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ORIGINAL PAPER

Toward the Integration of Education and Mental Health in Schools

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Abstract Education and mental health integration will be advanced when the goal of mental health includes effective schooling and the goal of effective schools includes the healthy functioning of students. To build a solid foundation for this reciprocal agenda, especially within the zeitgeist of recent educational reforms, a change in the fundamental framework within which school mental health is conceptualized is needed. This change involves acknowledging a new set of priorities, which include: the use of naturalistic resources within schools to implement and sustain effective supports for students' learning and emotional/behavioral health; inclusion of integrated models to enhance learning and promote health; attention to improving outcomes for all students, including those with serious emotional/behavioral needs; and strengthening the active involvement of parents. A strong research agenda to support these new priorities is essential.

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Recent national reform efforts in education and in mental health provide a unique opportunity for re-examining models to better integrate learning and behavioral health. Both the Surgeon General's report (US DHSS 1999) and the report from the President's New Freedom Commission on Mental Health (2003) propose the expansion of mental health services for children in schools. Likewise, the No Child Left Behind Act, signed into law in 2002, emphasized accountability, particularly for academic achievement and increased use of scientifically-based programs and teaching methods, and it stressed the need to ensure "student access to quality mental health care by developing innovative programs to link the local school system with the local mental health system" (U.S. Department of Education Office of Elementary and Secondary Education 2002, p. 427). Clearly, at the federal level there is support for a closer alignment between education and mental health.

While there is an emerging consensus for locating mental health programs in schools, the role and structure of these services are varied and the empirical base is limited (Hoagwood and Erwin 1997). We propose that new priorities within the educational reform movement provide a timely opportunity for integrating mental health goals and educational services. Specifically, educational reform efforts are driving a renewed focus on accountability, outcomes, personalized learning, early intervention, and flexible learning supports (e.g., Bill & Melinda Gates Foundation 2009; Lachat 2001) and schools are required to develop school improvement plans to meet federal and

state mandates to increase school effectiveness. In addition, with the reauthorization of the Individuals with Disabilities Education Act (IDEA 2004), early intervention (pre-referral) services were included, which allowed for special education funding to be allocated for evidence-based academic and behavioral support services. To implement this policy, the Response to Intervention (RtI) framework was developed (Reschly and Bergstrom 2009), which includes tiered responses from prevention to early intervention, to more intensive treatments and ongoing assessments to monitor improvement and the need for alternative interventions (Kratochwill et al. 2007). The Children' Education Council (2008) reported that 60% of districts had begun adopting an RtI approach as of March, 2008. Thus, these initiatives within education indicate that the potential for expanding behavioral health services within the paradigm of these educational efforts is considerable. However, to do so will require a different set of priorities for research and practice from those that dominate school-based services currently.

Given the limited progress in establishing consensus about effective and efficient school mental health programs that can be sustained within the varied ecologies of schools (see Adelman and Taylor 2006; Evans and Weist 2004), the purpose of this paper is to suggest a re-prioritized research agenda that privileges mental health programs and practices that are integrated into the school ecology. This change involves acknowledging the use of naturalistic resources within schools to implement and sustain effective supports for students' learning and emotional/behavioral health; inclusion of integrated models to enhance learning and promote health; the need for improved outcomes for all students, including those with serious emotional/behavioral needs; and the importance of strengthening the active involvement of parents. A research agenda to align with these priorities is described.

