SCHOOL-BASED MENTAL HEALTH SERVICES

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Introduction

It should come as no surprise that schools nationally are the major providers of mental health services for children (Rones & Hoagwood, 2000). Although only 16 percent of all children receive mental health services, 70 to 80 percent of this number receive that care in the school setting (The Center for Health and Health Care in Schools, 2002). Schools provide a setting for the early identification of emotional and behavioral problems and provision of services, due to the critical, daily role they play in the growth and development of children. Furthermore, services offered in the school environment are more convenient to children and families and therefore are far more likely to be utilized than many services in the community.

Although schools are not the primary agency responsible for addressing emotional and behavioral issues, they cannot ignore them if they intend to fulfill their mandate to educate all children. The Individuals with Disabilities in Education Act (IDEA) requires that schools follow specific procedures to meet the educational needs of children with disabilities. While a discussion of the requirements of the Act is beyond the scope of this document, it is important to recognize that children who are impaired by mental health disorders often have a diminished capacity to learn and must be adequately accommodated in the school setting in order to receive the benefits of educational services.

Section 504 of the Rehabilitation Act of 1973 is another federal statute designed to protect the rights of qualified school-aged persons who have a disability. This law protects students having a disability who require modifications to their educational program, but who do not require or are not eligible for special education (National Association of School Psychologists, 2002). Section 504 also requires schools that receive federal funds to provide a free appropriate public education to each qualified person (Virginia Department of Education, 2001). Further, Section 504 requires schools to provide students with disabilities appropriate educational services designed to meet their individual needs to the same extent as the needs of students without disabilities are met (Office for Civil Rights, 2001).

In addition to providing the accommodations required under IDEA and Section 504, schools have responded to the needs of these special populations by implementing numerous programs and services designed to foster prevention, risk-reduction, and intervention/treatment for children with emotional and behavioral difficulties. These services are generally designed to meet one of two broad purposes: universal protection or targeted prevention and intervention. Programs that are intended to provide universal protection are broader in scope, and typically include modification of school policy, implementation of classroom management strategies, development of curricular changes, and facilitation of parent-school communication. In contrast, targeted prevention and intervention efforts involve the identification of at-risk children and adolescents and the creation of accessible services to address their specific needs (Rones & Hoagwood, 2000).

However, while a broad range of school-based programs are reported to exist, the nature and effects of these services remain largely undocumented. There is very little research available to guide the efforts of school officials and policymakers in planning effective school-based services. The bulk of the research is focused on two areas: preventive strategies to manage disruptive behaviors among younger children and interventions for mood disorders among high school students. Consequently, the effectiveness of the treatment programs targeting other populations remains largely untested. Furthermore, many studies have underemphasized school-relevant outcomes, such as the effects of programming on student achievement, attendance, school-related behavior, and dropout prevention (Mattison, 2000). This is especially problematic because these issues are often directly related to serious emotional and behavioral disturbance (Mattison). For example, research has found that students who demonstrate school refusal or truancy often have anxiety disorders, mood disorders, or conduct disorder (Mattison). However, the available research does little to guide school officials in determining how to address these issues as manifestations of mental health disorders. Accountability provisions in *No Child Left Behind*, for example, suggest the urgent need for schools to gather evidence-and inform policymakers-of the positive academic outcomes that result from their activities as mental health service providers (Charvat, 2004). Moreover, a sense of student "connectedness" to schools has been found to have positive effects on academic achievement and to decrease risky behaviors (American Academy of Pediatrics [AAP], 2004).

In response to these gaps in research, analysts have made greater efforts to document the components of successful school-based programs (e.g., Mattison, 2000). These studies have identified several factors that appear to be common elements of successful school initiatives. These elements are outlined in the following paragraphs. However, it is important to note there are few studies that examine any of the topics that concern schools, including absenteeism, disciplinary referral, retention, and dropping out (Mattison).

National Overview

There are several different models for the delivery of school-based services. One of these approaches is the school-based health center model. A school-based health center is a safe, easily accessible location on a school campus where students can go for comprehensive preventive and primary health care services (Center for Mental Health in Schools, 1998). While comprehensive school-based health centers vary in staffing and patterns and services provided, they share some common features. The following is a listing of such features, as outlined by the Center for Mental Health in Schools:

- The health center is located in the school.
- Parents sign written consents for their children to enroll in the health center.
- An advisory board of community representatives, parents, youth and family organizations participate in planning and oversight of the health center.
- The health center works cooperatively with school staff to assure that the health center is an integral part of the life of the school.
- Clinical services are the responsibility of a qualified health provider.
- A multidisciplinary team providing health care for students.
- The health center provides a comprehensive range of services that specifically meets the serious health problems of young people.

