



*Improving Schools,  
Engaging Students*

*A Center Report*

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## **Youth Substance Use Interventions: Where Do they Fit into a School's Mission?**

Summer, 2010

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## Abstract

This report addresses the question: *Where do interventions for concerns about substance use fit into the work of schools?* By way of background, we begin by differentiating between use and abuse and briefly summarizing some major issues and data relevant to substance use and treatment of abuse and dependency. And, to highlight the importance of adopting a broad perspective in understanding the causes of substance problems seen at schools, we outline a reciprocal determinist paradigm.

Then, given increasing calls for interventions that go beyond basic direct treatment for substance abuse and dependency, a sample of such intervention needs is highlighted. These were chosen because they are likely candidates for school involvement. We follow this with a discussion of the negatives that arise when schools are asked to add interventions in an ad hoc, piecemeal manner and when the interventions are mainly framed in the context of a system of care model. Recognizing that multifaceted nature of youth problems, we outline the need to fit substance use concerns into efforts to move schools forward in establishing a comprehensive, cohesive approach that can more effectively address the range of student problems with which schools are faced. We conclude with a discussion of some key implications for school policy and implementation of innovative practices, including those that are evidence-based.

Please reference this document as follows: Center for Mental Health in Schools. (2010). *Youth Substance Use Interventions: Where Do they Fit into a School's Mission?* Los Angeles, CA: Author.

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## **Youth Substance Use Interventions: Where Do they Fit into a School's Mission?**

*Scientific advances have contributed greatly to our understanding of drug use and addiction, but there will never be a 'magic bullet' capable of making these problems disappear. Drug use and addiction are complex social and public health issues, and they require multifaceted approaches.*

Alan Leshner

**T**his report addresses the question: Where do interventions for concerns about substance use fit into the work of schools? By way of background, we begin by briefly summarizing some major issues and data relevant to substance use and treatment of abuse and dependency. Then, to highlight the importance of adopting a broad perspective in understanding the causes of substance problems seen at schools, we outline a reciprocal determinist paradigm.

With respect to increasing calls for interventions that go beyond basic direct treatment for substance abuse and dependency, we highlight a sample of needs that are likely candidates for school involvement. Following this is a discussion of the negatives that arise when schools are asked to add interventions in an ad hoc, piecemeal manner and when the interventions are mainly framed in the context of a system of care model. With these matters in mind, we outline the need to fit substance use concerns into efforts to move schools forward in establishing a comprehensive, cohesive approach that can more effectively address the multifaceted problems of youth that schools must play a role in addressing. We conclude with some key implications for school policy and implementation of innovative and evidence-based practices

### **Social Norms and Sanctions and the “War” on Drugs**

We start by differentiating between use and abuse. Almost everyone uses “drugs” in some form, such as over-the-counter and prescription medications, caffeinated products, and so forth. Clearly, it is not the use of such substances that is at issue with the majority of society. For the most part, society's concern is with those who use substances excessively to the point of abuse and dependency or are involved with buying or selling illegal drugs (MacCoun & Reuter, 1998; McBride, VanderWaal, Terry, & Van Buren, 1999; Office of Applied Studies, 2008). In this latter group are youth who access substances such as nicotine and alcohol products that are legal for adults but illegal for minors.

At schools, additional concerns arise because of the role schools play in socializing the young and because substance abuse is associated with poor school performance, interpersonal violence, and other forms of negative activity (Adelman & Taylor, 2010; Chandler, Chapman, Rand, & Taylor, 1998; Lowry, Cohen, Modzeleski, Kann, Collins, & Kolbe, 1999). The irony is that, while schools campaign and legislate against drugs, the surrounding society appears to sanction and glamorize many substances. The impact of all this with respect to substance use is compounded by the penchant of many young people to be curious, to experiment and test limits, and to be influenced by peer pressure.

Moreover, the economics surrounding legal substances guarantee the ongoing operation of major market forces and advertisement designed to counter the impact of efforts to convince youngsters not to use. Although tobacco ads are curtailed in the United States, mass media campaigns for alcohol and over-the-counter drugs and increasingly even for prescription drugs is omnipresent. Thus, youngsters are warned of the evils of substance use, while being bombarded with potent, pro-use commercial messages and provided relatively easy access to a wide range of substances. In addition, widespread use of prescribed medications for children and adolescents probably counters perceptions that drugs are dangerous. And, not surprisingly, the increased number of prescriptions has expanded the supply of drugs available for abuse.

Then, there is the business of trafficking in illegal drugs. Selling illicit drugs is a lucrative business enterprise. So much so that in some places the underground economy and life style of substance use is well-integrated into the daily life of the neighborhood.

Given the powerful forces operating around substance use, decisions about how to address substance abuse remain politically controversial. The ongoing debate is reflected in arguments about a "war on drugs," zero tolerance policies, drug testing, drug use decriminalization, the value of prevention and treatment programs, and so forth.

In schools, concern about drugs translates into a variety of strategies, some of which are proactive, some of which are reactive, and almost all of which have little research supporting cost effectiveness or clarifying negative side effects (Adelman & Taylor, 2003; Brown & Kreft, 1998; Gorman, 1998; Rosenbaum & Hanson, 1998). An example of one strategy is mandatory-random student drug testing. A recent report from the U.S. Department of Education comparing tested and nontested high school students found testing had no effect on intentions to use substances in the future, but did have some impact on reducing current substance use (James-Burdumy, Goesling, Deke, & Einspruch, 2010).

While data have suggested the potential cost-effectiveness and cost benefit of drug treatment (Harwood, Malhotra, Villarivera, Liu, Chong, & Gilani, 2002), some critics hypothesize that the financial costs and negative consequences of prevailing strategies for schools probably outweigh whatever benefits are accrued (Brown & Kreft, 1998; Weinberg, Rahdert, Collier, & Glantz, 1998).

For schools, it is essential to adopt a broad focus on student problems that encompasses not only a biological understanding, but also an appreciation of the psychological and socio-cultural factors that motivate youngsters' behavior. This ensures awareness of the degree to which substance use reflects the experimentation and risk taking that is so much a part of the developmental processes of moving toward individuation and independence. Characteristic behaviors during these facets of development include skepticism about the warnings and advice given by adults, as well as reactions against rules and authority. The very fact that substances are illegal and forbidden often adds to the allure. Fortunately, most youngsters navigate developmental transitions without serious upheaval. For too many, however, the lack of good alternative ways to feel competent, self-determining, and connected to significant others leads to problems (Deci & Ryan, 1985). One of these can be substance abuse and dependence.

### **What's the Data?**

How big a societal problem is substance abuse/dependency? What leads to use, abuse, dependency? How many need treatment? How many receive treatment? Because the data are limited, answers to these questions remain tentative.

### **Drug Use**

A sense of the nature and scope of substance use is provided by government-sponsored surveys, such as the *Monitoring the Future Study* (see Johnston, O'Malley, Bachman, & Schulenberg, 2009), the *National Survey on Drug Use and Health* (see the Office of Applied Studies, 2008), the *Partnership Attitude Tracking Study* (see Partnership for a Drug-Free American, 2009), and the *Youth Risk Behavior Surveillance System* conducted by the Centers for Disease Control and Prevention (see Eaton, Kann, Kinchen, et al., 2009). Such surveys have obvious limitations. And differences in findings underscore the need to look for consensus across surveys. Nevertheless, the findings constitute the most comprehensive data sets available on the *use* of substances and are commonly cited in policy discussions.

A few findings suffice to highlight the current state of affairs. The National Survey on Drug Use and Health (NSDUH) reports estimates indicating that in 2007 “20.1 million Americans aged 12 or older were current (past month) illicit drug users.... This estimate represents 8.0 percent of the population aged 12 years old or older”(Office of Applied Studies, 2008). We also note that the Division of Biometry and Epidemiology of the National Institute on Alcohol Abuse and Alcoholism, using data from a national survey in the 1990s, estimates that approximately one in four children (about 17 million) is exposed to familial alcohol abuse and/or dependence prior to age 18 ( National Institute of Health, 1999).

With specific respect to adolescents, the national Monitoring the Future survey done in 2009 (focusing on 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> graders) reports that 15 percent, 29 percent, and 37 percent, respectively, indicate they used illicit drugs in the past year (annual prevalence). In terms of trends, the majority of illicit drugs covered in the study showed little change from previous years, with most at levels considerably below recent peaks. Reports of marijuana increased. Drugs with an apparent continuing decline included ecstasy, crack cocaine, heroin, Vicodin, amphetamines, methamphetamine, crystal methamphetamine, tranquilizers, and the so-called “club drugs” Rohypnol, GHB, and ketamine. In addition, the long-term, gradual decline of alcohol was reported at all three grade levels; the decline from recent peak levels was over 40 percent among 8<sup>th</sup> graders, over 25 percent among 10<sup>th</sup> graders, and about one sixth among 12<sup>th</sup> graders. The rates for drinking alcohol were 15 percent, 30 percent, and 44 percent, respectively; the two-week prevalence of binge drinking (at least once in the prior two weeks) was 8 percent, 18 percent, and 25 percent. Anabolic steroids use was reported at 0.8 percent, 0.8 percent, and 1.5 percent in grades 8, 10, and 12, respectively. Among boys, who have considerably higher use than girls, the rates were 1.0 percent, 1.2 percent, and 2.5 percent.

NHSDA survey data for 2007 estimate that in the 12 to 17 year old range, 1.9 million (7.7 percent) were dependent on or abused illicit drugs (4.3 percent) or alcohol (5.4 percent (Office of Applied Studies, 2008). The highest rate of dependence on or abuse reported among these adolescents was for marijuana/hashish (783,000 adolescents/3.1 percent). Dependence on or abuse of other illicit substances was: nonmedical use of psychotherapeutics (1.3 percent), pain relievers (0.9 percent), hallucinogens (0.5 percent), cocaine (0.4 percent), inhalants (0.4 percent), stimulants (0.3 percent), tranquilizers (0.2 percent), sedatives (0.1 percent), and heroin (0.0 percent). Conclusions based on the NHSDA survey data suggest that many try illicit drugs (especially marijuana), but relatively few become dependent.

The overall picture emerging from the various surveys is not bleak. The data suggest that the majority of youth will not become addicted to illicit drugs. At the same time, in the absence of intervention, it is probable that significant numbers will use and abuse alcohol and will continue to smoke as they grow older. Moreover, a continuing concern is the association between substance use and illegal acts, violence, accidents, unprotected sex, physical, sexual, and psychological traumatization, a variety of negative youth risk taking behaviors, and poor performance at and dropouts from school (Center for Mental Health in Schools, 2007; Dennis & Stevens, 2003).

### **Data About Treatment**

It should be underscored at this point that adolescents diagnosed as manifesting *Substance Use Disorder* are acknowledged widely to have other diagnosable disorders (e.g., mood and anxiety disorders, oppositional defiant disorder, attention deficit hyperactivity disorder). Data from the Center for Mental Health Services reported in 2001 indicates that about 43 percent of youth receiving mental health services in the U.S. also had a substance use disorder diagnosis. Clearly, co-morbidity is common (Minkoff, 2001, Turner, Muck, Muck, et al., 2004). And, not surprisingly, treatment outcomes are poorer and the probability of relapse is increased when adolescents have multiple problems (Brown & Ramo, 2006; Winters, Botzet, Fahnhorst, et al., 2009).

It is estimated that 90% of adolescents who meet DSM-IV criteria for a substance use disorder do not receive drug treatment. About 144,000 adolescents do receive treatment for drug or alcohol problems each year (Office of Applied Studies, 2008). Of those in treatment, 64% are provided non-intensive outpatient care, 6% receive intensive outpatient service, and 16% go to residential programs. Many of these drop out during treatment (Deas & Thomas, 2001; Godley, Dennis, Godley et al., 2004). Winters (in press) suggests that the large gap between need and treatment utilization by youth is due to factors such as few local treatment options, poor health coverage, low client motivation, and unsupportive parents.

The fact that those in treatment represent a small proportion of those in need is a great limitation on treatment efficacy research. Reviews of the treatment literature have focused on evidenced based efficacy studies of family-based treatments, motivational enhancement approaches, 12-Step, therapeutic community, community reinforcement approach, cognitive behavioral, and pharmacological approaches (Winters et al., 2009). Brief interventions used in settings such as emergency rooms, school-based clinics, and juvenile detention settings have been reviewed by O'Leary and Monti (2004). In all instances, available data indicate high rates of relapse and cycles of recovery and relapse. The rate of relapse by the end of one year after completion of a treatment program is reported as ranging from 40 – 67% (Dennis & Scott, 2007; Dennis & Stevens, 2003; Lipsey, Tanner-Smith & Wilson, 2010; Winters et al., 2009).

### **Determinants of Substance Problems**

A review of the extensive literature focused on improving understanding and intervention related to drug use and abuse underscores the variety of transacting factors that lead to the behavior and, for some users, addiction. (See, for example, Catalano, Kosterman, Hawkins, et al, 1996; Cicchetti & Rogosch, 1999; Dennis & Scott, 2007; Elliot, Huizinga, & Menard, 1988; Glantz & Hartel, 1999; Hansen, Rose, & Dryfoos, 1993; Hawkins, Catalano, & Miller, 1992; Institute of Medicine, 1996; Johnson & Pandina, 1993; Lipsey, Tanner-Smith & Wilson, 2010; Loeber, Stouthamer-Loeber, & White, 1999; National Institute on Drug Abuse, 1999; Petraitis & Flay, 1995; Ray, Mackillop, & Monti, 2010; SAMHSA, 2009; Weinberg & Glantz, 1999; Weinberg, Rahdert, Collier, & Glantz, 1998; Winters et al., 2009.) Both proactive and reactive motivational models have been postulated within theories that emphasize biological, genetic, social, psychological, and environmental factors. Moreover, it is widely recognized that the same etiological factor(s) can produce a variety of problem behaviors and that several of these can co-occur, often exacerbating each other (e.g., delinquency, substance abuse, violence, comorbidity of mental disorders). Relatedly, it is clear that the same behavior may be caused by different factors.

No specific factors have been established as predetermining substance use, abuse, and dependency. Therefore, rather than reviewing the host of variables under study, we think it more useful for schools generally to adopt a developmentally-oriented, transactional paradigm of the determinants of student behavior. Such a model stresses that substance, and other student problems, can be grouped along a continuum. At one end are those for whom internal factors are the primary determinants of the behavior; at the other end are those for whom environmental factors are the primary determinants; and at each point along the continuum, there are those for whom some degree of transaction between internal and environmental factors determine the problem behavior (Adelman & Taylor, 1994, 2010).

