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# *Mental Health in Schools*

## *Past and Present*

*A variety of psychosocial and health problems have long been acknowledged as affecting learning and performance in profound ways. Moreover, behavior, learning, and emotional 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.*

**E**fforts to address mental health concerns in schools are not new. What's new is the emergence of the *field* of mental health in schools. We begin by highlighting some of what has transpired over the last 60 years.

### **PAST AS PROLOGUE**

Because of the obvious need, school policy makers have a lengthy, if somewhat reluctant, history of trying to assist teachers in dealing with problems that interfere with schooling. Prominent examples are seen in the range of health, social service, counseling, and psychological programs schools have provided from the end of the 19th century through today (Baumgartner, 1946; Christner & Mennuti, 2009; Dryfoos, 1994; Flaherty, Weist, & Warner, 1996; Tyack, 1992).

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One interesting policy benchmark appeared in the middle of the 20th century when the National Institute of Mental Health (NIMH) increased the focus on mental health in schools by publishing a monograph on the topic (Lambert, Bower, & Caplan, 1964). Since then, many initiatives and a variety of agenda have emerged. Included are efforts to expand clinical services in schools, develop new programs for *at risk* groups, and incorporate programs for the prevention of problems and the promotion of social-emotional development (Adelman & Taylor, 1994; Califano, 1977; Collaboration for Academic, Social, and Emotional Learning, 2003; Dryfoos, 1994; Knitzer, Steinberg, & Fleisch, 1990; Millstein, 1988; Steiner, 1976; Stroul & Friedman, 1986; Weist & Murray, 2007).

#### **Bringing Health and Social Services to Schools**

Over the past 20 years, a renewed emphasis in the health and social services sectors on enhancing access to clients led to increased linkages between schools and community service agencies, including colocation of services on school sites (Center for the Future of Children, 1992; Warren, 2005). This *school-linked services* movement added impetus to advocacy for mental health in schools. It promoted school-based health centers, school-based family resource centers, wellness centers, afterschool programs, and other efforts to connect community resources to the schools.

Many advocates for school-linked services coalesced their efforts with those working to enhance initiatives for youth development, community schools, and the preparation of healthy and productive citizens and workers (Blank, Berg, & Melaville, 2006). These coalitions expanded interest in social-emotional learning and protective factors as ways to increase students' assets and resiliency and reduce risk factors (Greenberg et al., 2003; Hawkins, Kosterman, Catalano, Hill, & Abbott, 2008). However, the amount of actual mental health activity in schools generated by these efforts remains relatively circumscribed (Foster et al., 2005; Teich, Robinson, & Weist, 2007).

#### **Federal Support for the *Field* of Mental Health in Schools**

In 1995, a direct effort to advance mental health in schools was initiated by the U.S. Department of Health and Human Services through its Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau, Office of Adolescent Health (Anglin, 2003). The purpose of the initiative is to enhance the role schools play in mental health for children and adolescents. Specifically, the emphasis is on increasing the capacity of policy makers, administrators, school personnel, primary care health providers, mental health specialists, agency staff, consumers, and other stakeholders so that they can enhance how schools and their communities address psychosocial and mental health concerns. Particular attention is given to mental health promotion, prevention, and responding early after the onset of problems as critical facets of reducing the prevalence of problems and enhancing well-being.

The core of the work has been embedded in two national centers. The two, which were initially funded in 1995 with a primary emphasis on technical assistance and training, successfully reapplied during the 2000 open competition. A third open competition for a five-year funding cycle was offered in 2005 with an increasing emphasis on policy and program analyses to inform policy, practice, research, and training. Again, the initially funded centers applied and were successful in the process. The two centers are the Center for Mental Health in Schools at UCLA and the Center for School Mental Health at the University of Maryland, Baltimore. (It should be noted from 2000 through 2006, HRSA and the Substance Abuse and Mental Health Services Administration [SAMHSA] braided resources to jointly support the initiative.)

Other federal initiatives promote mental health in schools through a smattering of projects and initiatives. These include (1) programs supported by the U.S. Department of Education's Office of Safe and Drug-Free Schools (including a grants program for the Integration of Schools and Mental Health Systems), its Office of Special Education and Rehabilitative Services, and some of the school improvement initiatives under the No Child Left Behind Act; (2) the Safe Schools/Healthy Students initiative, which is jointly sponsored by SAMHSA and the U.S. Departments of Education and Justice; (3) components of the Centers for Disease Control and Prevention's Coordinated School Health Program; and (4) various projects funded through SAMHSA's Elimination of Barriers Initiative and Mental Health Transformation State Incentive Grant Program. Several other federal agencies support a few projects that fit agenda for mental health in schools. All of the above have helped the field emerge; none of the federal programs are intended to underwrite the field. Government-funded projects are time limited and affected by economic downturns.

In recent years, a growing number of states have funded projects and initiatives, and a few have passed legislation with varying agenda related to mental health in schools. A variety of public and private entities also support projects that contribute to the emerging field.

Other countries are moving forward as well. The growing interest around the world is reflected in the establishment in the early 2000s of the International Alliance for Child and Adolescent Mental Health and Schools, which has members in 30 countries (Weist & Murray, 2007).

