Bridging the Divide: In Search of Common Ground in Mental Health and Education Research and Policy

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There is growing evidence that mental health and school functioning for children are intertwined. This article summarizes historical perspectives on U.S. child mental health policies and their interface with education and discusses trends in educational policy relevant to children's mental health, specifically the Individuals With Disabilities Education Act and No Child Left Behind. The traditional approach of mental health research in schools, which focuses on program and intervention development, has become stagnant. New paradigms are needed. These include attending to indigenous school resources, to the organizational context of learning, and to participatory models for constructing environments conducive to mental health promotion and learning. Persistent underfunding and fragmented fiscal support, however, render new approaches meaningless. If progress is to be made, new funding structures to support integrative educational and mental health practices are needed. (*Psychiatric Services* 60:1510–1515, 2009)

Children do not recognize the administrative differences between mental health and education. Children with mental health problems are more likely than their peers to experience school difficulties, including more absenteeism, higher rates of suspension and expulsion, lower grades and test scores, and greater high school dropout (1–10). Yet as researchers, providers, and policy makers, we continue to function in silos, a problem well recognized for decades (11–13), with educators primarily focusing on academic functioning and mental health clinicians targeting symptom reduction. Our service systems, and the policies and fiscal regulations under which they operate, reinforce the separate functioning of these systems, allowing many youths in need to fall through the cracks (13–15).

In recent years, school-based prevention strategies have aimed at simultaneously promoting positive mental health and school outcomes before the emergence of serious problems in either domain (16–24). Similarly, treatments for common childhood mental disorders have begun to lead to improvements in both symptoms and classroom performance (25). However, dissemination of effective treatments has not been widespread in community settings such as schools (13,26,27).

Increasingly, policy makers and researchers are examining ways to expand the provision of school-based mental health services (27). An extensive body of literature supports the assertion that mental health and educational outcomes are intertwined (28) and that schools and mental health providers can play an important role in supporting the overall development of children and adolescents (29). Despite the apparent intersection between these two fields, education and mental health research operate within very different paradigms. In this article we examine some of the historical trends within educational policy relevant to children's mental health and identify potential opportunities to bridge these two fields (30).

Historical perspectives

U.S. child mental health policies

It has been suggested that the United States has never had a comprehensive mental health policy for children (31). Such a policy would ensure that children with mental health care needs are able to receive appropriate services. From a historical perspective, Yarrow (32) credited the social reform movement at the end of the 19th century with raising awareness of the maltreatment of children both in the workplace and in orphanages. The Progressive Era of the early 1900s began to shed light on the social and, ultimately, emotional needs of children and families, with the for-

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mation of the Children's Bureau, which advocated for children's rights; separate courts for juvenile justice; and expansion of the educational mission of schools with the inclusion of nurses and school psychologists on campuses (33). The era of the New Deal ushered in a wave of unprecedented social reform facilitated by an expanded role of the federal government and increased federal spending, including Social Security and amendments that extended benefits beyond retirees to poor families and children and provided grants to states that were aimed at improving child health services, including funds for child welfare agencies (32).

During the Great Society, an expansion of social programs supported the poor, including the creation of Medicaid in 1960, which began covering health and mental health care for children of low-income families. Federal funding for the development of community mental health centers in the 1960s, through the Community Mental Health Centers Act, also shifted care from hospitals to specialty mental health care in outpatient community settings, and funding for the Child and Adolescent Service System Program (34) led to greater attention to a system-of-care framework, which attempts to integrate child-serving agencies and emphasizes a greater role of family members in care. Building on this framework, the President's New Freedom Commission report emphasized a public health approach in which care is family centered and evidence based (27). One way that the commission recommended that early detection and treatment occur was through expansion of school mental health programs.