As illustrated in Exhibit 1, substance problems originating from environmentally caused factors are designated at one end of the continuum. At the other end is use stemming primarily from factors within the person. In the middle are problems arising from a relatively equal contribution of environmental and person sources. It is yet to be empirically determined how many fall into each of these groups. However, generalizing from the literature on psychopathology, it seems likely that only a small percentage of substance problems are *caused primarily by internal factors within a person*. Youngsters are socialized by those around them.

They respond to competing environmental options. Thus, as with other psychosocial problems, there is a significant group at the other end of the continuum whose substance abuse arises primarily from factors outside the person. Such factors always should be considered in hypothesizing and assessing what *initially* caused a given person's behavior. By first ruling out environmental causes, hypotheses about internal factors become more viable. The majority of substance problems probably reflects varying degrees of environment-person transactions. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward one end of the continuum, environmental factors play a bigger role (shown as  $E \leftrightarrow p$ ). Toward the other end, person variables account for more of the problem (thus  $e \leftrightarrow P$ ).

Exhibit 1

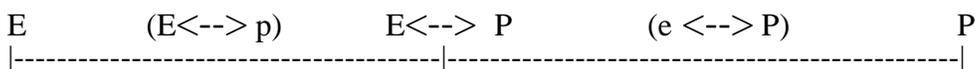
**A Continuum of Substance Abuse Reflecting a Transactional View of the Locus of Primary Instigating Factors**

**Primary Locus of Cause**

Substance abuse caused by factors in the environment (E)

Substance abuse Caused equally by environment and person

Substance abuse caused by factors in the person (P)



>caused primarily by environments and systems that are deficient and/or hostile  
>problems are mild to moderately severe and narrow to moderately pervasive

Example:  
A neighborhood where there are not strong norms against the use of substances and where illicit drugs are easily accessed.

>caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)  
>problems are mild to moderately severe and pervasive

Example:  
A youngster who is not doing well academically and who then gravitates to peers who also are not doing well and who are involved in abuse of substances.

>caused primarily by person factors of a pathological nature  
>problems are moderate to profoundly severe and moderate to broadly pervasive

Example:  
A youngster who is susceptible psychologically and/or physiologically, to addiction.

In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.

Adapted from: H.S. Adelman and L. Taylor (1993). *Learning problems and learning disabilities: Moving forward*. Pacific Grove, CA: Brooks/Cole.

Clearly, a simple continuum cannot do justice to the complexities of differentiating and labeling human behavior and designing interventions that fit specific needs. This conceptual scheme does, however, suggest the value of starting with a broad model of cause. In particular, it helps counter tendencies to jump prematurely to the conclusion that an individual's substance abuse is caused by internal deficiencies or pathology. It also helps highlight the notion that improving the environment may be sufficient to prevent many problems.

Discussions of risk and protective factors related to drug use and other problem behaviors reflect a transactional model. Such thinking emphasizes not only factors internal to individuals, but environmental factors related to school, home, and neighborhood, and stresses complex transactions between both classes of variables. Researchers, policy makers, and practitioners are especially interested in the interplay between biological and psychosocial risk factors in understanding cause and in protective factors as risk mediators (Coie, Watt, West, Hawkins, et al., 1993; Glantz & Sloboda, 1999; Institute of Medicine, 1994; Marsten & Coatsworth, 1998; National Institute on Drug Abuse, 1999; Pandina, 1998). At this stage, the evidence suggests that the more risk factors that are at play, the less likely it is that an accumulated set of protective factors can counteract their impact (Center for Substance Abuse Prevention, 1999).

In the early 1990s, Hawkins, Catalano, and Miller made a major contribution by providing a research-based discussion of common risk and protective variables relevant to substance abuse prevention. Among the environmental variables identified as common risks are such community/ school/family factors as norms favorable toward drug use, availability of drugs, extreme economic deprivation, high levels of mobility, low neighborhood attachment and community organization, friends who engage in the problem behavior, academic failure, family histories of the problem behavior, and family conflict. Person factors include various differences and vulnerabilities as manifested in behaviors seen as reflecting elevated degrees of withdrawal, alienation, impulsiveness, defiance, aggression, poor school performance, and so forth.

It is, of course, essential to remember that the various correlates have limited predictive value. As a 1999 report from the National Institute on Drug Abuse (NIDA) cogently states, a list of such factors "does not give much insight into how risk factors operate for individuals and groups because it does not consider the embeddedness of individuals in contexts that may place them at risk, the active role that individuals play in their own development through interactions and transactions within the social environment, developmental stages of individuals, and individual differences in the susceptibility to type and number of risks. Moreover, for many years the risk factor focus did not consider the influence of protective or resiliency factors ... [such as] a stable temperament, a high degree of motivation, a strong parent-child bond, consistent parental supervision and discipline, bonding to prosocial institutions, association with peers who hold conventional attitudes ..." (p. 45). (See the NIDA report for more discussion of etiology covering individual, family, peer group, school, and special population considerations.) As always, the more we understand about subgroups and individual differences, the more effective our interventions can be.

Finally and ironically, we note that an underlying motivational view leads to contrasting hypotheses about causal links between prevention efforts and substance experimentation. One view suggests that anti-substance abuse messages lead some youngsters to proactively seek out the experience. The other view hypothesizes that youngsters perceive such messages as filled with half truths and as attempts to indoctrinate them, and this leads to a form of psychological *reactance* motivating substance use. Neither of these hypotheses have been researched directly; they are extrapolated from theorizing about what motivates human behavior (e.g., see Deci & Ryan, 1985).

## **Some Intervention Elements Beyond Basic Treatment Practices**

Given the disparities in treatment access, the high rates of client dropout, and the relapse rates, many in the field are exploring a significantly expanded set of interventions. Beyond direct treatment, the emphasis has been on personalized continuing care, ongoing supports, ecological and collaborative approaches, and a recovery-oriented system of care that encompasses multifaceted, coordinated, and technologically enhanced interventions (SAMHSA, 2009).

The expanded set of interventions are driven by basic intervention concerns such as the need to (1) increase availability and access to treatment, (2) refine and expand referral and transition interventions, (3) facilitate reintegration and re-engagement in home, neighborhood, and school, (4) enhance ongoing care, and (5) address the positive and negative impact of family, peers, and schools. These concerns for improving access, retention, and long-term outcomes are briefly underscored below with youth and schools in mind.

### **Increasing Availability and Access to Treatment**

The new federal parity law will help enhance availability of and access to substance abuse and mental health treatment for some children and adolescents. However, given the nature and scope of existing disparities, increasing equity of opportunity for treatment in the near future requires shifts in prevailing youth policy to guide major systemic changes.

Policy makers need to promote expanded intervention frameworks, facilitate braiding of allocated resources, and rework operational infrastructures in ways that support development and sustainability of a comprehensive intervention approach that outreaches and connects closely with youth. Of particular importance is refining the school's role and expanding how schools and communities collaborate. This means building on and going well-beyond such concepts as school based health centers, school-linked services, family resource centers, full service schools, and wrap around services. Elsewhere, we have discussed these matters in considerable detail (e.g., Adelman & Taylor, 2010) and will highlight key points later in this report.

### **Refining and Expanding Interventions Related to Referral and Transition**

Given availability and means for access, enhancing referral follow-through and reducing treatment dropouts begins with improved *interventions for referral and transition into treatment*. Too often these steps are addressed in pro forma ways rather than as well-implemented interventions designed to enhance motivation and ability for referral follow-through and successful adjustment to the treatment regimen.

Critical here is effective monitoring to determine referral follow-through. Where there has been no follow-through, the process turns to providing additional assistance including alternative referrals. Where there has been follow-through, the first care-monitoring step involves determining whether a positive transition into treatment is underway; if not, an immediate focus on treatment dropout prevention is indicated.

## **Reintegration and Re-engagement of Returning Youth**

For those returning from residence treatment, the concern is not only for reintegration but for productive re-engagement with home, neighborhood, and school. There is a growing literature stemming from efforts to connect potential and returning school dropouts and students coming back from hospital stays and from special education and alternative programs (e.g., Edelman, Holzer, & Offner, 2006; Harris, 2009; Martin & Halpern, 2006; Thurlow, Sinclair, & Johnson, 2002).

A major element in all cases involves facilitating a successful *transition back* process. Examples of transition back concerns include maximizing youth and family motivation and capability for the transition, connecting an adolescent with one or more advocates, ensuring a meaningful welcoming back at home and school, facilitating transfer of records, educating staff and students to reduce stigmatization as much as feasible and to provide effective support, and connecting the adolescent and family members with immediate support mechanisms (e.g., peer buddies, mentors who have made a successful transition, support groups). See Exhibit 2 for a description of a well-cited transition program. Also see Brock, O’Cummings, and Milligan (2008) for a transition toolkit.

With specific respect to schools, Moberg and Finch (2008) stress: “For many adolescents, schools not only represent the environment of previous use and contact with pretreatment drug-using friends but the emotional turmoil involved with life transitions.” Researchers have found that returning students were offered drugs on their first day back in school (Spear & Skala, 1995). To counter negative experiences for returning youth and as a temporary alternative milieu for those in outpatient care, various forms of *transition placements* are seen as viable. For example, advocates for *recovery high schools* have argued that such placements help youth avoid factors that lead to relapse and enhance successful reintegration and re-engagement (Moberg & Finch, 2008).

## **Enhancing Ongoing Care**

Beyond continuing treatment, ongoing care involves a range of interventions focusing on recovery and preventing relapse. These include supports for physical, social, and emotional well-being and academic success. As federal policy emphasizes, the concept of a system of care provides a framework for such supports, with care management is a key facet of such a system (e.g., SAMHSA, 2009). Systems of care help identify, provide, coordinate, and coalesce multiple home, community, and school interventions (e.g., treatment, social services, daily transitions, grade and school transitions, postsecondary transitions, special education, probation, family respite and preservation). However, as discussed later in this report, a system of care is just one subsystem in the comprehensive intervention continuum needed to address youth substance problems.

## **Addressing the Positive and Negative Impact of Family, Peers, and Schools**

The impact of family, peers, and schools related to youth substance problems is well recognized. However, researchers mostly stress correlates with family (e.g., Liddle, Dakof, & Diamond, 2001). The role of peers in general and youth subcultural groups (e.g., stoners, gangs, skaters, ravers) has been relatively ignored (Center for Mental Health in Schools, 2010; Hunt, Moloney, & Evans, 2009). Moreover, while researchers have stressed the correlation between drug use and school performance, the impact of factors related to school climate is just resurfacing as a critical area of interest not just for prevention but for milieu support (National School Climate Center, 2010).

## Exhibit 2

### **School-Based Transition Program Connects High-Risk Adolescents to Mental Health and Support Services, Leading to Improved Academic and Familial Functioning**

[From: AHRQ Innovations Exchange – <http://www.innovations.ahrq.gov/content.aspx?id=2218> ]

In Brookline, MA, an urban community with great economic and cultural diversity, about 6 percent of high school students were thought to be in need of an intervention due to psychiatric hospitalization, substance abuse treatment, a serious medical event, or incarceration. Those returning to school after being hospitalized or otherwise dealing with these kinds of problems faced problems such as depression, anxiety, trouble concentrating, fear of relapse, and social rejection; these adolescents are at high risk of academic failure and social isolation. Their families also face hardships in trying to navigate the maze of medical, mental health, and substance abuse services that are needed to help the adolescent. The complex needs of these students overwhelm most public high school staff.

Brookline High School and the Brookline Community Mental Health Center implemented a program to help 14- to 18-year-olds (and their families) who had recently experienced serious emotional disorders, medical issues, substance abuse, or other issues. The program provides clinical support, case management, and academic assistance to these vulnerable adolescents, helping to reintegrate them into school life. The cornerstone of the program is a team of two school-based clinical coordinators and a classroom aide who work closely with students and their families during the crisis period and a 12- to 18-week transitional program that is offered free of charge. Key elements of the program are described below:

- **Clinical support for teens and families:** Two clinical coordinators who are trained social workers provide clinical support and counseling to teens and their families. The clinical coordinators do not serve as the primary therapists but rather provide emotional support with respect to managing depression and psychotic symptoms, dealing with stress, getting organized, and maintaining focus. They also provide clinical support to families, including adjusting expectations after a prolonged absence from school (and potentially from the home as well in the event of hospitalization). They meet with students and their families before reentry into school and help them decide on short-term goals and plans, such as schedule changes and tutoring. Students usually meet with clinical coordinators daily, the length of the meeting varying according to the needs of the adolescent. Family contact includes daily telephone calls or e-mails as well as family meetings on a weekly or biweekly basis.
- **Care coordination:** The clinical coordinators also provide case management services, helping students and their families negotiate the fragmented mental health and school system, facilitating communication with health care personnel and therapists, and serving as liaisons between students, teachers, and tutors. They organize and lead meetings of care providers and school staff directed at developing and implementing individualized plans for each student. In addition, they assist families in locating health resources in the school and community.
- **Academic assistance:** The classroom aide provides academic assistance and tutoring to students in a supportive in-school environment. The classroom aide serves as an advocate for the adolescent, negotiating workloads with teachers and helping students organize and complete assignments on time. BRYT staff also educate teachers on how to respond to the needs of seriously emotionally ill students.
- **Dedicated classroom for vulnerable students:** A specialized "home-base" classroom is located near the entrance of the high school, serving as a safe and manageable respite where vulnerable students can check in as needed during the day, receive tutoring, and get counseling and academic support (e.g., organizing and completing school work). The classroom accommodates 8 to 12 students at a time, and most students in the program schedule specific times to be there.

A strong example of growing concern about the role peers and school environment play in generating and exacerbating substance problems is found in the increasing attention to such matters on college campuses. It is estimated that 31 percent of college students meet criteria for alcohol abuse and 6 percent meet criteria for dependence (Knight et al, 2002). To guide campuses in addressing alcohol and other drug abuse, the U.S. Department of Education's Higher Education Center for Alcohol, Drug Abuse, and Violence Reduction is advocating *environmental management* (see <http://www.higheredcenter.org/>). The approach is described as

“grounded in the social ecological model of public health that acknowledges and attempts to address a broad array of factors that influence individual health decisions and behaviors on the institutional, community, and public policy levels, in addition to those at the individual and group levels. ... Environmental management seeks to bring about behavior change through multiple channels, both promoting positive behaviors and norms and also discouraging high-risk behaviors. It encompasses a range of activities from environmental change that includes policy changes at the campus and community level to early intervention programs aimed at students displaying signs of distress to awareness activities aimed at groups known to be at higher risk for engaging in problem behaviors, and finally, to health protection programs that aim to minimize the harm incurred by problem behaviors. While environmental management encompasses a spectrum of programs and interventions from primary prevention to early intervention and treatment, it stresses the prevention of high-risk behavior through changes to the environment in which students make decisions about their alcohol and other drug use.”

