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Reframing Mental Health in Schools and Expanding School Reform

Howard S. Adelman
University of California, Los Angeles

Linda Taylor
Los Angeles Unified School District

Explored in this article are (a) the long-standing relation between mental health and schools, (b) the current status of mental health programs and services in schools, (c) efforts to establish school–community collaboration, and (d) work related to reframing the approach to mental health in schools.

Some youngsters do have physical disabilities and mental disorders that can interfere with facets of development and learning. This, however, is not the case for the vast majority. Even those who have such internal problems usually have assets, strengths, or protective factors that can counter deficits and contribute to success. Most learning, behavior, and emotional problems seen in schools stem from situations in which (a) external barriers are not addressed, and (b) learner differences that require some degree of personalization by instructional systems are not accounted for. Furthermore, the problems often are exacerbated as youngsters internalize the frustrations of confronting barriers to development and learning and the debilitating effects of performing poorly at school.

The litany of barriers facing children and adolescents is all too familiar to anyone who lives or works in communities where families struggle with low incomes. In such neighborhoods, school and community resources often are insufficient for providing the type of basic (never mind enrichment) opportunities found in higher income communities. Furthermore, the resources are inadequate for dealing with such threats to well-being and learning as gangs, violence, and drugs. In many of these settings, inadequate attention to language and cultural considerations and to high rates of student mobility creates additional barriers not only to student learning but to efforts to involve families in youngsters' schooling.

How many are affected? Estimates vary. With specific respect to mental health concerns, between 12% and 22% of all children are described as suffering from a diagnosable mental, emotional, or behavioral disorder, with relatively few receiving mental health services (Costello, 1989; Hoagwood, 1995). If adding the many others experiencing significant psychosocial problems, the numbers grow dramatically. Harold Hodgkinson (1989), director of the Center for Demographic Policy, estimated that 40% of young people are in "very bad educational shape" and "at risk of failing to fulfill their physical and mental promise" (p. 24). Many live in inner cities or impoverished rural areas or are recently arrived immigrants. The problems they bring to the school setting often stem from restricted opportunities associated with poverty, difficult and diverse family circumstances, lack of English language skills, violent neighborhoods, and inadequate health care (Dryfoos, 1990; Knitzer, Steinberg, & Fleisch, 1990). Societal inequities obviously affect the proportions of students at a school affected by external barriers. The reality for many large urban and poor rural schools is that over 50% of their students manifest learning, behavior, and emotional problems.

At the same time, it should be evident that, although the proportions differ with respect to a school's demographics, no student is exempt from learning, behavior, and emotional problems caused by classroom programs that are not well designed to account for individual differences in student motivation and capability (Adelman & Taylor, 1993a). In addition, a significant range of out-of-classroom mental health and psychosocial concerns arise at every school every day (Dryfoos, 1998). Fortunately, relatively few youngsters have severe and pervasive problems. Too many, however, are manifesting moderate and multiple problems (e.g., behavior problems, underachievement, emotional upset, substance abuse).

Requests for reprints should be sent to Howard S. Adelman, Department of Psychology, UCLA, Box 951563, Los Angeles, CA 90095–1563.

MENTAL HEALTH AND SCHOOLS: A LONG-STANDING RELATION

It is not a new insight that mental health and psychosocial problems must be addressed if schools are to function satisfactorily and if students are to learn and perform effectively (see Cowen, Zax, Izzo, & Trost, 1966; Flaherty, Weist, & Warner, 1996; Kirst & McLaughlin, 1990; Lambert, Bower, & Caplan, 1964; Powers, Hauser, & Kilner, 1989; Tyack, 1979, 1992; U. S. Office of Education/National Institute of Mental Health, 1972; Zigler & Lang, 1991). Over the years, schools have instituted programs designed with a range of mental health and psychosocial problems in mind (school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, and delinquency and violence—including gang activity). School-based and school-linked programs have been developed for purposes of early intervention, treatment, crisis intervention, and prevention (including programs to foster positive social and emotional development). There is a large body of research supporting the promise of many such interventions.[1]

However, with expansion of school-based mental health and psychosocial interventions have come growing concerns about their effectiveness and place in schools. Among some segments of the population, schools are not seen as an appropriate venue for mental health interventions. The reasons vary from concern that such activity will take time away from the educational mission to fear that such interventions are another attempt by society to infringe on family rights and values.

Other concerns arise about the limitations of available research findings. For example, 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 any follow-up phase). The question of whether the results of such projects will hold up when the prototypes are translated into widespread applications remains unanswered (see Durlak, 1995; Elias, 1997; Schorr, 1997; Weisz, Donenberg, Han, & Weiss, 1995). In general, available evidence is insufficient to guide formulation of policy mandating specific approaches. At best, work accomplished to date provides a menu of promising prevention and corrective practices; the search for better approaches remains a necessity.

With a proliferation of school-based and school-linked services, a variety of systemic concerns has arisen. As already suggested, a most basic problem is the dearth of data on results. There is the related problem that planning and implementing programs and services often occurs in an unsystematic and ad hoc fashion. As widely discussed, the ensuing fragmented and piecemeal activities are an inefficient use of limited resources (Adelman & Taylor, 1997b; Adler & Gardner, 1994; Center for the Future of Children staff, 1992; U.S. Department of Education, 1995; U.S. General Accounting Office, 1993). Even more fundamental is the degree to which schools marginalize efforts to address barriers to student learning.

CURRENT STATUS OF MENTAL HEALTH PROGRAMS AND SERVICES IN SCHOOLS

A growing literature helps clarify the nature and scope of ongoing systemic support for mental health in schools.[2] In large school districts, one finds an extensive range of relevant preventive and corrective activity oriented to students' problems. Some programs are provided throughout a district, and others are carried out 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 they 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 deal with a large number of students with mental health and psychosocial problems. Most schools offer only bare essentials, and all schools tend to marginalize efforts to address mental health and psychosocial concerns.

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[1] There are too many references to cite here, but a bit of an overview of work that is directly relevant to school-based and school-linked interventions 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), Hoagwood and Erwin (1997), Henggeler (1995), Kazdin (1993), Karoly et al. (1998), Larson (1994), Schorr (1988, 1997), Slavin, Karweit, and Wasik (1994), and Thomas and Grimes (1995).

[2] See, for example, Adelman (1995, 1996a), Adelman and Taylor (1993b), Adler and Gardner (1994), Carnegie Council on Adolescent Development (1988), Conoley and Conoley (1991), Dryfoos (1993, 1994, 1995), Duchnowski (1994), Fagan and Wise (1994), Freeman and Pennekamp (1988), Gibson and Mitchell (1990), Haynes, Comer, and Hamilton-Lee (1988), Hickey, Lockwood, Payzant, and Wenrich (1990), Hodgkinson (1989), Holtzman (1992), Knoff (1995), Knoff and Batsche (1995), Lawson and Briar-Lawson (1997), Lawson and Hooper-Briar (1994), Melaville, Blank, and Asayesh (1993), Streeter and Franklin (1993), Taylor and Adelman (1996), and White and Wehlage (1995).

Brief Overview of Staffing and Functions

School districts use a variety of personnel to address mental health concerns. These may include "pupil services" or "support services" specialists such as psychologists, counselors, social workers, psychiatrists, and psychiatric nurses, as well as a variety of related therapists (e.g., art, dance, music, occupational, physical, speech, language-hearing, and recreation therapists). Such specialists tend to focus on students seen as problems or as having problems. As outlined in Table 1, their many functions can be grouped into three categories: (a) direct services and instruction; (b) coordination, development, and leadership related to programs, services, resources, and systems; and (c) enhancement of connections with community resources (Adelman & Taylor, 1993a, 1997b; Taylor & Adelman, 1996). In addition to responding to crises, prevailing direct intervention approaches encompass identification of the needs of targeted individuals, prescription of one or more interventions, brief consultation, and gatekeeping procedures (e.g., 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 or community resources. Well-developed systems include mechanisms for case coordination, ongoing consultation, program development, 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, although relatively few resources usually are allocated for such activity. Some major aims of school-related efforts are to reduce problem referrals, increase the efficacy of mainstream and special education programs, and enhance instruction and guidance that fosters healthy development. When given the opportunity, personnel dealing with mental health and psychosocial concerns also can contribute to program development and system reform, as well as help enhance school–community collaborations (Adelman, 1993; Adelman & Taylor, 1997b, 1998; Rosenblum, DiCecco, Taylor, & Adelman, 1995).

Federal and state mandates play a significant role in determining how many pupil services professionals are employed. Based on a representative sampling of 482 districts of varying sizes in 45 states, recent data indicate that 55% reported 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 to 2,500 students; for school counselors, the ratio is about 1 to 1,000 (Carlson, Paavola, & Talley, 1995). Given estimates that more than 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 (Knitzer et al., 1990). Nevertheless, the prevailing orientation remains focusing on discrete problems and overrelying on specialized services for individuals and small groups.

