Psychology in the Schools, Vol. 37(1), 2000

CCC 0033-3085/00/010049-12

SHAPING THE FUTURE OF MENTAL HEALTH IN SCHOOLS

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Systemic reform in education is changing how schools address mental health and psychosocial concerns and is redefining the role of pupil service personnel in the process. This paper (a) highlights how schools currently address mental health, (b) discusses new directions that build on emerging reform themes and reframe prevailing reform models, and (c) outlines ways pupil-service professionals can develop a proactive agenda for shaping the future of mental health in schools. © 2000 John Wiley & Sons, Inc.

With the upheaval going on in public education, the ways in which schools address mental-health concerns are changing and, therefore, so is the nature and scope of "support services." What will it all look like in the coming years? That depends on whether pupil-service personnel reactively approach the future or take the lead in restructuring systemic reform. It seems clear to us that a reactive stance will lead to dire consequences. Thus, our emphasis is on framing new directions and encouraging a visionary and proactive approach. To underscore the need for new directions, we begin by briefly highlighting the current state of the art and its deficiencies. We then discuss the importance of reframing current reforms and offer some suggestions for a proactive agenda to shape the future of mental health in schools.

How Do Schools Currently Address Mental Health?

Teachers ask for help everyday in dealing with problems; they also often would like support to facilitate their students' healthy, social, and emotional development and help in involving parents. Yet, despite long-standing and widespread acknowledgement of need, relevant programs and services continue to be a supplementary item on a school's agenda. This is not surprising. After all, schools are not in the mental-health or social-service business. Their mandate is to educate. Thus, they tend to see any activity not related directly to instruction as taking resources away from their primary mission.

Why, then, do schools have any mental-health-related programs? There are, of course, legal mandates requiring mental-health services for some students diagnosed with special-education needs. In addition, school administrators, board members, teachers, parents, and students long have recognized that social, emotional, and physical-health problems and other major barriers to learning and teaching interfere with schools meeting their mission. Recognition of and efforts to deal with such concerns have led to a variety of school-owned services and programs and to initiatives for school–community collaborations.

School-Owned Programs

Looked at as a whole, one finds in many school districts an extensive range of preventive and corrective activity oriented to students' needs and problems. Some programs are provided through-

This article was prepared in conjunction with work done by the Center for Mental Health in Schools at UCLA which is partially supported by funds from the U.S. Department of Health and Human Services, Public Health Services, Health Resources and Services Administration, Bureau of Maternal and Child Health, Office of Adolescent Health.

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out a school district, 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, to those identified as "at risk," and/or to those in need of compensatory education. The activities may be implemented in regular or special-education classrooms and may be geared to an entire class, groups, or individuals; they also may be designed as "pull-out" programs for designated students. They encompass ecological, curricular, and clinically oriented activities designed to reduce substance abuse, violence, teen pregnancy, and so forth.

It is common knowledge, however, that few schools come close to having enough resources to respond when confronted with a large number of students who are experiencing a wide range of psychosocial barriers that interfere with their learning and performance. Most schools offer only bare essentials. Too many schools can't even meet basic needs. Primary prevention often is only a dream. The simple fact is that education support activity is *marginalized* at most schools, and thus the positive impact such activity could have for the entire school is sharply curtailed.

While schools can use a wide range of persons to help students, most school-owned and operated services are offered as part of pupil-personnel services. Federal and state mandates tend to determine how many pupil-service professionals are employed, and states regulate compliance with mandates. Governance of daily practice usually is centralized at the school district level. In large districts, counselors, psychologists, social workers, and other specialists may be organized into separate units. Such units straddle regular, special, and compensatory education. Analyses of the situation find that the result is programs and services that are planned, implemented, and evaluated in a fragmented and piece-meal manner. Service staff at schools tend to function in relative isolation of each other and other stakeholders, with a great deal of the work oriented to discrete problems and with an over-reliance on specialized services for individuals and small groups. In some schools, a student identified as at risk for grade retention, dropout, and substance abuse may be assigned to three counseling programs operating independently of each other. Such fragmentation not only is costly, but also works against cohesiveness and maximizing results.