### **Call for Collaboration**

Few doubt the need for collaboration. Over the years, those with a stake in mental health in schools frequently have called for joining forces (Center for Mental Health in Schools, 2002; Rappaport, Osher, Garrison, Anderson-Ketchmark, & Dwyer, 2003; Taylor & Adelman, 1996). Building bridges across groups, however, is complex and requires a long-term commitment. We discuss this matter in detail in Chapter 13.

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One contemporary effort began in 2000 when the National Association of State Mental Health Program Directors and the Policymaker Partnership at the National Association of State Directors of Special Education (2002) met to explore how the two entities could collaborate to promote closer working relations between state mental health and education agencies, schools and family organizations. A concept paper entitled “Mental Health, Schools and Families Working Together for All Children and Youth: Toward a Shared Agenda” was produced with funds from the Office of Special Education Programs. The paper was designed to encourage state and local family and youth organizations, mental health agencies, education entities, and schools across the nation to enter new relationships to achieve positive social, emotional, and educational outcomes for every child. The vision presented is for schools, families, child-serving agencies, and the broader community to work collaboratively to promote opportunities for and to address barriers to healthy social and emotional development and learning. The aim is to align systems and ensure the promise of a comprehensive, highly effective system for children and youth and their families. In stating the need for agencies and schools to work together, the report stresses the following:

While sharing many values and overarching goals, each agency has developed its own organizational culture, which includes a way of looking at the world; a complex set of laws, regulations and policies; exclusive jargon; and a confusing list of alphabet-soup acronyms. Funding sources at the federal, state, and local levels have traditionally reinforced this separation into *silos*. The result is that agencies are almost totally isolated entities—each with its own research and technical assistance components and its own service delivery system, even though they are serving many of the same children. The isolation of each agency, combined with its bureaucratic complexity, requires a long-term commitment of all partners to bridge the gaps between them. Collaborative structures must be based on a shared vision and a set of agreed upon functions designed to enable a shared agenda. Legislative, regulatory or policy mandates may help bring agency representatives to the table, but development of true partnerships and the successful accomplishment of goals depends on participants gaining trust in one another as they pursue a shared agenda. (pp. 16–17)

The Policymaker Partnership provided some funds for six states to form state-based Communities of Practice for Education, Mental Health, and Family Organizations. When the funding for the Policymaker Partnership ended, the *Individuals with Disabilities Education Act (IDEA) Partnership* (funded by the U.S. Department of Education’s Office of Special Education Programs) has continued to facilitate the Communities of Practice initiative (IDEA Partnership, 2005).

### School Professionals Have Led the Way

Historical accounts stress that schools have used their resources to hire a substantial body of student support professionals—variously called support staff,

pupil personnel professionals, and specialists. Current status data are available from the *School Health Policies and Program Study* (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007; Centers for Disease Control and Prevention, 2007). This study, conducted by a unit of the Centers for Disease Control and Prevention (CDC), collected data from 51 state departments of education, 538 school districts, and 1,103 schools. Findings indicate that 56% of states and 73% of districts had a policy stating that student assistance programs would be offered to all students, but only 57% of schools offered such programs. Findings for specialist support staff indicate that 78% of schools had a part- or full-time counselor, 61% had a part- or full-time school psychologist, 42% had a part- or full-time social worker, 36% had a full-time school nurse, and an additional 51% had a part-time nurse. Considerable variation, of course, exists state by state.

While the numbers fluctuate, professionals employed by school districts continue to carry out most of the activity related to mental health in schools (Adelman & Taylor, 2006c; Carlson, Paavola, & Talley, 1995; Teich, Robinson, & Weist, 2007). As a result, they are the core around which programs have emerged.

## DATA ON NEED

Available data underscore an urgent need. Data cited on diagnosable mental disorders generally suggest that from 12% to 22% of all youngsters under age 18 need services for mental, emotional, or behavioral problems. These figures are cited in the Surgeon General's 1999 mental health report (U.S. Department of Health and Human Services, 1999). Referring to ages 9 to 17, the document states that 21% or "one in five children and adolescents experiences the signs and symptoms of a *DSM-IV* disorder during the course of a year" (p. 123)—with 11% of all children experiencing significant impairment and about 5% experiencing "extreme functional impairment" (p. 124). Similar data are noted in the Centers for Disease Control and Prevention's Youth Risk Behavior Surveys, in a 2004 report from the Annenberg Public Policy Center (see Exhibit 1), and in preliminary data from the 2005 National Health Interview Survey (Simpson, Cohen, Pastor, & Reuben, 2006).

### Exhibit 1 Some Data on Students' Mental Health

From April 5, 2004, to May 28, 2004, the Annenberg Public Policy Center surveyed over 1,400 public school professionals as part of the Annenberg Foundation Trust at Sunnylands' Initiative on Adolescent Mental Health. The focus was on how schools provide treatment and counseling for students.