In outlining the approach, the Higher Education Center identifies the following as strategic in altering the environment with respect to alcohol and other drug abuse:

- (1) Offer substance-free social, extracurricular, and public service options.
- (2) Create a health-promoting normative environment.
- (3) Restrict the marketing and promotion of alcohol and other drugs both on and off campus.
- (4) Limit availability of alcohol and other drugs.
- (5) Develop and enforce campus policies and enforce laws to address high-risk and illegal alcohol and other drug abuse and violence.

With respect to implementation, the Higher Education Center emphasizes the importance of strong leadership and a campus-wide “task force” that includes a broad spectrum of staff and students; a campus and community coalition; and active participation of college officials in public policy. But, also note that the Center stresses: “Environmental change strategies are only part of what is needed.... Researchers recommend a comprehensive approach that includes interventions designed to intervene with students who have shown some risk related to alcohol use or who have significant problems that warrant a diagnosis of abuse or dependence (DeJong & Langford, 2002).”

## Complex Problems, Limited Solutions

All of the above intervention elements reflect rational concerns. The trouble is that such concerns tend to be translated into categorical programs and ad hoc and piecemeal practices.

The term co-morbidity recognizes that individual's frequently have several problems; clinicians use this term to indicate that an individual has more than one diagnosable problem. Schools have long recognized that adolescents may be referred for one problem, such as drug use, but also have poor grades, are truant, at risk of dropping out, and more. Behavior problems are associated with learning and emotional problems. Learning and behavior problems tend to develop an overlay of emotional problems. And, of course, emotional problems can lead to and exacerbate behavior and/or learning problems. Each day, schools experience many overlapping concerns related to youth subgroups and youth subculture. Of special concern is addressing any negative impact (e.g., criminal acts, bullying, sexual harassment, interracial conflict, vandalism, mental health problems).

The point is that the problems manifested by adolescents who are not functioning well tend to be multifaceted and complex. Thus, schools rarely deal with students who only have a single problem.

However, at many schools the process for responding when students are not doing well ignores this fact. The trend is to refer such students directly for assessment in hopes of referral for special assistance, perhaps even assignment to alternative programs. In some schools and classrooms, the number of referrals is dramatic.

In a few cases where problems are severe, pervasive, and/or chronic, students are referred for a possible special education diagnosis (e.g., most often learning disabilities and attention deficit hyperactivity disorder). Most of the time teachers make requests for help to teams set up to accept referrals for moderate behavior, learning, and emotional problems. The list of such referrals grows as the year proceeds. In many schools, the number of students experiencing problems is staggering. The longer the list, the longer the lag time for review – often to the point that, by the end of the school year, the team has reviewed just a small percentage of those referred. *And, no matter how many are reviewed, there are always more referrals than can be served.*

When schools do provide supports and assistance to address student problems, the interventions usually have been developed and function in relative isolation of each other. Organizationally, the tendency is for policy makers to mandate and planners and developers to focus on specific programs. Functionally, most practitioners spend their time working directly with specific interventions and targeted problems and give little thought or time to developing comprehensive and cohesive approaches. Furthermore, the need to label students in order to obtain special, categorical funding and/or reimbursement from public/private insurance often skews practices toward narrow and unintegrated intervention approaches. One result is that a student identified as having multiple problems may be involved in programs with several professionals working independently of each other. Similarly, a youngster identified and helped in elementary school who still requires special support may cease to receive appropriate help upon entering middle school.

Pursuit of grant money for special projects (e.g., focused on substance use concerns) often further diverts attention from one concern to another. Whenever special funding opportunities appear to underwrite some form of student support, many districts and schools scramble to get

their share and then reshape their practices to meet the funder's requirements – until the funding ends. Innovators/researchers bring special projects; new strategies are tried; the project ends – usually within a period of a couple of years. (The failure to sustain in such cases has been labeled “projectitis.”)

As is widely recognized, the overall impact is that student and learning supports tend to be poorly conceptualized, fragmented, overspecialized, counterproductively competitive, unsustainable, and fundamentally marginalized in policy and practice (Center for Mental Health in Schools, 2008a). The result is a set of interventions that does not and cannot meet the needs of any school where large numbers of students are experiencing problems.

The solution is not found in efforts to convince policy makers to fund more special programs and services at schools. Even if the policy climate favored more special programs, such interventions alone are insufficient. More services to treat problems, such as substance use disorders, certainly are needed. But so are programs for prevention and early-after-problem onset that can reduce the number of students sent to review teams and special interventions at schools. It is time to face the fact that *multifaceted problems usually require comprehensive, integrated solutions applied concurrently and over time.*

### **About a Comprehensive Intervention Framework**

Discussions of comprehensive approaches are common. The descriptions vary markedly with respect to what is meant by comprehensive. For our purposes here, it is sufficient to present the outlines of an intervention framework being used by some forward thinking state department of educations and school districts (see *Where's It Happening?* -- online at <http://smhp.psych.ucla.edu/summit2002/nind7.htm> ).

As can be seen in Exhibit 3, the framework encompasses much more than the concept of a system of care. The framework is intended as a policy guide in developing a full continuum of systemic interventions by weaving together the resources of school, community/home.

The continuum in Exhibit 3 is conceived in terms of an integrated *system* encompassing three overlapping *subsystems*:

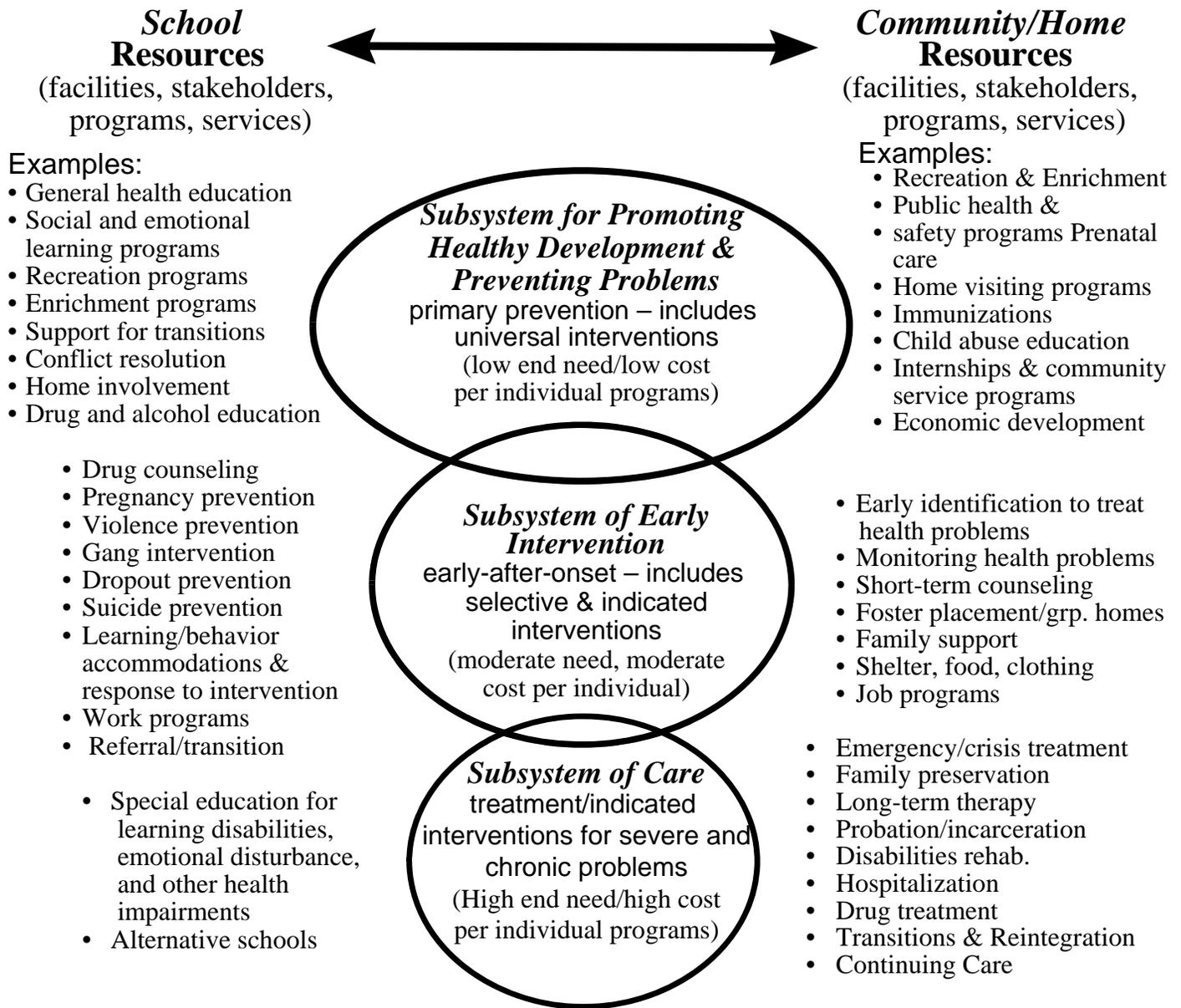
- a subsystem for positive development and prevention of problems
- a subsystem of early intervention to address problems as soon after their onset as feasible
- a subsystem of care for those with chronic and severe problems.

For schools, all the interventions related to each subsystem have been organized into six arenas of content (Center for Mental Health in Schools, 2008b).

The current reality is that the only subsystem anywhere near in place is the system of care model. This is the case because policy makers and other key stakeholders have not committed to establishing a full continuum of integrated subsystems to establish a *comprehensive, multifaceted, and cohesive* approach.

### Exhibit 3

#### A Continuum of Integrated Intervention Subsystems\*



Systematic school-community-home collaboration is essential to establish cohesive, seamless intervention on a daily basis and overtime within and among each subsystem. Such collaboration involves horizontal and vertical restructuring of programs and services.

\*Various venues, concepts, and initiatives permeate this continuum of intervention *systems*. For example, venues such as day care and preschools, concepts such as social and emotional learning and development, and initiatives such as positive behavior support, response to intervention, and coordinated school health. Also, a considerable variety of staff are involved. Finally, *note that this illustration of an essential continuum of intervention systems differs in significant ways from the three tier pyramid that is widely referred to in discussing universal, selective, and indicated interventions.*

As can be seen, the array of programmatic examples in Exhibit 4 amplifies the nature and scope of the continuum. It provides examples of (1) public health protection, promotion, and maintenance that foster positive development and wellness, (2) preschool-age support and assistance to enhance health and psychosocial development, (3) early-schooling targeted interventions, (4) improvement and augmentation of ongoing regular support, (5) other interventions prior to referral for intensive and ongoing targeted treatments, and (6) intensive treatments.

It should be noted that we conceive the continuum framed in Exhibits 3 and 4 as encompassing a holistic and developmental emphasis. The focus is on individuals, families, and the contexts in which they live, learn, work, and play. And, a basic assumption underlying the application of any of the interventions is that the least restrictive and nonintrusive forms of intervention required to address problems and accommodate diversity would be used initially. Another assumption is that problems are not discrete, and therefore, interventions that address root causes should be used.

In support of specific types of programs exemplified, a little bit of data can be gleaned from various facets of the research literature, most often project evaluations and dissertations. For obvious reasons, no study has ever looked at the impact of implementing the full continuum in any one geographic catchment area. However, we can make inferences from naturalistic “experiments” taking place in every wealthy and most upper middle income communities. Across the country, concerned parents who have financial resources, or who can avail themselves of such resources when necessary, will purchase any of the interventions listed in order to ensure their children’s well-being. This represents a body of empirical support for the value of such interventions that cannot be ignored. (As one wag put it: *The range of interventions is supported by a new form of validation – market validity!*)

**Exhibit 4. From primary prevention to treatment of serious problems: A continuum of community-school programs to address barriers to learning and enhance healthy development.**

<b><i>Intervention Continuum</i></b>	<b><i>Examples of Focus and Types of Intervention</i></b> (Programs and services aimed at system changes and individual needs)
<b>Primary prevention</b>	<ol style="list-style-type: none"> <li>1. <i>Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness</i> <ul style="list-style-type: none"> <li>• economic enhancement of those living in poverty (e.g., work/welfare programs)</li> <li>• safety (e.g., instruction, regulations, lead abatement programs)</li> <li>• physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)</li> </ul> </li> </ol>
<b>Early-after-onset intervention</b>	<ol style="list-style-type: none"> <li>2. <i>Preschool-age support and assistance to enhance health and psychosocial development</i> <ul style="list-style-type: none"> <li>• systems' enhancement through multidisciplinary team work, consultation, and staff development</li> <li>• education and social support for parents of preschoolers</li> <li>• quality day care</li> <li>• quality early education</li> <li>• appropriate screening and amelioration of physical and mental health and psychosocial problems</li> </ul> </li> <li>3. <i>Early-schooling targeted interventions</i> <ul style="list-style-type: none"> <li>• orientations, welcoming and transition support into school and community life for students and their families (especially immigrants)</li> <li>• support and guidance to ameliorate school adjustment problems</li> <li>• personalized instruction in the primary grades</li> <li>• additional support to address specific learning problems</li> <li>• parent involvement in problem solving</li> <li>• comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)</li> </ul> </li> <li>4. <i>Improvement and augmentation of ongoing regular support</i> <ul style="list-style-type: none"> <li>• enhance systems through multidisciplinary team work, consultation, and staff development</li> <li>• preparation and support for school and life transitions</li> <li>• teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support)</li> <li>• parent involvement in problem solving</li> <li>• resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth)</li> <li>• comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth)</li> <li>• Academic guidance and assistance (incl. use of Response to Intervention)</li> <li>• Emergency and crisis prevention and response mechanisms</li> </ul> </li> </ol>
<b>Treatment for severe/chronic problems</b>	<ol style="list-style-type: none"> <li>5. <i>Other interventions prior to referral for intensive, ongoing targeted treatments</i> <ul style="list-style-type: none"> <li>• enhance systems through multidisciplinary team work, consultation, and staff development</li> <li>• short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)</li> </ul> </li> <li>6. <i>Intensive treatments</i> <ul style="list-style-type: none"> <li>• referral, triage, placement guidance and assistance, care management, and resource coordination</li> <li>• family preservation programs and services</li> <li>• special education and rehabilitation</li> <li>• recovery and follow-up support</li> <li>• services for severe-chronic psychosocial/mental/physical health problems</li> </ul> </li> </ol>

## Implications for School Policy and Implementation

Those of us who want schools to play a role in addressing substance and mental health problems must begin by accepting two realities: (a) addressing such problems is not a primary facet of the mission of schools and (b) current school improvement policy and practice marginalizes interventions related to such problems. It is one thing to stress the desirability of an intervention (or of developing a full continuum of interventions); it is quite another to argue that schools should pursue what is proposed as a high priority. In the long-run, the success of such proposals probably depends on anchoring them in the context of the mission of schools (Adelman & Taylor, 2007a, 2000, 2010; Adelman & Taylor, 2010; Center for Mental Health in Schools, 2008a). That is, the proposals must be rooted in the reality that schools are first and foremost accountable for educating the young. As a result, schools tend to be most receptive to proposals focused on problems that clearly are major barriers to student *learning*.

