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Mental Health in Schools: Moving Forward

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Abstract: The type of shifts in perspective, policy, practice, and research that can help schools move forward in addressing mental health and psychosocial concerns are explored. Specifically discussed are the strengths and limitations of prevailing practices, the need to broaden current perspectives to improve efficacy for those served and to serve greater numbers, directions for moving forward with policy and practice, and implications of new directions for the training and work of school psychologists.

Why do schools have any mental health-related programs? One reason, of course, is that legal mandates require certain mental health services for students diagnosed with special education needs (Duchnowski, 1994). Another is that school policy makers and practitioners recognize that social, emotional, and physical health problems and other major barriers to learning must be addressed if schools are to function satisfactorily and students are to learn and perform effectively (see Dryfoos, 1994, 1998; Flaherty, Weist, & Warner, 1996; Tyack, 1992). Despite widespread acknowledgment of the need for interventions related to mental health and psychosocial concerns, such activities are not a primary item on a school's agenda. This is not surprising. After all, schools are not in the mental health business. Their mandate is to educate. Activities not directly related to instruction often are seen only as taking resources away from their primary mission.

Our intent here is to underscore the type of shifts in perspective, policy, practice, and research that can help schools move forward in addressing mental health and psychosocial concerns. Specifically, the article highlights the strengths and limitations of prevailing practices, the need to broaden current perspectives to improve efficacy for those served and to serve greater numbers, directions for moving forward with policy and practice, and implications of new directions for the work and training of school psychologists.

Prevailing Practices

An extensive literature reports positive outcomes for psychological interventions available to schools. Some benefits have been demonstrated not only for schools (e.g., better student functioning, increased attendance, less teacher frustration), but for society (e.g., reduced costs related to welfare, unemployment, and use of emergency and adult services).[1] At the same time, it is clear that school-based applications must be pursued cautiously. With respect to individual treatments, positive evidence generally comes from work done in tightly structured research situations; unfortunately, comparable results are not found when prototype treatments are institutionalized in school and clinic settings. Similarly, most findings on classroom and small group programs come from short-term experimental studies (usually without follow-up). It remains an unanswered question whether the results of such projects will hold up when the

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prototypes are translated into widespread applications (see Adelman & Taylor, 1997a; Durlak, 1995; Elias, 1997; Weisz, Donenberg, Han, & Weiss, 1995). Available evidence is insufficient to support any policy that restricts schools to use of empirically supported interventions, and the search for better practices remains a necessity. At best, the work accomplished to date provides a menu of promising prevention and corrective practices.

In large school districts, one finds an extensive range of preventive and corrective activity oriented to students' problems. Some programs are provided throughout a district, others are conducted at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at-risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs and may be designed for an entire class, groups, or individuals. With specific respect to mental health, the full range of topics arise, including matters related to promoting mental health, minimizing the impact of psychosocial problems, managing psychotropic medication, and participating in systems of care. It is common knowledge, however, that few schools come close to having enough resources to handle a large number of students with mental health and psychosocial problems. Most schools offer only bare essentials.

Federal and state mandates play a significant role in determining how many pupil services professionals are employed. Based on a sample of 482 districts of varying sizes in 45 states, recent data indicate that 55% report having counselors; 40.5% have psychologists; 21% have social workers; and 2.1% have psychiatrists (Davis, Fryer, White, & Igoe, 1995). In general, the ratio for school psychologists or school social workers averages 1 for every 2,500 students; for school counselors, the ratio is about 1 to 1,000 (Carlson, Paavola, & Talley, 1995). Given estimates that more than one-half the students in many schools are encountering major barriers that interfere with their functioning, such ratios inevitably mean that more than narrow-band approaches must be used if the majority are to receive the help they need (Fleisch, Knitzer, & Steinberg, 1990).

As school districts move to decentralize authority and empower all stakeholders at the school level, and as managed care takes hold, a realignment is likely regarding the governance of pupil service personnel, their involvement in school governance, and collective bargaining. Ultimately, this realignment and efforts to improve cost-effectiveness will have a major role in determining how many such interveners there are at a school (Hill & Bonan, 1991; Streeter & Franklin, 1993).

Professionals with psychological training are expected to bring to school settings understanding of key intervention considerations (see Table 1). These include a focus on psychosocial, developmental, and cultural factors that facilitate or interfere with positive functioning and interventions that emphasize attitude and motivation change, system strategies, use of "best fit" and "least intervention needed" approaches and more. Such knowledge and related skills are needed in assisting students with mild-to-moderate learning, behavior, and emotional problems and in addressing targeted problems (e.g., school avoidance and dropout, substance abuse, gang activity, teen pregnancy, depression). Such a range of expertise also is essential in working with the diversity of backgrounds and the wide range of individual and group differences found among students, their families, and school staff. (For those wanting to read more about the considerations outlined in Table 1, see our syntheses in Adelman & Taylor, 1993b, 1994.)

