# *Mental Health in Schools: Engaging Learners, Preventing Problems, and Improving Schools*

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# *Preface*

This book is about improving schools, preventing problems, and engaging students *by moving in new directions for mental health in schools.* This ambitious agenda requires the attention of all who have a stake in public education. Therefore, our intended audience is quite broad (e.g., leaders, administrators, student support staff, teachers, other practitioners, researchers, those involved in personnel preparation, and policy makers).

Many matters arise when the topic of mental health in schools is discussed. Prominent are questions such as the following:

Why should schools be involved with mental health?
Should the focus of mental health in schools be on

- mental *illness?* mental *health? both?*
- special education students or all students? or
- services or programs or a comprehensive system of supports?

What is the *context* for the work, and who should be *responsible* for its planning, implementation, and evaluation?

We explore all this and much more with a view to moving in new directions.

Over the years, we have pursued the advancement of mental health in schools by focusing on fully integrating the matter into school improvement policy, planning, and practice. Since 1986, our work has been carried out under the auspices of the School Mental Health Project at UCLA, and since 1995, our efforts have been embedded in the Project's national Center for Mental Health in Schools.

One facet of the Center's work is designed to facilitate discussion of issues, write and share policy and practice analyses and recommendations, and develop prototypes for new directions. Another facet provides guides to and resources for practice.

The following is a book-length compilation that pulls together our work over many years. It complements our two books published by Corwin in 2006: (1) *The School Leader's Guide to Student Learning Supports: New Directions for Addressing Barriers to Learning* and (2) *The Implementation Guide to Student Learning Supports*

*in the Classroom and Schoolwide: New Directions for Addressing Barriers to Learning.* Readers who want to drill deeper into the many topics covered in this book can turn to these and to the growing body of resources available at no cost on the UCLA Center's Web site (http://smhp.psych.ucla.edu).

Because of the urgency for creating a school environment that promotes mental health and reduces problems, our primary aim here is to stimulate major systemic transformation. To this end, we stress new directions and resources for systemic change. At the same time, we highlight resources to aid those who currently are striving each day to make lives better for students and school staff.

We begin with a brief reflection on what schools have been and are doing about mental health concerns. Then, we explore major concerns, emerging trends, new directions, policy and systemic change implications, and end with a call to action. While we identify system deficiencies, we have nothing but the highest respect for those professionals who strive each day to ensure that all students have an equal opportunity to succeed at school.

As always, we owe many folks for the contents of this book. We thank everyone for their contribution, and as always, we take full responsibility for any misinterpretations and errors.

Howard Adelman and Linda Taylor

## DEDICATION

*To those trailblazers who are moving the field forward.*

# *Acknowledgments*

No one will doubt that our work owes much to many. We have benefitted from the insights, challenges, and wisdom of so many colleagues and the shared treasure of the accumulated research and writing of scholars over the years.

We are especially indebted to those pioneers who are trailblazing new directions forward.

And we are oh so grateful to Perry Nelson and the host of graduate and undergraduate students at UCLA who contribute so much to our work each day, and we thank the many young people and their families who continue to teach us all.

We also want to acknowledge that partial support for the Center for Mental Health in Schools comes from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U45 MC 00175), U.S. Department of Health and Human Services.

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The two have worked together for over 30 years with a constant focus on improving how schools and communities address a wide range of psychosocial and educational problems experienced by children and adolescents.

Howard began his professional career as a remedial classroom teacher in 1960. In 1973, he returned to UCLA in the role of professor of psychology and also was the director of the Fernald Laboratory School and Clinic until 1986. In 1986, Linda and he established the School Mental Health Project at UCLA.

In her early career, Linda was involved in community agency work. From 1973 to 1986, she codirected the Fernald Laboratory School and Clinic at UCLA. In 1986, she became codirector of the School Mental Health Project. From 1986 to 2000, she also held a clinical psychologist position in the Los Angeles Unified School District and directed several large-scale projects for the school district.

Over the years, they have worked together on major projects focused on dropout prevention, enhancing the mental health facets of school-based health centers, and developing comprehensive, school-based approaches for students with learning, behavior, and emotional problems. Their work has involved them in schools and communities across the country.

The current focus of their work is on policies, practices, and large-scale systemic reform initiatives to enhance school, community, and family connections to address barriers to learning and promote healthy development. This work includes codirecting the national Center for Mental Health in Schools, which facilitates the *National Initiative: New Directions for Student Support.*

# *Introduction*

> *Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by the very institutions and systems that were created to take care of them.*
>
> U.S. Department of Health and Human Services (2001) <em dash>

One of those institutions is the school. Indeed, available research suggests that for some youngsters schools already are the main providers of mental health services. As Burns and her colleagues (1995) found, "the major player in the de facto system of care was the education sector—more than three-fourths of children receiving mental health services were seen in the education sector, and for many this was the sole source of care" (p. 152).

## WHY MENTAL HEALTH IN SCHOOLS?

In discussing the involvement of schools in mental health, the first question that arises is, "Why should there be a focus on mental health *in schools?*"

While many societal considerations are involved in responding to this question, for the most part the usual answers incorporate either or both of the following points:

- Accessing and meeting the needs of students (and their families) who require mental health services is facilitated at schools
- Addressing psychosocial and mental and physical health concerns is essential to the effective school performance of students

Implied in both answers 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.

Point one typically reflects the perspective and agenda of agencies and advocates 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 who want schools to play a greater role related to addressing young people's health concerns.

## ADVANCING MENTAL HEALTH IN SCHOOLS

Around the world, many stakeholders are determined to enhance how schools address mental health and psychosocial concerns. And now is a critical period for doing so.

Anyone who has spent time in schools can itemize the multifaceted mental health and psychosocial concerns that warrant attention. For those committed to advancing mental health in schools, the question is,

*How should our society's schools address these matters?*

The answers put forward tend to reflect different agenda. As a result, efforts to advance the imperative for mental health in schools are confronted with the problem of coalescing agenda and doing so in ways that are responsive to the oft-voiced public concern that schools cannot be responsible for meeting every need of their students.

Education is the mission of schools, and school policy makers are quick to point this out when schools are asked to do more, especially with respect to mental health. They do not disagree with the idea that healthier students learn and perform better. The problem is that prevailing school accountability pressures increasingly have concentrated on instructional practices—to the detriment of all matters not seen as *directly* related to raising achievement test scores.

Those concerned with enhancing mental health in schools must accept the reality that schools are not in the mental health business. Then, they must develop an understanding of what is involved in achieving the mission of schools. After that, they must be ready to clarify how any agenda item for mental health in schools helps accomplish that mission. Of particular importance is how proposed approaches help meet the demand for improving schools, reducing dropout rates, closing the achievement gap, and addressing racial, ethnic, disability, and socioeconomic disparities.

## EMBEDDING MENTAL HEALTH IN THE SCHOOL IMPROVEMENT AGENDA

In 2001, the Policy Leadership Cadre for Mental Health in Schools stressed that advancing mental health in schools is about much more than expanding services

and creating full-service schools. The aim is to become part of a comprehensive, multifaceted, systemic approach that strengthens students, families, schools, and neighborhoods and does so in ways that maximizes learning, caring, and well-being.

To this end, policy decision makers and school improvement leaders must transform the education support programs and services that schools own and operate. Such a transformation must draw on well-conceived, broad frameworks and the best available information and scholarship to develop a comprehensive system of supports for addressing problems and enhancing healthy development. Accomplishing this will require weaving together resources from the school, community, and family.

## BUILDING ON WHAT HAS GONE BEFORE

Advancing a field requires a perspective on the past and the present. Therefore, Part I offers a brief reflection on what schools have been and are doing about matters related to mental health and then highlights some basic considerations as a foundation for moving forward.

Advancing this field requires a perspective on major concerns and issues that have arisen about the focus on mental health in schools. Part II highlights such matters.

Advancing the enterprise requires a sense of current and emerging opportunities and new strategies for moving forward in developing a comprehensive system that is implemented in the classroom and schoolwide. This is the focus of Part III.

Advancing any field requires rethinking policy and facilitating systemic change. Part IV outlines some major policy and systemic change considerations.

# PART I

# *The Field of Mental Health in Schools*

*To paraphrase Goethe: Not moving forward is a step backward.*

In many schools, the need for enhancing mental health is a common topic. And as recognized by the final report of the President's New Freedom Commission on Mental Health (2003) and *The 2007 Progress Report* on the President's New Freedom Initiative, efforts to enhance interventions for children's mental health must involve schools. Thus, many of those interested in improving education and those concerned about transforming the mental health system in the United States of America and elsewhere are taking a new look at schools (Adelman & Taylor, 2008, 2009; Center for Mental Health in Schools, 2004c; Kutash, Duchnowski, & Lynn, 2006; O'Connell, Boat, & Warner, 2009).

However, while mental health in schools is widely discussed, what's being talked about often differs in fundamental ways. Various agenda are pursued. Divergent policy, practice, research, and training agenda emerge. The result is confusion and conflict. This all adds to the continuing marginalization of efforts to advance mental health in schools (Taylor & Adelman, 2002).

In spite of or perhaps because of the multiple agenda, mental health in schools is an emerging new field. This reality is reflected in federally funded national centers focused on policy and program analyses; published books, reports, and scholarly journals; and university research and training programs. In addition, organizations and centers that have relevance for a school's focus on mental health and psychosocial concerns continue to burgeon. These include a variety of

technical assistance, training, and resource centers (see *Gateway to a World of Resources for Enhancing MH in Schools*—available at http://smhp.psych.ucla.edu/gateway/gateway_sites.htm).

As we explore ways to advance the field, a brief overview of its past and present will provide a logical jumping off place and a good foundation for moving forward.

# 1

# *Mental Health in Schools*

## *Past and Present*

*A variety of psychosocial and health problems have long been acknowledged as affecting learning and performance in profound ways. Moreover, behavior, learning, and emotional 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.*

Efforts to address mental health concerns in schools are not new. What's new is the emergence of the *field* of mental health in schools. We begin by highlighting some of what has transpired over the last 60 years.

## PAST AS PROLOGUE

Because of the obvious need, school policy makers have a lengthy, if somewhat reluctant, history of trying to assist teachers in dealing with problems that interfere with schooling. Prominent examples are seen in the range of health, social service, counseling, and psychological programs schools have provided from the end of the 19th century through today (Baumgartner, 1946; Christner & Mennuti, 2009; Dryfoos, 1994; Flaherty, Weist, & Warner, 1996; Tyack, 1992).

One interesting policy benchmark appeared in the middle of the 20th century when the National Institute of Mental Health (NIMH) increased the focus on mental health in schools by publishing a monograph on the topic (Lambert, Bower, & Caplan, 1964). Since then, many initiatives and a variety of agenda have emerged. Included are efforts to expand clinical services in schools, develop new programs for *at risk* groups, and incorporate programs for the prevention of problems and the promotion of social-emotional development (Adelman & Taylor, 1994; Califano, 1977; Collaboration for Academic, Social, and Emotional Learning, 2003; Dryfoos, 1994; Knitzer, Steinberg, & Fleisch, 1990; Millstein, 1988; Steiner, 1976; Stroul & Friedman, 1986; Weist & Murray, 2007).

## Bringing Health and Social Services to Schools

Over the past 20 years, a renewed emphasis in the health and social services sectors on enhancing access to clients led to increased linkages between schools and community service agencies, including colocation of services on school sites (Center for the Future of Children, 1992; Warren, 2005). This *school-linked services* movement added impetus to advocacy for mental health in schools. It promoted school-based health centers, school-based family resource centers, wellness centers, afterschool programs, and other efforts to connect community resources to the schools.

Many advocates for school-linked services coalesced their efforts with those working to enhance initiatives for youth development, community schools, and the preparation of healthy and productive citizens and workers (Blank, Berg, & Melaville, 2006). These coalitions expanded interest in social-emotional learning and protective factors as ways to increase students' assets and resiliency and reduce risk factors (Greenberg et al., 2003; Hawkins, Kosterman, Catalano, Hill, & Abbott, 2008). However, the amount of actual mental health activity in schools generated by these efforts remains relatively circumscribed (Foster et al., 2005; Teich, Robinson, & Weist, 2007).

## Federal Support for the *Field* of Mental Health in Schools

In 1995, a direct effort to advance mental health in schools was initiated by the U.S. Department of Health and Human Services through its Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau, Office of Adolescent Health (Anglin, 2003). The purpose of the initiative is to enhance the role schools play in mental health for children and adolescents. Specifically, the emphasis is on increasing the capacity of policy makers, administrators, school personnel, primary care health providers, mental health specialists, agency staff, consumers, and other stakeholders so that they can enhance how schools and their communities address psychosocial and mental health concerns. Particular attention is given to mental health promotion, prevention, and responding early after the onset of problems as critical facets of reducing the prevalence of problems and enhancing well-being.

The core of the work has been embedded in two national centers. The two, which were initially funded in 1995 with a primary emphasis on technical assistance and training, successfully reapplied during the 2000 open competition. A third open competition for a five-year funding cycle was offered in 2005 with an increasing emphasis on policy and program analyses to inform policy, practice, research, and training. Again, the initially funded centers applied and were successful in the process. The two centers are the Center for Mental Health in Schools at UCLA and the Center for School Mental Health at the University of Maryland, Baltimore. (It should be noted from 2000 through 2006, HRSA and the Substance Abuse and Mental Health Services Administration [SAMHSA] braided resources to jointly support the initiative.)

Other federal initiatives promote mental health in schools through a smattering of projects and initiatives. These include (1) programs supported by the U.S. Department of Education's Office of Safe and Drug-Free Schools (including a grants program for the Integration of Schools and Mental Health Systems), its Office of Special Education and Rehabilitative Services, and some of the school improvement initiatives under the No Child Left Behind Act; (2) the Safe Schools/Healthy Students initiative, which is jointly sponsored by SAMHSA and the U.S. Departments of Education and Justice; (3) components of the Centers for Disease Control and Prevention's Coordinated School Health Program; and (4) various projects funded through SAMHSA's Elimination of Barriers Initiative and Mental Health Transformation State Incentive Grant Program. Several other federal agencies support a few projects that fit agenda for mental health in schools. All of the above have helped the field emerge; none of the federal programs are intended to underwrite the field. Government-funded projects are time limited and affected by economic downturns.

In recent years, a growing number of states have funded projects and initiatives, and a few have passed legislation with varying agenda related to mental health in schools. A variety of public and private entities also support projects that contribute to the emerging field.

Other countries are moving forward as well. The growing interest around the world is reflected in the establishment in the early 2000s of the International Alliance for Child and Adolescent Mental Health and Schools, which has members in 30 countries (Weist & Murray, 2007).

## Call for Collaboration

Few doubt the need for collaboration. Over the years, those with a stake in mental health in schools frequently have called for joining forces (Center for Mental Health in Schools, 2002; Rappaport, Osher, Garrison, Anderson-Ketchmark, & Dwyer, 2003; Taylor & Adelman, 1996). Building bridges across groups, however, is complex and requires a long-term commitment. We discuss this matter in detail in Chapter 13.

