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Diverse Populations and Challenges

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Chapter 5

Mental Health in Schools: Opportunities and Challenges

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Mental health concerns must be addressed if schools are to function satisfactorily and students are to succeed at school. It has long been acknowledged that a variety of psychosocial and health problems affect student learning and performance in profound ways. School policy makers have a lengthy history of trying to assist teachers in dealing with a variety of problems that interfere with schooling. Prominent examples of efforts to assist are seen in the range of counseling, psychological, and social service programs schools provide (Adelman & Taylor, 2010). In addition to interventions by school support staff, there has been renewed emphasis in recent years on increasing linkages between schools and community service agencies. This "school-linked services" agenda has added impetus to advocacy for mental health in schools.

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

1. Schools need to address psychosocial and mental and physical health concerns to enable effective school performance by some (often many) students.

2. Schools can provide good access to students (and their families) who require mental health services.

Implied in both these points 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 (Adelman & Taylor, 2006a). Point 1 reflects the perspective and agenda of student support professionals and some leaders for school improvement, and also provides a supportive rationale for those wanting schools to play a greater role related to addressing young people's health concerns. Point 2 typically reflects the perspective and agenda of agencies and advocates whose mission is to improve mental health services.

In most places, mental health in schools still gets defined mainly as mental illness, and the form of intervention tends to be case-oriented and clinical. This provides services for only a relatively few of the many students experiencing behavior, learning, and emotional problems. It is fortunate that school personnel and/or colocated and linked community service providers are able to provide individual and small group counseling/therapy for some children and adolescents who need it. It is tragic, however, that not enough of these clinical services are equitably available and accessible. It is poignantly evident that the number of students in need far outstrips the possibility of providing more than a small percentage with clinical services even if this were the best way to address the wide range of concerns. Moreover, an overemphasis on clinical services tends to work against developing programs to prevent problems and promote social and emotional health (Adelman & Taylor 2006b; Kutash, Duchnowski, & Lynn, 2006).

A FULL CONTINUUM APPROACH

Schools need and provide a unique opportunity to develop a comprehensive system for addressing mental health and psychosocial concerns. Such a system is built around a full continuum of interventions. The continuum is conceived as an integrated set of subsystems for

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

The continuum encompasses approaches for enabling academic, social, emotional, and physical development and addressing learning, behavior, and emotional problems. It does so in ways that yield safe and caring schools. Such a range of interventions is intended to meet the needs of all students and, properly implemented, should significantly reduce the number of students requiring individual assistance.

Promoting Positive Mental Health and Preventing Problems

Interventions to promote mental health encompass not only strengthening individuals but also enhancing nurturing and supportive conditions at school, at home, and in the neighborhood. All this includes a particular emphasis on increasing opportunities for personal development and empowerment by promoting conditions that foster and strengthen positive attitudes and behaviors (e.g., enhancing motivation and capability to pursue positive goals, resist negative influences, and overcome barriers). It also includes efforts to maintain and enhance physical health and safety and inoculate against problems (e.g., providing positive and negative information, skill instruction, and fostering attitudes that build resistance and resilience).

Although schools alone are not solely responsible, they do play a significant role, albeit sometimes not a positive one, in social and emotional development. School improvement plans need to specify ways for schools to (a) directly facilitate social and emotional (as well as physical) development and (b) minimize threats to positive development. In doing such planning, appreciation of differences in levels of development and developmental demands at different ages is fundamental, as is personalized implementation to account for individual differences. From a mental health perspective, helpful guidelines are found in research clarifying normal trends for school-age youngsters as they strive to feel competent, self-determining, and connected with significant others (Deci & Moller, 2005). Further, measurement of such feelings can provide indicators of the impact of a school on mental health (Center for Mental Health in Schools, 2011a). Positive findings are expected to correlate with school engagement and academic progress. Negative findings are expected to correlate with student anxiety, fear, anger, alienation, a sense of losing control, a sense of impotence, hopelessness, and powerlessness. In turn, these negative thoughts, feelings, and attitudes can lead to externalizing (aggressive, "acting out") or internalizing (withdrawal, self-punishing, delusional) behaviors. Promoting mental health has definite payoffs both for academic performance and reducing problems at schools. Furthermore, promoting healthy development, well-being, and a value-based life are important ends unto themselves (Adelman & Taylor 2008a).

