OPINION

Mental Health in Schools: Moving in New Directions

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It has long been acknowledged that a variety of psychosocial and health problems affect learning and performance in profound ways. And school policy makers have a lengthy history of trying to assist teachers in dealing with problems that interfere with schooling. Prominent examples are seen in the range of psychological, counseling, and social service programs schools provide (Adelman & Taylor 2010). Adding to the work done by student support personnel is whatever the community can offer to collocate and/or link to schools.

While many societal considerations are involved, for the most part the rationale for strengthening mental health in schools has stressed one or both of the following points:

- schools provide good access to students (and their families) who require mental health services;
- schools need to address psychosocial and mental and physical health concerns to enable effective school performance and student well being.

Point one typically reflects the perspective and agenda of mental health advocates and agencies whose mission is to improve mental health services. The second point reflects the perspective and agenda of student support professionals and some leaders for school improvement and also provides a supportive rationale for those wanting schools to play a greater role related to addressing young people's health concerns (Adelman & Taylor, 2006a, b). Implied in both agenda is the hope of enhancing the nature and scope of mental health interventions to fill gaps, enhance effectiveness, address problems early, reduce stigma, and fully imbue clinical and service efforts with public health, general education, and equity orientations. This issue of *Contemporary School Psychology* with its emphasis on promising approaches to wellness, social skills, and life competencies mainly reflects the second agenda.

The problem with both rationales is that, when proposals emphasize another specific approach, another initiative, another team, and so forth, the fragmentation of efforts to focus on the "total child" at a school and throughout a district tends to increase. And, when fragmentation is exacerbated, efforts to embed mental health and psychosocial concerns are further marginalized in school improvement policy and practice.

How Mental Health And Psychosocial Concerns Are Marginalized In Current School Improvement Policly And Practice

Prevailing policy and plans for turning around, transforming, and continuously improving schools are primarily shaped by a two-component framework which marginalizes efforts related to providing additional supports and attention where needed (Adelman & Taylor, 1998). This is graphically presented in Exhibit 1. As illustrated, the main thrust is on improving (1) instruction and (2) how schools manage resources, with the many student and learning support programs and services operated as supplementary add-ons.

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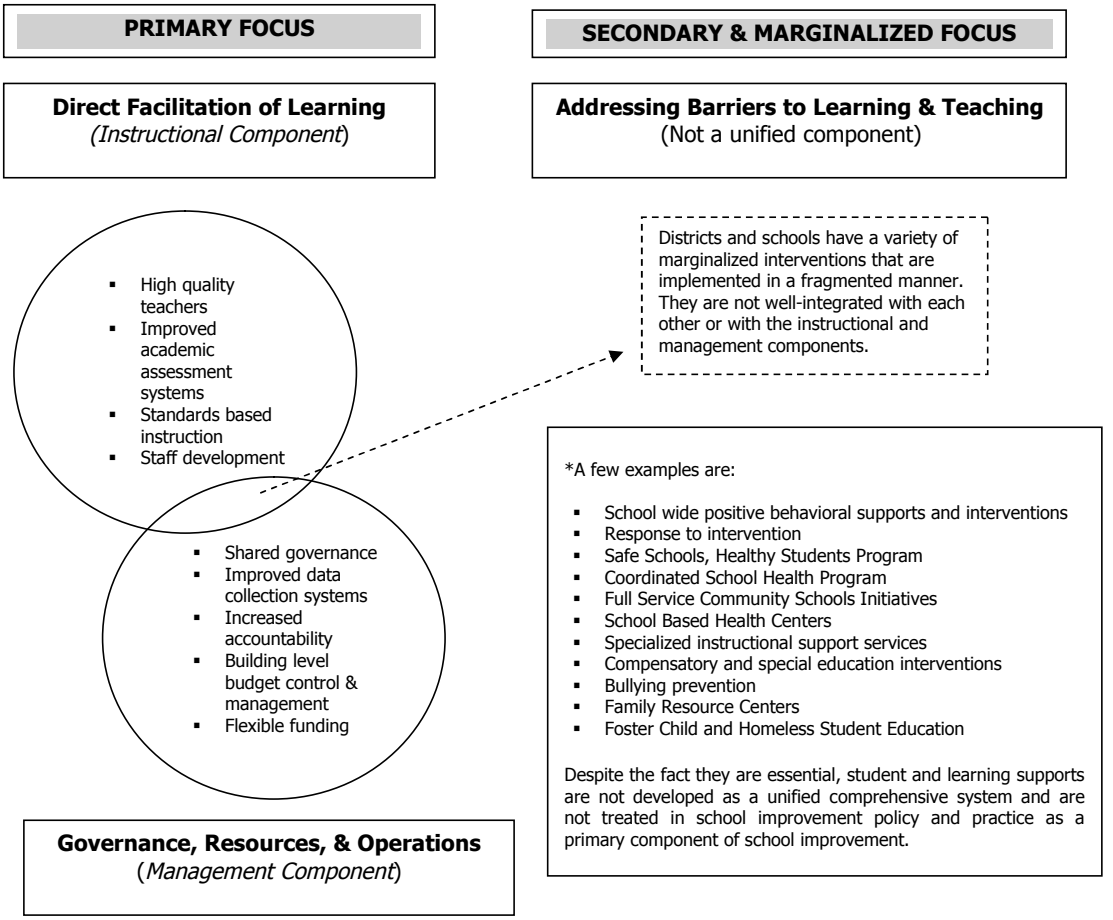
Exhibit 1. *Prevailing two-component framework shaping school improvement policy.*



