

1 Integrated School Mental Health Programming

INTRODUCTION

There has been a rise in mental health problems in children and adolescents in recent years. The proportion of pediatric patients seen in primary care who present with psychosocial problems has nearly tripled over the past 20 years (Kelleher et al., 2000). Results from a recent national study found that over one in five children (or 22.2%) have a mental disorder severe enough to disrupt their daily living (Merikangas et al., 2010). When left untreated, mental health problems in children and adolescents may lead to increases in suicide, school failure, juvenile and criminal justice involvement, and health care utilization (National Alliance on Mental Illness, 2011). Improvements in children's and adolescents' mental health will require a collaborative effort from families, communities, health care providers, and schools.

The public school system is the primary setting for identifying mental health problems and providing mental health services for youth in the United States (American Academy of Pediatrics, 2004; Farmer, Burns, Phillips, Angold, & Costello, 2003; Foster et al., 2005). The demands of school often necessitate specialized assistance for children with learning, behavioral, social, or emotional problems. Of course, the nature and severity of the problem as well as the child's resources, both internally and environmentally, influence the kinds of support the child may require.

This chapter provides a comprehensive overview of school-based mental health services. First, we discuss mental health needs of children and adolescents followed by a review of legislation that enables schools to provide

mental health support for students. Then, we discuss the importance of providing comprehensive and collaborative services through the use of an integrative service delivery model. The specific focus of this book, responsive school-based counseling, is framed within an integrative service delivery model in this chapter.

EDUCATING STUDENTS WITH MENTAL HEALTH ISSUES

Mental Health Needs of Students

Children’s social-emotional functioning is a critical factor in their academic achievement. Children with significant social, emotional, and/or behavioral problems place not only themselves at greater risk for academic failure, but their problems can also interfere with the learning of others. Research and legislation has increasingly sought to improve student’s learning and socialization by seeking ways to improve mental health in schools.

The first and only (to date) nationwide study of school mental health services, *School Mental Health Services in the United States, 2002–2003* (Foster et al., 2005), was released by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2005. The study found that 20% of students received some form of individualized mental health service due to a mental health concern. The greatest mental health concern as ranked by schools was social, interpersonal, or family problems for both males and females. The second and third most frequently cited concerns were different for male and female students—aggression or disruptive behavior and behavior problems associated with neurological disorders for males and anxiety and adjustment issues for females. The areas of concern also changed by school level; for example, for males and females, depression and substance use/abuse were reported more frequently for high school students.

Survey results from the 2005 SAMHSA study of school mental health services also revealed that certain types of services were more or less difficult to deliver. Individual and group counseling, behavior management, and crisis intervention were most frequently ranked as “not difficult” or “somewhat difficult,” while family support services, medication management, and substance abuse counseling were ranked as “difficult” or “very difficult.” Barriers to effective service delivery included financial constraints of families, insufficient school and community-based resources, competing priorities for use of funds, difficulties with transportation, and linguistic and insurance barriers (see Foster et al., 2005).

Providing mental health services in schools is beneficial, and even necessary, to provide students (1) a safe learning and social environment,

(2) an opportunity to grow and develop socially and academically, and (3) access to mental health services for some children who would otherwise not receive it. The school setting, too, is ideal for linking ecologically valid assessment, intervention, and progress monitoring. Multiple, ongoing formal and informal assessments of student progress are already built into educational programs.

Understanding and Supporting Students With Unique Needs

Because of the high expectations for achievement in school and the natural comparison group with same-age peers, a child may first be identified as at risk in school. These students may require additional support in order to make adequate progress in school. The individualized support a student receives in school can serve as a protective factor. Using the stress-diathesis model (Zubin & Spring, 1977), later reformulated as the stress-vulnerability-protective factors model, a student's ability to successfully manage the demands of school depends on the interaction of the student's individual characteristics, the standards in which the student is expected to perform, and the degree of supportiveness of the student's environment. Some students are able to manage the demands of school with relatively limited support. Others, with some additional assistance, are able to develop new skills to begin to manage school expectations with less support over time. Then, there are a small percentage of students who require extensive, ongoing support in order to progress in school.