A number of specific concerns related to schoolwide mental health prevention include substance abuse, suicide, bullying, and violence. Another important topic for prevention in schools is dropout rates. There has been a great deal of investment in evaluation of effective prevention programs (see the U.S. Department of Education's *What Works Clearinghouse* at http://ies.ed.gov/ncee/wwc; see also Terzian, Hamilton, & Ling, 2011).

Intervening as Soon as a Problem Is Noted

School personnel identify many mental health problems each day and seek assistance when it is available. Some identified students are best served by helping

to ensure that appropriate interventions are implemented to minimize the need for referral. For example, problems that are mild to moderate often can be addressed through participation in programs that do not require special referral for admission. Examples are regular curriculum programs designed to foster positive mental health and socioemotional functioning; social, recreational, and other enrichment activities; and self-help and mutual support programs. Because anyone can apply directly, such interventions can be described as *open-enrollment* programs.

Other students require immediate referral. The process of connecting the student with appropriate help can be viewed as encompassing four facets:

1. Screening/assessment
2. Client consultation and referral
3. Triage
4. Monitoring/managing care (Adelman & Taylor, 2010)

Many schools do this work through a team (e.g., student assessment team). Given that there are never enough resources to serve those who need individual services, it is inevitable that the processing of such students will involve a form of triage (or gatekeeping) at some point. When referrals are made to on-site resources, it falls to the school to decide which students need immediate attention and which can be put on a waiting list. Schools can enhance access to external referral resources by cultivating school–community collaboration.

In general, when someone becomes concerned about a student's problems, the main consideration is ensuring the student is connected directly with someone who can help. This involves more than simply referring the student or parents to a resource. Efforts to connect students with effective help are significant interventions in and of themselves. Such an intervention begins with a consultation session involving the concerned parties (student, family, teacher, other school staff). Using all the information that has been gathered, the focus is on exploring what seems to be wrong and what to do about it. The aim is to detail the steps involved in connecting with potential assistance.

From the time a student is first identified as having a problem, someone must be assigned to monitor and manage the case. Monitoring continues until the student's intervention needs are addressed. Care management is basic to ensuring coordination among all involved (e.g., other services and programs including the efforts of the classroom teacher and those at home). The process encompasses a constant focus on evaluating intervention appropriateness and effectiveness.

Providing Support for Chronic and Serious Problems

According to a recent report, approximately 11% of children in the United States are diagnosed with emotional, behavioral, or developmental conditions, and a large number do not get the mental health services they need (U.S. Department of Health and Human Services, 2010). In schools, the federal special education act

mandates that schools create an *Individualized Education Plan* (IEP) for students who meet criteria for diagnosis related to physical, learning, and emotional disabilities. The intent in formulating such plans is to assist diagnosed students in an inclusive school environment so they are not isolated or excluded from regular students and important educational opportunities (e.g., situations that do not restrict and disrupt their development).

Special education stresses a continuum of interventions, with an emphasis on using the least disruptive intervention necessary to meet a student's needs. In the past, this often meant pulling the student from regular classrooms for certain instructional periods to receive more personalized instruction in a *resource room* with special education staff. For those needing more intensive help, full-time special education classes were commonly used. These classrooms might be in the regular public school or a special school in the district. If appropriate facilities were not available, the student might be funded to attend a private special education school (a nonpublic school).

Over the past few years, evaluation of special education outcomes has resulted in significant changes related to special education (Bryant, Deutsch, Smith, & Bryant, 2007). One fundamental change was the mandate for *inclusion*, which aims to keep special education students in regular classrooms by bringing in such resources as a resource teacher, a special education aid, and special equipment and supplies. Although the process of identifying students with special education needs is carefully delineated, the extensive misdiagnoses of learning disabilities and attention-deficit/hyperactivity disorder have generated a federal policy introducing *Response to Intervention* (RtI) as a method for minimizing premature testing, mislabeling, and consumption of sparse special education resources.

Recognition of the reality that students with chronic and severe problems often are involved with out-of-school interventions has led to efforts to connect all the activity into a system of care, sometimes referred to as a wraparound approach. Hodges, Ferreira, Israel, and Mazza (2007) stressed that such a system is an adaptive network of structures, processes, and relationships reflecting system of care values and principles that is designed to provide children and youth and their families with access to necessary services and supports across administrative and funding jurisdictions. Efforts to promote school and community coordination of interventions vary. A recent statewide example is seen in a Louisiana initiative to ensure that four child-serving agencies (i.e., education, children and family services, health, and juvenile justice) work together to better support youth with significant behavioral health needs).