Survey findings indicate that the respondents view high school student depression and use of alcohol and illegal drugs as even more serious problems than various forms of violence, including bullying, fighting, and use of weapons. More than two-thirds (68%) of the high school professionals

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surveyed identified depression as a great (14%) or moderate (54%) problem in their schools. Similar overall levels of concern were raised about use of alcohol (71%) and illegal drugs (72%). In contrast, 54% of high school professionals identified bullying as a great (11%) or moderate (43%) problem. Even lower levels of concern were expressed about fighting between students (37%) and weapon carrying (6%) at the high school level. Other concerns cited were anxiety disorders (42%), eating disorders (22%), and various forms of self-harm such as cutting (26%).

Unlike their counterparts in high schools, middle school professionals are more concerned about interpersonal conflict. Although high proportions of middle school professionals identify depression (57%) and use of alcohol (28%) and illegal drugs (37%) as at least moderate problems, bullying is seen as a problem by 82% of professionals and fighting by 57% of professionals in middle schools. Weapon carrying remains a concern among only 5% of professionals.

Although 66% of the high schools indicated having a process for *referring* students with mental health conditions to appropriate providers of care, only 34% reported having a clearly defined and coordinated process for identifying such students. Comparable findings come from the middle schools; however, 42% of professionals reported having a clearly defined process identifying students with mental conditions. Only about 3% of the high schools indicated use of universal screening. An additional 5% claim to screen most of their students.

Asked what percentage of their students in need of counseling or treatment actually receive such services, only 7% of high school professionals said that all do and only 31% said that most do. The majority indicated that only half or fewer received the services they need. When asked the same question about receiving services on site at their school, the percentages were even lower—6% said all do and 22% said most do. Only 24% of school professionals say their high schools have counseling available for students with alcohol or drug dependence problems.

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SOURCE: Reported by the Annenberg Public Policy Center. <http://www.sunnylandstrust.org/>

The picture worsens when one expands the focus beyond the limited perspective on diagnosable mental disorders. Think in terms of all the young people experiencing psychosocial problems and who are “at risk of not maturing into responsible adults” (Dryfoos, 1990, p. 4). Many reports explore the situation from this broader perspective (Centers for Disease Control and Prevention, 2005; Forum on Child and Family Statistics, 2007; Greenberg, Domitrovich, & Bumbarger, 1999; Institute of Medicine, 1994; NIMH, 1993, 1998; also see fact sheets and reports on the Web sites for SAMHSA’s Center for Mental Health Services and USDOE’s Safe and Drug-Free Schools Program).

Demographic policy estimates suggest that 40% of young people are in bad educational shape and therefore will fail to fulfill their promise (Hodgkinson, 2008). For many large, urban schools, the reality is that well over 50% of their students manifest significant behavior, learning, and emotional problems (Center for Mental Health in Schools, 2003b). 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 child poverty in terms of future health and economic implications for individuals and society; the consistent call is for fundamental systemic reforms.



## UNDERSTANDING THE CONCEPT OF *MENTAL HEALTH* IN SCHOOLS

Mental health is recognized widely as a fundamental and compelling societal concern. The relationship between health and mental health problems is well established. From both the perspective of promoting positive well-being and minimizing the scope of mental health and other health problems, school professionals clearly have an important role to play. The matter is well-underscored when one appreciates the full meaning of the concept of mental *health* and the full range of factors that lead to mental health problems.

### **Mental *Health* or Mental *Illness*?**

The trend toward overusing psychiatric labels reflects the tendency to reduce mental health to mental illness, disorders, or problems. Many people hear the term *mental health*, and they think *mental illness*. When this occurs, *mental health* is defined, de facto, as the absence of problems. This trend ignores the facts: (1) the behavior, learning, and emotional problems experienced by most youngsters stem from sociocultural and economic factors not from psychopathology, and (2) such problems often can be countered through promotion of social and emotional development and preventive interventions.

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To address the definitional problem, the following guides are helpful:

- The report of the Surgeon General's Conference on Children's Mental Health (U.S. Department of Health and Human Services, 2001) offers the following vision statement: "Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals." This view is consistent with efforts to define mental health as a positive concept.
- The Institute of Medicine (1994) defines health as a "state of well-being and the capability to function in the face of changing circumstance."
- 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. 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." SAMHSA contrasts this with mental health problems. And the designation *mental disorder* is described as another term used for mental health problems. (They reserve the term *mental illness* for severe mental health problems in adults.)
- Finally, note that the World Health Organization (2004) also stresses that mental health is "a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

A more recent effort to emphasize mental *health* is found in *Bright Futures in Practice: Mental Health* (National Center for Education in Maternal and Child Health, 2002) that states,

Mentally healthy children and adolescents develop the ability to experience a range of emotions (including joy, connectedness, sadness, and anger) in appropriate and constructive ways; possess positive self-esteem and a respect for others; and harbor a deep sense of security and trust in themselves and the world. Mentally healthy children and adolescents are able to function in developmentally appropriate ways in the contexts of self, family, peers, school, and community. Building on a foundation of personal interaction and support, mentally healthy children and adolescents develop the ability to initiate and maintain meaningful relationships (love) and learn to function productively in the world (work).