Because the need is so great, others at a school often are called on to play a role in addressing mental health and psychosocial problems of youth and their families. These include other health professionals (school nurses and physicians), instructional professionals (health educators, other classroom teachers, special education staff, resource staff), administrative staff (principals, assistant principals), students (including trained peer counselors), family members, and almost everyone else involved with a school (aides, clerical and cafeteria staff, custodians, bus drivers, paraprofessionals, recreation personnel, volunteers, and professionals in training). In addition, some schools are using specialists employed by other public and private agencies, such as health depart-

TABLE 1
Functions Related to Addressing Mental Health and Psychosocial Concerns in Schools

Direct Services and Instruction (Based on Prevailing Standards of Practice and Informed by Research)	*Coordination, Development, and Leadership Related to Programs, Services, Resources, and Systems*
• Crisis intervention and emergency assistance (e.g., psychological first-aid and follow-up; suicide prevention; emergency services, such as food, clothing, transportation) • Assessment (individuals, groups, classroom, school, and home environments) • Treatment, remediation, rehabilitation (including secondary prevention) • Transition and follow-up (e.g., orientations, social support for newcomers, follow-through) • Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness (e.g., guidance counseling; contributing to development and implementation of health and violence reduction curricula; placement assistance; advocacy; liaison between school and home; gang, delinquency, and safe-school programs; conflict resolution) • Increasing the amount of direct service impact through multidisciplinary teamwork, consultation, training, and supervision	• Needs assessment, gatekeeping, referral, triage, and case monitoring and management (e.g., participating on student study and assistance teams; facilitating communication among all concerned parties) • 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

ments, hospitals, and community-based organizations, to provide mental health services to students, their families, and school staff.

Because so few resources are allocated, the contexts for the activity often are limited and makeshift. That is, a relatively small proportion of this activity seems to take place in school or clinical offices earmarked specifically for such functions. Health education and skill development interventions may take place in classrooms if they are part of the regular curriculum; otherwise they tend to be assigned space on an ad hoc basis. Home visits remain a rarity. Support service personnel such as school psychologists and social workers must rotate among schools as "itinerant" staff. A poignant joke among such personnel is that they must come to a school on different days because the boiler room to which they are all assigned can only hold one at a time. These conditions contribute to the tendency for such personnel to operate in relative isolation from each other and other stakeholders. These conditions clearly are not conducive to effective practice.

Professionals with psychological training are expected to bring to school settings understanding of key intervention considerations. 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). It also is essential in upgrading the capacity of other school personnel for working effectively with students. This range of expertise is also necessary for 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 these matters, see our syntheses in Adelman & Taylor, 1993b, 1994, in press.)

As with most professionals who come to schools directly from preservice programs, those hired for their psychological expertise still need considerably more training. Those school personnel who are called on to address mental health and psychosocial concerns without any special training clearly have even greater training needs. Unfortunately, there is no systematic inservice to follow up psychological preservice education, and continuing education is offered as discrete courses, many of which are not readily accessible to large segments of school personnel. For example, with respect to upgrading teachers' ability to improve classroom approaches for dealing effectively with mild to moderate learning, behavior, and emotional problems, the emphasis continues to be on providing a few hours on the topic of classroom management—usually limited to a quick overview of direct control and discipline strategies. Paraprofessionals and volunteers working in classrooms and in the area of pupil services still receive little or no formal training or supervision before or after they are assigned duties, and the idea of cross-disciplinary training remains mostly an unfulfilled vision (Lawson & Hooper-Briar, 1994).

Policy Support

With respect to policy, there is clear acknowledgment that some special programs and services may be needed to enable students to benefit from instruction. Awareness of the need can be found in a variety of statements generated by government agencies (e.g., offices and departments of education) and school administrators' associations (e.g., Council of Chief State School Officers, associations of school boards). Prominent examples of how policymakers have responded to the need are seen in funding for pupil services personnel, compensatory and special education, safe and drug-free schools, dropout prevention, pregnancy prevention, and home involvement in schooling. Related policy initiatives designed to increase health and human service agency collaboration and program integration emphasize school–community partnerships to foster school-linked services. All these initiatives have relevance for mental health in schools.

At the same time, it is clear from analyses of current policy and practice that there is no cohesive policy vision, and pupil services and school health programs do not have high status in the educational hierarchy and in current health and education policy initiatives (Adelman, 1996b; Adler & Gardner, 1994; Center for Mental Health in Schools, 1996, 1997; Dryfoos, 1998; Kirst & McLaughlin, 1990; Knitzer et al., 1990; Kolbe, 1993; Lawson & Briar-Lawson, 1997; Palaich, Whitney, & Paolino, 1991; Tyack, 1992). The continuing trend is for schools and districts to treat such activity, in policy and practice, as desirable but not essential. Because they are not seen as essential, the programs and staff are marginalized. Planning of programs, services, and delivery systems tends to be done on an ad hoc basis; interventions are referred to as "auxiliary" or "support" services. Specialist personnel almost never are a prominent part of a school's organizational structure. Even worse, pupil services personnel usually are among those deemed dispensable as budgets tighten.

Given the relatively low policy priority, it is not surprising so little has been done at any administrative level to create the type of vision, leadership, and organizational structure necessary for integrating pupil services into schools in a comprehensive way. At present, specialist personnel rarely are included on governance and planning bodies. 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 in how pupil service personnel are governed and involved in school governance and collective bargaining. Ultimately, this realignment and efforts to improve cost-effectiveness will play a major role in determining how

many interveners there are at a school (Hill & Bonan, 1991; Streeter & Franklin, 1993).

Currently, several policy initiatives are underway at national, state, and local levels that may enhance the status of mental health in schools. For example, over the last decade, leaders concerned with school health have stressed the combination of counseling, psychological, and social services as one of eight components that comprise a school health program (e.g., Kolbe, 1986). To foster development of each state's capacity to improve school health programs, the Centers for Disease Control and Prevention (CDC) have set in motion an initiative to support an administrative arrangement designed to enhance interagency coordination (Kolbe, 1993). Relatedly, the Educational Development Center, Inc., with funding from a cooperative agreement with CDC's Division of Adolescent and School Health, has initiated a large-scale project to clarify how national organizations and state and local education and health agencies can advance school health programs (Marx, Wooley, & Northrop, 1998). Another example is seen in activity by the U.S. Department of Education. Recognizing a lack of integrated effort across various federal agencies concerned with health and social services, in 1995 the Department initiated a working group to focus on the problem. The Department also included provisions under the Improving America's Schools Act for school districts to divert a portion of their federal funding to organize service coordination. Several branches of the U.S. Department of Health and Human Services are also involved in research and practice that benefits mental health in schools. For example, in 1995, the Office of Adolescent Health (Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau) undertook a major initiative to enhance mental health in schools. As a first step, two national training and technical assistance centers and five state projects were established and are already pursuing a wide range of activities designed to improve how schools address mental health concerns (Summit Report, 1998). Other examples of policy movement are seen in the increasing number of initiatives by states, counties, and philanthropic foundations to stimulate school–community collaborations and enhance service integration.

SCHOOL–COMMUNITY COLLABORATIONS

Concern about the fragmented way in which community health (including mental health) and human services are planned and implemented has renewed the 1960s human service integration movement. The hope is to better meet the needs of those served and use existing resources to serve greater numbers. To these ends, there is considerable interest in developing strong relations between school sites and public and private community agencies. As a result, a variety of forms of school–community collaborations are being tested around the country, including statewide initiatives in California, Florida, Kentucky, Missouri, New Jersey, Ohio, and Oregon, among others (Dryfoos, 1994; First, Curcio, & Young, 1994; Palaich et al., 1991; Schorr, 1997).

School-Linked and School-Based Services

Initiatives to restructure community health and human services have fostered the concept of school-linked services (Carnegie Council on Adolescent Development, 1988; U.S. Department of Education, 1995). It should be noted that, in practice, the terms *school-linked* and *school-based* encompass two separate dimensions: (a) where programs or services are located, and (b) who owns them. Taken literally, school-based should indicate activity carried out on a campus, and school-linked should refer to off-campus activity with formal connections to a school site. In either case, services may be owned by schools or a community-based organization or in some cases may be co-owned. As commonly used, however, the term *school-linked* refers to community-owned on- and off-campus services and is strongly associated with the notion of coordinated services. Relatedly, one hears the terms *wrap-around services, one-stop shopping, full-service schools,* and *community schools.* The concept of *systems of care* also encompasses concern for coordination of community and school services, but usually this term is reserved for individuals designated as emotionally disturbed (Bickman, 1997; Day & Roberts, 1991; Duchnowski & Friedman, 1990; Hoagwood, 1997). Adoption of these terms reflects the desire to develop a sufficient range of accessible interventions to meet the needs of those served. Many projects illustrating such concepts offer an array of medical, mental health, and social services housed in a family service or resource center established at or near a school (see Dryfoos, 1994, 1995).

As the notion of school–community collaboration spreads, *services* and *programs* are used interchangeably and the adjective *comprehensive* often is appended. This leads to confusion, especially because addressing a full range of factors affecting young people's development and learning requires going beyond services to utilize an extensive continuum of programmatic interventions. Services themselves should be differentiated to distinguish between narrow-band, personal or clinical services and broad-band, public health, and social services (Adelman, 1995). Furthermore, although services can be provided as part of a program, not all are. For example, counseling to ameliorate a mental health problem can be offered on an ad hoc basis or may be one element of a multifaceted program to facilitate healthy social and emotional development. Pervasive and severe psychosocial problems, such as substance abuse, teen pregnancy, physical and sexual abuse, gang violence, and delinquency, require multifaceted, programmatic interventions. Besides providing services to correct existing problems, such

interventions encompass primary prevention (e.g., public health programs that target groups seen as at risk) and a broad range of open-enrollment didactic, enrichment, and recreation programs. As Schorr's (1997) recent analysis indicates, "multiple and interrelated problems ... require multiple and interrelated solutions" (p. 319). Differentiating services and programs and taking care in using the term *comprehensive* can help mediate against tendencies to limit the range of interventions and underscores the breadth of activity requiring coordination and integration.