The Continuum and Response to Intervention

As noted, RtI is a recent federal policy focus delineating a method for schools in responding to problems as soon as they are noted. This approach is being operationalized across the country with a significant push from the federal government. Properly conceived and implemented, the strategy is expected to improve

the learning opportunities for many and reduce the number inappropriately diagnosed with learning disabilities and behavioral disorders. The approach stresses a continuum of three tiers but does so primarily in terms of intensity of instruction (Center for Mental Health in Schools, 2011b). The method overlaps some ideas for what have been called prereferral interventions but is intended to be more systematically implemented. The aim is also to improve assessment for determining whether more intensive and perhaps specialized assistance and diagnosis are required (Brown-Chidsey & Steege, 2010).

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

Basic to making the strategy effective is truly personalized instruction and appropriate special assistance that can be used as necessary. Think in terms of a two-step process. Step 1 involves *personalizing instruction*. The intent is to ensure a student *perceives* instructional processes, content, and outcomes as a good match with his or her interests and capabilities. The first emphasis is on *motivation*. Thus, Step 1a stresses use of motivation-oriented strategies to (re)engage the student in classroom instruction. This step draws on the broad science-base related to human motivation, with special attention paid to research on intrinsic motivation and psychological reactance. The aim is to enhance student perceptions of significant options and involvement in decision making. The next concern is *developmental capabilities*. Thus:

Step 1 stresses use of teaching strategies that account for current knowledge and skills. In this respect, the emphasis on tutoring (designated as supplemental services in Title I) can be useful if the student perceives the tutoring as a good fit for learning. Then, if necessary, the focus expands to encompass **Step 2** *special assistance*. The emphasis is on special strategies to address any major barriers to learning and teaching. The process stresses the intervention principle of using the least intervention necessary for addressing needs. There will, of course, be students for whom all this is insufficient. In such cases, some other forms of supportive assistance must be added to the mix inside and, as necessary, outside the classroom. Referral for special education assessment only comes after all this is found inadequate.

A core difficulty in using RtI strategically involves mobilizing unmotivated students (particularly those who have become actively disengaged from classroom

instruction). If motivational considerations are not effectively addressed, there is no way to validly assess whether a student has a true disability or disorder. If RtI is treated simply as a matter of providing more and better instruction, it is unlikely to be effective for a great many students. However, if the strategies are understood broadly and as part and parcel of a comprehensive system of classroom and schoolwide learning supports, schools will be in a position not only to address problems effectively early after their onset but to prevent many from occurring. We stress that instruction must be supported by schoolwide interventions (e.g., related to providing supports for transitions, responding to and preventing crises, enhancing connections with the home, and more). Response to intervention needs to be part of a comprehensive system designed to reduce learning, behavior, and emotional problems, promote social/emotional development, and effectively reengage students in classroom learning. This will not only reduce the numbers who are inappropriately referred for special education or specialized services, it will also enhance attendance, reduce misbehavior, close the achievement gap, and enhance graduation rates.

A Note about Evidence-Based Interventions

In recent years, schools have been challenged to adopt practices that are evidence-based (Bandy & Moore, 2011). Increasingly, terms such as *science-based* or *empirically supported* are assigned to almost any intervention identified as having research data generated in ways that meet scientific standards and that demonstrates a level of *efficacy* deemed worthy of application (Raines, 2008). A somewhat higher standard is used for the subgroup of practices referred to as evidence-based *treatments*. This designation is usually 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. No one argues against using the best science available to improve professional expertise. However, the evidence-based practices movement is reshaping public policy in ways that have raised concerns. A central concern is that practices developed under highly controlled laboratory conditions are being 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 whom the practice is to be used.

Until researchers demonstrate a prototype is effective under real-world conditions (e.g., schools and classrooms), it can only be considered a promising and not a proven practice. Even then it must be determined whether it is one of the

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

As the evidence-based movement has gained 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 will be sanctioned and rewarded. In addition, we have heard widespread concerns raised about "flavor of the month" initiatives being introduced by schools, districts, and states. Although all are well intentioned, the tendency is to introduce them in an ad hoc and piecemeal manner and as add-ons. It is commonplace for those staffing the various efforts 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. This contributes to widespread fragmentation, counterproductive competition, and wasteful redundancy (Adelman & Taylor, 2008b).