As they assist teachers, specialists with mental health orientations tend to focus upon students seen as problems or as having problems. The many functions of such specialists can be grouped into three categories: direct services and instruction; coordination, development, and leadership related to programs, services, resources, and systems; and enhancing connections with community resources (Adelman & Taylor, 1993b, 1997b; Taylor & Adelman, 1996). Prevailing direct intervention approaches encompass identification of the needs of targeted individuals, prescription of one or more interventions, brief consultation, and gatekeeping procedures (such as referral for assessment, corrective services, triage, and diagnosis). In some situations, however, resources are so limited that specialists can do little more than assess for special education eligibility, offer brief consultations, and make referrals to special education and/or community resources. Well-developed systems include mechanisms for case coordination, ongoing consultation, program develop-

Table 1
Some Key Intervention Considerations

❑ **Timing of interventions**

A. Primary prevention
(including a major emphasis on promoting opportunity and wellness)
B. Early-age
(including prereferral interventions)
C. Early after onset
(including prereferral interventions)
D. After the problem has become chronic

❑ **Form of intervention for individuals, groups, and families—accounting for diversity and resiliency**

A. Information giving
(e.g., printed materials, use of media and advanced technology, directions and information for obtaining assistance, information phone lines)
B. Assessment and information gathering
C. Didactic instruction and skill development (e.g., social, performance, and transition skills; career planning; drug and sex education; parenting classes)
D. Mobilizing and enhancing support for student (e.g., initiating support groups, adopt-a-student, developing special status roles, involving the efforts of others, including staff/systemic support, parent/family support)
E. Work and recreation programs
F. Systemic changes to enhance program efficacy (e.g., school improvement team participation)

❑ **Scope of interventions**

A. Open enrollment programs
B. Crisis response
C. Prescribed services—narrowly focused, short-term
D. Prescribed services—narrowly focused, continuing as long as the need exists
E. A prescribed comprehensive approach

❑ **Contexts for intervention**

A. School rooms, offices, recreation facilities
B. School clinics or health centers
C. School family service centers
D. Entire school used as a focal point for creating a sense of community
E. Home visits and involvement with community-based organization (including the courts)
F. Referral to community resources

❑ **Some basic intervention guidelines**

A. Balance current emphasis on discrete problems with appreciation for underlying commonalities (less categorical emphasis; more cross-disciplinary activity and training)
B. Personalize intervention (e.g., account for psychosocial, developmental, and cultural factors; match motivation and capability)
C. Use the least intervention needed (e.g., most normalized environment, least restrictive environment, community-based—preferably school-based, "best fit")
D. Design comprehensive, integrated approaches
E. Prioritize with reference to consumer needs, not service provider predilections

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

ment, advocacy, and quality assurance. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth, though relatively few resources usually are allocated for such activity.

Because resources are so limited, efforts to address barriers to learning and enhance healthy development are not seen as the sole province of professionals/specialists. Professionals trained to provide mental health interventions have a special role, but so do all staff hired by a school, and so do students, family members, community agency personnel, volunteers, and so forth; all can and should be part of efforts to address mental health and psychosocial concerns (see Adelman & Taylor, 1993b; Taylor & Adelman, 1996).

All efforts are meant to contribute to reduction of problem referrals, an increase in the efficacy of mainstream and special education programs, and enhanced instruction and guidance that fosters healthy development. When given the opportunity personnel addressing mental health and psychosocial concerns can contribute to program development and system reform as well as helping enhance school-community collaborations (Adelman, 1993; Adelman & Taylor, 1997b; Rosenblum, DiCecco, Taylor, & Adelman, 1995).

Broadening Perspectives

Efforts underway to refine existing reforms and fill major policy gaps can be expected to produce fundamental shifts in thinking about mental health in schools. Of particular importance are the push for cohesive intervention and the move from narrowly focused, specialist-oriented services to comprehensive general programmatic approaches.

The Push for Cohesiveness

Concern about the fragmented way community health and human services are planned and implemented has led to renewal of the 1960s human service integration movement (see Walsh, Chastenay-Simpson, Craigie, & Holmes, 1997). Like their community counterparts, most school health and human service programs (as well as compensatory and special education programs) are developed and function in relative isolation of each other. The resultant fragmentation has led to waste and limited efficacy.

National, state, and local initiatives aimed at increasing coordination and integration of community services are producing a variety of forms of school-community collaborations, including statewide initiatives in California, Florida, Kentucky, Missouri, New Jersey, Oregon, among others (First, Curcio, & Young, 1994). The hope in developing formal relationships between school sites and public and private community agencies is to produce cohesive services to better meet the needs of those served and to serve greater numbers by using existing resources more efficiently (Adler & Gardner, 1994; Kahn & Kamerman, 1992; Los Angeles Unified School District, 1995; U.S. General Accounting Office, 1993). Schools are viewed as invaluable points of access to students and families in need of mental health services. Schools also are seen as providing unique opportunities for developing and implementing intensive, multifaceted corrective approaches and as essential contexts for prevention programs and research activity.

The push for cohesiveness requires new strategies for coordinating, integrating, and redeploying resources (Tharinger, 1995). Of particular note are processes for mapping and matching resources and needs, and mechanisms for resource coordination and enhancement.

Resource and need mapping and analysis. As much as 40% of a school's resources may be assigned to functions other than regular instruction (Tyack, 1992). Some of these resources are used in essential and cost-effective ways; others are used in ways that are ill-conceived and ineffective. Acknowledged redundancy in how resources are used in schools and community agencies usually stems from ill-conceived policies and lack of coordination (Adelman, 1996a; Hodgkinson, 1989). Policy reform and system restructuring clearly are essential so resources are redeployed effectively to address unmet needs related to mental health and psychosocial concerns.