Many students who require additional support qualify for special education services. The school dropout rate is significantly higher for students in special education, and students labeled with an emotional disturbance have the highest dropout rate by disability, approximately 50%, within special education (Jans, Stoddard, & Kraus, 2004; U.S. Government Accounting Office, 2003). School dropout is associated with increased rates of unemployment, underemployment, and involvement in the corrections system. Schools that are committed to creating supportive school climates have demonstrated a decrease in the special education dropout rate over time. For example, in the state of Michigan, with the implementation of the *Michigan Merit Curriculum* that emphasizes relationships, relevance, and rigor, the special education dropout rate steadily declined from 58.3% to 23.5% between the years 1998 and 2005 (Michigan Department of Education [Annual Performance Report, 2005–06], 2011). Progress on key indicators at district and state levels requires well-coordinated and systemically implemented evidence-based models, programs, and practices. Trained educators and counselors can help facilitate a supportive environment for students with significant emotional problems by seeking greater understanding of students' unique strengths and interests, assisting students in communicating effectively and building

positive relationships with others, and working collaboratively with teachers, school staff, parents, and the community to promote student success.

School Mental Health Legislation

Legislation has led to greater levels of assistance for students with mental health issues. The groundbreaking legislation Public Law 94–142, or the Education for All Handicapped Children Act of 1975, required schools to provide a free and appropriate public education (FAPE) to all children with disabilities in order to receive federal funds. The disability category, serious emotional disturbance (SED), was defined by this legislation. With the re-authorization of PL 94–142 in 1997 and 2004, now referred to as the Individuals with Disabilities Education Act (IDEA), school mental health services were expanded further. Through IDEA, federal funds are available for early intervention services, counseling services for all students with disabilities, and counseling for parents to assist them in better understanding their child’s disability and with the implementation of their child’s Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). IDEA also authorizes positive behavioral intervention and support to facilitate inclusion of children with disabilities in the general education curriculum and in school activities with nondisabled peers.

The No Child Left Behind Act (NCLB) of 2001 enables schools to provide greater coverage in meeting the mental health needs of students who do not require special education services. NCLB authorizes grants for integrating schools and mental health systems and for programming for early childhood emotional and social development. The Consortium for Citizens with Disabilities Education Task Force advocates that “NCLB must continue to build on IDEA’s strengths” and, as a part of this emphasis, urges the following regarding students’ social and emotional needs:

Schools should create a climate that is conducive to learning and that addresses the social/emotional health of all students. Strategies such as positive behavior supports, response to intervention or other scientifically-based interventions should be implemented in schools to identify struggling learners or students with mental health issues or other issues that affect learning as early as possible and to provide targeted instruction and appropriate behavior supports for such students. (Consortium for Citizens with Disabilities, 2006, p. 1)

Prevention and Early Intervention

With a greater emphasis on schoolwide prevention and early intervention, it is hoped that the high need for intensive individualized services will

decrease. Funding to promote children's mental health in schools through prevention and early intervention has come through the Safe Schools Healthy Students Initiative, Drug-Free Schools and Community Act (DFSCA), Centers for Disease Control (CDC) and Prevention's Division of Adolescent and School Health (DASH), U.S. Department of Education, and IDEA, as well as from Medicaid and state and local funding. Based on a large and growing body of research, school-based universal prevention and early intervention efforts have shown to be effective in improving student outcomes in several areas, including decreasing school violence, improving academic performance, increasing children's social competence, reducing school dropout, and increasing school attendance (e.g., Beets et al., 2009; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Gottfredson & Wilson, 2003; Gottfredson, Wilson, & Najaka, 2002; Hahn et al., 2007; Ialongo, Poduska, Werthamer, & Kellam, 2001; Tobler & Stratton, 1997). Various prevention models, including Caring School Community (CSC) programs, Responsive Classroom programs, social and emotional learning (SEL) programs, character education, and Positive Behavioral Interventions and Supports (PBIS), have been influential in promoting children's social, emotional, and behavioral competencies through universal prevention (see Bear, 2008). Doll and Cummings (2008) provide a comprehensive review of universal prevention in schools.

Comprehensive Mental Health Services in Schools

The focus of this book is on secondary (i.e., service to some) and tertiary (i.e., service to few) prevention, but each level of prevention—primary (i.e., universal; service to all), secondary, and tertiary—is critical and contributes to the success of the others. For example, primary prevention sets the stage for effective secondary and tertiary prevention. Likewise, effective secondary and tertiary prevention contributes to the school's optimal functioning at the universal level. Collaboration within and between levels of prevention can result in synergy and positive feedback loops. Implementation of an integrative service delivery model can help set this into motion.

