Mental Health in the Schools: Promising Directions for Practice

LINDA TAYLOR, Ph.D.
HOWARD S. ADELMAN, Ph.D.

From the School Mental Health Unit
Los Angeles Unified School District
Van Nuys, CA
and
Department of Psychology
University of California, Los Angeles
Los Angeles, CA

Reprint requests to:
Linda Taylor, Ph.D.
School Mental Health Unit
Los Angeles Unified School District
6651 Balboa Blvd.
Van Nuys, CA 91406

Adolescence is a time when youngsters make difficult school and life transitions. They move from the close monitoring and support of one teacher to having to cope with a rotating set of teachers and classmates. They experience accelerating pressure to prepare for the future; standards for performance are intensified; peer relationships increasingly assume sexual overtones; large secondary school environments often are experienced as alienating by students and parents.

Comprehensive approaches to mental health recognize the role school, home, and community life play in creating and correcting adolescents' problems. From such a perspective, mental health activity in schools must encompass interventions that address individual problems and system changes. It is widely recognized that social, emotional, and physical health problems and other barriers to learning must be addressed if students are to learn in ways that allow schools to accomplish their educational mission.[19,41] In this regard, there is renewed interest in the notion that school-based and school-linked mental health services increase access to underserved and hard-to-reach adolescents.

An extensive literature reports on the promise of school-based interventions. One set of work highlights the value of comprehensive system changes, including new features to enrich school-based mental health service provision.[5-7,13,16,18-21,23,25,30,35] Other work describes specific counseling and curricular programs targeting high visibility problems.[11,12,16,17,27,34,36,39,40,42]

Research to date can be summarized as promising but limited in scope. Appropriately implemented programs demonstrate benefits for schools, for example, in the form of better student functioning,

increased attendance, and less teacher frustration and for society through reduced costs related to welfare, unemployment, and adult mental health services. Most, however, have been narrowly focused brief demonstrations with marginal impact.

Discontent with the state-of-the-art has led to fundamental shifts in thinking about mental health in the schools. The purpose of this article is to highlight promising directions and emerging trends that are reshaping practice.

PROMISING DIRECTIONS FOR PRACTICE

School mental health professionals are engaged in an increasingly wide array of activity, including mental health promotion, direct services, outreach to families, and various forms of support for teachers and other school personnel. There is enhanced emphasis on coordination and collaboration within a school and with community agencies to provide the *network of care* necessary to deal with complex problems over time. As Table 1 highlights, the nature and scope of mental health practices in the schools are expanding and changing rapidly.

To underscore the expanding nature and scope of schools' efforts to address adolescent mental health and psychosocial problems, it is useful to outline three areas of promising practice. The first highlights prevention and prereferral interventions, such as mental health promotion and nonintensive interventions, for mild problems; the second is concerned with intermediate interventions, such as high visibility programs, for high-frequency psychosocial problems; the third focuses on intensive interventions to address severe and pervasive mental health problems.

Prevention and Prereferral Interventions for Mild Problems

Problems that are mild often can be addressed through participation in programs that do not require diagnosis, prescription, or special referral for admission, such as regular curriculum programs designed to foster positive mental health and social-emotional functioning; social, recreational, and other enrichment activities; and self-help and mutual support programs. Because there is no gatekeeper who screens participants, such interventions can be described as *open-enrollment* programs.

In effect, most curricular and extracurricular offerings at schools and in communities can be conceived as open-enrollment programs. They offer excellent avenues for pursuing strategies that reduce the need for costly specialized mental health services. Examples include public health programs for prevention and early intervention, classroom offerings such as conflict resolution programs and stress reduction exercises, parent education, and staff development focused on such matters as increasing teachers' awareness of needs and general staff understanding of how to use volunteers and peers to prevent problems.

