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Schools, Children's Mental Health, and the Advocacy Challenge

Jane Knitzer, Zina Steinberg, and Brahm Fleisch
Bank Street College of Education

Draws on a recently completed 2-year national study. Highlights some of the mental health service related problems in the schools, describes ways in which schools and mental health agencies (either singly or collaboratively) are trying to enhance the school life of children and strengthen their access to mental health services, and explores the implications for advocacy. Increasing attention is being directed to the role of the schools in serving children with behavioral and emotional problems under the mandate of the Education for the Handicapped Act, as well as those with problems who are not referred to special education.

Schools play a major role in the lives of children. After the family, they are essential in building or undermining self-esteem and a sense of competence. Most children manage reasonably well in schools. But some children, and the numbers seem to be growing, do not. These children, who are disproportiontely victims of poverty, parental substance abuse, violence, or mental illness, and most recently, homelessness, often come to the attention of the schools because of disruptive and disturbing behavior. A proportion of them are labeled under the Education for the Handicapped Act (EHA, also known as PL 94-142) as "seriously emotionally disturbed" and thus entitled to receive special education and, if necessary, related services. A far greater proportion are at high risk of school failure whether or not they ever get special services.

Drawing on a recently completed 2-year national study, this article highlights some of the most critical issues that advocacy must address if schools and mental health agencies are to provide more responsive educational and support services to children for whom "schools as usual" do not work.

Why the Time is Right

In laying out this advocacy agenda, note that four different realities combine to make this a particularly opportune time to focus attention on the role of the schools responsibility to children's mental health. In the first place, there is a general consensus among educators, clinicians, and parents that for children identified under the EHA as having behavioral or emotional disorders, the promise of the law has been greater than the reality of its implementation (Forness, 1989; Knitzer, 1982).

As a corollary, there has also been a broader questioning of the entire special education system, based largely on evidence that in too many instances children, particularly those with so-called learning disabilities or those who do not behave properly, are referred to special education too quickly (Gartner, 1986; Wang, Reynolds, & Walberg, 1986). In response, the Department of Education, through the *Regular Education Initiative,* has been explicitly encouraging schools to develop mechanisms to divert children from special education and to provide better supports to teachers (Will, 1986). Similarly, school support personnel, and particularly school psychologists, are beginning to question the extent to which they spend their time doing evaluations for special education rather than working directly with students and especially consulting with teachers (Will, 1989).

Meanwhile, recent developments in the broader field of children's mental health, particularly with respect to the implementation of the Child and Adolescent Service System Program (CASSP) are turning the spotlight on the need for more in-home and community-based mental health services to troubled children. Recognition is growing that children and families need more than access to outpatient and inpatient care. The most seriously troubled also need day treatment and intensive in-home crisis intervention services (often called family preservation services), case management services, even wrap-around services, which are highly individualized (i.e., hiring a behavioral coach to help a child develop and practice social skills), as well as respite care for families.

CASSP efforts have largely been targeted to the most seriously disturbed. At the core of the CASSP approach is the recognition that serving these chil-

Requests for reprints should be sent to Jane Knitzer, Citizens' Committee for Children of New York, 105 East 22nd Street, New York, NY 10010.

dren is a multi agency, multi system challenge. As a result, by design, much of the effort to implement CASSP has involved building closer collaborations with the other systems in which troubled children and adolescents are found, particularly child welfare and juvenile justice, and providing services where the children are: in homes, in schools, and in detention (Knitzer, 1989a). To date, however, schools have not been central in these efforts.

Finally, this is an opportune time to reassess the role of the schools in meeting the mental health needs of children not in special education. For several years at the policy level, educational reform was defined by a focus on excellence, largely played out by increasing competency tests for either teachers or students. Policymakers now seem ready to attend to the reality that such strategies typically do not help high-risk children for whom making standards more rigorous, without building in a strong commitment to changing teaching strategies and strengthening support services, is not enough (Kean, 1989; Levy & Copple, 1989).

What has not been so clearly articulated, however, is the reality that many of these high-risk students are children with either identified or unidentified behavioral and emotional problems. (In a beginning effort to quantify this overlap, the state of Maine prepared an internal memo suggesting that during one year, 10% of all students who dropped out had been identified as behaviorally disordered or emotionally disturbed, and probably two thirds of the total population of dropouts had some kind of behavioral or emotional problems that had not been addressed.) Yet typically, the burgeoning dropout initiatives are being crafted without the involvement of mental health perspectives, dollars, or agencies.

