General Rationale for Mental Health in Schools

*A*s stressed by the Carnegie Council Task Force on Education of Young Adolescents (1989): *School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.* It is evident that a variety of psychological and physical health problems affect learning in profound ways. And, the problems are exacerbated as youngsters internalize frustrations of confronting external and internal barriers to learning, experience the debilitating effects of performing poorly at school, and are punished for the misbehavior that is a common correlate of school failure.

As recent widely-reported incidents underscore, violence is a specter hanging over all schools. And, while guns and killings capture media attention, other forms of violence affect and debilitate youngsters at every school. Even though the data sets have been criticized, those who study the many faces of violence tell us that large numbers of students are caught up in cycles where they are the recipient or perpetrator (and sometimes both) of physical and sexual harassment ranging from excessive teasing and bullying to mayhem and major criminal acts. Moreover, any student may suffer the effects of severe anxiety or depression. The rate of suicide among the young remains a constant concern. The litany of barriers to learning is especially familiar to anyone who lives or works in urban or rural settings where families struggle with low income. In such locales, school and community resources often are insufficient to the task of providing the type of basic (never mind enrichment) opportunities found in higher income communities. The resources also are inadequate for dealing with such threats to well-being and learning as health problems, difficult family circumstances, gangs, violence, and drugs. Inadequate attention to language and cultural considerations and to high rates of student mobility creates additional barriers not only to student learning but to efforts to involve families in youngsters' schooling. Such conditions are breeding grounds for frustration, apathy, alienation, and hopelessness. 8 School policy makers have a long-history of trying to assist teachers in dealing with problems that interfere with school learning. Prominent examples are seen in the range of counseling, psychological, and social service programs provided by schools. Similarly, policy makers in other arenas have focused on enhancing linkages between schools and community service agencies and other neighborhood resources. Paralleling these efforts is a natural interest in promoting healthy development and productive citizens and workers. This is especially evident in initiatives for enhancing students' assets and resiliency and reducing risk factors through an emphasis on social-emotional learning and protective factors. Despite all this, it remains the case that too little is being done, and prevailing approaches are poorly conceived and implemented in fragmented ways. An even more fundamental concern, however, is the low policy priority placed on the whole enterprise of addressing mental health and psychosocial factors that affect youngsters in most schools and communities. In schools, existing programs are characterized as supplemental services, treated as a side show at school sites, and are among the first to go when budgets become tight. In effect, they are marginalized in policy and practice. For this to change, greater attention must be paid to enhancing the policy priority assigned such matters and developing integrated infrastructures. This document is meant as a step toward improving the status of current practices and as an immediate aid to those who work so diligently everyday in the best interests of children and adolescents.

Guidelines for Mental Health in Schools

*U*nderlying any set of guidelines is a set of principles or tenets. These represent major philosophical commitments. This is not the place for a treatise on such matters, but it helps to list out some of the commitments that underlie the guidelines outlined on the following pages. Thus, we begin by highlighting the synthesis of "key principles for effective frontline practice" set forth by Kinney, Strand, Hagerup, and Bruner (1994).

Some Underlying Principles

At the outset of their synthesis, Kinney and colleagues offer a cautionary note. They stress that care must be taken not to let important principles simply become *the rhetoric of reform, buzzwords that are subject to critique as too fuzzy to have real meaning or impact . . . a mantra . . . that risks being drowned in its own generality.* With the above caution in mind, we present their list below. This list provides a sense of the general philosophy we think should guide all efforts to address barriers to development and learning, promote healthy development, and strengthen families and neighborhoods. As key principles, Kinney and colleagues stress:

- A focus on improving systems, as well as helping individuals
- A full continuum of interventions
- Activity clustered into coherent areas
- Comprehensiveness
- Integrated/cohesive programs
- Systematic planning, implementation, and evaluation
- Operational flexibility and responsiveness
- cross disciplinary involvements
- De-emphasis of categorical programs
- School-community collaborations
- High standards-expectations-status
- Blending of theory and practice

Some Generic Guidelines for Designing Comprehensive Approaches

As will be evident, the principles on the preceding page are reflected in the following list of generic guidelines, most of which have been widely advocated in some form by leaders for systemic changes designed to evolve comprehensive, multifaceted, and cohesive approaches. An infrastructure must be designed to ensure development of interventions that:

- includes a focus on prevention (including promotion of wellness), early-age and early-after-onset interventions, and treatment for chronic problems,
- is comprehensive (e.g., extensive and intensive enough to meet major needs)
- is coordinated/integrated (e.g., ensures collaboration, shared responsibility, and case management to minimize negative aspects of bureaucratic and professional boundaries),
- is made accessible to all (including those at greatest risk and hardest-to-reach),
- is of the same high quality for all,
- is user friendly, flexibly implemented, and responsive,
- is guided by a commitment to social justice (equity) and to creating a sense of community,
- uses the strengths and vital resources of all stakeholders to facilitate development of themselves, each other, the school, and the community,
- is designed to improve systems and to help individuals, groups, and families and other caretakers,
- deals with the child holistically and developmentally, as an individual and as part of a family, and with the family and other caretakers as part of a neighborhood and community (e.g., works with multi-generations and collaborates with family members, other caretakers, and the community),
- is tailored to fit distinctive needs and resources and to account for all forms of
- diversity (e.g., culture, gender, disability)
- is tailored to use interventions that are no more intrusive than necessary in meeting needs (e.g., least restrictive environment)
- facilitates continuing intellectual, physical, emotional and social development, and the general well being of the young, their families, schools, communities, and society,
- is staffed by stakeholders who have the time, training, skills and institutional and collegial support necessary to create an accepting environment and build relationships of mutual trust, respect, and equality,
- is staffed by stakeholders who believe in what they are doing,
- is strategically planned, implemented, evaluated, and evolved by highly competent, energetic, committed and responsible stakeholders (including young people). Furthermore, infrastructure procedures should be designed to
- ensure there are incentives (including safeguards) and resources for reform,

- link and weave together resources owned by schools and other public and private community entities,
- interweave all efforts to (a) facilitate development and learning, (b) manage and govern resources, and (c) address barriers to learning,
- encourage all stakeholders to advocate for, strengthen, and elevate the status of young people and their families, schools, and communities,
- provide continuing education and cross training for all stakeholders,
- Provide quality improvement and self renewal, demonstrate accountability (cost-effectiveness and efficiency) through quality improvement evaluations designed to lead naturally to performance-based evaluations.

GUIDELINES FOR MENTAL HEALTH IN SCHOOLS

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

1.1 Ensuring academic success and also promoting healthy cognitive, social, and emotional development and resilience (including promoting opportunities to enhance school performance and protective factors; fostering development of assets and general wellness; enhancing responsibility and integrity, self-efficacy, social and working relationships, self-evaluation and self-direction, personal safety and safe behavior, health maintenance, effective physical functioning, careers and life roles, creativity)

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

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

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

2.1 Addressing common educational and psychosocial problems (e.g., learning problems; language difficulties; attention problems; school adjustment and other life transition problems; attendance problems and dropouts; social, interpersonal, and familial problems; conduct and behavior problems; delinquency and gang-related problems; anxiety problems; affect and mood problems; sexual and/or physical abuse; neglect; substance abuse; psychological reactions to physical status and sexual activity)

2.2 Countering external stressors (e.g., reactions to objective or perceived stress/demands/ crises/deficits at home, school, and in the neighborhood; inadequate basic resources such as food, clothing, and a sense of security; inadequate support systems; hostile and violent conditions)

2.3 Teaching, serving, and accommodating disorders/disabilities (e.g., Learning Disabilities;

Attention Deficit Hyperactivity Disorder; School Phobia; Conduct Disorder; Depression; Suicidal or Homicidal Ideation and Behavior; Post Traumatic Stress Disorder; Anorexia and Bulimia; special education designated disorders such as Emotional Disturbance and Developmental Disabilities) (cont.) 12

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

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

3.2 Referral, triage, and monitoring/management of care

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

3.4 Coordination, development, and leadership related to school-owned programs, Services, resources, and systems – toward evolving a comprehensive, multifaceted, and Integrated continuum of programs and services

3.5 Consultation, supervision, and in service instruction with a transdisciplinary focus

3.6 Enhancing connections with and involvement of home and community resources

(Including but not limited to community agencies)

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

4.1 Primary prevention
4.2 Intervening early after the onset of problems
4.3 Interventions for severe, pervasive, and/or chronic problems

5. ***Assuring Quality of Intervention***

5.1 Systems and interventions are monitored and improved as necessary
5.2 Programs and services constitute a comprehensive, multifaceted continuum
5.3 Interveners have appropriate knowledge and skills for their roles and functions and Provide guidance for continuing professional development
5.4 School-owned programs and services are coordinated and integrated
5.5 School-owned programs and services are connected to home & community resources
5.6 Programs and services are integrated with instructional and governance/management Components at schools
5.7 Program/services are available, accessible, and attractive
5.8 Empirically-supported interventions are used when applicable
5.9 Differences among students/families are appropriately accounted for (e.g., diversity, Disability, developmental levels, motivational levels, strengths, weaknesses)
5.10 Legal considerations are appropriately accounted for (e.g., mandated services; mandated reporting and its consequences)
5.11 Ethical issues are appropriately accounted for (e.g., privacy & confidentiality; coercion)
5.12 Contexts for intervention are appropriate (e.g., office; clinic; classroom; home)

6. ***Outcome Evaluation and Accountability***

6.1 Short-term outcome data
6.2 Long-term outcome data
6.3 Reporting to key stakeholders and using outcome data to enhance intervention quality