School-Based Mental Health Services: Problems and Prospects

Since publication of Bronfenbrenner's ground-breaking theory of human ecological systems (Bronfenbrenner 1979; Bronfenbrenner and Morris 1998), children's development has been understood as influenced by the interacting natural contexts in which children live, work, and play. Schools represent among the most influential of these contexts by virtue of their long-term influence on children's cognitive and social development. Toward that end, schooling has been a long-standing concern of mental health professionals, and as importantly, children's social and emotional adjustment has been a long-standing concern of schools. Educators have long noted that the unmet psychosocial needs of children and families overwhelm the resources of schools and undermine their capacity to educate children (e.g., Carnegie Council on Adolescent Development 1989). With the passage in 1975 of PL 94-142, the first federal law mandating equal access to public education for children with handicaps, a range of expanded agendas—such as full-service schools and school-based mental health programs—has been advocated with the goal to integrate educational and mental health services (Cappella and Larner 1999; Dryfoos 1994). These programs, started in the mid-1980's in a handful of schools, have spread to thousands of schools across the nation (Foster et al. 2005). Lawson and Sailor (2000) review this history and note that, despite differences across programs, all presume the need to incorporate a broader agenda beyond academic achievement. Similarly, a consensus statement coordinated by the UCLA National Center for Mental Health in Schools (2001) promoted integrated mental health and educational goals.

However, while the goal of integrating mental health and education may be shared by many educators and mental health professionals, there is little consensus on the optimal ways to package or integrate supports within schools to achieve these goals. Although schools are commonly regarded as the dominant de facto providers of mental health services for youth (Burns et al. 1995; Farmer et al. 2003), providing an estimated 70–80% of psychosocial services to those children who receive services (Rones and Hoagwood 2000), there is, as yet, scant evidence for the effectiveness of current school-based service models, and reason to think that these services are providing little advantage over clinic-based services (Kutash et al. 2006).

A recent national survey of school-based mental health programs indicated that a vast majority of programs provide "pull-out" screening and counseling services to referred children (Foster et al. 2005), which are resource intensive and often compete with instructional time. In addition, the "clinic within schools" model provides few opportunities for interdisciplinary collaboration between mental health providers and educators, and even when successful, accommodates a relatively small proportion of the children in need of services (Baker et al. 2006). Furthermore, the negative environment in many schools in impoverished communities can overwhelm educational and mental health programs and is largely unaddressed by current school-based service models (Cappella et al. 2008; Gottfredson and Gottfredson 2002; Hoagwood et al. 2007). As many have noted, these issues suggest that the presumption of integrated services in schools is in need of critical analysis (e.g., Baker et al. 2006; Boyd and Shouse 1997; Ringeisen et al. 2003; Weinstein 2002).

An Ecological Approach for School-Based Mental Health Services

Ecological models for school-based mental health services provide a compelling unifying framework to guide research, policy, and practice. Ecological models are by definition individualized to the differing contexts within and across schools, which is important to offset the concern with current school-based models that they are unresponsive to school context (Hoagwood et al. 2007; Ringeisen et al. 2003). Among the most important implications of an ecological model is that the identification of mental health need would emerge from an assessment of children's functioning and competencies in natural settings (in this case, school), thus avoiding the often arbitrary diagnostic constructs prominent in child psychopathology (Jensen and Hoagwood 1997). In this way, the goal of focusing on improved functioning rather than symptom reduction (e.g., Hoagwood et al. 1996) would be prioritized. This focus on competency could also create a better alignment between educational and mental health policy, with many federal and state agencies adopting the concepts of impairment, functioning, and competencies within their definition of a mental health condition that requires services (Canino et al. 1999). In fact, in the latest version of the Institute of Medicine Report (National Research Council and Institute of Medicine 2009), promotion goals along with a focus on the development of competencies have been embraced.

Complimentary to this focus on the enhancement of competencies related to the core function of schooling is the fact that learning occurs within a social environment that includes interactions with teachers and other children (e.g., Brown et al. 2010). Thus, promoting the social-emotional aspects of development in children can be critical to the pursuit of academic learning (Payton et al. 2008). However, while it is acknowledged that schools spend considerable effort on implementing a wide range of programs that address the social-emotional development of students (Zins et al. 2004), these efforts are usually seen as tangential rather than core to the function of schools. More effective models for integrating social-emotional learning into the ongoing practices of schooling are needed.