Schools confronted with a large number of students experiencing barriers to learning pay dearly for the current state of affairs. Although specific evidence-based practices might be helpful, a few more services or programs will not equip most schools to ensure that all youngsters have an equal opportunity to succeed at school. For schools, the need is not just to add evidence-based practices; it is to do so in ways that contribute to development of a comprehensive system for addressing barriers to learning and teaching.

EMBEDDING MENTAL HEALTH INTO SCHOOL IMPROVEMENT POLICY AND PRACTICE

Earlier in this chapter, we highlighted the continuum of interventions relevant to mental health in schools. Operationalizing the continuum calls for organizing programs and services coherently at every level.

The Continuum Has Content

To enhance efforts across the continuum, pioneering work is underway to coalesce programs and services into a multifaceted and cohesive set of content arenas (Center for Mental Health in Schools, 2011c). In doing so, they have moved from a laundry list to a defined and organized way of capturing the essence of basic intervention domains. The prototype defines the following six content arenas as follows:

1. In the classroom: focuses on how the teacher and support staff affect student engagement and address students who are having difficulty with tasks. Specific emphasis is given to the following:

- Interventions to enhance engagement and minimize reducing engagement
- Interventions to reengage disconnected students
- Modifying instruction to fit those who are having difficulty
- Bringing support staff and volunteers into the classroom to work with the teacher in addressing engagement and instructional fit concerns

2. Transition support focuses on supports for the many transitions that occur daily and throughout the school year. For example, starting a new school is a critical transition period; so is changing schools. New personnel also need supports. In addressing newcomer transitions, for instance, schools need to have a well-designed and implemented welcoming program and mechanisms for ongoing social support (especially staff development) so that teachers, support staff, and other stakeholders can learn how to establish
   - Welcoming procedures
   - Social support networks
   - Proactive transition supports for family members, new staff, and any other newcomers
   - Training and resources to the members of the office staff so they can create a welcoming and supportive atmosphere to everyone who enters the school
3. Crisis prevention and response focuses on identifying what can be prevented and taking effective action, establishing appropriate schoolwide prevention strategies, and developing and implementing a well-designed system for crisis response and follow-up. From a psychological perspective, basic concerns are the degree to which experiences related to school
   - Enhance or threaten students' feelings of safety
   - Minimize threats to and maximize students' feelings of competence, self-determination, and connectedness with significant others (e.g., relationships between staff and students and among students)
   - Minimize overreliance on extrinsic reinforcers to enforce rules and control behavior or generate psychological reactance
4. In home involvement/engagement the stress is on home rather than parents to account for the variety of caretakers who schools may need to consider (including grandparents, siblings, foster caretakers). Although the value of home support for student schooling is well established, variations in caretaker motivation and ability to participate at school require a continuum of supports and outreach to any who are not able or motivated to positively support a child's success at school. Examples include interventions to
   - Address specific support and learning needs of the family
   - Enhance personalized communications with the home
   - Outreach positively to caretakers who have not shown the motivation and/or ability to connect with the school

- Involve all families in student decision making
- Provide effective programs to enhance home support for learning and development

5. Community outreach for involvement/engagement—focuses on recruiting and collaborating with a wide range of community resources (e.g., public and private agencies, colleges, local residents, artists and cultural institutions, businesses, service and volunteer organizations). Special attention is given to
   - Establishing mechanisms for outreach and collaboration
   - Building capacity for integrating volunteers into the school
   - Weaving together school and community resources
6. Specialized assistance for a student and family focuses on ensuring special needs are addressed appropriately and effectively. Special attention is given to ensuring there are systemic and effective processes for
   - Referral and triage
   - Providing extra support as soon as a need is recognized and in the best manner
   - Monitoring and managing special assistance
   - Evaluating outcomes

A Special Note about Involving Families in School Mental Health

When youngsters are referred for counseling, parent follow-through is estimated at less than 50%, and premature termination occurs in 40% to 60% of child cases (Kazdin, Holland, & Crowley, 1997). Clearly, not all parents feel that such counseling is worth pursuing. Even if they do enroll their child, dropping out in short order is likely if the family experiences the process as burdensome, unpleasant, or of little value. Conversely, children seem to do better when parents perceive few negatives related to the intervention and its potential outcomes (Kazdin & Wassell, 1999).