### Concerns About Differential Diagnosis

Not surprisingly, debates about diagnostically labeling young people are heated. Differential *diagnosis* is a difficult process fraught with complex issues.



Concern arises about the tendency to view “everyday” emotional and behavioral problems as “symptoms,” designate them as disorders, and assign them formal psychiatric diagnoses (Adelman, 1995a; Adelman & Taylor, 1994; Dryfoos, 1990). The prevailing comprehensive formal systems used to classify problems in human functioning convey the impression that all behavioral, emotional, or learning problems are instigated by internal pathology. This is well illustrated by the widely used *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (American Psychiatric Association, 1994). Some efforts to temper this trend frame pathology as a vulnerability that only becomes evident under stress. Most differential diagnoses of children’s problems, however, are made by focusing on identifying one or more disorders (e.g., attention deficit hyperactivity disorder, oppositional defiant disorder, learning disorders, adjustment disorders), rather than first asking, *Is there a disorder?*

Problems experienced by the majority of children and adolescents are sociocultural and economic. This, of course, in no way denies that the primary factor instigating a problem may be an internal disorder. The point simply recognizes that, comparatively, youngsters whose problems stem from person pathology constitute a relatively small group (Center for Mental Health in Schools, 2003a).

Biases in definition that overemphasize person pathology narrow what is done to classify and assess problems. Comprehensive classification systems do not exist for environmentally caused problems or for psychosocial problems (caused by the transaction of internal and environmental factors).

The overemphasis on classifying problems in terms of personal pathology has skewed theory, research, practice, and public policy. The narrow focus has limited discussions of cause, diagnosis, and intervention strategies, especially efforts to prevent and intervene early after onset.

Efforts to address a wider range of variables in labeling problems are illustrated by multifaceted systems. An example is the *Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC)* published by the American Academy of Pediatrics (Wolraich, Felice, & Drotar, 1996). The work provides a broad template for understanding and categorizing behavior. For each major category, behaviors are described to illustrate what should be considered (1) a developmental variation, (2) a problem, and (3) a disorder. Information also is provided on the environmental situations and stressors that exacerbate the behavior and on commonly confused symptoms. The material is presented in a way that can be shared with families, so that they have a perspective with respect to concerns they or the school identifies.

Available evidence suggests increasing numbers of youngsters manifesting emotional upset, misbehavior, and learning problems routinely are assigned diagnostic labels denoting serious disorders (e.g., attention deficit hyperactivity disorder, depression, learning disabilities). The numbers fly in the face of the reality that the problems of *most* youngsters are not rooted in internal pathology. The likelihood is that many troubling symptoms would not develop

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under more favorable environmental conditions. Moreover, the trend to label so many diagnosable disorders leads to frequent misdiagnoses and inappropriate and expensive treatments. All this contaminates research and training (Lyon, 2002).

An increasing focus in policy and practice is on reducing misdiagnoses and misprescriptions. One emphasis is on placing mental illness in perspective with respect to psychosocial problems; another aim is to ensure mental health is understood as encompassing the promotion of social and emotional development and learning (Adelman, 1995a; Adelman & Taylor, 1994). Schools are being asked to play a major role in all this through strategies such as assessing “response to intervention” (RtI) prior to diagnosis (discussed in Part III).

### **Mental Health in Schools: A Broad Concept**

Because mental health often is heard as mental *illness*, many people think *mental health in schools* is only about therapy and counseling. However, the reality is that the field is about much more than treating disorders and providing students with clinical services.

Mental health in schools aspires to do the following:

- Provide programs to (a) promote social-emotional development, (b) prevent mental health and psychosocial problems, and (c) enhance resiliency and protective buffers
- Provide programs and services to intervene as early after the onset of behavior, learning, and emotional problems as is feasible
- Enhance the mental health of families and school staff
- Build the capacity of all school staff to address barriers to learning and promote healthy development
- Address systemic matters at schools that affect mental health, such as high stakes testing, including exit exams, and other practices that engender bullying, alienation, and student disengagement from classroom learning
- Develop a comprehensive, multifaceted, and cohesive continuum of school-community interventions to address barriers to learning and promote healthy development

## **CURRENT STATE OF AFFAIRS**

The current state of affairs related to mental health in schools is discussed mostly in terms of services and programs. For example, Exhibit 2 provides a summary of findings excerpted from the first national survey of school mental health services (Foster et al., 2005). The sample was representative of public schools across the United States, and the data amplify and support previous findings, including those discussed above.

## **Exhibit 2** Some Baseline Data on School Mental Health Services

As reported in *School Mental Health Services in the United States, 2002–2003* (Foster et al., 2005), the survey topics included types of mental health problems encountered in school settings; types of mental health services that schools are delivering; numbers and qualifications of school staff providing mental health services; types of arrangements for delivering mental health services in schools, including collaboration with community-based providers; and major sources of funding for school MH services.

