Toward the integration of education and mental health in schools

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Abstract

Numerous models for integrating mental health goals and services in schools exist, yet consensus about their comparative effectiveness is lacking. Given the new focus of educational reforms that are driven by a commitment to personalized learning, flexible delivery, early intervention, and attention to learning supports, it may be timely to consider a reformulation of the school mental health research agenda to better align with new priorities. These priorities include: (1) promoting an ecological approach to focus on outcomes associated with effective schooling, (2) enhancing the use of indigenous resources within schools to effect change, (3) integrating prevention and treatment, (4) identifying functional competencies rather than diagnoses, (5) targeting programs to improve the educational outcomes for students with high needs, and (6) enhancing active involvement of parents in schools. A research agenda to align with these priorities is presented.

National reform efforts in education and in mental health provide an opportunity for re-examining models to better integrate learning and behavioral health. Both the Surgeon General's report (US DHSS, 1999) and the report from the President's New Freedom Commission on Mental Health (2003) propose the expansion of mental health services for children in schools. Likewise, the education system has called for the increased accountability and integration between the mental health and education systems. The No Child Left Behind Act, signed into law in 2002, emphasized accountability, particularly for academic achievement and increased use of scientifically-based programs and teaching methods, and it stressed the need to ensure "student access to quality mental health care by developing innovative programs to link the local school system with the local mental health system" (U.S. Department of Education Office of Elementary and Secondary Education, 2002, p. 427). Clearly, at the federal level there is support for a closer alignment between education and mental health.

While there is an emerging consensus for locating mental health programs in schools, the role and structure of these services are varied and the empirical base is limited (Hoagwood & Erwin, 1997). In addition, most studies of school mental health have focused almost exclusively on social and emotional functioning with little regard to school context nor to promotion of effective schooling (Hoagwood, Olin, Kerker, Kratochwill, Crowe, & Saka, 2007). To achieve progress in this area, it is important to be aware of the new priorities within the educational reform movement. For example, literally every school in the country has developed a school improvement plan to meet federal and state mandates to increase school effectiveness. The P-16/P20 agenda embraced by the National Governor's Association and the Gates Foundation, the Breaking Ranks initiative, and other reform efforts (e.g., New Generation Learners) are driving a renewed focus on accountability, outcomes, personalized learning, early intervention, and

flexible learning supports (Cashman et al., 2009 – NOT IN REF Section). The potential for expanding behavioral health services within the paradigm of these educational efforts is considerable. However, to do so will require a different set of research priorities.

Given the limited progress in establishing consensus about effective and efficient school mental health programs that can be sustained within the varied ecologies of schools (see Adelman and Taylor 2006; Evans and Weist 2004), the purpose of this paper is to suggest a set of priority areas that need attention and a complementary re-prioritized research agenda that privileges educational goals as opposed to separate mental health practices. These priorities include: (1) promoting an ecological approach to support school reform efforts and enhance outcomes associated with effective schooling; (2) using teachers and other indigenous resources within school settings to effect change; (3) integrating promotion, prevention and treatment services; (4) identifying functional competencies rather than psychiatric diagnoses in natural settings; (5) targeting improved outcomes for students with high needs, including those in special education; and (6) enhancing active involvement of parents in schools. A research agenda to align with these priorities is also described to expand the research base on school mental health.

An Ecological Approach with a Focus on the Core Function of Schools: Learning

One implication of an ecological model guiding school mental health services is to consider models that support children's development, their functional adaptation, and the school context as a means of promoting learning. While these goals are shared by many educators and mental health professionals, there is little consensus on the optimal ways to package or integrate supports within schools to achieve these goals. For example, an extensive literature has established the benefits of successful schooling to children's social and emotional adjustment, especially for children living in urban poverty (e.g., Cappella, Frazier, Atkins, Schoenwald, &

Glisson, 2008). However, there is currently no consensus regarding effective models that integrate development, adaptation and effective schooling for all children. Mental health services research can contribute to this literature by proposing targets for change and collaborating with educators to understand how to best effect these changes (Linney and Seidman, 1989; Seidman and Tseng, in press).

Complimentary to this focus on the core function of schooling is the fact that learning occurs within a social environment that includes interactions with teachers and other children. Thus, promoting the social-emotional aspects of development in children can be critical to the pursuit of academic learning. However, while it is acknowledged that schools spend considerable effort on implementing a wide range of programs that address the social-emotional development of students (Zins, Weissberg, Wang, & Walberg, 2004), these efforts are usually seen as additive rather than core to the function of schools. Additionally, many of the social-emotional programs in schools lack empirical support and implementation rigor.