Use of indigenous Resources Within School Settings

An important component of integrating mental health efforts into the ongoing routines of schools is the identification and support of indigenous persons and resources within schools as agents of change. This follows logically from the prioritizing of school goals for mental health programs and is important to insure the sustainability of program goals and processes, as well as to reconcile the workforce imbalance relative to regional disparities and the high need for services. The identification of indigenous resources involves both the selection of primary change agents and recognition of those factors involved in the successful performance of their roles. For example, the most obvious change agents in schools are teachers, as they control the setting of primary importance to children's learning, classrooms (Atkins et al. 2008). Factors associated with successful schooling would therefore be prioritized (e.g., effective instruction and classroom management), but goals such as enhancing teachers' ongoing support and learning structures would also become more central, as emerging evidence from several ongoing experimental classroom and school-based trials seems to suggest (Pianta and Allen 2008; LaRusso et al. 2009; Jones et al. under review). These same studies have also demonstrated a focus on effective instruction and classroom management as a strong predictor of children's future success. Similarly, children's peers have an important influence on students' schooling, with programs such as classroom peer tutoring demonstrating strong effects on children's learning and behavior (Rivera et al. 2006). Peer norms for achievement and behavior are relevant targets of change with a literature emerging on effective strategies to align peer influences with classroom academic and behavioral goals (e.g., Farmer and Xie 2007; Ryan et al. 2004).

While we acknowledge that schools, particularly in urban settings, continue to be challenged by the overall lack of resources and by the demands on teachers' time, the point here is the need to develop strategies that optimize, enhance, and augment the goals of education, rather than superimposing a new set of programs or professionals on these (often) beleaguered schools. Thus, it follows that using mental health staff as "educational enhancers" to assist teachers in providing effective instruction and classroom management may be wise and is a different paradigm from traditional mental health practices in schools. In addition, imbedding mental health staff within natural settings such as classrooms can improve consultation efforts through the relationships that are formed and improve the implementation of the programs that are developed through enhanced input from school staff (e.g., Atkins et al. 2006).

Diffusion of Innovation and Social Network Theory

Another implication of prioritizing indigenous resources is the application of diffusion theory to program development. Studies that have examined diffusion of innovation have determined that program response, or more precisely the degree to which programs are adopted within a setting, are largely a function of social interactional networks

(Greenhalgh et al. 2004; Rogers 2000). For example, Valente has shown that social networks are characterized by early adopters who may be influential within their own social network but whose influence within the larger setting may be small. Late adopters, or laggards, appear to wait until a threshold of program utilizers have emerged, which is referred to as a "tipping point". Valente has shown that this occurs often when 25% of a social network are utilizers (Valente and Davis 1999).

The implication of social network theory for mental health programs is twofold. First, program response should be understood as unfolding over time. A premature determination of poor program implementation may not only incorrectly assess the ultimate influence of the program, it may also *disrupt* the successful adoption of a novel intervention to a social setting. For example, this could occur when intervention supports (e.g., supervision, coaching) are withdrawn prematurely or by overly encouraging the use of an intervention by members who may need more time to accept the new intervention. An overemphasis on early acceptance of an intervention by skeptical providers can lead to program developers to categorize providers as either supportive or resistant to change, which is a naïve understanding of change occurring within social systems.

Second, if programs are not adopted throughout a social system (i.e., if programs are used only by early adopters or abandoned after supports are withdrawn), this could suggest that the program is not seen by a sufficient number of members as appropriate or important to their needs. Models for activating key opinion leaders to influence mental health program use have emerged with largely positive effects (Thomson O'Brien et al. 2006), including in schools (Atkins et al. 2008). In addition, key opinion leader involvement can assist program modifications that may be necessary to increase utilization and thereby encourage a more sustainable adoption of the intervention (Locock et al. 2001).