MODELS OF SCHOOL MENTAL HEALTH PROGRAMMING

Collaborative approaches to mental health are generally more effective than isolated approaches. Integrated school mental health programming holds that: (1) a guiding model that clearly defines goals and objectives within and between levels of care facilitates cohesion and continuity; (2) the exact

nature of services will depend on contextual factors, including the school and community's indigenous resources, the prioritized mental health needs within a population, and the individual needs of students; (3) clearly defined professional roles facilitates resource efficiency (including personnel efficiency); and (4) collaboration within and between multiple systems in the child's ecology benefits the whole child through enhancing protective factors, addressing risk factors, and promoting intervention consistency across settings (see Atkins, Hoagwood, Kutash, & Seidman, 2010; Stormshak et al., 2011). Examples of mental health programming models that promote integrative services include varieties of schoolwide programs that coordinate with parents and the community, PBIS, and the Ecological Approach to Family Intervention and Treatment (EcoFIT).

The ASCA Model

The ASCA Model, published by the American School Counselor Association (2003), was developed to guide school counselors in implementing comprehensive school counseling programs. The ASCA Model's delivery system is comprised of four components: (1) guidance curriculum, (2) individual student planning (e.g., planning and monitoring academic growth and development, educational and career/vocational planning), (3) responsive services (e.g., individual and group counseling, crisis response, referral, consultation, and peer mediation), and (4) systems support (e.g., implementation of a comprehensive guidance program, professional development, collaboration, teaming, program management, and program evaluation). The ASCA Model also exemplifies integrated school mental health programming.

PBIS

The PBIS model (also sometimes referred to as Positive Behavioral Supports [PBS]) delineates intervention levels in school mental health services. PBIS is a multilevel approach that focuses on prevention by creating a positive school environment. Within the PBIS model, all students receive support at the universal or primary level that involves schoolwide and classroom systems. Examples include positive school climate programs, systematic schoolwide screenings, and guidance lessons. Students who are identified as needing additional support beyond what is provided at the schoolwide level receive more intensive support at the secondary level that involves small-group and intense individualized plans. Students who continue to struggle behaviorally, socially, or emotionally despite "targeted" interventions require the most intensive level of support at the tertiary level. According to a position statement by the National Association of School

Psychologists (NASP; 2009), Level 3 supports may require services from specialized individuals, functional analyses of behavior, behavior intervention planning, multisystemic interventions, progress monitoring, special education services, and a highly individualized education plan. Different types of interventions within and between multiple systems are often necessary to promote positive coping and pro-social development. A team approach helps to ensure that a comprehensive, individualized intervention plan is developed and that specific strategies are implemented consistently across settings. Furthermore, the intervention components, such as academic modifications and accommodations, behavioral support strategies, peer supports, tutoring, home-school collaboration, counseling and community supports, should be implemented with integrity.