Education policy and the interface with mental health

Since World War II, education policy in the United States has backed away from the broad mission of Progressive Era education reformers, who had expanded the function of schools to include vocational education, health promotion, and "mental hygiene." More recently, schools have focused on a narrower mission—ensuring high levels of academic achievement for all students. This has resulted, in part, from a heightened concern among policy makers and the public about the low levels of academic achievement among American students, illustrated by the relatively poor performance of American students in international comparisons of educational achievement and by the stunningly large gaps in achievement between poor students and students from minority groups and their peers. Beginning with the launch of Sputnik, moving through the release of *A Nation at Risk* in 1983 (35), and culminating in today's emphasis on "standards-based" reform, education policies at both federal and state levels have placed increasing pressure on local schools to emphasize a single mission: improving the academic achievement of students.

Perhaps the most important policy lever promoting this trend has been the No Child Left Behind Act (NCLB) enacted in 2002 (36), which seeks to eliminate the achievement gap that exists among groups of U.S. students. Since 1965, Title I of the Elementary and Secondary Education Act has provided local school systems that serve large proportions of students in poverty with additional funding to improve the academic achievement of disadvantaged students. Because of this goal, an important feature of Title I has been its reporting system, which has required schools to report the standardized achievement scores of students served by Title I funding. The main "advance" of NCLB over earlier policies has been that school systems now must report the standardized achievement scores of all students in their schools. Failure by schools to make "adequate yearly progress" toward 100% academic proficiency of students can lead to a variety of sanctions for local schools and districts.

Several provisions of NCLB touch on prevention services in schools, including Title I, Part D (programs for children who are neglected, delinquent, or at risk); Title I, Part H (dropout prevention); Title IV, Part A (Safe and Drug Free Schools); Title V, Part D, Subpart 2 (elementary and secondary school counseling programs); Title V, Part D, Subpart 3 (Partnerships in Character Education); and Title V, Part D, Subpart 14 (Grants to Improve the Mental Health of Children) (36). However, these have been mostly modestly funded, discretionary grant programs, and the previous administration's budget greatly reduced funding for most of these programs (37).

A second important trend in American education has been the expansion of special education. Since 1975 the Education for All Handicapped Children Act (PL 94-142), renamed the Individuals With Disabilities Education Act (IDEA) in 1994 (38), has mandated free and appropriate public education for all children with disabilities, approximately 11% of students nationwide (39). Although 50% of those served by IDEA are eligible because of a learning disability, IDEA also supports students who have academic deficits resulting from disabilities involving emotional and behavioral concerns, such as "emotional disturbance" (8%), autism (1.2%), and other health impairments (4%), which includes students with attention-deficit hyperactivity disorder (40). IDEA mandates that schools provide "related services" to students with disabilities, which can include mental health interventions.

With the reauthorization of IDEA in 2004, one major change has been the inclusion of Early Intervening Services (prereferral services) (38). This change allows for allocation of special education funding for research-based academic and behavioral support services for students who may be at risk of needing special education. To implement this policy, the response to intervention (RTI) framework has been used, which includes tiered responses from prevention and early intervention to more intensive treatments and ongoing assessments to monitor improvement and the need for alternative interventions (41). A 2008 report by the Children's Education Council documented that as of March 2008, 60% of districts had begun adopting an RTI approach (42). The RTI approach, with its emphasis on research-based interventions, may represent an opportunity for the broader dissemination of evidence-based prevention and early

mental health interventions within the context of an educational framework to support learning.

NCLB and IDEA—the two highest-profile federal public education policies in the K–12 sector—provide only a relatively small share of education funding in the United States, yet they exercise a large influence on local education practices. For example, as of 2004–2005, federal funding constituted only 8.3% of total K–12 education funding in the country, with the lion's share of funding coming from state and local sources (43). Nevertheless, the influence of federal funding on local education practices is important, in large part because all states and most local school systems receive funding under NCLB and IDEA and because both of these laws mandate certain procedures with receipt of funds.