A first step in countering fragmentation involves mapping resources by identifying what exists at a site (e.g., enumerating programs and services used to support students, families, and staff; delineating referral and case management procedures). A comprehensive form of need and asset assessment is generated when resource mapping is paired with surveys of unmet needs and existing strengths of students, their families,

and school staff. Analysis of these data allow systematic formulation of strategies for resource enhancement, including outreach to link with additional resources at other schools, district sites, and in the community; and establishing better ways to use existing resources.

Mechanisms to coordinate and enhance resources. An example of a mechanism designed to reduce fragmentation and enhance resource availability and use (with a view to enhancing cost-effectiveness) is seen in the concept of a resource coordinating team (Adelman, 1993; Rosenblum et al., 1995). Such a mechanism is used to develop ways to weave together existing school and community resources and encourage services and programs to function in an increasingly cohesive way.

A resource-oriented team differs from teams that review individual students (such as a student study team, a teacher assistance team, a student success team, or a team to manage care). Its focus is not upon specific cases, but upon clarifying resources and their best use. In doing so, it provides what often is a missing mechanism for managing and enhancing systems to coordinate, integrate, and strengthen interventions. Such a team can (a) map and analyze activity and resources with a view to improving coordination; (b) ensure there are effective systems for referral, case management, and quality assurance; (c) guarantee there are procedures for effective 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 and suggesting better uses for resources as well as reaching out to connect with additional resources in the school district and community.

Although a resource-oriented team might be created solely around mental health and psychosocial programs, such a mechanism is meant to bring together representatives of all major programs and services supporting a school's instructional component (e.g., guidance counselors, school psychologists, nurses, social workers, attendance and dropout counselors, health educators, special education staff, bilingual program coordinators, and representatives of any community agency that is significantly involved at the school). The intent also is to include the energies and expertise of one of the site's administrators, one or more regular classroom teachers, noncertificated staff, parents, and older students. While creation of another team may be perceived as a burden, existing teams, such as student study teams, teacher assistance teams, and school crisis teams, have demonstrated the ability to extend their focus to resource coordination.

Properly constituted, trained, and supported, a resource-oriented team complements the work of the site's governance body through providing on-site overview, leadership, and advocacy for all activity aimed at addressing barriers to learning and enhancing healthy development. Having at least one representative from the resource team on the school's governing and planning bodies is seen as necessary in ensuring that essential programs and services are maintained, improved, and increasingly integrated with classroom instruction.

To facilitate resource coordination and enhancement among a complex of schools (e.g., a high school and its feeder middle and elementary schools), the mechanism of a resource coordinating *council* unites representatives of each school's resource *team*. A complex of schools can work together to achieve economies of scale. They also should work together because, in many cases, they are concerned with the same families (e.g., a family often has children at each level of schooling). Moreover, schools in a given locale usually are trying to establish linkages with the same set of community resources and can use a resource council to help ensure cohesive and equitable deployment of such resources.

Development of resource teams and councils requires the efforts of someone with special organizational knowledge and skills. In our work, school psychologists and other pupil service professionals have come to have a key role in establishing and evolving such key mechanisms.

The Need for Comprehensive Approaches

Most schools still limit many mental health interventions to individuals who create significant disruptions or experience serious personal problems and disabilities. In responding to the troubling and the troubled, the tendency is to rely on narrowly focused, short-term, cost-intensive interventions. Given that resources are sparse, this means serving a small proportion of the many students who require assistance and doing so in a noncomprehensive way. The deficiencies of such an approach have led to calls for increased

comprehensiveness—both to better address the needs of those served and to serve greater numbers. And to enhance accessibility, the call has been to establish schools as a context for providing a significant segment of the basic interventions that constitute a comprehensive approach to meeting such needs. One response to all this is seen in the growing movement to create comprehensive school-based centers, such as health clinics, family resource centers, "one-stop-shopping" service centers, and "full-service" schools. Another response is seen in efforts to balance generalist and specialist approaches in offering education support programs and services. Ultimately, the need is for a full continuum of prevention and corrective programs that are integrated with each other and with instruction.

Full-service schools. Policy initiatives to restructure community health and human services have fostered the concept of school-linked services and contributed to a burgeoning of school-based and school-linked health clinics and family resources centers (Advocates for Youth, 1994; Dryfoos, 1994; U.S. Department of Education, 1995). The intent in encouraging linkages between schools and community agencies is to increase efficacy by enhancing comprehensiveness, case management, integration of resources, accessibility, and use of services by students and their families. The movement also underscores the importance of offering mental health in schools. For example, at many of the now more than 1,000 school-based or school-linked health centers as much as 50% of student visits are for psychosocial concerns (Adelman, Barker, & Nelson, 1993; Anglin, Naylor, & Kaplan, 1996; Robert Wood Johnson Foundation, 1989).

Initiatives for school-community collaborations raise a variety of concerns (see Adelman, 1996b; Lawson & Briar-Lawson, 1997; Smrekar, 1994). Obviously, the aims listed above are highly desirable. In pursuing these ends, however, the tendency is to think mainly in terms of coordinating community services and putting some on school sites. This has produced tension between school district service personnel and their counterparts in community-based organizations. When external professionals are consulted or hired, school specialists often view that as discounting their skills and threatening their jobs. Moreover, the emphasis on school-linked services downplays the need for restructuring the various education support programs and services that schools own and operate. Initiatives for school-linked services also lead some policy makers to the mistaken impression that such an approach is sufficient in addressing barriers to learning. In turn, this leads some to view school-linked services as a way to free-up dollars underwriting school-owned services. The reality, of course, is that even when one adds together community and school assets, the total set of services in economically impoverished locales is woefully inadequate (Koyanagi & Gaines, 1993).

