

# Addressing Barriers

New ways to think . . .

Better ways to link

# to Learning

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There is no way to avoid the fact that better achievement and student well-being requires more than good instruction and well-managed classrooms and schools.

## Mechanisms for Delivering MH in Schools

What does the term *mental health in schools* mean?

Ask five people and you'll probably get five different answers.

To establish greater clarity, the *Policy Leadership Cadre for Mental Health in Schools* is working on a document outlining guidelines, describing delivery mechanisms, and much more. A working draft of the document currently is circulating to elicit feedback; the following excerpts are included here as part of the process.\*

Analyses of initiatives across the country suggest *five* delivery mechanisms are used to provide mental health programs/services in schools (see Exhibit on page 2). The mechanisms vary in format and differ in focus and comprehensiveness, but they are not necessarily mutually exclusive.

The focus may be primarily on treatment of MH and psychosocial problems, on prevention of such problems, or on promoting positive mental health

(e.g., healthy social and emotional development). In terms of comprehensiveness, the emphasis may be mainly on providing and/or referring for clinical treatment. Or the intent may be to develop a full continuum of programs and services to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment.

What follows is a brief discussion to clarify the major delivery mechanisms outlined on page 2.

### School-Financed Student Support Services

Most school districts employ student support or "pupil services professionals," such as school psychologists, counselors, and social workers. These personnel perform services connected with MH and psychosocial problems (including related services designated for special education students). The format usually is a combination of centrally-based and school-based services.

Federal and state mandates and special projects tend to determine how many pupil services professionals are employed by a district. Governance of their daily practices commonly is centralized at the school district level. In addition to school psychologists, counselors, and social workers, other personnel such as school nurses and special education staff (e.g., resource teachers, specialists for rehabilitation and occupational therapy) play a role in addressing mental health and psychosocial problems. Moreover, these professionals often extend their impact through supervision of aids, paraprofessional, and volunteers working in schools (e.g., classrooms, playgrounds, office, after-school and enrichment programs).

Any of these personnel may be engaged in a wide array of MH related activity, including promotion of social and emotional development, direct services and referrals, outreach to families, and various forms of support for teachers and other school personnel. The focus may be on (1) prevention and prereferral interventions for mild problems, (2) programs aimed at reducing high frequency psychosocial problems,

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## 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

and (3) strategies to meet the needs of severe and pervasive mental health problems.

While there is considerable day-to-day pressure for each school professional to work alone on a case-load, schools have increasingly created infrastructures to promote collaboration and cooperation. The most widely used is a case-focused team. This problem solving approach brings together support staff, teachers, and often family members and the student to discuss the student's problems and strengths, review effectiveness of past interventions, rethink strategies and feasible accommodations, and identify next steps. If problems are severe and pervasive, support staff may be involved in more formal assessment to see if a student qualifies for special education programs and/or other referrals. If special education is considered, an Individual Educational Program (IEP) team then determines whether the student meets criteria, and if the decision is yes, they work together with families to construct the specific plan. When related services, such as counseling are part of the IEP, these often are provided by support staff.

Most school districts distribute their pupil service personnel according to an established formula that results in assignment of an individual on a part time basis to multiple schools. Some schools supplement these allotments by using their budget allocation related to Title I or funds acquired through special project grants that allow for hiring additional support staff. Under this type of format, support personnel tend to pursue traditional roles and functions associated with their field of specialization and the mandates delineated in the categorical funding that provides their salaries. The result is piecemeal and fragmented activity that has not had a sufficient impact on the major problems students and schools are experiencing.

Some places have experimented with alternative ways to allocate student support service resources. For example, the *Denver Public Schools* designed a process whereby District coordinators inform each school of the total amount of support service time/salary they can have. A menu of options describes "non-traditional use of Specialized Services staff." This involves detailing skills that could be carried out by any support staff member (e.g., nurses, social workers, psychologists) and the skills that are unique to each profession (either due to mandate or specialized training). Schools and clusters of schools then decide on the best combination of support staff based on the needs of their building or community. In the first year of the new process, 24 schools opted to combine services that traditionally had been the responsibility of one professional and thus were able to have one support staff in their building for a greater amount of time.

## School-District Mental Health Unit

The organization of mental health personnel in most school districts tends to be by profession (e.g., school psychology unit, counseling unit). In a few districts, a multidisciplinary unit operates from centralized locations and provides intensive interventions for students and families to address a range of MH and psychosocial concerns. This is particularly the case where organized school MH units are in operation. In such units and centers, there may be social workers, school psychologists, psychiatric nurses, psychiatrists, and clinical psychologists. The format for this delivery mechanism tends to be centralized clinics that are able to outreach and provide school staff with direct services and consultation. Where districts are taking the lead in establishing and financing school-based health centers, the trend is for such centers to incorporate the same type of functions pursued by clinics operated by school mental health units.