Use of indigenous resources within school settings

Another implication of integrating social-emotional learning programs and broader mental health efforts into the ongoing routines of schools is the identification and support of indigenous resources within schools as agents of change. This follows logically from the prioritizing of school goals for mental health programs and is important to insure the sustainability of program goals and processes, as well as to reconcile the workforce imbalance relative to regional disparities and the high need for services. The identification of indigenous resources involves both the selection of primary change agents and recognition of those factors involved in the successful performance of their roles. For example, the most obvious change agents in schools are teachers, as they control the setting of primary importance to children's

learning, classrooms. Factors associated with successful schooling would therefore be prioritized (e.g., effective instruction and classroom management), but goals such as enhancing teachers' ongoing support and learning structures would also become more central, as emerging evidence from several ongoing experimental classroom and school-based trials seems to suggest (Pianta & Allen, 2008; LaRusso, Brown, Jones, & Aber, in press; Jones, Brown, Hoglund, & Aber, revision under review). These same studies have also demonstrated a focus on effective instruction and classroom management as a strong predictor of children's future success. Similarly, children's peers have an important influence on students' schooling, with programs such as classroom peer tutoring demonstrating strong effects on children's learning and behavior (Rivera, Al-Otaiba & Koorland, 2006). Peer norms for achievement and behavior are relevant targets of change with a literature emerging on effective strategies to align peer influences with classroom academic and behavioral goals (Farmer & Xie, 2007). Finally, imbedding mental health staff within natural settings such as classrooms can improve consultation efforts through the relationships that are formed and improve the implementation of the programs that are developed through enhanced input from school staff.

Integration of promotion, prevention and treatment

Currently, programs that focus on promotion, prevention, or intervention services often compete for priority within schools. With diminishing resources, this competition is likely to increase. For children with intensive needs, the advantages of linking mental health services to schooling are considerable. Children's mental health difficulties commonly manifest themselves in schools with a resulting decrement in performance, or, in the extreme, expulsion. Teachers and other school staff often do not have the resources or skills to manage high need children, especially in high-poverty communities where student-to-staff ratios are high and technology or

other resources are scarce. Many children with mental health needs are highly susceptible to setting events such as disruptions in daily transitions, and therefore classroom-wide programming for normative events can often ameliorate their difficulties. In addition, classroom or school-wide programs can serve as a naturalistic base from which individualized programs can be developed for children with more intensive needs, avoiding the stigmatization that often arises when individualized programs are implemented in isolation of other program goals.

As an example of a school-wide program that can serve as a facilitator of more intensive individualized programs for high need youth, Embry and his colleagues (Embry, 2002; Embry & Straalemeier, 2001) have developed a range of programs for the *Good Behavior Game* that begin with classroom-wide (and often school-wide) implementation, with specified adaptations to design individualized programs for children who require them. The LIFT program (Eddy, Reid, & Fetow, 2000) for example, examined educational strategies, classroom management approaches, and linkage to parents for youth at risk of emotional or behavioral problems and found that this model delayed the onset of problematic behaviors.

Another example reflective of the ecological and mental health approach is the interest and growth in implementing a form of school-wide positive behavior support called Positive Behavior Intervention and Supports (PBIS: Lewis and Sugai, 1999). PBIS includes a set of evidence-based strategies at the individual and system levels with the goal of improving student behavior and learning and is currently being implemented in over 7,500 schools (Bradshaw, Koth, Thornton, & Leaf, 2009). Cappella et al. (2008) suggest that mental health professionals, including those based in schools (e. g, school counselors and part-time psychologists), as well as community-based personnel can assume roles within each of the universal, targeted, and intensive levels of the PBIS framework. Mental health providers can support the school

counselor in implementing school-wide, universal programs in the cafeteria, hallways, and playgrounds by providing training and supervision of security guides, lunchroom aides, and playground monitors. At the targeted level, mental health personnel can assist school administrators in collecting data and intervene in high need classrooms or settings. At the intensive level, a community mental health provider linked with the school can provide direct services as well as activate additional personnel for students with more chronic needs (Atkins, et al., 2006).

Despite these advances, however, few integrative models for delivery of combined school-based mental health and educational programs exist. Studies examining the implementation challenges and the organizational fit of these models within schools are needed. This is especially true for children in special education.

A focus on improving outcomes for students in special education

The education system is the only child-serving institution mandated to serve children and youth with emotional disorders. The Individuals with Disability Educational Improvement Act (IDEIA, 2004) guarantees access to a free, appropriate public education for all children with disabilities; that group now includes approximately 450,000 children with emotional disorders. However, for the majority of these children and youth, the outcomes are poor. For over half of these youth, their educational experience ends in decision to drop out of school (U.S. Department of Education, 2002), the highest dropout rate of any disability category. These dropout rates reflect the fact that these students earn lower grades and fail more courses than any other disability group served in special education environments (Landrum, Tankersley & Kauffman, 2003). Adding to these bleak outcomes is the fact that 47% of all elementary/middle school children classified as ED have been suspended or expelled at some time during their school

career, while 73% of youth with ED at the secondary level have been subject to this kind of disciplinary action. Additionally, 61% of youth with ED served in a special education setting score in the bottom quartile on standardized reading measures. Yet, about only 40% of these youth are receiving any type of mental health services along with their special education classroom services (Wagner, et al., 2006).