Methodology and Questions of the Study

Given these realities, our study set out to capture the current state of the art with respect to both identified and at-risk children and adolescents. More specifically, we sought information about school-based or school-related program models for serving children with serious behavioral or emotional difficulties, as well as those at risk; about how educational and mental health policies and programs for children with severe behavioral difficulties encourage or discourage the involvement of parents in the education and treatment of their children; how current policies and programs encourage or discourage a multiagency response to the needs of seriously troubled children and youth; what promising state level policy initiatives are in place; how regular education teachers, principals, school board members, and others can be encouraged to serve at-risk students more effectively; how the federal role can be modified to encourage increased state and local attention to both the identified and the at-risk population; and what advocacy efforts exist on behalf of children with behavioral and emotional difficulties to improve school-related and interagency services to them and their families.

We should also note that there are four assumptions underlying these questions. First, parents should be involved in some meaningful way in the school life both of children at risk of being identified, or of those already identified. Second, for the least seriously disturbed, the response from regular education is as important to examine as is the response from special education. Third, for the most seriously disturbed population, a multiagency approach is necessary, because the children are likely to be involved with not only education and mental health, but also either concurrently or sequentially, with child welfare, juvenile justice, health agencies, and vocational education (Knitzer, 1982, 1989b). Fourth, the school climate itself is a psychological intervention, and the teacher plays a vital role in how this climate is fostered.

We gathered four types of data. First, to understand the scope of the policy challenge we carried out two surveys, one of the state directors of special education, the other of the state directors of child and adolescent mental health. Second, using a key informant strategy, we identified programs that state officials, parents, and professionals in leadership positions saw as worthy of note. In total, we reviewed information on over 130 programs and made site visits to 26 located in 13 different states. Third, we surveyed parents of children with serious emotional or behavioral disorders, using a questionnaire form that was completed by over 200 parents. (We recognize, of course, that our sample was not a random one of all parents of children with serious mental health needs, but we nonetheless believe it lends a perspective and an urgency to our data that is critical.) Finally, we reviewed the more formal education and mental health literature.

The final report synthesizes both the research literature and the findings from our site visits and surveys in detail (Knitzer, Steinberg, & Fleisch, 1990). In this article we focus on two central issues, the quality of the education and related services accorded to children and the ways in which education and mental health are singly or collaboratively seeking to be more responsive. To set the context, first consider some of the basic data.

Some Statistical Realities

During the 1987–1988 school year, 374,000 students were identified as seriously emotionally disturbed (or the state equivalent term, e.g., behavior-

ally impaired, behaviorally and emotionally disordered). This represents about 9% of the total special education population and .85% of the total school population, although, as has been frequently noted, there is considerable variation from state to state and district to district (United States Office of Special Education Services, 1989).

From an epidemiological perspective, these figures are surprisingly low. The most current estimates suggest that between 8% and 12% of the population, or 10 million children, have conditions warranting interventions (Brandenburg, Friedman, & Silver, 1987; Institute of Medicine, 1989). Without much of an empirical base, schools often use the estimate of 2% (Smith & Wood, 1986). However, a recent study in Washington State found that 6.7% of the children in regular education were rated by teachers as having behavioral profiles comparable to children in the most restrictive mental health facilities in the state (Turpin, Low, Forsyth-Stephens, Tarico, & Cox, 1988).

Moreover, although the phenomenon often called the *underidentification* of students is reflected in national school identification rates, it is not at all clear that the right children are always identified. For instance, in general, Black students are more likely to be overidentified. In Connecticut, for example, Black students are identified at a rate twice that of White students (Connecticut Department of Education, 1987). Other ethnic groups such as Native Americans and Asian students are likely to be under-represented (Forness, 1989). Similarly, the nature of the problem may also affect identification; some districts refer only children who "act out," whereas others ignore them, preferring to see them as socially maladjusted and therefore excluded from the law's mandate.

It is also of concern that in a new and very troubling trend in some states and communities, schools are seeking to exclude children with conduct disorders—a *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. [DSM–III]; American Psychiatric Association, 1980) category—from the mandate of the law. Underlying this is the dubious assumption that these children can somehow control their behavior, although while genuinely seriously emotionally disturbed children cannot, despite clinical experience and data showing that many conduct disordered children are also depressed and anxious (Friedman, et al., 1988).