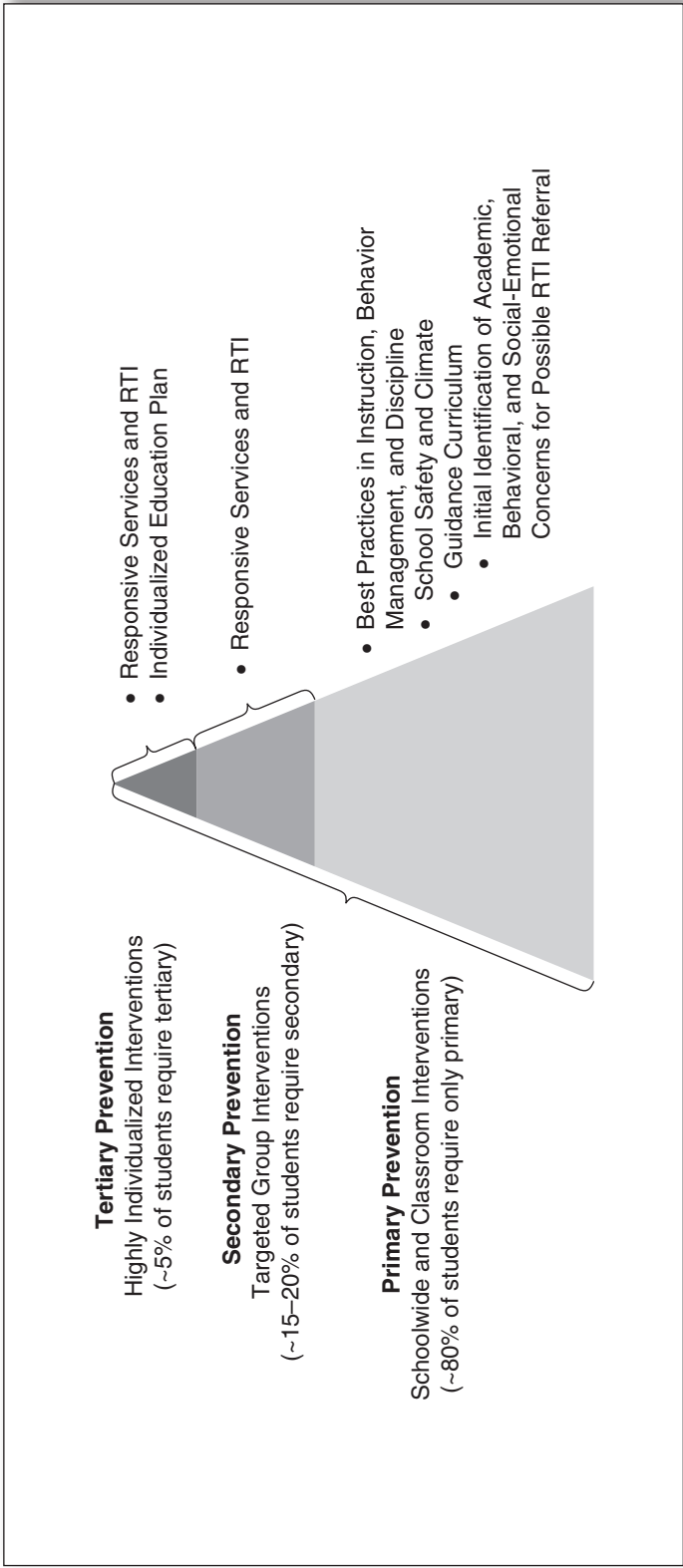
PBIS and RTI

PBIS provides a *Response to Intervention* (RTI) function that seeks to identify struggling students based on their performance level, implement interventions, and assess student progress. Students who do not progress despite supportive interventions may be identified as requiring more intensive interventions or multidisciplinary evaluation for special education support. Comprehensive information, resources, and support about PBIS is provided through the Office of Special Education Programs (OSEP) and through the National Technical Assistance Center on PBIS. The National Education Association (NEA) views RTI and PBIS as general education initiatives, though the impetus for both was derived from the special education law IDEA (NEA, 2012).

Common Goals of NCLB, ASCA, IDEA, and PBIS/RTI

A concentrated effort to promote universal or primary prevention helps ensure a positive school environment that sets the stage for effective and coordinated services for students who may require targeted or intensive, individualized support. The ASCA Model, NCLB, and IDEA each have somewhat different emphases, but they all support high expectations for student success as well as equal access to a quality education, and they all can be conceptualized within an integrative framework, such as the PBIS model (see Figure 1.1). Kutash, Duchnowski, and Lynn (2006) conclude that “the early results of PBIS interventions implemented at the indicated level, and the growing body of support for implementation at the universal and selective levels for children who have emotional/behavioral problems is very promising” (p. 32) and that “administrators have a preponderance of evidence to support their exploration of PBIS as a viable model for School-based Mental Health programs” (p. 33). Further, Fixsen, Blase, Duda,

Figure 1.1 Common Goals of NCLB, IDEA, and the ASCA Model Within the PBIS Model and RTI



Naoom, and Van Dyke (2010), in their discussion of implementation of evidence-based treatments for children and adolescents, spotlight school-wide PBIS as an example of a well-implemented evidence-based program.

SCHOOL MENTAL HEALTH COMPETENCIES

Recognizing the importance of integrative mental health services, school mental health providers and educators can become increasingly effective as they acquire knowledge and develop competencies in core areas, including normal child and adolescent development, principles of learning and behavior, effective team problem solving, evidence-based interventions, effective service delivery, and mental health systems of care. A foundation of interdisciplinary competencies will promote effective communication, problem solving, and collaborative interventions. Teachers and school support staff work “in the trenches” every day with students, so mental health professionals should provide consultative support that can assist teachers in the most useful ways possible.

