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# Enhancing Collaboration within and across Disciplines to Advance Mental Health Programs in Schools

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Schools across the country are increasingly utilizing the expertise of multiple disciplines to enhance the mental health of their students and address barriers to learning through the provision of a range of services in schools. School mental health providers, including nurses, counselors, school psychologists, school social workers, special educators, and their clinical partners—psychologists, psychiatrists, and psychiatric nurses—have a unique opportunity to address the mental health needs of students. The continuum of mental health services offered support, primary prevention (e.g., universal interventions targeting bullying, abuse, and violence), early intervention (e.g., counseling for students whose behavior indicates that they are at risk), and intensive treatment for students with severe and/or chronic problems (e.g., proven therapies, crisis intervention, and wraparound supports). Collaboration is critical to avoid competition for scarce resources, fragmentation of services, needless duplication of effort, and the potential isolation of

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service providers. To ensure more comprehensive, cost-effective, and accessible services, collaboration must involve concerted efforts by all stakeholders.

Collaboration to enhance overall student adjustment and academic performance arises between and among mental health professionals in several contexts. First, it occurs between and among various school-hired mental health personnel working in the school setting. Second, if systems are to coordinate family-friendly services, collaboration can take place between and among school-hired personnel and mental health professionals offering services in the community. And third, collaboration can increasingly be found in school settings among school-hired and community-based mental health professionals working with other educators, families, and clinicians in school health clinics, or as adjunct school staff members in intensive special programs. For those community mental health professionals working within the school, the overall degree of collaboration with school-hired personnel and with students and their families may vary as a function of how well integrated they are into the school's culture and daily operations and how well they align their services to the school's existing services.

This chapter presents collaboration as a vital tool for effective mental health service delivery in school settings. It describes the critical components of collaboration, including the involvement of school administrators, educators, and school- and community-based mental health personnel, and most importantly, of the students and their families. Attention is also directed to the need to recognize and overcome potential obstacles to collaboration and to address such critical issues as school policy, educational leadership, and school culture.

### CRITICAL COMPONENTS OF EFFECTIVE COLLABORATION

Although collaboration is generally accepted as a useful and laudable goal, realizing effective collaboration is not easy. Collaboration, when successfully implemented in schools, comprises more than its building blocks of cooperation and coordination. It involves altering the means by which mental health practitioners and schools traditionally do business. To ensure the implementation of effective collaborative relationships in school settings, those involved need to engage in the following four tasks: (1) Define mutually agreed upon goals that provide incentive for the investment of effort in the collaborative process. (2) Decide on an overall strategy that integrates services and accept shared responsibilities for designated activities. (3) Create a working environment that fosters accountability for actions and outcomes. (4) Where possible, shift from separate funding sources to viable integrated mechanisms for the allocation of financial resources to support collaborative strategies.

A critical component of successful interdisciplinary collaboration is a capacity to appreciate and build on the competencies of the individual disciplines involved. Professionals from different disciplines bring unique frames of reference, as well as different backgrounds, priorities, expectations, and clinical responsibilities. They may have different ways of conceptualizing students' strengths and difficulties, which, taken together, provide a comprehensive view to guide interventions. Ideally, early on in the collaborative process, school teams can devote time to understand the function of each participant, clarify roles, and understand professional paradigms. They also need to understand one another's technical

language to enhance communication. Otherwise, professionals run the risk of engaging in discipline turf wars and rigidly adhering to a certain body of knowledge without exploring alternative perspectives. Avoiding this narrow approach involves practicing the disciplinary equivalent of cultural competency.

Providers need to value interdisciplinary diversity and recognize how multidisciplinary resources enhance their ability to respond to the complex needs of students. Mental health professionals benefit from opportunities within the collaborative process to conduct self-assessment. The process of self-assessment allows providers to reflect upon their own discipline and how their training and practice knowledge may lead them to interpret and respond to situations in a certain predictable way.

John, a ninth grader, was displaying progressively more disruptive behavior in school and was suspended for the fifth time in two months for fighting with another student. His school confidential record noted that he was under the supervision of a probation officer for a prior assault charge. The probation officer and assistant principal were frustrated with John's recurring discipline problems and threatened his expulsion and return to juvenile court for probation violation. Likewise, one of his teachers was becoming increasingly irritated with his outbursts in class and low frustration tolerance. The school psychologist was discouraged that John refrained from participating in the psychoeducational group provided by the counselor. John was receiving anger management training from the school psychologist as a related service to his special education program. Due to the parents' initial desire for confidentiality, school personnel were not informed that John was receiving psychiatric medication and individual therapy from a community clinic psychiatrist. None of the providers or agencies were communicating with each other as a problem-solving team. Out of concern for John's welfare, the parents requested a meeting of school, clinic, and court personnel. Once all the professionals understood the complexity of the problems and the nature of services being provided, they began to collaborate in providing a network of supportive school, home, and community wraparound services, which enabled John to remain in the school setting and improve academically and socially.