A Focus on Improving Outcomes for all Students

Even under ideal conditions to support program adaption and adoption, the field faces a major challenge in developing a unified research agenda on effective school models that will support the learning and behavioral health for students in special education due to emotional or behavioral disorders. This population of youth, estimated at 450,000 (Jans et al. 2004), have the poorest outcomes of all youth served in special education, with over half of these youth dropping out of school each year; the highest rate for any educational disability category (Jans et al. 2004). This dropout rate reflects the fact that these students earn lower grades and fail more courses than any other disability group served in special education environments (Landrum et al. 2003). As noted by data from the U. S. Department of Education (2002), adding to these bleak outcomes is the fact that 47% of all elementary/middle school children classified as emotionally disturbed have been suspended or expelled at some time during their school career, while 73% of youth with emotional disturbances at the secondary level have been subject to this kind of disciplinary action. Additionally, 61% of youth with emotional disturbance served in a special education setting score in the bottom quartile on standardized reading measures. Yet, less than 40% of these youth are receiving any type of mental health services along with their special education classroom services (Wagner et al. 2006). Thus, this remains a critically understudied group of youth with few empirically supported integrative models available to overcome these poor outcomes.

In an attempt to understand the lack of mental health services delivered to these youth, Minow (2001) found that psychological services were not often implemented for students who have emotional disturbance and are in special education because professionals were diverted to testing and crisis intervention rather than sustained support. She further found that "many school systems resist the provision of related services on the theory that they are not educational but medical or psychological, even though these services are required under the act where necessary to enable the student's free appropriate public education. Provision of related services often fails when school districts and other local agencies disagree over who should provide and pay for them" (Minow 2001, p. 4). These results highlight several issues surrounding the implementation of effective mental health for children with emotional disorders served in special education and point to next steps for the research community.

First, there continues to be a weak research base supporting effective interventions that address both the educational and emotional functioning of youth with emotional disorders who are served in special education programs (Rones and Hoagwood 2000), with the majority of school-based mental health research initiatives excluding this group of youth. Second, there is a lack of theoretical models to guide the development of the components needed to address both the emotional and educational needs of this population within a special education setting. Third, research on implementation challenges needs to focus on this specific population and setting, as general implementation research may not be adequate to address issues related to this setting and population.

Integration of Promotion, Prevention and Intervention

Currently, programs that focus on promotion, prevention, or intervention services often compete for priority within

schools. With diminishing resources, this competition is likely to increase. For children with intensive needs, such as those receiving special education services, the advantages of linking mental health services to schooling are considerable. Children's mental health difficulties commonly manifest themselves in schools with a resulting decrement in performance, or, in the extreme, suspension or expulsion (e.g., Atkins et al. 2002). Teachers and other school staff often do not have the resources or skills to manage high need children, especially in high-poverty communities where student-to-staff ratios are high and technology or other resources are scarce. Many children with mental health needs are highly susceptible to disruptions in daily activities. Therefore, classroom-wide programming for normative events such as transitions throughout the school day, or class-wide routines such as silent reading or group instruction, can often ameliorate their difficulties. In addition, classroom or school-wide programs can serve as a naturalistic base from which individualized programs can be developed for children with more intensive needs, avoiding the stigmatization that often arises when individualized programs are implemented in isolation of other program goals (Kratochwill 2007). See the APA Task Force on Evidence-Based Practices for Children and Adolescents (2008) for more details about integrative models.

As an example of a school-wide program that can serve as a facilitator of more intensive individualized programs for high need youth, Embry and his colleagues (Embry 2002; Embry and Straalemeier 2001) have developed a range of programs for the *Good Behavior Game* that begin with classroom-wide (and often school-wide) implementation, with specified adaptations to design individualized programs for children who require them. The LIFT program (Eddy et al. 2000) for example, examined educational strategies, classroom management approaches, and linkage to parents for youth at risk of emotional or behavioral problems and found that this model delayed the onset of problematic behaviors.