School-based health centers have increasingly become a key provider of health services for children and adolescents (Association for Supervision and Curriculum Development, 2001). This is particularly true for receiving mental health services. The need for appropriate mental health services in schools was documented in a 1997-1998 survey which found that the primary reason students visited the center was to obtain mental health services (Association for Supervision and Curriculum Development).

School nurses also have a key role in assisting children and adolescents in accessing health care within the school system. According to the National Association of School Nurses, ensuring access to quality health care is an important component of school nursing practice (2002). By providing and supervising health care services, in addition to assisting with entry into community sources of health care, the school nurse plays a pivotal role in improving the health and educational success of the school-age child (National Association of School Nurses).

Other delivery approaches include expanding the current role of the school counselor or school psychologist to provide mental health services in school. School-based health services may also be provided by certified nurse practitioners, physician assistants, or licensed or credentialed mental health professionals (social workers, psychologists, etc) (AAP, 2001). *Table 1* shows a listing of various national delivery models.

Implementation Issues

Integration of Mental Health Professionals into the School Environment

Research supports the integration of clinicians, behavior specialists, school psychologists, and social workers into the schools to work directly with students, their families, and members of the school faculty and administration. These professionals offer intensive mental health services, and thereby enable schools to more effectively identify at-risk students and provide early intervention to prevent further emotional and behavioral difficulties (Woodruff et al., 1999).

Creation of a "System of Care" Within the School Environment

School-based wraparound services have also been found to support learning and transition for children with special needs. Wraparound services in this context may include assistance in getting a child to school, after-school care, and successful transitions from more restrictive educational placements into the regular classroom setting. These services may be coordinated through the creation of service planning teams consisting of family members, school-based clinicians, and agency representatives (Woodruff et al., 1999).

Table 1

Delivery Mechanisms for U.S. School-Based Mental Health Programs

1. **School-Financed Student Support Services** – Most school districts employ pupil services professionals such as school psychologists, counselors, social workers, and school nurses to perform services related to mental health and psychosocial problems (including related services designated for special education students). The format for this delivery mechanism tends to be a combination of centrally based and school-based services.

2. **School-District Mental Health 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.

3. **Formal Connections with Community Mental Health Services** – Some 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 (wraparound services for those in special education).

4. **Classroom-Based Curriculum and Special "Pull Out" Interventions** – Most schools include 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. Special education classrooms always are supposed to have a constant focus on mental health concerns.

5. **Comprehensive, Multifaceted, and Integrated Approaches** – Some districts have assessed their fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. They have restructured their student support services with community resources and integrated all this with instructional efforts that effect healthy development. Mental health and psychosocial concerns are a major focus.

Source: Policy Leadership Cadre for Mental Health in Schools, 2001.

Within this school-based system of care, research has found that the use of school-based case management is highly beneficial. Case managers can support the planning process by working with parents and school staff to establish behavioral management and long-term academic goals. They can also be used to coordinate school- and community-based services for students and families to ensure that the child successfully remains in the school and in the home (Woodruff et al., 1999). Research has shown that the use of monitors of this type can increase the participation and performance of at-risk students in school (Mattison, 2000).

School-based wraparound services have also been found to support learning and transition for children with special needs. The concept of wraparound is a strength-based approach to service delivery (Milwaukee County Mental Health Division, 1999). Wraparound, as defined by the Wraparound Milwaukee Project, focuses on planning and utilizes an approach based on identifying what services families really need to take care of a child with mental health disorders or severe emotional problems. Personal, community and professional resources are identified to meet these needs and then those services are "wrapped" around the child and family (Milwaukee County Mental Health Division). Wraparound services in this context may include assistance in getting a child to school, after-school care, and successful transitions from more restrictive educational placements into the regular classroom setting. These services may be coordinated through the creation of service planning teams consisting of family members, school-based clinicians, and agency representatives (Woodruff et al., 1999).

The system of care should also incorporate the three-stage approach to mental health services: prevention, early intervention, and targeted intervention. Successful school-based programs incorporate school wide programs to help identify students with or at risk of developing emotional or behavioral disorders and assist them in behavior management and treatment. However, they also provide prevention programming designed to enable students who are not at risk to learn the skills and behaviors that help them to follow school rules and perform well both academically and socially (Woodruff et al., 1999).

Research also supports the creation of “centers” within the school to provide support to children and youth with emotional and behavioral needs. Much like a clinic, these centers are described as areas set aside to provide students with a place to go to meet with clinicians when they feel they need emotional, behavioral, or academic support (Woodruff et al., 1999). School-based health center models are discussed in “National Overview” within this section.