In a national study on the implementation of IDEA, Minow (2001) found that psychological services were not often implemented for students who have ED and are in special education because professionals were diverted to testing and crisis intervention rather than sustained support. She further found that "many school systems resist the provision of related services on the theory that they are not educational but medical or psychological, even though these services are required under the act where necessary to enable the student's free appropriate public education. Provision of related services often fails when school districts and other local agencies disagree over who should provide and pay for them" (Minow, 2001, p.4).

There is not a unified research agenda on effective school models that will support learning and behavioral health among students in special education with emotional or behavioral needs. In fact, it remains one of the most neglected areas of study in all of education.

A focus on identification of competencies and functioning in natural settings

Another implication of an ecological model for children's mental health services is that the identification of mental health need would emerge from an assessment of children's functioning and competencies in natural settings, thus avoiding the often arbitrary diagnostic constructs prominent in child psychopathology (Jensen & Hoagwood, 1997). In this way, the goal of focusing on improved functioning rather than symptom reduction (e.g., Hoagwood, Jensen, Petti, & Burns, 1996) would be prioritized. This focus on competency could also create a

better alignment between educational and mental health policy, with many federal and state agencies adopting the concepts of impairment, functioning, and competencies within their definition of a mental health condition that requires services (Canino, Costello & Angold, 1999). In fact, in the latest version of Institute of Medicine Report (National Research Council and Institute of Medicine, 2009), promotion goals along with a focus on the development of competencies have been embraced.

The shift from reducing disorder-based interventions to those focused on enhancing schooling is similar to the shift that occurred in the 1970's from a reliance on treatments focused on family processes (e.g., Minuchin, 1974) to an expanded use of programs to provide parents the skills to manage their children in homes and other natural settings (e.g., Patterson, 1975). Although family therapy remains an active treatment modality (see Diamond & Josephson, 2005), parenting interventions are now well developed for a range of concerns including early onset conduct disorder (see Brestan & Eyberg, 1998), as well as more intensive applications such as the Nurse Home Visitation Program for teenage mothers (Olds, 2006) and Multidimensional Therapeutic Foster Care for foster parents (Chamberlain, Leve, & DeGarmo, 2007). We suggest that a focus on schooling could similarly advance a new set of interventions as an alternative or supplement to existing disorder-based interventions.

Enhancing active involvement of parents in schools

Although active involvement of parents in their child's learning and participation in school has been given considerable attention within the school psychology literature (see, for example, Sheridan & Kratochwill, 2008), many schools still limit family involvement to a narrow set of activities, such as assessment and problem solving. Ways to expand involvement of parents in schools are being examined with different approaches and strategies through for

example targeted engagement processes (McKay & Bannon, 2004), specialized outreach programs delivered by parents to parents of students with mental health needs (Kutash & Duchnowski, 2008), and use of strategic family support techniques (Hoagwood, Cavaleri, Olin, Burns, Gruttadaro, Slaton, Hughes, in press; Robbins et al., 2008). However, the research base remains thin and uneven although some components of family support (i.e., skill-building, parent management) have received more research attention than others (i.e., advocacy support) (Hoagwood, et al., in press).

Research Agenda

A research agenda to promote a new model of children's mental health services should examine the operation of classroom-, school-, and district-level processes and policies and how they facilitate or hinder the educational and social-emotional development objectives for all children and youth. More specifically, research should focus on the examination of classroom- and school-based processes and identify where levels of change exist to promote children's school success and social-emotional development. For example, we need to increase our understanding of teacher-student interactions, student-to-student interactions, and teacher support structures that facilitate classroom management, learning, and development of both teachers and students. It follows that, by necessity, improvements in the measurement of these processes are also needed. Additionally, future research should examine how best to deploy and support indigenous resources within school settings to meet the mental health needs of students (e.g., Atkins et al., 2008). Effective and efficient service models that integrate promotion, prevention and interventions are needed. Additionally, school programs that enhance learning and promote transitions of students with emotional disorders served in special education settings should be a priority. The impact of school district policies on educational and mental health promotion is

another unaddressed area of our understanding. For example, fiscal barriers to integrating mental health supports should be examined and strategies for eliminating economic disincentives to integrative services need to be identified. Finally, it is important to develop and test models that focus on the activation of parents in schools, especially for parents of children with emotional or behavioral needs.

Education and mental health integration will be advanced when the goal of mental health is effective schooling and the goal of effective schools is the healthy functioning of students (Linney & Seidman, 1989). To build a solid foundation for this reciprocal agenda, especially within the zeitgeist of recent educational reforms, a change in the fundamental framework within which school mental health is conceptualized is needed. This change involves acknowledging a new set of priorities, which include: the use of naturalistic resources within schools to implement and sustain effective supports for students' learning and emotional/behavioral health; inclusion of integrated models to enhance learning and promote health; attention to improving outcomes for all students, including those with serious emotional/behavioral needs; and strengthening the active involvement of parents. A strong research agenda to support these new priorities is essential.

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