Expanded School Mental Health Programs: Advancing Reform and Closing the Gap Between Research and Practice

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ABSTRACT: *Expanded school mental health (ESMH) programs provide a range of mental health services to youth in special and regular education including prevention, assessment, treatment, and case management. Despite the rapid growth of ESMH programs in the United States and elsewhere, many communities still do not have ESMH programs and those that do exist often fail to implement empirically validated intervention and treatment strategies. Systematic prevention efforts remain a lauded, yet illusive goal. For ESMH programs to fulfill their promise of improved access, increased productivity and improved behavioral outcomes, researchers, school-based mental health service providers, and educators must work together to move child mental health programs beyond limiting constructs and approaches. These issues are reviewed and an example of an "ideal" approach to implement best practices in schools and close the gap between research and practice is offered.* (J Sch Health. 2000;70(5):195-200)

A national movement to bring comprehensive mental health services to youth where they are — in schools — began in the mid1980s and developed rapidly in the 1990s. Expanded school mental health (ESMH) programs augment traditional school mental health services offered by school counselors, school psychologists, and school social workers[1] by linking schools to community mental health centers, health departments, and other social services. In this way, ESMH programs provide an array of mental health services to youth in special and regular education including assessment, case management, treatment, and prevention programs.[2,3]

The growth of ESMH programs coincides with the development of school-based health centers (SBHCs) that offer primary health care including treatment of injury and acute illness, physical examinations and laboratory tests, and in some cases, reproductive health services. First established in the early 1970s in Texas and Minnesota, SBHCs have aggressively expanded in the past three decades. ESMH services are an integral component in many of the 1,200 SBHCs that exist in the United States.[4,5] In many cases, the need for mental health services is often the number one or two reason for referral to the SBHC.[6,7] In the absence of a SBHC, the increasing mental health needs of students also has led to the development of "stand alone" ESMH programs which are easier and less costly to establish than a full-service SBHC.

There also has been much progress over the past decade in the development of programs by schools and school systems to address barriers to learning. The model to enable student learning by Adelman and Taylor is being adopted by many school districts and engineering important policy and programmmatic change.[8,9]

Federal and state funding as well as support from private foundations and professional organizations has fostered the movement toward comprehensive health and mental health care for youth in schools. The Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA) currently funds two national centers that provide technical support to school mental health programs: the University of California, Los Angeles, and the University of Maryland, Baltimore. Several states, such as Maryland, Ohio, Texas, and California, are providing increased levels of funding to enhance school mental health programs, and five states, Kentucky, Maine, Minnesota, New Mexico, and South Carolina, are receiving HRSA funds to conduct programs. The Kellogg Foundation and Robert Wood Johnson Foundation are supportive, and the American School Health Association and the National Assembly on School-Based Health Care continue as strong advocates.

All these efforts have raised awareness of the need for and benefits of ESMH programs and established supportive policies in states and localities throughout the country.[3,9-12] As planners establish more ESMH programs, improved systems of quality assurance and evaluation have documented positive outcomes for youth, families, and schools,[13-16] and identified unique needs and effective approaches to involve teachers and families and maintain confidentiality.[17-19] ESMH programs have evolved toward truly collaborative, nonhierarchical and interdisciplinary approaches to service.[1,20,21] To thrive, they had to develop an array of funding mechanisms that involve grants and contracts, state and local allocations (eg, based on line items in state budgets and local tax levies), and other common fee-for-service approaches.[3,11,22]

Despite this progress, relatively few schools have comprehensive ESMH programs and youth continue to have difficulties accessing mental health care.[23,24] School mental health professionals continue to face challenges that limit their ability to address the mental health needs of children and youth.

THE FIRST CHALLENGE: IMPROVING PRACTICE

The Need for More Proactive Service Delivery in Natural Settings

Community mental health centers (CMHCs) can provide valuable mental health care, particularly for those youth who present with severe and/or chronic emotional/behavioral problems.[26] However, many communities over-rely on CMHCs to meet the mental health care needs of young

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people and their families.[27] For many reasons, including stigma, poor understanding of mental health treatment approaches, or transportation problems,[3,28] many youth do not access CMHCs. Thus, in many communities a need exists for a more proactive approach to mental health service delivery that reaches youth in their natural settings, such as schools.