Obviously, effective instruction is fundamental to a school's mission; no one wants to send children to a school where teachers lack high standards, expectations, and competence; and sound governance and management of resources are essential. What is equally obvious is that teachers need and want considerable help in addressing barriers to student and school success.

Unfortunately, many overlapping factors interfere with learning and teaching. Teachers in low performing schools point to how few students appear motivationally ready and able to learn what the daily lesson plan prescribes. Teachers in the upper grades report that a significant percentage of students are actively disengaged and alienated from classroom learning. And, acting out behavior, especially bullying and disrespect for others, is rampant. (So is passivity, but this attracts less attention.) One result of all this is seen in the increasing number of students misdiagnosed as having learning disabilities (LD) and attention deficit hyperactivity disorders (ADHD). Another result is too many dropouts and pushouts.

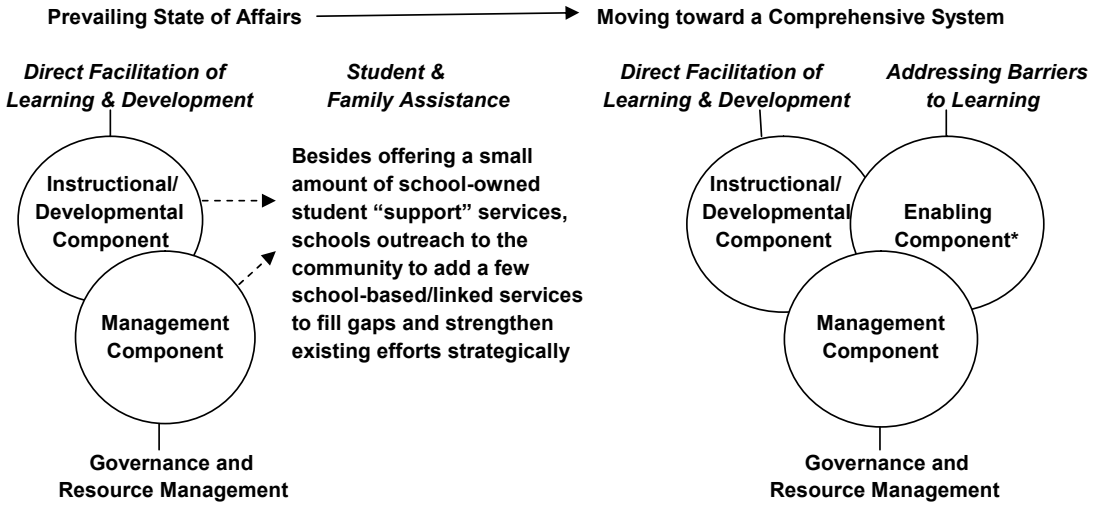
The help teachers currently receive is poorly conceived and designed in ways that meet the needs of relatively few students. This inadequate response to their needs is the product of two-component thinking. The reality is that the many interventions designed to provide student and learning supports are introduced through ad hoc and piecemeal policy and operate in a fragmented manner. This often has resulted in a counterproductive competition for resources as staff representing different interests

push separate, narrow agenda for student and learning supports. And the competition contributes to the continuing marginalization and resultant fragmentation of such endeavors. Efforts to improve the situation have overemphasized yet another approach, better coordination, and other forms of tinkering, rather than pursuing fundamental transformation by moving toward a *unified* and *comprehensive system* for *enabling* all students to learn and all teachers to facilitate development of the whole child.