### **Key Findings as Reported in the Executive Summary**

- Nearly three-quarters (73%) of the schools reported that “social, interpersonal, or family problems” were the most frequent mental health problems for both male and female students.
- For males, aggression or disruptive behavior and behavior problems associated with neurological disorders were the second and third most frequent problems.
- For females, anxiety and adjustment issues were the second and third most frequent problems.
- All students, not just those in special education, were eligible to receive mental health services in the vast majority of schools (87%).
- One-fifth of students on average received some type of school-supported mental health services in the school year prior to the study.
- Virtually all schools reported having at least one staff member whose responsibilities included providing mental health services to students.
- The most common types of school mental health providers were school counselors followed by nurses, school psychologists, and social workers. School nurses spent approximately a third of their time providing mental health services.
- More than 80% of schools provided assessment for mental health problems, behavior management consultation, and crisis intervention, as well as referrals to specialized programs.
- A majority also provided individual and group counseling and case management.
- Financial constraints of families and inadequate school mental health resources were the most frequently cited barriers to providing mental health services.
- Almost half of school districts (49%) used contracts or other formal agreements with community-based individuals and/or organizations to provide mental health services to students. The most frequently reported community-based provider type was county mental health agencies.
- Districts reported that the most common funding sources for mental health services or interventions were the Individuals with Disabilities Education Act (IDEA), state special education funds, and local funds. In 28% of districts, Medicaid was among the top five funding sources for mental health services.

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- One-third of districts reported that funding for mental health services had decreased since the beginning of the 2000–2001 school year, while over two-thirds of districts reported that the need for mental health services increased.
- Sixty percent of districts reported that since the previous year, referrals to community-based providers had increased. One-third reported that the availability of outside providers to deliver services to students had decreased.

While survey findings indicate that schools are responding to the mental health needs of their students, they also suggest increasing needs for mental health services and the multiple challenges faced by schools in addressing these needs. Furthermore, more research is needed to explore issues identified by this study, including training of school staff delivering mental health services, adequacy of funding, and effectiveness of specific services delivered in the school setting.

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SOURCE: Foster et al., 2005, pp. 1–2.

Another example comes from a national survey by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2008). The report indicates that for youth 12 to 17 years of age, the combined 2005 and 2006 data show an annual average of 3.0 million youths (12.0%) received services for emotional or behavioral problems in a school-based setting. In contrast, 3.3 million youths (13.3%) received services for emotional or behavioral problems in a specialty mental health setting and around 752,000 (3.0%) received such services in a general medical setting. Females were more likely than their male counterparts to receive services in a specialty mental health or educational setting.

Cataloging services and their use certainly is necessary. However, a deeper understanding requires appreciation of the diverse agenda stakeholders bring to the field, the funding situation, and current policy and practice.

### Diverse Agenda for Mental Health in Schools

Different stakeholders are pursuing different and sometimes conflicting agenda. Analyses of the contrasting enterprises pursued under the banner of mental health in schools find seven different agenda concerned in varying degrees with policy, practice, research, and/or training. In Exhibit 3, the agenda are grouped and subdivided in terms of the *primary* vested interests of various parties. While some agenda are complementary, some are not.

**Exhibit 3** Diverse Agenda for Mental Health in Schools

1. Efforts to use schools to increase *access* to kids and their families for purposes of
  - a. conducting research related to mental health concerns
  - b. providing services related to mental health
2. Efforts to increase *availability* of mental health interventions
  - a. through expanded use of school resources
  - b. through colocating community resources on school campuses
  - c. through finding ways to combine school and community resources
3. Efforts to get schools to adopt and/or enhance specific programs and approaches
  - a. for treating specific individuals
  - b. for addressing specific types of problems in targeted ways
  - c. for addressing problems through schoolwide, *universal* interventions
  - d. for promoting healthy social and emotional development
4. Efforts to *improve specific processes and interventions* related to mental health in schools (e.g., improve systems for identifying and referring problems and for case management, enhancing *prereferral* and early intervention programs)
5. Efforts to enhance the *economic interests* of various entities (e.g., specific disciplines, guilds, contractors, businesses, organizations) that are
  - a. already part of school budgets
  - b. seeking to be part of school budgets
6. *Efforts to change how student supports are conceived* at schools (e.g., rethink, reframe, reform, restructure) through
  - a. enhanced focus on multidisciplinary teamwork (e.g. among school staff, with community professionals)
  - b. enhanced coordination of interventions (e.g., among school programs and services, with community programs and services)
  - c. appropriate integration of interventions (e.g., that schools own, that communities base or link with schools)
  - d. modifying the roles and functions of various student support staff
  - e. developing a comprehensive, multifaceted, and cohesive component for systematically addressing barriers to student learning at every school
7. Efforts to *reduce school involvement* in mental health programs and services (e.g., to maximize the focus on instruction, to use the resources for youth development, to keep the school out of areas where family values are involved)

Given the diverse agenda, competing interests often come into conflict with each other. For example, those concerned with nurturing positive youth development and mental health and those focusing on the treatment of mental and

behavioral disorders often find themselves in counter-productive competition for sparse school time and resources. This contributes to the low priority and the backlash to efforts to enhance policy and practice for mental health in schools.