The Need for Collaborative, Non-Hierarchical Approaches to Treatment

There is increasing awareness of the limitations associated with clinical approaches developed in isolation of the individuals involved in implementing them. To be successful, students, families, teachers, and other individuals important to the student must be involved collaboratively in developing the treatment plan.[1,17,19,20,29]

The Need to Increase Mental Health Staff

Despite evidence that nonprofessional and paraprofessional staff can play important and effective roles in delivering mental health services to youth,[30] most mental health care in the United States is provided by professionals with master's and doctoral degrees. Many of these professionals are engaged in activities such as background assessments or case management that do not require advanced graduate training.[31] Since children's mental health needs surpass the current system's ability to meet them,[2,23,32] significant collaborative efforts among professionals, paraprofessionals, and nonprofessionals are required. The Primary Mental Health Project[33] is one example of a program that uses paraprofessional and nonprofessional staff in providing nurturant and supportive time to at-risk elementary youth that has been shown to have powerful outcomes over the short-term and long-term for participating youth.

Related to the over-reliance on mental health professionals to deliver care, is the failure to recognize the important role that individuals with prominent roles in the lives of children can play. For example, several programs have successfully used teachers to enhance protective factors and increase assets in youth.[34-39] The average teacher at the elementary level spends more than 1,000 hours per year with a group of children; mental health staff might see a few of these children for six or seven hours each. Training teachers to better understand mental health issues and to implement prevention-oriented skill building and asset-enhancing interventions has tremendous potential. Well-trained teachers also are critical to efforts to identify signs and symptoms of potential problems and to appropriately refer.

The Need for Developmentally Appropriate and Empirically Supported Approaches

The mental health field has historically been plagued with the public perception that many treatment approaches involve unproven techniques and psychological nonsense. Contributing to this problem is the assumption among some that adult diagnostic patterns replicate in children[40] or the common practice of using interventions "borrowed" from the adult mental health field without any systematic attempt to question their relevance and appropriateness for use with children.[41] One example is "assertiveness training" programs that teach children a sequences of responses that are at odds with their developmental capabilities, eg, "When you took my bike, it hurt my feelings. In the future, please ask permission before you borrow my bike." Also illustrative of this problem is the 50-minute hour, which continues to be the standard time for the provision of therapy to children, despite no evidence confirming that this is the right amount of time for helpful progress. Within psychology, as with other professional disciplines, there is increasing emphasis on empirically supported theory and practice.[42,43] The challenge remains, however, for these approaches to infiltrate daily practice in community settings.[20,44]

The Need for Services Independent of Diagnoses

Awareness is increasing of a number of problems associated with reliably diagnosing mental health problems in youth.[27,45] When done by trained interviewers using structured diagnostic interviews, diagnostic reliabilities average 60% or less. Reliabilities in common practice are much worse. There also is a tendency for clinic-specific diagnoses, ie, certain diagnoses seem to be "favorites" at particular sites and appear more frequently than one would typically expect. Some diagnoses and their characteristics appear circular, eg, "How do you know he has Oppositional Defiant Disorder (ODD)? Because he disobeys and will not follow instructions. How come he is disobeying? Because he has ODD." Too many times children are held accountable for their problems when many emotional and behavioral problems in youth are strongly determined by the environment; we attempt to "fix" the student, when the real problem lies elsewhere. The sad reality is that many mental health diagnoses continue to carry stigma. Maintaining confidentiality regarding diagnosis is difficult and there continue to be anecdotal reports of denied health care coverage or opportunity for military services based on past mental health diagnosis. Unfortunately, at the current time, reimbursement for services often requires a diagnosis. Given these problems, a need exists for funding mechanisms that do not involve an initial diagnosis.

The Need for Ongoing Relationships with Mental Health Service Providers

As currently delivered, mental health care is episodic. A person experiences emotional distress and seeks professional help. An intake assessment is conducted, four therapeutic sessions are provided, and the "patient" is "terminated." Cummings,[46] a leading health care reformer and visionary, has recommended brief, supportive mental health care for people throughout their life spans, similar to medical care provided by family physicians. In this model, the individual establishes a relationship with a mental health professional. When problems arise, they are treated. However, when problems are solved, the relationship does not end, rather, it continues over a period of years, providing helpful information, familiarity, and comfort.

The Need to Integrate Systems of Care

Physical health, emotional well-being, behavior, thoughts, and beliefs are intertwined. Yet services for children (and adults) are most often provided in distinct and separate bureaucratic "silos" of care. When a young person is experiencing emotional distress, several physical complications might exist. A variety of coping strategies might be attempted, including substance abuse and acting out behav-

iors, resulting in involvement of juvenile justice officials. Youth with problems, whether physical or emotional, usually have multiple symptoms and require services in several systems of care.[47-50] These separate systems create additional barriers to care, contributing to higher levels of frustration and stress. It is also noteworthy that, with few exceptions, medical professionals, mental health professionals, and members of the faith community seldom work together.[51] This might be due to differences in professional preparation, claims of distinctive treatment realms, or prejudicial ideas held about the other groups. Fortunately, a movement away from such limited thinking is occurring and the beginnings of alliances between the faith and school health communities are forming.[51,52]

