



*Policy Leadership Cadre for  
Mental Health in Schools\**

Mental Health in Schools:  
Guidelines, Models, Resources, &  
Policy Considerations



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*Executive Summary:*

## **Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations**

*What is meant by the term mental health in schools?*

Ask five people and you'll probably get five different answers.

That is why so many leaders in the field have called for clarification of what mental health (MH) in schools is and is not. Toward these ends, the *Policy Leadership Cadre for Mental Health in Schools* has developed the resource and reference document summarized here.\* The focus of the work is on:

- ⊆ definitional concerns
- ⊆ the rationale for mental health in schools
- ⊆ a set of guidelines to clarify the nature and scope of a comprehensive, multifaceted approach
- ⊆ the ways in which mental health and psychosocial concerns currently are addressed in schools
- ⊆ advancing the field.

To embellish the document's value as a resource aid for policy and capacity building, a variety of supportive documents and sources for materials, technical assistance, and training are provided.

Concerns . . .  
about definition  
and  
As is widely recognized, there is a tendency to discuss mental *health* mainly in terms of mental illness, disorders, or problems. This de facto definition has led school policy makers to focus primarily on concerns about emotional disturbance, violence, and substance abuse and to deemphasize the school's role in the positive development of social and emotional functioning. The guidelines presented in this document are meant to redress this tendency. They stress that the definition of MH in schools should encompass the promotion of social and emotional development (i.e., positive MH) and efforts to address psychosocial and MH problems as major barriers to learning.

the place of  
MH in schools  
Among some segments of the populace, schools are not seen as an appropriate venue for MH interventions. The reasons vary from concern that such activity will take time away from the educational mission to fear that such interventions are another attempt of society to infringe on family rights and values. There also is the long-standing discomfort so many in the general population feel about the subject of mental health because it so often is viewed only in terms of mental illness. And, there is a historical legacy of conflict among various stakeholders stemming from insufficiently funded legislative mandates that have produced administrative, financial, and legal problems for schools and problems of access to entitled services for some students.

Whatever one's position about MH in schools, we all can agree on one simple fact: *schools are not in the mental health business*. Education is the mission of schools, and policymakers responsible for schools are quick to point this out when they are asked to do more about physical and mental health. It is not that they disagree with the idea that healthier students learn and perform better. It is simply that prevailing school accountability pressures increasingly have concentrated policy on instructional practices – to the detriment of all matters not seen as *directly* related to raising achievement test scores.

Rationale Given these realities, as a general rationale for MH in schools, we begin with the view of the Carnegie Council Task Force on Education of Young Adolescents (1989) which states:

*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, of course, not a new insight that physical and mental health concerns must be addressed if schools are to function satisfactorily and students are to learn and perform effectively. It has long been acknowledged that a variety of psychological and physical health problems affect learning in profound ways. Moreover, these problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure.

Despite some reluctance, 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, policymakers 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 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.

Guidelines Based on a set of underlying principles and some generic guidelines for designing comprehensive, multifaceted, and cohesive approaches to MH in schools, the following set of guidelines is presented along with rationale statements and references related to each guideline. Clearly, no school currently offers the nature and scope of what is embodied in the outline. In a real sense, the guidelines define a vision for how MH in schools should be defined and implemented.

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## ***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)

### ***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; prereferral 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 inservice instruction with a transdisciplinary focus
- 3.6 Enhancing connections with and involvement of home and community resources (including but not limited to community agencies)

(cont.)

*Guidelines For Mental Health in Schools (cont.)*

**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

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What schools  
are already  
doing

Currently, there are almost 91,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted programs designed with a range of mental health and psychosocial concerns in mind. And, there is a large body of research supporting the promise of many of the approaches schools are pursuing.

School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development (see the next page for an Exhibit highlighting five major *delivery mechanisms and formats*). Despite the range of activity, it remains the case that too little is being done in most schools, and prevailing approaches are poorly conceived and are implemented in fragmented ways.