School–Community Collaborations

Recent years have seen an increasing interest in school–community collaborations as one way to provide more support for schools, students, and families. The interest is bolstered by a renewed policy concern about countering wide-spread fragmentation of community health and social services and by various initiatives for school reform, youth development, and community development. Various forms of school–community collaborations are being tested, including statewide initiatives in California, Florida, Kentucky, Missouri, New Jersey, Oregon, and Washington among others. This movement has fostered such concepts as *school-linked services, coordinated services, wrap-around services, one-stop shopping, full-service schools, and community schools*. The growing youth-development movement adds concepts such as *promoting protective factors, asset building, wellness, and empowerment*.

Not surprisingly, early findings primarily indicate how hard it is to establish collaborations. Still, a reasonable inference from available data is that school–community collaborations can be successful and cost effective over the long run. By placing staff at schools, community agencies make access easier for students and families—especially those who usually are under served and hard to reach. Such efforts not only provide services, but they seem to encourage schools to open their doors in ways that enhance recreational, enrichment, and remedial opportunities and greater family involvement. Analyses of these programs suggest better outcomes are associated with empowering children and families, as well as with having the capability to address diverse constituencies and contexts. Families using school-based centers become interested in contributing to school and commu-

nity 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. It is evident that school–community collaborations have great potential for enhancing school and community environments and outcomes.

Marginalization and Fragmentation Are Still the Norm

Policy makers have come to appreciate the relationship between limited intervention efficacy and the widespread tendency for complementary programs to operate in isolation. Limited efficacy does seem inevitable as long as interventions are carried out in a piece-meal fashion and with little follow through. From this perspective, reformers have directed initiatives toward reducing service fragmentation and increasing access to health and social services.

The call for "integrated services" clearly is motivated by a desire to reduce redundancy, waste, and ineffectiveness resulting from fragmentation (Adler & Gardner, 1994). Special attention is given to the many piece-meal, categorically funded approaches, such as those created to reduce learning and behavior problems, substance abuse, violence, school dropouts, delinquency, and teen pregnancy. By focusing primarily on the above matters, policy makers fail to deal with the overriding issue, namely that addressing barriers to development and learning remains a marginalized aspect of policy and practice. Fragmentation stems from the marginalization, but concern about such marginalization is not even on the radar screen of most policy makers.

Despite the emphasis on enhancing collaboration, the problem remains that the majority of programs, services, and special projects designed to address barriers to student learning still are viewed as supplementary (often referred to as support or auxiliary services) and continue to operate on an ad hoc basis. The degree to which marginalization is the case is seen in the lack of attention given such activity in consolidated plans and certification reviews and the lack of efforts to map, analyze, and rethink how resources are allocated. Educational reform virtually has ignored the need to reform and restructure the work of school professionals who carry out psychosocial and health programs. As long as this remains the case, reforms to reduce fragmentation and increase access are seriously hampered. More to the point, the desired impact for large numbers of children and adolescents will not be achieved.

At most schools, community involvement also is a marginal concern, and the trend toward fragmentation is compounded by most school-linked services' initiatives. This happens because such initiatives focus primarily on coordinating *community* services and *linking* them to schools, with an emphasis on *co-locating* rather than integrating such services with the ongoing efforts of school staff. In short, policies shaping current agendas for school and community reforms are seriously flawed. Although fragmentation and access are significant concerns, marginalization is of greater concern. It is unlikely that the problems of fragmentation and access will be resolved appropriately in the absence of concerted attention in policy and practice to ending the marginalized status of efforts to address factors interfering with development, learning, parenting, and teaching.

Reshaping the Future: Building on Emerging Themes

Despite their flaws, existing reform initiatives represent attempts to improve on an unsatisfactory status quo. Their deficiencies are stimulating ideas for new directions that reflect fundamental shifts in thinking about mental health in schools and about the personnel who provide such services. Three major themes have emerged so far: (a) the move *from* fragmentation *to* cohesive intervention, (2) the move *from* narrowly focused, problem-specific, and specialist- oriented services *to* comprehensive general programmatic approaches, and (3) the move toward research-based interventions, with higher standards and ongoing accountability emphasized.