SUMMARY

Expanded school mental health programs are addressing each of these needs to some extent. ESMH programs help integrate various systems of care by providing a single point of access.[1,2] ESMH programs work closely with a variety of individuals, youth, families, school staff, community leaders, and clergy, to develop interdisciplinary and nonhierarchical approaches to best serve children, youth and their families.[1,17,19-21,31,53] In some programs children do not need diagnoses to be seen and emphasis on building individual and community strengths is increasing.[53,54] Further, the nature of school-based practice allows youth to receive clinical services when they need them and other approaches when these are more appropriate, in relationships that continue over several years.[3] The ideal ESMH program is embedded in the context of a caring environment that offers a range of services to children, often through school-based health centers or in full-service schools.[4-7,32]

ESMH programs are part of a broader reform effort to improve mental health care for youth in communities. In turn, they are linked to significant efforts to reform education by removing barriers to learning, addressing the needs of all youth, connecting to community agencies, and improving accountability.[56,57] The Center for Mental Health in Schools in Los Angeles[4,5,10] offers technical assistance to schools attempting to span both reform initiatives.

THE SECOND CHALLENGE: LINKING RESEARCH AND PRACTICE IN SCHOOLS

Many of these issues act as barriers to meeting the mental health needs of children and youth. Even if all of the barriers to improved practice were overcome, a clear bias toward providing care to youth with serious and/or chronic problems would remain. Prevention is still a lauded, yet illusive goal.[25] It remains to build better bridges between prevention researchers, mental health service providers, and educators. Prevention research in schools has advanced considerably in recent years. As the number of school-based prevention programs for children and adolescents has increased, increasingly sophisticated research evaluations have demonstrated their effectiveness in achieving several desirable outcomes. Further, they have documented that many of these positive changes generalize across settings and maintain over time.[59] Prevention research has much to offer mental health professionals but its impact has been limited due to barriers that generally exist between research and practice.

An ideal shared by many in the health and academic communities is that research should inform practice and that in turn, practice should inform science in an iterative process whereby progress in both realms is advanced.[44] While many espouse this view, a significant gap between research and practice remains.[60-63] For example, clinicians might disregard scientifically established protocols in the name of the "art" of clinical practice, while researchers are accused of functioning in the insulated world of the "ivory tower."[25]

There are many reasons this gap between research and practice persists. Differences in training can be significant. Researchers are trained to develop and evaluate the efficacy of interventions, but rarely to disseminate them and evaluate their real-world applications,[63,64] or to analyze their cost-effectiveness.[65] Conversely, many clinicians have limited backgrounds in research and are too busy to keep abreast of the latest scientific developments presented in professional journals. The desired goals and outcomes are different. Clinicians are primarily concerned with the application of interventions to assist individuals who have unique experiences and circumstances. Researchers, however, generally study the impact of interventions on groups of individuals who are often carefully selected based on certain homogenous characteristics.[60,61] Consequently, interventions developed in highly controlled situations might have limited applicability in the real world of clinical practice.[61] Other issues, such as different work contingencies and funding demands, time pressures, and limited channels for diffusion of innovations, such as densely written journal articles, serve to constrain collaboration between researchers and practitioners.

Many of the issues that characterize relationships between researchers and clinicians, in general, also are applicable to relationships between prevention researchers and school mental health service providers and between school mental health professionals and other important groups in schools such as board members, school administrators, and teachers.[1,19,25,67] While barriers to collaboration among these groups might be significant, they can be overcome through explicit and concerted efforts.

Step 1: Raise Awareness

An initial step toward collaboration between prevention researchers and school mental health professionals is to raise awareness within each group of major developments in the other area. Tashman and colleagues[25] reviewed prevention research in schools and identified key issues and exemplary programs in school mental health. Becoming better informed is a necessary but not sufficient step. Mechanisms for enhancing dialogue between groups at all levels is needed.

Step 2: Engage in Regular, Interdisciplinary Dialogue

Several national organizations and professional associations exist that foster and promote dialogue between prevention researchers and school mental health service providers and other members of the school community. They sponsor workshops, conferences, and national meetings that offer numerous opportunities for those in the practice, education, and research communities in schools to come together. While an enriching source of professional development, not everyone can take advantage of these

opportunities. For this reason, similar discussion needs to occur regularly and frequently at the local level where prevention research and expanded mental health programs are being planned or implemented in schools. Participants should leave preconceptions and stereotypes behind and work to develop a collaborative team respectful of the contributions of each member. For example, in Baltimore, the School Mental Health Outcomes Group (SMHOG) includes researchers, practitioners, program developers, education staff, clinical staff, and community leaders, and is helping to guide ESMH programs in the city. Through meaningful dialogue, researchers and school-based clinical and education staff can develop a shared agenda. School-based staff can inform researchers about issues and concerns that can help guide research and the development of new programs, and researchers can assist program staff in documenting program processes and demonstrating effectiveness.[25]