With respect to major barriers, as stressed above, the majority of students who end up having difficulties experience a range of external factors that interfere with their succeeding at school. Anyone who works with youngsters is all too familiar with the litany of such factors (e.g., violence, youth subcultures that promote drug abuse, frequent school changes, and the host of problems confronting recent immigrants and families living in poverty). It is the entire constellation of barriers to learning that argues for schools, families, and communities working together to develop a comprehensive systemic approach rather than continuing to address each problem as an individual enterprise.

With these considerations in mind and from the perspective of the full continuum described above, let's look at some implications for policy and implementation.

### **Needed: A Policy Shift**

Our analysis of prevailing policies for improving schools indicates that the primary focus is on two major components: (1) enhancing instruction and curriculum and (2) restructuring school governance/management. The implementation of such efforts is shaped by demands for every school to adopt high standards and expectations and be accountable mainly for academic results, as measured by standardized achievement tests. Toward these ends, policy has emphasized enhancing direct academic support and moving away from a "deficit" model by adopting a strengths or resilience-oriented paradigm. As noted above, problems that cannot be ignored – school violence, drugs on campus, dropouts, teen pregnancy, delinquency, and so forth – continue to be addressed in a piecemeal manner. The result at schools is a variety of "categorical" initiatives which generate auxiliary programs, some supported by school district general funds and some underwritten by federal and private sector money.

Overlapping the efforts of schools are initiatives from the community to link their resources to schools. Terms used in conjunction with these initiatives include school-linked services (especially health and social services), full-service schools, school-community partnerships, and community schools.

A third and narrower set of initiatives is designed to promote coordination and collaboration among *governmental* departments and their service agencies. The intent is to foster integrated services, with an emphasis on greater local control, increased involvement of parents, and locating services at schools when feasible. Although the federal government has offered various forms of support to promote this policy direction, few school districts have pursued the opportunity in ways that have resulted in comprehensive approaches to address student problems. To facilitate coordinated planning and organizational change, local, state, and federal intra- and interagency councils have been established. Relatedly, legislative bodies have been

rethinking their committee structures, and some states have gone so far as to create new executive branch structures (e.g., combining education and all agencies and services for children and families under one cabinet level department).

The various initiatives do help *some* students who are not succeeding at school. However, they come nowhere near addressing the scope of need.

Policy makers have come to appreciate that inability to meet the needs of the many and limited intervention effectiveness are related to the widespread tendency for programs to be funded and operate in isolation of each other. As a result, calls have been made for greater coordination to reduce *fragmentation*. However, policy makers have failed to focus on the underlying fact that efforts to deal with youth problems are *marginalized* in prevailing public health and public education policy and practice. In schools, because such efforts are treated as supplementary, auxiliary services, they are among the first cut when budgets tighten. The result is that little attention is paid to developing a comprehensive, systemic approach for addressing student problems, and those efforts that are in place are plagued by counterproductive competition for sparse resources.

Increased awareness of school policy deficiencies has stimulated analyses and initiatives to move from the current two- to a three- component framework for school improvement. The third component is conceptualized as a component that unifies all school-based and linked interventions designed to address barriers to learning and teaching and re-engage disconnected students (see Appendix A).

Efforts to enhance how schools address student problems will benefit from a policy shift to a three component framework and an expansion of school accountability to drive development of the third component and its full integration with the instructional and management components (Adelman & Taylor, 2010). The shift will enable an extensive restructuring of all school-owned activity, such as pupil services, safe and drug free school initiatives, and compensatory and special education programs.

### **Reworking Operational Infrastructure: Beginning at the School Level**

Beyond policy changes, emergence of a cohesive and effective approach to addressing youth problems requires some reworking of *operational* infrastructure so that interventions play out at the school level every day. This calls for conceiving the operational infrastructure from the school outward. That is, first the focus is on mechanisms needed at the school level. Based on this, mechanisms are designed to enable a complex of schools to work together and with families and other neighborhood resources in ways that increase efficiency and effectiveness and achieve economies of scale. Finally, system-wide mechanisms can be (re)conceived to provide equitable capacity building for what each locality is trying to develop.

Clearly, the focus on operational infrastructure is concerned with more than enhancing coordination. The reworking needs to allow for weaving together what is available at a school, expanding this through integrating school, community, and home resources, and enhancing access to community resources by linking as many as feasible to work at the school. Braiding resources is essential for addressing student problems in cohesive, cost-efficient, and equitable ways. Moreover, such an approach is highly supportive of the intent to evolve a comprehensive intervention continuum that plays out effectively in *every locality*. It also addresses issues related to enhancing the functionality of school-community collaboratives.

Appendix B offers examples and prototypes to clarify these points. Appendix C provides some background on initiatives for connecting school-community-home resources.

## **Evidence-Based Practices and the Implementation Problem at Schools**

Increasingly schools are being called on to implement science-based practices. While it is clear that many concerns confronting schools cannot wait for researchers to provide proven prototypes, it is also clear that adopting an existing empirically-supported intervention to meet a priority need is the appropriate course of action. At the same time, just because an evidence-based practice exists is not a reason for schools to adopt it. At any school, the first question that arises about any new practice is where and how does it fit into the school's priorities.

Schools experience many overlapping concerns. Of special concern is addressing any negative impact (e.g., criminal acts, bullying, sexual harassment, interracial conflict, vandalism, mental health problems). But, also essential is a continuous focus on promoting healthy development and fostering a positive school climate.

Given that a new practice is to be adopted, the multifaceted and complex problems associated with implementation arise. These problems are familiar to anyone who has tried to move prototypes found efficacious under highly controlled conditions into the real world of schools. As the National Implementation Research Network (NIRN) has stressed, research to support implementation activities is scarce and little is known especially about the processes required to effectively implement evidence-based programs to scale. (For the NIRN literature synthesis, see Fixsen, Naoom, Blase, Friedman, & Wallace, 2005.)

Early research on the implementation problem has focused on concerns about and barriers to matters such as dissemination, readiness for and fidelity of implementation, generalizability, adaptation, sustainability, and replication to scale (Addis, 2002; Castro, Barrera, & Martinez, 2004; Elliot & Mihalic, 2004; Franklin, DeRubeis, & Westin, 2006; Hall, 2001; Herschell, McNeil & McNeil, 2004; Lau, 2006; Schoenwald, Henggeler, Brondino, & Rowland, 2000; Schoenwald & Hoagwood, 2001; Shirk, 2004; Spoth & Redmond, 2002; Stirman, Crits-Christoph, & DeRubeis, 2004; Weisz, Jensen, & McLeod, 2004). All of these matters obviously are important.

However, the tendency has been to analyze and approach the implementation problem with too limited a procedural framework and with too little attention to context. These deficiencies become apparent when the implementation process is conceived in terms of the complexities of (1) diffusing innovations and (2) doing so in the context of organized settings with well-established institutional cultures and infrastructures that must change if effective widespread application is to take place. Addressing these matters requires drawing on the growing bodies of literature on diffusion of innovations and systemic change (e.g., see Ackoff, 1998; Adelman & Taylor, 2007b; Duffy, 2005; Greenhalgh, McFarlane, Bate, & Kyriakidou, 2004; Greenhalgh, et al., 2005; Lehman, Greener, & Simpson, 2002; Magnabosco, 2006; Pentz, 2004; Rogers, 2003; Rosenheck, 2001; Senge, 1999; Sherry, 2003). From the perspective of work in these arenas, the implementation problem needs to be framed as a process of diffusing innovation through major systemic change. Such a perspective encompasses the complexities of facilitating systemic changes that lead to appropriate and effective adoption/adaptation of prototypes at a particular site and the added complexities of replication-to-scale. (For more on this, see Center for Mental Health in Schools, 2009).

## **Attending to Youth Subcultures and Diversity in Addressing Problems**

Given the complexity of the negative behaviors that arise at schools, those who are concerned about and have responsibility for gangs, safe schools, violence prevention, bullying, interracial conflict, substance abuse, vandalism, truancy, and school climate need to work collaboratively. The *immediate objectives* are to (1) educate others about motivational and behavioral factors

associated with a particular subgroup and individual difference within subgroups, (2) counter the trend in policy and practice to establish initiatives in terms of separate categories that lead to a host of fragmented and too often ineffective programs and services, and (3) facilitate opportunities on campus for youth subgroups to engage positively in subcultural activity and connect with effective peer supports.

Toward these ends, schools must reach out to the community and establish a collaborative mechanism where those with specialized knowledge not only bring that knowledge to the table, but also work to build the needed comprehensive system of student and learning supports that addresses a wide range of barriers to learning, teaching, parenting, and development (Adelman & Taylor, 2006a, 2006b, 2007a,). And it is essential to remember that those with specialized knowledge include youth themselves (Center for Mental Health in Schools at UCLA, 2009).

### Concluding Comments

What unites so many of us is the desire to ensure the well-being of the young. Clearly schools play a big role both in shaping the futures of everyone.

Because schools are a portal for enhancing access to young people and their families, the tendency is for many researchers and practitioners with specific, yet different agenda to come to the school door seeking entry. Those concerned about substance use represent one agenda among many.

Taken individually, each agenda appears imminently reasonable. Taken as a whole, the demands for time with students, access to teachers, additions to the curriculum, introduction of specialized interventions, and so forth produces priorities and demands for sparse resources.

In this report, we have suggested the need to move beyond specific agenda for schools in seeking greater attention for addressing substance use and mental health concerns. Specifically, we have emphasized the need for expanding policy and practice in ways that can embed such concerns into the type of comprehensive, systemic approach necessary for addressing the many complex factors interfering with schools accomplishing their mission. By working collaboratively and differentiating the causes of observed problems, schools and communities can integrate fragmented and marginalized initiatives and counter the trend to establish initiatives in terms of separate categories that lead to a host of fragmented and too often ineffective programs and services. Over time, this will enable development of a comprehensive system of student and learning supports that (a) addresses a wide range of barriers to learning, teaching, parenting, and development and (b) re-engages disconnected youth.

To guide development of a systemic approach, we have suggested using a continuum of integrated school-community intervention systems as a unifying framework. This includes school-community subsystems for promoting healthy development, preventing problems, intervening early to address problems as soon after onset as is feasible, and addressing chronic and severe problems. We have also indicated a need to fundamentally *rework operational infrastructure* so that there is leadership and mechanisms for building integrated intervention system at schools and for connecting school and community resources.

It is our view that, only by developing such a comprehensive system, will it be feasible to facilitate the *emergence* of a school environment that fosters successful, safe, and healthy students and staff. (It is important to remember that *school climate and culture are emergent qualities* that stems from how schools provide and coalesce on a daily basis the components dedicated to instruction, student and learning supports, and management/governance.)

Ultimately, enhanced access and availability to the interventions many youth need depends on moving the whole enterprise of student and learning supports out of the margins of school improvement policy and practice. In this respect, the impending reauthorization of the *Elementary and Secondary Education Act* (ESEA) represents a golden opportunity for moving to a *three-component framework* for turning around, transforming, and continuously improving schools. Properly conceived and implemented, the third component can provide a unifying concept and an umbrella under which schools can weave together all interventions specifically intended to address barriers to learning and teaching and re-engage disconnected students.

Across the country, pioneering work to enhance student and learning supports heralds movement toward a comprehensive system for addressing factors interfering with learning and teaching. Thus, whether or not the impending reauthorization of the ESEA incorporates a three-component blueprint, we anticipate more and more movement in this direction at state, regional, district, and school levels. As the Carnegie Task Force on Education has stressed:

*School systems are not responsible for meeting every need of their students.  
But when the need directly affects learning, the school must meet the challenge.*

The call for ensuring equity and opportunity for all youth demands no less.

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## **Appendices**

- A. Enhancing the Blueprint for School Improvement in the ESEA Reauthorization:  
Moving from a Two to a Three-Component Approach
- B. Frameworks for *Reworking Infrastructure* at School, Feeder Patterns, District  
Levels, and for School-Community Collaboratives
- C. Background on Initiatives for Connecting School-Community-Home Resources



## Appendix A



NATIONAL  
ASSOCIATION OF  
SCHOOL  
PSYCHOLOGISTS

# Enhancing the Blueprint for School Improvement in the ESEA Reauthorization: *Moving From a Two- to a Three-Component Approach*

As Congress considers reauthorizing the Elementary and Secondary Education Act (ESEA), it is essential to include a consolidated and cohesive focus on addressing barriers to learning and re-engaging disconnected students. External and internal barriers to learning pose some of the most pervasive and entrenched challenges to educators across the country, particularly in chronically low performing schools. Failure to directly address these barriers ensures that (a) too many children and youth will continue to struggle in school, and (b) teachers will continue to divert precious instructional time to dealing with behavior and other problems that can interfere with classroom engagement for all students.

Currently, the need to systemically lower or eliminate barriers to learning and teaching is given only marginal attention in our national debate about the policies and programs needed to improve schools. As long as this is the case, the best improvements in curriculum, instruction, management, and governance will be insufficient to improve outcomes for large numbers of students.

### **A More Complete Policy Blueprint Framework**

To date, federal policy addresses two primary components as essential to school reform. One component emphasizes instructional factors that impact learning, and the other addresses the governance and operations of schools. Research has clarified the need for a third component that directly and comprehensively focuses on (a) addressing barriers to learning and teaching and (b) re-engaging students who have become disconnected from classroom instruction.<sup>1</sup> In most school systems today, the supports necessary to accomplish these objectives are treated as secondary to school improvement efforts, resulting in the delivery of piecemeal services with no comprehensive or integrated focus. Typically, these interventions are provided by school employed student support personnel (e.g., school counselors, psychologists, social workers, nurses, etc.) who collaborate with and link to community-based resources. Access to these services improves behavior, academic performance, instruction, school climate, family engagement, and data-based decision-making.<sup>2</sup> However, the resources and leadership dedicated to supporting the services of these professionals remain marginalized and fragmented in most schools, making them less effective and cost-efficient than they could be.