## Delivery Mechanisms and Formats

The five mechanisms and related formats are:

- 1. *School-Financed Student Support Services*** – Most school districts employ pupil services professionals such as school psychologists, counselors, and social workers to perform services related to mental health and psychosocial problems (including related services designated for special education students). The format for this delivery mechanism tends to be a combination of centrally-based and school-based services.
- 2. *School-District Mental Health Unit*** – A few districts operate specific mental health units that encompass clinic facilities, as well as providing services and consultation to schools. Some others have started financing their own School-Based Health Centers with mental health services as a major element. The format for this mechanism tends to be centralized clinics with the capability for outreach to schools.
- 3. *Formal Connections with Community Mental Health Services*** – Increasingly, schools have developed connections with community agencies, often as the result of the school-based health center movement, school-linked services initiatives (e.g., full service schools, family resource centers), and efforts to develop systems of care (“wrap-around” services for those in special education). Four formats have emerged:
  - C co-location of community agency personnel and services at schools – sometimes in the context of School-Based Health Centers partly financed by community health orgs.
  - C formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center
  - C formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of MH services
  - C contracting with community providers to provide needed student services
- 4. *Classroom-Based Curriculum and Special “Pull Out” Interventions*** – Most schools include in some facet of their curriculum a focus on enhancing social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. And, of course, special education classrooms always are supposed to have a constant focus on mental health concerns. Three formats have emerged:
  - C integrated instruction as part of the regular classroom content and processes
  - C specific curriculum or special intervention implemented by personnel specially trained to carry out the processes
  - C curriculum approach is part of a multifaceted set of interventions designed to enhance positive development and prevent problems
- 5. *Comprehensive, Multifaceted, and Integrated Approaches*** – A few school districts have begun the process of reconceptualizing their piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. They are starting to restructure their student support services and weave them together with community resources and integrate all this with instructional efforts that effect healthy development. The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment regimens. Mental health and psychosocial concerns are a major focus of the continuum of interventions. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care and the growing movement to create community schools. Three formats are emerging:
  - C mechanisms to coordinate and integrate school and community services
  - C initiatives to restructure student support programs and services and integrate them into school reform agendas
  - C community schools

The document concludes with a discussion of policy-focused ideas related to advancing the field. At present, a low policy priority is assigned to addressing mental health and psychosocial factors that negatively affect youngsters development and learning. In schools, existing programs are characterized as supplemental services and are among the first to go when budgets become tight. In

effect, they are marginalized in policy and practice. For this situation to change, greater attention must be paid to enhancing the policy priority assigned such matters, developing integrated infrastructures including new capacity building mechanisms, enhancing use of available resources, and rethinking the roles, functions, and credentialing of pupil service personnel.

### **Concluding Comments**

In terms of policy, practice, and research, all activity related to MH in schools, including the many categorical programs funded to deal with designated problems, eventually must be seen as embedded in a cohesive continuum of interventions and integrated thoroughly with school reform efforts.

When this is done, MH in schools will be viewed as essential to addressing barriers to learning and not as an agenda separate from a school's instructional mission.

In turn, this will facilitate establishment of school-community-home collaborations and efforts to weave together all activity designed to address mental health problems and other barriers to learning.

All this can contribute to the creation of caring and supportive environments that maximize learning and well-being and strengthen students, families, schools, and neighborhoods.

Leaders for mental health in schools suggest that the well-being of young people can be substantially enhanced by addressing key policy concerns in this arena. In this respect, they recognize that policy must be developed around well-conceived models and the best available information. Policy must be realigned to create a cohesive framework and must connect in major ways with the mission of schools. Attention must be directed at restructuring the education support programs and services that schools own and operate and weave school owned resources and community owned resources together into comprehensive, integrated approaches for addressing problems and enhancing healthy development. Policy makers also must deal with the problems of “scale-up” (e.g., underwriting model development and capacity building for system-wide replication of promising models and institutionalization of systemic changes). And, in doing all this, more must be done to involve families and to connect the resources of schools, neighborhoods, and institutions of higher education.

The above ideas guide the work of the *Policy Cadre for Mental Health in Schools*. If you are interested in becoming a member of the Policy Leadership Cadre for Mental Health in Schools, you can sign up by sending your contact information (name, agency, address, etc) either through email at [smhp@ucla.edu](mailto:smhp@ucla.edu) or call (310) 825-3634.