Over the years, our center at UCLA has pursued a broad agenda for advancing mental health in schools. We emphasize (1) embedding the work into every school's need to address barriers to learning and teaching and promote healthy development and (2) fully integrating the agenda into school improvement policy and practice. We stress that the agenda encompasses enhancing greater family and community involvement in education. And it requires a fundamental shift in thinking about what motivates students, staff, and other school stakeholders.

In the absence of a broad agenda, mental health in schools commonly is viewed as concerned mainly with providing interventions for a relatively few of the many students who need some form of help. Efforts to promote social and emotional health and prevent problems are sparse. Diverse agenda have created counter-productive competition for sparse funds. Ad hoc policy and categorical funding have created a fragmented and piecemeal enterprise.

## Funding

Inadequate data are available on how much schools spend to address behavior, emotional, and learning problems. Exhibit 4 provides a bit of a perspective.

### Exhibit 4 What Is Spent in Schools?

As reported by the National Center for Educational Statistics (2008), data for fiscal year (FY) 2006 indicate that approximately \$520.6 billion was collected in revenues for public elementary and secondary education in the 50 states and the District of Columbia. "The greatest percentage of revenues came from state and local governments, which together provided \$473.1 billion, or 90.9% of all revenues; the federal government's contribution was \$47.6 billion, or 9.1% of all revenues."

"Current expenditures" totaled \$449.6 billion. These include those for "day-to-day operation of schools and school districts (salaries, benefits, supplies, and purchased services) for public elementary and secondary education." They exclude expenditures for construction, equipment, property, debt services, and programs outside of public elementary and secondary education such as adult education and community services.

Current expenditures per pupil for public elementary and secondary education were \$9,154. Adjusting for inflation, current expenditures per pupil have grown 25.1% since FY 1995 (\$7,315) and 51.0% since FY 1985 (\$6,062). In FY 2006, \$274.2 billion was spent on instruction. This includes spending on salaries and benefits for teachers and teacher aides, classroom supplies and services, and extracurricular and cocurricular activities.

Looking at per pupil current expenditures for public elementary and secondary education, instruction expenditures ranged from \$10,109 in New York to \$3,453 in Utah. Instruction accounted for 61.0% of all current expenditures for public elementary and secondary education. Total support services accounted for 34.9%, food services accounted for 3.8%, and enterprise operations made up 0.2% of total current expenditures.

Breaking all this down to clarify what goes for regular student and learning supports and special education is not easy.

In 1997, Monk, Pijanowski, and Hussain reported that 6.7% of school spending is used for student support services such as counseling, psychological services, speech therapy, health services, and diagnostic and related special services for students with disabilities. The amount specifically devoted to learning, behavior, and emotional problems is unclear.

*But* note that these figures do not include costs related to time spent on such matters by other school staff such as teachers and administrators. Also not included are expenditures related to initiatives such as safe and drug-free school programs and arrangements such as alternative and continuation schools and funding for school-based health, family, and parent centers, and much more.

Federal government figures indicate that total spending to educate all students with disabilities found eligible for special education programs was \$78.3 billion (U.S. Department of Education, 2005). About \$50 billion was spent on special education services; another \$27.3 billion was expended on regular education services for students with disabilities eligible for special education; and an additional \$1 billion was spent on other special needs programs (e.g., Title I, English language learners, or gifted and talented education). Estimates in many school districts indicate that about 20% of the budget is consumed by special education. How much is used directly for efforts to address learning, behavior, and emotional problems is unknown, but remember that over 50% of those in special education are diagnosed as learning disabled and over 8% are labeled emotionally and/or behaviorally disturbed.

Focusing only on pupil service personnel salaries in calculating how much schools spend on addressing behavior, emotional, and learning problems probably is misleading and a major underestimation. This is particularly so for schools receiving special funding. Research needs to clarify the entire gamut of resources school sites devote to student problems. Budgets must be broken apart in ways that allow tallying all resources allocated from general funds, support provided for compensatory and special education, and underwriting related to programs for dropout prevention and recovery, safe and drug-free schools, pregnancy prevention, teen parents, health services, family literacy, homeless students, and more. In some schools receiving funds from multiple categorical funding streams, school administrators tell us that as much as 25% to 30% of the budget may be expended on problem prevention and correction.

As stressed by the Policy Leadership Cadre for Mental Health in Schools (2001):

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 to determining equity and enhancing system effectiveness.

Whatever the expenditures, few schools come close to having enough resources to deal with a large number of students with behavior, emotional, and learning problems. Moreover, the contexts for intervention often are limited and makeshift because

of how current resources are allocated and used. A relatively small proportion of space at schools is earmarked specifically for programs that address student problems. Many special programs and related efforts to promote health and positive behavior are assigned space on an ad hoc basis. Support service personnel often must rotate among schools as *itinerant* staff. These conditions contribute to the tendency for such personnel to operate in relative isolation of each other and other stakeholders. To make matters worse, little systematic inservice development is provided for new *support* staff when they arrive from their preservice programs. Obviously, all this is not conducive to effective practice and is wasteful of sparse resources.