### **Defining a Comprehensive System of Learning Supports for Policy Purposes**

*Learning supports are the resources, strategies, and practices that provide physical, social, emotional, and intellectual supports to enable all students to have an equal opportunity for success at school by directly addressing barriers to learning and teaching and re-engaging disconnected students.*

*A comprehensive, multifaceted, and cohesive learning support system provides essential interventions in classrooms and school-wide. To ensure effectiveness, it is fully integrated in school improvement policies and practices designed to enhance instruction and school management.*

In place of the fragmented interventions generated by current school policy (Exhibit 1A), an effective third component of school improvement facilitates the development of a comprehensive and cohesive system of learning supports that is fully integrated with management and instruction (Exhibit 1B).

## Exhibit 1. Moving from a Two- to a Three- Component Framework for Improving Schools

### A. Current School Improvement Framework

#### PRIMARY FOCUS

**Direct Facilitation of Learning**  
(Instructional Component)

- High quality teachers
- Improved academic assessment systems
- Standards based instruction
- Staff development

- Shared governance
- Improved data collection systems
- Increased accountability
- Building level budget control & management
- Flexible funding

**Governance, Resources, & Operations**  
(Management Component)

#### SECONDARY/MARGINALIZED FOCUS

**Addressing Barriers to Learning & Teaching**  
(Learning Supports—Not a unified component)

Despite the fact that student and learning supports are essential to student success, they are not implemented as a comprehensive system and are not treated in school improvement policy and practice as a primary component of school improvement.

A few examples of programs currently implemented are:

- School wide positive behavioral supports and interventions
- Response to intervention
- Safe Schools, Healthy Students Program
- Coordinated School Health Program
- Full Service Community Schools Initiatives
- School Based Health Centers
- Specialized Instructional Support Services
- Compensatory and special education interventions
- Bullying prevention
- Family Resource Centers
- Foster Child and Homeless Student Education
- Student Assistance Programs

### B. Needed: Policies to Establish an Umbrella for School Improvement Planning Related to Addressing Barriers to Learning and Promoting Healthy Development

Direct Facilitation of Learning

Addressing Barriers to Learning & Teaching

Instructional Component

Learning Supports Component

Management Component

Governance, Resources & Operations

#### Full Integration of Learning Supports Component

The **Learning Supports Component** establishes an umbrella for ending marginalization by unifying fragmented efforts and evolving a comprehensive system. Major content areas for developing learning supports are:

- Building teacher capacity to re-engage disconnected students and maintain their engagement
- Providing support for the full range of transitions that students & families encounter as they negotiate school and grade changes
- Responding to and preventing academic, behavioral, social-emotional problems and crises
- Increasing community and family involvement and support
- Facilitating student & family access to effective services and special assistance as needed

Effective integration of this component is dependent upon promoting collaborative models of practice that value and capitalize on the services and expertise of school and community services personnel. By integrating the learning supports component on par with the instructional and management components, the marginalization of associated programs, services, and policies ceases and a comprehensive school improvement framework is realized.

## Addressing Barriers, Supporting Teachers, Re-Engaging Learners

Failing to address barriers to learning has high costs. The good news is that there are many schools where the majority of students are doing just fine, and in any school, one can find youngsters who are succeeding. The bad news is that in any school one can find youngsters who are failing, and there are too many schools, particularly those serving lower income families, where large numbers of students are doing poorly. Nearly 2,000 high schools (about 13 percent of American high schools) account for more than 50% of all high school dropouts. Located in rural, suburban, and urban areas with typically high poverty and high minority populations, these schools see the typical freshman class shrink by 40 percent or more by the time students reach their senior year.<sup>3</sup> Any combination of the factors highlighted in Exhibit 2 can put a student at risk, but the higher the concentration of risk factors, the greater the risk of dropping out.<sup>1, 4</sup>

The costs of dropping out are high for individuals and pose a significant threat to our nation's economic security. The Alliance for Excellent Education estimates that if the 1.2 million high school dropouts from the Class of 2008 had graduated instead of dropping out, the U.S. economy would have seen an additional \$319 billion in wages over these students' lifetimes. Over a decade, these losses are projected to total more than one trillion dollars.<sup>5</sup>

### Exhibit 2: Examples of Conditions That Can Increase Barriers to Learning

Environmental Conditions		Person Conditions	
<p><b>Neighborhood</b></p> <ul style="list-style-type: none"> <li>▪ High poverty</li> <li>▪ High rates of crime, drug use, violence, gang activity</li> <li>▪ High unemployment, abandoned/floundering businesses</li> <li>▪ Disorganized community</li> <li>▪ High mobility</li> <li>▪ Lack of positive youth development opportunities</li> </ul>	<p><b>Family</b></p> <ul style="list-style-type: none"> <li>▪ Domestic conflicts, abuse, distress, grief, loss</li> <li>▪ Unemployment, poverty, homelessness</li> <li>▪ Immigrant and/or minority status</li> <li>▪ Family physical or mental health illness</li> <li>▪ Poor medical or dental care</li> <li>▪ Inadequate child care</li> <li>▪ Substance abuse</li> </ul>	<p><b>School and Peers</b></p> <ul style="list-style-type: none"> <li>▪ Poor quality schools, high teacher turnover</li> <li>▪ High rates of bullying and harassment</li> <li>▪ Minimal offerings and low involvement in extra curricular activities</li> <li>▪ Frequent student-teacher conflicts</li> <li>▪ Poor school climate, negative peer models</li> <li>▪ Many disengaged students and families</li> </ul>	<p><b>Internal Student Factors</b></p> <ul style="list-style-type: none"> <li>▪ Neurodevelopmental delay</li> <li>▪ Physical illness</li> <li>▪ Mental disorders</li> <li>▪ Disabilities</li> <li>▪ Inadequate nutrition &amp; health care</li> <li>▪ Learning, behavior, and emotional problems stemming from negative environmental conditions</li> </ul>

The move from a two- to a three-component policy framework significantly enhances efforts to develop a blueprint and roadmap for transforming school improvement policy and practice to deal with such barriers. It does this by providing a unifying umbrella policy under which all resources expended for student and learning supports can be woven together. Doing so increases effectiveness and reduces costs. Specifically, this requires a systematic focus on how to:

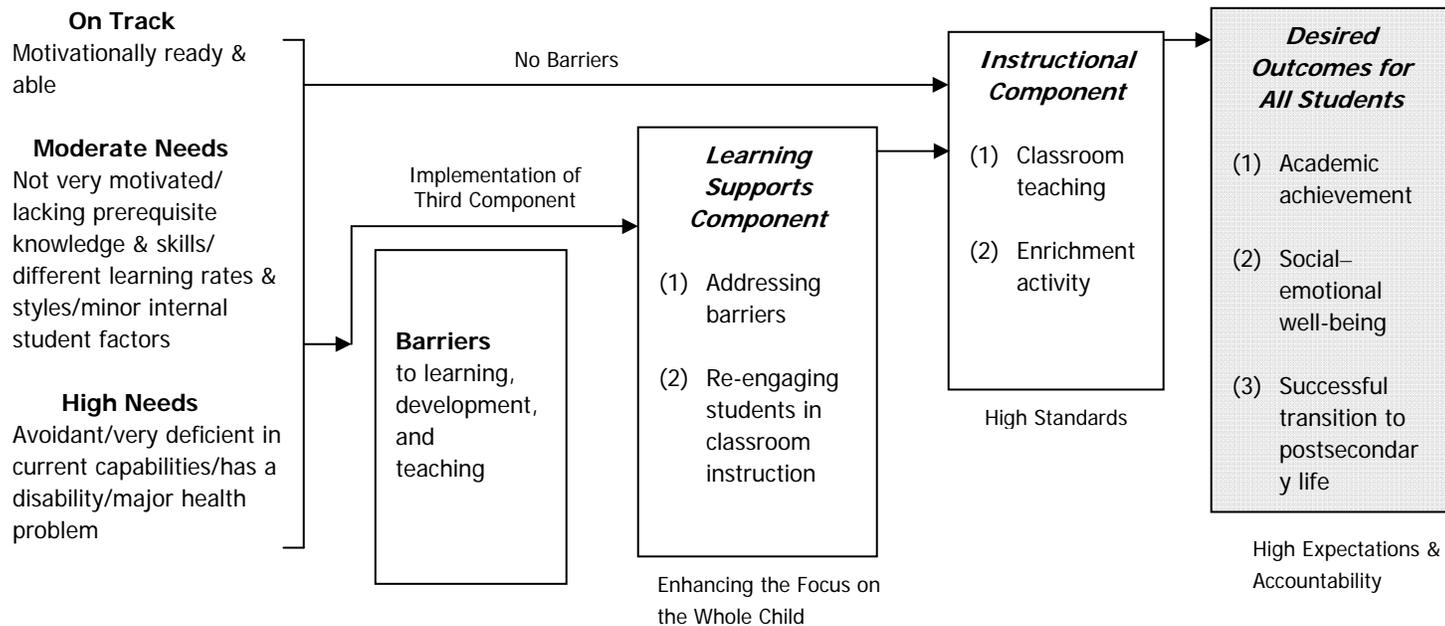
- reframe current student support programs and services and redeploy the resources to develop a comprehensive, multifaceted, and cohesive system for enabling learning
- develop both in-classroom and school-wide approaches that reinforce individual student interventions—including interventions to support transitions, increase home and community connections, enhance teachers' ability to respond to common learning and behavior problems, and respond to and prevent crises
- realign district, school, and school-community infrastructures to weave resources together with the aim of enhancing and evolving the learning supports system
- pursue school improvement and systemic change with a high degree of policy commitment to fully integrate supports for learning and teaching with efforts to improve instruction and school governance
- expand accountability systems both to improve data-based decision-making, and to reflect a comprehensive picture of students' and schools' performance that incorporates efforts to address barriers to learning and teaching<sup>1, 2</sup>

Exhibit 3 below illustrates that the intent is to support *all* students by both addressing interfering factors and re-engaging those who have become disconnected from classroom instruction.

## Exhibit 3: A Learning Supports Component to Address Barriers and Re-Engage Students in Classroom Instruction

### Range of Learners

(based on their response to academic instruction at any given point in time)



### The Time for Moving to a Three-Component Blueprint for School Improvement is Now

A common thread identified throughout the ESEA reauthorization recommendations from many stakeholder groups, including the U.S. Department of Education and members of Congress, is the need to address barriers to learning and teaching. The recommendations, however, typically lack a systemic or integral approach.<sup>6</sup> Now is the time to correct this deficiency.

Pioneering work in states already is moving learning supports from the margins to play a central role in school improvement.<sup>7, 8</sup> Federal policy that provides a cohesive vision and structure for sharing this work will make it possible to develop a comprehensive, multifaceted, and cohesive system of learning supports in every school, to the benefit of all children and the nation at large.<sup>1, 2</sup> Properly conceived and implemented, such a system can close the achievement gap, enhance school safety, reduce dropout rates, shut down the pipeline from schools to prisons, and promote well-being and responsible citizenship.

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**A joint statement from the National Center for MH in Schools at UCLA and the National Association of School Psychologists**  
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## Appendix B

### **Frameworks for Reworking Infrastructure at School, Feeder Patterns, District Levels, and for School-Community Collaboratives**

**W**ell-designed, compatible, and interconnected infrastructures at schools, for school complexes, at the district level, and for school-community collaboratives are essential for developing a comprehensive system of learning supports to address barriers to learning and teaching. Each level plays a key role in weaving together existing school and community resources and developing a full continuum of interventions over time. Moreover, content and resource-oriented infrastructure mechanisms enable programs and services to function in an increasingly cohesive, cost-efficient, and equitable way.

#### **Rethinking Infrastructure for Districts and Schools**

The fundamental principle in developing an organizational and operational infrastructure is that *structure follows function*. That is, the focus should be on establishing an infrastructure that enables accomplishment of major functions and related tasks in a cost-effective and efficient manner.

#### **Structure follows function**

For school districts, the vision of leaving no child behind encompasses ensuring that all students have an equal opportunity to succeed at school. As we have stressed, pursuing such a vision requires effectively operationalizing three core functions: (1) facilitating learning and development, (2) addressing barriers to learning and teaching in ways that enable learning and development, and (3) governing and managing the district. In pursuing each of these, the major processes involve *systemic* planning, implementation, and evaluation and accountability.

#### **A component for learning supports requires integrated infrastructure mechanisms that are fully integrated into school improvement efforts**

The infrastructure need is to establish a connected set of mechanisms to steer and carry out these fundamental functions and processes on a regular basis in keeping with the vision for public education. Such an infrastructure enables leaders to steer together and to empower and work productively with staff on major tasks related to policy and practice (e.g., designing and directing activity, planning and implementing specific organizational and program objectives, allocating and monitoring resources with a clear content and outcome focus, facilitating coordination and integration to ensure cohesive implementation, managing communication and information, providing support for capacity building and quality improvement, ensuring accountability, and promoting self-renewal).

Developing and institutionalizing a comprehensive component for learning supports requires infrastructure mechanisms that are integrated with each other and are fully integrated into school

improvement efforts. Along with unifying various initiatives, projects, programs, and services, the need *at a school* is to rework infrastructure to support efforts to address barriers to learning in a cohesive manner and to integrate the work with efforts to facilitate instruction and promote healthy development. *At the district level*, the need is for administrative leadership and capacity building support that helps maximize development of a comprehensive system of learning supports to address barriers to learning and teaching at each school. And, it is crucial to establish the district's leadership for this work at a high enough level to ensure the administrator is always an active participant at key planning and decision-making tables.

**Infrastructure for a comprehensive system of learning supports should be designed from the school outward**

From our perspective, the infrastructure for a comprehensive system of learning supports should be designed from the school outward. That is, conceptually, the emphasis is first on what an integrated infrastructure should look like at the school level. Then, the focus expands to include the mechanisms needed to connect a family or complex (e.g., feeder pattern) of schools and establish collaborations with surrounding community resources. Ultimately, central district (and community agency) units need to be restructured in ways that best support the work at the school and school complex levels. Indeed, a key guideline in designing district infrastructure is that it must provide leadership and build capacity for (a) establishing and maintaining an effective learning supports infrastructure at every school and (b) a mechanism for connecting a family of schools.

All this involves reframing the work of personnel responsible for student/learning supports, establishing new collaborative arrangements, and redistributing authority (power). With this in mind, those who do such restructuring must have appropriate incentives, safeguards, and adequate resources and support for making major systemic changes. (We do recognize all this is easy to say and extremely hard to do.)

***At School and School Complex Levels***

Every school is expending significant resources on student and learning supports to enable learning. Yet, few have mechanisms to ensure appropriate use of these resources and to work on enhancing current efforts. Content and resource-oriented mechanisms contribute to cost-efficacy by ensuring student and learning support activity is planned implemented, and evaluated in a coordinated and increasingly integrated manner. Creation of such mechanisms is essential for braiding together existing school and community resources and, encouraging services and programs to perform in an increasingly cohesive way.

