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What is School-Based Mental Health?

Why School-Based?

There is an abundance of evidence that most children in need of mental health services do not receive them, and those that do, receive them, for the most part, through the school system (Burns et al., 1995). Consequently, advocates for improved children's mental health service delivery are now attending to the need to channel additional mental health services into school settings. The reasons seem clear—schools have a long history of providing mental health and support services to children, and inherently provide convenient access for a majority of children.

How best to implement school-based mental health services, however, has been understudied; real-world practice is currently comprised of competing models and approaches. These models emerge from diverse theories and philosophical underpinnings that are characterized by different terminology as well as varied intervention strategies. Together, this collection of models provides a plethora of ideas on how to best provide mental health services in schools and by whom. Implementation, however, has generally been piecemeal with only parts of the models being actualized in any one community.

In short, the general condition of school-based mental health services in this country is such that communities seeking to increase utilization of these services in their schools will encounter a wealth of available information. However, they will find no comprehensive blueprint that integrates advocacy, empirical support, and the community capacity for implementation.

The purpose of this monograph is to sketch out such a blueprint, and to help forward the school-based mental health agenda by (1) describing the various models and approaches both in mental health and in the education literature, (2) reviewing and critiquing the empirical support for the approaches described, and (3) suggesting the next steps in terms of integrating science, policy, and practice to achieve effective school-based mental health service delivery systems.

It is hoped that policy- and decision-makers in both mental health and education will find the information presented helpful as they begin to build or refine their school-based mental health services.

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Definition of School-Based Mental Health

The term "school-based mental health" has become a commonly used phrase much like the phrase "community-based mental health services" or "less restrictive environment." These terms appear to have a common meaning among the professionals that use them without any further specification needed. However, as concepts evolve from rhetoric to actual implementation, definitions and clarity of the parameters of the concept become more important. This was the case with the term "community-based," as advocates pressed for mental health services for children to become less restrictive (e.g., non-hospital based) and move to community-based services. However, it was soon realized that some hospital-based services could also be community-based and the concept of "community-based" was refined to include any necessary resource that could involve the family and was the least restrictive environment available to address the needs of the child.

The term "school-based mental health services" now needs a clearer conceptual framework. The term has generally come to be understood as any mental health service delivered in a school setting. School settings, however, can range from neighborhood schools to academic public school-administered programs in hospitals and juvenile justice facilities. Schools also deliver mental health services and support through the special education program for students with emotional disturbance. In fact, efforts to deliver mental health services and manage challenging behaviors have been a mandate in special education for over 30 years. These diverse school environments challenge the clarity of the concept "school-based mental health," as does the history of uneven collaboration between mental health and education. Within this context, the diverse mental health needs of students contribute another dimension to the confusion surrounding school based mental health services.

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History of School-Based Mental Health Services

The current movement toward channeling mental health resources into schools is reminiscent of the inception of child mental health services in the U.S. At the end of the 1800s, in response to increasing numbers of children being placed in adult jails, the first child mental health services began by providing counseling to children with school problems. These services, along with juvenile court clinics that incorporated the first multi-disciplinary teams to work with children, gave rise to advocacy for building child guidance clinics throughout the country in 1922. The initial clinics were primarily staffed by social workers and later evolved to include multi-disciplinary teams that encouraged community-based, and non-hospital based, care for children, with many created to work specifically with school districts. These early clinics provided the foundation for currently operating community mental health centers throughout the country (Pumariega & Vance, 1999).

However, in the 1970s and '80s there was a movement toward the medicalization of child mental health with child and adolescent psychiatric services directed toward a more hospital-based model of care, driven in part by financing policies. This led to a split between psychiatric hospital-based services and community-based mental health services. This split between the two treatment modalities allowed public mental health dollars to be absorbed by hospitals, leaving few resources for community-based care.