Moving To A Three Component Framework For School Improvement

Exhibit 2 illustrates the notion that policy for improving schools needs to shift from a two- to a three-component framework. The third component becomes the unifying concept and umbrella under which all resources currently expended for student and learning supports are woven together to develop a cohesive, comprehensive, and multifaceted system. As with the other two components, this component must be treated in policy and practice as *primary and essential* in order to combat marginalization and fragmentation of the work. Furthermore, to be effective in classrooms and schoolwide, it must be fully integrated into school improvement.

Exhibit 2. *Moving to a three-component policy framework for school improvement.*



***The Enabling Component is designed to enable learning by (1) addressing factors that interfere with learning, development, and teaching and (2) re-engaging students in classroom instruction. The component is established in policy and practice as *primary and essential* and is developed into a unified, comprehensive system by weaving together school and community resources. Some venues where this comprehensive approach is adopted refer to the third component as a Learning Supports Component**

The move to a three-component framework is meant to be a fundamental paradigm shift. The intent is to ensure that schools are well-positioned both to (1) enable students to get around barriers to learning and (2) re-engage them in classroom instruction. The emphasis on re-engagement recognizes that efforts to address interfering factors, provide positive behavior support, and prevent disengagement and dropouts must include a focus on re-engaging students in classroom instruction, or they are unlikely to be effective over the long-run (Adelman and Taylor, 2006a,b, 2008). Furthermore, as we will outline, the overlapping nature of the three-component framework provides major opportunities for student support staff to play a significant role in enhancing classroom and schoolwide programs in ways that promote student, family, and community healthy development, well-being, and engagement with schools.

Embedding Mental Health Into School Improvement Policy And Practice

For many years, our Center's policy analyses have stressed that agenda for mental health in schools and all other narrow student and learning support endeavors need to be brought together under a unifying concept (e.g., see Adelman & Taylor, 2006a,b, 2010; Center for Mental Health in Schools & NASP, 2010). The three-component framework designates that concept as *addressing barriers to learning and teaching*. The concept provides a beneficial umbrella under which to embed and cohesively pursue a wide range of mental health and psychosocial interventions.

Unifying student and learning supports into a third component will empower efforts to counter the continuing marginalization of student and learning supports and provide leverage for full integration into school improvement policy and practice. This position has now been adopted by the National Association of School Psychologists (NASP), and 29 national and state organizations have signed on to the policy recommendation that NASP and our Center have prepared (Center for Mental Health in Schools & NASP, 2010). And several state education agencies and a growing number of districts are pioneering designs that embed and weave together the various supports to better address barriers to learning and teaching and re-engage disconnected students (e.g., see *Where's it Happening?* online at http://smhp.psych.ucla.edu/summit2002/nind7.htm).

In our work, we refer to the third component as an *Enabling Component* (i.e., a component to enable learning by addressing the barriers). As the third component has been adopted by trailblazing state education agencies and districts, it often is designated as their *Learning Supports Component.*

In operationalizing the third component, we emphasize both (1) a *continuum* and (2) a set of content arenas. The resulting framework guides development of a unified, comprehensive, and multifaceted system that plays out cohesively in classrooms and schoolwide.