Although schools are a major provider of mental health services for children, many schools are not offering a system of care that creates an adaptive continuum of services (Rones & Hoagwood, 2000). This may be attributed to a variety of reasons, including lack of resources to offer these services. There are several gaps that have been identified in the types of mental health and social problems targeted by school-based mental health programs. For example**,** Rones & Hoagwood found a lack of school-based programs related to anxiety prevention or intervention. This is problematic, because anxiety is one of the most common mental disorders among children and adolescents, and has often been found to lead to lost school days due to somatic complaints and school refusal. The study also identified a need to develop a greater number of interventions targeted toward middle and high school students with conduct disorder, as well as elementary school students with depression. In addition, the study found a significant lack of programs focusing on special education students, particularly those diagnosed with serious emotional disturbance (Rones & Hoagwood).

Engagement of Families in Educational Planning and Services

Families are a critical component in the provision of mental health services for children. Because of the central role the family plays in the lives of their children, involvement in their child’s educational planning and services ensures that services are responsive to the needs of the child and of the community. The inclusion of parents, teachers, and peers in treatment efforts is vital to enhancing wraparound effect of services. Furthermore, gathering information and assistance from family members ensures that the potential needs of students are effectively

identified and treated in all contexts. Consequently, schools need to ensure that families are fully engaged in the educational and mental health services that are provided to the child, and must make every effort to assist them in understanding and navigating the system and services available in the community (Woodruff et al., 1999).

Schools may enhance this process by utilizing family liaisons or advocates. These individuals may attend meetings with family members and assist them in locating resources. Their role may also include conducting courses to educate and empower families and working with the clinicians to ensure that families are meeting the academic, behavioral, and emotional needs of their children (Woodruff et al., 1999). Such an approach promotes family involvement and ensures that the child receives the most favorable treatment and educational experience.

Consistent Program Implementation

Poor program implementation can mitigate the potential benefits of services (Rones & Hoagwood, 2000). Therefore, schools must ensure that the programs they design are being carried out in the most efficient manner possible. Several elements have been identified as crucial to effective program implementation. These are described in Table 2.

Other Environmental and Community Factors

Other factors can also have a significant impact on program success. In order to foster a climate of acceptance, school administrators should create a mission statement that explicitly recognizes the needs of special education students and ensures commitment to specialized programming (McLaughlin, 1993). In addition, it is important that the school leadership supports all efforts and demonstrates willingness to contribute staff and resources to these programs. Furthermore, school officials should remain committed to ensuring that teachers and staff are properly trained and that professional development programs are available (McLaughlin).

The establishment of new school-based initiatives may require administrators and policymakers to be creative in their pursuits of additional funding and resources within the community. Sources of funding may include private health insurance plans, traditional school health funds, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, Medicaid, the Comprehensive Services Act, and other local, state and federal resources. It is extremely important that the funding issues be addressed during the planning phases of program development, as under funded, poorly implemented programming will do little to assist these children and adolescents. The shortage of qualified mental health professionals is another element that cannot be ignored.

Another area that is crucial in the successful delivery of services is the delicate relationship between mental health providers and schools. The lack of functional collaboration between community based mental health systems and the schools is most problematic. Furthermore, there is limited transition planning for children entering into hospitals or returning to school. There is a definite need for coordination among mental health providers and schools to encourage transition planning. This can be accomplished through improved interagency involvement. Such coordination is crucial and enables the individual student to reap maximum benefits from treatment (SJR 99 Advisory Group Meeting, August 14, 2002).

Table 2

Elements Crucial to Effective Program Implementation

- The program goals, rationale, and components should be communicated clearly to faculty, staff, and students. The policy should provide a detailed description of individual responsibilities and expectations, and should include an explanation of all rules, consequences, and any reward system (Rones & Hoagwood).
- The components of the program should be developmentally appropriate. Services should be designed to address specific concerns within a particular age group based on the students' maturity level and social skills (Rones & Hoagwood).
- The most effective programs target specific behaviors and skills, e.g., depression, conduct problems, drug use (Rones & Hoagwood). Consequently, there should be an objective identification and screening process within the school system to identify at-risk students and clarify their intervention needs (Mattison, 2000).
- The program should include multiple approaches to changing behavior. For example, effective school-based programs have been found to incorporate skill building, academic tutoring, parent training, and home visits within the overall service plan (Rones & Hoagwood).
- The program should offer recreational opportunities in non-traditional learning environments such as summer camps and after-school programs, in order to provide learning and exposure to other children in less formal environments. These experiences can also be used to reinforce the pro-social behaviors taught in school-based clinics in other environments (Woodruff et al., 1999).
- The program content should be integrated into the general classroom curriculum. Separate and specialized lessons have been found to be less effective than the incorporation of program elements into the normal educational routine of the school (Rones & Hoagwood).
- All of the parties affected by the service should receive the necessary training and instruction. For example, programs should include teacher training in classroom management techniques, parent training in child management, and child cognitive-social skills training (Rones & Hoagwood).
- The staff involved in these programs should remain continuous in order to allow for stable, long-term relationships with the children and their families (Woodruff et al.).
- Feedback should be provided on a regular basis. The program effects should be continuously evaluated, and consultation and support should be provided to teachers, including refresher training, classroom observation, and small group discussions (Rones & Hoagwood).

