, and offer treatment regimens.

Although many school-based programs and services seem well entrenched, there continue to be segments of the populace that question whether schools are an appropriate venue for mental health interventions (Sedlak, 1997). The reasons vary from concern that such activity will take time away from the educational mission to fear that such interventions are another attempt by society to infringe on family rights and values. There also is the long-standing discomfort so many in the general population feel about the subject of mental health—which 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 (Taylor & Adelman, 2000b).

One straightforward rationale for schools addressing psychosocial and mental health concerns is well stated by the Carnegie Council's Task Force on Education of Young Adolescents (1989): "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" (p. 7). Additional arguments point to the mandate schools have to foster positive social and personal functioning.

Fortunately, from a research-based perspective, there is a large body of evidence supporting the promise of many current school practices that fit under a broad definition of mental health (Greenberg, Domitrovich, & Bumbarger, 1999; Hoagwood & Erwin, 1997; Rones & Hoagwood, 2000). At this juncture, however, the field is still in its infancy. It can draw on empirically supported practices, but it cannot be limited to them if it is to be effective in responding to the full range of complex, overlapping psychosocial and mental health concerns all schools must address.

Nature and Scope of Interventions

The problem rests with the restricted nature and scope of interventions that currently have strong research support (Elliott, 1998). The best (not always equated with good) evidence-based strategies for identifying and working with psychosocial and mental health concerns of young people are related to a small number of noncomorbid disorders. Even then the data are for studies of the efficacy of highly controlled investigations—not of effectiveness of implementation under regular school conditions. That is, the most positive findings come from work done in tightly structured research situations. Unfortunately, comparable results are not found when prototype treatments are institutionalized in school settings. Similarly, most findings on classroom and small group programs come from short-term experimental studies (usually without any follow-up phase). The question of whether the results of such projects will

hold up when the prototypes are translated into widespread applications remains unanswered (see Durlak, 1998; Elias, 1997; Schorr, 1997; Weisz, Donnenberg, Han, & Weiss, 1995). A barrier related to available evidence-based interventions involves developing ways to improve effectiveness in community and school settings and gathering data that demonstrates enhanced cost-effectiveness. An even bigger problem in addressing the mental health needs of children and adolescents involves investing in the development and evaluation of interventions that go beyond one-to-one and small group approaches and that incorporate a full intervention continuum in the form of systems of prevention, systems of early intervention, and systems of care. Thus, the field must adopt and be guided by a comprehensive, unifying framework that encompasses the full range of activity schools have to address.

With all this in mind, the case for mental health in schools probably is best made by not presenting it separately, but embedding it as one element of a comprehensive, multifaceted continuum of programs and services schools need to enable effective learning and teaching. Such a continuum encompasses efforts both to promote healthy development and address barriers to development, learning, parenting, and teaching. Properly developed and implemented, a focus on mental health in schools can contribute toward ensuring all students have an equal opportunity to develop to their fullest cognitive, social, and emotional capabilities.

COMPREHENSIVE AND MULTIFACETED GUIDELINES FOR MENTAL HEALTH IN SCHOOLS

With the need for advancing the field in mind, a national leadership "mini-summit" was held in June, 1999, to explore policy and infrastructure concerns relevant to advancing mental health in schools. One outcome of the mini-summit was establishment of the Policy Leadership Cadre for Mental Health in Schools. Drawing on the varied and growing literature relevant to mental health in schools, one of the first tasks undertaken by the Cadre was development of a field-defining document entitled *Mental Health in Schools: Guidelines, Models, Resources & Policy Considerations*. This timely work complements and enhances recent federal initiatives designed to advance the agenda for children's mental health. Of particular importance are the rationale and comprehensive and multifaceted set of guidelines that the Cadre delineates for mental health in schools.

Table 2.2 outlines the guidelines. (For the rationale statements, references, and outcomes related to each of the guidelines, see the Cadre document, which can be accessed on the internet (*http://smhp.psych.ucla.edu*); a hardcopy is available for the cost of copying and handling (contact: Center for Mental Health in Schools at UCLA, Box 951563, Department of Psychology, UCLA, Los Angeles, CA 90095-1563).) As can be seen from the breadth of the outline, the Cadre operated under the premise that any definition of mental health in schools must encompass considerations of the school's role related to both positive mental health (e.g., promotion of social and emotional development) and mental health problems (e.g., psychosocial concerns and mental disorders).