One example of a school district MH unit is in the *Memphis City School District*. This unit, in operation since 1969, is designed to integrate MH services. The staff are primarily school psychologists and social workers organized into teams. The unit offers a variety of clinical and consultation services in support of school programs. There are three satellite centers housing staff who rotate through each school in the district on a regular basis. Their primary functions are to offer psychological evaluations, counseling and therapy, abused/neglected children services, alcohol and drug abuse services, school based prevention efforts, homemaker services, staff development, parent study groups, and compliance/ reporting/record keeping.

Another example is in the *Los Angeles Unified School District* which has operated a School Mental Health Unit since 1945. The unit makes services available to the entire school population through school referrals to one of three clinics. Services include psychiatric and psychosocial assessments; individual, group, and family therapy; case management; crisis intervention; and program development and demonstration projects. The unit is staffed by psychiatric social workers, clinical psychologists, psychiatric nurses, and child psychiatrists. There is close collaboration with school-based support service staff, and with teachers and administrators. The clinics are a site for research to move empirically supported treatments from laboratory to clinic settings. The unit has administrative responsibility for the training and operation of all district level crisis intervention teams. Through an interagency contract, the unit has become a MediCal Certified Child Psychiatry Outpatient Clinic and a Los Angeles County Dept. of Mental Health Contract Provider.

## 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 (“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 financed in part 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 mental health services
- contracting with community providers to offer mandated and designated student services

Exemplars of each of these approaches are included in the Policy Leadership Cadre’s document.\*

Whether initiated by the community or the school, this delivery mechanism is intended to increase access to MH services and, in some formats, to enhance coordination among services provided to students and their families. Some problems have arisen related to some formats. For example, the co-location approach often has produced a new form of fragmentation in which community personnel occupy space at a school but operate as a separate entity from school support programs and services. Another problem is that some policy makers have begun to view school-linked services as a less expensive way to provide mandated services, and this perspective is increasing policies for “contracting-out” services – thereby eliminating/ reducing pupil personnel positions.

Contracting-out is especially attractive to small school districts where pupil personnel are not available in sufficient numbers to meet the mandated needs. Other instances arise when district policy makers decide only to meet mandates and determine it is less expensive to contract with outside agencies. For example, while special education designated services, such as counseling, can be provided by school staff (e.g., school counselors, social workers, or psychologists), some school districts have begun to contract privately for the services. In some places, contract agency staff also link to schools as providers for the Early Periodic Screening, Diagnosis, and Treatment program. A broader example is seen in places where contract agencies provide a range of mental health services on school campuses for students designated as eligible by county mental health assessment. An unfortunate result of the way contracting-out policies have played out in some places has been to reduce the

overall amount of resources available to schools for addressing mental health and psychosocial concerns.

### Classroom-Based Curriculum and Special “Pull Out” Interventions

Most schools include in some facet of the curriculum ways to enhance social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. 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 trained to carry out the processes
- a curriculum approach that is part of a multi-faceted set of interventions designed to enhance positive development and prevent problems

Mental health in schools reaches into the classroom through general instructional processes and special assistance strategies. Teachers who are sensitive to the importance of promoting social and emotional development can integrate such a focus seamlessly into their daily interactions with students. This may or may not include devoting part of the day to teaching a curriculum designed to foster relevant knowledge, skills, and attitudes. In some instances, other personnel come to the classroom or take students to another site in the school to teach such a curriculum or to involve students in special interventions designed to address specific problems. Because of the limited impact on problem behavior of only pursuing a curriculum, there has been constant advocacy for weaving classroom programs into multifaceted strategies.

The type of focus that can be integrated into the classroom is seen in the core framework of social and emotional competencies delineated by the consortium funded by the W.T. Grant Foundation. This framework can be used by school staff as guidelines for promoting healthy social and emotional development throughout the school day. (See W.T. Grant Consortium on the School-Based Promotion of Social Competence [1992]. Drug and alcohol prevention curriculum. In J.D. Hawkins, et al. [Eds.], *Communities that care*. San Francisco: Jossey-Bass.)

There are many examples of specific curriculum. For instance, *Promoting Alternative Thinking Strategies* (PATHS) is a prominently used curriculum developed by Mark Greenberg and his colleagues. It is designed to promote emotional and social competence, reduce aggression and behavior problems, and enhance the classroom educational process. It can be used by educators and counselors as a multi-year, universal prevention approach. The curriculum provides systematic, developmentally-based lessons, materials, and instructions for teaching students emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem solving skills.