Exhibit B-1 illustrates a school infrastructure prototype. Obviously, a small school has less staff and other resources than most larger schools. Nevertheless, the three major functions necessary for school improvement remain the same in all schools, namely (1) improving instruction, (2) providing learning supports to address barriers to learning and teaching, and (3) enhancing management and governance. The challenge in any school is to pursue all three functions in an integrated and effective manner.

The added challenge in a small school is how to do it with so few personnel. The key is to use and, to the degree feasible, modestly expand existing infrastructure mechanisms. In a small school, however, rather than stressing the involvement of several administrative leaders and numerous staff members, the emphasis is on the role a *School Leadership Team* can play in establishing essential infrastructure mechanisms.

With less personnel, a principal must use who and what is available to pursue all three functions. Usually, the principal and whoever else is part of a school leadership team will lead the way in improving instruction and management/governance. As presently constituted, however, such a team may not be prepared to advance development of a comprehensive system of learning supports. Thus, someone already on the leadership team will need to be assigned this role and provided training to carry it out effectively.

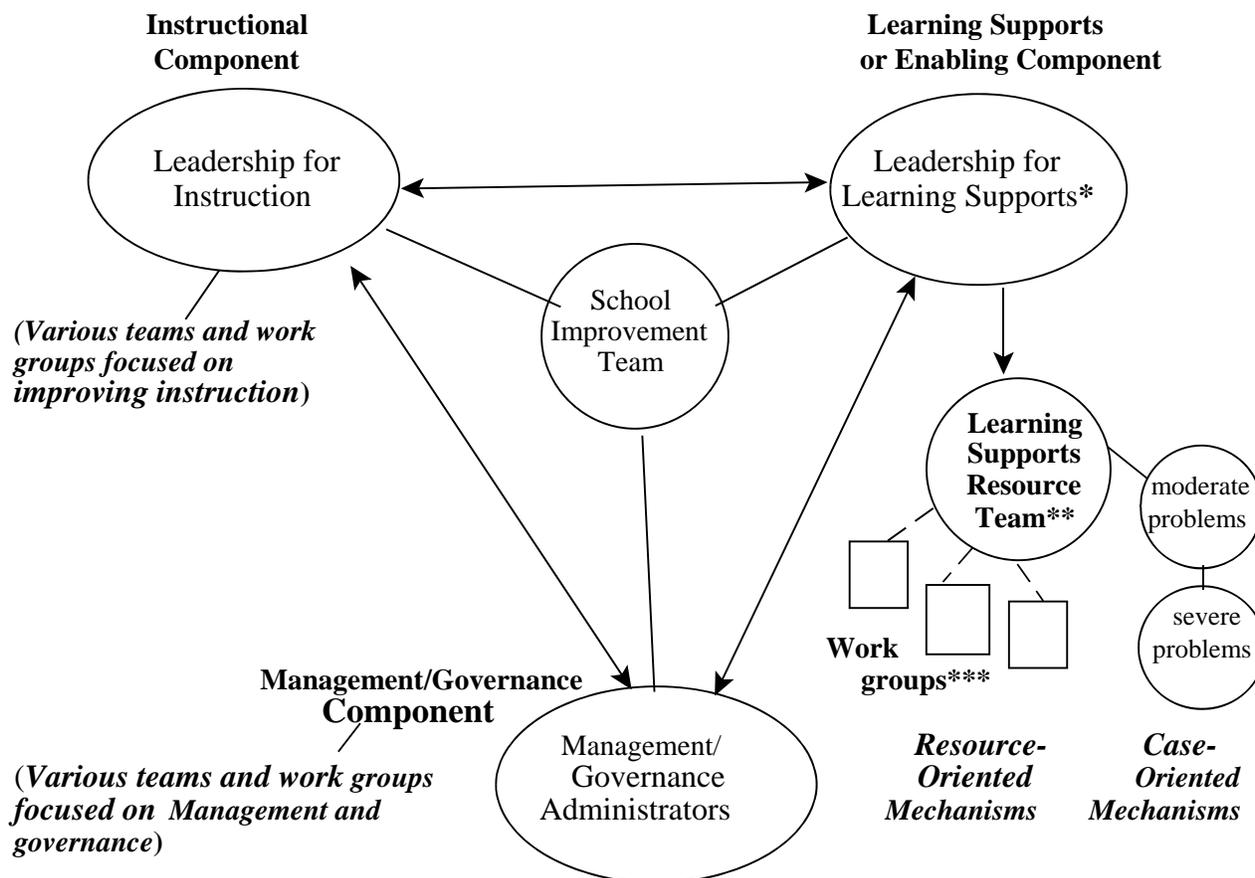
**Needed:  
an  
administrative  
leader for the  
school's  
learning  
supports  
component**

Alternatively, someone in the school who is involved with student supports (e.g. a pupil services professional, a Title I Coordinator, a special education resource specialist) can be invited to join the leadership team, assigned responsibility and accountability for ensuring the vision for the component is not lost, and provided additional training for the tasks involved in being a Learning Supports or Enabling Component Lead. The lead, however chosen, will benefit from eliciting the help of other advocates/champions at the school and from the community. These all can help ensure development, over time, of a comprehensive system of learning supports.

Obviously administrative leadership is key to ending marginalization of efforts to address behavior, learning, and emotional problems. Another key is establishment of a team that focuses specifically on how learning support resources are used.

Exhibit B-1

**Example of an Integrated Infrastructure at the School Level**



\*Learning Supports or Enabling Component Leadership consists of an administrator and other advocates/champions with responsibility and accountability for ensuring the vision for the component is not lost. The administrator meets with and provides regular input to the Learning Supports Resource Team.

\*\*A Learning Supports Resource Team ensures component cohesion, integrated implementation, and ongoing development. It meets weekly to guide and monitor daily implementation and development of all programs, services, initiatives, and systems at a school that are concerned with providing learning supports and specialized assistance.

\*\*\*Ad hoc and standing work groups – Initially, these are the various “teams” that already exist related to various initiatives and programs (e.g., a crisis team) and for processing “cases” (e.g., a student assistance team, an IEP team). Where redundancy exists, work groups can be combined. Others are formed as needed by the Learning Supports Resource Team to address specific concerns. These groups are essential for accomplishing the many tasks associated with such a team’s functions.

For more on this, see

- ><http://smhp.psych.ucla.edu/pdfdocs/infrastructure/anotherinitiative-exec.pdf>
- ><http://smhp.psych.ucla.edu/pdfdocs/studentssupport/toolkit/aidk.pdf>

***About Resource-Oriented Teams***

Although content and resource-oriented mechanisms might be created solely around psychosocial programs, they are meant to focus on all major student and learning supports. And, when the mechanisms include a resource-oriented "team," a new means is created for enhancing working relationships and solving turf and operational problems.

**Content and resource-oriented mechanisms contribute to cost-efficacy**

A resource-oriented team provides a mechanism for pursuing overall cohesion and ongoing development of support programs and systems. Minimally, it can reduce fragmentation and enhance cost-efficacy by guiding programs to perform in a coordinated and increasingly integrated way. More generally, the group can provide leadership in guiding school personnel and clientele in evolving the school's vision, priorities, and practices for student and learning support.

In pursuing its work, the team provides what often is a missing link for managing and enhancing programs and systems in ways that integrate, strengthen, and stimulate new and improved interventions. For example, such a mechanism can be used to (a) map and analyze activity and resources to improve their use in preventing and ameliorating problems, (b) build effective referral, case management, and quality assurance systems, (c) enhance procedures for management of programs and information and for communication among school staff and with the home, and (d) explore ways to redeploy and enhance resources – such as clarifying which activities are nonproductive, suggesting better uses for resources, and establishing priorities for developing new interventions, as well as reaching out to connect with additional resources in the school district and community.

**Resource-oriented teams focus on how resources are used, not on specific individuals**

One of the primary and essential tasks resource-oriented mechanisms undertake is that of delineating school and community resources (e.g., programs, services, personnel, facilities) that are in place to support students, families, and staff. A comprehensive "gap" assessment is generated as resource mapping is aligned with unmet needs and desired outcomes.

Analyses of what is available, effective, and needed provide a sound basis for formulating priorities, redeploying resources, and developing strategies to link with additional resources at other schools, district sites, and in the community (see list of resources and references). Such analyses guide efforts to improve cost-effectiveness and enhance resources.

Note that resource-oriented teams do not focus on specific individuals, but on how resources are used (see Exhibit B-2). Such a team has been designated by a variety of names including "Resource Coordinating Team," "Resource Management Team," and "Learning Supports Resource Team."

Exhibit B-2  
**Contrasting Team Tasks**

***A Case-Oriented Team***

Focuses on specific *individuals* and discrete services to address barriers to learning

Sometimes called:

- Child Study Team
- Student Study Team
- Student Success Team
- Student Assistance Team
- Teacher Assistance Team
- IEP Team

**EXAMPLES OF MAJOR TASKS:**

- >triage
- >referral
- >case monitoring/management
- >case progress review
- >case reassessment

***A Resource-Oriented Team***

Focuses on *all* students and the *resources, programs, and systems* to address barriers to learning & promote healthy development

Possibly called:

- Resource Coordinating Team
- Resource Coordinating Council
- School Support Team
- Learning Support Team

**EXAMPLES OF MAJOR TASKS:**

- >aggregating data across students and from teachers to analyze school needs
- >mapping resources
- >analyzing resources
- >enhancing resources
- >program and system planning/development – including emphasis on establishing a full continuum of intervention
- >redeploying resources
- >coordinating and integrating resources
- >social "marketing"

In establishing the team, the intent is to bring together representatives of all relevant programs and services. This might include, for example, school counselors, psychologists, nurses, social workers, attendance and dropout counselors, health educators, special education staff, after school program staff, bilingual and Title I program coordinators, safe and drug free school staff, and union reps. Such a team also should include representatives of any community agency that is significantly involved with a school. Beyond these stakeholders, it is advisable to add the energies and expertise of classroom teachers, non-certificated staff, parents, and older students. Properly constituted at the school level, such a team provides on-site leadership for enhancing efforts to address barriers comprehensively.

Where creation of "another team" is seen as a burden, existing teams, such as student or teacher assistance teams and school crisis teams, have demonstrated the ability to perform resource-oriented tasks. In adding the resource-oriented tasks to another team's work, great care must be taken to structure the agenda so sufficient time is devoted to the additional tasks. For small schools, a large team often is not feasible, but a two person team can still do the job.

***Rethinking  
Infrastructure  
for Districts***

**Needed:  
a cabinet level  
administrative  
leader for the  
learning  
supports  
component**

Exhibit B-3 layouts a framework to consider in reworking district infrastructure in ways that promote development of a comprehensive system of learning supports to address barriers to learning and teaching. As indicated, it is essential to have a cabinet level administrative leader (e.g., an associate superintendent, a chief officer) who is responsible and accountable for all resources related to addressing barriers to learning. The resources of concern come from the general fund, compensatory education, special education, and special projects (e.g., student support personnel such as school psychologists, counselors, social workers, nurses; compensatory and special education staff; special initiatives, grants, and programs for afterschool, wellness, dropout prevention, attendance, drug abuse prevention, violence prevention, pregnancy prevention, parent/family/health centers, volunteer assistance, community resource linkages to schools).

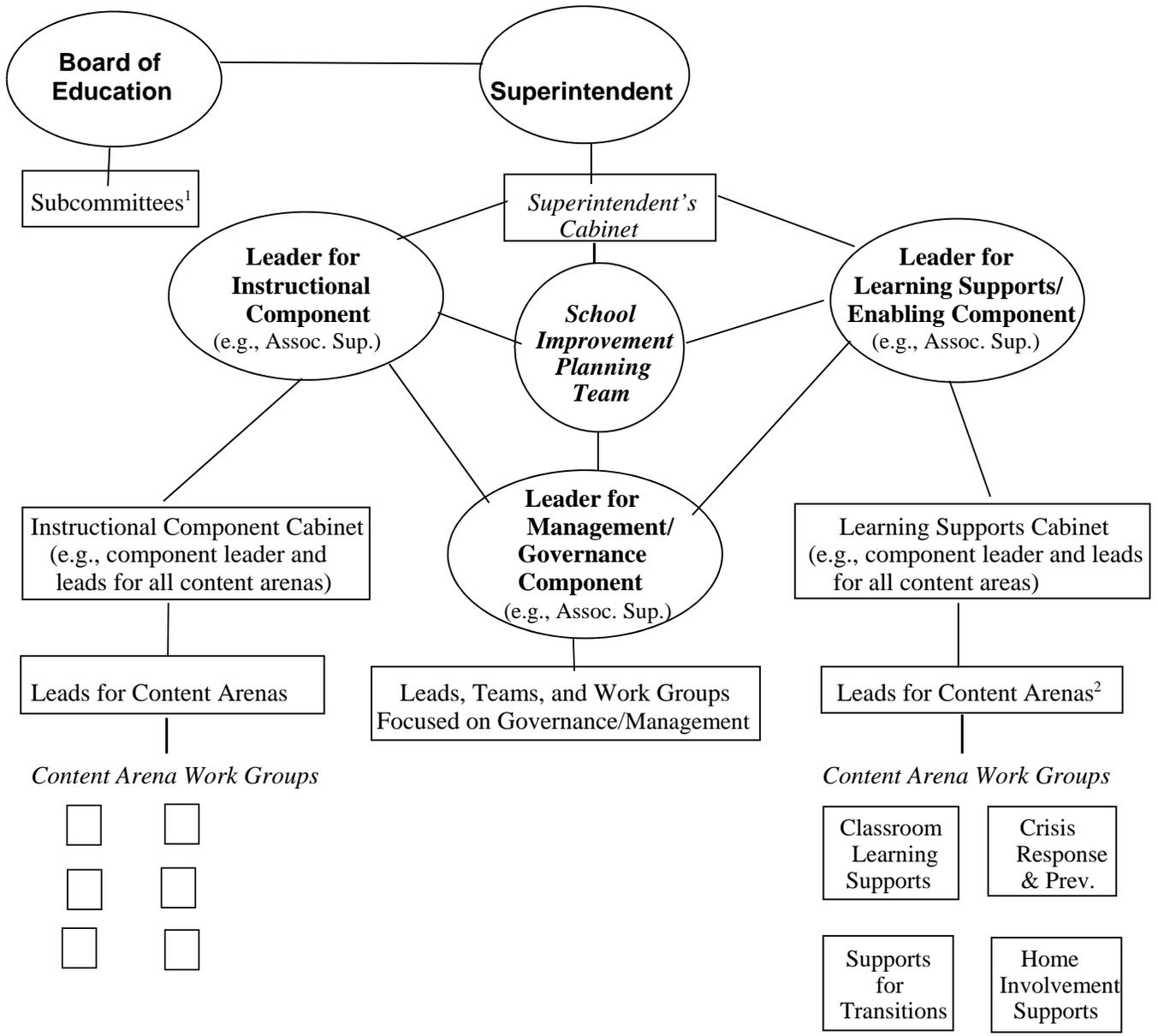
As stressed, it is important to coalesce all this activity into a comprehensive system of learning supports (e.g., an enabling or learning supports component) that encompasses an integrated and refined set of major content arenas. It also should be stressed that such a system is meant not only to help students around barriers but also to intervene in ways that reconnect or re-engage students in classroom learning.