Another prerequisite to successful collaboration is preventing status differentials between professions (e.g., physicians working with counselors), including differential authority and access to resources, from impeding interdisciplinary collaboration. Sometimes, interdisciplinary efforts generate questions concerning the respective competencies of individual professions. Through open and honest communication such potentially problematic issues can be raised and addressed, early and effectively.

As this vignette suggests, collaboration is increasingly challenging when there are multiple providers from many arenas, and there is no clear forum established for communication. Potential conflicts may arise when professionals interpret the involvement of other disciplines as an imposition and/or challenge to their competency or diagnostic capabilities. Professionals may also feel threatened by the involvement of family members who may question their professional competence to understand the specific problems at issue. However, with the mutual investment

of time and resources, along with a clear understanding of one another's professional contributions, the student and family can feel even more supported. The process of detailing responsibilities and opportunities for each team member to enhance student competencies will contribute to the achievement of this goal.

#### CONTRIBUTIONS OF SEVERAL KEY MENTAL HEALTH DISCIPLINES TO SCHOOL COLLABORATION

Each of the core mental health disciplines of psychology, social work, and psychiatry offers unique and significant contributions (alone and in conjunction with one another) in the school context. The following sections provide a brief overview of their respective functions and the ways in which they collaborate with other school- and community-based mental health professionals. For a more detailed description of the roles, as well as education and training, of each of the school mental health disciplines (including counseling and nursing), see the article on this topic by Flaherty et al. (1998).

#### PSYCHOLOGY

*School psychologists* contribute to collaboration by applying learning and other psychological theory to improve instruction and behavior of children. They utilize consultation and teaming skills to support behavioral interventions and strategies, and they provide individual and group counseling to students and families. They are responsible for conducting psychological and educational assessments to identify students' needs for additional regular education support or special education services. School psychologists provide individual and group counseling, consultation, and also evaluate educational and treatment plans to address the needs of students with special learning, behavioral, and/or emotional problems (Marx & Wooley, 1998). School psychologists draw upon psychological research, theory, and practice to develop learning and behavioral interventions for individual students or groups of students, classrooms, or on a schoolwide basis (e.g., prevention and crisis intervention programs). School psychologists are adept at helping connect and monitor clinical mental health interventions in the classroom helping support both learning and behavior.

*Health service psychologists in the community* (e.g., clinical and counseling psychologists) can increasingly be found in schools working closely with teachers and other school-based personnel in providing counseling services to referred students and their families and in providing support and consultation to staff. In this regard, they may conduct professional training for teachers to enable them to identify students in need of mental health counseling, particularly students who may be overlooked, since they may be anxious or withdrawn (rather than disruptive). These psychologists also work closely with school psychologists in providing related psychological services to special education students, and also partner in assessing and treating students whose mental health disturbance is intensely affecting their lives. These professionals engage families in treatment and frequently have more flexibility than school-hired personnel in conducting

in-home intensive services and meeting with families during evening or weekend hours. In some cases, agency personnel are more familiar with the network of community providers and can help connect families with a range of needed services.

### SOCIAL WORK

*School social workers* provide individual and group counseling on a limited basis and conduct social skills or other specialty groups as determined necessary by the schools they serve. They also offer in-service training to school staff on a variety of topics, ranging from how to teach social skills, conduct functional behavioral assessments, and access resources in the community. School social workers also work together as members of the pupil services team, which supports students in their learning environment. They are often part of the assessment team to determine eligibility for special education. They are also responsible for making the appropriate referrals for interventions that are needed to improve student progress, prior to a special education assessment.

School social workers often provide the primary link between the home, school, and community. They can provide case management to assist student learning and adjustment. Their role extends from the coordination of school and community services to accessing systems and resources to better address the learning and related needs of students. School social workers are trained to understand how to bring together different and oftentimes competing systems for the benefit of the student and family. When *clinical social workers* provide services in the schools, school social workers benefit from the opportunity to refer students to them and to engage in case consultation for the betterment of students and their families. Clinical social workers also provide intensive therapeutic counseling to students and families.