Source: Commission on Youth Graphic of Citations as noted, 2002.

Use of Medication in School Settings

Another issue surrounding school-based mental health services that must be addressed is medication delivery. Medication is a customary, evidence-based treatment modality for children and adolescents with certain diagnosed mental health disorders. While once-daily medications are becoming more common, psychotropic drugs may require multiple daily doses that necessitates taking these medications at school (National Conference of State Legislatures, 2005). A report by an urban school district in Minnesota indicated that administration of

medications had increased from 1,294 in 1985 to 35,111 in 2000 (National Conference of State Legislatures). This same report estimates that it takes 22.5 hours per year to administer medication safely to one student diagnosed with attention deficit hyperactivity disorder (ADHD).

As outlined by Superintendent Memorandum Number 54, the Virginia Board of Education issued a policy in 2002 that prohibited school personnel from recommending the use of psychotropic medications for any student. However, school health staff, classroom teachers, or other school professionals could recommend that an appropriate medical practitioner evaluate a student (Virginia Department of Education, 2002).

In Virginia, the majority of school districts have registered nurses employed by the school board or the public health districts in the area. However, school districts frequently have unlicensed, trained individuals administering medications to students (Virginia Department of Health and Department of Education, 1999). Children with mental health needs receive medication in the same manner as children with other medical needs (Sherry Shrader, RN., BSN, Personal Communication, July 18, 2005).

Federal Activity on School Mental Health

School-based mental health delivery has been addressed at the federal level. The President's New Freedom Commission on Mental Health report asserts that schools can clearly assist in addressing mental health problems of school-age youth (2003). No single agency or system has clearly delineated responsibility for children or adolescents with serious emotional disturbances. Moreover, these children are usually involved with more than one system, including mental health, special education, child welfare, juvenile justice, substance abuse, and health (President's New Freedom Commission on Mental Health, 2003).

The President's New Freedom Commission on Mental Health indicated that schools must become partners in mental health care because schools are where children spend a majority of their day (2003). Every day, more than 52 million students attend over 114,000 schools in the United States. When combined with the six million adults working at those schools, almost one-fifth of the population passes through the nation's schools on any given school day (President's New Freedom Commission on Mental Health). Recommendation 4.2 of this report addresses the promotion and expansion of school mental health programs.

The detailed recommendations contained in this report for improving school-based mental health programs are:

- Collaboration between schools and parents, local providers, and local agencies to support screening, assessment, and early intervention;
- Ensuring that mental health services are part of school health centers;
- Provision of federal funding for health, mental health, and education programs;
- Implementation of empirically supported prevention and early intervention approaches at the school district, local school, classroom, and individual student levels; and
- Creating a state-level structure for school-based mental health services to provide consistent State-level leadership and collaboration between education, general health, and mental health systems (President's New Freedom Commission on Mental Health, 2003).

Conclusion

It is important that policy makers recognize the tremendous potential that exists in reaching children with mental health needs through school-based programming. The increased involvement of the educational system in the process of mental health intervention and treatment could dramatically influence the accessibility and utilization of services, and could result in substantial growth in the number of positive child outcomes.

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Center for Health and Health Care in Schools
http://www.healthinschools.org/home.asp

National Association of School Psychologists
4340 East West Highway, Suite 402 - Bethesda, MD 20814
Email: center@naspweb.org
http://www.nasponline.org

National Technical Assistance Center for Children's Mental Health
http://www.gucdc.georgetown.edu

School Mental Health Project
http://smhp.psych.ucla.edu

UCLA Center for Mental Health in Schools
Department of Psychology
P.O. Box 951563 - Los Angeles, CA 90095-1563
310-825-3634
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http://smhp.psych.ucla.edu

University of Maryland
Center for School Mental Health Assistance
680 West Lexington St, 10th Floor - Baltimore, MD 21201
http://csmha.umaryland.edu

U.S. Office of Special Education Programs (OSEP)
Center on Positive Behavioral Interventions and Supports (PBIS)
http://www.PBIS.org

Virginia Resources

Joint Commission on Health Care. (2003). *Review of Emergency Medical and Mental Health Services in Public Schools.*

Parent Educational Advocacy Training Center (PEATC)
6320 Augusta Drive, Suite 1200 - Springfield, VA 22150
703-923-0010 or (VA only) 800-869-6782
Latino Outreach: 703-569-6200
Email: partners@peatc.org
http://www.peatc.org

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P.O. Box 2120 - Richmond, VA 23218-2120
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