Data on services accorded to identified students are spotty. We know most about the settings in which they are educated. According to the 11th Annual Report to Congress on the Implementation of the Education for the Handicapped Act, 10% of the students are served in regular classrooms, 35% are in resource rooms for some part of the day, and 37% are in self-contained classrooms. Altogether, over 80% of students identified as seriously emotionally and behaviorally handicapped are served in regular public schools. (Of the remainder, 12% are in day schools or day treatment programs, 4% are in residential settings, and the rest either in correctional facilities, hospitals, or on home-bound instruction, which usually means the schools do not know what to do with them at all.)

The federal government does not collect meaningful data on the nature of mental health services identified children and adolescents receive. But we do know that notwithstanding the provision in the EHA that related services must be provided to enable a child to benefit from an education, and that counseling and therapy are both included in regulations as a possible related service, in fact, the capacity to provide publicly supported mental health services to these children is very limited. Schools often lack the capacity to provide them in-house, yet they are reluctant to refer children officially (i.e., as part of the required Individualized Education Plan) to outside mental health agencies because of potential fiscal liability. (Under the law, if a related service is required as a part of the child's Individualized Education Plan, the schools must ultimately pay.) Instead, in a longstanding sub rosa pattern, schools often suggest that parents seek counseling for their children on their own.

Data to confirm these patterns are limited but growing. One study, for example, found that 58% of the school districts have no capacity to provide any counseling services on their own (Moore, Strang, Schwartz, & Braddock, 1988). Another study, using as a sample five metropolitan elementary school districts, found that access to therapy varies enormously. Of the 61% of the students receiving some counseling, between 60% and 70% received no more than 5 sessions. Moreover, of those students who had more than 5 sessions, almost half of the time, parents, not the schools, paid the bill (Palfrey, Singer, Raphael, & Walker, 1987). Because this is not the case for children receiving other related services, an equity issue is clearly raised. Moreover, the pattern is fully consistent with our findings; parents repeatedly report depleting insurance and savings to get mental health services for their children. It is also problematic that regardless of who pays, under the prevailing system when a child does get therapy, it is unconnected to the school life of the child and is of little help to the teacher. (Informally, one community reported that in a review of the cases of 80 children who were actually referred to clinics by the schools, only four of the clinicians spoke directly to the teachers.)

The evidence suggests that as a group, children with identified behavioral and emotional disorders

do not fare well educationally. Close to two thirds function below grade level, and many have a history of repeated failures (Friedman et al., 1988; Kauffman, Cullinan, & Epstein, 1987; Wagner & Shaver, 1989). Moreover, once in the special education track, few leave it to return to the mainstream, except to drop out completely. Studies have found, for example, that under 10% of the students return to the mainstream (Walker et al., 1988). The federal data suggest a staggering 42% of those 16 and older drop out, in comparison to 26% of students with any handicapping condition. And, not surprisingly, a still ongoing study also confirms the predictable realities that many do not do well after school; in a sample of 800 secondary students, the first year out, over one quarter had been involved with the courts; by the second year this had increased to 44% (Wagner, 1989).

Data are also accumulating to show that the ravages of poverty and racism take their toll in the emergence of problems. For example, in a number of studies, the percentage of low-income students in classes for students with behavioral and emotional handicaps hovers around 50% (Clark, 1985; Friedman et al., 1988; Palfrey et al., 1987; Trupin et al., 1988).

A Troubling Collage: Impressions From the Field

The overall purpose of our study was to identify best policies and practices; we did not set out to identify problems. But in making our site visits, some troubling patterns about the realities of the daily school lives of children with identified disorders emerged. We highlight these next. Problems in the daily school lives of children without such disorders have already been well described (Goodlad, 1984).

The Classroom Life and the Curriculum of Control

In too many programs that we observed, the theme of control that is implicit in regular education was explicit for children with behavioral and emotional disorders. It appears that the goal is more to maintain silence in the classroom than to help children cope with anger, sadness, or impulses, or to help them engage in and get excited about learning. The behavioral management system (often defined in terms of points and levels) is viewed as the heart of the curriculum; yet in many instances it is simplistic and not designed to help children gain control over their own behavior. In one classroom we observed, children could erase "sentences" given for bad behavior by reciting the Gettysburg Address. Not surprisingly, the child who explained the intricacies of the system did not know who wrote the Gettysburg Address, although she did say she knew it backward and forward.