In analyzing school-linked service initiatives, Franklin and Streeter (1995) grouped them as informal, coordinated, partnerships, collaborations, and integrated services. These categories differ in the degree of system change required. As would be anticipated, most initial efforts focus on developing informal relationships and beginning coordinating services.

School health centers. Over the last decade, many of the now over 1,000 school-based or linked health clinics have been described as comprehensive centers (Advocates for Youth, 1994; Dryfoos, 1994; Robert Wood Johnson Foundation, 1993). The majority of these were initiated by community agencies. Initially, school-based clinics were created in response to concerns about teen pregnancy and a desire to enhance access to physical health care for underserved youth. Soon after opening, such clinics found it essential also to address mental health and psychosocial concerns. The need to do so reflects two basic realities: First, some students' physical complaints are psychogenic, and thus, treatment of various medical problems is aided by psychological intervention. Second, in a large number of cases, students come to clinics primarily for help with nonmedical problems, such as 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 clinic visits are for nonmedical concerns (Adelman, Barker, & Nelson, 1993; Anglin, Naylor, & Kaplan, 1996; Robert Wood Johnson Foundation, 1989; U.S. Department of Health and Human Services, 1994). Thus, as these clinics evolve, so does the provision of counseling, psychological, and social services in the schools. At the same time, given the limited number of staff at such clinics and in the schools, it is not surprising that the demand for psychosocial interventions quickly outstrips the resources available, and the problem is compounded if the staff overrelies on a clinical model of direct services.

Broader linkages with community agencies. As already noted, policy initiatives in an increasing number of states encourage linkages between schools and community agencies to enhance comprehensiveness, integration, accessibility, and use of services by students and their families. The focus on serving families is seen as ensuring benefits to all youngsters in a community. Pioneering demonstrations of school-based family service centers show the promise and problems related to developing relations between schools and such community agencies as county public health, mental health, and child and family services.

Dryfoos (1994, 1995) encompassed 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. As she concluded in her 1994 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. (p. 169)

Impact of School–Community Collaborations

As Knapp's (1995) review stresses, the contemporary literature on school-linked services is heavy on advocacy and prescription and light on data. Each day brings additional reports from projects such as New Jersey's School-Based Youth Services Program, the Healthy Start Initiative in California, the Beacons Schools and other community school models in New York, Communities-in-Schools, the New Futures Initiative, Missouri's Caring Communities, and Schools of the 21st Century. Not surprisingly, the reports primarily indicate how hard it is to establish school–community collaborations. Still, a reasonable inference from available evidence is that school–community collaborations can be successful and cost-effective over the long run (Schorr, 1997). By placing staff at schools, community agencies enable easier access for students and families, especially in areas with underserved and hard-to-reach populations. Such efforts not only provide services; they seem to encourage schools to open their doors in ways that enhance family involvement. Analyses suggest better outcomes are associated with empowering children and families, and with having the capability to address diverse

constituencies and contexts. Families using school-based centers are described as becoming interested in contributing to the school and community by providing social support networks for new students and families, teaching each other coping skills, participating in school governance, helping create a psychological sense of community, and so forth (White & Wehlage, 1995).

Ironically, although initiatives to integrate health and human services are meant to reduce fragmentation (with the intent of enhancing outcomes), in many cases fragmentation is compounded because these initiatives focus mostly on linking community services to schools. As a result, when community agencies place personnel at schools, such personnel tend to operate in relative isolation of existing school programs and services. Little attention is paid to developing effective mechanisms for coordinating complementary activity or integrating parallel efforts. The problem is compounded by the failure of educational reform to restructure, in fundamental ways, the work of school professionals who carry out psychosocial and health programs. Consequently, in some schools, a student identified as at risk for dropout, suicide, and substance abuse may be involved in three counseling programs operating independently of each other.

Related to all this has been a rise in tension between school district service personnel and their counterparts in community-based organizations. When outside professionals are brought in, school specialists often view it as a discounting of their skills and a threat to their jobs. The "outsiders" often feel unappreciated and may be rather naive about the culture of schools (Sarason, 1996). Conflicts arise over "turf," use of space, confidentiality, and liability.

In general, the movements toward integrated services and school–community collaboration aim at enhancing access to services by youth and their families, reducing redundancy, improving case management, coordinating resources, and increasing effectiveness. Obviously, these are desirable goals. In pursuing these ends, however, the tendency is to think mainly in terms of coordinating community services and putting some on school sites. This emphasis downplays the need for also restructuring the various education support programs and services that schools own and operate. Initiatives for school–community collaboration also have led some policymakers to the mistaken impression that community resources can effectively meet the needs of schools in addressing barriers to learning. In turn, this has led some legislators to view the linking of community services to schools as a way to free up the dollars underwriting school-owned services. The reality is that even when one adds together community and school assets, the total set of services in economically impoverished locales is woefully inadequate (Koyanagi & Gaines, 1993). After the first few sites demonstrating school–community collaboration are in place, community agencies find they have stretched their resources to the limit.

REFRAMING THE APPROACH TO MENTAL HEALTH IN SCHOOLS

That efforts to address mental health and psychosocial concerns are not a primary item on a school's agenda should surprise no one, as schools are not in the mental health business. Their mandate is to educate. From that perspective, activities not directly related to instruction usually are seen as taking resources away from the school's primary mission.

Given this reality, we believe initiatives aimed at directly and narrowly expanding physical and mental health activity in schools will continue to have a relatively low priority. Thus, in working with schools, we approach mental health and psychosocial concerns from the broader framework of addressing barriers to development, learning, and teaching. This broader approach allows us to encompass a range of policy concerns and strategies designed to counter marginalization and enhance integrated collaboration between school and community resources.

The Focus on Addressing Barriers to Development, Learning, and Teaching

When the lens of addressing barriers to development, learning, and teaching is applied to current reform and restructuring initiatives, major gaps in policy and practice become evident (Center for Mental Health in Schools, 1997). These policy gaps can be grouped into five fundamental areas (see Figure 1).

As suggested in Figure 1 and elaborated in Figure 2, the framework used by policymakers should encompass a comprehensive, integrated continuum of community and school programs for local geographical or catchment areas. Such a continuum encompasses a holistic and developmental emphasis and ranges from primary prevention and early-age intervention through approaches for treating problems soon after onset, to treatment for severe and chronic problems. The interventions focus on individuals, families, and the contexts in which they live, work, and play. 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. Gaps in the continuum of programs can be clarified through analyses of social, economic, political, and cultural factors associated with the problems of youth and from needs assessments and reviews of promising practices. A basic assumption is that the least restrictive and nonintrusive forms of intervention required to address problems and accommodate diversity should be used. Another assumption is that many problems are not discrete, and therefore, interventions that address root causes can minimize the trend to develop separate programs for every observed problem.