Step 3: Make Collaboration a Priority

In addition to meeting regularly, researchers and school-based clinical and teaching staff should work together to implement programs and best practices in schools. For example, school-based staff can assist research staff in resolving pragmatic difficulties encountered in research such as obtaining parental consent for student involvement. In turn, research staff can share ideas for enhancing interventions and implementing empirically supported practice. At times, researchers may be able to participate in clinical efforts or efforts to improve classroom behavior, and practitioners and educators can contribute to writing articles for publication.[25]

Step 4: Spread the Good News

Researchers need to communicate their findings from school-based studies so that they can be readily understood by everyone interested in promoting the mental health of children and youth: youth, families, teachers, principals, program directors, and community leaders. Brief reports, written without jargon, highlighting the main program components and explaining what was and was not successful is the most useful information. Further, researchers have an obligation to ensure that findings from the project actually benefit the school.

"In a Perfect World"

The following example illustrates how researchers and ESMH programs might work together to benefit children and youth. An ESMH program is operating in an inner-city middle school and involves staff from a CMHC working closely with the school mental health professionals (eg, school counselor, school psychologist), school health staff, and teachers to deliver an array of services to the students. The program has been in operation for four years, is guided by an advisory board that includes all the stakeholder groups, has a major emphasis on prevention and empirically supported practices, and has strong quality assurance and evaluation mechanisms in place.

A team from a local university is hoping to field test a program involving students entering sixth grade in the fall. The program includes a skill-building component as well as assessment of a variety of factors important to mental health: stressors, protective factors, and extent of emotional and behavioral problems. The program will be integrated into the school curriculum, and institutional review boards for the university and the school have waived parental consent. The impact of the program will be determined by examining grades, attendance and discipline problems for youth who participate in the program compared to sixth-grade youth from a demographically comparable school that will not receive the program.

Collaboration between the research and school-based staff begins in early spring. All facets of the project are jointly planned: how to integrate it into the curriculum, how to convey information to school staff, how to standardize data collection across schools. Clinical staff from the ESMH program introduce the researchers to school staff and preliminary meetings are held. All three groups participate in a summer orientation. All three groups also participate in two focus groups held for community members to provide input. As the program is implemented, ESMH staff counsel students identified by the researchers who appear to need assistance, and assist in general problem solving. In turn, researchers share the latest information to improve clinical interventions or classroom management.

At the end of the year, ESMH and teaching staff assist research staff in collecting evaluative data. Based on her significant involvement in the project, an ESMH staff person is offered the opportunity to assist with data analysis. She is invited to present at a national conference and is a co-author on a paper submitted for publication. Research staff prepare a one-page summary and four-page executive summary of the project for dissemination to staff in the school and those interested in the community. ESMH and teaching staff provide feedback on these reports. Together, ESMH staff, teaching, and research staff write an editorial to the local newspaper about the project, preliminary findings, and plans for the coming year.

CONCLUSION

While the above example is hypothetical, it captures the pragmatics and the promise of close collaboration between researchers, school mental health professionals and education staff in the context of a school with an ongoing ESMH program committed to best practice and reform. For those committed to helping children and youth succeed in school and achieve physical, emotional, and social health, the times are exciting. There has been significant progress in the last 20 years. But, much still needs to be done. In this article, two major dimensions of the work ahead were identified — improving ESMH programs and building meaningful and genuine relationships between researchers, school mental health professionals, and education staff. ■

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Healthy People 2010 Objectives for Improving Health

Mental Health Objectives - Children and Youth

18-2. Reduce the rate of suicide attempts by adolescents from 2.6 percent to 1 percent.

18-5. (Developmental) Reduce the relapse rates for persons with eating disorders including anorexia nervosa and bulimia nervosa from 25 percent after 4 weeks and 49 percent after 9 months.

18-7. (Developmental) Increase the proportion of children with mental health problems who receive treatment.

Mental Health Info-Bites

- In 1996, suicide was the third leading killer of young persons between the ages of 15-24 in the U.S.
- Studies suggest that 30 percent to 50 percent of patients treated successfully in the hospital become ill again within one year of leaving the hospital.
- For many children aged 18 years and under, life-long mental disorders may start in childhood or adolescence. For many other children, normal development is disrupted by biological, environmental, and psychosocial factors, which impair their mental health, interfere with education and social interactions, and keep them from realizing their full potential as adults.