Furthermore, often so much time is spent implementing the point system that the academic life of the classroom takes a back seat, defined in most instances by an endless stream of worksheets. Computers are used for games (often violent ones) as part of the reward system, rather than as a learning tool to engage children. We also did not see many instances of nontraditional teaching strategies such as peer tutoring or cooperative learning. And despite the reality that many children are placed because they lack social skills, little emphasis is placed on creating situations to help them gain such skills, although in several instances we observed packaged social skills curricula being used in a mechanical way. In one classroom, for example, the teacher gave the six students who sat around a table sentence stems: "I am unhappy when . . . ; it is hard to make friends because. . . ." Once each child completed the sentence the teacher moved on to the next child, never engaging any of them in a discussion. It also appeared that, either as punishment or on the grounds that they cannot handle it, often students identified as seriously emotionally disturbed are denied access to physical activity. Similarly, they also may be excluded from extracurricular activities, whether during or after school (despite the fact that this has been challenged successfully under the provisions of Section 504 of the Rehabilitation Act of 1973).

Lack of a Mental Health Presence Revisited

Earlier we highlighted data about the lack of access to therapy for children with identified behavioral and emotional problems and the equity issues for parents. But our site visits put the problem into even greater relief. It is not enough to be concerned with the lack of access to individual therapy or counseling for students, particularly those with more serious disabilities, or with the fiscal burdens on parents. The lack of a mental health presence is also defined by the absence of support systems for teachers of identified students, especially those who teach in self-contained classrooms and who often feel (and are) isolated and beleaguered.

Limited Strategies for Working With Parents

Increasingly, both for children identified as having behavioral or emotional disorders, as for other children, schools are recognizing that families are critical to positive outcomes for children. Yet despite rhetoric about family involvement, concrete strategies to ensure that families are seen as partners

are limited, reflected for example, in asking parents to sign daily point cards. Often school personnel communicate a sense that families are to blame, leaving parents feeling closed out or accused. Sometimes, though, they turn to them when all else fails—sending students home, for example. Yet, as one parent said, "If I knew what to do, I would have done it long ago." Moreover, school–parent meetings are often filled with negatives. One parent we spoke with, for example, told us of being confronted in the school parking lot by the special education director, her child's teacher, and the principal, who told her, "We never want to see him again." The child was a second-grader who locked himself in the principal's office.

Inattention to Transitions and Continuities

Teachers, parents, and clinicians recognize how difficult and even disruptive change can be for all children, whether it is change from lunch to reading or from playground to nap. For children with identified behavioral or emotional disorders, the transition issues loom even larger. Yet very often these are not attended to; and children, families, and teachers must cope with the disruptions typically in an ad hoc manner.

This is particularly so in public school settings, where staff or strategies to ease transitions for students are the exception, not the rule. Recent federal efforts have emphasized the need for transitional planning for older handicapped students moving into the workplace. Similarly, the new law (PL 99–457), extending the principles of PL 94–142 to infants and toddlers with special needs, also underscores the importance of transition planning. But for children in the middle, facilitating transitions is still all too infrequent.

In one program we visited, for instance, a child returning from a segregated setting to a large public school had not seen her counselor at all; in another instance, a third-grade child who had just been placed in a self-contained classroom cried intermittently throughout the morning, but no one helped him. The problem is particularly acute for those children who are decertified; many school districts believe that once decertified, children cannot receive any further help, a confusion that must be clarified in regulation.

Some Promising Alternatives

Efforts to enhance the capacity of the schools to respond more effectively to children with behavioral and emotional problems are taking three directions: (a) strengthening the mental health presence in regular school settings; (b) enriching and rethinking appropriate services for children identified under the mandate of the law; and (c) for the most seriously troubled, forming working cross-system collaborations to create multiagency case plans, to build linkages across different programs, and to provide a community-based forum for garnering new and reallocating old resources for mental health services, including school-based mental health services. Although in a short article it is not possible to provide detailed information on these developments in the following sections we highlight some of the conceptual frameworks and strategies that undergrid these initiatives, because they too should help inform an advocacy agenda.