Clearly, no school currently encompasses what is embodied in the outline. In a broad sense, the guidelines define a vision for how mental health in schools should be defined and implemented. They provide a focal point for clarifying the nature and

Table 2.2
Guidelines for Mental Health in Schools

1. *General Domains for Intervention in Addressing Students' Mental Health*

1.1 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)

1.2 Addressing barriers to student learning and performance (including educational and psychosocial problems, external stressors, psychological disorders)

1.3 Providing social/emotional support for students, families, and staff

2. *Major Areas of Concern Related to Barriers to Student Learning*

2.1 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; nelect; substance abuse; psychological reactions to physical status and sexual activity)

2.2 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)

2.3 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; Post Traumatic Stress Disorder; Anorexia and Bulimia; special education designated disorders such as Emotional Disturbance and Developmental Disabilities)

3. *Type of Functions Provided related to Individuals, Groups, and Families*

3.1 Assessment for initial (first level) screening of problems, as well as for diagnosis and intervention planning (including a focus on needs and assets)

3.2 Referral, triage, and monitoring/management of care

3.3 Direct services and instruction (e.g., primary prevention programs, including enhancement of wellness through instruction, skills development, guidance counseling, advocacy, school-wide prorams to foster safe and caring climates, and liaison connections between school and home; crisis intervention and assistance, including psychological first-aid, prereferral inteventions; accommodations to allow for differences and disabilities; transition and follow-up programs; short- and longer- term treatment, remediation, and rehabilitation)

3.4 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

3.5 Consultation, supervision, and inservice instruction with a transdisciplinary focus

3.6 Enhancing connections with and involvement of home and community resources (including but not limited to community agencies)

4. *Timing and Nature of Problem-Oriented Interventions*

4.1 Primary prevention

4.2 Intervening early after the onset of problems

(continued on next page)

Table 2.2 (cont'd)

4.3 Interventions for severe, pervasive, and/or chronic problems

5. *Assuring Quality of Interventions*

5.1 Systems and interventions are monitored and improved as necessary

5.2 Programs and services constitute a comprehensive, multifaceted continuum

5.3 Interveners have appropriate knowledge and skills for their roles and functions and provide guidance for continuing professional development

5.4 School-owned programs and services are cordinated and integrated

5.5 School-owned programs and services are connected to home & community resources

5.6 Programs and services are integrated with instructional and governance/management components at schools

5.7 Program/services are available, accessible, and attractive

5.8 Empirically-supported interventions are used when appliable

5.9 Differences among students/families are appropriately accounted for (e.g., diversity, disability, developmental levels, motivational levels, strengths, weaknesses)

5.10 Legal considerations are appropriately accounted for (e.g., mandated services; mandated reporting and its consequences)

5.11 Ethical issues are appropriately accounted for (e.g., privacy & confidentiality; coercion)

5.12 Contexts for intervention are appropriate (e.g., office; clinic; classroom; home)

6. Outcome Evaluation and Accountability

6.1 Short-term outcome data

6.2 Long-term outcome data

6.3 Reporting to key stakeholders and using outcome data to enhance intervention quality

From: Policy Leadership Cadre for Mental Health in Schools (2001). *Mental health in schools: Guidelines, models, resources & policy considerations*. Los Angeles: Center for Mental in Schools at UCLA.

scope of mental health in schools. They represent a framework for designing comprehensive, multifaceted, and cohesive approaches to mental health in schools. They also provide a step toward an operational definition of mental health in schools. Moreover, they do so in a way that is a good match with the mission of schools.

Note that the guidelines avoid conveying the impression that schools should be in the mental health business, but rather indicate the many ways that a mental health focus supports the school's mission. This reflects an awareness that those who mean to advance mental health in schools must work to ensure that their agenda is not seen as separate from a school's educational mission. Indeed, in terms of policy, practice, and research, all activity related to mental health in schools, including the many categorical programs for designated problems, eventually must be integrated fully into school reform initiatives (Goldman, 1997). This is the way to increase appreciation of how essential such efforts are to the learning and teaching agenda. It is also the key to ending the marginalization and fragmentation that currently characterize most endeavors for promoting mental health and addressing barriers to learning at schools.

The guidelines underscore that more than good instruction is needed if every student is to have an equal opportunity to succeed at school. They delineate the "more" as calling for establishment of comprehensive, multifaceted, and cohesive approaches that address mental health and psychosocial concerns, including initiatives for promoting and enhancing healthy development.

AN INTEGRATED FRAMEWORK FOR ADDRESSING BARRIERS TO LEARNING AND ENHANCING HEALTHY DEVELOPMENT AT A SCHOOL SITE

In our efforts to advance mental health in schools, we have reconciled ourselves to the fact that the mission of schools is education and they are not in the mental health business. At the same time, we have built on the reality that schools must play a role in addressing factors that interfere with their agenda of ensuring "no child is left behind." Thus, rather than arguing that schools must provide mental health services, we embed this concern into a broader framework of addressing barriers to student learning and promoting healthy social and emotional development.