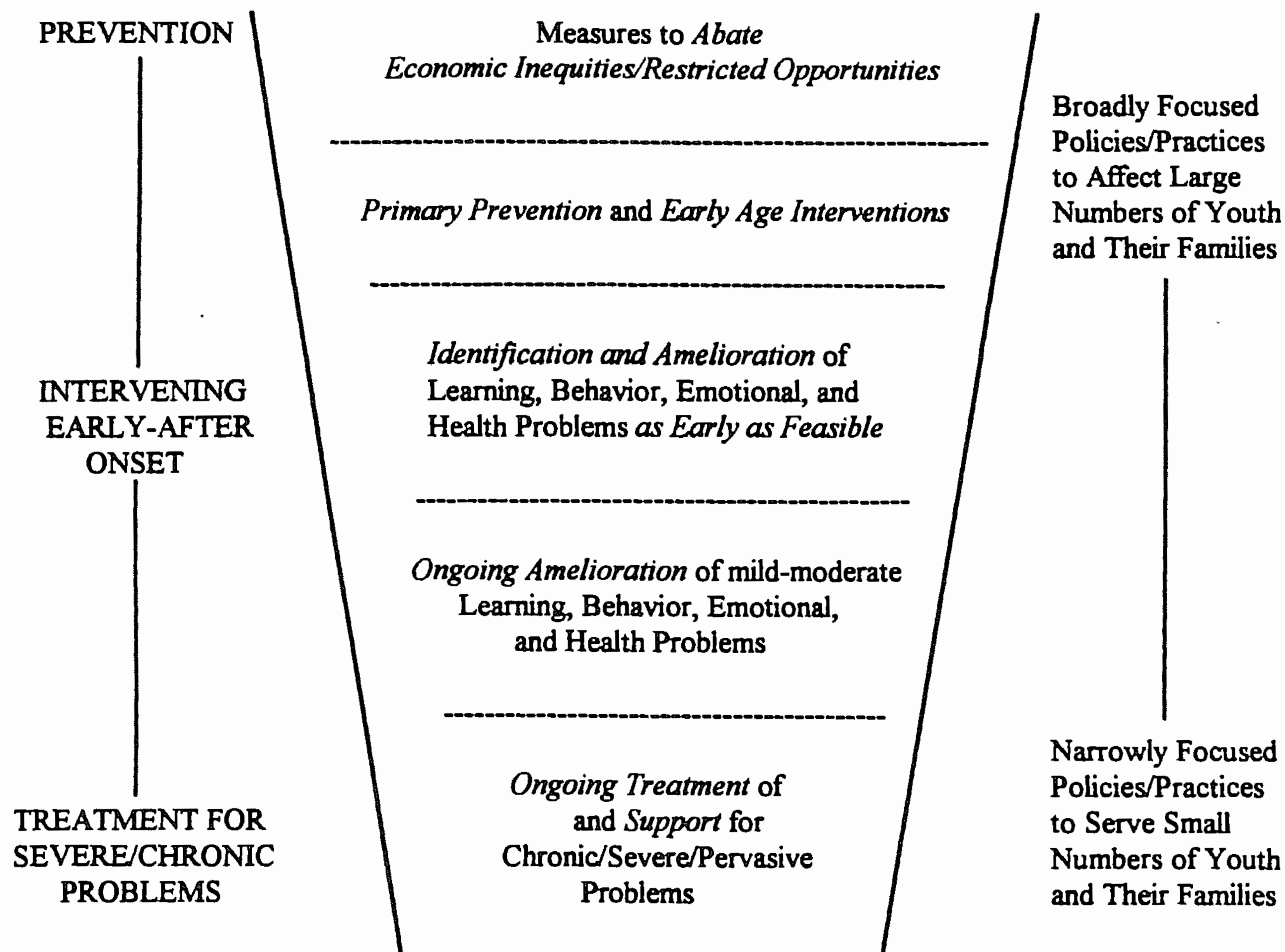


FIGURE 1 Addressing barriers to development, learning, and teaching: A continuum of five fundamental areas for analyzing policy and practice.

With respect to concerns about integrating activity, the continuum of community and school interventions exemplified in Figure 2 underscores that systemic collaboration is essential to establishing interprogram connections on a daily basis and over time. 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. Each of these systems must be connected effectively. Such connections may involve horizontal and vertical restructuring of programs and services (a) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies; and (b) within jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters of schools).

Currently, most reforms are not generating the type of comprehensive, integrated approach necessary to address the many overlapping barriers, including those factors that make schools and communities unsafe and lead to substance abuse, teen pregnancy, dropouts, and so forth. As discussed in the following, 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.

Moving From a Two- to a Three-Component Reform Framework: The Concept of an Enabling Component

Viewing school and community environments through the lens of addressing barriers to development, learning, and teaching (including social, emotional, and physical health problems) suggests the need for a basic policy shift. The present situation is one in which, despite awareness of the many barriers, school and community reformers continue to concentrate mainly on improving efforts to directly facilitate

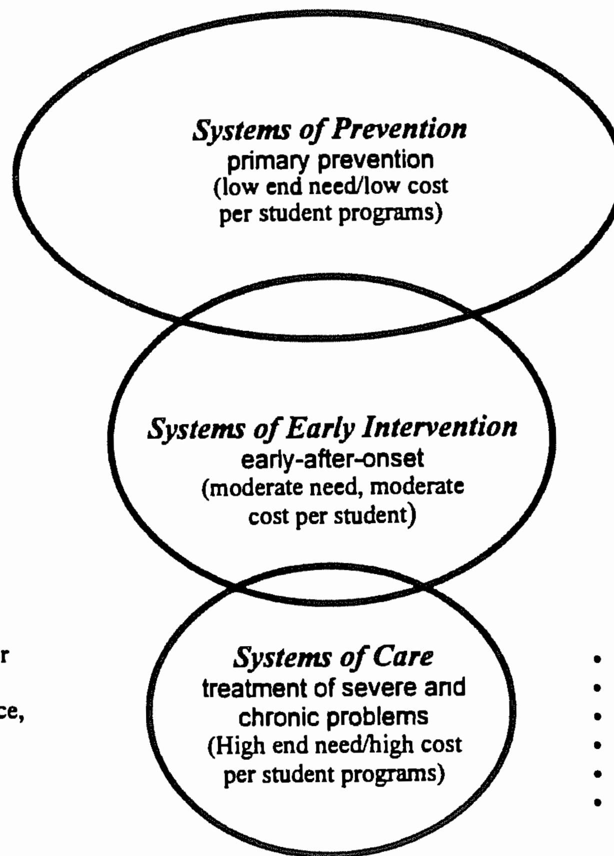


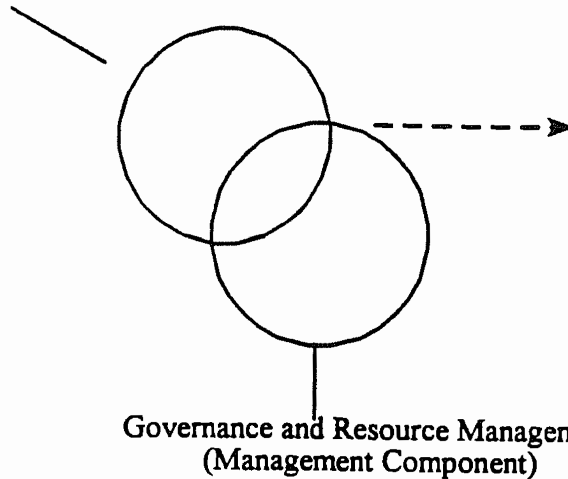
FIGURE 2 Interconnected systems for meeting the needs of all students.

learning and development (e.g., instruction) and system management. This is depicted in Figure 3a. In effect, current policy pursues school and community reforms using a two-component rather than a three-component model. This ignores the need to fundamentally restructure school and community support programs and services and continues to marginalize efforts to design the type of environments that are essential to the success of school reforms (i.e., environments that are designed to effectively address barriers to teaching and learning).

To address gaps in current reform and restructuring initiatives, we have introduced the concept of the *enabling component* as a policy-oriented notion around which to unify efforts to address barriers to development, learning, and teaching (Adelman, 1996a, 1996b; Adelman & Taylor, 1994, 1997a). The concept is intended to underscore that (a) current reforms are based on an inadequate two-component model for restructuring school and community resources, and (b) movement to a three-component model is necessary if all young people are to benefit appropriately from their formal schooling.

A three-component model calls for elevating efforts to address barriers to development, learning, and teaching to the level of one of three fundamental and essential facets of education reform and school and community agency restructuring (see Figure 3b). That is, to enable teachers to teach effectively, we suggest there must not only be effective instruction and well-managed schools, but that barriers must be handled in a comprehensive way. All three components are seen as essential, complementary, and overlapping.

By calling for reforms that fully integrate a focus on addressing barriers, the concept of an enabling component provides a unifying concept for responding to a wide range of psychosocial factors interfering with young people's learning and performance and encompasses the type of models described as full-service schools—and goes beyond them (Adelman, 1996a). Adoption of such an inclusive unifying concept is seen as pivotal in convincing policymakers to



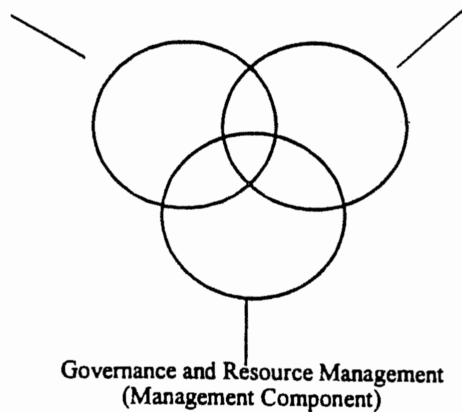


FIGURE 3 (a) A two-component model for reform and restructuring. (b) A three-component model for reform and restructuring.

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.

Emergence of a cohesive enabling component requires policy reform and operational 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 resources by linking as many 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. In the process, mechanisms must be developed to coordinate and eventually integrate school-owned enabling activity and school and community-owned resources. Restructuring must also ensure that the enabling component is

well integrated with the developmental and instructional and management components. The importance of such integration, of course, is to minimize fragmentation, avoid marginalization, and ensure that efforts to address problems (e.g., learning and behavior problems) are implemented on a schoolwide basis and play out in classrooms.

Although some calls for comprehensive, integrated approaches are attracting attention, they do not convey the perspective that interventions addressing barriers to development, learning, and teaching are essential to the success of school reform. The next step in moving toward a comprehensive approach is for school and community reformers to expand their vision beyond refining processes to facilitate instruction and development and improve system management. To this end, the following message must be brought home to policymakers at all levels: Current reforms cannot produce desired outcomes as long as the third primary and essential set of functions related to enabling development, learning, and teaching is so marginalized.

Evidence of the value of rallying around a broad unifying concept, such as an enabling component, is seen in the fact that one of the New American Schools design teams has adopted the concept (Learning Center Model, 1995). Moreover, in 1995 the state legislature in California considered the type of policy shift outlined here as part of a major urban education bill. In 1997, California's Department of Education included a version of such a concept (called Learning Support) in their school program quality review guidelines (California Department of Education, 1996, 1997).