One contemporary effort began in 2000 when the National Association of State Mental Health Program Directors and the Policymaker Partnership at the National Association of State Directors of Special Education (2002) met to explore how the two entities could collaborate to promote closer working relations between state mental health and education agencies, schools and family organizations. A concept paper entitled "Mental Health, Schools and Families Working Together for All Children and Youth: Toward a Shared Agenda" was produced with funds from the Office of Special Education Programs. The paper was designed to encourage state and local family and youth organizations, mental health agencies, education entities, and schools across the nation to enter new relationships to achieve positive social, emotional, and educational outcomes for every child. The vision presented is for schools, families, child-serving agencies, and the broader community to work collaboratively to promote opportunities for and to address barriers to healthy social and emotional development and learning. The aim is to align systems and ensure the promise of a comprehensive, highly effective system for children and youth and their families. In stating the need for agencies and schools to work together, the report stresses the following:

> While sharing many values and overarching goals, each agency has developed its own organizational culture, which includes a way of looking at the world; a complex set of laws, regulations and policies; exclusive jargon; and a confusing list of alphabet-soup acronyms. Funding sources at the federal, state, and local levels have traditionally reinforced this separation into *silos.* The result is that agencies are almost totally isolated entities—each with its own research and technical assistance components and its own service delivery system, even though they are serving many of the same children. The isolation of each agency, combined with its bureaucratic complexity, requires a long-term commitment of all partners to bridge the gaps between them. Collaborative structures must be based on a shared vision and a set of agreed upon functions designed to enable a shared agenda. Legislative, regulatory or policy mandates may help bring agency representatives to the table, but development of true partnerships and the successful accomplishment of goals depends on participants gaining trust in one another as they pursue a shared agenda. (pp. 16–17)

The Policymaker Partnership provided some funds for six states to form state-based Communities of Practice for Education, Mental Health, and Family Organizations. When the funding for the Policymaker Partnership ended, the *Individuals with Disabilities Education Act (IDEA) Partnership* (funded by the U.S. Department of Education's Office of Special Education Programs) has continued to facilitate the Communities of Practice initiative (IDEA Partnership, 2005).

## School Professionals Have Led the Way

Historical accounts stress that schools have used their resources to hire a substantial body of student support professionals—variously called support staff,

pupil personnel professionals, and specialists. Current status data are available from the *School Health Policies and Program Study* (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007; Centers for Disease Control and Prevention, 2007). This study, conducted by a unit of the Centers for Disease Control and Prevention (CDC), collected data from 51 state departments of education, 538 school districts, and 1,103 schools. Findings indicate that 56% of states and 73% of districts had a policy stating that student assistance programs would be offered to all students, but only 57% of schools offered such programs. Findings for specialist support staff indicate that 78% of schools had a part- or full-time counselor, 61% had a part- or full-time school psychologist, 42% had a part- or full-time social worker, 36% had a full-time school nurse, and an additional 51% had a part-time nurse. Considerable variation, of course, exists state by state.

While the numbers fluctuate, professionals employed by school districts continue to carry out most of the activity related to mental health in schools (Adelman & Taylor, 2006c; Carlson, Paavola, & Talley, 1995; Teich, Robinson, & Weist, 2007). As a result, they are the core around which programs have emerged.

## DATA ON NEED

Available data underscore an urgent need. Data cited on diagnosable mental disorders generally suggest that from 12% to 22% of all youngsters under age 18 need services for mental, emotional, or behavioral problems. These figures are cited in the Surgeon General's 1999 mental health report (U.S. Department of Health and Human Services, 1999). Referring to ages 9 to 17, the document states that 21% or "one in five children and adolescents experiences the signs and symptoms of a *DSM-IV* disorder during the course of a year" (p. 123)—with 11% of all children experiencing significant impairment and about 5% experiencing "extreme functional impairment" (p. 124). Similar data are noted in the Centers for Disease Control and Prevention's Youth Risk Behavior Surveys, in a 2004 report from the Annenberg Public Policy Center (see Exhibit 1), and in preliminary data from the 2005 National Health Interview Survey (Simpson, Cohen, Pastor, & Reuben, 2006).

**Exhibit 1** **Some Data on Students' Mental Health**

From April 5, 2004, to May 28, 2004, the Annenberg Public Policy Center surveyed over 1,400 public school professionals as part of the Annenberg Foundation Trust at Sunnylands' Initiative on Adolescent Mental Health. The focus was on how schools provide treatment and counseling for students.

Survey findings indicate that the respondents view high school student depression and use of alcohol and illegal drugs as even more serious problems than various forms of violence, including bullying, fighting, and use of weapons. More than two-thirds (68%) of the high school professionals

*(Continued)*

(Continued)

surveyed identified depression as a great (14%) or moderate (54%) problem in their schools. Similar overall levels of concern were raised about use of alcohol (71%) and illegal drugs (72%). In contrast, 54% of high school professionals identified bullying as a great (11%) or moderate (43%) problem. Even lower levels of concern were expressed about fighting between students (37%) and weapon carrying (6%) at the high school level. Other concerns cited were anxiety disorders (42%), eating disorders (22%), and various forms of self-harm such as cutting (26%).

Unlike their counterparts in high schools, middle school professionals are more concerned about interpersonal conflict. Although high proportions of middle school professionals identify depression (57%) and use of alcohol (28%) and illegal drugs (37%) as at least moderate problems, bullying is seen as a problem by 82% of professionals and fighting by 57% of professionals in middle schools. Weapon carrying remains a concern among only 5% of professionals.

Although 66% of the high schools indicated having a process for *referring* students with mental health conditions to appropriate providers of care, only 34% reported having a clearly defined and coordinated process for identifying such students. Comparable findings come from the middle schools; however, 42% of professionals reported having a clearly defined process identifying students with mental conditions. Only about 3% of the high schools indicated use of universal screening. An additional 5% claim to screen most of their students.

Asked what percentage of their students in need of counseling or treatment actually receive such services, only 7% of high school professionals said that all do and only 31% said that most do. The majority indicated that only half or fewer received the services they need. When asked the same question about receiving services on site at their school, the percentages were even lower—6% said all do and 22% said most do. Only 24% of school professionals say their high schools have counseling available for students with alcohol or drug dependence problems.

SOURCE: Reported by the Annenberg Public Policy Center. http://www.sunnylandstrust.org/

The picture worsens when one expands the focus beyond the limited perspective on diagnosable mental disorders. Think in terms of all the young people experiencing psychosocial problems and who are "at risk of not maturing into responsible adults" (Dryfoos, 1990, p. 4). Many reports explore the situation from this broader perspective (Centers for Disease Control and Prevention, 2005; Forum on Child and Family Statistics, 2007; Greenberg, Domitrovich, & Bumbarger, 1999; Institute of Medicine, 1994; NIMH, 1993, 1998; also see fact sheets and reports on the Web sites for SAMHSA's Center for Mental Health Services and USDOE's Safe and Drug-Free Schools Program).

Demographic policy estimates suggest that 40% of young people are in bad educational shape and therefore will fail to fulfill their promise (Hodgkinson, 2008). For many large, urban schools, the reality is that well over 50% of their students manifest significant behavior, learning, and emotional problems (Center for Mental Health in Schools, 2003b). For a large proportion of these youngsters, the problems are rooted in the restricted opportunities and difficult

living conditions associated with poverty. Almost every current policy discussion stresses the crisis nature of child poverty in terms of future health and economic implications for individuals and society; the consistent call is for fundamental systemic reforms.


## UNDERSTANDING THE CONCEPT OF *MENTAL HEALTH* IN SCHOOLS

Mental health is recognized widely as a fundamental and compelling societal concern. The relationship between health and mental health problems is well established. From both the perspective of promoting positive well-being and minimizing the scope of mental health and other health problems, school professionals clearly have an important role to play. The matter is well-underscored when one appreciates the full meaning of the concept of mental *health* and the full range of factors that lead to mental health problems.

### Mental *Health* or Mental *Illness?*

The trend toward overusing psychiatric labels reflects the tendency to reduce mental health to mental illness, disorders, or problems. Many people hear the term *mental health,* and they think mental *illness.* When this occurs, mental *health* is defined, de facto, as the absence of problems. This trend ignores the facts: (1) the behavior, learning, and emotional problems experienced by most youngsters stem from sociocultural and economic factors not from psychopathology, and (2) such problems often can be countered through promotion of social and emotional development and preventive interventions.

To address the definitional problem, the following guides are helpful:

- The report of the Surgeon General's Conference on Children's Mental Health (U.S. Department of Health and Human Services, 2001) offers the following vision statement: "Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals." This view is consistent with efforts to define mental health as a positive concept.
- The Institute of Medicine (1994) defines health as a "state of well-being and the capability to function in the face of changing circumstance."
- A similar effort to contrast positive health with problem functioning is seen in SAMHSA's Center for Mental Health Services glossary of children's mental health terms. Mental health is defined as "how a person thinks, feels, and acts when faced with life's situations. . . . This includes handling stress, relating to other people, and making decisions." SAMHSA contrasts this with mental health problems. And the designation *mental disorder* is described as another term used for mental health problems. (They reserve the term *mental illness* for severe mental health problems in adults).
- Finally, note that the World Health Organization (2004) also stresses that mental health is "a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

A more recent effort to emphasize mental *health* is found in *Bright Futures in Practice: Mental Health* (National Center for Education in Maternal and Child Health, 2002) that states,

> Mentally healthy children and adolescents develop the ability to experience a range of emotions (including joy, connectedness, sadness, and anger) in appropriate and constructive ways; possess positive self-esteem and a respect for others; and harbor a deep sense of security and trust in themselves and the world. Mentally healthy children and adolescents are able to function in developmentally appropriate ways in the contexts of self, family, peers, school, and community. Building on a foundation of personal interaction and support, mentally healthy children and adolescents develop the ability to initiate and maintain meaningful relationships (love) and learn to function productively in the world (work).

## Concerns About Differential Diagnosis

Not surprisingly, debates about diagnostically labeling young people are heated. Differential *diagnosis* is a difficult process fraught with complex issues.

Concern arises about the tendency to view "everyday" emotional and behavioral problems as "symptoms," designate them as disorders, and assign them formal psychiatric diagnoses (Adelman, 1995a; Adelman & Taylor, 1994; Dryfoos, 1990). The prevailing comprehensive formal systems used to classify problems in human functioning convey the impression that all behavioral, emotional, or learning problems are instigated by internal pathology. This is well illustrated by the widely used *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) (American Psychiatric Association, 1994). Some efforts to temper this trend frame pathology as a vulnerability that only becomes evident under stress. Most differential diagnoses of children's problems, however, are made by focusing on identifying one or more disorders (e.g., attention deficit hyperactivity disorder, oppositional defiant disorder, learning disorders, adjustment disorders), rather than first asking, *Is there a disorder?*

Problems experienced by the majority of children and adolescents are sociocultural and economic. This, of course, in no way denies that the primary factor instigating a problem may be an internal disorder. The point simply recognizes that, comparatively, youngsters whose problems stem from person pathology constitute a relatively small group (Center for Mental Health in Schools, 2003a).

Biases in definition that overemphasize person pathology narrow what is done to classify and assess problems. Comprehensive classification systems do not exist for environmentally caused problems or for psychosocial problems (caused by the transaction of internal and environmental factors).

The overemphasis on classifying problems in terms of personal pathology has skewed theory, research, practice, and public policy. The narrow focus has limited discussions of cause, diagnosis, and intervention strategies, especially efforts to prevent and intervene early after onset.

Efforts to address a wider range of variables in labeling problems are illustrated by multifaceted systems. An example is the *Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care* (*DSM-PC*) published by the American Academy of Pediatrics (Wolraich, Felice, & Drotar, 1996). The work provides a broad template for understanding and categorizing behavior. For each major category, behaviors are described to illustrate what should be considered (1) a developmental variation, (2) a problem, and (3) a disorder. Information also is provided on the environmental situations and stressors that exacerbate the behavior and on commonly confused symptoms. The material is presented in a way that can be shared with families, so that they have a perspective with respect to concerns they or the school identifies.

Available evidence suggests increasing numbers of youngsters manifesting emotional upset, misbehavior, and learning problems routinely are assigned diagnostic labels denoting serious disorders (e.g., attention deficit hyperactivity disorder, depression, learning disabilities). The numbers fly in the face of the reality that the problems of *most* youngsters are not rooted in internal pathology. The likelihood is that many troubling symptoms would not develop

under more favorable environmental conditions. Moreover, the trend to label so many diagnosable disorders leads to frequent misdiagnoses and inappropriate and expensive treatments. All this contaminates research and training (Lyon, 2002).

An increasing focus in policy and practice is on reducing misdiagnoses and misprescriptions. One emphasis is on placing mental illness in perspective with respect to psychosocial problems; another aim is to ensure mental health is understood as encompassing the promotion of social and emotional development and learning (Adelman, 1995a; Adelman & Taylor, 1994). Schools are being asked to play a major role in all this through strategies such as assessing "response to intervention" (RtI) prior to diagnosis (discussed in Part III).

### Mental Health in Schools: A Broad Concept

Because mental health often is heard as mental *illness,* many people think *mental health in schools* is only about therapy and counseling. However, the reality is that the field is about much more than treating disorders and providing students with clinical services.

Mental health in schools aspires to do the following:

- Provide programs to (a) promote social-emotional development, (b) prevent mental health and psychosocial problems, and (c) enhance resiliency and protective buffers
- Provide programs and services to intervene as early after the onset of behavior, learning, and emotional problems as is feasible
- Enhance the mental health of families and school staff
- Build the capacity of all school staff to address barriers to learning and promote healthy development
- Address systemic matters at schools that affect mental health, such as high stakes testing, including exit exams, and other practices that engender bullying, alienation, and student disengagement from classroom learning
- Develop a comprehensive, multifaceted, and cohesive continuum of school-community interventions to address barriers to learning and promote healthy development

## CURRENT STATE OF AFFAIRS

The current state of affairs related to mental health in schools is discussed mostly in terms of services and programs. For example, Exhibit 2 provides a summary of findings excerpted from the first national survey of school mental health services (Foster et al., 2005). The sample was representative of public schools across the United States, and the data amplify and support previous findings, including those discussed above.

**Exhibit 2** Some Baseline Data on School Mental Health Services

As reported in *School Mental Health Services in the United States, 2002–2003* (Foster et al., 2005), the survey topics included types of mental health problems encountered in school settings; types of mental health services that schools are delivering; numbers and qualifications of school staff providing mental health services; types of arrangements for delivering mental health services in schools, including collaboration with community-based providers; and major sources of funding for school MH services.

