

**What Every Administrator Needs to Know About**

**Ways to Serve Students with Significant Mental Health Needs:**

**From Inservices-in-a-Box to Conversations in a Kitchen**

Polly Nichols, Ph.D.

University of Iowa

Each year brings administrators greater challenges in meeting the needs of students with serious mental health problems. There are three main trends that have caused this.

The first is the reduced availability of out-of-home placements for mentally ill children. At one time, these young people were deemed either too ill or too unpredictable to get along in the real world of general classrooms and were maintained in residential settings in their own states or elsewhere. Or else, if students had disruptive behavior disorders, they could be excluded from school altogether, as these were not considered to be true mental health problems and such youths were rarely considered for special education. Now, if sent to psychiatric medical facility or a group home for children where they do not become manageable or “fit well with the program,” they are likely to be sent home to attend public school where No Child is Left Behind.

The second is the belief in the medical community of the greater effectiveness of drugs to resolve mood and behavior problems than in the past, thereby allowing students to remain in their home communities with little or no further need for interventions. Medicines may be started under close clinical supervision but left to general practitioners or families to titrate and monitor. Other critical interventions such as cognitive behavioral therapies for children or assistance for families and schools may be non-existence in home communities, and without them, recovery is impossible.

A third are increases in the proportions of children and adolescents who suffer from serious emotional disturbances, simply increasing the likelihood that families, schools, and communities will be close to such troubled young people who might formerly have been seen as “those others.” In the decade between 1990 and 2000, for instance, community hospital admissions for affective disorders increased 138 percent nationwide. The rates of hospitalization for autism and ADHD increased nearly 400 percent. There are many points of view about such statistics, but the truth for school administrators, teachers, and parents is that more students with what are now perceived to be mental, emotional, or behavioral health issues severe enough to have gained the attention of medical as well as of judicial and social welfare professionals are now theirs to include in their schools’ learning environments.

We know from recent research that there is higher purpose in educating these children and doing it well than simply that we do it by default and because federal law says we have no choice in the matter. A huge 2005 study in which 9, 282 adults with severe mental illness were personally interviewed resulted in this AP news release: “One-half of all lifetime cases of mental illness begin by age 14, and despite effective treatments for the disorders, there are long delays between the onset of symptoms and seeking treatment, according to the largest survey ever of the nation’s mental health . . .”

Schools across the country have stepped up to meet this challenge, and *schools are now the primary providers of mental health services for children*. But 70 to 80 percent of school-age people with mental health issues get *no* specialized services. Those with diagnoses and functional impairments are seven times more likely to receive them. And of those who do, 70 percent receive mental health services from the schools—for nearly half of those, school is the *only* provider.

What can and do schools provide? There are two main branches of school-based mental health services in schools:

1. SCHOOL-BASED CLINICAL MODEL —Qualified mental health providers funded directly by the schools or by their community agencies provide therapeutic services, primarily to diagnosed individuals from whom they may collect Medicaid or other insurance payments. Their offerings may range from full mental –health clinics to various kinds of group or individual counseling and therapies that do not include psychopharmacology.
2. SCHOOL-BASED EDUCATIVE-PREVENTIVE MODEL — programs developed for delivery to whole schools, to certain grades, or to groups with special needs within schools. These are designed to teach skills in such areas as anger management, social problem solving, or relationships.

**Important in both branches at this point is that the programs offered be examples of Evidence-Based Practice. What are the overall key components of EBP in mental health interventions that need to be included in schools?**

Following are descriptions of two school-based mental health programs, The first is an extremely simple but effective one called *Inservices In-A-Box*, and the second is a complex model that may not even directly involve a mental health professional but is certainly a highly individualized process involving other community agencies. It is called called *Wraparound*.

**Inservices-in-a-Box** are a project of the Iowa Department of Education’s Special Services Group whose purpose has been to provide support for those working in schools with students who have moderate to severe social, emotional, or behavior disorders. Produced by the educators at the University of Iowa’s Child and Adolescent Psychiatry Service, each box contains materials for an inservice or study group on a serious disorder. The materials include books, a notebook of readable-by-laymen articles, video and audiotapes from professional organizations such as CHADD, pamphlets and brochures, and a special videotape of a discussion with a child psychiatrist, a general educator from a public school, and several others (often a parent) with

questions or answers about the topic of the inservice box. The discussion gives an overview of the diagnosis and treatments and, most importantly, the kinds of problems it may bring up at school and how they may be resolved.

The complete sets of 15 boxes are placed in each AEA's Parent-Educator Connection media library. Placed there, they are available not only to educators, but to parents and members of the community as well. The subjects are:

### **Inservices-In-A-Box Subjects**

Depression

Schizophrenia

Obsessive Compulsive Disorder

Tourette Disorder

Asperger Disorder

Serious Emotional Instability focusing on Deliberate Self Injury

Eating Disorders

Oppositional Defiant Disorder

Seriously Disruptive Behavior — Secondary

Seriously Disruptive Behavior — Elementary

Anxiety Disorders

Bipolar Disorder

Reactive Attachment Disorder

Substance-affected kids (pre-natal - FAS et al)

Traumatic Brain Injury

The materials often stand in for the missing expert to give the teacher or the entire faculty or even the classmates of a student with a serious problem the information they need to be helpful and supportive instead of wary or afraid.

**Wraparound** is the parent- and student-centered intervention considered most appropriate and useful for helping students with significant mental health problems in schools using the school-wide behavior planning tools of Positive Behavior Supports. Parent and community involvement at all levels of school life is a hallmark of PBS, and the key components

of Evidence Based Practice are contained within these 10 Basic Principles of Wraparound, too, making it an ideal fit.

**10 Principles of Wraparound:**

- Family voice and choice
- Team Based
- Natural Supports
- Collaboration
- Community based
- Culturally competent
- Individualized
- Strengths based
- Persistence
- Outcomes based

**Wraparound** is less tied to specific clinical diagnoses than it is to school functioning in general, but usually to disruptive behaviors that would be readily diagnosable. Its greatest help is with those students whose problems have lead to disagreements between parents or other mentoring adults having conflicts with school personnel so that people are not getting along or seeing eye to eye on what needs doing about the student. The youngster is often embroiled in more than one part of the system – with juvenile justice or human services, for instance.

Wraparound begins with the crucial “initial conversation.” Someone with WRAP team experience who is not in conflict with the family calls the primary caretaker to say, “You know, Ms. Jackson, I don’t think we at school are doing a good job of reaching Ted this year at all. Our ideas for helping him just aren’t working out and may be making things worse. I’m hoping that *you might have some better ideas about what he really needs* to have happen stay out of trouble and do well at school. Would there be a time when I could come over and talk about what you think we all could do to really help Ted? We could meet with him there, or we could meet

somewhere else if you'd rather. . . “ The goal of this kitchen conversation will be to start focusing on Ted's *strengths*, to truly understand Ms Jackson's perception of his problems, and to get her to think of the people in her family or circle of personal support that could help get things straightened around for him — perhaps an uncle or a neighbor — and who could be on a team of school people and others to plan real workable solutions that meet her and her son's needs as well as the schools.

Hard and time-consuming? Sure. Will it be worth it?

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