The Continuum

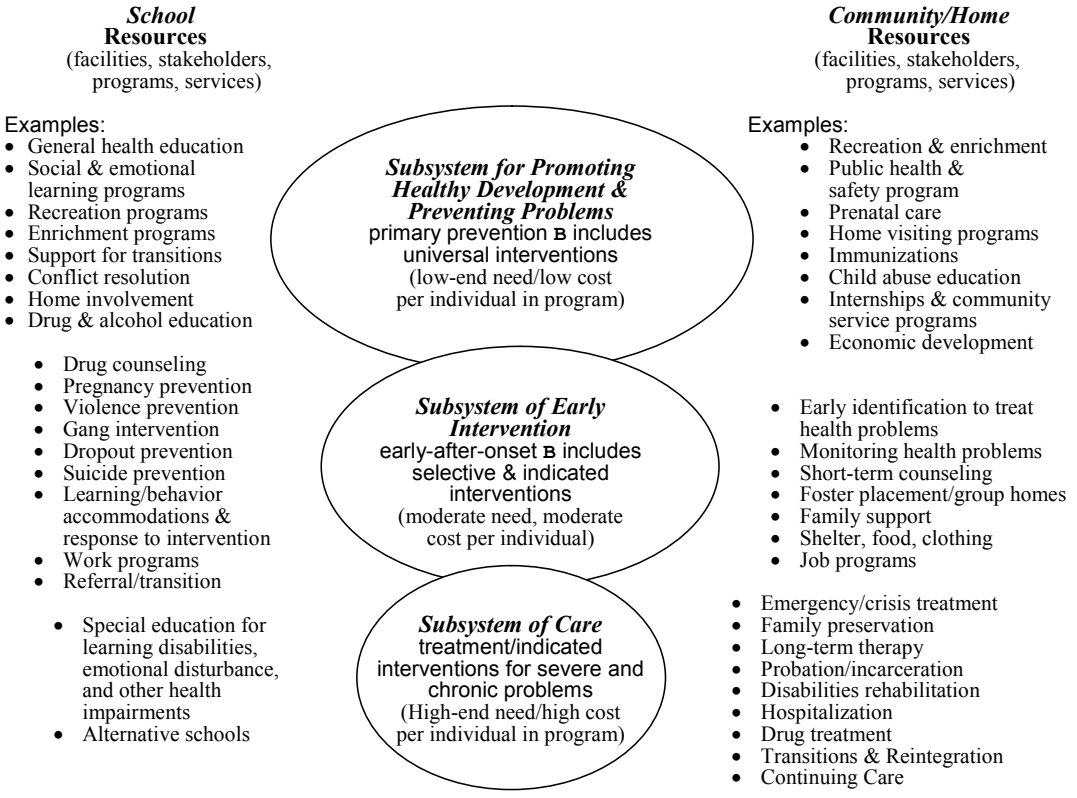
The continuum is conceived as integrated subsystems for

- promoting healthy development and preventing problems
- intervening early to address problems as soon after onset as is feasible
- assisting those with chronic and severe problems.

The continuum encompasses approaches for enabling academic, social, emotional, and physical development and addressing learning, behavior, and emotional problems and does so in ways that yield safe and caring schools. As illustrated in Exhibit 3, the intent is to weave together school resources and strategically braid in a wide range of available community resources in order to meet the needs of many (not just the few) students and significantly reduce the number requiring individual assistance.

Note that the continuum in Exhibit 3 differs in many ways from the widely referenced three-tier intervention pyramid introduced into federal policy related to response to intervention (RTI) and positive behavior intervention and supports (PBIS). As usually presented, the pyramid mainly highlights three levels or tiers of intervention in terms of intensity and suggests the percent of students at each level. While the focus on levels has made a positive contribution, the pyramid is a one dimensional intervention framework. Its continuing overemphasis is limiting development of the type of unified and multifaceted intervention framework that policy and practice analyses indicate are needed to guide schools in developing a comprehensive system of student and learning supports.

Exhibit 3. *Connecting systems to provide an integrated continuum of school-community interventions.*



Notes: Systematic school-community-home collaboration is essential to establish cohesive, seamless intervention on a daily basis and overtime within and among each subsystem. Such collaboration involves horizontal and vertical restructuring of programs and services.

Various venues, concepts, and initiatives permeate this continuum of intervention *systems*. For example, venues such as day care and preschools, concepts such as social and emotional learning and development, and initiatives such as positive behavior support, response to intervention, and coordinated school health. Also, a considerable variety of staff are involved. Finally, *note that this illustration of an essential continuum of intervention systems differs in significant ways from the three-tier pyramid that is widely referred to in discussing universal, selective, and indicated interventions*.