Pioneering demonstrations of school-based centers show both the promise and problems related to developing relationships between schools and such community agencies as county public health, mental health, and child and family services. Dryfoos (1994, 1995) encompasses the trends to develop family service centers, 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.) As she notes in her review:

> Much of the rhetoric in support of the full-service schools concept has been presented in the language of *systems change*, calling for radical reform of the way educational, health, and welfare agencies provide services. Consensus has formed around the goals of one-stop, seamless service provision, whether in a school- or community-based agency, along with empowerment of the target population. . . . most of the programs have moved services from one place to another; for example, a medical unit from a hospital or health department relocates into a school through a contractual agreement, or staff of a community mental health center is reassigned to a school, or a grant to a school creates a coordinator in a center. As the program expands, the center staff work with the school to draw in additional services, fostering more contracts between the schools and community agencies. But few of the school systems or the agencies have changed their governance. The outside agency is not involved in school restructuring or school policy, nor is the school system involved in the governance of the provider agency. The result is not

> yet a new organizational entity, but the school is an improved institution and on the path to becoming a different kind of institution that is significantly responsive to the needs of the community. (Dryfoos, 1994, p. 169)

Currently, most school and community reforms are not generating the type of comprehensive, integrated approach necessary to address the many overlapping barriers to learning including those factors that make schools and communities unsafe and lead to substance abuse, teen pregnancy, dropouts, and so forth. Developing such a comprehensive, integrated approach requires more than outreach to link with community resources (and certainly more than adopting a school-linked services model), more than coordination of school-owned services, more than coordination of school and community services, and more than family resource centers and full-service schools.

Balancing specialist and generalist approaches in providing education support programs and services. Another response to the call for comprehensiveness involves balancing problem-specific and specialist-oriented interventions with a generalist approach to addressing barriers to learning, including less categorical, cross-disciplinary programs (e.g., Henggeler, 1995). Specialized approaches currently dominating psychosocial interventions in schools are shaped primarily by two factors. One is funding agency regulations and guidelines, for example, those related to legislatively mandated compensatory and special education programs and to categorical programs for addressing social problems such as substance abuse, gang and on-campus violence, and teen pregnancy. The other shaping force is the prevailing intervention models taught by fields of specialization, such as school and clinical psychology, social work, and counseling.

To counter what some describe as "hardening of the categories," the trends are toward granting flexible use of categorical funds and temporary waivers from regulatory restrictions. There also is renewed interest in cross-disciplinary training—with several universities already testing interprofessional programs. These trends are meant to increase use of generalist strategies in addressing common factors underlying many student problems. The aim also is to encourage less emphasis on who owns a program and more attention to accomplishing desired outcomes (see Adelman, 1996a, 1996b; Adelman & Taylor, 1994, 1997b; Dryfoos, 1998; Lawson & Briar-Lawson, 1997; Lawson & Hooper-Briar, 1994; Young, Gardner, Coley, Schorr, & Bruner, 1994).

From the perspective of developing comprehensive, integrated approaches for addressing barriers to learning and enhancing healthy development, the intent is to evolve a continuum of programs and services encompassing instruction and guidance, primary prevention, early-age and early-after-onset interventions, and treatments for severe problems. To this end, the most radical proponents of a generalist-orientation argue for a completely noncategorical approach. In doing so, they present data suggesting limited efficacy of categorical programs (e.g., Jenkins, Pious, & Peterson, 1988; Kahn & Kamerman, 1992; Slavin et al., 1991). Their advocacy lends support for policy shifts toward block grants in distributing federal welfare, health, and education dollars to states. More moderate proponents of a generalist perspective argue for a softening of the categories and use of waivers to encourage exploration of the value of blended funding. Debates about balancing generalist and specialist roles have given renewed life to discussions of differentiated staffing and specific roles and functions for generalists, specialists, and properly trained paraprofessionals and nonprofessionals.

Examples of a nonradical (moderate) generalist approach are seen in two extensive demonstrations, one of which is designed to restructure health and human services throughout a large urban school district (Los Angeles Unified School District, 1995). The other is part of one of the nine "break the mold" models funded by the New American Schools Development Corporation (Learning Center Model, 1995). Both drew upon analyses which suggest that existing education support interventions cluster rather naturally into six general, interrelated, programmatic areas. The six areas encompass interventions to enhance classroom-based efforts to enable learning, provide prescribed student and family assistance, respond to and prevent crises, support transitions, increase home involvement in schooling, and outreach to develop greater community involvement and support, including recruitment of volunteers (Adelman, 1996a; Adelman & Taylor, 1994). At participating school sites where existing interventions were mapped and analyzed

with reference to the six areas, the process quickly identified redundant and nonproductive programs. 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 regarding redesigning interventions and enhancing outcome efficacy.

In sum, current demonstrations highlight the undesirable redundancy stemming from addressing overlapping problems through categorical funding and the value of a generalist approach that is balanced with specialist assistance for those who need it. More specifically, the work underscores that enhancing programs in each of the six basic areas designated above often requires turning specialist knowledge and skills into generalist programs carried out collaboratively by various stakeholders at a school. And the demonstrations validate that some students (albeit considerably less than current reports suggest) continue to require assistance of a specialist nature; thus, *specialist* personnel must still devote a portion of their time to meeting these needs.