As Exhibit B-3 illustrates, once a learning supports' administrator is appointed, that leader should establish mechanisms for accomplishing the unit's work. These should be comparable to content and process mechanisms established for the instructional component. Specifically, we suggest establishing a "cabinet" for learning supports consisting of leaders for major content arenas. Organizing in this way moves student/learning supports away from the marginalization, fragmentation, unnecessary redundancy, and counterproductive competition that has resulted from organizing around traditional programs and/or in terms of specific disciplines. The intent is for personnel to have accountability for advancing a specific arena *and* for ensuring a systemic and integrated approach to all learning supports. This, of course, requires cross-content and cross-disciplinary training so that all personnel are prepared to pursue new directions.

A formal infrastructure link also is needed to ensure the learning supports system is fully integrated with school improvement efforts (e.g., in the classroom and school-wide). This means the leader and some of the cabinet for learning supports must be included at district planning and decision making tables with their counterparts working on improving instruction and management/governance. (In Exhibit B-3, we designate the district mechanism for this as the "School Improvement *Planning* Team;" most such teams, of course, also establish guidelines, monitor progress, and so forth.)

Exhibit B-3

**Prototype for an Integrated Infrastructure at the District Level with Mechanisms for Learning Supports That Are Comparable to Those for Instruction**



Notes:

1. If there isn't one, a board subcommittee for learning supports should be created to ensure policy and supports for developing a comprehensive system of learning supports at every school(see Center documents *Restructuring Boards of Education to Enhance Schools' Effectiveness in Addressing Barriers to Student Learning* <http://smhp.psych.ucla.edu/pdfdocs/boardrep.pdf> and *Example of a Formal Proposal for Moving in New Directions for Student Support* <http://smhp.psych.ucla.edu/pdfdocs/newdirections/exampleproposal.pdf>)

2. All resources related to addressing barriers to learning and teaching (e.g., student support personnel, compensatory and special education staff and interventions, special initiatives, grants, and programs) are integrated into a refined set of major content arenas such as those indicated here. Leads are assigned for each arena and work groups are established.

## Connecting Families of Schools

A well-designed infrastructure helps minimize redundancy, reduce costs, achieve economies of scale, and enhance equity

At this point, it is important to stress the value of linking a family of schools to maximize use of limited resources and achieve economies of scale. Schools in the same geographic or catchment area have a number of shared concerns. Furthermore, some programs and personnel already are or can be shared by several neighboring schools, thereby minimizing redundancy, reducing costs, and enhancing equity. Exhibit B-4 outlines a mechanism connecting schools in a feeder pattern with each other and with the district and the community.

A multi-site team can provide a mechanism to help ensure cohesive and equitable deployment of resources and also can enhance the pooling of resources to reduce costs. Such a mechanism can be particularly useful for integrating the efforts of high schools and their feeder middle and elementary schools. This clearly is important in addressing barriers with those families who have youngsters attending more than one level of schooling in the same cluster. It is neither cost-effective nor good intervention for each school to contact a family separately in instances where several children from a family are in need of special attention. With respect to linking with community resources, multi-school teams are especially attractive to community agencies who often don't have the time or personnel to make independent arrangements with every school.

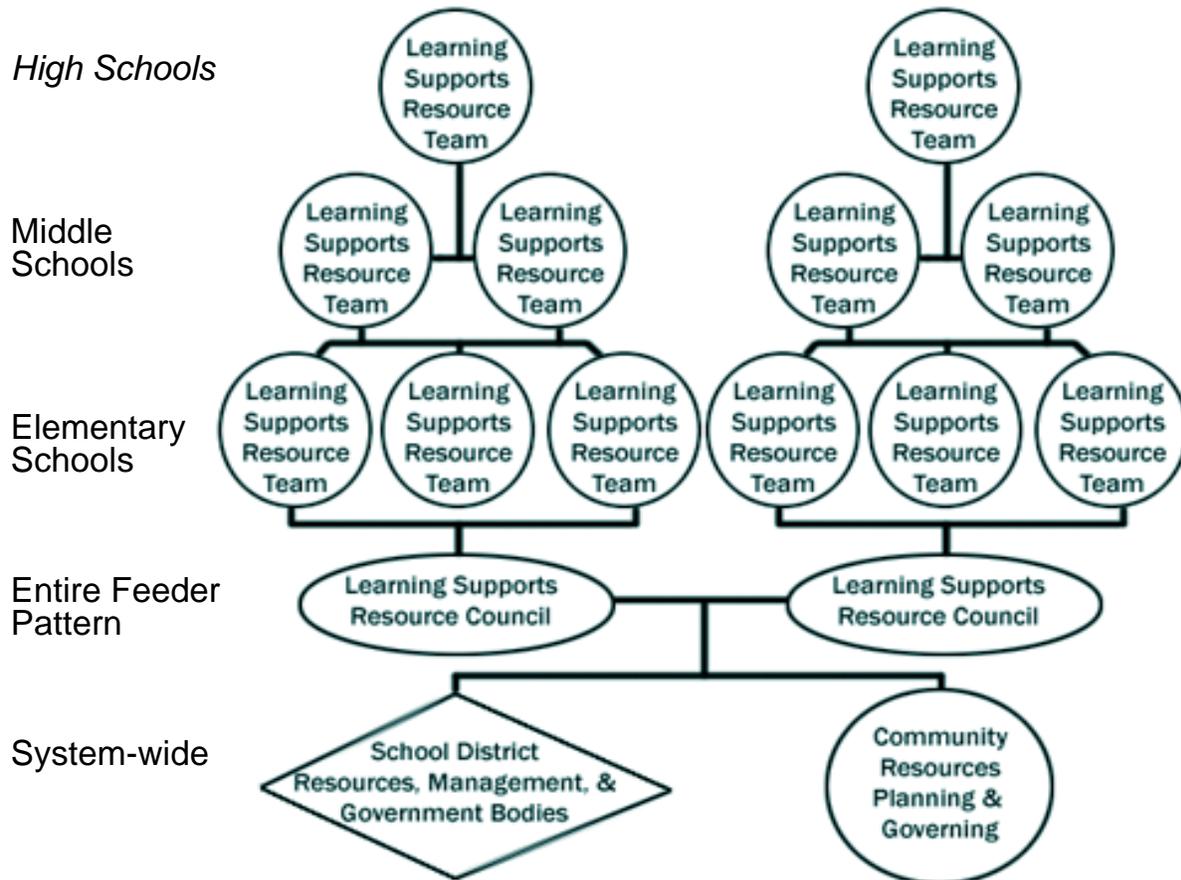
In general, a group of schools can benefit from a multi-site resource mechanism designed to provide leadership, facilitate communication and connection, and ensure quality improvement across sites. For example, a multi-site body, or what we call a *Learning Supports Resource Council*, might consist of a high school and its feeder middle and elementary schools. It brings together one-two representatives from each school's resource *team* (see Exhibit B-4).

The Council meets about once a month to help (a) coordinate and integrate programs serving multiple schools, (b) identify and meet common needs with respect to guidelines and staff development, and (c) create linkages and collaborations among schools and with community agencies. In this last regard, it can play a special role in community outreach both to create formal working relationships and ensure that all participating schools have access to such resources.

More generally, the Council provides a useful mechanism for leadership, communication, maintenance, quality improvement, and ongoing development of a comprehensive continuum of programs and services. Natural starting points for councils are the sharing of needs assessments, resource maps, analyses, and recommendations for reform and restructuring. Specific areas of initial focus would be on local, high priority concerns, such as addressing violence and developing prevention programs and safe school and neighborhood plans.

Exhibit B-4

**Developing and Connecting Mechanisms at Schools Sites,  
among Families of Schools, and District and Community-wide**



Resource-oriented mechanisms at schools, for families of schools, and at the district level are essential for weaving together existing school and community resources and developing a full continuum of interventions over time. Such mechanisms enable programs and services to function in an increasingly cohesive, cost-efficient, and equitable way. By doing so, they contribute to reducing marginalization and fragmentation of learning supports.

Note: Representatives from Learning Supports Resource Councils can be invaluable members of community planning groups (e.g., Service Planning Area Councils, Local Management Boards). They bring information about specific schools, clusters of schools, and local neighborhoods and do so in ways that reflect the importance of school-community partnerships. They can readily be transformed into an effective school-community collaborative.

## Infrastructure for School- Community Collaboratives

Finally, we turn to school-community collaboratives. Collaboration among schools, families, and other major resources in a community are essential to developing a comprehensive and cohesive system of learning supports. Such a collaboration requires establishment of an effective collaborative. And, this requires development of a well-conceived infrastructure of mechanisms that are appropriately sanctioned and endorsed by governing bodies (see Exhibit B-5). Besides basic resources, key facets of the infrastructure are designated leaders (e.g., administrative, staff) and work group mechanisms (e.g., resource- and program-oriented teams).

At the most basic level, the focus is on connecting families and community resources with one school. At the next level, collaborative connections may encompass a cluster of schools (e.g., a high school and its feeder schools) and/or may coalesce several collaboratives to increase efficiency and effectiveness and achieve economies of scale. Finally, “systemwide” (e.g., district, city, county) mechanisms can be designed to provide support for what each locality is trying to develop.

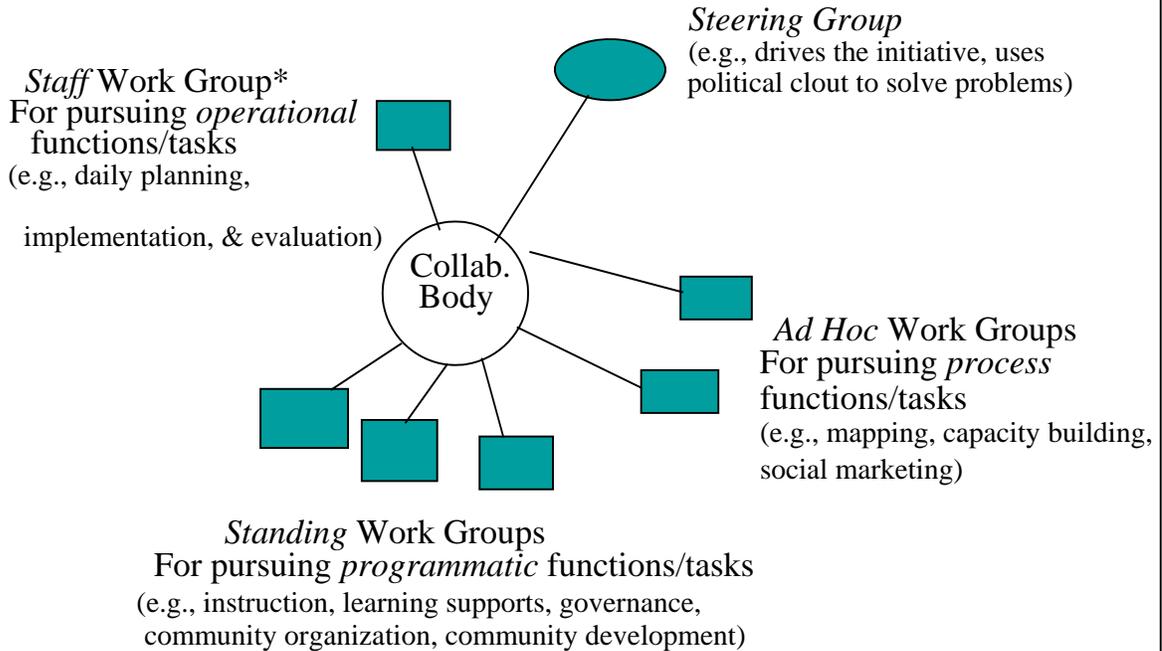
## All collaboratives need a core team to steer the process

All collaboratives need a core team to steer the process. The team must consist of competent individuals who are highly motivated – not just initially but over time. The complexity of collaboration requires providing continuous, personalized guidance and support to enhance knowledge and skills and counter anxiety, frustration, and other stressors. This entails close monitoring and *immediate* follow-up to address problems.

Local collaborative bodies should be oriented to enhancing and expanding resources. This includes such functions as reducing fragmentation, enhancing cost-efficacy by analyzing, planning, and redeploying resources, and then coordinating, integrating, monitoring, evaluating, and strengthening ongoing systemic organization and operations. Properly constituted with school, home, and community representatives, such a group develops an infrastructure of work teams to pursue collaborative functions. To these ends, there must be (1) adequate resources (time, space, materials, equipment) to support the infrastructure; (2) opportunities to increase ability and generate a sense of renewed mission; and (3) ways to address personnel turnover quickly so new staff are brought up to speed. Because work or task groups usually are the mechanism of choice, particular attention must be paid to increasing levels of competence and enhancing motivation of all stakeholders for working together. More generally, stakeholder development spans four stages: orientation, foundation-building, capacity-building, and continuing education.

Exhibit B-5

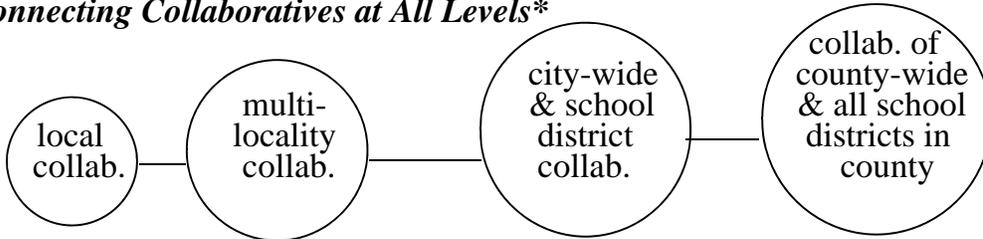
**Basic Facets of a Comprehensive Collaborative Infrastructure<sup>a</sup>**



*\*Staffing*  
>Executive Director  
>Organization Facilitator (change agent)

*Who should be at the table?*  
>families<sup>b</sup>  
>schools<sup>c</sup>  
>communities<sup>d</sup>

**Connecting Collaboratives at All Levels\***



<sup>a</sup>Collaboratives can be organized by any group of stakeholders. Connecting the resources of families and the community through collaboration with schools is essential for developing comprehensive approaches. At the multi-locality level, efficiencies and economies of scale are achieved by connecting a complex (or “family”) of schools (e.g., a high school and its feeder schools). In a small community, such a complex often is the school district. Conceptually, it is best to think in terms of building from the local outward, but in practice, the process of establishing the initial collaboration may begin at any level.