Mental health education illustrates an especially important category of open-enrollment programs designed to prevent problems and enhance future opportunities. There is curriculum for (1) enhancing social skills and interpersonal relationships; (2) drug abuse education; (3) sex education, including concern for prevention of pregnancy and sexually transmitted diseases; (4) physical and sexual abuse prevention; (5) delinquency, gang, and violence prevention; (6) enhancing self-esteem and self-determination, including affirming cultural and sexual identity; and (7) vocational, career, and college exploration. The curriculum may be included in a required health or social studies course or offered as an elective. Such course work often encompasses or is complemented by the use of peer and adult models and mentors from the community, universities, businesses, and so forth. Technology supporting such courses soon will

TABLE 1. Understanding Prevailing School Mental Health and Psychosocial Practices: An Outline Aid

Key dimensions of interest and concern are outlined, and a number of specifics are listed under each. The outline is not exhaustive. It is meant to provide a picture of possibilities for use as a template in analyzing the combined activity stemming from school-related mental health and psychosocial practices. Such activity encompasses programs and services designed to increase the opportunities, ameliorate the problems, and enhance the well-being of students, families, and school staff. Obviously, many of the specifics listed are not found in many schools or are present only to a minimal degree. Also, it is common knowledge that, although some districts and schools have more than others, few come close to having a comprehensive, integrated continuum of programs and services for addressing barriers to learning and enhancing healthy development. Critical factors limiting the state-of-the-art are the types of intervention models that dominate thinking about school health and the policies currently shaping resource allocation and deployment.

Nature and scope of student needs that must be addressed
- Barriers to learning/ parenting/teaching (beyond medical/dental needs)
  - Observable problems
    - School adjustment problems (including prevention of truancy, pregnancy, and dropouts)
    - Relationship difficulties (including dysfunctional family situations, insensitivity to others)
    - Language difficulties
    - Abuse by others (physical and sexual)
    - Substance abuse
    - Emotional upset
    - Delinquency (including gang-related problems and community violence)
    - Psychosocial concerns stemming from sexual activity
    - Psychopathology
  - General stressors and underlying psychological problems associated with
    - External stressors (objective and perceived) and deficits in support systems
    - Competence deficits (low self-efficacy/self-esteem, skill deficits)
    - Threats to self-determination/autonomy/control
    - Feeling unrelated to others or perceiving threats to valued relationships
    - Personality disorders or psychopathology
  - Crises and emergencies
    - Personal/familial (including home violence)
    - Subgroup
    - Schoolwide
  - Difficult transitions
    - Associated with stages of schooling
    - Associated with stages of life
    - Associated with changes in life circumstances
- Severity and pervasiveness of problems addressed
  - Mild-moderate-severe
  - Narrow-pervasive
- Areas of focus in enhancing healthy psychosocial development
  - Responsibility and integrity
  - Self-esteem
  - Social and working relationships
  - Self-evaluation and self-direction/self-regulation
  - Temperament
  - Personal safety and safe behavior
  - Health maintenance
  - Effective physical functioning
  - Careers and life roles
  - Creativity

Addressing needs at the school and district level
- Types of functions provided by mental health personnel
  - Direct services and instruction (based on prevailing standards of practice and informed by research)
    - Crisis intervention and emergency assistance
    - Assessment (individuals, groups, classroom, school, and home environments)
    - Treatment, remediation, rehabilitation (including secondary prevention)

(Table continued on following page.)

TABLE 1. Understanding Prevailing School Mental Health and Psychosocial Practices: An Outline Aid *(Cont.)*