**Key Findings as Reported in the Executive Summary**

- Nearly three-quarters (73%) of the schools reported that "social, interpersonal, or family problems" were the most frequent mental health problems for both male and female students.
- For males, aggression or disruptive behavior and behavior problems associated with neurological disorders were the second and third most frequent problems.
- For females, anxiety and adjustment issues were the second and third most frequent problems.
- All students, not just those in special education, were eligible to receive mental health services in the vast majority of schools (87%).
- One-fifth of students on average received some type of school-supported mental health services in the school year prior to the study.
- Virtually all schools reported having at least one staff member whose responsibilities included providing mental health services to students.
- The most common types of school mental health providers were school counselors followed by nurses, school psychologists, and social workers. School nurses spent approximately a third of their time providing mental health services.
- More than 80% of schools provided assessment for mental health problems, behavior management consultation, and crisis intervention, as well as referrals to specialized programs.
- A majority also provided individual and group counseling and case management.
- Financial constraints of families and inadequate school mental health resources were the most frequently cited barriers to providing mental health services.
- Almost half of school districts (49%) used contracts or other formal agreements with community-based individuals and/or organizations to provide mental health services to students. The most frequently reported community-based provider type was county mental health agencies.
- Districts reported that the most common funding sources for mental health services or interventions were the Individuals with Disabilities Education Act (IDEA), state special education funds, and local funds. In 28% of districts, Medicaid was among the top five funding sources for mental health services.

*(Continued)*

(Continued)

- One-third of districts reported that funding for mental health services had decreased since the beginning of the 2000–2001 school year, while over two-thirds of districts reported that the need for mental health services increased.
- Sixty percent of districts reported that since the previous year, referrals to community-based providers had increased. One-third reported that the availability of outside providers to deliver services to students had decreased.

While survey findings indicate that schools are responding to the mental health needs of their students, they also suggest increasing needs for mental health services and the multiple challenges faced by schools in addressing these needs. Furthermore, more research is needed to explore issues identified by this study, including training of school staff delivering mental health services, adequacy of funding, and effectiveness of specific services delivered in the school setting.

SOURCE: Foster et al., 2005, pp. 1–2.

Another example comes from a national survey by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2008). The report indicates that for youth 12 to 17 years of age, the combined 2005 and 2006 data show an annual average of 3.0 million youths (12.0%) received services for emotional or behavioral problems in a school-based setting. In contrast, 3.3 million youths (13.3%) received services for emotional or behavioral problems in a specialty mental health setting and around 752,000 (3.0%) received such services in a general medical setting. Females were more likely than their male counterparts to receive services in a specialty mental health or educational setting.

Cataloging services and their use certainly is necessary. However, a deeper understanding requires appreciation of the diverse agenda stakeholders bring to the field, the funding situation, and current policy and practice.

## Diverse Agenda for Mental Health in Schools

Different stakeholders are pursing different and sometimes conflicting agenda. Analyses of the contrasting enterprises pursued under the banner of mental health in schools find seven different agenda concerned in varying degrees with policy, practice, research, and/or training. In Exhibit 3, the agenda are grouped and subdivided in terms of the *primary* vested interests of various parties. While some agenda are complementary, some are not.

**Exhibit 3** Diverse Agenda for Mental Health in Schools

1. Efforts to use schools to increase *access* to kids and their families for purposes of
   a. conducting research related to mental health concerns
   b. providing services related to mental health
2. Efforts to increase *availability* of mental health interventions
   a. through expanded use of school resources
   b. through colocating community resources on school campuses
   c. through finding ways to combine school and community resources
3. Efforts to get schools to adopt and/or enhance specific programs and approaches
   a. for treating specific individuals
   b. for addressing specific types of problems in targeted ways
   c. for addressing problems through schoolwide, *universal* interventions
   d. for promoting healthy social and emotional development
4. Efforts to *improve specific processes and interventions* related to mental health in schools (e.g., improve systems for identifying and referring problems and for case management, enhancing *prereferral* and early intervention programs)
5. Efforts to enhance the *economic interests* of various entities (e.g., specific disciplines, guilds, contractors, businesses, organizations) that are
   a. already part of school budgets
   b. seeking to be part of school budgets
6. *Efforts to change how student supports are conceived* at schools (e.g., rethink, reframe, reform, restructure) through
   a. enhanced focus on multidisciplinary teamwork (e.g. among school staff, with community professionals)
   b. enhanced coordination of interventions (e.g., among school programs and services, with community programs and services)
   c. appropriate integration of interventions (e.g., that schools own, that communities base or link with schools)
   d. modifying the roles and functions of various student support staff
   e. developing a comprehensive, multifaceted, and cohesive component for systematically addressing barriers to student learning at every school
7. Efforts to *reduce school involvement* in mental health programs and services (e.g., to maximize the focus on instruction, to use the resources for youth development, to keep the school out of areas where family values are involved)

Given the diverse agenda, competing interests often come into conflict with each other. For example, those concerned with nurturing positive youth development and mental health and those focusing on the treatment of mental and

behavioral disorders often find themselves in counter-productive competition for sparse school time and resources. This contributes to the low priority and the backlash to efforts to enhance policy and practice for mental health in schools.

Over the years, our center at UCLA has pursued a broad agenda for advancing mental health in schools. We emphasize (1) embedding the work into every school's need to address barriers to learning and teaching and promote healthy development and (2) fully integrating the agenda into school improvement policy and practice. We stress that the agenda encompasses enhancing greater family and community involvement in education. And it requires a fundamental shift in thinking about what motivates students, staff, and other school stakeholders.

In the absence of a broad agenda, mental health in schools commonly is viewed as concerned mainly with providing interventions for a relatively few of the many students who need some form of help. Efforts to promote social and emotional health and prevent problems are sparse. Diverse agenda have created counter-productive competition for sparse funds. Ad hoc policy and categorical funding have created a fragmented and piecemeal enterprise.

## Funding

Inadequate data are available on how much schools spend to address behavior, emotional, and learning problems. Exhibit 4 provides a bit of a perspective.

**Exhibit 4 What Is Spent in Schools?**

As reported by the National Center for Educational Statistics (2008), data for fiscal year (FY) 2006 indicate that approximately $520.6 billion was collected in revenues for public elementary and secondary education in the 50 states and the District of Columbia. "The greatest percentage of revenues came from state and local governments, which together provided $473.1 billion, or 90.9% of all revenues; the federal government's contribution was $47.6 billion, or 9.1% of all revenues."

"Current expenditures" totaled $449.6 billion. These include those for "day-to-day operation of schools and school districts (salaries, benefits, supplies, and purchased services) for public elementary and secondary education." They exclude expenditures for construction, equipment, property, debt services, and programs outside of public elementary and secondary education such as adult education and community services.

Current expenditures per pupil for public elementary and secondary education were $9,154. Adjusting for inflation, current expenditures per pupil have grown 25.1% since FY 1995 ($7,315) and 51.0% since FY 1985 ($6,062). In FY 2006, $274.2 billion was spent on instruction. This includes spending on salaries and benefits for teachers and teacher aides, classroom supplies and services, and extracurricular and cocurricular activities.

Looking at per pupil current expenditures for public elementary and secondary education, instruction expenditures ranged from $10,109 in New York to $3,453 in Utah. Instruction accounted for 61.0% of all current expenditures for public elementary and secondary education. Total support services accounted for 34.9%, food services accounted for 3.8%, and enterprise operations made up 0.2% of total current expenditures.

Breaking all this down to clarify what goes for regular student and learning supports and special education is not easy.

In 1997, Monk, Pijanowski, and Hussain reported that 6.7% of school spending is used for student support services such as counseling, psychological services, speech therapy, health services, and diagnostic and related special services for students with disabilities. The amount specifically devoted to learning, behavior, and emotional problems is unclear.

*But* note that these figures do not include costs related to time spent on such matters by other school staff such as teachers and administrators. Also not included are expenditures related to initiatives such as safe and drug-free school programs and arrangements such as alternative and continuation schools and funding for school-based health, family, and parent centers, and much more.

Federal government figures indicate that total spending to educate all students with disabilities found eligible for special education programs was $78.3 billion (U.S. Department of Education, 2005). About $50 billion was spent on special education services; another $27.3 billion was expended on regular education services for students with disabilities eligible for special education; and an additional $1 billion was spent on other special needs programs (e.g., Title I, English language learners, or gifted and talented education). Estimates in many school districts indicate that about 20% of the budget is consumed by special education. How much is used directly for efforts to address learning, behavior, and emotional problems is unknown, but remember that over 50% of those in special education are diagnosed as learning disabled and over 8% are labeled emotionally and/or behaviorally disturbed.

Focusing only on pupil service personnel salaries in calculating how much schools spend on addressing behavior, emotional, and learning problems probably is misleading and a major underestimation. This is particularly so for schools receiving special funding. Research needs to clarify the entire gamut of resources school sites devote to student problems. Budgets must be broken apart in ways that allow tallying all resources allocated from general funds, support provided for compensatory and special education, and underwriting related to programs for dropout prevention and recovery, safe and drug-free schools, pregnancy prevention, teen parents, health services, family literacy, homeless students, and more. In some schools receiving funds from multiple categorical funding streams, school administrators tell us that as much as 25% to 30% of the budget may be expended on problem prevention and correction.

As stressed by the Policy Leadership Cadre for Mental Health in Schools (2001):

> To date there has been no comprehensive mapping and no overall analysis of the amount of resources used for efforts relevant to mental health in schools or of how they are expended. Without such a *big picture* analysis, policy-makers and practitioners are deprived of information that is essential to determining equity and enhancing system effectiveness.

Whatever the expenditures, few schools come close to having enough resources to deal with a large number of students with behavior, emotional, and learning problems. Moreover, the contexts for intervention often are limited and makeshift because

of how current resources are allocated and used. A relatively small proportion of space at schools is earmarked specifically for programs that address student problems. Many special programs and related efforts to promote health and positive behavior are assigned space on an ad hoc basis. Support service personnel often must rotate among schools as *itinerant* staff. These conditions contribute to the tendency for such personnel to operate in relative isolation of each other and other stakeholders. To make matters worse, little systematic inservice development is provided for new *support* staff when they arrive from their preservice programs. Obviously, all this is not conducive to effective practice and is wasteful of sparse resources.

Clearly, diverse school and community resources are attempting to address complex and overlapping psychosocial and mental health concerns. The need is great. The current response is insufficient.

## Nature of Current Practice and Policy

Data on schools, districts, and students in public schools are in a constant state of flux. Available data indicate over 90,000 public schools in about 15,000 districts enroll about 49 million students. Over the years, most—but obviously not all—schools have instituted policies and programs designed with a range of mental health and psychosocial concerns in mind.

Policies are in place to support school counseling, psychological, and social service programs and personnel and to connect community programs and personnel with schools. As a result, most schools have some interventions to address a range of mental health and psychosocial concerns, such as school adjustment and attendance problems, substance abuse, emotional problems, relationship difficulties, violence, physical and sexual abuse, delinquency, and dropouts. A large body of research supports the promise of much of this activity.[1]

*Practices.* School-based interventions relevant to mental health encompass a wide variety of practices, an array of resources, and many issues. However, as we have noted, addressing psychosocial and mental health concerns in schools typically is not assigned a high priority. Such matters gain stature for a while whenever a high visibility event occurs—a shooting on campus, a student suicide, an increase in bullying. Because of their usual humble status, efforts continue to be developed in an ad hoc, piecemeal, and highly marginalized way.

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. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as *at risk.* The activities may be implemented in regular or special education classrooms or as out of classroom programs and may be designed for an entire class, groups, or individuals. A focus may also be on primary prevention and enhancement of healthy development through use of health

education, health services, guidance, and so forth—though relatively few resources usually are allocated for such activity.

Exhibit 5 highlights the five major *delivery mechanisms and formats* used in schools to pursue the various agenda for mental health.

**Exhibit 5 Delivery Mechanisms and Formats for Mental Health in Schools**

The five mechanisms and related formats are as follows:

1. *School-Financed Student Support Services*—Most school districts employ pupil services professionals such as school psychologists, counselors, school nurses, 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 usually is a combination of centrally based and school-based services.

2. *School-District Mental Health Unit*—A few districts operate specific mental health units with clinics and school services and consultation. Some have started to finance their own school-based health centers with mental health services as a major element. The format for this mechanism has been a centralized unit with the capability for outreach to schools.

3. *Formal Connections With Community Mental Health Services*—Increasingly, schools have connected 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 and combinations predominate:

- Colocation of community agency personnel and services at schools—sometimes in the context of school-based health centers partly financed by community health organizations
- 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
- Formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of MH services
- Contracts with community providers to provide needed student services

4. *Classroom-Based Curriculum and Special Out of Classroom Interventions*—Most schools include a focus on enhancing social and emotional functioning in some facet of their curriculum. 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 are as follows:

- Integrated instruction as part of the regular classroom content and processes
- Specific curriculum or special intervention implemented by personnel specially trained to carry out the processes
- Curriculum implemented as part of a multifaceted set of interventions designed to enhance positive development and prevent problems

*(Continued)*

(Continued)

5. *Comprehensive, Multifaceted, and Integrated Approaches*—A few school districts have begun to reconceptualize piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. The intent is to develop a comprehensive system of student and learning supports and integrate it with instructional efforts that affect healthy development. The process involves restructuring student support services and weaving them together with community resources. Minimally, the focus is on establishing a full continuum of programs and services 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, as reflected in initiatives designated as expanded school mental health. Efforts to move toward comprehensive, multifaceted approaches are reflected in initiatives to integrate schools more fully into systems of care and the growing movement to create community schools. Three formats are emerging:

- Mechanisms to coordinate and integrate school and community services
- Initiatives to restructure student support programs/services and integrate them into school reform agenda
- Community schools

<delete x2>

*Personnel*. As already noted, school districts employ personnel such as psychologists, counselors, social workers, psychiatrists, nurses, special educators, and a variety of others whose focus encompasses mental health and psychosocial concerns. Federal and state mandates tend to determine how many pupil services professionals are employed, and states regulate compliance with mandates. Governance of their work usually is centralized at the district level. In large districts, counselors, psychologists, social workers, and other specialists may be organized into separate units, overlapping regular, compensatory, and special education.

Specialists tend to focus mainly on students causing problems or having problems. The many *functions* of such professionals can be grouped into the following: (1) direct services and instruction; (2) coordination, development, and leadership related to programs, services, resources, and systems; and (3) enhancement of connections with community resources. Some of this involves linking and collaborating with community agencies and programs to enhance resources and improve access, availability, and outcomes.

Prevailing direct intervention approaches encompass responding to crises; identifying the needs of targeted individuals; prescribing one or more interventions; offering brief consultation; and providing referrals for assessment, corrective services, triage, diagnosis, and various gatekeeping functions. In some situations, however, resources are so limited that specialists can do little more than assess for special education eligibility, offer brief consultations, and make referrals to special education and/or community resources.

Because the need is so great, other personnel often are called on to play a role in addressing problems of youth and their families. These include instructional professionals (health educators, other classroom teachers, special education staff, resource

staff), administrative staff (principals, assistant principals), students (including trained peer counselors), family members, and almost everyone else involved with a school (aides, clerical and cafeteria staff, custodians, bus drivers, paraprofessionals, recreation personnel, volunteers, and professionals in training). As noted, districts are connecting with specialists employed by other public and private agencies, such as health departments, hospitals, social service agencies, and community-based organizations, to provide services to students, their families, and school staff (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003; Romer & McIntosh, 2005).

In summation, most districts provide schools with some personnel to address a range of mental health and psychosocial concerns, such as school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, delinquency, and violence. Some are funded by the district or through extramural grants; others are the result of linkages with community service and youth development agencies.