A Model for an Enabling Component at a School Site

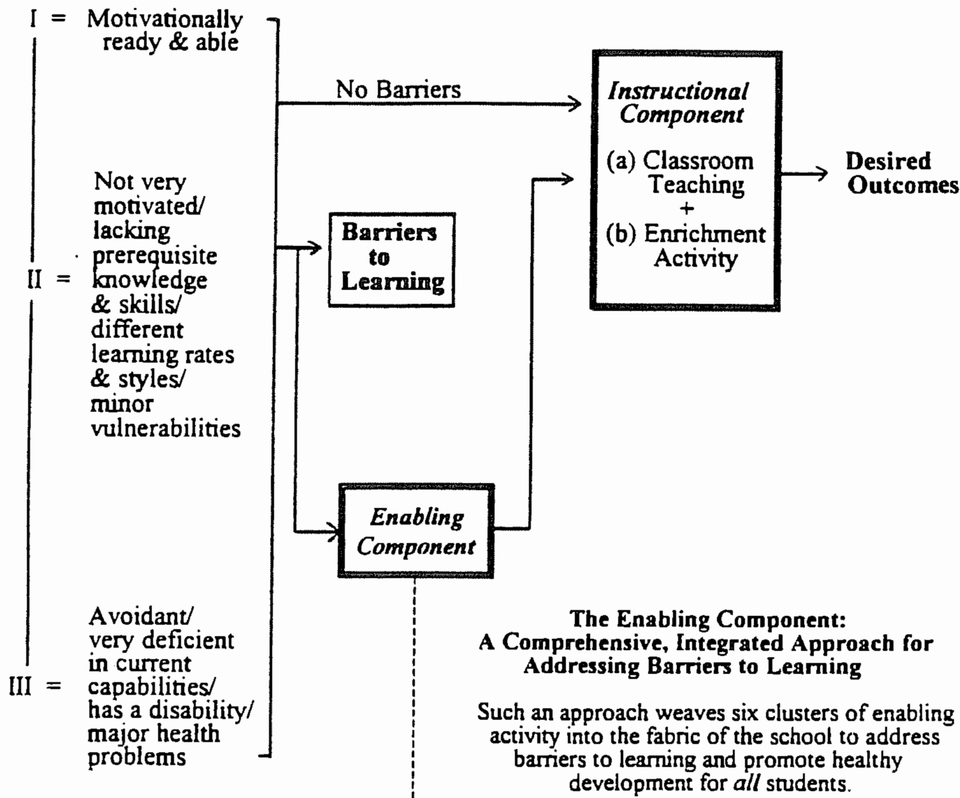
As illustrated in Figure 3b, an enabling component overlaps the instructional component. The intent is to ensure a schoolwide approach that enhances instructional processes in every classroom. Operationalizing an enabling component requires formulating a delimited framework of basic programmatic areas and creating an infrastructure to restructure enabling activity. Based on an extensive analysis of activity used to address barriers to learning, we cluster enabling activity into six interrelated areas (see Figure 4; for detailed discussion, see Adelman, 1996b, and the Learning Center Model, 1995). A brief description of the six areas is provided in the following; some implications for research are discussed in a subsequent section.

Classroom-focused enabling. This area provides a fundamental example not only of how the enabling component overlaps the instructional component, but how it adds value to instructional reform. When a teacher has difficulty working with a youngster, the first step is to address the problem within the regular classroom and perhaps to involve the home to a greater extent. Through programmatic activity, classroom-based efforts that enable learning are enhanced. This is accomplished by increasing teachers' effectiveness so they can account for a wider range of individual differences, foster a caring context for learning, and prevent and handle a wider range of problems when they arise. Such a focus is seen as essential to increasing the effectiveness of regular classroom instruction, supporting inclusionary policies, and reducing the need for specialized services.

Work in this area requires programs and systems designed to (a) personalize professional development of teachers and support staff, (b) develop the capabilities of paraeducators and other paid assistants and volunteers, (c) provide temporary out-of-class assistance for students, and (d) enhance resources. For example, personalized help is provided to increase a teacher's array of strategies for accommodating, as well as teaching students to compensate for, differences, vulnerabilities, and disabilities. Teachers learn to target the activity of paid assistants, peer tutors, and volunteers to enhance social and academic support. (The classroom curriculum already should encompass a focus on fostering socioemotional and physical development; such a focus is seen as an essential element in preventing learning, behavior, emotional, and health problems.) As appropriate, support in the classroom is provided by resource and itinerant teachers and counselors. This involves restructuring and redesigning the roles, functions, and staff development of resource and itinerant teachers, counselors, and other pupil service personnel so they are able to work closely with teachers and students in the classroom on regular activities. All this provides the teacher with the knowledge and skills to develop a classroom infrastructure that transforms a big classroom into a set of smaller ones.

Student and family assistance. Student and family assistance should be reserved for the relatively few problems that cannot be handled without adding special interventions. In effect, this one area encompasses most of the services and related systems that are the focus of integrated service models.

The emphasis is on providing special services in a personalized way to assist with a broad range of needs. To begin with, social, physical, and mental health assistance available in the school and community are used. As community outreach brings in other resources, these are linked to existing activity in an integrated manner. Additional attention is paid to enhancing systems for triage, case and resource management, direct services for immediate needs, and referral for special services and special education resources and placements as appropriate. Ongoing efforts are made to expand and enhance resources. A valuable context for providing such services is a center facility (e.g., a family, community, health, or parent resource center).



The Enabling Component: A Comprehensive, Integrated Approach for Addressing Barriers to Learning

Such an approach weaves six clusters of enabling activity into the fabric of the school to address barriers to learning and promote healthy development for *all* students.

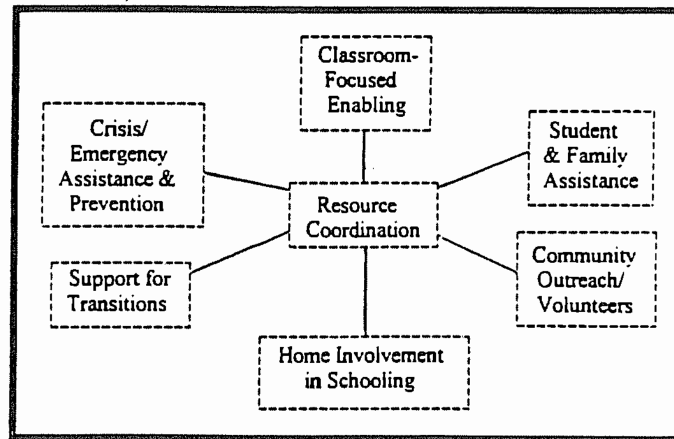


FIGURE 4 A model for an enabling component at a school site.

A programmatic approach in this area requires systems and activities designed to (a) support classroom-focused enabling with emphasis on reducing teachers' need to seek special programs and services, (b) provide all stakeholders with information clarifying available assistance and how to access help, (c) facilitate requests for assistance and evaluate such requests (including strategies designed to reduce the need for special intervention), (d) handle referrals, (e) provide direct service, (f) implement effective case and resource management, and (g) interface with community outreach to assimilate additional resources into current service delivery. As major outcomes, the intent is to ensure that special assistance is provided when necessary and appropriate and that such assistance is effective.

Crisis assistance and prevention. Schools must respond to, minimize the impact of, and prevent crises. This re-

quires systems and programs for (a) emergency and crisis response at a site, throughout a school complex, and communitywide (including a focus on ensuring follow-up care); and (b) prevention at school and in the community to address school safety and violence reduction, suicide prevention, child abuse prevention, and so forth.

Desired outcomes of crisis assistance include ensuring provision of immediate emergency and follow-up care so students are able to resume learning without undue delay. Prevention activity outcomes are reflected in indexes showing there is a safe and productive environment and that students and their families have the type of attitudes and capacities needed to deal with violence and other threats to safety.

A key mechanism in this area often is development of a crisis team trained in emergency response procedures, physical and psychological first aid, ensuring aftermath needs are addressed, and so forth. The team also can take the lead in planning ways to prevent certain crises by facilitating the development of programs for conflict mediation and enhancing human relations and a caring school culture.

Support for transitions. Students and their families are regularly confronted with a variety of transitions (e.g., changing schools, changing grades, and encountering a range of other daily hassles and major life demands). Many of these can interfere with productive school involvement.

A comprehensive focus on transitions requires systems and programs designed to (a) establish schoolwide and classroom-specific activities for welcoming new arrivals (students, their families, staff) and rendering ongoing social support; (b) provide counseling and articulation strategies to support grade-to-grade and school-to-school transitions, moving to and from special education, going to college, and moving to postschool living and work; and (c) organize before- and after-school and intersession activities to enrich learning and provide recreation in a safe environment. Anticipated outcomes are reduced alienation, enhanced positive attitudes toward school and learning, and increased involvement in school and learning activities. Outcomes related to specific programs in this area can include reduced tardiness as the result of participation in before-school programs and reduced vandalism, violence, and crime at school and in the neighborhood as the result of involvement in after-school programs and experiencing the school as a caring place. There also are suggestions that a caring school climate can play a significant role in reducing student transiency. Articulation problems can be expected to reduce school avoidance and dropouts and enhance the number of students who make successful transitions to higher education and postschool living and work.