- **Addressing needs at the school and district level** (cont.)
  - Types of functions provided by mental health personnel (cont.)
    - Direct services and instruction (cont.)
      - Transition and follow-up
      - Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness
      - Increasing the amount of direct service impact through multidisciplinary teamwork, consultation, training, and supervision
    - Coordination, development, and leadership related to programs, services, resources, and systems
      - Needs assessment, gatekeeping, referral, triage, and case monitoring/management
      - Coordinating activities (across disciplines and components; with regular, special, and compensatory education; in and out of school)
      - Mapping and enhancing resources and systems
      - Developing new approaches (including facilitating systemic changes)
      - Monitoring and evaluating intervention for quality improvement, cost-benefit accountability, research
      - Advocacy for programs and services and for standards of care in the schools
      - Pursuing strategies for public relations and for enhancing financial resources
    - Enhancing connections with community resources
      - Strategies to increase responsiveness to referrals from the school
      - Strategies to create formal linkages among programs and services
  - Timing of interventions
    - Primary prevention (including a major emphasis on promoting opportunity and wellness)
    - Early-age (including prereferral interventions)
    - Early after onset (including prereferral interventions)
    - After the problem has become chronic
  - Form of intervention for individuals, groups, and families—accounting for diversity and resiliency
    - Information giving
    - Assessment and information gathering
    - Didactic instruction and skill development
    - Mobilizing and enhancing support for students
    - Work and recreation programs
    - Systemic changes to enhance program efficacy
  - Scope of interventions
    - Open enrollment programs
    - Prescribed services—narrowly-focused, short-term
    - Prescribed services—narrowly-focused, continuing as long as the need exists
    - A prescribed comprehensive approach
  - Types of personnel who might play primary or secondary roles in mental health interventions
    - Instructional professionals
    - Health office professionals
    - Counseling and psychological professionals
    - Itinerant therapists
    - Personnel-in-training for the above roles
    - Others
      - Aides
      - Classified staff
      - Paraprofessionals
      - Peers
      - Recreation personnel
      - Volunteers (professional/paraprofessional/nonprofessional)
  - Contexts for intervention
    - School rooms, offices, recreation facilities
    - School clinics or health centers
    - School family service centers
    - Entire school used as a focal point for creating a sense of community
    - Home visits and involvement with community-based organizations (including the courts)
    - Referral to community resources

(Table continued on following page.)

TABLE 1. Understanding Prevailing School Mental Health and Psychosocial Practices: An Outline Aid *(Cont.)*

Addressing needs at the school and district level *(cont.)*
- Some basic intervention guidelines
  - Balance current emphasis on discrete problems with appreciation for underlying commonalities (less categorical emphasis; more cross-disciplinary activity and training)
  - Personalize intervention
  - Use the least intervention needed
  - Design comprehensive, integrated approaches

Nature and scope of school-community collaborative arrangements
- Focus
  - Improvement of program and service provision
  - Major systemic reform
- Scope of collaboration
  - Number of programs and services involved
  - Level of school jurisdiction involved
    - One school
    - Family of schools
    - District
    - County
    - State
- Ownership of programs and services
  - Owned by school
  - Owned by community
  - Shared ownership
- Location of programs and services
  - School-linked
  - School-based
- Degree of cohesiveness among multiple interventions serving the same student/family
  - Unconnected
  - Coordinated
  - Integrated

(Note:The important role advanced technology can play in all this is beginning to be appreciated but is still to be realized.)

expand beyond audio and video tapes to capitalize on CD-ROM software and access the information superhighway.

Because many adolescents are vulnerable, a comprehensive approach to mental health in schools should ensure access to an array of open-enrollment programs. For reformers trying to enhance comprehensiveness, special challenges include increasing the availability, visibility, and attractiveness of extracurricular programs. This is essential if students and families are to seek programs out on their own or in response to a counselor's suggestion.

When indicated, curricular approaches can be followed up with cross-age individual or group support. More generally, a significant number of adolescents identified with moderate problems can be helped without referral to professional counseling through use of strategies designed to improve how teachers, peers, and families provide support. This process is designated *prereferral intervention* and is meant to reduce the numbers who end up requiring formal testing, diagnosis, and specialized assistance. Indeed, well-designed prereferral interventions are essential if counseling programs are not to be swamped. A particular emphasis in enhancing prereferral efforts is on providing staff support and consultation to help teachers and other staff learn new ways to work with students who manifest "garden variety" learning, behavior, and emotional problems. Over time, such a staff development emphasis can evolve into broader "stakeholder" development, in which all certificated and classified staff, family members,

volunteers, and peer helpers are taught additional strategies for working with those who manifest problems.

Another form of prevention involves strategies to change the school environment in ways that make it more inviting and accommodating to adolescents. Again, this requires working with school staff, but even more, it involves restructuring schools so that they effectively promote a sense of community. Examples include establishing welcoming programs for new students and families and strategies to support other transitions, developing *families* of students and teachers to create schools within schools, and teaching peers and volunteer adults to provide support and mentoring. Intervening at the environmental level also encompasses working with community agencies and businesses to enhance the range of opportunities adolescents have with respect to recreation, work, and community service.

Effective open-enrollment and prereferral intervention programs and environmental change strategies are meant to minimize the number of mild problems that develop into severe ones. In turn, the expectation is that this reduces the number in need of specialized interventions and helps reserve such interventions for those who truly require them.