*But It Is All Marginalized.* While a range of mental health and psychosocial problems are addressed, no one should think that mental health is a high priority in school policy and practice (Adelman & Taylor, 2006d; Taylor & Adelman, 2000). Schools and districts treat student and learning supports as desirable but not an imperative. Since the activity is not seen as essential, the programs and staff are pushed to the margins. Planning of programs, services, and delivery systems is done on an ad hoc basis; interventions are referred to as *auxiliary* or *support* services, and student support personnel almost never are a prominent part of a school's organizational structure. Such staff usually are among those deemed dispensable as budgets tighten.

Because student supports are so marginalized, they are developed in a piecemeal manner. The marginalization spills over to how schools pursue special education mandates and policies related to inclusion. The low policy status shapes how they work with community agencies and initiatives for systems of care, wrap-around services, school-linked services, and other school-community collaborations. And all this negatively affects adoption and implementation of evidence-based practices.

Evidence of the marginalization is found in school improvement plans. Analyses of such planning indicate that schools give sparse attention to mental health and psychosocial concerns (Center for Mental Health in Schools, 2005a, 2005b, 2005d).

## CONCLUDING COMMENTS

Anyone who has worked in a school knows how hard school professionals toil. Anecdotes about great programs and outcomes are legion.

Our discussion in this chapter and the rest of the book underscores that exceptional talent and effort has brought the field of mental health in schools to this stage in its development. At the same time, we stress that too little is being done in most schools and significant work lies ahead.

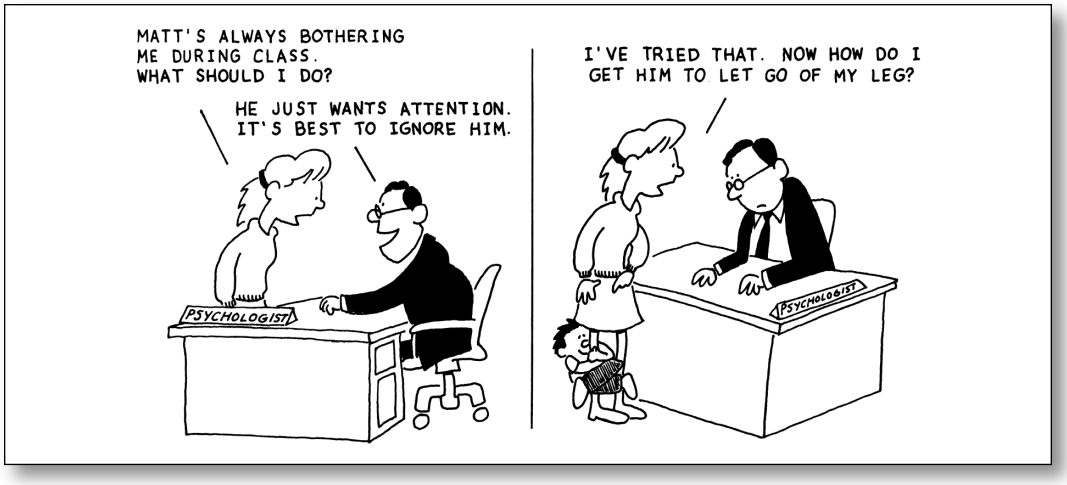
Current practices have been generated and function in relative isolation of each other. Intervention planning and implementation are widely characterized

as fragmented and piecemeal. This, of course, is an ineffective way for schools to deal with the complex sets of problems confronting teachers and other staff.

Organizationally, policy makers tend to mandate and planners and developers focus on specific services and programs with too little thought or time given to mechanisms for program development and collaboration. The work rarely is envisioned in the context of a comprehensive approach to addressing behavior, emotional, and learning problems and promoting healthy development.

Functionally, most practitioners spend their time applying specialized interventions to targeted problems, usually involving individual or small groups of students. Consequently, programs to address behavior, emotional, learning, and physical problems rarely are coordinated with each other or with educational programs.

The above state of affairs is not meant as a criticism of those who are doing their best to help students in need. Our intent is to underscore a fundamental policy weakness, namely: *Efforts to address barriers to learning and teaching are marginalized in current education policy.* This maintains an unsatisfactory status quo related to how schools address learning, behavior, and emotional problems. Analyses indicate that school policy is currently dominated by a two-component systemic model (Adelman, 1995b, 1996a, 1996b; Adelman & Taylor, 1994, 1997b, 1998, 2006c; Center for Mental Health in Schools, 1996, 1997). That is, the primary thrust is on improving instruction and school management. While these two facets obviously are essential, ending the marginalization of efforts to effectively address barriers to learning, development, and teaching requires establishing a third component as a fundamental facet of transforming the educational system. We amplify on this matter in the next chapter and throughout the book.




## NOTE

1. In addition to the references included in this book, an online list of relevant references is regularly updated and available from the national Center for Mental Health in Schools at UCLA at http://smhp.psych.ucla.edu/qf/references.htm. Also see Chapter 14 for an annotated listing of sources for identifying evidence-based strategies for strengthening student supports; the list also is online with direct links at http://smhp.psych.ucla.edu/pdfdocs/aboutmh/annotatedlist.pdf.

# 2

# *About Moving Toward a Comprehensive Approach*

*We can't solve problems by using the same kind of thinking we used when we created them.*

—Albert Einstein

The problems students bring to school are multifaceted and complex. Moreover, in many schools, the number of students experiencing problems is extensive. It is well-known that a student who has a learning problem is likely to have behavior problems and vice versa. Moreover, students with learning and behavior problems usually develop an overlay of emotional problems. Of course, emotional problems can lead to and exacerbate behavior and/or learning problems. Schools find that a student who abuses drugs often also has poor grades, is truant, at risk of dropping out, and more.

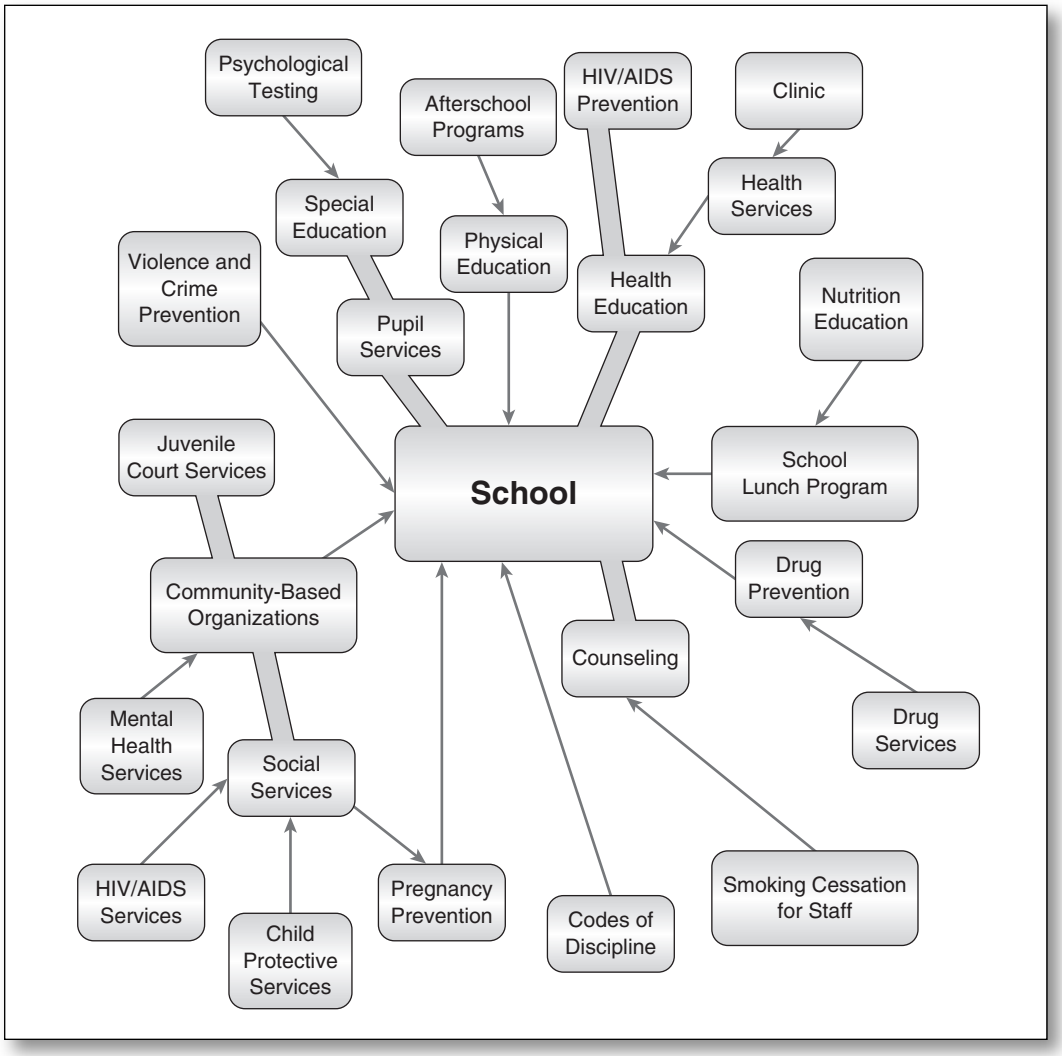
When students are not doing well, teachers often refer them directly for assessment in hopes of referral for special assistance, perhaps even assignment to special education. In some schools and classrooms, the number of referrals is dramatic. Where special teams exist to review students for whom help is requested, the list grows as the year proceeds. The longer the list, the longer the lag time for review—often to the point that, by the end of the school year, only a few have been processed. *And, no matter how many are reviewed, there are always more referrals than can be served.* In many schools, the numbers of students experiencing problems is staggering.

## NEEDED: A COMPREHENSIVE APPROACH

The fragmentation of programs and services described in Chapter 1 and illustrated graphically in Figure 2.1 reflects the tendency for policy makers to mandate and planners and developers to focus on specific problems and categorical programs. As a result, most practitioners spend their time working on targeted problems and give little thought or time to developing comprehensive and cohesive approaches.

Moreover, the need to label students in order to obtain special, categorical funding further skews practices toward narrow and unintegrated intervention

**Figure 2.1 Talk About Fragmented!**




SOURCE: Adapted from *Health Is Academic: A Guide to Coordinated School Health Programs,* by E. Marx and S. Wooley with D. Northrop (Eds.), 1998, New York: Teachers College Press. Copyright 1998 by Teachers College Press. Adapted with permission.

approaches. One result is that a student identified as having multiple problems may be involved in programs with several professionals working independently of each other. Similarly, a youngster identified and helped in elementary school may cease to receive needed help upon entering middle school. Pursuit of grant money often further diverts attention from one problem to another. Exhibit 6 highlights concerns that arise about categorical and other funding as related to development of a comprehensive and cohesive system for addressing barriers to learning and teaching.

**Exhibit 6 Concerns About Categorical and Other Sources of Funding**

*Are the ways that schools underwrite student and learning supports undermining creation of an effective system for addressing overlapping psychosocial and mental health problems?*

School budgets always are tight. So schools seek all forms of extra funding from public and private sectors to help underwrite student and learning supports. Tight budgets lead schools to embrace categorical funding and a range of other sources to underwrite programs and services. This contributes to the use of narrow, targeted initiatives focused on discrete problems such as bullying, suicide screening, substance abuse prevention, and on and on. Moreover, the sporadic and cyclical way policy attends to such matters leads to *flavor of the month* strategies.

Categorical approaches, however, conflict with the science-base that indicates many student problems overlap. Evidence also indicates that categorical approaches don't produce major changes in mobilizing large numbers of students to reengage in learning.

We find that certain types of funding distort, distract, and undermine efforts to develop a comprehensive student support system. Major examples include funding for *Supplemental Services* under Title I (which has focused only on tutoring and has limited and skewed after-school programming), Medicaid funding for school-based services that ends up redefining the roles of some school support staff (by turning them mainly into providers of fee-based clinical services), and extramural project funding for relatively small projects that end up redirecting staff attention away from system building and cause mission drift (dubbed *projectitis*).

Tight budgets also lead to recommendations to do away with programs and the personnel who staff them. Policy makers are contracting out services provided by personnel such as school psychologists, social workers, counselors, nurses, and others who deal with psychosocial and mental health matters. A related concern is the degree to which managed care and changes in Medicaid and health insurance influence such decisions. Such matters have the impact of reducing rather than increasing the total amount of resources available in schools for dealing with psychosocial and mental health concerns. And they work against redeploying resources to develop a comprehensive system of *learning supports* as a critical step for making durable progress in raising test scores and closing the achievement gap.

The solution is not found in efforts to convince policy makers to fund more special programs and services at schools. Even if the policy climate favored more special programs, such interventions alone are insufficient. More services to treat problems certainly are needed. But so are programs for prevention and early after problem onset that can reduce the numbers that teachers send to review teams.

The fact is that *multifaceted problems usually require comprehensive, integrated solutions applied concurrently and over time.* The field must move beyond the type of categorical thinking that dominates current policy and practice (Maser et al., 2009).

## HOW CLOSE ARE SCHOOLS TO HAVING A COMPREHENSIVE APPROACH?

As highlighted in Chapter 1, analyses consistently find major gaps and a high degree of fragmentation and marginalization related to school and community efforts to address barriers to learning. Few collaborative initiatives braid resources and establish effective mechanisms for sustainability. Little horizontal and vertical integration is found for programs and services within and between jurisdictions (e.g., among departments, divisions, units, schools, clusters of schools, districts, community agencies, public and private sectors). Such integration is needed to counter tendencies to develop separate programs for every observed problem.

For the most part, schools are not developing the type of support systems that *enable* all students to benefit from higher standards and improved instruction. In particular, schools do relatively little to prevent or intervene early after the onset of a student's learning, behavior, or emotional problem. As budgets have tightened, they are doing less and less to provide students with social supports and recreational and enrichment opportunities. Even as educators call for greater home involvement, proactive outreach to help family members overcome barriers to involvement remains sparse (e.g., improving family literacy, facilitating social support networks).

## WHAT'S HOLDING THINGS BACK?

Let's look at school reform and improvement through the lens of learning, behavior, and emotional problems and the need for a comprehensive system to address such problems. Doing so, we find school improvement policies and planning mostly give short shrift to these matters. The exceptions proving the point are a few pioneering initiatives demonstrating how schools and communities can meet the challenge.

Our analysis of prevailing policies for improving schools indicates that the primary focus is on two components: (1) enhancing instruction and curriculum

and (2) restructuring school management. Implementation of such efforts is shaped by demands for every school to adopt high standards and expectations and be more accountable for results, as measured by standardized achievement tests. Toward these ends, the calls are to enhance direct academic support and move away from a *deficit* model by adopting a strength- or resilience-oriented paradigm. All this is reflected in federal guidelines and the emphasis on tutoring as the main *supplemental service.*

At the same time, barriers that cannot be ignored—school violence, drugs on campus, dropouts, teen pregnancy, delinquency, and so forth—are funded and pursued as *categorical* initiatives. Analyses consistently underscore the fragmented and marginalized way in which policy makers attend to these multifaceted barriers that interfere with students learning and performing well at school.

