5 The Role of Federal Policy and Initiatives on School-Based Mental Health

Federal Focus on SBMH

There are approximately 100,000 schools in the U.S. with about 53 million students and 6 million adults working in these schools. This is about one-fifth of the population of the country and as a "target population" it has tremendous potential to realize the promise of federal policies at a scale that will be clearly noticeable.

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While there is sparse evidence of wide-spread implementation of effective SBMH services, there is no lack of federal policies, regulations, and initiatives promoting the implementation of evidence-based SBMH services. Such initiatives extoll the potential of these services to significantly increase access to mental health services for children, increase the number of children in need who actually receive services, and subsequently improve a range of outcomes including social and emotional functioning, and academic progress. It is no exaggeration that all federal agencies that have responsibility for some aspect of the well-being of children and youth have some reference to at least collaborate with schools to better achieve their own particular mission as it relates to the welfare of the children they serve. The lion's share of these policies and initiatives emanates from the various branches of the U.S. Department of Education (USDOE) and the Department of Health and Human Services (DHHS). Consequently, the role of these two federal agencies is the focus of this chapter. It is our hope that this profile of current federal policy will serve decision-makers as they strive to design SBMH service systems that meet the needs of local communities in a manner compatible with the requirements, mandates, and intent of federal programs and legislation.

USDOE

Arguably, the Individuals with Disabilities Education Act (IDEA), originally passed in 1976 as the Education of all Handicapped Children's Act, is the most comprehensive piece of federal legislation to affect children who have disabilities and their families, including children who have emotional disturbances. In the case of children who have emotional

disabilities, however, IDEA is narrowly focused on students who have an identifiable disability that may affect various life domains but must also interfere with the student's educational achievement. The interpretation of eligibility criteria at the local level has resulted in the continuous under-identification of this disability group. There has never been more than 1% of the school age population identified and served in special education programs, despite prevalence estimates closer to 5% (Kutash et al., 2005). Based on a population of approximately 53 million children in school, the number who have significant emotional disturbance is about 3 million, while only about a half million are served in special education programs. In addition, children who have emotional disturbances have the poorest outcomes compared to all other disability groups (Wagner, 1995).

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A more recent piece of legislation aimed at all children and youth is the No Child Left Behind Act (NCLB) signed into law in 2002 by President Bush. In NCLB, the emotional well-being of all children is addressed and a specific section of the Act (Title V) outlines initiatives aimed at assuring the emotional well-being of America's youth. With 53 million children in school and an estimated 20% of all children meeting criteria, at a point in time, for a diagnosable mental illness at a level of impairment that requires some type of intervention (Kutash et al., 2005), there is the potential that over 10 million children will need some type of help to meet the goals relating to emotional well-being in NCLB. These numbers reveal the scope of the challenge for the nation to meet the mental health needs of America's school age children and youth.

Both IDEA and NCLB contain language, guidelines, and regulations aimed at meeting this challenge. For example, in the case of children covered under IDEA, related services needed to ensure an appropriate education are prescribed as an entitlement of the Act. Related services may include psychological counseling, the implementation of behavioral plans based on functional behavioral assessments, and the inclusion of positive behavioral interventions and supports. Some examples of strategies offered under NCLB include character education, safe and drug free school initiatives, violence prevention programs, and specific programs for children who are neglected, exposed to violence, or at-risk for failure due to low income. In both Acts, interagency collaboration is encouraged to enhance service capacity. Because approximately three-fourths of children who receive any mental health service at all receive it through the school system (Burns et al., 1995), the attention to the provision of mental health services to children in schools by the USDOE is most appropriate as the school system can be considered the de facto mental health system for children in this country.

DHHS and School-Based Mental Health

For the Department of Education, enhancing academic achievement is the primary goal, the mental health of children is a mediating variable that may affect academic achievement and therefore it is a variable of interest. In the Department of Health and Human Services (DHHS), there are divisions, such as SAMHSA, for which positive mental health of children and adults is the primary focus. The policies and initiatives of DHHS relating to children's mental health were significantly energized in the early 1980s, to some degree as a response to Jane Knitzer's critical examination of the field. In the report of her landmark study *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services* (1982), Knitzer described the "dismal" situation that existed. She found that the agencies responsible for providing children's mental health services shuttled children and families through a revolving door from office to office and agency to agency in a frustrating search to find help. This prompted the development of a series of federal initiatives aimed at promoting a seamless, community-based system of care that would provide the range of services needed by these children and their families. (For an extensive review of the history of these initiatives and the current status of the system of care, see Kutash et al., 2005, and Lourie, Stroul, & Friedman, 1998.)

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From the early 1980s to the present, the system of care model developed by Stroul and Friedman (1994) has continued to serve as a blueprint for SAMHSA's children's mental health initiatives. Its potential value has been reinforced by the Surgeon General's report on the nation's mental health (U.S. DHHS, 1999), and most recently by the report of the President's New Freedom Commission on Mental Health (2003). The policies and emphasis on systems of care have implications and relevance for SBMH. As noted in Chapter 3, the system of care proposes that the child-serving agencies that have responsibility for some aspect of children's mental health service provision be united in an integrated, collaborative system of equal partnership. Schools are identified as critical in this partnership because the location of services in schools can significantly increase access to service, schools can foster the implementation of universal prevention programs and early identification programs, and interventions in schools may have reduced stigma associated with mental health problems.