### PSYCHIATRY

*Child and adolescent psychiatrists* may consult in school settings and with other mental health professionals and school staff. They also participate in diagnostic evaluations and make treatment recommendations. Because psychiatrists are relatively few in number, compared to the other mental health professionals, their role as consultant allows for maximal use of their expertise. In keeping with their general training emphasis on the more severe psychiatric disorders, child and adolescent psychiatrists tend to be more involved with students in mental health and special education facilities as well as with public school students eligible for special education services.

#### **Importance of Family Involvement in Collaboration**

Meaningful involvement of family members can provide critical information in the mental health assessment process and further the adoption and implementation of treatment plans. When families are involved with decision making, treatments are likely to be more culturally competent and better designed to build on child and family strengths. Parents can help by providing critical direction

about approaches and incentives that may work, while also encouraging the child and reinforcing adherence to the treatment plan. Parents are also in a unique position to monitor daily the impact of the therapeutic interventions.

Under federal education law, active participation is mandated for those children eligible for special education and related services to ensure that they and their parents feel supported by the school system. While an exceedingly valuable mandate, there are often barriers to family involvement created by administrative structures and service delivery mechanisms within schools. To address these difficulties, the National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance (2000) suggests the following approaches that schools can employ:

Any collaborative relationship should be marked by a demonstration of respect and compassion for family members; an understanding and an accommodation of different styles of social interaction; the use of straightforward language; creative outreach efforts; respect for families' cultures and experiences; providing families with crucial information and viable options; and the scheduling of individual education plan meetings at convenient times and places for families, caregivers, and surrogates.

Meeting processes can be refined to facilitate family participation. Schools in Westerly, Rhode Island, for example, have premeetings with families to discuss the individual education plan (IEP) process, solicit family input into the agenda, and provide families with necessary background on concerns that may arise at the meeting.

### **Educators as Key Collaborators**

Collaboration with educators is also vital, since classroom teachers spend the most time with students and are often the most knowledgeable about them. Consequently, they can provide critical insights about student motivation and behavior. They also tend to be the most committed, both personally and professionally, to the success of individual students in the classroom and beyond. Difficulty may arise, however, when teachers and administrators feel increased pressure to focus on short-term academic goals and standardized test scores, often at the expense of student and family adjustment. They may also find themselves overattending to the time and energy demands of a disruptive student who may undermine the progress of other students. Understandably, teachers may need to be convinced by mental health providers that their efforts to monitor and encourage a student are likely to yield positive change in academic outcomes. There is better "buy in" from teachers if there are mechanisms to allow for them to support strategic planning. For example, school-based wraparound initiatives in Illinois and Nebraska provide substitute teachers in the classroom to enable the regular teachers to engage in planning activities and participate in the IEP meetings.

Sonia, a sixth-grader in middle school, was suspended for swearing and other disrespectful behavior toward her teachers and classmates. Previous offers of counseling support had been rejected by

her parents. The school administrator recently discovered that both of Sonia's parents were alcoholic and that her father was terminally ill. Prior to Sonia's return to school, the school administrator, recognizing the seriousness of the problem, called a student support team meeting with the school psychologist, social worker, and teachers and the school mental health clinic representative to share their observations and shape their interventions to be most responsive to Sonia's pressing needs. As a result, the student and her family agreed for the first time to meet with a substance abuse counselor. The parents also consented for Sonia to join a group run by the school psychologist to address the stress related to her father's terminal illness and her vulnerability to peer risk behaviors. Parents also agreed to have Sonia meet with a child and adolescent psychiatrist to be evaluated for possible attention deficit/hyperactivity disorder. The school administrator made adjustments in Sonia's schedule to allow for these services and additional academic support. However, even though Sonia began to take many positive steps, some teachers were still exhausted by her challenging behavior and wanted her out of their classrooms. Classroom observation was then initiated by the school social worker to identify and remove precipitants of Sonia's disruptive behavior. Encouragement by the school social worker, concrete steps by the administrator, more focused mental health and educational services, and the sharing of realistic expectations with the teachers allowed the school to successfully maintain this fragile girl in the regular classroom.

Mental health providers and teachers engaged in collaborative relationships may have different expectations about how quickly students should and can turn around their performance. Accordingly, all those involved need to adopt realistic expectations for students. There also needs to be flexibility in prioritizing areas in which students need to improve and developing concrete ways of achieving progress. The previous vignette illustrates the commitment by educators, administrators, and mental health clinicians to carefully craft opportunities for student progress. Mental health providers may also be involved in offering whole classroom interventions to promote social competency skills, either directly or through training teachers to offer various modules. They also can provide teachers with suggestions about ways to encourage positive student behavior in the classroom and improve school climate.