Marginalization is seen in the sparse attention consolidated school improvement plans and certification reviews pay to addressing barriers to learning and teaching. It also is seen in the lack of mapping, analysis, and rethinking related to allocating resources for addressing barriers. A prime example is the fact that educational reformers virtually ignore the need to reframe the work of pupil services professionals and other student support staff. All this seriously hampers efforts to provide the help teachers and students so desperately need.

## NEEDED: A POLICY SHIFT

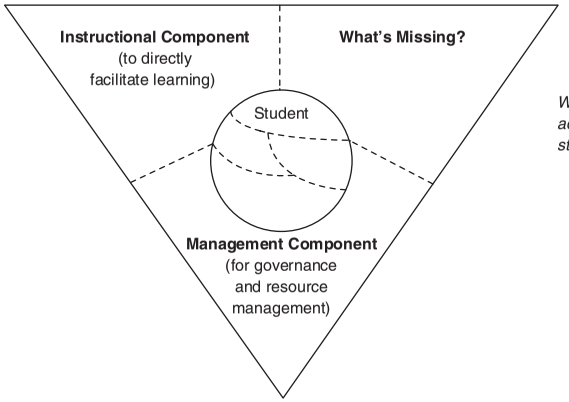
Some policy makers appreciate that limited intervention efficacy is related to programs operating in isolation of each other. Thus, we hear calls for enhancing program coordination. Initiatives for improving coordination, however, fail to come to grips with the underlying *marginalization* that leads to piecemeal approaches and maintains fragmentation.

Present policies designed to enhance support for teachers, students, and families are seriously flawed. An agenda to enhance academics is unlikely to succeed in the absence of concerted attention to ending the marginalized status of efforts to address barriers to learning and teaching. As long as the whole enterprise of addressing barriers is treated as supplementary in policy and practice, little attention will be given to integrating it fully into school improvement planning.

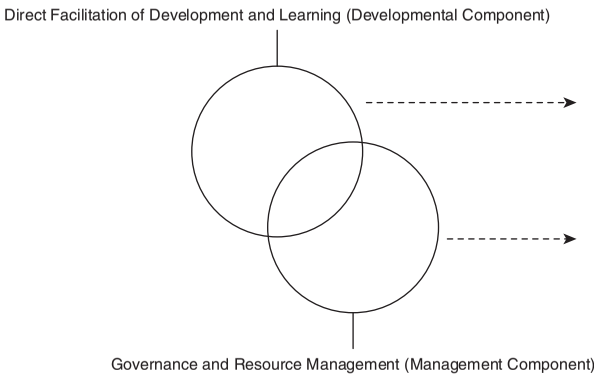
Increased awareness of policy deficiencies has stimulated analyses that indicate current education policy is dominated by a two-component model of school improvement. That is, the primary policy focus is on improving instruction and school management. While these two facets obviously are necessary, our analyses emphasize that a third well-designed component—one to enable students to learn and teachers to teach—is missing in policy (see the top part of Exhibit 7).

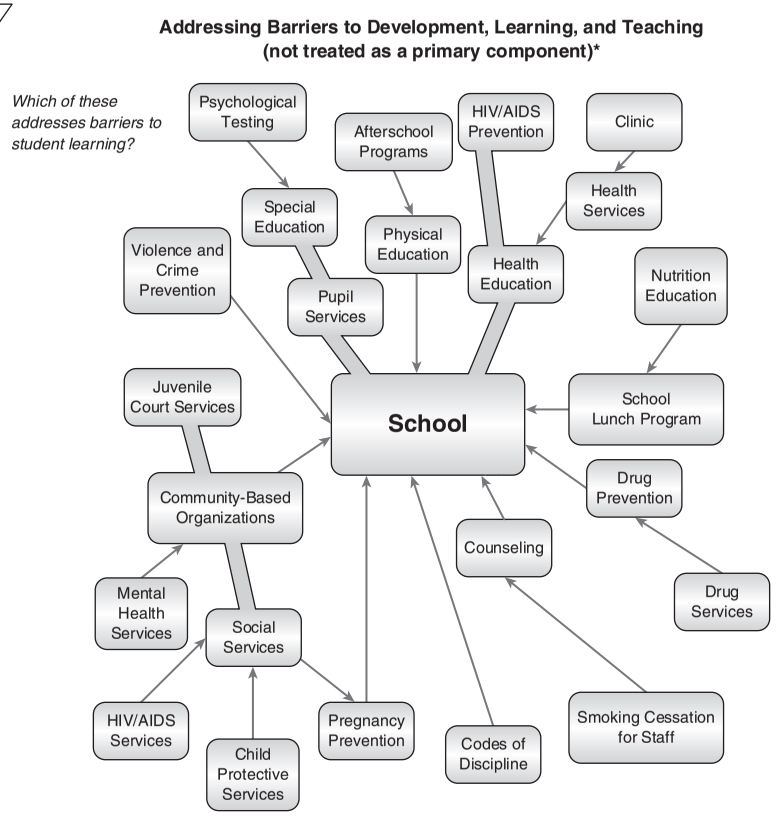
## Exhibit 7 Current Two-Component Model for Reform and Restructuring

*(a) What's missing?*




*(b) Not really missing but marginalized and fragmented in policy and practice*




*While not treated as a primary and essential component, every school offers a relatively small amount of school-owned student support services—some of which link with community-owned resources. Schools, in particular, have been reaching out to community agencies to add a few more services. All of this, however, remains marginalized and fragmented in policy and practice.

Used as a proxy for the missing component are all the marginalized and fragmented activity that goes on as school after school struggles to address the many factors interfering with student learning and performance (see the bottom section of Exhibit 7). Various states and localities are moving in the direction of pulling all these resources together into a primary and essential third component for *school improvement.* (Some of the pioneering efforts are highlighted on our center's Web site—see *Where's It Happening?* online at http://smhp.psych.ucla.edu/summit2002/wheresithappening.htm.) In each case, there is recognition at a policy level that schools must do much more to enable *all* students to learn and *all* teachers to teach effectively. In effect, the intent, over time, is for schools to play a major role in establishing a full continuum of school-community interventions.

Overlapping what schools offer are initiatives from the *community* to link resources to schools (e.g., school-linked services, full-service schools, community and school partnerships, community schools). Some of these efforts braid resources together; however, others contribute to further fragmentation, counterproductive competition, and marginalization of student support.

A third set of initiatives is designed to promote coordination and collaboration among *governmental* departments and their service agencies. For instance, establishment of local, state, and federal intra-agency and interagency councils is meant to facilitate coordinated planning and organizational change. On a local level, some school boards are rethinking their committee structures. The intent is to foster integrated approaches. Some of this emphasizes greater local control, increased involvement of parents, and locating services at schools when feasible.

Although federal and state government agencies offer various forms of support to promote coordination and collaboration, few school districts have pursued the opportunity in ways that have resulted in comprehensive and multifaceted approaches for addressing barriers to learning. The various initiatives do help *some* students who are not succeeding at school. However, they come nowhere near addressing the scope of need. Indeed, their limited potency further highlights the degree to which efforts to address barriers to learning are marginalized in policy and practice.

## A THREE-COMPONENT POLICY FRAMEWORK FOR SCHOOL IMPROVEMENT

The limited impact of current policy points to the need to rethink school reform and improvement. Our analyses indicate that the dominating two-component model is inadequate for significantly improving the role of schools in helping prevent and correct learning, behavior, and emotional problems.

Prevailing approaches to school improvement do not address the factors leading to and maintaining students' problems, especially in schools where large proportions of students are not doing well. Despite this, in their rush to raise test scores, school leaders usually pursue instruction as if this was sufficient to ensure that every student will succeed. That is, the emphasis is mostly on intensifying

and narrowing the agenda for school improvement to discussions of curriculum, instruction, and classroom discipline. (See almost any school improvement planning guide.) This ignores the need to restructure fundamentally school and community resources for *enabling learning*.

No one denies improved instruction is necessary. For too many youngsters, however, improved instruction is insufficient. Students who arrive at school lacking motivational readiness and/or certain abilities need more. We suggest that what they need is best conceived as a major component to address barriers to learning. Adoption of a three-component framework elevates addressing barriers to the level of a fundamental and primary facet of school improvement.

Movement to a three-component model is necessary so schools can do better in enabling all young people to have an equal opportunity to succeed at school.

## CONCLUDING COMMENTS

How often have you been asked the following?

*Why don't schools do a better job in addressing students' problems?*

We answer the question by stressing that *efforts to address such problems are marginalized in school policy and daily practice.* We emphasize that most programs, services, and special projects providing learning supports at a school and districtwide are treated as nonessentials. The following may happen as a result:

- Planning and implementation often are done on an ad hoc basis.
- Staff tend to function in relative isolation of each other and other stakeholders, with a great deal of the work oriented to discrete problems and with an overreliance on specialized services for individuals and small groups.
- In some schools, the deficiencies of current policies give rise to such aberrant practices as assigning a student identified as at risk for grade retention, dropout, and substance abuse to three counseling programs operating independently of each other. This fragmentation not only is costly, it works against cohesiveness and maximizing results.

We note that the fragmentation is compounded by most school-linked services initiatives. This happens because such initiatives focus primarily on coordinating *community* services and *linking* them to schools using a colocation model rather than integrating such services with the ongoing efforts of school staff. Reformers often offer the notions of *Family Resource Centers* and *Full-Service Schools* to link community resources to schools and coordinate services. Clearly, much more fundamental changes are needed.

We also stress that reforms often focus only on fragmentation, which is a symptom not a cause of the poor impact of student support programs. The result is an overreliance on enhancing coordination as a solution. Better coordination is a good idea. But this one-factor solution ignores the ongoing marginalization of school-owned student supports. And it does little to enhance the involvement of a full range of community resources.

The marginalized status and associated fragmentation of efforts to address student problems are long-standing and ongoing. The situation is unlikely to change as long as reforms continue to ignore the need to rethink the work of student support professionals. Most school improvement plans do not focus on using such staff to develop a comprehensive, multifaceted, and integrated approach for addressing the many overlapping barriers to learning, development, and teaching.

Also, mediating against developing schoolwide approaches to address factors interfering with learning and teaching is the way in which these matters are handled in providing on-the-job education. Little or none of a teacher's inservice training focuses on improving classroom and schoolwide approaches for dealing effectively with mild-to-moderate behavior, learning, and emotional problems. Paraprofessionals, aides, and volunteers working in classrooms or with special school projects and services receive little training and/or supervision before or after they are assigned duties. Plus, little or no attention is paid to inservice for student support staff.

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The time has come to change all this. New directions for student and learning supports must become a fundamental agenda item for school improvements. From an educational and a public health perspective, the need is for a full continuum of interventions and organized content conceived as an integrated system that braids together the resources of schools and communities.

As a colleague of ours often says, "All children want to be successful—let's give them a fighting chance." This requires *enabling* every student to have an equal opportunity to succeed at school and in life.

Our work has led us to understand that moving toward a comprehensive approach that fully embeds mental health and psychosocial concerns begins with an expanded policy for addressing barriers to learning and teaching. Then, school decision makers and planners must confront three other fundamental and interrelated matters—namely the following:

- Student-learning supports must be reframed into a unifying, comprehensive system of intervention.
- The organizational and operational infrastructure for schools, feeder patterns, districts, and school-community collaboration must be reworked to facilitate the development of a comprehensive system.
- New approaches must be adopted for planning necessary system changes and for sustaining and replicating them to scale.

Each of these will be discussed later in this book as we explore new directions and strategies for mental health in schools—strategies that create a school environment that promotes mental health and reduces learning, behavior, and emotional problems.

For more on this topic, see the following policy reports from the Center:

*School Improvement Planning: What's Missing?*

http://smhp.psych.ucla.edu/whatsmissing.htm

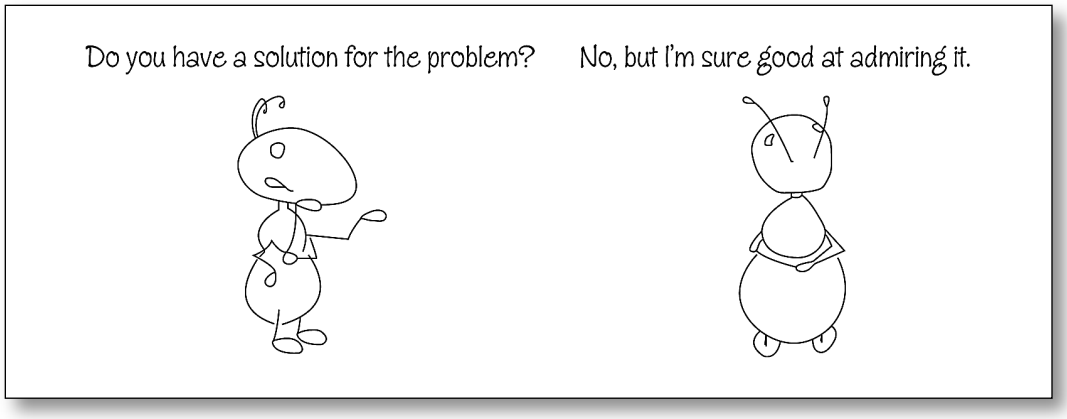
*Addressing What's Missing in School Improvement Planning: Expanding Standards and Accountability to Encompass an Enabling or Learning Supports Component*

http://smhp.psych.ucla.edu/pdfdocs/enabling/standards.pdf

*Another Initiative? Where Does It Fit? A Unifying Framework and an Integrated Infrastructure for Schools to Address Barriers to Learning and Promote Healthy Development*

http://smhp.psych.ucla.edu/pdfdocs/infrastructure/anotherinitiative-exec.pdf

Also see *The School Leader's Guide to Student Learning Supports: New Directions for Addressing Barriers to Learning* (2006d) by Howard Adelman and Linda Taylor (published by Corwin).



# PART II

# *Three Major Issues Confronting the Field*

*In the last analysis, we see only what we are ready to see. We eliminate and ignore everything that is not part of our prejudices.*

—Jean-Martin Charcot (1857)

Not long ago a group in Virginia called for the removal of counselors from their elementary schools. The group argued the following: (1) school counselors introduce matters to their children that are inappropriate, such as child abuse, death, and opposite-sex relationships, and (2) schools should not be centers for mental health and should focus solely on academics.

In response, teachers and counselors launched a counter campaign. They stressed the need for support services in schools by noting the many problems students experience that must be addressed in order to succeed.

The incident underscores that mental health in schools remains highly controversial in some places and that certain practices may be controversial almost anywhere. Those who support mental health in schools must understand the issues and problems and be prepared to help schools make decisions about how to address them.

In this section, we explore three fundamental matters that highlight why the field is controversial. These matters permeate the field and represent ongoing challenges in moving forward.