Home involvement in schooling. This area expands concern for parent involvement to encompass anyone in the home who plays a key role in influencing the student's formal education. In some cases, parenting has been assumed by grandparents, aunts, or older siblings. In many cases, older brothers and sisters are the most significant influences on a youngster's life choices. Thus, schools and communities must go beyond focusing on parents in their efforts to enhance home involvement.

This area includes systems and programs to (a) address the specific learning and support needs of adults in the home, such as offering them English as a second language, literacy, vocational, and citizenship classes, enrichment and recreational opportunities, and mutual support groups; (b) help anyone in the home learn how to meet basic obligations to a student, such as providing instruction for parenting and helping with schoolwork; (c) improve communication that is essential to the student and family; (d) enhance the home–school connection and sense of community; (e) foster participation in making decisions essential to a student's well-being; (f) facilitate home support of a student's basic learning and development; (g) mobilize those at home to solve problems related to student needs; and (h) elicit help (support, collaborations, and partnerships) from those at home with respect to meeting classroom, school, and community needs. The context for some of this activity may be a parent center (which may be part of a family service center facility if one has been established at the site). Outcomes include indexes of parent learning, student progress, and community enhancement specifically related to home involvement.

Community outreach for involvement and support (including a focus on volunteers). Outreach to the community is designed to build linkages and collaborations, develop greater involvement in schooling, and enhance support for efforts to enable learning. Outreach is made to (a) public and private agencies, organizations, universities, colleges, and facilities; (b) businesses and professional organizations and groups; and (c) volunteer service programs, organizations, and clubs. Activities include systems and programs designed to (a) recruit community involvement and support (e.g., linkages and integration with community health and social services; cadres of volunteers, mentors, and individuals with special expertise and resources; local businesses to adopt a school and provide resources, awards, incentives, and jobs; formal partnership arrangements); (b) train, screen, and maintain volunteers (e.g., parents, college students, senior citizens, peer cross-age tutors and counselors, and professionals in training to provide direct help for staff and students, especially targeted students); (c) reach out to hard-to-involve students and families (those who do not come to school regularly, including truants and dropouts); and (d) enhance community–school connections and sense of community (e.g., orientations, open houses, performances and cultural and sports events, festivals and celebrations, workshops and

fairs). Outcomes include indexes of community participation, student progress, and community enhancement.

Clearly, a well-designed and supported infrastructure is needed to establish, maintain, and evolve this type of a comprehensive, programmatic approach. Such an infrastructure includes mechanisms for governance; capacity building (including stakeholder development); coordination among enabling activities; enhancement of resources by developing direct linkages between school and community programs; movement toward increased integration of school and community resources; and integration of the developmental and instructional, enabling, and management components (see Adelman, 1993; Adelman & Taylor, 1997b, 1998; Rosenblum et al., 1995). The infrastructure also benefits when multimedia advanced technology is incorporated to support all activity.

It should be evident that what we are describing represents a significant shift in thinking among those responsible for schools and a major transformation in the ways schools operate. The scope of change is so great that getting from here to there must be carried out in phases.

Getting From Here to There

A policy shift and programmatic focus are necessary but insufficient. For significant systemic change to occur, policy and program commitments must be demonstrated through allocation and redeployment of resources (e.g., finances, personnel, time, space, equipment) that can adequately operationalize policy and promising practices. In particular, there must be sufficient resources to develop an effective structural foundation for system change. Existing infrastructure mechanisms must be modified in ways that guarantee new policy directions are translated into appropriate daily practices. Well-designed infrastructure mechanisms 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 that changes are implemented and renewed over time.

Institutionalizing a comprehensive, integrated approach requires redesigning mechanisms with respect to at least five basic infrastructure concerns: (a) governance, (b) planning implementation associated with specific organizational and program objectives, (c) coordination and integration for cohesion, (d) daily leadership, and (e) communication and information management. 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 over time—to those who operate the mechanisms. There must also be appropriate incentives and safeguards for those undertaking the tasks.

In terms of task focus, infrastructure changes must attend to (a) interweaving school and community resources for addressing barriers (a component to enable learning), direct facilitation of learning (instruction), and system governance and resource use (management); (b) reframing inservice programs, including an emphasis on cross-training so that professionals from different disciplines can learn some of each other's bases of knowledge and skills; and (c) establishing appropriate forms of quality improvement, accountability, and ways to periodically reenergize staff. Clearly, all this requires greater involvement from professionals providing health and human services and other programs addressing barriers to learning. This means involvement in every facet, especially governance.

Furthermore, 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., see Adelman, 1993; Adelman & Taylor, 1997a; Argyris, 1993; Elias, 1997; Fullan & Stiegelbauer, 1991; Knoff, 1995; Replication and Program Services, Inc., 1993; Sarason, 1996; Schorr, 1997).

Elsewhere (Adelman & Taylor, 1997a), we present the model we are evolving for the widespread diffusion of new approaches such as an enabling component. The model draws on a diverse body of literature related to organizational change and community psychology, as well as practices evolved as part of several restructuring efforts. It must suffice to highlight a few points here. At school and district levels, key stakeholders and their leadership must understand and commit to restructuring. Commitment must be reflected in policy statements and creation of an organizational structure that ensures effective leadership and resources. The process begins with activities designed to create readiness for the necessary changes by enhancing a climate and culture for change. Steps involved include: (a) building interest and consensus for developing a comprehensive approach to addressing barriers to learning and enhancing healthy development, (b) introducing basic concepts to relevant groups of stakeholders, (c) establishing a policy framework that recognizes that the approach is a primary and essential facet of the institution's activity, and (d) appointment of leaders (of equivalent status to the leaders for the instructional and management facets) at school and district levels who can ensure policy commitments are carried out.

Overlapping efforts to create readiness are processes to develop an organizational structure for start-up and phase-in. This involves (a) establishment of mechanisms and procedures to guide reforms, such as a steering group and leadership training; (b) formulation of specific start-up and phase-in plans; (c) establishment and training of a team that analyzes, restructures, and enhances resources with the aim of evolving

a comprehensive, integrated approach; (d) phased-in reorganization of all enabling activity; (e) outreach to establish collaborative linkages among schools and district and community resources; and (f) establishment of systems to ensure quality improvement, momentum for reforms, and a sense of ongoing renewal.

Schools require assistance in establishing and maintaining an appropriate infrastructure for enabling activity. A specially trained organization facilitator represents a mechanism that embodies the necessary expertise to help (a) develop essential school-based leadership; (b) establish program, coordinating, and resource teams; and (c) clarify how to link up with community programs and enhance community involvement (Adelman, 1993; Adelman & Taylor, 1993b, 1994, 1997b). Current restructuring efforts in the Los Angeles Unified School District suggest that a facilitator can rotate within a group of 10 to 12 schools to assist in phasing in an appropriate infrastructure over a period of a few years. The facilitator can then move on to another group of schools. After moving on, plans call for the facilitator to return periodically to assist with maintenance, share new ideas for enabling activity, help with development of additional programs, and contribute to related inservice. Work to date suggests that a relatively small cadre of organization facilitators should be able to phase in desired mechanisms throughout a relatively large district over a period of about 5 to 6 years.

IMPLICATIONS FOR RESEARCH

Viewing current policy and practice through the lens of addressing barriers to learning and the concept of an enabling component leads to a host of research questions. Additional areas for a concentrated program of research arise from the need to clarify essential mechanisms for and ways to overcome the problems associated with institutionalizing, replicating, and scaling up comprehensive school reforms designed to address barriers.

With respect to policy, research has not focused on why the field of education does virtually nothing to reform how student support programs are conceived and implemented. Indeed, researchers have paid relatively little attention even to describing such activity and the amount of resources expended on it. This is another reflection of the lack of attention paid to such matters by policymakers. A key researchable question asks why policymakers at all levels pay so little attention to creating an agenda to reform and restructure the way such resources are used. (Stated in a broader way, why is the problem of addressing barriers to learning so marginalized?) Another basic question involves what is actually happening at school sites each day to address barriers.

Also needed is a program of policy research focused on resource concerns. With respect to cost-effectiveness, school finance studies suggest that about 7% of school budgets formally go to student support services (Monk, Pijanowski, & Hussain, 1997). However, it remains unclear how much additional money actually is used to address barriers to learning, drawing on funding for compensatory education, special education, and safe and drug-free schools, as well as various other resource pools. It seems likely that at many schools the percentage of the school budget spent on enabling activity is significantly greater than 7%. Studies are needed to address what percentage of a school's resources is expended on such activity. A related but more complex matter for study arises because of widespread complaints about the fragmentation produced by categorical funding. Research is needed to describe the impact and assess the cost benefits of separate funding streams and the degree to which they contribute to a lack of cohesion in daily practice at school sites.