A full intervention continuum. Ultimately, addressing barriers to learning and enhancing healthy development must be viewed from a societal perspective and requires systemic changes. From this viewpoint, the aim becomes that of developing a comprehensive, integrated continuum of community and school programs for local catchment areas. The framework for such a continuum emerges from analyses of social, economic, political, and cultural factors associated with the problems of youth and from reviews of promising practices. It encompasses a holistic and developmental emphasis. Such an approach requires a significant range of programs focused on individuals, families, and environment and includes peer and self-help strategies.

As previously noted, such a continuum ranges from primary prevention and early-age intervention, through approaches for treating problems soon after onset, to treatment for severe and chronic problems. Included are programs designed to promote and maintain safety at home and at school, programs to promote and maintain physical and mental health, preschool programs, early school-adjustment programs, programs to improve and augment ongoing social and academic supports, programs to intervene prior to referral for intensive treatments, and programs providing intensive treatments (Adelman & Taylor, 1994). Implied is the importance of using the least restrictive and nonintrusive forms of intervention required to address problems and accommodate diversity. With respect to concerns about integrating activity, the continuum of community and school interventions underscores that interprogram connections (for coordination, collaboration, integration) are essential on a daily basis and over time (Adelman, 1993). That is, the continuum must include *systems* of *prevention, systems* of *early intervention* to address problems as soon after onset as feasible, and *systems of care* for those with chronic and severe problems. And each of these systems must be connected seamlessly.

Moving Forward

The prevailing state of affairs and emerging trends just described suggest the need for *fundamental* systemic reform. Central to such reform are policies and strategies that can counter fragmentation by integrating the efforts of school, home, and community.

Needed: A Shift in Policy

To address gaps in current initiatives to reform and restructure education and also in those efforts to restructure community health and human services, a basic policy shift must occur. To this end, we have introduced the concept of the enabling component as a policy-oriented notion around which to unify efforts to address barriers to student learning (Adelman, 1996a, 1996b; Adelman & Taylor, 1994, 1997b).[2] Such a concept is intended to underscore that current reforms are based on an inadequate two-component model for restructuring school and community resources and that it is essential to move to a three-component model if low student achievement is to increase significantly. The current situation is one in which, despite awareness of the many barriers to learning, school reformers continue to concentrate mainly on improving instruction and school management. The primary and essential nature of relevant programs and services that enable students to become full participants in their own academic achievement and healthy development has not been thrust before policy makers and education reformers in an effective manner. As

a result, the need to restructure education support programs and services remains unmet, and this works against meshing school resources with initiatives to integrate community services and link them to schools.

A three-component model calls for elevating efforts to address barriers to learning, including social, emotional, and physical health problems, to the level of one of three fundamental and essential facets of education reform and school and community agency restructuring (see Figure 1). That is, to enable teachers to teach effectively, we suggest there must not only be effective instruction and well-managed schools, but that barriers to learning must be handled in a comprehensive way. From this perspective, comprehensive approaches to addressing barriers to learning and enhancing healthy development require splicing together programs to address mental health and psychosocial concerns and much more.

Emergence of a cohesive enabling component requires policy reform and restructuring that allow for weaving together what is available at a school, expanding this through integrating school, community, and home resources, and enhancing access to community programs and services by linking as much as feasible to programs at the school. This involves extensive restructuring of school-owned enabling activity such as pupil services and special and compensatory education programs (Adelman, 1996b). Such restructuring includes development of mechanisms to coordinate and eventually integrate school-owned enabling activity, school and community-owned resources, and the enabling, instructional, and management components. Thus, the concept of an enabling component encompasses the type of models described as full-service schools—and extends beyond them. In our work, the enabling component is operationalized into the six interrelated, programmatic areas outlined in a preceding section of this review. (For a detailed discussion of the six areas, see Adelman, 1996a, and the Learning Center Model, 1995.)

Although emerging trends demonstrating comprehensive and integrated approaches are attracting some attention, they do not convey the perspective that interventions addressing barriers to teaching and learning are essential to the success of school reform. The next step in moving toward a comprehensive approach is to bring the following message home to policy makers at all levels. For reforms to produce desired student outcomes, school and community reformers must expand their vision beyond refining instructional and management functions and recognize that there is a third primary and essential set of functions involved in enabling teaching and learning.