# 3

# *Labeling, Screening, and Over-Pathologizing*

*Normality and exceptionality (or deviance) are not absolutes; both are culturally defined by particular societies at particular times for particular purposes.*

—Ruth Benedict (1934)

*Consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one high school crisis is followed by another, we concentrate on the particular people involved—their values, their character, their personal failings—rather than asking whether something about the system in which these students find themselves might also need to be addressed.*

—Alfie Kohn (1999)

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes, the images are useful generalizations; sometimes, they are harmful stereotypes. Sometimes, they guide practitioners toward good ways to help; sometimes, they contribute to *blaming the victim*—making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal

disorders. Thus, terms such as *attention deficit hyperactivity disorder* (ADHD), *depression,* and *learning disabilities* (LD) are used increasingly. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had differed in appropriate ways.

**Concern**

***Misdiagnosis***

Of particular concern for schools is the widespread *misuse of the terms ADHD and LD.* This includes nonprofessional applications of these labels and the reality of misdiagnoses. Almost 50% of those assigned a special education diagnosis are identified as having learning disabilities. This has contributed to the backlash to LD seen in the move toward response to intervention that emerged from the last reauthorization of the Individuals with Disabilities Education Act (retitled the Individuals with Disabilities Education Improvement Act but still widely referred to as IDEA). Concern also is on the rise about the number of youngsters who manifest *garden-variety* misbehavior who may be misdiagnosed as ADHD. Reports appear rather regularly that suggest a growing backlash, especially as related to the increasing use of medication to treat children. For example, research from the Eastern Virginia Medical School reports significant overdiagnosis; this led to hearings and community forums and a bill by the legislature prohibiting school personnel from recommending psychotropic medications for students.

## DIAGNOSING BEHAVIORAL, EMOTIONAL, AND LEARNING PROBLEMS

As we stressed in Part I, prevailing formal systems used to classify problems in human functioning convey the impression that all behavioral, emotional, or learning problems are instigated by internal pathology. Some efforts to temper this notion see the pathology as a vulnerability that only becomes evident under stress. However, most differential diagnoses of children's problems still are made by focusing on identifying specific disorders (e.g., oppositional defiant disorder, ADHD, or adjustment disorders), rather than first asking, *Is there a disorder?*

Bias toward labeling problems in terms of personal rather than social causation is bolstered by factors such as (1) attributional bias—a tendency for observers to perceive others' problems as rooted in stable personal dispositions and (2) economic and political influences—whereby society's current priorities and other extrinsic forces shape professional practice.

Overemphasis on classifying problems in terms of personal pathology skews theory, research, practice, and public policy. For instance, comprehensive classification systems do not exist for environmentally caused problems or for psychosocial problems (caused by the transaction of internal and environmental factors). As a result, these matters often are deemphasized in assessing cause.

The irony is that so many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature versus nurture biases in thinking about problems, it helps to approach diagnostic classification guided by a broad perspective of what determines human behavior.

## THE DEBATE ABOUT THE ROLE OF SCHOOLS IN SCREENING

Reasonable concern for the well-being of children and adolescents and the need to address barriers to learning and teaching has led schools to deploy resources to deal with a variety of health and psychosocial matters (e.g., bullying, depression, suicide, ADHD, LD, obesity). Some of the activity is helpful; some is not; some has unintended negative consequences. And concerns arise.

*Are schools colluding with practices that sensationalize and pathologically label young people's behavior?*

*Should schools be involved in universal, first-level screening for behavior and emotional problems?*

We all have experienced the tendency to generalize from extreme and rare incidents. While one school shooting is too many, fortunately few students ever act out in this way. One suicide is too many; fortunately, few students take their own life. Some young people commit violent crimes, but the numbers are far fewer than news media convey, and the trajectory is downward.

No one is likely to argue against the value of preventing violence, suicide, and other mental heath and psychosocial concerns. In recent years, schools have been increasingly vigilant about potential violent incidents on campus. Even so, policy makers conflict over whether schools should play an institutionalized role in screening for mental health problems. Issues arise around the following:

*Is such monitoring an appropriate role for schools to play?*

*If so, what procedures are appropriate, and who should do it?*

*If so, how will schools avoid doing more harm than good in the process?*

In discussing these issues, concerns are raised about (1) the lack of evidence supporting the ability to predict who will and won't be violent or commit suicide; (2) what will be done to those identified as *threats* or *at risk*, including a host of due process considerations; (3) whether the procedures are antithetical to the schools education mission; and (4) the negative impact on the school environment of additional procedures that are more oriented to policing and monitoring than to creating school environments that foster caring and a sense of community.

Concerns also arise about parental consent, privacy and confidentiality protections, staff qualifications, involvement of peers, negative consequences of monitoring (especially for students who are false positive identifications), and access and availability of appropriate assistance.

Examples of often heard pro and con positions are as follows:

- School personnel are well situated to keep an eye on kids who are *risky* or *at risk.*
- Teachers can't take on another task and aren't qualified to monitor such students.
- Such monitoring can be done by qualified student support staff.
- Monitoring infringes on the rights of families and students.
- It's irresponsible not to monitor anyone who is *risky* or *at risk.*
- It's inappropriate to encourage kids to *spy* on each other.
- Monitoring is needed so that steps can be taken to help quickly.
- Monitoring has too many negative effects.

**Concern**

***Screening and Profiling***

With growing interest in expanding preschool education programs comes an increasing reemphasis on *early-age screening for behavioral, emotional, and learning disabilities,* (e.g., enhancing Early Periodic Screening, Diagnosis, and Treatment [EPSDT]) and screening programs in Head Start and kindergarten.

- *Drug testing at school has long been advocated as a way to deter drug use.*
- *Student-threat profiling is proposed as a way to prevent school violence.*
- *Schools are called on to screen for suicide risk.*

On a regular basis, legislators at federal and state levels express concern about some facet of the agenda for mental health in schools. An ongoing debate focuses on the role of public schools in screening for mental health and psychosocial problems.

Advocates for primary and secondary prevention want to predict and identify problems early. Large-scale screening programs, however, can produce many false positives, lead to premature prescription of *deep end* interventions, focus mainly on the role of factors residing in the child and thus collude with tendencies to *blame victims,* and so forth. As with most debates, those in favor emphasize benefits (e.g., "Screening lets us identify problems early, and can help prevent problems such as suicide."). Those against stress costs. For example, one state legislator is quoted as saying, "We want all of our citizens to have access to mental health services, but the idea that we are going to run everyone through some screening system with who knows what kind of values applied to them is unacceptable."

*(Continued)*

(Continued)

With respect to drug testing at school, in an article from the New York Times Online, Lloyd Johnston and colleagues at the University of Michigan have reported the first major study (76,000 students nationwide) on the impact of drug testing in schools. They conclude such testing does not deter student drug use any more than doing no screening at all. Based on the study's findings, Dr. Johnston states, "It's the kind of intervention that doesn't win the hearts and minds of children. I don't think it brings about any constructive changes in their attitudes about drugs or their belief in the dangers associated with using them" (Winter, 2003). At the same time, he stresses, "One could imagine situations where drug testing could be effective, if you impose it in a sufficiently draconian manner—that is, testing most kids and doing it frequently. We're not in a position to say that wouldn't work" (Winter, 2003). Graham Boyd, director of the ACLU Drug Policy Litigation Project who argued against drug testing before the Supreme Court last year, said, "In light of these findings, schools should be hard-pressed to implement or continue a policy that is intrusive and even insulting for their students" (Winter, 2003). But other researchers contend that the urinalysis conducted by schools is so faulty, the supervision so lax, and the opportunities for cheating so plentiful that the study may prove only that schools do a poor job of testing. Also noted is that the Michigan study does not differentiate between schools that do intensive, regular, random screening and those that test only occasionally. As a result, the findings do not rule out the possibility that the most vigilant schools do a better job of curbing drug use.

Those arguing that schools should screen emphasize the need to monitor anyone at risk or who is a risk to others in order to intervene quickly. They state that school personnel are well situated to screen students and with training can screen effectively using appropriate safeguards for privacy and confidentiality. Moreover, proponents believe that positive benefits outweigh any negative effects.

A central argument against screening students to identify threats and risks is that the practice infringes on the rights of families and students. Other arguments stress the following: teachers should not be distracted from teaching; teachers and other nonclinically trained school staff are ill equipped to monitor and make such identifications; existing monitoring practices are primarily effective in following those who have already attempted suicide or have acted violently and that monitoring others has too many negative effects (e.g., costs can outweigh potential benefits).

For more on all this, see the Center's Online Clearinghouse Quick Find topics:

*Assessment and Screening*—http://smhp.psych.ucla.edu/qf/p1405_01.htm

*Stigma Reduction*—http://smhp.psych.ucla.edu/qf/stigma.htm

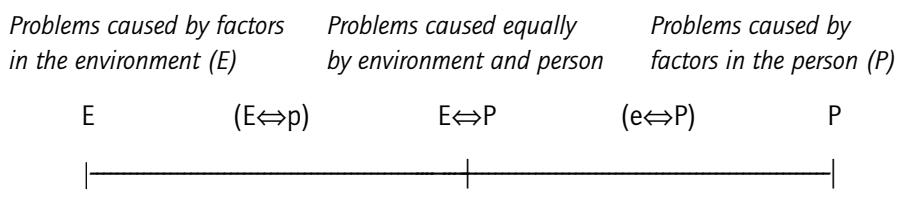
## NEEDED: A BROADER CLASSIFICATION FRAMEWORK

The need to address a wider range of variables in labeling problems is seen in efforts to develop multifaceted systems. The multiaxial classification system developed by the American Psychiatric Association in its recent editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) represents the dominant approach. This system does include a dimension acknowledging *psychosocial stressors*. However, this dimension is used mostly to deal with the environment as a contributing factor rather than as a primary cause.

The conceptual example illustrated in Exhibit 8 is a broad framework that offers a useful starting place for classifying behavioral, emotional, and learning problems in ways that avoid overdiagnosing internal pathology. As outlined in the exhibit, such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

**Exhibit 8** A Continuum of Problems Based on a Broad Understanding of Cause*

PRIMARY SOURCE OF CAUSE




| *Type I Problems* | *Type II Problems* | *Type III Problems (e.g., LD, ADHD, other disorders)* |
|---|---|---|
| • Caused primarily by environments and systems that are deficient and/or hostile | • Caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology) | • Caused primarily by personal factors of a pathological nature |
| • Problems are mild to moderately severe and narrow to moderately pervasive | • Problems are mild to moderately severe and pervasive | • Problems are moderate to profoundly severe and moderate to broadly pervasive |

*Using a transactional view, the continuum emphasizes the *primary source* of the problem and in each case is concerned with problems that are beyond the early stage of onset.

Problems caused by the environment are placed at one end of the continuum and referred to as Type I problems. At the other end are problems caused primarily by pathology within the person; these are designated as Type III problems. In the middle are problems stemming from a relatively equal contribution of environmental and person sources, labeled Type II problems.

To be more specific, in this scheme, diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category. Obviously, some problems caused by pathological conditions within a person are not manifested in severe, pervasive ways, and there are persons without such pathology whose problems do become severe and pervasive. The intent is not to ignore these individuals. As a first categorization step, however, they must not be confused with those seen as having Type III problems.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of personal characteristics and failure of the environment to accommodate that individual.

Of course, variations occur along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies.

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating problems. Furthermore, some problems are not easily assessed or do not fall readily into a group due to data limitations and individuals who have more than one problem (i.e., comorbidity). However, the above scheme shows the value of starting with a broad model of cause. In particular, the continuum helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual. This can help combat tendencies toward blaming the victim. It also helps highlight the notion that improving the way the environment accommodates individual differences often may be a sufficient intervention strategy.

**Using Response to Intervention to Minimize False Identification**

By now, most people working in and with schools have heard about response to intervention (RtI). The process is proposed as a corrective to misdiagnosis and first-level screening. However, considerable differences arise in how the concept is discussed by school policy makers and practitioners. With respect to operationalizing the process, two extremes can be identified. One mainly stresses the introduction of better (i.e., evidence-based) instruction and using the intervention to clarify whether the problem stems from a teaching deficit or if a referral is needed for disability assessment. At the other extreme, the emphasis is on proceeding in stages beginning with personalized instruction designed to enhance a better match with the learner's current motivation and capabilities and as necessary, sequencing in a hierarchical way to (1) develop missing learning and performance prerequisites and/or (2) provide needed specialized interventions that can address other existing barriers to learning (both external and internal barriers).

## ADDRESSING THE FULL RANGE OF PROBLEMS AND POTENTIAL BARRIERS TO HEALTHY DEVELOPMENT AND LEARNING

Amelioration of the full continuum of problems requires a comprehensive continuum of interventions. The continuum ranges from programs for primary prevention, including the promotion of mental health, and early-age intervention—through those for addressing problems soon after onset—to treatments for severe and chronic problems. The range of programs highlights that many problems must be addressed developmentally and with a wide spectrum of programs—some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. With respect to concerns about integrating programs, the continuum underscores the need for concurrent inter-program linkages and for linkages over extended periods of time.

The continuum also recognizes the full nature and scope of factors that can lead to problems. In particular, care is taken not to lose sight of research findings indicating that the primary causes for most youngsters' behavior, learning, and emotional problems are external factors related to neighborhood, family, school, and/or peers. Problems stemming from individual disorders and differences affect only a few. An appreciation of the research on the role played by external and internal factors makes a focus on such matters a major part of any effort to address the needs of all students.

**Examples of Risk-Producing Conditions That Can Become Barriers to Healthy Development and Learning**

| *Environmental Conditions** | | | *Personal Factors** |
|---|---|---|---|
| *Neighborhood* | *Family* | *School and Peers* | *Individual* |
| • Extreme economic deprivation<br>• Community disorganization, including high levels of mobility<br>• Violence, drugs, and so on<br>• Minority and/or immigrant status | • Chronic poverty<br>• Conflict, disruptions, violence<br>• Substance abuse<br>• Models problem behavior<br>• Abusive caretaking<br>• Inadequate provision for quality child care | • Poor quality school<br>• Negative encounters with teachers<br>• Negative encounters with peers and/or inappropriate peer models | • Medical problems<br>• Low birth weight/ neurodevelopmental delay<br>• Psychophysiological problems<br>• Difficult temperament & adjustment problems<br>• Inadequate nutrition |

*A reciprocal determinist view of behavior recognizes the interplay of environment and personal variables.

## CONCLUDING COMMENTS

Strong images are associated with diagnostic labels, and people act upon these notions. Sometimes, the images are useful generalizations, but often they are harmful stereotypes. Sometimes, they guide practitioners toward good ways to help. But often, they contribute to *blaming the victim* by making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem. In all cases, diagnostic labels can profoundly shape a person's future.

A large number of young people are unhappy and emotionally upset; only a small percentage are clinically depressed. A large number of youngsters behave in ways that distress others; only a small percentage have ADHD or a conduct disorder. In some schools, the majority of students have garden-variety learning problems; only a few have learning disabilities. Thankfully, those suffering from true internal pathology (those referred to above as Type III problems) represent a relatively small segment of the population. Society must never stop providing the best services it can for such individuals, and doing so means taking great care not to misdiagnose others whose *symptoms* may be similar but are caused to a significant degree by factors other than internal pathology (those referred to above as Type I and II problems).