High-Visibility Programs for High-Frequency Psychosocial Problems

Because they are of great concern to schools and society at large, considerable resources are spent on targeted problems such as teen pregnancy, adolescent depression and suicide prevention, substance abuse, sexual abuse, gang involvement, violence on campus, and dropout prevention. Programs for such problems are meant to be highly visible and accessible to students. Properly implemented, they act as beacons beckoning students who have problems. Besides widely publicizing a program, proven beacons that attract those in need of help include novel approaches such as student-led support groups, professional staff whom adolescents value, and new contexts such as health centers.

Excellent reviews of programs for targeted psychosocial problems are readily available.[12,17,39] In general, analyses of the most successful programs suggest the importance of providing students with personalized and intensive support through use of a broad and ongoing network of resources—including families, school personnel, peer leaders, and community-based professionals and agencies. Personalized support includes ensuring that resources are accessible in terms of location and affordability and have credibility. This includes matching students' capabilities and interests as reflected in sensitivity to developmental level, gender, socioeconomic status, and cultural diversity. Ongoing support requires establishing follow-up interventions. Other key program characteristics identified by reviewers include an emphasis on early identification and intervention, especially in the form of enhancing social skills and self-esteem, and provision for career planning and job training. Finally, if a program is to make a significant dent related to a specific problem, it is evident that there must be appropriate staff development and an institutionalization of the effort.

Concern has been raised about the validity of addressing targeted problems as if they were unrelated to each other. In particular, the suggestion is made that factors such as poverty, low self-esteem, and lack of hope for the future are the root causes of disparate psychosocial problems. The implications of such a view are that targeting specific problems may be unnecessary, and the resulting proliferation of *categorical* programs may be wasteful of scarce resources.

Addressing Severe and Pervasive Mental Health Problems

Some adolescents require intensive, clinical services, such as long-term individual or family counseling or psychotherapy. With the exception of designated services for special

education students, most schools can provide only limited counseling for individuals and groups. Few secondary schools include families in the process. By way of contrast, schools establishing special service centers, such as health clinics and family centers, are including a broader range of counseling and psychotherapy services (more on this later).

Because few schools can provide extensive mental health care, adolescents identified as needing such treatment must be referred elsewhere. To meet this need, schools must develop an interrelated set of procedures for systematically identifying, triaging, referring, and following up students with serious problems. Table 2 provides an overview of tasks and steps related to such practices.

TABLE 2. Problem Identification, Triage, Referral, and Case Management

Problem identification

- Problems may be identified by anyone (staff, parent, student)
- There should be an Identification Form that anyone can access and fill out
- There must be an easily accessible place for people to turn in forms
- All stakeholders must be informed regarding the availability of forms, where to turn them in, and what will happen after they do so

Triage processing

- Each day the submitted forms must be reviewed, sorted, and directed to appropriate resources by a designated and trained triage processor. Several individuals can share this task; for example, different persons can do it on a specific day or for specified weeks
- After the sorting is done, the triage processor should send a Status Information Form to the person who identified the problem (assuming it was not a self-referral)

Clients directed to resources or for further problem analysis and recommendations

- For basic necessities of daily living (e.g., food, clothing, etc.), the triage processor should provide information about resources either through the person who identified the problem or directly to the student/family in need
- If the problem requires a few sessions of immediate counseling to help a student/ family through a crisis, the triage processor should send the form to the person who makes assignments to on-site counselors
- The forms for all others are directed to a small triage "team" (1-3 trained professionals) for further analysis and recommendations. (If there is a large case load, several teams might be put into operation) Members of such a team may not have to meet on all cases; some could be reviewed independently with recommendations made and passed on to the next reviewer for validation. In complex cases, however, not only might a team meeting be indicated, but also it may be necessary to gather more information from involved parties (e.g., teacher, parent, student)

Interventions to ensure recommendations and referrals are pursued appropriately

- In many cases, prereferral interventions should be recommended. This means a site must be equipped to implement and monitor the impact of such recommendations
- When students/families are referred for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Case management should be designed to determine follow-through, coordination, impact, and possible need for additional referrals
- Referrals to assess the need for special or compensatory education often are delayed because of a waiting list. Back logs should be monitored and arrangements made to catch-up (e.g., by organizing enough released time to do the assessments and case reviews)