The *Social Competence Promotion Program* is a structured curriculum, developed by Roger Weissberg and his colleagues. It focuses on general skill training with domain-specific instruction. The curriculum has units on stress management, self-esteem, problem solving skills, substance and health information, assertiveness training, and social networks. It is designed to enhance protective factors by teaching conflict resolution and impulse control.

An example of a special intervention is the *Primary Mental Health Project's* strategy. Developed by Emory Cowen and his colleagues and operating under various names (e.g., the Primary Intervention Program, Early Mental Health Initiative), this intervention focuses on young children with school adjustment problems such as shyness, aggression, or inattentiveness. A specially trained paraprofessional takes a child out of the classroom into a specially designed "play" room and uses play techniques and reflective listening to help the youngster enhance coping skills.

An example of a curriculum approach that is part of a multifaceted set of interventions is the *Seattle Social Development Project*. This universal, multidimensional intervention was developed by J. David Hawkins and Richard Catalano and their colleagues. It is designed to increase prosocial bonds, strengthen attachment and commitment to schools, and decrease delinquency. Teachers learn to emphasize proactive classroom management, interactive teaching, and cooperative learning – allowing students to work in small, heterogeneous groups to increase their social skills and contact with prosocial peers. Sessions encourage parents to improve communication between themselves, teachers, and students; create positive home learning environments; help their children develop academic skills, and support their academic progress.

Another example of a school-wide approach is *Project ACHIEVE* developed by Howard Knoff and George Batsche. It focuses on problem-solving, social skills, anger management, effective teaching, curriculum based assessment, parent education, academics, and organizational planning, development, and evaluation.

## 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 student support programs and services and integrate them into school reform agendas
- ⊆ community schools

Around the country, a few pioneering initiatives are coming to grips with the realities involved in addressing barriers to student learning and promoting healthy development. In doing so, they are taking advantage of existing opportunities to use categorical funds flexibly and to request waivers from regulatory restrictions. They also are using specialized personnel and other resources in increasingly cross-disciplinary and collaborative ways.

By moving toward comprehensive, multifaceted, and integrated approaches, these initiatives have started to redefine their relationship to school reform movements in order to end the marginalization of education support programs and services. For example, some approaches are conceived in terms of being an essential component of school reform and are calling on policy makers to recognize them as such. Moreover, they are demonstrating the reality of this position. Exemplars have been developed that explicitly expand school reform policy and practices beyond the prevailing limited perspective on restructuring instructional and management functions. These demonstrations address barriers to student learning as a third set of primary and essential functions for enabling students to have an equal opportunity for success at school.

*Systems of Care.* One of the most extensive efforts to coordinate and integrate school and community services is seen in efforts to establish *Systems of Care*. In states and localities across the nation, this initiative focuses on developing systems to coordinate and integrate mental health and related services and supports designed to help a child or adolescent with serious emotional disturbances. Local public and private organizations work in teams to plan and implement a tailored set of services for each individual child's physical, emotional, social, education, and family needs. Teams include family members and advocates and may include representatives from mental health, health, education, child welfare, juvenile justice, vocational counseling, recreation, substance abuse. The range of services may include case management, community-based in-patient psychiatric care, counseling, crisis residential care, crisis outreach teams, day treatment, education/special education services, family support, health services, independent living supports, intensive family-based counseling, legal services, protection and advocacy, psychiatric consultation, recreation therapy, residential treatment, respite care, self-help support groups, therapeutic foster care, transportation, tutoring, and vocational counseling. A case manager facilitates the individualized treatment plan.

A few pioneering efforts are underway to restructure student supports and integrate them with school reform. For example:

*New American Schools' Urban Learning Center Model.* This is one of the comprehensive school reform designs federal legislation encourages school to adopt. It incorporates a comprehensive, multifaceted, and integrated approach to addressing barriers to learning as a third component of school reform – equal to the instructional and governance components. This third enabling component is called "Learning Supports." In addition to focusing on addressing barriers to learning, there is a strong emphasis on facilitating healthy development, positive behavior and asset-building as the best way to prevent problems. There is a major emphasis on weaving together what is available at a school, expanding these resources through integrating school/community/home resources, and enhancing access to community resources through formal linkages. A key operational infrastructure mechanism is a resource-oriented team that clarifies resources and their best use. The elements of the learning supports component at each school involve: classroom-focused enabling to ensure a potent focus on commonplace behavior, learning, and emotional problems, support for transitions, crisis assistance and prevention, home involvement in schooling, student and family assistance, and community outreach for involvement and support.