In addition to reducing dropouts, there are many reasons to involve parents. For example, it seems essential to do so when they are the cause of or an ongoing contributor to a youngster's problems. Moreover, in more cases than not, we want the family's cooperation in facilitating, nurturing, and supporting desired changes in the youngster. Equally important, what parents learn in the process may generalize to other venues, such as home involvement in school and parent advocacy (Taylor & Adelman, 2001).

Focusing on Managing Behavior Problems as More Than Social Control

Good classroom teaching is the ability to create an environment that first can mobilize the learner to pursue the curriculum and then can maintain that mobilization, while effectively facilitating learning. Misbehavior disrupts this. In some

forms, such as bullying and intimidating others, it is hurtful, and observing such behavior may disinhibit others. Because of this, discipline and classroom management are daily topics at every school.

Concern about responding to behavior problems and promoting social and emotional learning are related and are embedded into the six content arenas described in the previous section. How these concerns are addressed is critical to the type of school and classroom climate that emerges and to student engagement and reengagement in classroom learning. As such, they need to be fully integrated into all agendas for mental health in schools.

In an extensive review of the literature, Fredricks, Blumenfeld, and Paris (2004) concluded that the disengagement of many students is associated with behavior and learning problems and eventual dropout. The degree of concern about student engagement varies depending on school population. In schools that are the greatest focus of public criticism, teachers are confronted with the challenge of finding ways to reengage students who have become disengaged and are often resistant to broadband (nonpersonalized) teaching approaches. To the dismay of most teachers, however, strategies for reengaging students in learning are rarely a prominent part of preservice or in-service preparation and seldom are the focus of interventions pursued by professionals whose role is to support teachers and students (National Research Council and the Institute of Medicine, 2004). As a result, they learn more about *socialization* and *social control* as classroom management strategies than about how to engage and reengage students in classroom learning, which is the key to enhancing and sustaining good behavior.

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 and classroom management. An often-stated assumption is that stopping a student's misbehavior will make her or him amenable to teaching. In a few cases, this may be so. However, the assumption ignores all the research that has led to understanding *psychological reactance* and the need for individuals to maintain and restore a sense of self-determination (Deci & Moller, 2005). Moreover, it belies two painful realities: the number of students who continue to manifest poor academic achievement and the staggering dropout rate in too many schools.

Unfortunately, in their efforts to deal with deviant and devious behavior and to create safe environments, too many schools overrely on negative consequences and plan only for social control. Such practices model behavior that can foster rather than counter the development of negative values and often produce other forms of undesired behavior. Moreover, the tactics often make schools look and feel more like prisons than community treasures. In schools, short of suspending a student, punishment essentially takes the form of a decision to do something that the student does not want done. In addition, a demand for future compliance usually is made, along with threats of harsher punishment if compliance is not

forthcoming. The discipline may be administered in ways that suggest the student is seen as an undesirable person. As students get older, suspension increasingly comes into play. Indeed, suspension remains one of the most common disciplinary responses for the transgressions of secondary students.

As with many emergency procedures, the social control benefits of using punishment often are offset by negative consequences. These include increased negative attitudes toward school and school personnel. These attitudes often lead to more behavior problems, antisocial acts, and various mental health problems. Because disciplinary procedures are also associated with dropping out of school, it is not surprising that some concerned professionals refer to extreme disciplinary practices as push-out strategies. In general, specific discipline practices should be developed with the aim of leaving no child behind. That is, stopping misbehavior must be accomplished in ways that maximize the likelihood that teachers engage or reengage the student in instruction and positive learning. The growing emphasis on positive approaches to reducing misbehavior and enhancing support for positive behavior in and out of the classroom is a step in the right direction. So is the emphasis in school guidelines stressing that discipline should be reasonable, fair, and nondenigrating (i.e., should be experienced by recipients as legitimate reactions that neither denigrate one's sense of worth nor reduce one's sense of autonomy). Introduction of strategies such as Positive Behavioral Interventions and Supports (PBIS) represent a step in moving away from the overemphasis on punishment.