Case monitoring/management

- Some situations require only a limited form of case monitoring (e.g., to ensure follow-through). A system must be developed for assigning case monitors as needed. Aides and paraprofessionals often can be trained to perform this function
- Other situations require intensive management by specially trained professionals to (a) ensure interventions are coordinated/integrated and appropriate, (b) continue problem analysis and determine whether appropriate progress is made, (c) determine whether additional assistance is needed, and so forth
- There are many models for intensive case management. For example, one common approach is to assign the responsibility to the professional who has the greatest involvement (or best relationship) with the student/family
- One key and often neglected function of the case monitor/manager is to provide appropriate status updates to all parties who should be kept informed

EMERGING TRENDS

Proliferation of mental health and psychosocial programs in schools often takes place with no overall plan and little coordination. For example, a student identified as at risk for dropout, suicide, and substance abuse may be involved in three counseling programs operating independently of each other at the same school.

Funding policies are partly responsible for deficiencies in program conceptualization and integration. Funding aside, however, much of the problem stems from the fact that the school reform movement pays little attention to restructuring the work of school professionals who carry out psychosocial and health programs. Organizationally, these professionals operate in relative isolation from each other; functionally, they spend almost all their time working in essentially a *clinical* fashion with individuals and small groups of students.

As awareness of deficiencies has increased, major systemic changes have been proposed, and several major trends are emerging. Four are discussed here: (1) the move *from* narrowly focused *to* comprehensive approaches; (2) the move *from* fragmentation *to* coordinated and integrated intervention; (3) the move *from* problem-specific and specialist-oriented services *to* less categorical, cross-disciplinary programs; and (4) the move *from* viewing mental health programs as *supplementary services to* policy changes that recognize mental health services as an essential element in enabling learning.

From Narrowly Focused to Comprehensive Approaches

Most schools still limit mental health interventions to individuals creating significant disruptions or experiencing serious personal problems. In responding to the troubling and the troubled, the tendency is to rely on narrowly focused, time-intensive interventions—especially short-term counseling. Given limited mental health resources, this means serving a small proportion of the many students encountering barriers to learning and doing so in a noncomprehensive manner. The deficiencies of such an approach have led to calls for increased comprehensiveness—both to address the needs of those served and to serve greater numbers.

Efforts to evolve comprehensive approaches to ameliorate learning, behavior, socioemotional, and health problems require developing an accessible continuum of programs encompassing primary prevention, early-age and early-after-onset correction, and treatments for severe, chronic problems.[6,8] To enhance accessibility, policy makers are exploring ways to establish schools as a context for providing a significant segment of basic programs and services as part of a comprehensive system of care. This trend is seen in the growing movement to create comprehensive school-based centers.

Policy initiatives in an increasing number of states encourage linkages between schools and community agencies to enhance service comprehensiveness, integration, accessibility, and use. As a result, there are increasing numbers of projects illustrating the concept of "one-stop shopping"—a family service center established at or near a school site that houses an array of medical, mental health, and social services.[14,18,19,24–26,28,31] Dryfoos[19] encompasses the trend to develop school-based primary health clinics, youth service programs, community schools, and other similar activity under the rubric of *full-service schools*. (She credits the term to Florida's comprehensive school-based legislation.)

Pioneering demonstrations of *school-based centers* show that a broad range of services can be provided at school sites. Moreover, as the data from projects in New Jersey, California, New York, Kentucky, and Florida suggest, a focus on serving families

ensures benefits to all youngsters in a community. School-based family service centers are developing strong relationships with community agencies, such as county public health, mental health, child, and family services. Public agencies are stationing staff at schools to provide easier access to and for students and families—especially in areas with underserved and hard-to-reach populations. Such centers not only provide services, but also they seem to encourage schools to open their doors in ways that enhance many forms of family involvement. For example, families using the centers are described as becoming interested in contributing to their schools and community by (1) providing social support networks to facilitate transitions for new students and families, (2) teaching each other coping skills, (3) participating in school governance, (4) helping create a psychological sense of community, and so forth.