Strengthening the Mental Health Presence in Regular Education

Schools seeking to build a mental health presence into regular education are using five strategies. First, building on the widespread interest in using school-based support teams to help teachers generate and carry out short-term interventions to divert children with special needs (especially learning disabled children) from special education, some school districts are enriching basic pre-referral strategies with adaptations designed to facilitate interventions for children with behavioral problems. One midwestern school district, for example, trained a cadre of behavior management aides who, with supervision from the school psychologist, carry out interventions designed by the school-based support team. The aides not only help individual children, but they serve as models to the teachers, thus expanding the teachers' repertoire of specialized skills in dealing with difficult children. Prereferral efforts are not without criticism (Kauffman, Garber, & Semmel, 1988), and careful evaluation is critical to ensure that the children are not simply denied the rights and benefits of the law.

Second, community mental health agencies are moving out of the clinic and into the schools. For example, in a northeastern school district, the community mental health center, working with the schools, developed an early intervention program targeted to a specific group of children at high risk: siblings of children already identified as seriously emotionally disturbed, children who have been abused and neglected, and children whose parents manifest significant psychopathology. (The program exists in a community with a large psychiatric hospital.) In a midwestern school district serving a large proportion of low-income students, the staff of the mental health agency provide consultation to teachers as well as short-term therapy and crisis intervention. In this instance, the school has become a medicaid provider agency in order to bill Medicaid for these services, a new option now allowable under federal law.

In a third development, mental health personnel, sometimes from within the schools, sometimes from outside, are involved in setting up special classes designed to supplement the academic day of students with specialized programming, often focused on social and academic skill development. Florida, for example, has established a network of such programs, targeted largely to middle school children and delivered under the auspices of either the schools or community agencies, including mental health and substance abuse agencies. Special classes, of course, like special education, carry the danger of stigmatizing students who participate (Oakes, 1985). But they also provide a vehicle for intensive short-term interventions and supports to students that may make a difference.

Fourth, we also identified several models for providing crisis intervention to both students and school personnel in the face of potentially traumatic events that are becoming sadly predictable, involving either violence or natural disasters (Berkovitz & Seliger, 1984).

Fifth, although they are far less prevalent, we also identified several programs that seek, systematically, to strengthen school–family alliances, particularly for high-risk, low-income students. Some of these focus more on individual children, whereas others focus more on reforms changing the whole school climate. For example, in New York City, the Ackerman Family Institute has developed the School-Family Collaboration. Originally, its goal was to conduct and then teach school personnel to conduct, problem-solving meetings for individual children experiencing problems (e.g., truancy, bringing knives to school, or failing to do work). Using the principles of family systems therapy, school personnel, parents, children, and whoever else is important in the child's world, generate, agree on, and carry out specific interventions that are then monitored and refined. As the schools become more comfortable with this approach, the project staff increasingly find themselves working collaboratively to develop broader-based reform strategies, affecting the very climate of the school. The often described School Development Program, developed by Comer at Yale, also places a high value on building stronger alliances between parents and schools as a key tool in reducing student disruptions and problems and enhancing achievement (Comer, 1985).

Strengthening Programs for Identified Students

Our visits to both self-contained classrooms and day treatment programs suggest that educators and clinicians are also trying to reduce the bleakness that pervades the lives of many emotionally and behaviorally disordered students in each of the areas that we found to be problematic. In some instances, this involves enriching the behavioral management system; one school we visited, for instance, established a fairness committee, where each of the children, along with the teacher and the psychologist, meet with students who violate the rules and together determine fair consequences; a day treatment program has created a "time-in" room where a staff member works with the students to help them learn alternate ways of responding. Students are either referred by teachers, or self-refer. In several instances, the schools use the curriculum itself as a vehicle for engaging the students, giving up the ubiquitous drill sheets for a more lively approach to learning. Thus, one district has developed a special high school program incorporating extracurricular activities into the daily curriculum.

As was the case for students showing problems but not yet formally identified as having behavioral or emotional disorders, several schools are also turning to mental health agencies to provide support services both to students and to teachers, sometimes with startlingly positive impact. So, for example, in one county, the mental health center provided a social worker to the self-contained classrooms, charged to help the teacher deal with crises, provide limited therapy to students, and work with the families. As a result, the teacher was able to focus more on making the learning interesting, and the school principal agreed for the first time to let some of the students participate in the regular sports. This in turn reduced their social isolation and increased the very social skills they were supposed to develop in the absence of such opportunities.

Perhaps most impressive is a long established districtwide program in Montgomery County, PA. There, therapeutic groups meet every day in the self-contained classroom. These are led 4 days a week by the teachers and 1 day by a consulting mental health professional, who also meets separately with the teachers (Anderson & Marrone, 1977). In this district, the retention rate for teachers of behaviorally disordered and emotionally disturbed students is significantly higher than the typical pattern, in which many teachers move into and then out of this work as quickly as possible (Smith-Davis, Burke, & Noel, 1983).