The Content Arenas

Operationalizing the continuum calls for organizing programs and services coherently at every level. To enhance efforts across the continuum, programs and services are coalesced into a multifaceted and cohesive set of content arenas (Adelman & Taylor,2006b). Doing this transforms a laundry list of initiatives into a set of defined, organized, and fundamentally essential intervention domains. Our prototype defines six content arenas as follows:

(1) *Enabling classroom effectiveness* – the focus is on how the teacher and support staff enhance student engagement and address students who are having difficulty with tasks. Specific emphasis is given to

- interventions to enhance engagement and minimize reducing engagement
- interventions to re engage disconnected students
- modifying instruction to fit those who are having difficulty
- bringing support staff and volunteers into the classroom to work with the teacher to address engagement and instructional fit concerns

(2) *Transition supports* – the focus is on supports for the many transitions that occur daily and throughout the school year. For example, starting a new school is a critical transition period; so is changing schools. New personnel also need supports. In addressing newcomer transitions, for instance, schools need to

- have a well designed and implemented welcoming program and mechanisms for ongoing social support
- build capacity (especially staff development) so that teachers, support staff, and other stakeholders can learn how to establish (a) welcoming procedures, (b) social support networks, and (c) proactive transition supports for family members, new staff, and any other newcomers
- provide training and resources to the office staff so they can create a welcoming and supportive atmosphere to everyone who enters the school

(3) *Crisis prevention and response* – the focus is on identifying what can be prevented and taking effective action, establishing appropriate schoolwide prevention strategies, and developing and implementing a well designed system for crisis response and follow up. From a psychological perspective, basic concerns are the degree to which experiences related to school

- enhance or threaten students' feelings of safety
- minimize threats to and maximize students' feelings of competence, self determination, and connectedness with significant others (e.g., relationships between staff and students and among students)
- minimize overreliance on extrinsic reinforcers to enforce rules and control behavior with a view to reducing psychological reactance

(4) *Home involvement/engagement* – the focus is on home, rather than parent, to account for the variety of caretakers who schools may need to consider (including grandparents, siblings, foster caretakers). While the value of home support for student schooling is well established, variations in caretaker motivation and ability to participate at school require a continuum of supports and outreach to any who are not able or motivated to positively support a child's success at school. Examples include interventions to

- address specific support and learning needs of the family
- enhance personalized communications with the home
- outreach positively to caretakers who have not shown the motivation and/or ability to connect with the school
- involve all families in student decision making
- provide effective programs to enhance home support for learning and development

(5) *Community outreach for involvement/engagement* – the focus is on recruiting and collaborating with a wide range of community resources (e.g., public and private agencies, colleges, local residents, artists and cultural institutions, businesses, service and volunteer organizations). Special attention is given to

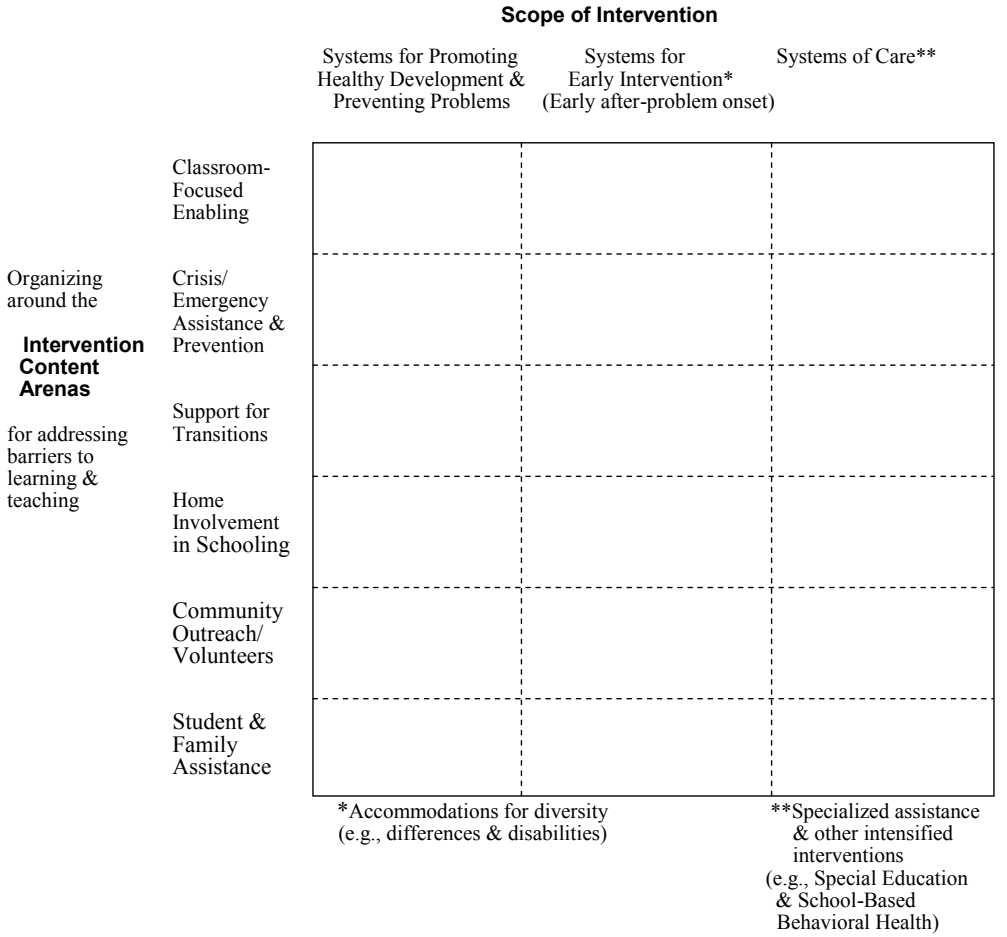
- establishing mechanisms for outreach and collaboration
- building capacity for integrating volunteers into the school
- weaving together school and community resources