Intersection between mental health services and education

Schools have traditionally provided a wide range of psychosocial support to students, especially as it relates to learning in the classroom. A recent study of mental health services in schools estimates that most U.S. schools provide prevention services (63%) and programs for behavioral problems (59%), and about 75% of schools report having schoolwide programs that support safe and drug-free schools (44). Of interest, the services ranked as among the most difficult to deliver in schools were family support services. However, promising school-based strategies are being developed to engage parents in an effort to increase involvement in both school activities and mental health treatment (45).

Although there appears to be widespread availability of school services, what remains to be determined is the content of those services and their impact on educational outcomes. In fact, practices known to be effective in treating mental disorders are not consistently used in community settings such as schools (13,46), even though untreated disorders can lead to school difficulties. The lack of availability is in part a result of the dysfunction of the mental health service system and in part a function of the lack of fit between effective mental health interventions and school contexts (47,48). This issue is especially important in low-income communities, which have been poorly represented in research samples (45).

Children in special education represent a population at particularly high risk of mental disorders (49–52); those classified as "emotionally disturbed" have worse outcomes, such as lower grades, more absenteeism, higher grade retention, and greater high school dropout than students with other types of disabilities (52,53). Approximately 450,000 children are classified as emotionally disturbed within the special education system. More than half of these youths drop out (52), resulting in the highest dropout rate in any disability category. The dropout rates reflect the fact that these students earn lower grades and fail more courses than any other disability group served in special education environments (54–56). Historically, there are multiple reasons that could account for such poor long-term outcomes, including lack of early interventions for at-risk students, a disconnection between the special education and mental health definitions of disabilities and subsequent treatments, and the "wait to fail" approach of special education before reauthorization of IDEA, which often led to late identification of needs and delayed delivery of appropriate interventions.

In addition to services for students in special education and specific prevention and early interventions to address behavioral and emotional problems, there have also been promising whole-school approaches, such as positive behavior supports and expanded school mental health programs (57,58). Researchers have also begun examining the quality of mental health services in schools and the relationship with program adoption (59).

Funding sources for mental health services in schools

One major barrier to maintaining—not to mention expanding—mental health services in schools is the obvious focus of schools on instructional spending; however, this often comes at the expense of the school's "learning support services." Put differently, in most schools, provision of mental health services is not seen as a core cost and is instead supported by supplementary (often categorical) funding. For example, the Substance Abuse and Mental Health Services Administration's report, *School Mental Health Services in the United States, 2002–2003,* showed that the most widely used funding source for mental health services was IDEA, used by 63% of districts, followed by state special education funds (55%), local funds (49%), state general funds (38%), Medicaid reimbursements (28%), and NCLB (20%) (44). The Safe and Drug Free Schools program funded prevention programs in 57% of districts, followed by local funds (43%) and state general funds (39%). This study showed that a lack of funding was a major barrier to the provision of mental health services in schools and that use of funds for mental health interventions and prevention efforts was limited by competing priorities (such as a focus on improving academic achievement), insufficient community mental health resources, the difficulties of using multiple funding streams to provide services, restrictions in service provision by insurance companies or health maintenance organizations, and lack of administrative support for third-party reimbursement by districts.

Future research opportunities

The persistent divide between the aims of education, the irregular patterns of funding and underfunding, the educational needs of students with mental health problems, and the separate trajectories of research within mental health and education has led to stagnancy. Although it is widely acknowledged that the school system is a promising frontier for improving a range of child outcomes—educational, social-emotional, and developmental—the way to accomplish these goals is not clear. It would appear that another paradigm is needed.

Elements of a new paradigm

Adoption of community-based participatory research methods. Mental health interventions in schools typi-

cally do not reflect the context of the school environment, which results in significant barriers to implementation and mismatch of organizational culture and structure (48,60). One way to move beyond "placing" mental health interventions in schools is by engaging in a community-based participatory research process that involves a "collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings" (61). This approach can bridge the divide between education and mental health and can also help identify areas of overlap between the educational and mental health needs of students.