Addressing Barriers to Student Learning

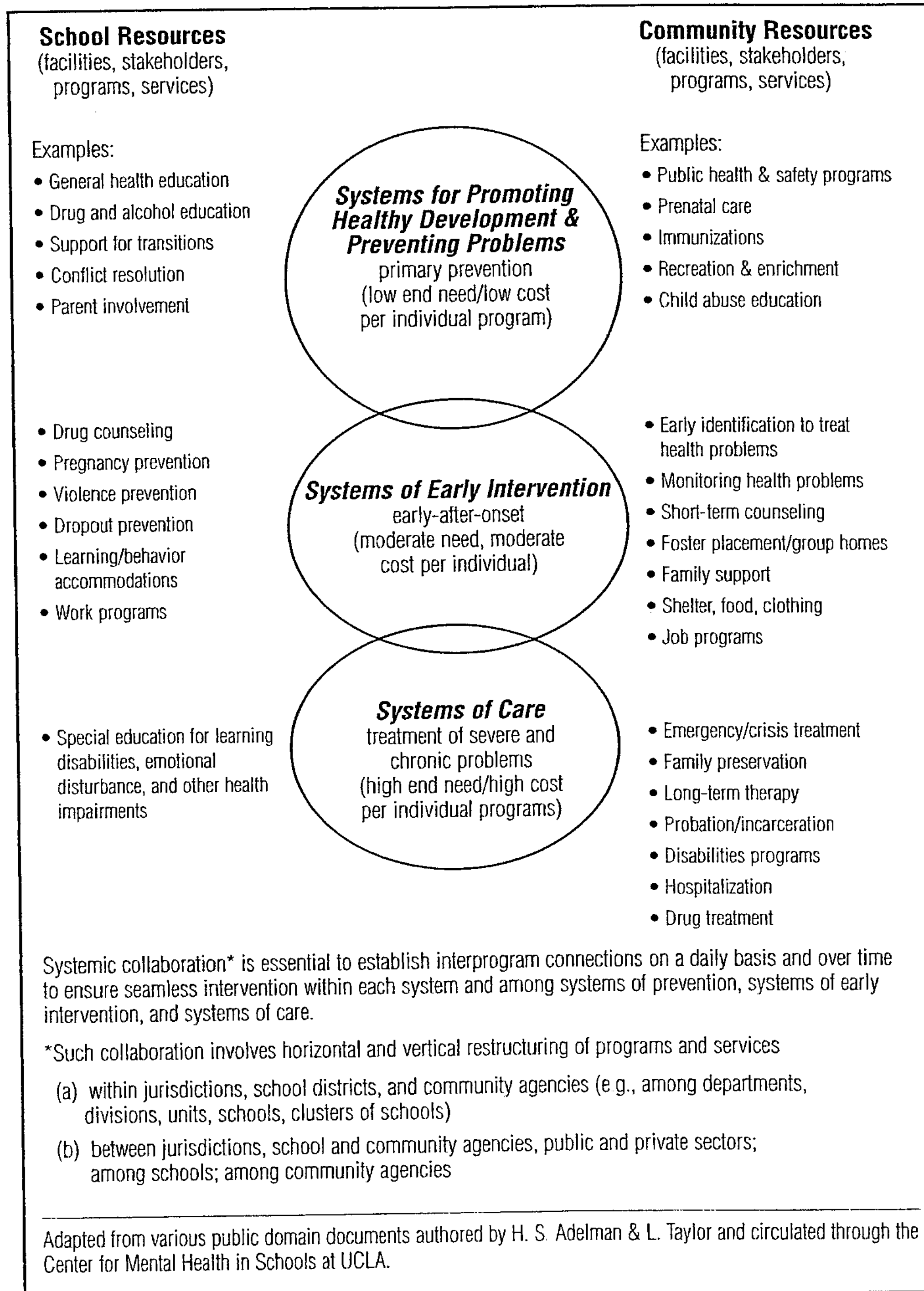
The notion of barriers to learning encompasses external and internal factors. It is clear that too many youngsters are growing up and going to school in situations that not only fail to promote healthy development, but are also antithetical to the process. A few children also bring with them intrinsic conditions that make learning and performing difficult. At some time or another, most students bring problems with them to school that affect their learning and perhaps interfere with the teacher's efforts to teach. In some geographic areas, many youngsters bring a wide range of problems stemming from restricted opportunities associated with poverty and low income, difficult and diverse family circumstances, high rates of mobility, lack of English language skills, violent neighborhoods, problems related to substance abuse, inadequate health care, and lack of enrichment opportunities. The result of all this is that some youngsters at every grade level come to school unready to meet the setting's demands effectively and a cycle of failure often ensues. In some locales, the reality often is that over 50 percent of students manifest forms of behavior, learning, and emotional problems. And, in most schools in these locales, teachers are ill-prepared to address the problems in a potent manner.