(6) *Specialized assistance for a student and family* – the focus is on ensuring special needs are addressed appropriately and effectively. Special attention is given to ensuring there are systemic and effective processes for

- referral and triage
- providing extra support as soon as a need is recognized and in the best manner
- monitoring and managing special assistance
- evaluating outcomes

As already noted, the *continuum* and *six content arenas* constitute an intervention framework for a comprehensive system of learning supports. In Exhibit 4, it is presented as a matrix. Such a framework can guide and unify school improvement planning for developing the system. The matrix provides a tool for mapping what is in place and analyzing gaps with respect to high priority needs. Overtime, this type of mapping and analyses can be done at the school level, for a family of schools (e.g., a feeder pattern), at the district level, community-wide, and at regional, state, and national levels.

Exhibit 4. *Matrix outlining scope and content of a unified, comprehensive, and systematic component for addressing barriers to learning and teaching and re-engaging disconnected students.*



Note: General initiatives and specific school-wide and classroom-based programs and services can be embedded into the matrix. Think about those related to positive behavioral supports, programs for safe and drug-free schools, full-service community schools and Family Resource Centers, special project initiatives such as the *School-Based Health Care* movement, projects such as *Safe Schools/Healthy Students* and the *Coordinated School Health Program*, efforts to address bilingual, cultural, and other diversity concerns, compensatory and special education programs, and mandates stemming from the No Child Left Behind Act.

About Response To Intervention In The Context Of A Comprehensive System Of Learning Supports

As noted above, *Response to Intervention* (RtI) also stresses a continuum of levels of intervention. However, the three tiers it uses primarily emphasize differences in intensity of instruction (Center for Mental Health in Schools, 2011). RtI needs to be part of a more comprehensive system designed to reduce learning, behavior, and emotional problems, promote social/emotional development, and effectively re-engage students in classroom learning (Fredricks, Blumenfeld, & Paris, 2004).

Properly conceived and implemented, RtI is expected to improve the learning opportunities of many students and reduce the number *inappropriately* diagnosed with learning disabilities and behavioral disorders. The approach overlaps some ideas about "pre-referral" interventions but is intended to be more systematically implemented. The aim also is to improve assessment for determining whether more intensive and perhaps specialized assistance and diagnosis are required (Brown-Chidsey & Steege, 2010).

Viewed broadly, response to intervention calls for designing changes in the classroom that improve the student's learning and behavior as soon as problems are noted and using the student's response to such modifications as info for making further changes if needed. The process continues until it is evident that it cannot be resolved through classroom changes alone. Through this sequential approach, students who have not responded well enough to regular classroom interventions receive additional supportive assistance designed to help them remain in the regular program; and only when all this is found insufficient is a referral made for special education assessment. (If the problem proves to be severe and disruptive, an alternative setting may be necessary on a temporary basis to provide more intensive and specialized assessments and assistance.)