Taking another approach, some schools are rethinking the role and function of resource rooms, seeking, for example, to build in more group therapy/problem-solving experiences, similar to the Montgomery County program. Still other schools are going even further and eliminating self-contained classrooms. One district, for example, eliminated its self-contained classrooms and instead created a greatly enriched day treatment program and at the

same time strengthened support services to regular education. Also note that, although we could not gather systematic data, day treatment programs often jointly funded by mental health and education appear to be increasing, many of them on school grounds. This seems to be a very positive development that ultimately will force us to blur the distinctions—now often meaningless—between self-contained classrooms, day schools, and day treatment.

The efforts just highlighted are largely addressed to the quality of school life for children with behavioral and emotional disorders. But we also identified both relatively ad hoc efforts and more systematic ones to provide supports to the families of troubled children. Perhaps the most innovative of these is in a Vermont program known as Project Wrap Around (Burchard & Clarke, in press). That program, capitalizing on the interest of Vermont, through its Department of Social Services in providing intensive, crisis intervention family preservation services to families with children at imminent risk of out-of-home placement through child welfare, links the provision of intensive, school-based mental health services, delivered by a clinical intern, with family preservation services. The program is also unique and noteworthy because all the students with behavioral and emotional handicaps are mainstreamed; indeed, in that school system, virtually all children with handicapping conditions are mainstreamed.

We also identified some especially responsive efforts to help students make transitions. Often this is manifested simply in careful planning for such transitions; teaching teacher survival skills, for example, based on what a new teacher will be like; preparing students and new teachers or schools for transitions, arranging visits, and the like. But several programs go further; one, for example, in Durham, NC, Project Cope, established a buddy system in an elementary school with a self-contained classroom, deliberately structured to facilitate transitions. In addition to pairing students with individual staff members from regular education at the point the students enter the program, when they are ready to move back into regular education, students are paired with a child from that classroom. Together they participate in a program of shared activities.

Finally, burgeoning state efforts, largely spawned by CASSP, to create multisystem initiatives on behalf of the most seriously disturbed represent a significant strategy in improving access to mental health and other services for multineed students. Many of these have been described in detail elsewhere (Knitzer, 1989a). Our interviews suggest, however, that as these first generation initiatives evolve, schools are becoming more active partners. Moreover, in a few places around the country, schools are actively orchestrating cross-system case management initiatives, although these are still very limited.

As a whole, our scan of the field indicates that there are a growing number of initiatives within regular education on behalf of children with problems, as well as the most seriously disturbed children. Far fewer efforts seem to be directed toward the children in the middle; children identified by the schools as emotionally or behaviorally disordered and served either in resource rooms or self-contained classrooms. Yet, even for this group of children, approaches to enhance the curriculum, rethink simplistic behavior modification strategies, ensure access to therapy and support services for teachers, work harder on transitions, and relate to families differently are beginning to surface.

A Note on Policy Initiatives

This article focuses largely on program models and their implications for advocacy. But it is useful to point out that the relationship between schools and children's mental health is largely a "non" policy issue. State departments of special education have, in general, focused very little attention on children with emotional and behavioral disorders, save to respond to federal or legal imperatives. (Recently, for instance, most states have revised regulations regarding discipline, largely in response to a Supreme Court decision.) Similarly, mental health departments report few major initiatives solely with education, although education has been a limited partner in several CASSP activities.

At the same time, a handful of states are embarking on collaborative ventures. The state of Washington, for example, is expanding its network of jointly funded school-based day treatment programs. Other states are using mental health monies to encourage community mental health centers to work with local schools. California has enacted legislation mandating that mental health monies be used to provide needed mental health services to students identified under the mandate of the EHA (regardless of whether they are identified as seriously emotionally disturbed or as having some other handicapping condition). However limited, these initiatives mark important directions and are likely to increase.

Toward an Advocacy Agenda

It is clear that this is an opportune time for refocusing attention on the role of the schools and children's mental health. Change is needed within regular education, within special education, and at the community level, across service systems.