A related move toward comprehensive school-based or school-linked centers is seen in places where *health clinics* connected with school sites are expanding into comprehensive centers.[19] As these clinics evolve, so does the provision of mental health services in the schools. Currently, there are more than 600 such clinics nationwide. Initially, most clinics are created in response to concerns about teen pregnancy and a desire to enhance access to physical health care for underserved adolescents. Soon after opening, most sites find it essential also to address mental health concerns. The need to do so arises from appreciation that stemming the tide of adolescent problems requires a comprehensive approach that includes psychosocial interventions. It also becomes evident that some students' physical complaints are psychogenic and that treatment of various medical problems is aided by psychological intervention. Added to these considerations is the fact that, in a large number of cases, students come to clinics primarily for help with nonmedical problems, such as personal adjustment and peer and family relationship problems, emotional distress, problems related to physical and sexual abuse, and concerns stemming from use of alcohol and other drugs. Indeed, up to 50% of visits at the clinics are for nonmedical concerns.[14,37]

What have we learned from school-based clinics with respect to addressing mental health concerns? In addressing nonmedical problems, the initial response at most school-based clinics is to hire a part-time mental health professional who offers individual or group psychological counseling and provides referrals. Not surprisingly, the demand for psychological treatment quickly outstrips the resources available. It is evident the *clinical* model being widely used is a good one for providing intensive and specialized services not usually available at schools. Moreover, the clinics have demonstrated the power of bringing mental health services to school sites. Evaluation shows that students use the services appropriately and benefit from easy access.[4,15,19,37] In addition, such clinics provide an important opportunity to increase understanding of the mental health status and help-seeking attitudes and behavior of underserved populations.[10]

At the same time, it has not taken long for those involved with school-based clinics to realize that reliance on a clinical model of direct services means only a few of the many students who need help can be seen. There is increasing recognition that individual and small group psychological treatment is not the most efficient or even the most effective intervention approach for all problems.

A comprehensive, integrated mental health intervention model for school health centers expands the approach used so that the problems of the many students who do not require individually prescribed treatments are addressed.[5,7] One aspect of this involves participating in the school's overall efforts to provide staff development and education. Another facet involves helping weave together a clinic's services with school and community programs to develop a broad range of relevant interventions. To these

ends, a center's mental health professionals must play a multifaceted role that includes providing clinical services and much more, such as participation in school staff development and acting as a catalyst in establishing outreach and coordination mechanisms with other school staff and programs (more on this later).

From Fragmented to Coordinated Intervention

As already noted, for the most part mental health programs and the other *support services* and special education programs in schools are developed and function in relative isolation of each other. Analysis of the current state of affairs suggests that what has been developed to date is insufficient to meet growing needs and that what there is operates in ways that waste already overtaxed resources.

Fortunately, at national, state, and local levels, policy makers are generating initiatives to increase coordination and integration of services.[9] At the same time, school practitioners are coming to the realization that they really cannot work any harder, so they must work smarter. Consistent with policy trends, they are beginning to see that working smarter involves resource coordination, integration, and redeployment. This means designing and establishing (1) mechanisms for resource coordination and development and (2) processes to map and match resources and needs.

MECHANISMS FOR RESOURCE COORDINATION AND DEVELOPMENT

Creation of a *resource coordinating team* at a school provides a good starting place for weaving together existing school and community resources.[1,38] By encouraging services and programs to function in an increasingly cohesive way, such a team helps reduce fragmentation and enhances cost-efficacy. A resource coordinating team differs from teams designed to review individual students. That is, its focus is not on specific cases, but on clarifying resources and their best use. In doing so, it provides a necessary mechanism for enhancing *systems* for coordination, integration, and development of intervention. The team analyzes activity and resources to enhance coordination; it ensures that effective referral and case management systems are in place; it guarantees there are processes for effective communication among school staff and with the home; it explores ways to develop additional resources. Such a team not only can begin the process of transforming what already is available, but also it can help reach out to connect with additional resources elsewhere in the school district and community.

Although a resource coordinating team might be created solely around mental health and psychosocial programs, it is really meant to include representatives of all major programs and services designed to support a school's instructional efforts. Thus, the team might include counselors, psychologists, nurses, social workers, attendance and dropout counselors, health educators, special educators, and bilingual program coordinators as well as representatives from any community agency that is significantly involved at the school. To increase integration with the school's instructional component, at least one representative from a resource coordinating team should be on the school's governing and planning bodies.