Ultimately, of course, addressing barriers to learning must be approached from a societal perspective and requires fundamental systemic reforms designed to improve efforts to support and enable learning. This calls for developing and weaving together a continuum of community and school interventions (see Figure 2.1).

Moving From a Two- to a Three-Component Framework for School Reform

With the full continuum in mind, pioneer initiatives around the country are demonstrating the need to rethink how schools and communities can meet the chal-

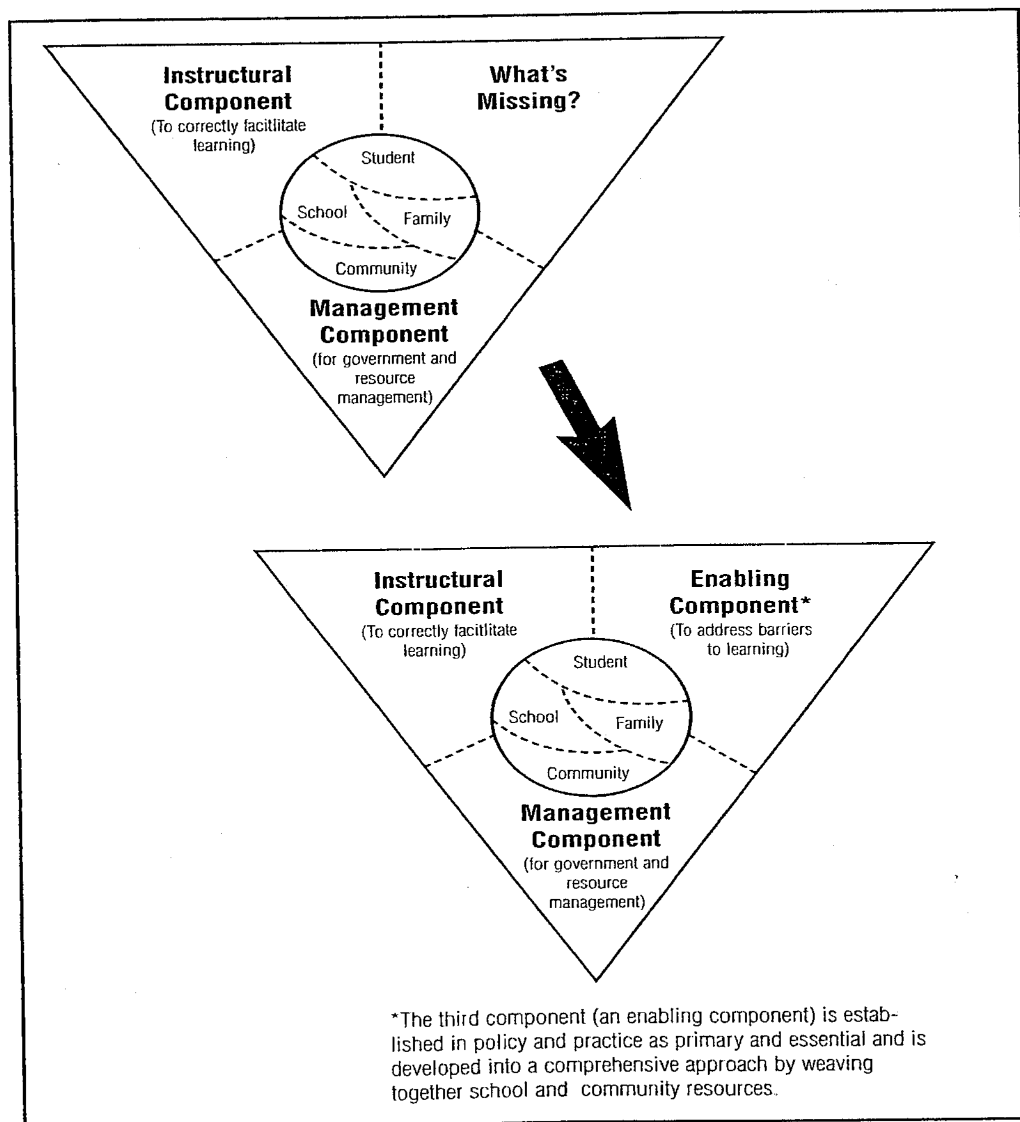
Figure 2.1
Interconnected Systems for Meeting the Needs of All Students



lenge of addressing persistent barriers to students' learning and to healthy development. These initiatives are underscoring that (a) current reforms are based on an inadequate two-component model for restructuring schools and (b) movement to a three-component model is necessary if schools are to benefit all young people appropriately (see Figure 2.2).