In general, it is increasingly recognized that social control strategies are insufficient in preventing future misbehavior. Schools need to address the roots of misbehavior, especially underlying motivational bases, and move beyond overreliance on behavior modification. This calls for an expanded view of engagement and human motivation and of facilitating social and emotional development. Such thinking is essential to improving (a) efforts to prevent and anticipate misbehavior and (b) actions taken during and after misbehavior, with fundamental consideration given to concerns about the impact on engagement in classroom learning.

Responding to behavior problems and promoting social and emotional development and learning can and should be done in the context of a comprehensive system designed to address barriers to learning and teaching and reengaging disconnected students. An agenda for mental health in schools must be embedded in such a system.

Embedding Case-Oriented into a Resource-Oriented Operational Infrastructure

Most schools have teams that focus on individual students identified as having problems. Among the many terms used for these teams are *student support team* and *student assistance team*. Teams focus on such functions as referral, triage, and care monitoring or management. In embedding mental health into school

improvement policy and practice, case-oriented teams need to be part of an operational infrastructure that is resource-oriented and not marginalized (Adelman & Taylor, 2008a, 2008b, 2010). Such an infrastructure assumes responsibility for guiding how resources are deployed and redeployed in developing a comprehensive system for addressing barriers to learning and teaching. A key mechanism is a resource-oriented team. In various places across the country, these teams are called *learning supports resource teams.*

Whatever it is called, a resource-oriented team focuses specifically on ensuring appropriate use of existing resources and enhancing efforts to address barriers to learning and teaching. Such a team works with a school's administrators to expand on-site leadership for comprehensively addressing these matters. In doing so, it ensures all such activity is coordinated and increasingly integrated to develop a comprehensive system of student and learning supports. Properly constituted and operated, the mechanism can reduce marginalization and fragmentation and enhance cost-efficacy. For this to happen, it must be fully integrated as a primary component of school improvement planning. More specifically, the team's work provides ways to

- Make prioritized decisions about resource allocation
- Maximize systematic and integrated planning, maintenance, and evaluation of learning supports (enabling) activity
- Outreach to create formal working relationships with community resources to bring some to a school and establish special linkages with others
- Upgrade and modernize the enabling or learning supports component to reflect the best intervention thinking and use of technology

Examples of the team's major functions are as follows:

- Aggregating data across students and from teachers to analyze school needs
- Mapping resources in school and community
- Analyzing resources
- Identifying the most pressing program development needs at the school
- Coordinating and integrating school resources and connecting with community resources, establishing priorities for strengthening programs and developing new ones
- Planning and facilitating ways to strengthen and develop new programs and systems
- Recommending how resources should be deployed and redeployed
- Developing strategies for enhancing resources
- Social "marketing"

Connecting school resource-oriented mechanisms across a cluster of schools (e.g., a feeder pattern) and at the district level provide oversight, leadership,

resource development, ongoing support, and economies of scale. At each system level, the tasks require that staff adopt some new roles and functions and that parents, students, and other representatives from the community enhance their involvement. They also call for redeployment of existing resources as well as finding new ones.

CONCLUSION

Current approaches to mental health in schools promote an orientation that overemphasizes individually prescribed treatment services to the detriment of prevention programs, exacerbates the marginalization and fragmentation of interventions, and undervalues the human and social capital indigenous to every neighborhood. School improvement policy must be expanded to support development of the type of comprehensive, multifaceted, and cohesive approach that can effectively address barriers to learning and teaching. To do less is to make values such as *We want all children to succeed* and *No child left behind* simply rhetorical statements. Needed is a fundamental, systemic transformation in the ways schools, families, and communities address major barriers to learning and teaching. Such a transformation is essential to enhancing achievement for all, closing the achievement gap, reducing dropouts, and increasing the opportunity for schools to be valued as treasures in their neighborhood.

REFERENCES

Adelman, H. S., & Taylor, L. (2006a). *The school leader's guide to student learning supports: New directions for addressing barriers to learning.* Thousand Oaks, CA: Corwin Press.

Adelman, H. S., & Taylor, L. (2006b). *The implementation guide to student learning supports in the classroom and schoolwide: New directions for addressing barriers to learning.* Thousand Oaks, CA: Corwin Press.

Adelman, H. S., & Taylor, L. (2008a). Best practices in the use of resource teams to enhance learning supports. In A. Thomas & J. Grimes (Eds.). *Best practices in school psychology.* Bethesda, MD: National Association of Psychologists.