### EXPANDED SCHOOL MENTAL HEALTH SERVICES

As a means to extend school-based mental health services, schools are increasingly turning to community mental health professionals to provide group or individual therapy for students in the school setting or in the community. This collaborative process works well when the following four conditions are met. First, community mental health providers are oriented to the school culture and daily routines and have the opportunity to observe students in structured and unstructured settings (e.g., recess and lunch) and gain insights from the teachers

and school personnel. Second, school professionals are included in the planning and implementation process of adding community mental health providers to the school environment. Third, the roles and responsibilities for school-based and community-based professionals are clearly delineated. And fourth, there is a mechanism or structure in place to facilitate productive, meaningful, and ongoing communication between school- and community-based providers.

### **Special Issues to Address**

#### ***Confidentiality***

All school mental health providers and counselors are required to adhere to a code of ethics respecting confidentiality. In the school setting, mental health providers including those from different disciplines and professional affiliations (e.g., hospitals and community health centers), negotiate the delicate balance of protecting the confidentiality of students against the desire of the school and parents to obtain important information. School administrators and parents may need to be informed of these necessary confidentiality requirements for any therapeutic relationship to be sustained. Clinicians tactfully can avoid this situation by being explicit about their policies surrounding confidentiality and working to encourage students to give permission for information sharing with educators when it may allow the school to make certain critical modifications beneficial to the student. Sharing information with parents should follow the same principles.

#### ***Complementary Roles***

Another challenge involves how community-based mental health clinicians can complement the delivery of services by school personnel. Sometimes, school personnel may turn to community-based mental health providers to assist students in need of more acutely intensive services provided through a continuum of care in the community (e.g., family stabilization teams, emergency room coverage, and psychiatric hospitalization). In these instances, collaboration between school and community mental health personnel is essential to engage the student and family in treatment to ensure necessary consultation and follow-up.

An illustrative example concerns Leroy, a high school junior, who was tearful in a guidance counselor's office, and irritable and withdrawn in class. During a more detailed interview with a clinical psychologist, Leroy revealed that his mother, who had schizophrenia, had temporarily moved back home with him and his father. This recent change in his family situation had led to his increased sense of being overwhelmed. With the family's permission, the clinical psychologist initiated an emergency evaluation of the mother and then continued to monitor the student and family's progress. Leroy chose an autobiographical literature course with the psychologist's encouragement and was able to examine his protective feelings toward his mother, while also negotiating some needed psychological distance from her. The collaboration with the school enabled Leroy to be more engaged in academics and feel more supported in his family situation.

### ***Protocol for Initiating Mental Health Services***

It is also critical that all involved school- and community-based providers appreciate the protocol for initiating mental health evaluation or treatment with a student. Oftentimes, the decision to access specific providers is shaped by whether students have an IEP, certain types of health insurance (if the student does not have an IEP), or certain types of identifiable problems (e.g., substance abuse, oppositional behavior). It can also be challenging to offer mental health support in ways that can enhance the student's sense of competency. School administrators and teachers need to present mental health services in a positive light as an opportunity rather than as a form of punishment or the last resort in a declining trajectory. This is facilitated in a school climate that does not stigmatize mental health needs.

### ***Emergency Care***

Emergency situations, where students are hospitalized psychiatrically or evaluated for violent intentions or acts, can strain the collaboration among mental health and school personnel. Oftentimes, when an emergency hospitalization occurs, there is no immediate communication with the school staff. School clinicians might not be contacted until the hospitalization is well under way or after the student is discharged. Other times, the adequacy or appropriateness of the student's educational placement may be questioned by hospital staff during or following the admission period. Yet communication is vital in these instances. School staff not only are likely to possess critical information about the student to enhance the hospital treatment, but they also need guidance from hospital staff to facilitate the student's transition back to school. Procedures need to be developed regarding communication about and monitoring of the student, and how to delineate meeting the needs of the student in a nonthreatening way.