Clearly, diverse school and community resources are attempting to address complex and overlapping psychosocial and mental health concerns. The need is great. The current response is insufficient.

### Nature of Current Practice and Policy

Data on schools, districts, and students in public schools are in a constant state of flux. Available data indicate over 90,000 public schools in about 15,000 districts enroll about 49 million students. Over the years, most—but obviously not all—schools have instituted policies and programs designed with a range of mental health and psychosocial concerns in mind.

Policies are in place to support school counseling, psychological, and social service programs and personnel and to connect community programs and personnel with schools. As a result, most schools have some interventions to address a range of mental health and psychosocial concerns, such as school adjustment and attendance problems, substance abuse, emotional problems, relationship difficulties, violence, physical and sexual abuse, delinquency, and dropouts. A large body of research supports the promise of much of this activity.<sup>1</sup>

*Practices.* School-based interventions relevant to mental health encompass a wide variety of practices, an array of resources, and many issues. However, as we have noted, addressing psychosocial and mental health concerns in schools typically is not assigned a high priority. Such matters gain stature for a while whenever a high visibility event occurs—a shooting on campus, a student suicide, an increase in bullying. Because of their usual humble status, efforts continue to be developed in an ad hoc, piecemeal, and highly marginalized way.

School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as *at risk*. The activities may be implemented in regular or special education classrooms or as out of classroom programs and may be designed for an entire class, groups, or individuals. A focus may also be on primary prevention and enhancement of healthy development through use of health



education, health services, guidance, and so forth—though relatively few resources usually are allocated for such activity.

Exhibit 5 highlights the five major *delivery mechanisms and formats* used in schools to pursue the various agenda for mental health.

### **Exhibit 5** Delivery Mechanisms and Formats for Mental Health in Schools

The five mechanisms and related formats are as follows:

1. *School-Financed Student Support Services*—Most school districts employ pupil services professionals such as school psychologists, counselors, school nurses, and social workers to perform services related to 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.

2. *School-District Mental Health Unit*—A few districts operate specific mental health units with clinics and school services and consultation. Some have started to finance their own school-based health centers with mental health services as a major element. The format for this mechanism has been a centralized unit with the capability for outreach to schools.

3. *Formal Connections With Community Mental Health Services*—Increasingly, schools have connected 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 and combinations predominate:

- Colocation 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
- Contracts with community providers to provide needed student services

4. *Classroom-Based Curriculum and Special Out of Classroom Interventions*—Most schools include a focus on enhancing social and emotional functioning in some facet of their curriculum. 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 are as follows:

- 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 implemented as part of a multifaceted set of interventions designed to enhance positive development and prevent problems

*(Continued)*

(Continued)

5. *Comprehensive, Multifaceted, and Integrated Approaches*—A few school districts have begun to reconceptualize piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. The intent is to develop a comprehensive system of student and learning supports and integrate it with instructional efforts that affect healthy development. The process involves restructuring student support services and weaving them together with community resources. Minimally, the focus is on establishing a full continuum of programs and services 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, as reflected in initiatives designated as expanded school mental health. Efforts to move toward comprehensive, multifaceted approaches are reflected in 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/services and integrate them into school reform agenda
- Community schools

*Personnel.* As already noted, school districts employ personnel such as psychologists, counselors, social workers, psychiatrists, nurses, special educators, and a variety of others whose focus encompasses mental health and psychosocial concerns. Federal and state mandates tend to determine how many pupil services professionals are employed, and states regulate compliance with mandates. Governance of their work usually is centralized at the district level. In large districts, counselors, psychologists, social workers, and other specialists may be organized into separate units, overlapping regular, compensatory, and special education.

Specialists tend to focus mainly on students causing problems or having problems. The many *functions* of such professionals can be grouped into the following: (1) direct services and instruction; (2) coordination, development, and leadership related to programs, services, resources, and systems; and (3) enhancement of connections with community resources. Some of this involves linking and collaborating with community agencies and programs to enhance resources and improve access, availability, and outcomes.

Prevailing direct intervention approaches encompass responding to crises; identifying the needs of targeted individuals; prescribing one or more interventions; offering brief consultation; and providing referrals for assessment, corrective services, triage, diagnosis, and various gatekeeping functions. In some situations, however, resources are so limited that specialists can do little more than assess for special education eligibility, offer brief consultations, and make referrals to special education and/or community resources.

Because the need is so great, other personnel often are called on to play a role in addressing problems of youth and their families. These include instructional professionals (health educators, other classroom teachers, special education staff, resource

staff), administrative staff (principals, assistant principals), students (including trained peer counselors), family members, and almost everyone else involved with a school (aides, clerical and cafeteria staff, custodians, bus drivers, paraprofessionals, recreation personnel, volunteers, and professionals in training). As noted, districts are connecting with specialists employed by other public and private agencies, such as health departments, hospitals, social service agencies, and community-based organizations, to provide services to students, their families, and school staff (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003; Romer & McIntosh, 2005).

In summation, most districts provide schools with some personnel to address a range of mental health and psychosocial concerns, such as school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, delinquency, and violence. Some are funded by the district or through extramural grants; others are the result of linkages with community service and youth development agencies.