As community agencies and schools struggle to find ways to finance programs for troubled and troubling youth, they continue to tap into resources

that require assigning youngsters labels conveying severe pathology. Reimbursement for mental health and special education interventions is tied to such diagnoses. The situation dramatically illustrates how social policy shapes decisions about who receives assistance and the ways in which problems are addressed. Labeling young people also represents a major ethical dilemma for practitioners. That dilemma is not whether to use labels but rather how to resist the pressure to inappropriately use labels that yield reimbursement from third-party payers.

Misdiagnoses lead to policies and practices that exhaust available resources and serve a relatively small percentage of those in need. That is one reason why resources are sparse for addressing the barriers interfering with the education and healthy development of so many youngsters who are seen as troubled and troubling.

For these and other reasons, considerable criticism exists about some diagnostic labels, especially those applied to young children. Nevertheless, sound reasons underlie the desire to differentially label problems. One reason is that if properly identified, some can be prevented; another is that proper identification can enhance correction.

However, the labeling process remains difficult. Severity has been the most common factor used to distinguish many student problems (e.g., ADHD and LD) from the many commonplace behavior, learning, and emotional problems that permeate schools. Besides severity, concern exists about how pervasive the problem is (e.g., how far behind an individual lags in academic and social skills). Specific criteria for judging severity and pervasiveness depend on prevailing age, gender, subculture, and social status expectations. Also important is how long the problem has persisted.

Because of the dramatic increase in misdiagnoses over the last 20 years, *response to intervention* is offered as a precursor and aid in differentiating commonplace problems from individual pathology. As we suggest in a subsequent chapter, however, mobilizing unmotivated students remains a core difficulty in using this process to rule out whether a student has a true disability or disorder. Schools must do even more to counter inappropriate labeling (see Exhibit 9).

**Exhibit 9** **Are Schools Doing Enough to Counter Inappropriate Labeling of Students?**

1. Are student support staff doing the following?
   - Providing general information about the wide range of *normal* behavior and individual differences and the importance of not over-pathologizing (e.g., distributing information and fact sheets, offering information as part of a school's inservice program)
     - See *Bias in Psychiatric Diagnosis* (2004) by P. J. Caplan & L. Cosgrove (Eds.)

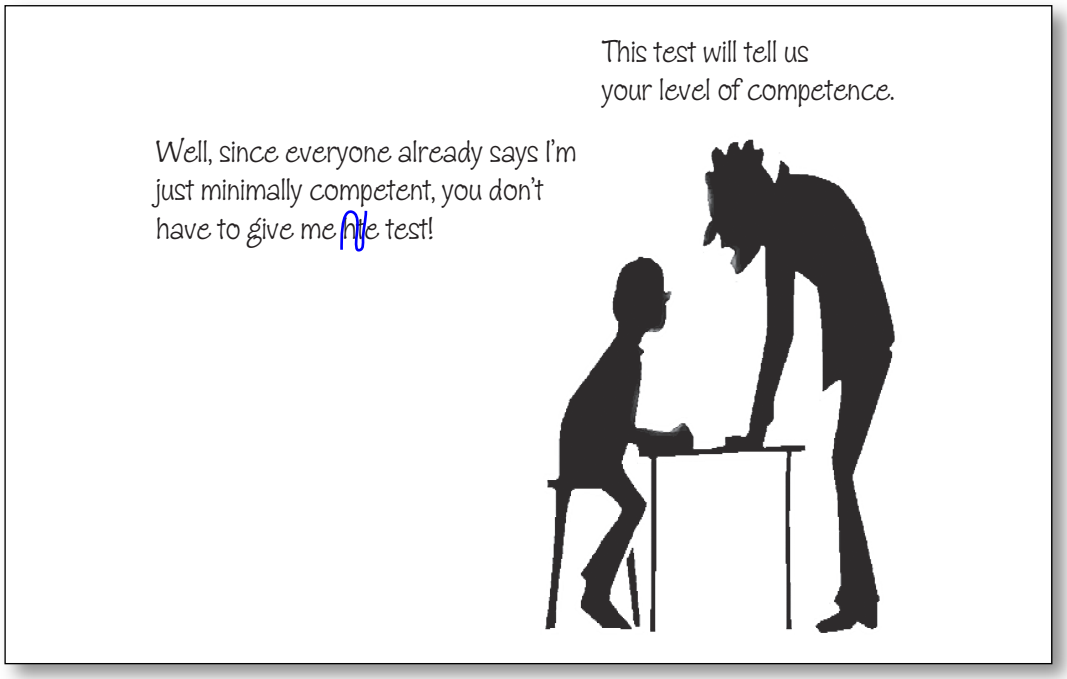
*(Continued)*

(Continued)

- Offering specific feedback on specific incidents and students (e.g., using staff concerns and specific referrals as opportunities to educate them about what is and is not pathological and what should be done in each instance)
  - See *Guidebook on Common Psychosocial Problems of School Aged Youth: Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment* http://smhp.psych.ucla.edu/pdfdocs/psysocial/entirepacket.pdf
  - See *Revisiting Learning & Behavior Problems: Moving Schools Forward* http://smhp.psych.ucla.edu/pdfdocs/contedu/revisitinglearning.pdf
- Resisting the pull of special funding (One of the hardest things to do is avoid using the need for funds and other resources as justification for interpreting a student's actions as *pathological*.)
  - See *The Impact of Fiscal Incentives on Student Disability Rates* (1999) by Julie Berry Cullen, National Bureau of Economic Research, Working Paper 7173. http://www.nber.org/papers/w7173
  - See *Effects of Funding Incentives on Special Education Enrollment* (2002) by J. P. Greene, & G. Forster, Manhattan Institute for Policy Research http://www.manhattan-institute.org/html/cr_32.htm
- Using the least intervention appropriate when students require special assistance
  - See *Least Intervention Needed: Toward Appropriate Inclusion of Students With Special Needs* http://smhp.psych.ucla.edu/pdfdocs/leastint/leastint.pdf

2. Is there a focus in the professional development of teachers to ensure they have the knowledge and skills to do the following?
   - Engage all students in learning
   - Reengage students who have become disengaged from classroom learning
   - Accommodate a wider range of individual differences when teaching
   - Use classroom assessments that better inform teaching
     - See *Reengaging Students in Learning* (Quick Training Aid) http://smhp.psych.ucla.edu/pdfdocs/quicktraining/reengagingstudents.pdf
     - See *Reengaging Students in Learning at School* (article) http://smhp.psych.ucla.edu/pdfdocs/Newsletter/winter02.pdf
     - See *Enhancing Classroom Approaches for Addressing Barriers to Learning: Classroom-Focused Enabling* (Continuing Education Modules) http://smhp.psych.ucla.edu/pdfdocs/contedu/cfe.pdf

As Nicholas Hobbs (1975) stressed many years ago, "Society defines what is exceptional or deviant, and appropriate treatments are designed quite as much to protect society as they are to help the child. . . . To take care of them can and should be read with two meanings: to give children help and to exclude them from the community" (pp. 20–21). Clearly, the trend to over-pathologize students contributes more to the latter than to the former.


This test will tell us
your level of competence.
Well, since everyone already says I'm just minimally competent, you don't have to give me the test!

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# 4

# *Evidence-Based Practices in Schools*

## *Concerns About Fit and Implementation*

*Effective practices typically evolve over a long period in high-functioning, fully engaged systems.*

—Tom Vander Ark (2002)

Another project, another program, another initiative to address students' behavior, learning, and emotional problems, make school safe, and promote healthy development. The following are two questions that the field must answer:

*What's the evidence that it works?*

*How does it all fit together?*

These are pressing matters for efforts to improve schools. And they are fraught with controversy.

Increasingly, proposals for adding another program, project, or initiative have been met with the demand that schools adopt practices that are evidence based.

As a result, terms such as *science based* or *empirically supported* are assigned to almost any intervention identified with data generated in ways that meet *scientific standards* and that demonstrate a level of *efficacy* deemed worthy of application (see Exhibit 10).

**Exhibit 10 Finding Information About Evidence-Based Practices**

Information about evidence-based programs for prevention, early intervention, and treatment are available from the Center's Quick Find Online Clearinghouse and from our Resource Packets (free online) at http://smhp.psych.ucla.edu/.

Examples of Topics:

*Program/Process Concerns*

- Violence Prevention and Safe Schools
- Screening and Assessing Students: Indicators and Tools
- Responding to Crisis at a School
- Behavioral Initiatives in Broad Perspective
- Least Intervention Needed: Toward Appropriate Inclusion of Students With Special Needs
- Parent and Home Involvement in Schools
- Assessing to Address Barriers to Learning
- Cultural Concerns in Addressing Barriers to Learning
- Early Development and Learning from the Perspective of Addressing Barriers
- Transitions: Turning Risks Into Opportunities for Student Support
- School-Based Client Consultation, Referral, and Management of Care
- School-Based Mutual Support Groups (for Parents, Staff, Older Students)
- Volunteers to Help Teachers and School Address Barriers to Learning
- Welcoming and Involving New Students and Families
- After-School Programs and Addressing Barriers to Learning
- Resource Mapping and Management to Address Barriers to Learning: An Intervention for Systemic Change
- Evaluation and Accountability Related to Mental Health in Schools

*Psychosocial Concerns*

- Attention Problems: Intervention and Resources
- Affect and Mood Problems Related to School-Aged Youth
- Anxiety, Fears, Phobias, and Related Problems: Intervention and Resources for School-Aged Youth
- Autism Spectrum Disorders and Schools
- Conduct and Behavior Problems in School-Aged Youth
- Dropout Prevention
- Learning Problems and Learning Disabilities

*(Continued)*

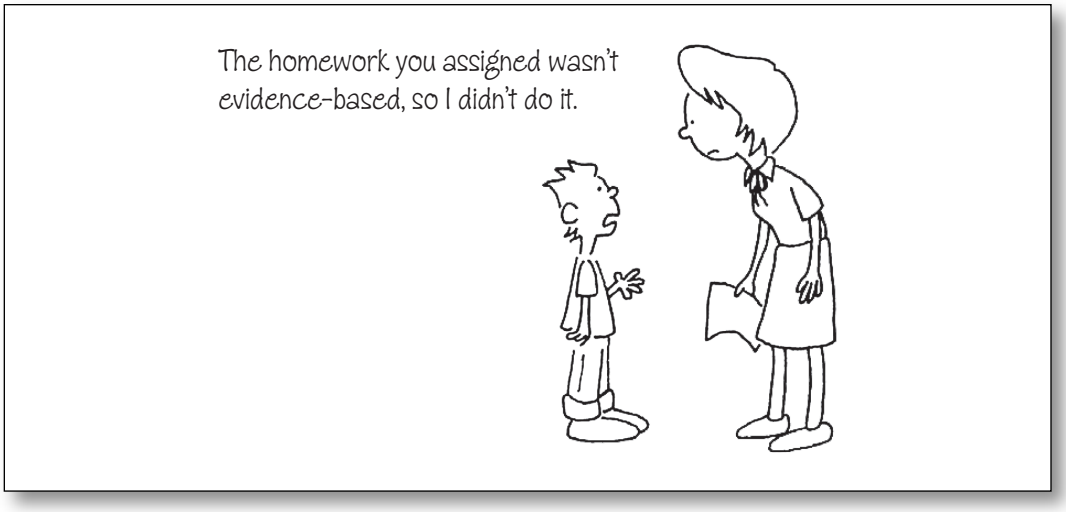
(Continued)

- Protective Factors (Resiliency)
- Preventing Youth Suicide
- Teen Pregnancy Prevention and Support
- Social and Interpersonal Problems Related to School-Aged Youth
- Substance Abuse
- Sexual Minority Students

Also see Chapter 14 for an annotated listing of compilations of empirically supported and evidence-based interventions for school-aged children and adolescents; also online at http://smhp.psych.ucla.edu/pdfdocs/aboutmh/annotatedlist.pdf

A somewhat higher standard is used for the subgroup of practices referred to as evidence-based *treatments*. This designation usually is reserved for interventions tested in more than one rigorous study (multiple case studies, randomized control trials) and consistently found better than a placebo or no treatment.

Currently, most evidence-based practices are discrete interventions designed to meet specified needs. A few are complex sets of interventions intended to meet multifaceted needs, and these usually are referred to as programs. Most evidence-based practices are applied using a detailed guide or manual and are time limited.




## CONCERNS AND CONTROVERSIES

No one argues against using the best science available to improve professional expertise. However, the evidence-based practices movement is reshaping mental health in schools in ways that raise concerns. For example, as suggested in the previous chapter, there is a skewed emphasis on gathering evidence for practices that focus on individual pathology.

From a school perspective, a central concern is that practices developed under highly controlled laboratory conditions are pushed prematurely into widespread application based on unwarranted assumptions. This concern is especially salient when the evidence base comes from short-term studies and has not included samples representing major subgroups with which the practice is to be used.

Until researchers demonstrate a prototype is effective under *real world* conditions, it can only be considered a promising and not a proven practice. Even then, best practice determination must be made.

With respect to the designation of *best,* remember that best simply denotes that a practice is better than whatever else is currently available. How *good* the practice is depends on complex analyses related to costs and benefits.

As the evidence-based movement gains momentum, an increasing concern is that certain interventions are officially prescribed and others are proscribed by policy makers and funders. This breeds fear that only those practitioners who adhere to official lists are sanctioned and rewarded.

For purposes of our discussion here, we start with the assumption that evidence exists that a practice is good, and advocates want schools to adopt it. In such cases, the question for decision makers is, "How well does it *fit* into efforts to improve schools?" If the answer is positive, the problem becomes how to *implement* the practice in an optimal way.

Policy and practice analyses conducted by our center have explored concerns about fit and implementation. We briefly highlight some major points here.

**Controversy**

***Can Schools Wait for Empirical Support?***

Given the need to address psychosocial and mental health concerns, can schools afford to wait for research support? Should they drop activity where not enough sound research is available (e.g., approaches that address problems in noncategorical ways; schoolwide approaches; comprehensive, multifaceted approaches)? In general, the potential *tyranny* of evidence-based practices is a growing concern, and the possibility that overemphasizing such programs can inadvertently undermine rather than enhance schoolwide reform efforts. Virtually no evidence exists that evidence-based practices contribute to overall school effectiveness, and ironically, little data on the matter are gathered.

## ANOTHER INTERVENTION—WHERE AND HOW DOES IT FIT?

In isolation, evidence-based interventions are viewed only in terms of advancing the state of the art. From a systemic and public policy perspective, however, introducing any new practice into an organization such as a school requires justification in terms of how well it fits into and can advance the organization's mission.

For schools trying to improve how they address barriers to learning and teaching, we suggest that a proposed practice should contribute to *developing* a comprehensive system of student supports. From this perspective, school decision makers must consider whether the practice is designed to do the following:

- Replace a necessary, but ineffective practice
- Fill a high-priority gap in a school's efforts to meet its mission
- Integrate into school improvement efforts
- Promote healthy development, prevent problems, respond early after problem onset, or treat chronic problems
- Help many not just a few students
- Integrate into a comprehensive continuum of interventions rather than become another fragmented approach

To appreciate the importance of these matters, review the discussion of the current state of the art in Part I. In doing so, note that dealing with behavior, learning, and emotional problems in schools involves two major considerations: (1) helping students address these barriers to performing well at school *and* (2) engaging and reengaging them in classroom instruction. Interventions that do not accomplish the second consideration generally are insufficient in sustaining student involvement, good behavior, effective learning at school, and general well-being.