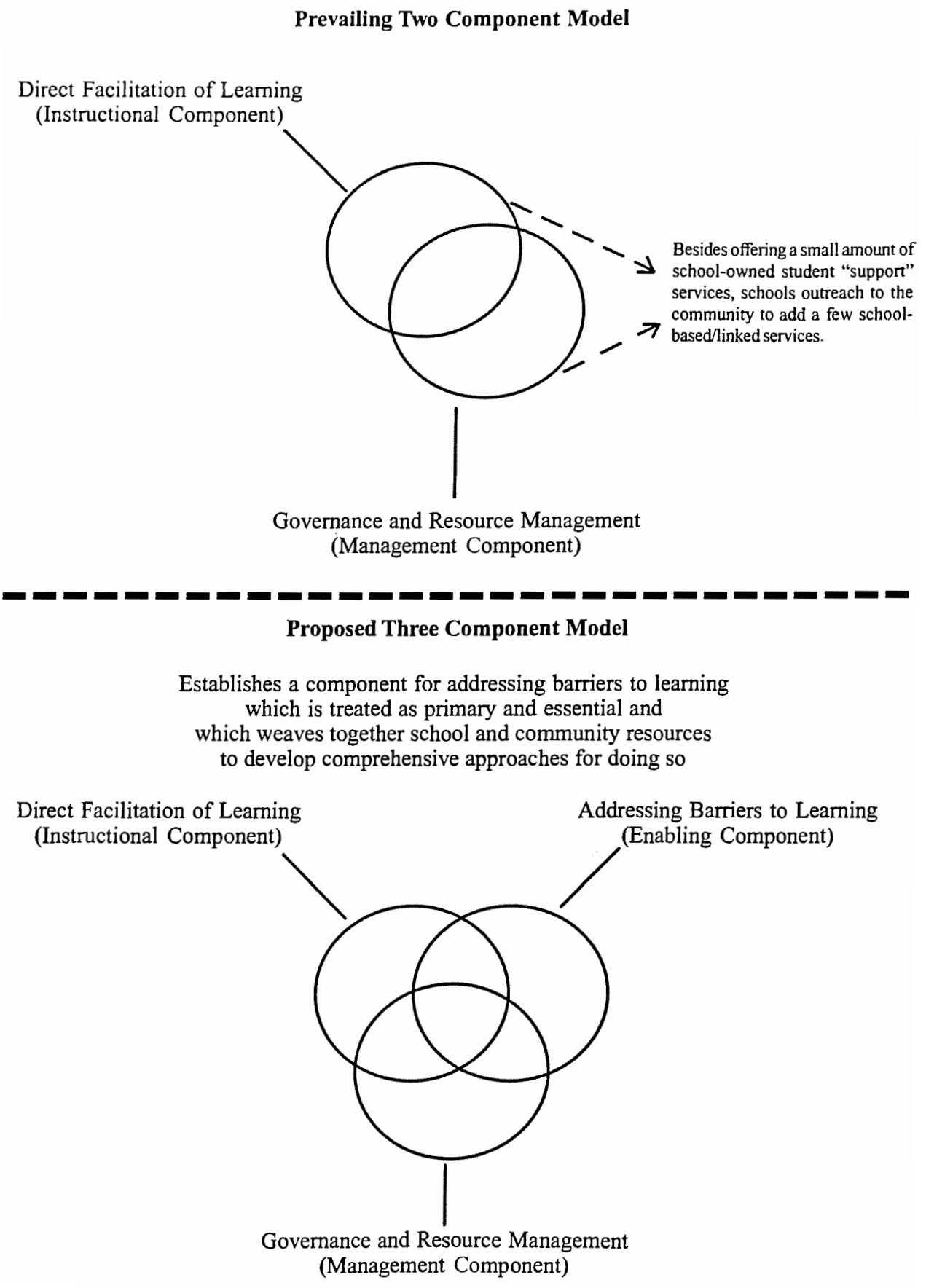
By calling for reforms that fully integrate a focus on addressing barriers to learning, the concept of an enabling component responds to a wide range of psychosocial factors interfering with school learning and performance and encompasses the type of models described as full-service schools—and extends beyond them (Adelman, 1996b). By providing a moderate generalist perspective for restructuring school-owned enabling activity and blending school and community resources, the concept provides a much needed unifying focus around which to formulate new policy. Adoption of an inclusive unifying concept is seen as pivotal in convincing policy makers to move to a position that recognizes the essential nature of activity to enable learning. More specifically, the enabling component concept calls on reformers to expand the current emphasis on improving instruction and school management to include a comprehensive component for addressing barriers to learning. All three components are seen as essential, complementary, and overlapping. Evidence of the value of rallying around a broad unifying concept is seen in the fact that in 1995 the state legislature in California considered the type of policy shift outlined here as part of a major urban education bill (AB 784). And in 1997, California's Department of Education included a version of such a concept (entitled Learning Support) in their school program quality review guidelines

Moving Toward a Comprehensive Integrated Approach

After policy makers recognize that a component for addressing barriers to learning is essential, it should be easier to blend such activity together (including special and compensatory education) and elevate the status of programs to enhance healthy development. It also should be less difficult to gain acceptance for fundamental policy shifts to reshape preservice and inservice professional education.

A policy shift is necessary but insufficient. For significant systemic change to occur, new

Figure 1. Prevailing and proposed models for school reform.



policies must be translated into appropriate daily practices. This is accomplished through allocation/redeployment of resources (e.g., finances, personnel, time, space, equipment) and modification of existing organization mechanisms. Mechanism redesign is necessarily related to at least five fundamental organizational concerns: governance, planning and implementation related to specific organizational and program objectives, coordination and integration to ensure cohesive functioning, daily leadership, and communication and information management. Well-designed mechanisms must ensure there is local ownership, a critical mass of committed stakeholders, processes that can overcome barriers to stakeholders working together effectively, and strategies that can mobilize and maintain proactive effort so changes are properly implemented and renewed with time. In terms of specific task focus, mechanisms must attend to integrating resources related to the enabling, instructional, and management facets of school and community; reframing inservice programs including an emphasis on cross-training; and establishing suitable forms of quality improvement, accountability, and self-renewal.