The three-component model calls for elevating efforts to address barriers to development, learning, and teaching to the level of one of three fundamental and essential

Figure 2.2
Moving From a Two- to a Three-Component Model for Reform and Restructuring



facets of education reform. We call this third component an Enabling Component. The concept of an Enabling Component is formulated around the proposition that a comprehensive, multifaceted, integrated continuum of enabling activity is essential in addressing the needs of youngsters who encounter barriers that interfere with their benefitting satisfactorily from instruction. Thus, to enable teachers to teach effectively, there must not only be effective instruction and well-managed schools, but also barriers must be handled in a comprehensive way. All three components are seen as essential, complementary, and overlapping.

In establishing such a third component, some schools and education agencies around the country have labeled it a "Learning Supports" component or a "Supportive Learning Environment" component or a "Comprehensive Student Support System." By calling for reforms that fully integrate a focus on addressing barriers to student learning, the notion of a third component (whatever it is called) provides a unifying concept for responding to a wide range of factors interfering with young people's learning and performance. And, the concept calls on reformers to expand the current emphasis on improving instruction and school management to include a comprehensive component for addressing barriers to learning and to ensure that it is well integrated with the other two components.

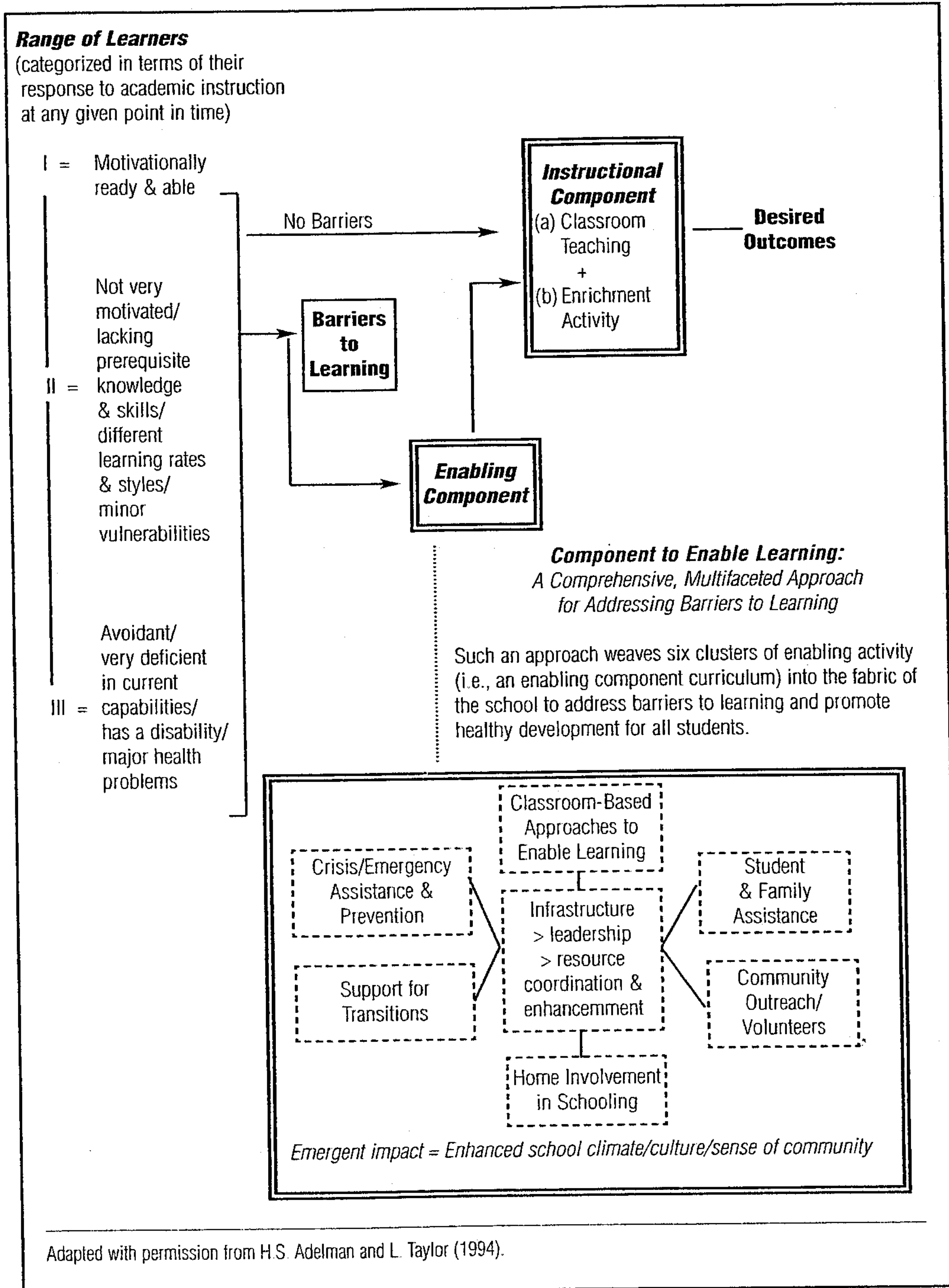
Framing an Enabling Component for a School Site

Operationalizing an enabling component requires (1) formulating a delimited framework of basic program areas and then (2) creating an infrastructure to restructure and enhance existing resources. Based on an extensive analysis of activity schools use to address barriers to learning, we cluster enabling activity into six interrelated areas (see Figure 2.3). A brief description of each of the six areas is provided in the following paragraphs. A set of surveys covering the six areas is available from the Center for Mental Health in Schools at UCLA (see contact information at the end of the text). These surveys can be used as part of a school's self-study or quality review processes to map what a school has and what it needs to address barriers to learning in a multifaceted and comprehensive manner.