Concomitantly, the first public law was passed addressing the education of students with disabilities, P.L. 94-142, the Education of All Handicapped Children Act, later reauthorized as the Individuals with Disabilities Education Act (IDEA). P.L. 94-142 placed a larger responsibility on the education system to meet the mental health needs of students with emotional disturbances (Pumariega & Vance, 1999). This legislation required that all support services needed to help educate students with disabilities must ultimately be supplied by the education system.

Leaders in the mental health system viewed this new legislation as a mandate for schools to pay for mental health services—services that were under-funded within the community mental health centers. Leaders in the education system viewed this as an unfunded mandate and had to engineer ways to piece together meager resources across a multitude of students with physical and emotional disabilities with hopes that the mental health system would supply necessary resources for children with emotional disturbances.

IDEA legislation has played a key role in blurring the lines of who is responsible for providing mental health services to children and adolescents. This confusion in roles and responsibility between education and mental health persists to this day in many communities and the renewed interest in school-based mental health services has, for some, triggered renewed conflict between the two systems.

It is clear that both the education and mental health systems have a long history of providing mental health services to students. Sometimes these services are delivered collaboratively between the two systems, but more often, the services work in parallel fashion with each other or do not operate effectively at all in either system. Efforts to conceptualize school-based mental health services will be advanced by including a clear delineation of the role of each system.

Current Status and Understanding of Children with Emotional Disturbances

Our knowledge base is slowly being updated regarding the number of children who have some type of emotional disturbance and the nature of those disturbances (Greenbaum et al., 1998; Wagner, Kutash, Duchnowski

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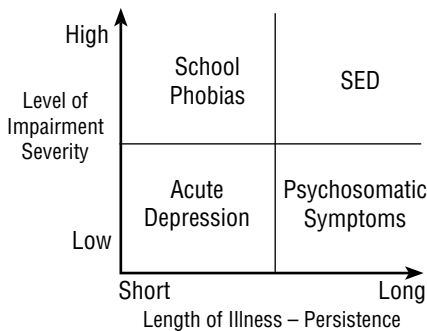
& Epstein, 2005a; Wagner, Kutash, Duchnowski, Epstein & Sumi, 2005b). Estimates of the number of children with emotional disturbances are always more than expected, and their conditions are more diverse and often more long-standing than previously estimated. A recent national study of adults with mental health disabilities documented that their problems reportedly started in early adolescence or around 14 years of age (Kessler, Berglund, Demler, Jin, & Walters, 2005).

The knowledge base on the *causes* of emotional disturbance in children is also growing. There is rarely a single cause of this condition, but rather it can be explained as a combination of biological factors, and environmental factors with the influence of each of these changing across the developmental spectrum. For a discussion of the causes associated with emotional disorders in children, see Chapter Three of the Surgeon General's report on Mental Health (U.S. Department of Health and Human Services [U.S. DHHS], 1999) and Eyberg, Schuhmann, and Rey (1998).

For schools, however, cause is not as relevant as are the characteristics of the behaviors that are currently being exhibited in the classroom—such as the intensity, duration, and level of impairment associated with the behaviors (Zionts, Zionts, & Simpson, 2002).

One way of illustrating the range of emotional and behavioral problems in children and adolescents has been to classify the mental health need by severity of the impairment (i.e., how much does the problem interfere with daily functioning) as well as by the expected duration of the illness (Stroul & Friedman, 1994). As illustrated in Figure 1.1, a child experiencing fear of attending school or school phobia, for example, has a condition that can be severely disruptive to everyday functioning since attending school is a major activity of childhood. However, the length or duration of the problem is thought to be of a short-term nature. On the other hand, children with a severe emotional disorder (SED) are thought to have functional impairments in multiple life domains (in school, the community, and within the family), and the condition is projected to persist for a long period of time. The concepts of severity and persistence have played major roles in designing mental health delivery systems and treatment approaches.