In the area of school and community interventions, studies have documented the promise of many short-term and noncomprehensive practices. As suggested earlier, research must still demonstrate that the promise can be fulfilled when the interventions are applied widely, and the search for better practices remains a necessity. However, the enabling component points to a much broader focus for research. By their very nature, most of the interventions studied are not designed as a cohesive answer to the multitude of mental health and psychosocial concerns schools must address to enable student learning and promote healthy development. Rather, such research focuses on specific types of problems and yields a patchwork of findings. The work contributes little to understanding how the pieces should be put together and what the impact of doing so might be. The research on evaluating systems of care, cited earlier, goes a step beyond focusing on specific interventions to look at a complex package of programs and services. Next steps need to encompass development of systems of prevention and systems of early intervention, processes for weaving the whole continuum together, and evaluation of results. In this context, the six clusters of programmatic activity defined in operationalizing an enabling component provide a guiding framework. Any program of research focusing on such a comprehensive, multifaceted, integrated approach to addressing barriers to development, learning, and teaching will be complex and costly. Obviously, it will be difficult and in some instances impossible to isolate specific elements that produce specific effects. Such research, however, would have the virtue of determining the impact of a comprehensive approach. In this respect, the work would parallel efforts to study comprehensive curricular and instructional reforms.

Finally, we turn to the topic of scale up. The desire for comprehensive school reform is frustrated by the problems associated with institutionalizing and taking such reforms to scale. In the section of this article called Getting From Here to There, we have sketched our views about the processes and problems involved in efforts to replicate and scale up prototype models. Based on the available literature and our work, we have taken the liberty of expressing these views as practices. It is evident, however, that the practices we suggest are in need of study, and to this end, the formulations can readily

be transformed into a set of researchable questions and hypotheses. Moreover, a major opportunity to study such matters is provided by the 1998 federal initiative to foster adoption of comprehensive school reform models by providing financial incentives to schools that are eligible for Title I basic grants. (The legislation specifies 22 models from which schools can choose.)

CONCLUDING COMMENTS

Mental health in schools should not be viewed as a separate agenda from the instructional mission. In terms of policy, practice, and research, it is more fruitful to see mental health as embedded in the continuum of interventions that comprise a comprehensive, integrated component for addressing barriers and enhancing healthy development and learning. Once policymakers recognize the essential nature of such a component, it should be easier to weave together all efforts to address barriers and, in the process, elevate the status of programs to enhance healthy development.

With policy in place, work can begin to restructure, transform, and enhance school-owned programs and services and community resources, and include mechanisms to coordinate and eventually integrate them all. To these ends, the focus needs to be on all school resources (e.g., compensatory and special education, activity supported by general funds, support services, adult education, recreation and enrichment programs, extended use of facilities) and all community resources (e.g., public and private agencies, families, businesses, services, programs, facilities, volunteers, professionals in training). The aim is to weave all these resources together into the fabric of every school and evolve a comprehensive, integrated approach that effectively addresses barriers to development, learning, and teaching.

We cannot forget about linking schools to maximize use of limited resources. When a "family" of schools in a geographic area works together to address barriers, they can share programs and personnel in many cost-effective ways. This includes streamlined processes to coordinate and integrate assistance to a family that has children at several of the schools. For example, the same family may have youngsters in the elementary and middle schools and both students may need special counseling. This might be accomplished by assigning one counselor or case manager to work with the family. Also, in connecting with community resources, a group of schools can maximize distribution of such limited resources in ways that are efficient, effective, and equitable.

When resources are combined properly, the end product can be cohesive and potent school–community partnerships. Such partnerships seem essential if we are to strengthen neighborhoods and communities and create caring and supportive environments that maximize learning and well-being.

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REFERENCES

Adelman, H. S. (1993). School-linked mental health interventions: Toward mechanisms for service coordination and integration. *Journal of Community Psychology, 21*, 309–319.

Adelman, H. S. (1995). Clinical psychology: Beyond psychopathology and clinical interventions. *Clinical Psychology: Science and Practice, 2*, 28–44.

Adelman, H. S. (1996a). Restructuring education support services and integrating community resources: Beyond the full service school model. *School Psychology Review, 25*, 431–445.

Adelman, H. S. (1996b). *Restructuring support services: Toward a comprehensive approach*. Kent, OH: American School Health Association.

Adelman, H. S., Barker, L. A., & Nelson, P. (1993). A study of a school-based clinic: Who uses it and who doesn't? *Journal of Clinical Child Psychology, 22*, 52–59.

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

Adelman, H. S., & Taylor, L. (1993b). School-based mental health: Toward a comprehensive approach. *Journal of Mental Health Administration, 20*, 32–45.

Adelman, H. S., & Taylor, L. (1994). *On understanding intervention in psychology and education*. Westport, CT: Praeger.

Adelman, H. S., & Taylor, L. (1997a). Addressing barriers to learning: Beyond school-linked services and full service schools. *American Journal of Orthopsychiatry, 67*, 408–421.

Adelman, H. S., & Taylor, L. (1997b). Toward a scale-up model for replicating new approaches to schooling. *Journal of Educational and Psychological Consultation, 8*, 197–230.

Adelman, H. S., & Taylor, L. (1998). Involving teachers in collaborative efforts to better address the barriers to student learning. *Preventing School Failure, 42*, 55–60.

Adelman, H. S., & Taylor, L. (in press). Mental health in schools and system restructuring. *Clinical Psychology Review*.

Adler, L., & Gardner, S. (Eds.). (1994). *The politics of linking schools and social services*. Washington, DC: Falmer.

Advocates for Youth. (1994). *School-based and school-linked health centers: The facts*. Washington, DC: Author.

Albee, G. W., & Gullotta, T. P. (Eds.). (1997). *Primary prevention works*. Thousand Oaks, CA: Sage.

Anglin, T. M., Naylor, K. E., & Kaplan, D. W. (1996). Comprehensive, school-based health care: High school students' use of medical, mental health, and substance abuse services. *Pediatrics, 97*, 318–330.

Argyris, C. (1993). *Knowledge for action: A guide to overcoming barriers to organizational change*. San Francisco: Jossey-Bass.

Bickman, L. (1997). Resolving issues raised by the Fort Bragg evaluation: New directions for mental health services research. *American Psychologist, 52*, 562–565.

Borders, L. D., & Drury, S. M. (1992). Comprehensive school counseling programs: A review for policymakers and practitioners. *Journal of Counseling & Development, 70*, 487–498.

California Department of Education. (1996). *Factbook 1996–97: Handbook of education information*. Sacramento, CA: Author.

California Department of Education. (1997). *Guide and criteria for program quality review: Elementary*. Sacramento, CA: Author.

Carlson, C., Paavola, J., & Talley, R. (1995). Historical, current, and future models of schools as health care delivery settings. *School Psychology Quarterly, 10,* 184–202.

Carnegie Council on Adolescent Development. (1988). *Review of school-based health services*. New York: Carnegie Foundation.

Center for the Future of Children staff. (1992). School linked services: Analysis. *The Future of Children, 2,* 6–18.

Center for Mental Health in Schools. (1996). *Policies and practices for addressing barriers to student learning: Current status and new directions*. Los Angeles: Author.

Center for Mental Health in Schools. (1997). *Addressing barriers to learning: Closing gaps in school–community policy and practice*. Los Angeles: Author.

Conoley, J. C., & Conoley, C. W. (1991). Collaboration for child adjustment: Issues for school and clinic-based child psychologists. *Journal of Consulting and Clinical Psychology, 59,* 821–829.

Costello, E. J. (1989). Developments in child psychiatric epidemiology. *Journal of the American Academy of Child and Adolescent Psychiatry, 28,* 836–841.

Cowen, E. L., Zax, M., Izzo, L. D., & Trost, M. A. (1966). The prevention of emotional disorders in the school setting: A further investigation. *Journal of Consulting Psychology, 30,* 381–387.

Davis, M., Fryer, G. E., White, S., & Igoe, J. B. (1995). *A closer look: A report of select findings from the National School Health Survey 1993–1994*. Denver: Office of School Health, University of Colorado Health Sciences Center.

Day, C., & Roberts, M. C. (1991). Activities of the Children and Adolescent Service System Program for improving mental health services for children and families. *Journal of Clinical Child Psychology, 20,* 340–350.

Dryfoos, J. G. (1990). *Adolescents at risk: Prevalence and prevention*. London: Oxford University Press.

Dryfoos, J. G. (1993). Schools as places for health, mental health, and social services. *Teachers College Record, 94,* 540–567.

Dryfoos, J. G. (1994). *Full-service schools: A revolution in health and social services for children, youth, and families*. San Francisco: Jossey-Bass.

Dryfoos, J. (1995). Full service schools: Revolution or fad? *Journal of Research on Adolescence, 5,* 147–172.

Dryfoos, J. (1998). *Safe passage: Making it through adolescence in a risky society*. New York: Oxford University Press.

Duchnowski, A. J. (1994). Innovative service models: Education. *Journal of Clinical Child Psychology, 23,* 13–18.

Duchnowski, A. J., & Friedman, R. M. (1990). Children's mental health: Challenges for the nineties. *Journal of Mental Health Administration, 17,* 3–12.

Durlak, J. A. (1995). *School-based prevention programs for children and adolescents*. Thousand Oaks, CA: Sage.

Duttweiler, P. C. (1995). *Effective strategies for educating students in at risk situations*. Clemson, SC: National Dropout Prevention Center.

Elias, M. J. (1997). Reinterpreting dissemination of prevention programs as widespread implementation with effectiveness and fidelity. In R. P. Weissberg, T. P. Gullotta, R. L. Hamptom, B. A. Ryan, & G. R. Adams (Eds.), *Establishing preventive services* (pp. 253–289). Thousand Oaks, CA: Sage.