<sup>b</sup>*Families.* It is important to ensure that all who live in an area are represented – including, but not limited to, representatives of organized family advocacy groups. The aim is to mobilize all the human and social capital represented by family members and other home caretakers of the young.

<sup>c</sup>*Schools.* This encompasses all institutionalized entities that are responsible for formal education (e.g., pre-K, elementary, secondary, higher education). The aim is to draw on the resources of these institutions.

<sup>d</sup>*Communities.* This encompasses all the other resources (public and private money, facilities, human and social capital) that can be brought to the table at each level (e.g., health and social service agencies, businesses and unions, recreation, cultural, and youth development groups, libraries, juvenile justice and law enforcement, faith-based community institutions, service clubs, media). As the collaborative develops, additional steps must be taken to outreach to disenfranchised groups.

Because adjoining localities have common concerns, they may have programmatic activity that can use the same resources. Many natural connections exist in catchment areas serving a high school and its feeder schools. For example, the same family often has children attending all levels of schooling at the same time. In addition, some school districts and agencies already pull together several geographically-related clusters to combine and integrate personnel and programs. Through coordination and sharing at this level, redundancy can be minimized and resources can be deployed equitably and pooled to reduce costs.

Toward these ends, a multilocality collaborative can help (1) coordinate and integrate programs serving multiple schools and neighborhoods; (2) identify and meet common needs for stakeholder development; and (3) create linkages and enhance collaboration among schools and agencies. Such a group can provide a broader-focused mechanism for leadership, communication, maintenance, quality improvement, and ongoing development of a comprehensive continuum of programs and services. Multilocality collaboratives are especially attractive to community agencies that often don't have the time or personnel to link with individual schools.

One natural starting point for local and multilocality collaboratives are the sharing of need-assessments, resource mapping, analyses, and recommendations for addressing community-school violence and developing prevention programs and safe school and neighborhood plans.

At the systemwide level, the need is for policy, guidance, leadership, and assistance to ensure localities can establish and maintain collaboration and steer the work toward successful accomplishment of desired goals. Development of systemwide mechanisms should reflect a clear conception of how each supports local activity. Key at this level is systemwide leadership with responsibility and accountability for maintaining the vision, developing strategic plans, supporting capacity building, and ensuring coordination and integration of activity among localities and the entire system. Other functions at this level include evaluation, encompassing determination of the equity in program delivery, quality improvement reviews of all mechanisms and procedures, and review of results.

## Appendix C

### Background on Initiatives for Connecting School-Community-Home Resources

Initiatives to link community resources with each other and with schools are underway across the country. Along with such initiatives has come an increasing emphasis on establishing *collaboratives* involving school, home, and community. There is much to learn from these efforts as we move forward.

#### Linking with Community Resources

With respect to a host of concerns, including substance use, there is considerable interest in developing strong relationships between school sites and public and private community agencies. Such interest meshes nicely with the renewed attention given to human service integration over the last decade. Major aims include reducing fragmentation of effort and, in the process, evolving better ways to meet needs and use existing resources. In analyzing such initiatives, Franklin and Streeter (1995) group them as -- informal, coordinated, partnerships, collaborations, and integrated services. These categories are seen as differing in terms of the degree of system change required. As would be anticipated, most initial efforts focus on developing informal relationships and beginning to coordinate services.

With a view to improving access to and for clients, community agencies have developed the notion of *school-linked services*. A recent nation-wide survey of school board members reported by Hardiman, Curcio, & Fortune (1998) indicates widespread presence of school-linked programs and services in school districts. For purposes of the survey, school-linked services were defined as “the coordinated linking of school and community resources to support the needs of school-aged children and their families.” The researchers conclude that school-linked services are used in varying degrees to address many educational, psychological, health, and social concerns, including substance abuse, job training, teen pregnancy, juvenile probation, child and family welfare, and housing. Not surprisingly, the majority of schools report using school-linked resources as part of their efforts to deal with substance abuse; far fewer report such involvement with respect to family welfare and housing. Most of this activity reflects collaboration with agencies at local and state levels. Respondents indicate that these collaborations operate under a variety of arrangements: “legislative mandates, state-level task forces and commissions, formal agreements with other state agencies, formal and informal agreements with local government agencies, in-kind (nonmonetary) support of local government and nongovernment agencies, formal and informal referral network, and the school administrator’s prerogative.” About half the respondents note that their districts have no policies governing school-linked services.

Projects across the country demonstrate how schools and communities are connecting with the intent of improving results for youngsters, families, and neighborhoods. Various levels and forms of school-community connections have been tested in California, Florida, Kentucky, Missouri, New Jersey, Ohio, Oregon, and Utah among others. The aim is to improve coordination and eventually integrate many programs and enhance their linkages to school sites. To these ends, projects incorporate as many health, mental health, and social services as feasible into “centers” (including school-based health centers, family and parent centers) established at or near a school. They adopt terms such as school-linked and coordinated services, wrap-around, one-stop shopping, full service schools, system of care, and community schools. There are projects to (a) improve access to health services (including substance abuse programs) and access to social service programs, such as foster care, family preservation, child care, (b) expand after school academic, recreation, and enrichment, such as tutoring, youth sports and clubs, art, music, museum programs, (c) build systems of care,

such as case management and specialized assistance, (d) reduce delinquency (preventing drug abuse and truancy, providing conflict mediation and reducing violence), (e) enhance transitions to work/career/post-secondary education, and (f) enhance life in school and community, such as programs to adopt-a-school, use of volunteer and peer supports, and building neighborhood coalitions.

Such "experiments" are prompted by diverse initiatives: most are connected to efforts to reform community health and social service agencies; some stem from the youth development movement; a few are driven by school reform; and a few others arise from community development initiatives. Thus, in addition to involvements related to school-linked services, schools are connecting, for example, with the growing youth development movement (e.g., Kim, Crutchfield, Williams, & Hepler, 1998). This movement encompasses concepts and practices aimed at promoting protective factors, asset-building, wellness, and empowerment. This focus on community embraces a wide range of stakeholders, including families and community based and linked organizations such as public and private health and human service agencies, schools, businesses, youth and faith organizations, and so forth. In some cases, institutions for postsecondary learning also are involved, but the nature and scope of their participation varies greatly, as does the motivation for the involvement. Youth development initiatives encourage a view of schools not only as community centers where families can easily access services, but also as hubs for community-wide learning and activity. Increased federal funding for after school programs at school sites is enhancing this view by expanding opportunities for recreation, enrichment, academic supports, and child care (Larner, Zippiroli, & Behrman, 1999).

Schorr (1997) also approaches community-school initiatives from an expanded perspective. Her emphasis is on strengthening families and neighborhoods. Based on her analysis of promising partnerships, she, too, concludes that a synthesis is emerging that "rejects addressing poverty, welfare, employment, education, child development, housing, and crime one at a time. It endorses the idea that the multiple and interrelated problems . . . require multiple and interrelated solutions."

In surveying school-community initiatives, the Coalition for Community Schools (Blank, Melaville, & Shah, 2003; Coalition for Community Schools, 2009) reports that the number is skyrocketing and the diversity in terms of design, management, and funding arrangements is dizzying and daunting. As Melaville and Blank noted in 1998, analyses suggest (1) the initiatives are moving toward blended and integrated purposes and activity and (2) the activities are predominantly school-based and the education sector plays "a significant role in the creation and, particularly, management of these initiatives" and there is a clear trend "toward much greater community involvement in all aspects" of such initiatives -- especially in decision making at both the community and site levels. They also stress that "the ability of school-community initiatives to strengthen school functioning develops incrementally," with the first impact seen in improved school climate.

Findings from our work (e.g., Adelman & Taylor, 2010; Center for Mental Health in Schools, 1999; 2008) are in considerable agreement with other reports. However, we also stress that the majority of school and community programs and services still function in relative isolation of each other. Most school and community interventions continue to focus on discrete problems and specialized services for individuals and small groups. Moreover, because the primary emphasis is on restructuring community programs and co-locating some services on school sites, a new form of fragmentation is emerging as community and school professionals engage in a form of parallel play at school sites. Thus, ironically, while initiatives to integrate health and human services are meant to reduce fragmentation (with the intent of enhancing outcomes), in many cases fragmentation is compounded because these initiatives focus mostly on *linking* community services to schools. It appears that too little thought has been given to the importance of *connecting* community programs with existing programs operated by the school. As a result, when community agencies collocate personnel at schools, such personnel tend to operate in relative isolation of existing school programs

and services. Little attention is paid to developing effective mechanisms for coordinating complementary activity or integrating parallel efforts. Consequently, a youngster identified as at risk for substance abuse, dropout, and suicide may be involved in three counseling programs operating independently of each other.

Based on the evidence to date, fragmentation is worsened by the failure of policy makers at all levels to recognize the need to reform and restructure the work of school and community professionals who are in positions to address youth problems and promote healthy development. Reformers mainly talk about "school-linked integrated services" -- apparently in the belief that a few health and social services will do the trick. Such talk has led some policy makers to the mistaken impression that community resources alone can effectively meet the needs of schools in addressing problems such as substance abuse and other barriers to learning. In turn, this has led some legislators to view linking of community services to schools as a way to free-up the dollars underwriting school-owned services. The reality is that even when one adds together community and school assets, the total set of services in impoverished locales is woefully inadequate. In situation after situation, it has become evident that as soon as the first few sites demonstrating school-community collaboration are in place, community agencies find they have stretched their resources to the limit. Another problem is that the overemphasis on school-linked services is exacerbating rising tensions between school district service personnel and their counterparts in community based organizations. As "outside" professionals offer services at schools, school specialists often view the trend as discounting their skills and threatening their jobs. At the same time, the "outsiders" often feel unappreciated and may be rather naïve about the culture of schools. Conflicts arise over "turf," use of space, confidentiality, and liability.

Because of the type of piece meal and ad hoc approaches described above and the overemphasis on school-linked service models, little attention is paid to pursuing a comprehensive restructuring of what schools and communities already do to prevent and ameliorate youngsters' problems. And a key facet of all this is the need to develop models to guide development of the type of school-community-home partnerships that can accomplish such restructuring.

### **School-Community-Home Collaboratives**

Collaboratives involving the school, home, and community are sprouting in a dramatic and ad hoc manner throughout the country. They have the potential for improving schools, strengthening neighborhoods, and leading to a marked reduction in young people's problems. Or, such "collaborations" can end up being another reform effort that promised a lot, but did little. While it is relatively simple to make informal linkages, establishing major long-term partnerships is complicated. They require vision, cohesive policy, and basic systemic reforms. The complications are readily seen in efforts to evolve a comprehensive, multifaceted, and integrated continuum of interventions. Such a continuum clearly involves much more than linking a few services, recreation, and enrichment activities to schools. Major processes are required to develop and evolve formal and institutionalized sharing of a wide spectrum of responsibilities and resources. And, the intent must be to sustain such partnerships over time.

School-community-home partnerships must weave together a critical mass of resources and strategies to enhance caring communities that support all youth and their families and enable success at school and beyond. From a local perspective, there are three overlapping challenges in developing partnerships for comprehensive, multifaceted programs to address matters such as substance abuse prevention. One involves weaving existing school resources together. A second entails evolving programs so they are more effective. The third challenge is to reach out to additional resources and broaden the range of partnerships.

Comprehensive school-home-community partnerships represent a promising direction for efforts to generate essential interventions to prevent substance abuse, address other youth problems, enhance healthy development, and strengthen families and neighborhoods. Clearly, getting from here to there involves weaving together school, home, and community resources. At this juncture, most collaborative initiatives are not braiding resources and establishing effective mechanisms for sustaining regular and long-term interprogram planning, implementation, and evaluation. There is a need for horizontal and vertical restructuring of programs and services within and between jurisdictions (e.g., among departments, divisions, units; schools, clusters of schools, districts; public and private sector community enrichment, recreation, and service resources; homes, businesses, and faith communities). Such connections are essential to counter tendencies to develop separate programs for every observed problem and to move toward developing a comprehensive system for promoting healthy development and addressing problems.

### Appendix C References

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## Exhibit for Appendix C

### Some Guidelines for Creating Partnerships

Based on our understanding of the state of the art related to the body of literature that has relevance for creating school-home-community partnerships, we can extrapolate some guidelines. Our intent in doing so is to further underscore the type of policy and systemic changes that researchers and practitioners must be prepared to address if they want to significantly reduce the rates of psychosocial problems that permeate school and community.

- Move existing *governance* toward shared decision making and appropriate degrees of local control and private sector involvement -- a key facet of this is guaranteeing roles and providing incentives, supports, and training for effective involvement of line staff, families, students, and other community members.
- Create *change teams and change agents* to carry out the daily activities of systemic change related to building essential support and redesigning processes to initiate, establish, and maintain changes over time.
- Delineate high level *leadership assignments* and underwrite essential *leadership/management training* regarding vision for change, how to effect such changes, how to institutionalize the changes, and generate ongoing renewal.
- Establish institutionalized *mechanisms to manage and enhance resources* for school-community partnerships and related systems (focusing on analyzing, planning, coordinating, integrating, monitoring, evaluating, and strengthening ongoing efforts).
- Provide adequate funds for *capacity building* related to both accomplishing desired system changes and enhancing intervention quality over time -- a key facet of this is a major investment in staff recruitment and development using well-designed, and technologically sophisticated strategies for dealing with the problems of frequent turnover and diffusing information updates; another facet is an investment in technical assistance at all levels and for all aspects and stages of the work.
- Use a sophisticated approach to *accountability* that initially emphasizes data that can help develop effective approaches for collaboration in providing interventions and a results-oriented focus on short-term benchmarks and that evolves into evaluation of long-range indicators of impact. (Here, too, technologically sophisticated and integrated management information systems are essential.).

All this, of course, is complicated and will take time. In the interim, what is the most responsible and effective role adults in the school, home, and community can play? Given that substance abuse is multi-determined, the most straightforward advice remains to take the problem seriously, have and provide accurate information (but be careful not to undermine one's credibility through use of unbelievable scare messages), and implement interventions that go well beyond providing information, skill training, surveillance, and punishment. And, as with all interventions, programs to prevent substance abuse must be designed to fit the various groups and individuals who populate a school and neighborhood and whose relationship to substance use differs markedly.