System, Agency, and Stakeholder Collaboration to Advance Mental Health Programs in Schools

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The U.S. Surgeon General’s report on mental health underscores that prevention and treatment are both needed to help reduce social, emotional, and behavioral problems in children and adolescents (U.S. Department of Health and Human Services, 1999). The report also emphasizes that schools are a “major” setting for identifying mental health concerns in youth. Schools are one of the most universal, natural settings and provide unparalleled access to youth (Weist, 1997). In fact, it is estimated that one-fourth of the U.S. population can be found in schools (Jamieson, Curry, & Martinez, 2001).

Considering the extensive mental health needs of today’s youth, it is not surprising that any single agency or organization would have difficulty meeting the rising demand for services. There is growing acceptance that collaboration among school and community health, primary care, mental health, and education is crucial for effectively delivering services to youth and their families (Dryfoos, 1994; Flaherty et al., 1998). As reflected in other chapters in this book, expanded school mental health (ESMH) programs are built around these school–community partnerships (Weist, 1997). By blending the partners’ skills and resources, students
and families are afforded a richer array of mental health services (Acosta, Tashman, Prodente, & Proescher, 2002). However, collaboration among people of different backgrounds and disciplines and between agencies and programs from throughout the community and state is by no means easy. In this chapter we provide background to and ideas and examples of effective school–community–state collaboration to advance mental health in schools.

Throughout the chapter, we use the term stakeholder to refer to individuals, agencies, and groups who have some stake or investment in the development, implementation, and evaluation of a given endeavor. For expanded school mental health, key stakeholders include the following groups: youth, parents or guardians, teachers, administrators, school and community mental health and health staff, local and state government officials, staff from other child-serving agencies, community leaders, faith leaders, businesses, civic organizations, funders, and advocates (Kretzmann & McKnight, 1993; Nabor et al., 1998; Waxman, Weist, & Benson, 1999).

There is some literature emphasizing the need to work with diverse stakeholders and multiple community and state organizations to develop or improve child and adolescent mental health programs (U.S. Department of Health and Human Services, 1999; Nabor, Weist, Holden, et al., 1999; Weist, 1997). However, examples of and explicit guidance for this work are lacking. Within this chapter, the definition of, barriers to, and components of successful collaboration at multiple levels will be explored. Specific use of these collaborative strategies in developing and improving expanded school mental health programs will then be addressed. The chapter concludes with two examples—one focusing on state-level collaboration to advance school mental health in New Mexico and a second focusing on the experiences of a program in Baltimore in its efforts to connect with diverse stakeholders to enhance resources and to improve quality.

DEFINING COLLABORATION

Collaboration is a process of participation through which people, groups, and organizations work together to achieve desired results (National Network for Collaboration, 1995). Collaboration can be viewed as a process to reach goals that cannot be achieved acting singly (or, at least not achieved as efficiently) (Bruner, 1991). For collaborations to be successful, individuals and groups must be able to see a contribution to their own mission and purpose (Golden, 1991). Research involving children's services shows that collaboration can lead to improved access, better tracking of services, and a reduction in barriers to care for families (Bruner, 1991). Collaboration can help to expand available resources through cooperative programming and the sharing of facilities, information, training, and staff (Lippitt & Van Til, 1981). By demonstrating improved outcomes, increased client satisfaction, and increased savings due to the reduction of service duplication, working collaboratively can also change the way agencies are perceived by the community (National Assembly of National Voluntary Health and Social Welfare Organizations (NASWO), 1991; Roberts, 1994).

Barriers to Successful Collaboration

Several researchers have explored why collaboration is difficult in the area of child and family services (see Gardner, 1989; Schorr, 1988; Weiss, 1981;