Classroom-Focused Enabling. This area provides a fundamental example not only of how the enabling component overlaps the instructional component, but also how it adds value to instructional reform. When a teacher has difficulty working with a youngster, the first step is to address the problem within the regular classroom and involve the home to a greater extent. Through programmatic activity, classroom-based efforts that enable learning are enhanced. This is accomplished by increasing teachers' effectiveness so they can account for a wider range of individual differences, foster a caring context for learning, prevent and handle a wider range of problems when they arise, and re-engage students in actively pursuing school learning. Such a focus is seen as essential to increasing the effectiveness of regular classroom instruction, supporting inclusionary policies, and reducing the need for specialized services.

Work in this area requires programs and systems designed to personalize professional development of teachers and support staff, develop the capabilities of paraeducators and other paid assistants and volunteers, provide temporary out-of-class assistance for students, and enhance resources. For example: Personalized help is provid-

Figure 2.3
An Enabling Component to Address Barriers to Learning and Enhance Healthy Development at a School Site



Adapted with permission from H.S. Adelman and L. Taylor (1994).

ed to increase a teacher's array of strategies for accommodating, as well as teaching, students to compensate for differences, vulnerabilities, and disabilities. Teachers learn to target the activity of paid assistants, peer tutors, and volunteers to enhance social and academic support. (The classroom curriculum already should encompass a focus on fostering socioemotional and physical development; such a focus is seen as an essential element in preventing learning, behavior, emotional, and health problems.) As appropriate, support in the classroom is also provided by resource and itinerant teachers and counselors. This involves restructuring and redesigning the roles, functions, and staff development of resource and itinerant teachers, counselors, and other pupil service personnel so they are able to work closely with teachers and students in the classroom and on regular activities. All this provides the teacher with the knowledge and skills to develop a classroom infrastructure that transforms a big classroom into a set of smaller ones.

Student and Family Assistance. Student and family assistance should be reserved for the relatively few problems that cannot be handled without adding special interventions. In effect, this one area encompasses most of the services and related systems that are the focus of integrated service models.

The emphasis is on providing special services in a personalized way to assist with a broad range of needs. To begin with, social, physical and mental health assistance available in the school and community are used. As community outreach brings in other resources, these are linked to existing activity in an integrated manner. Additional attention is paid to enhancing systems for triage, case and resource management, direct services for immediate needs, and referral for special services and special education resources and placements as appropriate. Ongoing efforts are made to expand and enhance resources. A valuable context for providing such services is a center facility (e.g., Family/Community/Health/Parent Resource Center).

A programmatic approach in this area requires systems and activities designed to support classroom-focused enabling—with emphasis on reducing teachers' need to seek special programs and services, provide all stakeholders with information clarifying available assistance and how to access help, facilitate requests for assistance and evaluate such requests (including strategies designed to reduce the need for special intervention), handle referrals, provide direct service, implement effective case and resource management, and interface with community outreach to assimilate additional resources into current service delivery. As major outcomes, the intent is to ensure that special assistance is provided when necessary and appropriate and that such assistance is effective.

Crisis Assistance and Prevention. Schools must respond to, minimize the impact of, and prevent crises. This requires systems and programs for (1) emergency/crisis response at a site, throughout a school complex, and community-wide (including a focus on ensuring follow-up care) and (2) prevention at school and in the community to address school safety and violence reduction, suicide prevention, child abuse prevention, and so forth.

Desired outcomes of crisis assistance include ensuring provision of immediate emergency and follow-up care so students are able to resume learning without undue delay. Prevention activity outcomes are reflected in indices showing there is a safe and

productive environment and that students and their families have the type of attitudes and capacities needed to deal with violence and other threats to safety.

A key mechanism in this area often is development of a crisis team. Such a team is trained in emergency response procedures, physical and psychological first-aid, ensuring that aftermath needs are addressed, and so forth. The team also can take the lead in planning ways to prevent certain crises by facilitating the development of programs for conflict mediation and enhancing human relations and a caring school culture.