Basic to making the strategy effective is truly personalized instruction and appropriate special assistance that can be used as necessary. Think in terms of a two step process. Step 1 involves *personalizing instruction*. The intent is to ensure a student *perceives* instructional processes, content, and outcomes as a good match with his or her interests and capabilities. The first emphasis is on *motivation*. Thus: Step 1a stresses use of intrinsic motivation-oriented strategies to re-engage the student in classroom instruction. This step draws on the broad science-base related to human motivation, with special attention paid to research on intrinsic motivation and psychological reactance (Deci & Moller, 2005; National Research Council and the Institute of Medicine, 2004). The aim is to enhance student perceptions of significant options and involvement in decision making. The next concern is *developmental capabilities*. Thus: Step 1b stresses use of teaching strategies that account for current knowledge and skills. In this respect, individual tutoring and mentoring can be useful if the student perceives these as a good fit for learning. Then, if necessary, the focus expands to encompass Step 2 – *special assistance*. The emphasis is on special strategies to address any major barriers to learning and teaching. And the process stresses the intervention principle of using the least specialized interventions necessary for addressing needs. There, of course, will be students for whom all this is insufficient. In such cases, some other forms of supportive assistance must be added to the mix – inside and, as necessary, outside the classroom. Referral for special education assessment only comes after all this is found inadequate (Adelman & Taylor 2006b).

A core difficulty in using response to intervention strategically involves mobilizing unmotivated students (and particularly those who have become actively disengaged from classroom instruction). If motivational considerations are not effectively addressed, there is no way to validly assess whether a student has a true disability or disorder. If response to intervention is treated simply as a matter of providing more and better instruction, it is unlikely to be effective for a great many students. However, if the strategies are understood broadly and as part and parcel of a comprehensive system of classroom and schoolwide learning supports, schools will be in a position not only to address problems effectively early after their onset, but will build teacher capacity so that similar problems are prevented in the future. We stress that instruction must be supported by schoolwide interventions (e.g., related to providing supports for transitions, responding to and preventing crises, enhancing connections with the home, and more).

Implied in all this is that someone is working to ensure (1) classroom teachers have or are learning how to implement "well-designed early intervention" in the classroom, and (2) support staff are learning how to play a role, sometimes directly and broadly focused in the classroom, to expand intervention strategies if needed. Understood as part of a unified and comprehensive system of learning supports, RtI can play a significant role not only in reducing the numbers who are inappropriately referred for special education or specialized services, it can help enhance attendance, reduce misbehavior, close the achievement gap, and enhance graduation rates.

CONCLUSION

Current approaches to mental health in school tend to overemphasize individually prescribed treatment to the detriment of prevention programs. Moreover, they are implemented as another fragmented set of interventions, and this contributes to the continuing marginalization of student and learning supports. Finally, when the focus is on individuals' problems, mental health interventions contribute to the widespread undervaluing of the human and social capital represented by students, their families, and a wide spectrum of other resources in the community

As this issue of *Contemporary School Psychology* indicates, student support personnel think about mental health in schools as having the potential to play a significant role in school improvement efforts. To do so, however, involves doing much more than expanding the range of mental health approaches. Needed is a fundamental transformation of student and learning supports so that all the fragmented pieces are unified as a primary and essential component that is fully integrated into school improvement policy and practice at every school. Such a transformation is essential to enhancing achievement for all, closing the achievement gap, reducing dropouts, and increasing the opportunity for many more schools to be valued as treasures in their neighborhood.

The bottom line is that it is time to adopt a comprehensive concept as the umbrella under which those who push for expanding the focus on mental (and physical) health must embed themselves. A health agenda (and especially a clinical health agenda) by itself is too narrow to fit into the broad mission of schools in our society and is inadequate for enabling equity of opportunity for all students to succeed at school. We can continue to build a few islands of excellence (demonstrations, pilots) and "Cadillac models," but with over 90,000 schools in the U.S.A., the scale of need demands moving quickly in fundamentally new directions.

All this has revolutionary implications for professional preparation of all student support personnel. In the next decade, although some current roles and functions will continue, many will disappear, and others will emerge. Opportunities will arise for student support staff not only to provide direct assistance, but to play increasing roles as advocates, catalysts, brokers, and facilitators of reform and to provide an increase variety of consultation and inservice training. All who work to address barriers to learning and teaching must be prepared to carry out system development and transformation roles and functions and to participate fully and effectively on school and district governance, planning, and evaluation bodies. To do less is to make values such as *We want all children to succeed* and *No child left behind* simply rhetorical statements.

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