The implementation of SBMH services in the context of a system of care involves procedures such as formal interagency agreements, blended funding mechanisms, shared personnel, and a leveraging of resources to maximize the impact of services on children and their families. The policies of DHHS and SAMHSA have also promoted the concepts of the

involvement of families as equal decision making partners in all aspects of the treatment of their children and provision of services that are culturally competent—a vision that has not yet been fully implemented.

The Maternal and Child Health Bureau

In 1995 the Maternal and Child Health Bureau reported increasing awareness of the need to make mental health services more accessible for the school-age population. Similar to other branches of DHHS, the Maternal and Child Health Bureau viewed schools as an important component of newly directed policies and initiatives the Bureau was developing to promote mental health services to children in need. The first major step was to fund two Centers for SBMH and several state-level initiatives to foster mental health in schools. The two Centers, at UCLA and the University of Maryland, were referred to earlier in Chapter 3. The core of these initiatives was to pursue a wide range of activities to improve how schools address barriers to learning and enhance healthy development, especially mental health. These initiatives are not overly prescriptive and the Centers and state grantees have produced a wide range of programs aimed at achieving their goals (Adelman & Taylor, 2006).

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The policies and directions espoused by the Maternal and Child Health Bureau can best be summarized as promoting the Interconnected Systems model described in Chapter 3. Schools are considered to be ideal locations and key partners in implementing a comprehensive system of prevention and intensive intervention aimed at improving the overall mental health of children. Along with community-based partners, schools are encouraged to develop innovations to implement the model.

The Challenges of Implementation

Clearly, there is no dearth of federal policies and initiatives aimed at enhancing SBMH services. The effectiveness of these policies in improving service accessibility and mental health outcomes remains to be demonstrated. The recent findings from the Special Education Elementary Longitudinal Study (SEELS) and the National Longitudinal and Transition Study 2 (NLTS2) describing the service history and outcomes of children who have emotional disturbances and who are served in special education programs are not encouraging (Wagner et al., in press). Less than half of these children receive mental health services in schools, and even fewer are clients of community mental health agencies. This is especially troubling in that school outcomes for children with emotional disturbances—such as academic achievement, behavior referrals, and engagement in the school culture—are the poorest of all disability groups, and dismal when compared to outcomes for peers who are not disabled.

A major problem facing current policies is their lack of specificity in both concepts and structures for implementation. While federal administrations walk the tight-rope of the new federalism on one hand, with the desire to hold states to a higher degree of accountability for child and family well-being, the policies that are promoted lack the focus necessary to achieve outcomes in a manner that affords evaluation of effective implementation and outcome.

For example, throughout IDEA, NCLB, and the New Freedom Commission on Mental Health there are references to schools and community mental health agencies collaborating to develop effective SBMH services, but little direction is offered on what this should look like, and how it is to be accomplished. In practice, this turns out to be a close to impossible task for the average community. The task is complex and each agency has many competing demands. School personnel are not uniformly convinced of the value of SBMH in their pursuit of improved academic outcomes (Adelman & Taylor, 2006). The advocates of PBS have demonstrated that without 80% buy in from faculty and staff, the probability of achieving an effective level of program implementation is very slim. Likewise, without the commitment of school administrators, confidence that sufficient resources exist, and a sensitive cadre of mental health professionals as partners, the probability of implementing an effective school-wide prevention and intervention program to meet the mental health needs of students is also very slim. Consequently, the situation today is a network of grant supported demonstration programs that typically cannot be sustained after the grant terminates.

The branches of federal agencies need to re-evaluate policies aimed at enhancing SBMH and become more pro-active in providing leadership to achieve integrated, collaborative, and effective programs aimed at improving the mental health of America's children. There are some definite signs that this is beginning to happen. For example, a frequently mentioned barrier to collaboration is the difference in language and terminology used across agencies. It is encouraging that we now can find phrases such as *family-driven* and *culturally competent* in initiatives promoted by most federal agencies. While SAMHSA can take much credit for requiring potential grantees in their demonstration programs to clearly specify family partnerships and cultural competency, they can do the same thing with school-mental health collaboration. Currently, the requirements for such partnerships are general and lack the detailed documentation of an infrastructure that can support SBMH. By becoming more direct in this requirement, SAMHSA may be able to bring about significant improvement in the implementation of SBMH services in their community-based demonstration programs.

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The successful implementation of policy is clearly a multi-level process. However, in the case of SBMH, federal and state agencies can address the issue of low levels of implementation by providing leadership for local communities. Good policies require a threshold level of specificity that is not always present. Policy implementation requires technical assistance and support to the intended implementers with sufficient vigor to ensure sustainability. As communities overcome barriers to accomplishing the goals mandated by policy, we must document how they used knowledge of their community context to implement effective programs, and resources must be invested to capture such best practices and transmit them to the field. Without these components, grants to fund policy implementation demonstration projects will continue to fall short of the intention to show change at a scale that is more national than local.