Support for Transitions. Students and their families are regularly confronted with a variety of transitions (e.g., changing schools, changing grades, and encountering a range of other daily hassles and major life demands). Many of these can interfere with productive school involvement.

A comprehensive focus on transitions requires systems and programs designed to:

- Establish school-wide and classroom-specific activities for welcoming new arrivals (students, their families, staff) and rendering ongoing social support;
- Provide counseling and articulation strategies to support grade-to-grade and school-to-school transitions, moving to and from special education, going to college, and moving to post-school living and work; and
- Organize before- and after-school and intersession activities to enrich learning and provide recreation in a safe environment.

Anticipated outcomes are reduced alienation, enhanced positive attitudes toward school and learning, and increased involvement in school and learning activities. Outcomes related to specific programs in this area can include reduced tardiness as the result of participation in before-school programs and reduced vandalism, violence, and crime at school and in the neighborhood as the result of involvement in after-school programs and increased experiencing of school as a caring place. There also are suggestions that a caring school climate can play a significant role in reducing student transiency. Articulation problems can be expected to reduce school avoidance and dropouts, as well as enhancing the number who make successful transitions to higher education and post school living and work.

Home Involvement in Schooling. This area expands concern for parent involvement to encompass anyone in the home who plays a key role in influencing the student's formal education. In some cases, parenting has been assumed by grandparents, aunts, or older siblings. In many cases, older brothers and sisters are the most significant influences on a youngster's life choices. Thus, schools and communities must go beyond focusing on parents in their efforts to enhance home involvement.

This area includes systems and programs to:

- Address the specific learning and support needs of adults in the home, such as offering them ESL, literacy, vocational, and citizenship classes, enrichment and recreational opportunities, and mutual support groups;
- Help anyone in the home learn how to meet basic obligations to a student, such as providing instruction for parenting and helping with schoolwork,

- Improve communication that is essential to the student and family;
- Enhance the home-school connection and sense of community;
- Foster participation in making decisions essential to a student's well-being;
- Facilitate home support of a student's basic learning and development;
- Mobilize those at home to problem-solve related to student needs; and
- Elicit help (support, collaborations, and partnerships) from those at home with respect to meeting classroom, school, and community needs.

The context for some of this activity may be a parent center (which may be part of a Family Service Center facility if one has been established at the site). Outcomes include indices of parent learning, student progress, and community enhancement specifically related to home involvement.

Community Outreach for Involvement and Support (Including a Focus on Volunteers). Most schools do their job better when they are an integral and positive part of the community. Unfortunately, schools and classrooms are often seen as separate from the community in which they reside. This contributes to a lack of connection between school staff, parents, students, and other community residents and resources. For schools to be seen as an integral part of the community, steps must be taken to create and maintain collaborative partnerships. Potential benefits include enhanced community participation, student progress, and community development.

Outreach to the community can build linkages and collaborations, develop greater involvement in schooling, and enhance support for efforts to enable learning. Outreach is made to public and private agencies, organizations, universities, colleges, and facilities; businesses and professional organizations and groups; and volunteer service programs, organizations, and clubs. Activity includes systems and programs designed to:

- Recruit community involvement and support (e.g., linkages and integration with community health and social services; cadres of volunteers, mentors, and individuals with special expertise and resources; local businesses to adopt a school and provide resources, awards, incentives, and jobs; formal partnership arrangements);
- Train, screen, and maintain volunteers (e.g., parents, college students, senior citizens, peer cross-age tutors and counselors, and professionals-in-training to provide direct help for staff and students—especially targeted students);
- Outreach to hard-to-involve students and families (those who don't come to school regularly—including truants and dropouts);
- Enhance community-school connections and sense of community (e.g., orientations, open houses, performances and cultural and sports events, festivals and celebrations, workshops and fairs).

A good place to start is with community volunteers. Greater volunteerism on the

part of parents, peers, and others from the community can break down barriers and increase home and community involvement in schools and schooling. Thus, a major emphasis in joining with the community is establishment of a program that effectively recruits, screens, trains, and nurtures volunteers. Another key facet is the opening up of school sites as places where parents, families, and other community residents can engage in learning, recreation, enrichment, and find services they need.

As can be seen from the above description, the enabling component framework calls for a greatly expanded role for all who are interested in mental health in schools. Only one of the areas, "special assistance for students and families," focuses on traditional mental health treatment approaches. The other five areas encompass a wide range of prevention and early intervention programs (universal and targeted interventions that include strategies for promoting healthy social and emotional development).

A well-designed and supported infrastructure is needed to establish, maintain, and evolve the comprehensive approach to addressing barriers to student learning outlined above. Such an infrastructure includes mechanisms for coordinating among enabling activities, for enhancing resources by developing direct linkages between school and community programs, for moving toward increased integration of school and community resources, and for integrating the developmental/instructional, enabling, and management components (see Adelman, 1993; Rosenblum, DiCecco, Taylor, & Adelman, 1995; Adelman & Taylor, 1997a). It also includes reframing the roles of education support personnel (Center for Mental Health in Schools, 2001).