Various types of interventions may be implemented to promote positive student mental health and learning (see Figure 1.2). Comprehensive, integrative intervention planning recognizes the potential benefits of different types of intervention strategies as well as their synergistic effects. Intervention team members (e.g., general education teacher, special education teacher, administrator, counselor, psychologist, speech therapist, occupational therapist, teacher aide, social worker, community intervention support member, or parent) have different roles, specializations, vantage points, and perspectives that contribute to the overall intervention plan. School mental health services are increasingly efficient and effective as intervention team members understand each other’s roles and how intervention components are interrelated. Implementation of a comprehensive, integrated approach can help services flow more productively.

ROLES AND RESPONSIBILITIES OF SCHOOL MENTAL HEALTH PROFESSIONALS

The roles and responsibilities, as well as professional backgrounds and competencies, of school mental health providers, including school counselors, school psychologists, school social workers, and pupil personnel workers, can vary significantly. This book is about providing counseling interventions at the *secondary* and *tertiary* prevention levels within an integrative mental health framework. The amount of time a service provider can devote to responsive counseling services depends on one’s roles, responsibilities, and resources.

Figure 1.2 Types of School-Based Mental Health Interventions

- Schoolwide Universal Prevention
- Comprehensive Schoolwide Positive Reinforcement Systems
- After-School Programs, Social Clubs, Peer Mentoring
- School Counseling Programs
- Early Childhood Intervention
- Parent Collaboration
- Behavioral Consultation
- Individual and Group Counseling/Therapy
- Social Skills Training
- Crisis Management
- Psychological Assessment
- Functional Behavioral Assessment
- Behavior Management Plan
- In-Class Teacher Support
- Educational Supports (e.g., academic accommodations and modifications, related services)
- Change of Placement (e.g., specialized classroom settings)
- Discipline and Manifestation Determination Review
- Training for School Personnel
- Family Support Services (e.g., parent training, family counseling)
- Medication Management and Health Services
- Collaboration With Community Mental Health Providers
- Community Referral and Resource Information for Parents
- Transition Planning

From a systems perspective, while the implementation of research-based comprehensive and integrative prevention models in schools (e.g., PBIS) does require resources (e.g., time, personnel, and money), research is demonstrating the cost effectiveness of these kinds of prevention models (see Horner et al., 2012; Kutash et al., 2006; Simonsen et al., 2012). Furthermore, effective planning, organization, leadership, and collaboration can enable schools to implement effective prevention programming even with limited resources.

Our goal in writing this book is to provide research-based material that is readily accessible and useable for school mental health professionals. We hope this book will not only provide a conceptual framework, but also spark creativity and enthusiasm in school mental health service providers to provide high-quality services for children and adolescents.

CONCLUSION

Recent laws, new initiatives, and contemporary guidelines from the ASCA, NEA, NCLB, and IDEA clearly expect school personnel to use best practices

in meeting the needs of all students. In order to address children's and adolescents' mental health problems effectively, there must be collaboration between multiple systems, with schools playing a significant role.

Research suggests that providing comprehensive and integrative mental health services in schools is efficacious. Broadly speaking, the implementation of integrative mental health services can result in synergistic effects. In other words, the effects from the interconnected intervention parts are greater than the sum of the individual intervention parts. In sum, Chapter 1 provides a framework for responsive school-based counseling—integrated mental health services. In the following chapters, we focus more specifically on school-based counseling as an intervention. In Chapter 2, we discuss the potential benefits and limitations of school-based counseling.

DISCUSSION QUESTIONS

1. Approximately 1 in 5 children and adolescents have some type of mental health problem. What kinds of mental health problems do children and adolescents most commonly display? How does mental health impact school performance?
2. What kinds of mental health services are most needed in schools today?
3. Who is competent to provide mental health services in schools?
4. Define integrated school mental health programming.
5. What are some potential barriers to implementing integrated school mental health programming and services? How might these barriers be addressed effectively?
6. What might be some effective ways of enhancing mental health competencies across all professional roles (e.g., teachers, administrators, mental health providers) within a school or school district in order to promote integrative mental health services?