*But It Is All Marginalized.* While a range of mental health and psychosocial problems are addressed, no one should think that mental health is a high priority in school policy and practice (Adelman & Taylor, 2006d; Taylor & Adelman, 2000). Schools and districts treat student and learning supports as desirable but not an imperative. Since the activity is not seen as essential, the programs and staff are pushed to the margins. Planning of programs, services, and delivery systems is done on an ad hoc basis; interventions are referred to as *auxiliary* or *support* services, and student support personnel almost never are a prominent part of a school's organizational structure. Such staff usually are among those deemed dispensable as budgets tighten.

Because student supports are so marginalized, they are developed in a piecemeal manner. The marginalization spills over to how schools pursue special education mandates and policies related to inclusion. The low policy status shapes how they work with community agencies and initiatives for systems of care, wrap-around services, school-linked services, and other school-community collaborations. And all this negatively affects adoption and implementation of evidence-based practices.

Evidence of the marginalization is found in school improvement plans. Analyses of such planning indicate that schools give sparse attention to mental health and psychosocial concerns (Center for Mental Health in Schools, 2005a, 2005b, 2005d).

## CONCLUDING COMMENTS

Anyone who has worked in a school knows how hard school professionals toil. Anecdotes about great programs and outcomes are legion.

Our discussion in this chapter and the rest of the book underscores that exceptional talent and effort has brought the field of mental health in schools to this stage in its development. At the same time, we stress that too little is being done in most schools and significant work lies ahead.

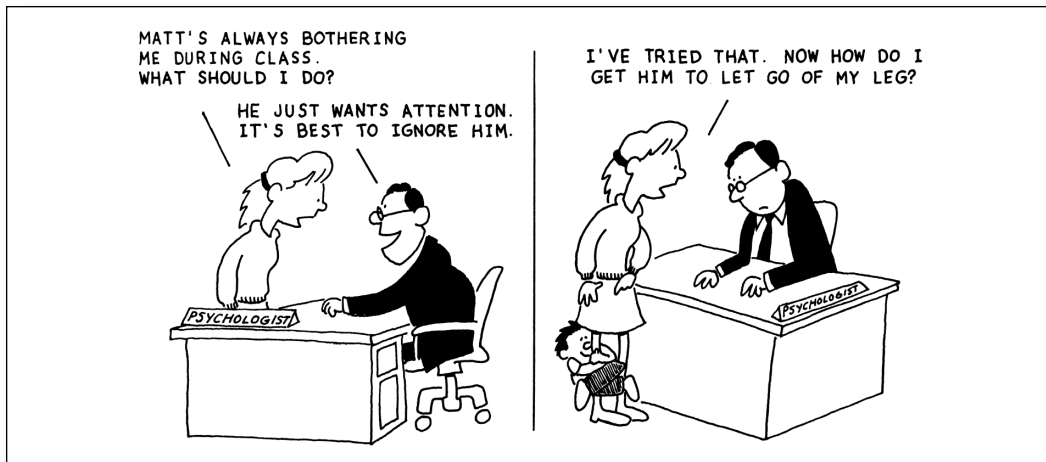
Current practices have been generated and function in relative isolation of each other. Intervention planning and implementation are widely characterized

as fragmented and piecemeal. This, of course, is an ineffective way for schools to deal with the complex sets of problems confronting teachers and other staff.

Organizationally, policy makers tend to mandate and planners and developers focus on specific services and programs with too little thought or time given to mechanisms for program development and collaboration. The work rarely is envisioned in the context of a comprehensive approach to addressing behavior, emotional, and learning problems and promoting healthy development.

Functionally, most practitioners spend their time applying specialized interventions to targeted problems, usually involving individual or small groups of students. Consequently, programs to address behavior, emotional, learning, and physical problems rarely are coordinated with each other or with educational programs.

The above state of affairs is not meant as a criticism of those who are doing their best to help students in need. Our intent is to underscore a fundamental policy weakness, namely: *Efforts to address barriers to learning and teaching are marginalized in current education policy.* This maintains an unsatisfactory status quo related to how schools address learning, behavior, and emotional problems. Analyses indicate that school policy is currently dominated by a two-component systemic model (Adelman, 1995b, 1996a, 1996b; Adelman & Taylor, 1994, 1997b, 1998, 2006c; Center for Mental Health in Schools, 1996, 1997). That is, the primary thrust is on improving instruction and school management. While these two facets obviously are essential, ending the marginalization of efforts to effectively address barriers to learning, development, and teaching requires establishing a third component as a fundamental facet of transforming the educational system. We amplify on this matter in the next chapter and throughout the book.



## NOTE

1. In addition to the references included in this book, an online list of relevant references is regularly updated and available from the national Center for Mental Health in Schools at UCLA at <http://smhp.psych.ucla.edu/qf/references.htm>. Also see Chapter 14 for an annotated listing of sources for identifying evidence-based strategies for strengthening student supports; the list also is online with direct links at <http://smhp.psych.ucla.edu/pdfdocs/aboutmh/annotatedlist.pdf>.