Just adding evidence-based practices, then, does not meet a school's needs. For schools, the fundamental concern is, *Does a practice contribute to development of a comprehensive system for addressing barriers to learning and teaching?*

In a practice guide for dropout prevention from the federal *What Works Clearinghouse*, the authors stress that while individual strategies clearly can help a few students, "the greatest success in reducing dropout rates will be achieved where multiple approaches are adopted as part of a comprehensive strategy to increase student engagement" (Dynarski et al., 2008, p. 5). They stress that "while dropping out typically occurs during high school, the disengagement process may begin much earlier and include academic, social, and behavioral components. The trajectory of a young person progressing in school begins in elementary grades, where students establish an interest in school and the academic and behavioral skills necessary to successfully proceed.

During the middle school years, students' interest in school and academic skills may begin to lag, so that by . . . high school, students . . . may need intensive individual support or other supports to reengage them. . . . Educators and policymakers need to consider how to implement intermediate strategies aimed at increasing student engagement." (Dynarski et al., 2008, 4)

p.

The guide offers six recommendations in the context of the following three categories:

- Diagnostic processes for identifying student level and schoolwide dropout problems
- Targeted interventions for a subset of middle and high school students who are identified as at risk of dropping out
- Schoolwide reforms designed to enhance engagement for all students and prevent dropout more generally

Dynarski, M., Clarke, L., Cobb, B., Finn, J., Rumberger, R., & Smink, J. (2008). *Dropout prevention: A practice guide.* Washington, DC: USDOE. http://ies.ed.gov/ncee/wwc/pdf/practiceguides/dp_pg_090308.pdf

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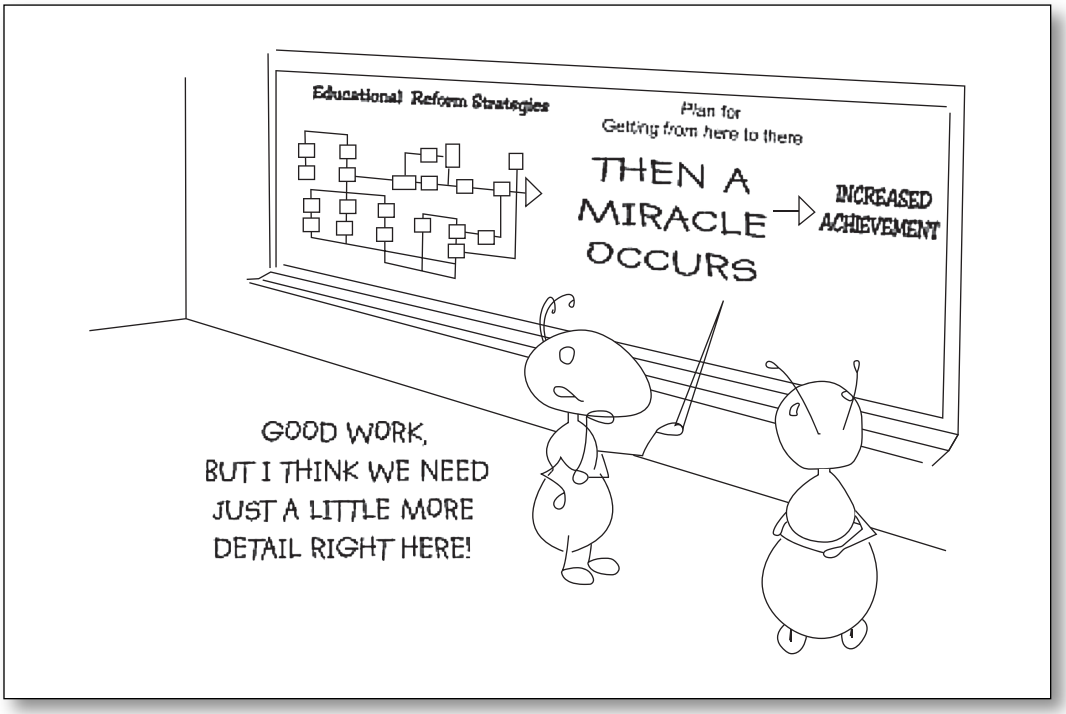
This brings us to the implementation problem.




## THE IMPLEMENTATION PROBLEM

When the decision is made to add any practice, implementation plans must be formulated for how best to integrate it into the organization. For schools, this should involve fully integrating the practice into school improvement plans for reframing

student-learning supports and weaving together school, community, and home resources. For school districts, additional concerns arise around planning for sustainability and equitable replication in all schools.

Implementing new practices requires careful planning based on sound intervention fundamentals. Key facets of the work include social marketing, articulation of a shared vision for the work, ensuring policy commitments, negotiating agreements among stakeholders, ensuring effective leadership, enhancing and developing an infrastructure (e.g., mechanisms for governance and priority setting, steering, operations, resource mapping, and coordination), redeploying resources and establishing new ones, building capacity (especially personnel development), establishing strategies for coping with the mobility of staff and other stakeholders, developing standards, and establishing formative and summative evaluation processes and accountability procedures.

Clearly, moving efficacious prototypes into the real world is complex. Unfortunately, for the most part, the complexities have not been well addressed.

As the National Implementation Research Network (2009) has stressed,

> . . . very little is known about the processes required to effectively implement evidence-based programs on a national scale. Research to support the implementation activities that are being used is even scarcer.

Early research on the implementation problem is directed at matters such as dissemination, readiness, fidelity and quality of implementation, generalizability, adaptation, sustainability, and replication to scale. All of these matters obviously are important.

However, for the most part, the implementation problem is studied with too limited a procedural framework and with too little attention to context. This results in skipping by fundamental considerations involved in moving evidence-based practices into common use.

**Controversy**

***Fidelity of Implementation or Meaningful Adaptation?***

Frequently reported failure to transfer empirically supported interventions into widespread daily school practice has increased focus on the *implementation* problem (sometimes discussed as the fidelity of replication problem). An emerging issue is whether it makes sense to frame the problem in such a manner. Critics suggest that expecting schools to adopt a program without adapting it to fit the specific setting is unrealistic and inappropriate (e.g., the need is to match the motivation and capacities of staff who will do the implementation). As Richard Price states, "Effective implementation depends not on exclusive and narrow adherence to researcher definitions of fidelity but also on mutual adaptation between the efficacious program features and needs and competencies of the host organization" (Price, 1997, p. 176).

The deficiencies of many implementation efforts become apparent when the process is conceived in terms of the complexities of (1) *diffusing innovations* and (2) doing so in the context of *organized systems* that have well-established institutional cultures and infrastructures. This calls for viewing the implementation problem from the vantage point of the growing bodies of literature on diffusion of innovations and systemic change. These two overlapping arenas provide the broad perspective necessary for advancing research associated with moving evidence-based practices into the real world. This broad perspective helps reframe the implementation problem as *a process of diffusing innovation through major systemic change.* Such a process encompasses the complexities of facilitating systemic changes for appropriate and effective adoption and adaptation at a particular site, as well as the added complexities of replication to scale (see Exhibit 11).

**Exhibit 11 Resistance, Reluctance, or Relevant Concerns?**

The following matters are often heard in schools when efforts are made to introduce some evidence-based practices:

"I don't believe their *evidence-based* intervention is better than what I do; they need to do the research on what I do before they claim theirs is better."

"That intervention is too narrow and specific to fit the problems I have to deal with."

"We wanted to use the grant money to enhance the work we already are doing, but we've been told we have to use it to buy evidence-based programs that we think don't really fit our needs."

"How do we know that if the school adopts this evidence-based program we will get the results they got in their research?"

"We have so many things we have to do now; when are we going to have time to learn these new practices?"

"They make it sound as if I am doing bad things. Soon, they will be suggesting that we are incompetent and need to be fired."

"I've heard that some of the highly touted science-based programs have been found not to work well when they are tried throughout a school district."

"I'm not taking the risk of giving up what I believe works until they prove their laboratory model does better than me out here in the real world."

Beyond these off-the-cuff remarks, more sophisticated concerns about the demand for adoption of evidence-based practices in schools come from policy makers and practitioners who are enmeshed

*(Continued)*

(Continued)

in transforming public education. In reacting to such concerns, researchers must be careful not to dismiss them as antiscientific and mindless resistance.

It is a truism that not everyone is ready for major changes in their lives. At the same time, not all concerns raised about proposed changes are simply resistance. The motivation for each of the above statements may simply reflect a desire not to change, or it may stem from a deep commitment to the best interests of schools and the students and families they serve. Still, such rhetoric has influenced interpretations about why achieving prototype fidelity in schools (and clinics) is so difficult.

Whatever the motivation, the controversies and concerns about what practices are appropriate and viable are major contextual variables affecting implementation. Their impact must be addressed as part of the process of implementation, especially in settings that have well-established institutional cultures and organizational and operational infrastructures.

Researchers need to avoid the blame game and appreciate the complexities of diffusing innovations and making major systemic changes. From such a vantage point, the focus shifts from "I'm right, and they're wrong" to "What haven't I done to promote readiness for change?"

## SOME KEY FACETS OF CHANGE

Michael Fullan (2005) stresses that effective change requires leadership that "motivates people to take on the complexities and anxieties of difficult change" (p. 104). We would add that such leadership also must develop a refined understanding of how to facilitate change.

Major elements involved in implementing empirically supported innovative practices in an institutional setting are logically connected to considerations about systemic change. That is, the same elements can frame key intervention concerns related to implementing the practice and making systemic changes, and each is intimately linked to the other.

At any given time, an organization may be involved in introducing one or more innovations at one or more sites; it may also be involved in replicating one or more prototypes on a large scale. The nature and scope of the activity and the priorities assigned by policy and decision makers are major factors influencing implementation. For example, the broader the scope, the higher the costs; the narrower the scope, the less the innovation may be important to an organization's overall mission. Both high costs and low valuing obviously can work against implementation and sustainability.

Critical to implementation, sustainability, and replication to scale is a well-designed and developed organizational and operational infrastructure. This includes *administrative leadership* and *infrastructure mechanisms* to facilitate changes

(e.g., well-trained change agents). Usually, existing infrastructure mechanisms must be modified to guarantee new practices are effectively operationalized.

A well-designed organizational and operational infrastructure ensures local ownership of innovations and a critical mass of committed stakeholders. Mechanisms pursue processes that overcome barriers to stakeholders working productively together and use strategies that mobilize and maintain proactive effort so that changes are implemented and renewed over time.

Whether the intent is to establish a prototype at one site or replicate it at many, systemic change involves four overlapping phases: (1) *creating readiness*—increasing a climate and culture for change through enhancing both the motivation and the capability of a critical mass of stakeholders, (2) *initial implementation*—change is phased in using a well-designed infrastructure for providing guidance and support and building capacity, (3) *institutionalization*—accomplished by an established infrastructure for maintaining and enhancing productive changes, and (4) *ongoing evolution and creative renewal*—through use of mechanisms to improve quality and provide continuing support in ways that enable stakeholders to become a community of learners who creatively pursue renewal.

Unsuccessful implementation and failure to sustain are associated with infrastructure deficits that are not addressed in ways that ensure major tasks related to these four phases are accomplished effectively. We discuss systemic change in more detail in Chapter 15.

## ABOUT READINESS FOR CHANGE

One of the most flagrant systemic change errors is failing to give sufficient attention and time to creating readiness. Effective systemic change begins with activity designed to create readiness in terms of both motivation and capability among a critical mass of key stakeholders.

Organization researchers in schools, corporations, and community agencies clarify factors for creating an effective climate for institutional change. In reviewing this literature, the following points are highly relevant to enhancing readiness for change:

- A high level of policy commitment that is translated into appropriate resources, including leadership, space, budget, and time
- Incentives for change, such as intrinsically valued outcomes, expectations for success, recognition, and rewards
- Procedural options from which those expected to implement change can select those they see as workable
- A willingness to establish mechanisms and processes that facilitate change efforts, such as a governance mechanism that adopts ways to improve organizational health
- Use of change agents who are perceived as pragmatic—maintaining ideals while embracing practical solutions

- Accomplishing change in stages and with realistic timelines
- Providing progress feedback
- Institutionalizing mechanisms to maintain and evolve changes and to generate periodic renewal

Enhancing readiness for and sustaining change involves ongoing attention to daily experiences. Stakeholders must perceive systemic changes in ways that make them feel they are valued and contributing to a collective identity, destiny, and vision. From the perspective of intrinsic motivation theory as outlined by Ed Deci and Richard Ryan (1985, 2002), both individual and collective work must be facilitated in ways that enhance feelings of competence, self-determination, and connectedness with and commitment to others and must minimize conditions that produce psychological reactance. From the perspective of theories about enhancing a sense of community and fostering empowerment, there is growing emphasis on understanding that empowerment is a multi-faceted concept. In this context, Stephanie Riger (1993) distinguishes *power over* from *power to* and *power from.* Power over involves explicit or implicit dominance over others and events; power to is seen as increased opportunities to act; power from implies ability to resist the power of others.

## CONCLUDING COMMENTS

Those who set out to implement evidence-based practices in schools are confronted with a complex set of tasks related to demonstrating *fit* and implementing systemic change. This is especially so because "the current evidence base . . . consists almost entirely of ['efficacy' studies] and very little 'effectiveness' research" (Green & Glasgow, 2006, p. 127).

A myriad of political and bureaucratic difficulties are involved in making institutional changes, especially with limited financial resources. The process rarely is straightforward, sequential, or linear. A high degree of commitment, relentlessness of effort, and realistic time frames are required.

Our intent at this point is only to foster greater appreciation for and more attention to concerns about fit and implementation as related to evidence-based practices. A more sophisticated approach is necessary to improve schools in general and address barriers to learning and teaching in particular. Chapter 15 amplifies the matter.

# 5

# *Social Control Versus Engagement in Learning*

## *A Mental Health Perspective*

*A SmartBrief sent out by the Association for Supervision and Curriculum Development (ASCD) states the following: Southern schools increasingly are requiring students to take "character" classes as part of an effort to combat disrespectful behavior. Louisiana lawmakers, for instance, recently passed "courtesy conduct" legislation that requires elementary students to address their teachers as "ma'am" and "sir."*

—*Association for Supervision and Curriculum* Development (2000) <rom>

Misbehavior disrupts. In some forms, such as bullying and intimidating others, it is hurtful. And observing such behavior may disinhibit others.

When a student misbehaves, a natural reaction is to want that youngster to experience and other students to see the consequences of misbehaving. One hope is that public awareness of consequences will deter subsequent problems. As a result, a considerable amount of time at schools is devoted to discipline; a common concern for teachers is *classroom management.*

In their efforts to deal with deviant and devious behavior and to create safe environments, the degree to which schools rely on social control strategies becomes a significant issue. For example, concerns have been raised that such