Another example reflective of the ecological and mental health approach is the interest and growth in implementing a form of school-wide positive behavior support called Positive Behavior Intervention and Supports (PBIS: Lewis and Sugai 1999). PBIS includes a set of evidence-based strategies at the individual and system levels with the goal of improving student behavior and learning and is currently being implemented in over 7,500 schools (Bradshaw et al. 2009). Cappella et al. (2008) suggest that mental health professionals, including those based in schools (e. g, school counselors and part-time psychologists), as well as community-based personnel can assume roles within each of the universal, targeted, and intensive levels of the PBIS framework. Mental health providers can support the school counselor in implementing school-wide, universal programs in the cafeteria, hallways, and playgrounds by providing training and supervision of security guides, lunchroom aides, and playground monitors. At the targeted level, mental health personnel can assist school administrators in collecting data and intervene in high need classrooms or settings. At the intensive level, a community mental health provider linked with the school can provide direct services as well as activate additional personnel for students with more chronic needs (Atkins et al. 2006).

Enhancing Active Involvement of Parents in Schools

Although active involvement of parents in their child's learning and participation in school has been given considerable attention within the school psychology literature (e.g., Sheridan and Kratochwill 1992), many schools still limit family involvement to a narrow set of activities, such as assessment and problem solving. Ways to expand involvement of parents in schools are being examined with different approaches and strategies through targeted engagement processes (McKay and Bannon 2004), specialized outreach programs delivered by parents to parents of students with mental health needs (Atkins et al. 1998; Kutash and Duchnowski 2008), and use of strategic family support techniques (Hoagwood et al. 2010; Robbins et al. 2008), for example. This paradigm is in sharp contrast to the separatist tradition of having schools assume the role of "in locus parentis" (Weist et al. 2009). However, the research base remains thin and uneven, although some components of family support (i.e., skill-building, parent management) have received more research attention than others (i.e., advocacy support) (Hoagwood et al. 2010).

Research Agenda

A research agenda to promote a new model of children's mental health services should examine the operation of classroom-, school-, and district-level processes and policies and how they facilitate or hinder the educational and social-emotional development objectives for all children and youth. Specific recommendations are:

1. The examination of classroom- and school-based processes and identification of where levels of opportunity exist to promote children's school success and social-emotional development. For example, we need to increase our understanding of teacher–student interactions, student-to-student interactions, and teacher support structures that facilitate classroom management, learning, and development of both teachers

and students. It follows that, by necessity, improvements in the measurement of these processes are also needed.

2. Future research should examine how best to deploy and support indigenous resources within school settings to meet the mental health needs of students. Examples are the involvement of teachers as key informants to promote classroom and school-based programs (e.g., Atkins et al. 2008), and the involvement of parents and other community members to enhance parent involvement activities (e.g., Frazier et al. 2007).
3. Effective and efficient service models that integrate promotion, prevention and interventions are needed. This should include consideration of the mental health needs of the entire school population, especially for children receiving special education resources, a highly underserved population in regard to their mental health needs. Research needs to focus on this specific population and setting, as general implementation research may not be adequate to address issues related to children receiving special education services.
4. The impact of school district policies on educational and mental health promotion is another unaddressed area of our understanding. For example, fiscal barriers to integrating mental health supports should be examined and strategies for eliminating economic disincentives to integrative services need to be identified.

Summary

Current models of school-based mental health remain overly focused on conventional definitions of mental health practice and provide inadequate attention to contextual issues that may influence both schooling and mental health. We propose a renewed agenda for school mental health services that considers the school context as a means of promoting children's mental health, and makes children's adaptation to school a primary goal for services. This agenda involves acknowledging a new set of priorities, which include: the use of naturalistic resources within schools to implement and sustain effective supports for students' learning and emotional/behavioral health; inclusion of integrated models to enhance learning and promote health; attention to improving outcomes for all students, including those with serious emotional/behavioral needs; and strengthening the active involvement of parents. Toward this goal, mental health services research can contribute to effective schooling by proposing targets for change and collaborating with educators to understand how to best effect these changes (Linney and Seidman 1989; Seidman and Tseng 2010). A strong research agenda to support these new priorities is essential.

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