*Hawaii's Comprehensive Student Support System.* This is the umbrella concept under which the state's Dept. of Education is developing a continuum of programs/services to support a school's academic, social, emotional, and physical environments so that all students learn. The system provides five levels of student support: basic support for all students, informal additional support through collaboration, services through school-level and community programs, specialized services from the

Department of Education and/or other agencies, and intensive and multiple agency services. The aim is to align programs and services in a responsive manner to create a caring community. Key elements of the program include personalized classroom climate and differentiated classroom practices, prevention/early intervention, family involvement, support for transitions, community outreach and support, and specialized assistance and crisis/emergency support and follow through. This range of proactive support requires teaming, organization and accountability. To help achieve all this, a cadre of school-based and complex-level Support Service Coordinators are being trained. (See discussion on page 12.)

*Los Angeles Unified School District.* Several years ago, the district formulated a *Strategic Plan for Restructuring of Student Health & Human Services*. The goals were to (1) increase effectiveness, and efficiency in providing learning supports to students and their families and (2) enhance partnerships with parents, schools, and community-based efforts to improve outcomes for youth. Building on the same body of work that was used in developing the Urban Learning Center model, the plan called for a major restructuring of school-owned pupil services in order to develop a comprehensive, multifaceted, and integrated "Learning Supports" component to address barriers to learning. Key operational infrastructure mechanisms are a school-based resource team and a cluster coordinating council that focuses on clarifying resources and their best use – all of which are concerned with developing the key elements of the learning supports component at each school. To facilitate restructuring, a cadre of change agents called Organization Facilitators was developed. The plan called for these change agents to assist in establishing the infrastructure at each school and for the high school feeder pattern with the aim of enhancing resource use, as well as integrating other resources from the community.

*Community Schools.* As exemplified by the Children's Aid Society, Community Schools in New York City is a partnership between the Children's Aid Society, the New York City Board of Education, the school district, and community based partners. The focus is on a model that is designed to help strengthen the educational process for teachers, parents, and students in a seamless way. The approach combines teaching and learning with the delivery of an array of social, health, child and youth development services that emphasizes community and parental involvement. Current demonstrations provide on-site child and family support services – from health-care clinics and counseling to recreation, extended education, early childhood programs, job training, immigration services, parenting programs and emergency assistance.

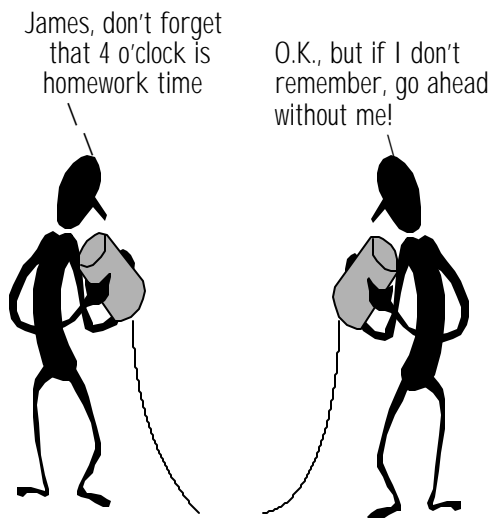
\*For more, see <http://smhp.psych.ucla.edu> – go to Contents, scroll to Policy Leadership Cadre for MH in Schools, click, and then access the document *Mental Health in Schools: Guidelines, Models, Resources & Policy Considerations*.

## A Few Compilations of Practices

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### Father

(in a helpful tone):



### High Stakes Testing, MH, and Barriers to Learning

Those concerned about MH and addressing barriers to learning must focus on how to counteract the negative effects of high stakes testing. Of particular concern are the problems some students (and staff) are having coping with the increasing pressure to perform. In some school settings this is a significant problem for many, and schools have the responsibility to address the matter as an additional barrier to learning for those students affected.

It should be anticipated that the problems of students who will do poorly when tested will be exacerbated. Those who face retention or face the likelihood of not qualifying for graduation need more than additional academic support. Without appropriate attention to the social and emotional consequences, the long-term problem is that we are likely to lose many students and teachers. The correlation between high stakes testing and student dropout rates is worrisome: graduation tests are used in nine of the 10 states with the highest dropout rates and are not in use in the ten states with the highest graduation rates. And, with so many teachers leaving the field, we need to consider the likelihood that using high stakes testing as the primary accountability measure may be making a bad situation worse.