Fagan, T. K., & Wise, P. S. (1994). *School psychology: Past, present, and future*. New York: Longman.

First, P. F., Curcio, J. L., & Young, D. L. (1994). State full-service school initiatives: New notions of policy development. In L. Adler & S. Gardner (Eds.), *The politics of linking schools and social services* (pp. 63–74). Washington, DC: Falmer.

Flaherty, L. T., Weist, M. D., & Warner, B. S. (1996). School-based mental health services in the United States: History, current models, and needs. *Community Mental Health Journal, 25,* 341–352.

Franklin, C., & Streeter, C. L. (1995). School reform: Linking public schools with human services. *Social Work, 40,* 773–782.

Freeman, E. M., & Pennekamp, M. (1988). *Social work practice: Toward a child, family, school, community perspective*. Springfield, IL: Thomas.

Fullan, M. G., & Stiegelbauer, S. (1991). *The new meaning of educational changes* (2nd ed.). New York: Teachers College Press.

Gibson, R. L., & Mitchell, M. H. (1990). *Introduction to counseling and guidance* (3rd ed.). New York: Macmillan.

Goleman, D. (1995). *Emotional intelligence*. New York: Bantam Books.

Haynes, N. M., Comer, J. P., & Hamilton-Lee, M. (1988). The school development program: A model of school improvement. *Journal of Negro Education, 57,* 11–21.

Henggeler, S. W. (1995). A consensus: Conclusions of the APA Task Force report on innovative models of mental health services for children, adolescents, and their families. *Journal of Clinical Child Psychology, 23,* 3–6.

Hickey, N. W., Lockwood, J., Payzant, T. W., & Wenrich, J. W. (1990). *New beginnings: A feasibility study of integrated services for children and families* (Final report). San Diego, CA: County of San Diego, Office of Chief Administrative Officer.

Hill, P., & Bonan, J. (1991). *Decentralization and accountability in public education*. Santa Monica, CA: Rand.

Hoagwood, K. (1995). Issues in designing and implementing studies of non-mental health care sectors. *Journal of Clinical Child Psychology, 23,* 114–120.

Hoagwood, K. (1997). Interpreting nullity: The Fort Bragg experiment—A comparative success or failure? *American Psychologist, 52,* 546–550.

Hoagwood, K., & Erwin, H. (1997). Effectiveness of school-based mental health services for children: A 10-year research review. *Journal of Child and Family Studies, 6,* 435–451.

Hodgkinson, H. L. (1989). *The same client: The demographics of education and service delivery systems*. Washington, DC: Institute for Educational Leadership, Inc., and Center for Demographic Policy.

Holtzman, W. H. (1992). Community renewal, family preservation, and child development through the school of the future. In W. H. Holtzman (Ed.), *School of the future* (pp. 3–18). Austin, TX: American Psychological Association and Hogg Foundation for Mental Health.

Karoly, L. A., Greenwood, P. W., Everingham, S. S., Hoube, J., Kilburn, M. R., Rydell, C. P., Sanders, M., & Chiesa, J. (1998). *Investing in our children: What we know and don't know about the costs and benefits of early childhood interventions*. Santa Monica, CA: Rand.

Kazdin, A. E. (1993). Adolescent mental health: Prevention and treatment programs. *American Psychologist, 48,* 127–141.

Kirst, M. W., & McLaughlin, M. (1990). Rethinking children's policy: Implications for educational administration. In B. Mitchell & L. L. Cunningham (Eds.), *Educational leadership and changing context of families, communities, and schools: 89th yearbook of the National Society for the Study of Education* (Part 2, pp. 69–90). Chicago: University of Chicago Press.

Knapp, M. S. (1995). How shall we study comprehensive collaborative services for children and families? *Educational Researcher, 24,* 5–16.

Knitzer, J., Steinberg, Z., & Fleisch, B. (1990). *At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional problems*. New York: Bank Street College of Education.

Knoff, H. M. (1995). Best practices in facilitating school-based organizational change and strategic planning. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology III* (pp. 234–242). Washington, DC: National Association of School Psychologists.

Knoff, H. M., & Batsche, G. M. (1995). Project ACHIEVE: Analyzing a school reform process for at-risk and underachieving students. *School Psychology Review, 24,* 579–603.

Kolbe, L. J. (1986). Increasing the impact of school health programs: Emerging research perspectives. *Health Education, 17,* 47–52.

Kolbe, L. J. (1993). An essential strategy to improve the health and education of Americans. *Preventive Medicine, 22,* 544–560.

Koyanagi, C., & Gaines, S. (1993). *All systems fail.* Washington, DC: National Mental Health Association.

Lambert, N. M., Bower, E. M., Caplan, G. (1964). *The protection and promotion of mental health in the schools.* Washington, DC: U.S. Government Printing Office.

Larson, J. (1994). Violence prevention in the schools: A review of selected programs and procedures. *School Psychology Review, 23,* 151–164.

Lawson, H., & Briar-Lawson, K. (1997). *Connecting the dots: Progress toward the integration of school reform, school-linked services, parent involvement and community schools.* Oxford, OH: The Danforth Foundation and the Institute for Educational Renewal at Miami University.

Lawson, H., & Hooper-Briar, K. (1994). *Expanding partnerships: Involving colleges and universities in interprofessional collaboration and service integration.* Oxford, OH: The Danforth Foundation and the Institute for Educational Renewal at Miami University.

Learning Center Model. (1995). *A design for a new learning community.* Los Angeles: Los Angeles Educational Partnership.

Marx, E., Wooley, S., & Northrop, D. (1998). *Health is academic.* New York: Teachers College Press.

Melaville, A., Blank, M., & Asayesh, G. (1993). *Together we can: A guide for crafting a profamily system of education and human services.* Washington, DC: U.S. Government Printing Office.

Monk, D. H., Pijanowski, J. C., & Hussain, S. (1997). How and where the education dollar is spent. *The Future of Children, 7,* 51–62.

Palaich, R. M., Whitney, T. N., & Paolino, A. R. (1991). *Changing delivery systems: Addressing the fragmentation in children and youth services.* Denver, CO: Education Commission of the States.

Powers, S. I., Hauser, S. T., & Kilner, L. A. (1989). Adolescent mental health. *American Psychologist, 44,* 200–208.

Replication and Program Services, Inc. (1993). *Building from strength: Replication as a strategy for expanding social programs that work.* Philadelphia: Author.

Robert Wood Johnson Foundation. (1989). *Annual report.* Princeton, NJ: Author.

Robert Wood Johnson Foundation. (1993). *Making the grade: State and local partnerships to establish school-based health centers.* Princeton, NJ: Author.

Rosenblum, L., DiCecco, M. B., Taylor, L., & Adelman, H. S. (1995). Upgrading school support programs through collaboration: Resource coordinating teams. *Social Work in Education, 17,* 117–124.

Sarason, S. B. (1996). *Revisiting "The culture of school and the problem of change."* New York: Teachers College Press.

Schorr, L. B. (1988). *Within our reach: Breaking the cycle of disadvantage.* New York: Doubleday.

Schorr, L. B. (1997). *Common purpose: Strengthening families and neighborhoods to rebuild America.* New York: Anchor.

Slavin, R., Karweit, N., & Wasik, B. (1994). *Preventing early school failure: Research on effective strategies.* Boston: Allyn & Bacon.

Streeter, C. L., & Franklin, C. (1993). Site-based management in public education: Opportunities and challenges for school social workers. *Social Work in Education, 15,* 71–81.

Summit Report. (1998). *The MCHB initiative for mental health in schools.* Los Angeles: Center for Mental Health in Schools.

Taylor, L., & Adelman, H. S. (1996). Mental health in the schools: Promising directions for practice. *Adolescent Medicine: State of the Art Reviews, 7,* 303–317.

Thomas, A., & Grimes, J. (Eds.). (1995). *Best practices in school psychology III.* Washington, DC: National Association for School Psychologists.

Tyack, D. B. (1979). The high school as a social service agency: Historical perspectives on current policy issues. *Education Evaluation and Policy Analysis, 1,* 45–57.

Tyack, D. B. (1992). Health and social services in public schools: Historical perspectives. *The Future of Children, 2,* 19–31.

U.S. Department of Education. (1995). *School-linked comprehensive services for children and families: What we know and what we need to know.* Washington, DC: Author.

U.S. Department of Health and Human Services. (1994). *School-based clinics that work.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Bureau of Primary Health Care.

U.S. General Accounting Office. (1993). *School-linked services: A comprehensive strategy for aiding students at risk for school failure* (Rep. No. GAO/HRD-94-21). Washington, DC: Author.

U.S. Office of Education/National Institute of Mental Health. (1972). *Mental health and learning.* Washington, DC: U.S. Government Printing Office.

Weisz, J. R., Donenberg, G. R., Han, S. S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63,* 699–701.

White, J. A., & Wehlage, G. (1995). Community collaboration: If it is such a good idea, why is it so hard to do? *Educational Evaluation and Policy Analysis, 17,* 23–38.

Zigler, E. F., & Lang, M. (1991). *Child care choices.* New York: Macmillan.