In reforming mechanisms, new collaborative arrangements must be established, and authority (power) must be redistributed—all of which is easy to say and extremely hard to accomplish. Reform obviously requires providing adequate support (time, space, materials, equipment)—not just initially, but with time—to those who operate critical mechanisms. And, there must be appropriate incentives including safeguards for those undertaking the tasks. Perhaps a bit less evident is the need to staff mechanisms with persons who already are highly motivated and competent to enter into collaborative working relationships.

Clearly, all this requires greater involvement of school psychologists and other pupil service professionals in every facet and especially in the governance structure at the district level and at their schools. For this to happen, however, there must be a shift in roles as well as in priorities with respect to daily functions. Their's must be a multifaceted role of providing services and much more. Jobs must be recast so that personnel such as school psychologists have time to focus more upon functions related to coordination, development, and leadership and evolving long-lasting collaborations with community resources. There must be guaranteed time and opportunity for representatives of enabling activity to serve on school and district governance, planning, and evaluation bodies.

Getting from here to there. The institutional changes for moving toward comprehensive, integrated approaches cannot be achieved without sophisticated and appropriately financed systemic change processes. Restructuring on a large scale involves substantive organizational and programmatic transformation at multiple jurisdictional levels. Although this seems self-evident, its profound implications are widely ignored (e.g., Adelman, 1993; Adelman & Taylor, 1997a; Argyris, 1993; Elias, 1997; Fullan & Stiegelbauer, 1991; Knoff, 1995; Replication and Program Services, 1993; Sarason, 1996).

At any site, key stakeholders and their leadership must understand and commit to restructuring existing activity. Commitment must be reflected in policy statements and creation of an organizational structure that ensures effective leadership and resources. The process begins with activity designed to create readiness for the necessary changes by enhancing a climate/culture for change. Steps involved include building interest and consensus for developing a comprehensive approach to addressing barriers to learning and enhancing healthy development, introducing basic concepts to relevant groups of stakeholders, establishing a policy framework that recognizes the approach is a primary and essential facet of the school's activity, and appointment of a site leader (of equivalent status to the leaders for the instructional and management facets) who can ensure policy commitments are conducted.

Overlapping efforts to create readiness are processes to develop an organizational structure for start-up and phase-in. This involves establishing mechanisms and procedures such as a steering group and leadership training to guide reforms; formulating specific start-up and phase-in plans; establishing and training a resource coordinating team; phasing in a reorganization of all activity to enable learning; outreaching to establish collaborative linkages with schools and district and community resources; and establishing systems to ensure quality improvement, momentum for reforms, and ongoing renewal.

Use of pupil services personnel to facilitate systemic change has long been advocated. Recent

work demonstrates the value of redeploying and training a cadre of such professionals, including school psychologists, as change agents in moving schools toward better approaches for addressing barriers to learning (Early Assistance for Students and Families Program, 1995). Designated as *organization facilitators*, such personnel come to the work with a relevant base of knowledge and skills. In addition, because they are seen as internal agents for change, many of the negative reactions their colleagues direct at outside reformers are minimized. Specialized training provides them with an understanding of the specific activities and mechanisms required for establishing and maintaining comprehensive, integrated approaches and increases their capacity for handling the processes and problems of organizational change.

Implications for School Psychologists

School psychologists and other pupil service professionals are confronted with a rapidly changing work situation. It seems clear that jobs will be reshaped as initiatives to restructure education and community services play out during the next decade. A widespread concern is that positions will be cut.

Rather than respond reactively, school psychologists must proactively continue to assume major, varied, and expanding roles related to mental health in schools. As public schools struggle to address poor achievement and escalating psychosocial problems, many specific needs and opportunities related to addressing barriers to learning and enhancing healthy development warrant greater attention. There are fundamental concerns that must be handled regarding the understanding and classification of problems, what approaches are appropriate for different groups and individuals, how to plan and implement the most cost-effective intervention, and how to improve interventions and evaluate cost-effectiveness. These are areas to which school psychologists have contributed already and can continue to do so. To clarify the point, a few examples should suffice.

Improving Efficacy and Cost Effectiveness

Emerging trends are reshaping the work of school psychologists. With respect to intervention, school psychologists must become a major force in expanding prevailing models and shaping current policy reforms. Efforts are particularly needed that focus on improving intervention efficacy and cost effectiveness through integrating physical and mental health and social services and restructuring that component of school programs designed to address psychosocial problems. For this to occur, however, attention must be devoted to conceptualizing, developing, implementing, and evaluating comprehensive, integrated models of intervention.

One place to begin is with analyses of the curricula used to train school psychologists. Ultimately, the field must develop a cadre of leaders who have a broader perspective than currently prevails if the next generation is to make significant breakthroughs in understanding and ameliorating students' problems and in facilitating psychosocial development.

New directions call for going beyond direct service and beyond traditional consultation. School psychologists must be prepared not only to provide direct help but to assume key roles as advocates, catalysts, brokers, and facilitators of systemic reform and in resolving planning, implementation, and evaluation problems that arise related to school psychosocial and mental health programs. A pressing need is for research that clarifies what is involved in increasing the fidelity with which empirically supported interventions are translated into large-scale programs. In the process, such work will provide data upon which programs and systemic change strategies work and which do not in school settings. In this respect, a special focus is needed on expanding the concept of systems of care to all students who are involved in multiple programs of assistance and adding concepts such as systems of prevention and systems of early intervention and evolving ways such systems can operate in a seamless manner. By developing and demonstrating the efficacy of processes resulting in well-planned and implemented programs that weave together a continuum of interventions for youngsters, it should finally be possible to conduct evaluative research that fairly tests the cost-effectiveness of comprehensive, integrated approaches. Such research also should yield fundamental knowledge about human behavior and the nature of interventions that influence such behavior.