At times, the entire membership of a coordinating team needs to meet. As the team grows, however, it must identify a core working group whose members interact informally each day and meet regularly, perhaps weekly. The rest of the team is kept informed through established communication procedures and meets monthly. Properly constituted, trained, and supported, a resource coordinating team complements the work of the site's governance body by providing on-site overview, leadership, and advocacy for all activity designed to address barriers to learning and by ensuring the activity is maintained and improved.

To facilitate resource coordination and development among a family of schools, for example, a high school and its feeder middle and elementary schools, a resource coordinating *council* can be established by bringing together representatives of each site's resource coordinating *team*. Such a complex of schools needs to work together because in many cases they are concerned with the same families; that is, a family often has children at each level of schooling. Moreover, schools in a given locale try to establish linkages with the same community resources. A coordinating council for a family of schools can help ensure coordinated and equitable deployment of such resources.

MAPPING AND MATCHING RESOURCES AND NEEDS

The literature on resource coordination makes it clear that a first step in dealing with fragmentation involves *mapping* resources by identifying and listing what exists at a site: What programs and services are in place? Are there triage, referral, and case management systems? A comprehensive form of *needs analysis* is feasible when resource mapping is paired with a survey of the unmet needs of students, their families, and school staff. Once this step is accomplished, strategies can be formulated to enhance resource availability and use. Efforts to add programs and services usually involve outreaching to link-up with resources at other schools, school district sites, and community agencies.

Major demonstrations of resource mapping and coordination are seen in the various statewide initiatives, such as the Healthy Start project in California. As discussed subsequently, these demonstrations also are illuminating new roles and functions for school staff, such as psychologists, social workers, counselors, and nurses as well as clarifying the problems that arise as these personnel pursue new directions.

From Problem Specific and Specialist-Oriented Services to Less Categorical, Cross- Disciplinary Programs

Dominant approaches to providing mental health in schools are shaped primarily by (1) governmental regulations and guidelines related to categorical funding and mandated services, compensatory and special education programs, and social problems such as substance abuse, gang and on-campus violence, and teen pregnancy, and (2) prevailing intervention models taught by disciplines training such professionals as school and clinical psychologists, social workers, and counselors. There is growing consensus that these factors must be addressed in any effort to develop a comprehensive integrated approach.[22]

To facilitate school reform by countering what has been described as a "hardening of the categories," the trends are toward granting (1) flexibility in the use of categorical funds and (2) temporary waivers from regulatory restrictions. There are also proposals and pilot programs focused on cross-disciplinary training; for instance, several universities are piloting interprofessional collaboration programs. These trends are intended to influence the design of interventions so there is less emphasis on who owns the program and greater attention on accomplishing desired outcomes and understanding underlying commonalities among student problems and strategies that can ameliorate them.[8,32,43]

A direct effort to shift toward less categorical and specialist-oriented approaches is seen in two current extensive demonstrations, one of which is designed to restructure pupil services throughout a large urban school district.[29] The other is part of one of the nine "break the mold" models funded by the New American Schools Development Corporation.[33] Both are based on analyses that found existing education support interventions to cluster rather naturally into six general, interrelated, programmatic areas. The six areas reflect interventions to (1) enhance classroom-based efforts to enable learning,

(2) provide prescribed student and family assistance, (3) respond to and prevent crises, (4) support transitions, (5) increase home involvement in schooling, and (6) outreach to develop greater community involvement and support including recruitment of volunteers. At participating school sites where existing interventions were mapped and analyzed with reference to the six areas, the process quickly identified parallel programs funded by different sources and carried out by professionals representing different disciplines. It also helped clarify the strengths and weaknesses in each area, including a variety of coordination and resource needs. The mapping and analyses then became the bases for making priority decisions aimed at enhancing outcome efficacy, for example, by redesigning interventions to make them less categorical and more cross-disciplinary.

To date, the work has made it clear there is undesirable redundancy stemming from the fact that so many overlapping problems are being addressed through separate, categorical funding sources. It is also clear that only a few programs require the skills of a single discipline and that efforts to enhance programs in each of the six areas designated require the collaboration of all professionals at school sites.