For example, Atkins, Frazier, and colleagues (62,63) have identified already available "indigenous" school services and embedded mental health consultations and supports within these existing and accepted school functions, which has been well received by schools. Use of community-based participatory research can also lead to the development of quality improvement strategies that encompass mental health and functioning (64) and that improve counseling services received under IDEA through partnership with school psychologists and other school staff.

Building capacity to measure broad outcomes in research and practice. One area of convergence between education and mental health policies is accountability, with continuous monitoring of standardized test scores by schools and the emphasis on evidence-based treatments in the mental health field. Too few school-based mental health models have documented joint effects on mental health and academic outcomes. A recent review of studies of school mental health interventions, for example, identified 64 articles from 1990 to 2006 that used experimental designs to assess the impact of school mental health interventions (25). Among these, only 24 examined both mental health and educational outcomes. The majority failed to include even rudimentary measures of school-related outcomes. Analysis of the 24 studies found a constricted range of measures for assessing academic or mental health outcomes, suggesting the need for integrative measurement development. Fifteen of the 24 studies demonstrated a positive impact of the intervention on both educational and mental health outcomes. Three-quarters of the interventions with a positive impact included intensive supports targeting both parents and teachers.

The implications are that the literatures on education and on mental health are only now beginning to be integrated conceptually, pragmatically, and instrumentally. A different paradigm that promotes psychological science in the service of educational outcomes would attend to context variables, such as characteristics of the school setting (for example, attitudes and behaviors of teachers and counselors, school organizational variables, and community characteristics), and involvement of families and school community stakeholders (65,66). Expanding collaborative participatory processes with schools may also be important in sharing existing school data along with research-generated data for quality improvement and program evaluation.

In evaluating interventions in the context of school functioning, distal outcomes, such as dropout, grades, and attendance, that are important to educators may be less likely than more proximal variables, such as school engagement and disciplinary actions, to demonstrate immediate change as a result of the interventions. Further development of research designs and measures that can incorporate meaningful child- and classroom-level outcomes are needed.

Evaluating financing strategies that facilitate learning and social-emotional development. Current sources of funding for school mental health services are idiosyncratic, unsystematic, and undependable. It is time for concerted attention to the issues of financing mental health services in schools. This will require the development of different models of mental health financing, including those that reduce tax competition and conflict over scarce resources. One promising model for increasing service capacity without drawing down scarce education dollars is to enlist community providers to spend more time on school campuses and to structure billing for those services (67). Use of parent coordinators, family advisors, and other community providers to deliver adjunctive support services is billable in some jurisdictions. Studies assessing the relative costs and effectiveness of different models of delivery, such as colocation and coordination and on-site versus off-site delivery, would be instrumental in formulating stronger fiscal policies.

In a 2008 report *Unclaimed Children Revisited,* Cooper and colleagues (68) noted that fiscal constraints was one of the main barriers cited by states in responding to the mental health needs of children. Some states reported restrictions in Medicaid reimbursement for care that is not office based, such as care provided in schools or recreational settings, and other states identified barriers in providing prevention and early intervention services because of the requirement of a diagnosis for reimbursement.

Conclusions

New paradigms that bridge the divide between education and mental health are long overdue. Educational policies are increasingly promoting academic achievement as the primary goal of schooling. Teachers are increasingly being held accountable for student learning. The traditional approach of mental health research in the schools has focused on identification and testing of specific programs or practices—preventive interventions and treatments for targeted disorders (anxiety and depression)—with the expectation that these will easily fit and be accepted by schools. By and large, this has not happened. Practices with no evidence supporting their effectiveness are adopted (for example, the DARE program), instead of evidence-based practices, which are often left to gather dust on academic shelves.

A different approach that builds on indigenous resources of schools, that attends to the organizational context of learning, and that applies participatory models for developing and testing school-relevant practices may do more to promote student learning

and mental health than adherence to the current paradigm. Persistent underfunding and fragmented fiscal support render even the most promising new approaches meaningless. If progress is to be made, new funding structures to support integrative educational and mental health practices are needed.

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