Needed: A Radical Change in the Systems that Educate School Psychologists

Clearly, this discussion stresses the need for

major modification of preservice and continuing education for school professionals. Efforts to change the prevailing curriculum, of course, are continuing, and this is not the place for another discussion of the deficiencies in preservice and inservice education.

Instead, we offer an initial draft of a working curriculum content outline developed by the Center for Mental Health in Schools at UCLA. The outline is intended as an aid in rethinking the content of what school psychologists need to know to play a potent role in creating a comprehensive, integrated approach to meeting the needs of the young by interweaving what schools can do with what the community offers. (See Table 2.) As a next step in operationalizing a curriculum, the Center staff has generated continuing education modules based on this outline and has begun widespread dissemination through the Internet, as well as in hard copy format. The Center invites feedback to guide continuing efforts to evolve this work.

As the outline suggests, changing roles for school psychologists means a much expanded

Table 2
Mental Health in Schools: Curriculum Content for School Psychologists

I. Mental Health in School: An Introductory Overview

II. The Need

A. Barriers to Learning (including physical and mental health problems)
B. Promoting Healthy Development (physical and mental including fostering resiliency)
C. Personal and Systemic Barriers to Learning
- Psychosocial problems
- Psychopathology
- Environmental stressors
- Student and environment mismatch

D. Family Needs for Social/Emotional Support
E. Staff Needs for Social/Emotional Support
F. Limitations as Challenges

III. Addressing the Needs

A. Understanding What Causes Different Types of Problems
B. Legislative Mandates
C. Clinical Approaches in School Sites
D. Programmatic Approaches: Going Beyond Clinical Interventions
- Working with classroom teachers
- Systems for student and family assistance
- Crises/emergencies: responseprevention
- Supporting student and family transitions
- Mobilizing parent/home involvement in schooling and health promotion

E. Toward a Comprehensive, Integrated Continuum of Interventions
- Primary prevention of problems (including a major emphasis on promoting opportunities, wellness, and positive physical and mental development)
- Early-age interventions for problems (including prereferral interventions)
- Early-after-problem onset interventions (including prereferral interventions)
- After the problem has become chronic

IV. Roles for School Psychologists: A Multifaceted Focus

A. Problem Identification, Referral, Triage, and Assistance (including helping to develop referral and triage systems)
- Assessment
- Psychological first aid
- Open-enrollment programs
- Information-giving and didactic approaches
- Counseling
- Support and maintenance of students receiving psychotropic medication

B. Developing Systems for Case, Resource, and Program Coordination, Monitoring, and Management
C. Collaborative Teams
D. Community Outreach
E. Training Aides, Volunteers, and Peers to Help with Targeted Individuals and Groups
F. Providing Inservice Staff Training
G. Working for Systemic Changes and Getting the Right Support from the School District

V. Working Relationships and Cultural, Professional, and Individual Differences

A. Matching Motivation and Capabilities
- Building on strengths and resiliency
- Minimizing weaknesses, resistance, and reactance
- Least intervention needed

B. Support, Guidance, Accommodations, and Appropriate Limit Setting

curriculum. It has always been clear that preservice education can provide only a modicum of what a professional must know and be able to do. Despite this awareness, the curriculum for professionals rarely is conceived as a coordinated whole: preservice presents the *minimal* standards required for practice; the first years of inservice focus in a cohesive way on the uncovered content; and continuing education addresses the problems of specialization and continuing changes in the field. Although the modules developed by our Center are aimed at offering the content as continuing education to help meet the needs of practicing school psychologists, the intent also is to influence the redesign of preservice curricula and encourage a rethinking of inservice programs.

Concluding Comments

As indicated by the Carnegie Council on Adolescent Development's Task Force on Education of Young Adolescents (1989): "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" (p. 61). To meet this challenge, all who work in schools to address barriers to student learning must have the time, continuing education, and opportunity not only to provide direct help but to act as advocates, catalysts, brokers, and facilitators of reform. And, it is important to reemphasize that these additional duties include participation on school and district governance, planning, and evaluation bodies. Reform provides both a challenge and an opportunity for all pupil service professionals to play multifaceted roles of providing services and much more. For this to happen, however, steps must be taken to ensure that such staff are not completely consumed by their daily caseloads. Education reformers have found it essential to restructure teachers time to enable their meaningful participation in reform efforts; obviously, the same accommodations must be made for pupil service personnel (National Education Commission on Time and Learning, 1994). To do any less is to ensure the continuing failure of a major segment of the country's youth.

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Footnotes

[1] There are too many references to cite here, but a bit of an overview can be garnered from Adelman and Taylor (1993a), Albee and Gullotta (1997), Borders and Drury (1992), Carnegie Council on Adolescent Development (1988), Dryfoos (1990, 1994, 1998), Durlak (1995), Duttweiler (1995), Goleman (1995), Kazdin (1993), Larson (1994), Schorr (1988), Slavin, Karweit, and Wasik (1994), Thomas and Grimes (1995).

[2] The term *enabling* was chosen to connote the idea of enabling learning by addressing barriers to learning. *Webster's Dictionary* defines the term as "providing with the means or opportunity; making possible, practical, or easy; giving power, capacity, or sanction to."

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