Adelman, H. S., & Taylor, L. (2008b). School-wide approaches to addressing barriers to learning and teaching. In B. Doll & J. Cummings (Eds.), *Transforming school mental health services: Population-based approaches to promoting the competency and wellness of children.* Thousand Oaks, CA: Corwin Press.

Adelman, H. S., & Taylor, L. (2010). *Mental health in schools: Engaging learners, prevention problems, and improving schools.* Thousand Oaks, CA: Corwin Press.

Bandy, T., & Moore, K. (2011). What works for promoting and enhancing positive social skills: Lessons from experimental evaluations of programs and interventions. *Child Trends Fact Sheet.* Retrieved from http://www.childtrends.org/Files/Child_Trends_2011_03_02_RB_WWSocialSkills.pdf

Brown-Chidsey, R., & Steege, M. (2010). *Response to intervention: Principles and strategies for effective practice* (2nd ed.). New York, NY: Guildford Press.

Bryant, D., Deutsch, D., Smith, D., & Bryant, B. (2007). *Teaching students with special needs in inclusive classrooms*. New York, NY: Allyn & Bacon.

Center for Mental Health in Schools. (2011a). *About short-term outcome indicators for school use and the need for an expanded policy framework*. Los Angeles, CA: Center for Mental Health in Schools, University of California at Los Angeles. Retrieved from http://smhp.psych.ucla.edu/pdfdocs/outind.pdf

Center for Mental Health in Schools. (2011b). *Moving beyond the three tier intervention pyramid toward a comprehensive framework for student and learning supports*. Los Angeles, CA: Center for Mental Health in Schools, University of California at Los Angeles. Retrieved from http://smhp.psych.ucla.edu/pdfdocs/briefs/threetier.pdf

Center for Mental Health in Schools. (2011c). *Where's it happening? Examples of new directions for student support & lessons learned*. Los Angeles, CA: Center for Mental Health in Schools, University of California at Los Angeles. Retrieved from http://smhp.psych.ucla.edu/summit2002/nind7.htm

Deci, E. L., & Moller, A. C. (2005). The concept of competence: A starting place for understanding intrinsic motivation and self-determined extrinsic motivation. In A. J. Elliot & C. J. Dweck (Eds.), *Handbook of competence and motivation* (pp. 579–597). New York, NY: Guilford Press.

Fredricks, J. A., Blumenfeld, P. C., & Paris, A. H. (2004). School engagement: Potential of the concept, state of the evidence. *Review of Educational Research, 74*, 59–109.

Hodges, S., Ferreira, K., Israel, N., & Mazza, J. (2007). *Lessons from successful systems [of Care]*. Tampa: University of South Florida. Retrieved from http://rtckids.fmhi.usf.edu/rtcpubs/study02/IssueBrief1Definition.pdf

Kazdin, A., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination for child therapy. *Journal of Consulting and Clinical Psychology, 65*, 453–463.

Kazdin, A., & Wassell, G. (1999). Predictors of barriers to treatment and therapeutic change in outpatient therapy for antisocial children and their families. *Mental Health Service Research, 2*, 27–40.

Kutash, K., Duchnowski, A., & Lynn, N. (2006). *School-based mental health: An empirical guide for decision makers*. Tampa: University of South Florida.

National Research Council and the Institute of Medicine. (2004). *Engaging schools: Fostering high school students' motivation to learn*. Washington, DC: National Academies Press.

Raines, J. (2008). *Evidence-based practice in school mental health*. New York, NY: Oxford University Press.

Taylor, L., & Adelman, H. S. (2001). Enlisting appropriate parental cooperation and involvement in children's mental health treatment. In E. R. Welfel & R. E. Ingersoll (Eds.), *The mental health desk reference*. New York, NY: Wiley.

Terzian, M., Hamilton, K., & Ling, T. (2011). What works for acting-out (externalizing) behavior: Lessons from experimental evaluations of social interventions. *Child Trends Fact Sheet*. Retrieved from http://www.childtrends.org/Files//Child_Trends-2011_03_03_RB_WWExternalizing.pdf

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2010). The mental and emotional well-being of children: A portrait of states and the nation 2007. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from http://mchb.hrsa.gov/nsch/07emohealth/moreinfo/pdf/nsch07titlecitetoc.pdf