### ***External Supervision***

External supervisors and consultants can provide significant assistance to school mental health personnel, especially when the supervision (or consultation) is provided by clinicians who are familiar with the challenges of a school environment. Supervisors can help provide access to a broad continuum of services and therapeutic approaches. They can help recognize when a student needs more extensive testing or offer unique perspectives on complicated diagnostic questions. The external supervisor's clinical experience can give school personnel added confidence and impetus to manage a complex situation. Also, external supervision can optimally provide protected time when school personnel can have the opportunity to be more reflective. Sometimes, school personnel may be on the frontlines and in crisis mode for extended periods of time. Supervision allows time to look at recurrent patterns and to determine necessary systemic changes. External supervisors can also reinvigorate staff by validating their efforts and encouraging them to be vigilant about potential burnout and gain needed support within the school. Similarly, experienced school-hired mental health professionals can provide effective strategies and supervision for clinicians providing services in the schools.

## POLICY AND LEADERSHIP

School and districtwide leadership can facilitate or undermine interdisciplinary collaboration. Collaboration can more readily be developed and sustained when it is supported at a policy level, embraced by senior-level school managers (e.g., superintendents and principals) and middle managers (e.g., district coordinators), and implemented by providers on a student-by-student level (Hodges, Nesman, & Hernandez, 1999). The effective implementation of collaboration often depends upon policymakers and administrators ensuring adequate staffing allocations for teaming, training across disciplines, and sufficient time for collaboration. Leaders within the school system, such as principals and special education administrators, often are pressured to follow certain priorities that do not involve mental health. Mental health may also be viewed as beyond the primary academic mission of the school system. Typically, there is no regular funding base for mental health services. These services may only be regarded as necessary to respond to crises involving individual students or within the broader school environment.

Negotiating with leaders and policymakers is a long-term proposition, particularly when advocating for increased resource allocation to expand mental health services for students. Mental health clinicians need to understand how schools order their priorities and maintain an ongoing dialogue with school administrators about how mental health fits into the larger priorities that schools are expected to meet. For example, school-based mental health professionals are often assigned to multiple sites at different times, which naturally hinders their accountability and capacity to collaborate. In such a case administrators should be apprised of how they can enhance mental health services in the school setting, through aligning the schedules of mental health professionals and prioritizing needs.

### Working with Schools

Schools have distinct cultures (Sarason, 2001), which are different from those of mental health agencies. To be responsive to the needs of the school community, mental health providers should understand the context of their work (i.e., the culture of the school and its history with school improvement efforts), try to become part of the school culture, and attend to the concerns of the educators. Carefully outlined protocols can establish a process for decision making that can avoid conflicts.

Mental health personnel can successfully integrate their work into schools through a variety of ways. One approach is to find a good navigator, someone who is seasoned and well respected within the school community. This individual can help avoid and resolve stalemates and describe effective strategies employed in the past to overcome and promote change in the school. Another approach is to establish a positive working relationship with the school-hired mental health professionals, plan with them, and complement their services. Some have developed a forum for clinical case reviews. While this tactic has the potential to be somewhat more confrontational in nature, it can be carried out in a respectful, nonthreatening way. It allows for the resolution of potentially problematic situations in a direct,

objective manner. This type of debriefing is particularly useful after a crisis (e.g., the evaluation of a violent threat or act of a student), where staff are encouraged to comment on management decisions and offer suggestions for future actions in such situations.

A fourth approach involves systemic change through the creation of a school-wide team to integrate mental health, safety procedures, and school reform, and link to a student support team that works with individual students. The school-wide team plans, aligns, and oversees all schoolwide activities, while the student support team assesses, consults about, and develops mental health interventions for individual students. Both teams include three key personnel: the principal to harness the authority of senior leadership; a teacher to link to educators; and a mental health professional to focus on the mental health needs of the students and school. This model has been cited in two major documents, *Safeguarding Our Children: An Action Guide* (Dwyer & Osher, 2000), which was released by the U.S. Departments of Education and Justice, and *Every Student Learning: Safe and Supportive Schools* (Learning First Alliance, 2001), which was produced by 12 leading educational organizations.

## CONCLUSION

As described in this chapter, collaboration is well worth the commitment and investment of time and energy for all those involved in the school setting—the school administrators, teachers, and school- and community-based mental health professionals, as well as for the students and their families. Collaboration almost inevitably has the “ebb and flow” of relationships. It is a precious commodity that needs to be safeguarded by structures that provide for sufficient resources, adequate time for teachers and mental health staff to work effectively, and professional training to help staff build new skills. Commitment to collaboration entails the capacity to recognize conflicts and barriers, and to address them systematically and creatively. Building upon professional and familial relationships, interdisciplinary collaboration has the potential to transform a loosely knit patchwork of school- and community-based services into a quilted fabric of comprehensive, coordinated, and integrated services to the benefit of individual students, their families, and the larger school community.

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