First, there must be efforts to strengthen the capacity within the schools to deal with the predictable

crises (violence, homelessness, natural disasters) that no child in this society can fully escape. Second, there must be systematic efforts to improve the support system for regular education teachers so that they can better cope with the kinds of behavioral and emotional problems that children, large numbers of children, bring to school, and that, if not attended to or approached insensitively, are bound to escalate to the detriment of the educational climate and the individual children. Efforts to strengthen pre-referral strategies to be more responsive to children with behavioral and emotional disorders and to provide ongoing training and consultation to teachers are particularly critical.

Third, we must find ways to challenge the prevailing bleakness of the implementation of the EHA on behalf of students identified as having behavioral or emotional problems, particularly those who are in self-contained classrooms. At the local level, clinicians, educators, and parents should together assess the quality of the existing programs for such children, focusing on the behavioral management system, the academic curriculum, the availability of mental health supports for teachers and students, the attention to transitions, and the nature of outreach and supports to families available through the schools. At the state and local levels, efforts should be made to encourage school/mental health collaborations.

Fourth, efforts to engage the schools in cross-system efforts to serve the most seriously disturbed children and adolescents in their own communities must be supported and expanded. At a district/community level, this means paying particular attention to linking intensive in-home family preservation services and school strategies, increasing the availability of day treatment and respite care, and ensuring that case management systems include a focus on the schools.

Fifth, at the policy level, there must be more sustained advocacy efforts in two directions: finding ways (including exploiting potential Medicaid funding fully) to provide mental health dollars to serve children with identified behavioral and emotional disorders, and to ensure that the momentum for the kinds of changes in the child's mental health system embodied in CASSP are sustained. Sixth, there must be more research, particularly ethnographic research, focused on the classrooms, and evaluation research assessing the impact of different programming strategies.

It is not easy, in a time when dollars for human services are in short supply, to call for change. Yet in this instance, although new monies may be needed, the more critical challenge is to find ways to reallocate existing resources so that they can be used in more effective ways.

Equally important is the need to rethink the prevailing professional paradigms, as the programs highlighted in this article seek to do. From an educational perspective, for example, challenging the "pull-out" mentality that has governed services to this population by educational agencies is critical. Energies instead need to be focused on the intensity and quality of services, and on the adequacy of support services to both regular education and special education teachers. It is no longer enough to focus on the procedural aspects of ensuring children with behavioral and emotional problems an appropriate education, just as it is no longer enough to consider the special education system in isolation from the regular education system.

From a mental health perspective, challenging the equivalent of the "pull-out" mentality, the "put-out" through out-of-home placement mentality is critical. To fail to do this, in the face of growing and convincing evidence that given the right mix and intensity of services, families, in concert with schools, can maintain children at home, runs counter to both policy and professional mandates.

Implications for Clinicians

Given that a mental health perspective is critical to strengthening the capacity to serve children with behavioral and emotional problems, the advocacy agenda just highlighted has particular implications for practicing mental health professionals, as well as those involved in the training of future clinicians.

Clinicians are in an important position to lend their expertise to the schools in observing children, in understanding behavior, and in crafting interventions to facilitate change. To do this, however, they must be willing to enter into the culture of the school, to recognize the burdens on teachers who deal not with one child at a time but with many, and to work with teachers and principals and to listen to what they need.

But clinicians are also in an important position to influence broader efforts. For instance, as a group they can lead or at least participate in efforts to assess the adequacy of a district's program for students with behavioral and emotional disorders. Moreover, at a program level, they can help to conceptualize and implement joint school-based programs. To support this, mental health administrators can work to see that funds are made available, for example by participating in the priority setting of community mental health boards, or, at the state level, through modifying state Medicaid plans, or capturing discretionary mental health funds. Those who train students are in a strong position to ensure that new students gain experience not just in tradi-

tional outpatient and inpatient settings, but also in the schools, as well as in other child serving agencies like child welfare and the courts. All the signs are that increasingly, the public dollar, including the public mental health dollar, will be used to serve such children.

At some level, the kind of programs identified as promising in this article are neither new nor innovative; they simply seek to apply mental health principles and program components in an arena where such efforts have been, for a long time, notably absent. In that sense, the task is made easier; we do not have to invent a role for the schools with respect to children's mental health; we have to reinvent it (Biber, 1961). But the advocacy challenge is nonetheless real and difficult. If in truth we are to respond to the needs of high-risk children, and if indeed we are to meet the policy mandate of both education and mental health laws to serve children and adolescents in the least restrictive, most appropriate settings, then the schools where children spend so much time are central. It is time once again for mental health professionals to reach out and enter into the complex world of the schools. There are many children waiting.

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