From Supplementary Services to an Essential Component in Enabling Learning

Despite the fact that some educators argue that schools should not be expected to operate nonacademic programs, it is commonplace to find school districts citing the need for mental health and other *support* or pupil services as a way to enable students to become full participants in their own academic achievement and social development. Schools also are increasingly talking about reaching out to the greater community to coordinate and expand services to support and enrich the child's education. Thus, there is little doubt that schools are aware of the value of health, mental health, and psychosocial interventions. The trends toward comprehensive and integrated approaches are creating a new perspective that suggests interventions that address barriers to teaching and learning are essential to the success of school reform. Thus, the fourth trend discussed here is really a vision of the future.

For school reform to produce desired student outcomes, school reformers must expand their vision beyond restructuring instructional and school management functions. That is, they must recognize there is a third primary and essential component to enable schools to teach and students to learn. This component encompasses reform efforts designed to (1) restructure school support services and programs and (2) promote appropriate integration of community health and human services. Development of such a component requires a fundamental reconception of school-based and school-linked activity to promote healthy development and address barriers that interfere with teaching and learning. The authors have designated this third facet of school restructuring the Enabling Component.[2,3,8] Such a component emerges from what is available at a school site, expands what is available by working to integrate school and community resources, and enhances access to community programs and services by linking as many as feasible to programs at the site. For all this to happen, there must be a policy shift that moves enabling activity from being viewed as supplementary to a position in which such programs and services are conceived as an integrated whole and treated as essential to ensuring that schools attain their goals.

NEW ROLES FOR MENTAL HEALTH PROFESSIONALS

Table 1 outlines three groups of functions that mental health personnel may be performing for a school district: (1) direct service and instruction; (2) coordination,

development, and leadership related to programs, services, resources, and systems; and (3) enhancing connections with community resources. These professionals bring an in-depth understanding of positive and problem functioning, especially psychosocial and cultural factors and psychopathology; they also bring a specialized perspective of intervention that includes enhancement of functioning and amelioration of problems through attitude and motivation change and system strategies. Such a range of knowledge and skills can have many benefits. For instance, use of *best fit* and *least intervention needed* strategies can contribute to a reduction in problem referrals and an increase in the efficacy of mainstream and special education programs. With respect to preservice and in-service staff development, the perspectives such personnel offer can expand educators' views of how to help students deal with mild-to-moderate learning, behavior, and emotional problems and how to do so in ways that contribute to a youngster's positive growth. Their specialized understanding can be translated into programs for such targeted problems as depression, dropout prevention, drug abuse, gang activity, and teen pregnancy.

Despite the range of knowledge and skills they bring to a setting, mental health professionals usually find that their overwhelming student case load keeps them from pursuing functions other than direct services. They also find, however, that even though they devote full-time to direct services, they are able to see only a small proportion of the many students, families, and school staff who could benefit from their efforts. This is not surprising given the relatively limited cadre of specialists school districts employ.

This lamentable state of affairs raises several points for discussion. One often explored idea is that greater dividends in terms of helping more people might be forthcoming if such personnel devoted their talents more to prevention. At an even more fundamental level, it seems likely that larger numbers would benefit if these professionals devoted a greater portion of their expertise to helping create a comprehensive, integrated approach for addressing barriers to learning and enhancing healthy development. For this to happen, however, there must be a shift in priorities with respect to how they use their time. Specifically, this involves redeploying time to focus more on functions related to (1) coordination, development, and leadership (e.g., to evolve and maintain resource integration) and (2) evolving long-lasting collaborations with community resources. Used properly, such personnel can contribute a great deal to the creation of a comprehensive, integrated approach.

CONCLUDING COMMENTS

Emerging trends are reshaping the work of mental health professionals in schools. New directions call for functions that go beyond direct service and beyond traditional consultation. All who work with adolescents in schools must be prepared not only to provide direct help, but also to act as advocates, catalysts, brokers, and facilitators of systemic reform. Particularly needed are efforts to improve intervention efficacy through integrating physical and mental health and social services. On a more comprehensive level, the need is for systemic restructuring of all education support programs and services to improve the state-of-the-art and provide a safety net of care for generations to come.

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