ENHANCING STRATEGIC APPROACHES FOR ADVANCING MENTAL HEALTH IN SCHOOLS

In an effort to advance the field, we established the School Mental Health Project in 1986 in the Department of Psychology at UCLA to pursue theory, research, practice, and training related to addressing mental health and psychosocial concerns through school-based interventions. Under the auspices of the Project, the National Center for Mental Health in Schools was funded in 1995 and, in October, 2000, began a second five-year cycle of operation. The Center is one of two national centers focusing directly on mental health in schools. The other national center, called the Center for School Mental Health Assistance, is located at the University of Maryland at Baltimore and is directed by Mark Weist. Both Centers are partially supported by the U.S. Deptment of Health and Human Services through the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Its goals are to enhance in strategic ways:

- Availability of and access to resources to improve and advance mental health in schools;
- The capacity of systems/personnel; and
- The role of schools in addressing mental health, psychosocial, and related health concerns.

From the perspective of the guiding frameworks described above, addressing mental health of youngsters involves ensuring:

- Mental illness is understood within the broader perspective of psychosocial and related health problems 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.

Thus, the Center's work aims not only at improving practitioners' competence, but also at fostering changes in the systems with which they work. Such activity also addresses the varying needs of locales and the problems of accommodating diversity among those trained and among populations served.

Given the number of schools across the country, resource centers such as ours must work in well-conceived strategic ways. Thus, our emphasis is on expanding programmatic efforts that enable all students to have an equal opportunity to succeed at school and on accomplishing essential systemic changes for sustainability and scale-up through (1) enhancing resource availability and the systems for delivering resources, (2) building state and local capacity, (3) improving policy, and (4) developing leadership.

The strategies for accomplishing all this include:

- Connecting with major initiatives of foundations, federal government and policy bodies, and national associations;
- Connecting with major initiatives of state departments and policy bodies, counties, and school districts;
- Collaborating and network-building for program expansion and systemic change;
- Providing catalytic training to stimulate interest in program expansion and systemic change; and
- Catalytic use of technical assistance, the Internet, publications, resource materials, and regional meetings to stimulate interest in program expansion and systemic change.

As discussed above, because we know that schools are not in the mental health business, all our work strives to approach mental health and psychosocial concerns in ways that integrally connect with school reform. We do this by integrating health and related concerns into the broad perspective of addressing barriers to learning and promoting healthy development. We stress the need to restructure current policy and practice to enable development of a comprehensive and cohesive approach that is an essen-

tial and primary component of school reform, without which many students cannot benefit from instructional reforms and thus achievement scores will not rise in the way current accountability pressures demand.

CONCLUSION

The current norm related to efforts to advance mental health policy is for a vast sea of advocates to compete for the same dwindling resources. This includes advocates representing different professional practitioner groups. Naturally, all such advocates want to advance their agenda. And to do so, the temptation is usually to keep the agenda problem-focused and rather specific and narrow. Politically, this make some sense. But in the long run, it may be counterproductive in that it fosters piecemeal, fragmented, and redundant policies and practices.

It is time to take a close look at all the pieces. To date, there has been no comprehensive mapping and no overall analysis of the amount of resources used for efforts relevant to mental health in schools or of how they are expended. Without such a "big picture" analysis, policy makers and practitioners are deprived of information that is essential in determining equity and enhancing system effectiveness. The challenge for those focused on mental health in schools is not only to understand the basic concerns hampering the field (many of which have been highlighted in this chapter), but also to function on the cutting edge of change so that the concerns are effectively addressed.

Clearly, enhancing mental health in schools in comprehensive ways is not an easy task. Indeed, it is likely to remain an insurmountable task until school reformers accept the reality that such activity is essential and does not represent an agenda separate from a school's instructional mission. For this to happen, we must encourage them to view the difficulty of raising achievement test scores through the complementary lenses of addressing barriers to learning and promoting healthy development. When this is done, it is more likely that mental health in schools will be understood as essential to addressing barriers to learning and not as an agenda separate from a school's instructional mission.

Then, we must show how all policy, practice, and research related to mental health in schools, including the many categorical programs funded to deal with designated problems, can be woven into a cohesive continuum of interventions and integrated thoroughly with school reform efforts. In the process, we will need to stress the importance of school–community–home collaborations in weaving together the resources for comprehensive, multifaceted approaches.

In sum, advancing mental health in schools is about much more than expanding services and creating full-service schools. It is about establishing comprehensive, multifaceted approaches that help ensure schools are caring and supportive places that maximize learning and well-being and strengthen students, families, schools, and neighborhoods.

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