The various mental health service strategies used by schools and the mental health system may be classified in terms of when the intervention is implemented in relation to the onset of a condition. That is, is the purpose of the program to *prevent* or to *treat* a mental health or behavioral challenge in children and adolescents? A majority of children are thought to never exhibit an emotional or behavioral problem that is of sufficient severity or persistence to impair their functioning or daily interactions. However, there are many programs and approaches that are aimed at all children in hopes of helping

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figure 1.1

Severity and Persistence in Children's Mental Health Disorders

to prevent the onset of various emotional or behavioral challenges. These *universal prevention programs,* as they are called, are provided to all children through school-wide implementation. Some children and adolescents, however, are at-risk for the development of emotional or behavioral disorders either due to familial or environmental conditions. There are many programs, called *selective or secondary prevention programs*, which in addition to focusing on individual students, can combine students with similar risk factors for group interventions aimed at helping to prevent the onset of behavior or emotional problems. Mental health treatments are usually employed once the disorder or condition has been established in a child or adolescent. These specialized individual interventions are grouped under the heading of *tertiary or indicated prevention.*

These three levels or types of programs have become a useful heuristic when discussing the array and range of mental health supports and treatments useful in preventing and treating mental health problems in children. However, the conceptualization and definitions of these three levels of intervention are not universally agreed upon within the school-based mental health services field and confusion has emerged. A review of these definitional issues is presented in Chapter 2 to promote the common language necessary to support collaboration, and better selection and implementation of programs and practices.

Our Approach to Organizing the Empirical Support

Our approach to harness, describe, and critique the empirical support for school-based mental health approaches has been influenced by three factors. The first factor that influenced our work is the array of quality websites describing and organizing the empirical literature on social, emotional, and learning enhancement programs that currently exist. There are presently several websites that identify an array of "best practices" and "empirically supported" programs, and these sites are usually organized around the three levels of prevention: universal, selective, and indicated approaches.

The next factor that influenced our work was a recent review of the extant literature by Rones and Hoagwood (2000) that examined the empirical literature published between 1985 and 1999 on school based mental health services. While their literature search uncovered over 5,128 entries containing the term school-based mental health services for children, only 47 entries described programs or treatment approaches that met the criteria of being rigorously evaluated or researched. Of this group, 36 articles described randomized controlled trials, nine described quasi-experimental designs, and two studies used a multiple baseline design.

Universal prevention programs provided to all children through school-wide implementation to prevent onset of emotional or behavioral challenges.

Selective or Secondary prevention programs combine students with similar risk factors due to familial or environmental conditions for group interventions aimed at helping to prevent the onset of behavior or emotional problems.

Tertiary or indicated prevention mental health treatments usually employed once the disorder or condition has been established in a child or adolescent.

The third factor that influenced our work was the realization that the empirical literature supporting special education and educational programs was often separate from the mental health literature, with neither citing each other's work. There are bridges to build here.

In this monograph, we synthesize our work to provide readers with a broader context in which to (a) understand the major models that guide the development of school-based mental health services (SBMH), (b) evaluate the empirical base supporting these approaches, and (c) interpret the key federal policies that promote SBMH services.

The following chapters build upon each other to frame a prerequisite context for decision makers. Following the current discussion of background, we explore the various definitions of prevention and intervention related to SBMH (Chapter 2), and review and summarize three current and influential models addressing issues in SBMH service delivery (Chapter 3). Chapter Four organizes the programs and approaches from both the websites and from the extant literature published on SBMH services along the prevention continuum (i.e., universal, selective, and indicated). Chapter Five contains a discussion of the major federal policies that have supported, and in some cases mandated, SBMH. A brief summary of the research on organizational structures and financing mechanisms found in SBMH programs is presented in Chapter Six. In the final chapter, we conclude with a reflection on the current status of SBMH, future research needs, and the potential for the extensive implementation of effective SBMH services to significantly improve the outcomes for children and youth across a broad array of life domains.