Toward Cohesiveness

As already noted, 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. Available evidence suggests this produces fragmentation that, in turn, results in waste and limited efficacy. National, state, and local initiatives to increase coordination and integration of community services are just beginning to direct school policy makers to a closer look at school-owned services (Adler & Gardner, 1994; California Department of Education, 1997; Central Oahu District, 1999; Los Angeles Unified School District, 1995; Memphis City Schools, 1999; Urban Learning Center, 1995). This is leading to new strategies for coordinating, integrating, and re-deploying resources.

Toward Comprehensiveness

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 address better the needs of those served and to serve greater numbers. 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 for meeting such needs. One response to all this is the growing movement to create comprehensive school-based centers. More broadly, to counter what some describe as "hardening of the categories," there are trends 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 collaboration programs. Such initiatives are intended to increase the use of generalist strategies in addressing the common factors underlying many student problems. The aim also is to encourage less emphasis on who owns the program and more attention to accomplishing desired outcomes (see Adelman & Taylor, 1994, 1998; Dryfoos, 1998; Schorr, 1997; Young, Gardner, Coley, Schorr, & Bruner, 1994).

Research-Based Interventions

Increasing demands for accountability are blending with the desire of scholars to improve the state of the art related to mental-health interventions. Various terms are used, including research-based, empirically supported, and empirically validated. An extensive literature reports positive outcomes for psychological interventions available to schools. However, the reality of the restricted range of dependent variables (e.g., short-term improvement on small, discrete tasks), limited generalization, and uncertain maintenance of outcomes temper enthusiasm about positive findings. With respect to individual treatments, most positive evidence comes from work done in tightly structured research situations (e.g., "hot house" environments); unfortunately, comparable results are not found when prototype treatments are institutionalized in school and clinic settings. (See Weisz, Donenberg, Han, & Kauneckis, 1995, for discussion of this matter specifically focused on psychotherapy; see Gitlin, 1996, for a comparable discussion related to psychopharmacology.) Similarly, most findings on classroom and small group programs reflect short-term experimental studies (usually without any follow-up phase). It remains an unanswered question as to whether the results of such projects will be sustained when prototypes are translated into widespread applications. And the evidence clearly is insufficient to support any policy restricting schools in the use of empirically supported interventions. Still, there is a menu of promising practices with benefits not only for schools (e.g., better stu-

dent functioning, increased attendance, and less teacher frustration), but also for society (e.g., reduced costs related to welfare, unemployment, and use of emergency and adult services). The state of the art is promising; the search for better practices remains a necessity.

Expanding Merging Themes to Counter Marginalization

For mental health in schools to play a significant role in the lives of children and their families, policy and practice must undergo a radical transformation. The keys to ending the marginalized status of efforts to address barriers to learning involve expanding the theme of comprehensiveness and expanding school-reform initiatives to fully integrate "education-supported activity."

Expanding the theme of comprehensiveness. A major breakthrough in the battle against learning, behavior, and emotional problems probably can be achieved only when a full range of programs is implemented. Developing comprehensive approaches requires *more than* specific prevention and early intervention programs, *more than* outreach to link with community resources (and certainly more than adopting a school-linked services model), *more than* coordinating school-owned services, *more than* coordinating school services with community services, and *more than* creating Family Resource Centers, Full-Service Schools, and Community Schools. None of these constitute school- or community-wide approaches, and the growing consensus is that comprehensive, multifaceted, and integrated approaches are essential in addressing the complex concerns confronting schools, families, and neighborhoods.

With respect to designing a comprehensive, integrated approach, the intent is to develop and 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 point to 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 over 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.

Figure 1 illustrates the type of school–community continuum that seems essential. The outlined examples highlight that a comprehensive approach is built with a holistic and developmental emphasis. Such an approach requires a significant range of programs focused on individuals, families, and environments and encompasses peer and self-help strategies. 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 are essential on a daily basis and over time. From our perspective, a high level of policy emphasis on developing a comprehensive, multifaceted continuum is the key not only to unifying fragmented activity, but also to using all available resources in the most productive manner.

Expanding school reform. Because no comprehensive approach can be established without weaving together school and community resources, it is essential to develop models and policies that expand the nature and scope of school reform. Indeed, it is time for a basic policy shift. In this regard, we have proposed that policy makers move from the inadequate two-component model that dominates school reform to a three-component framework (see, for example, Adelman & Taylor,

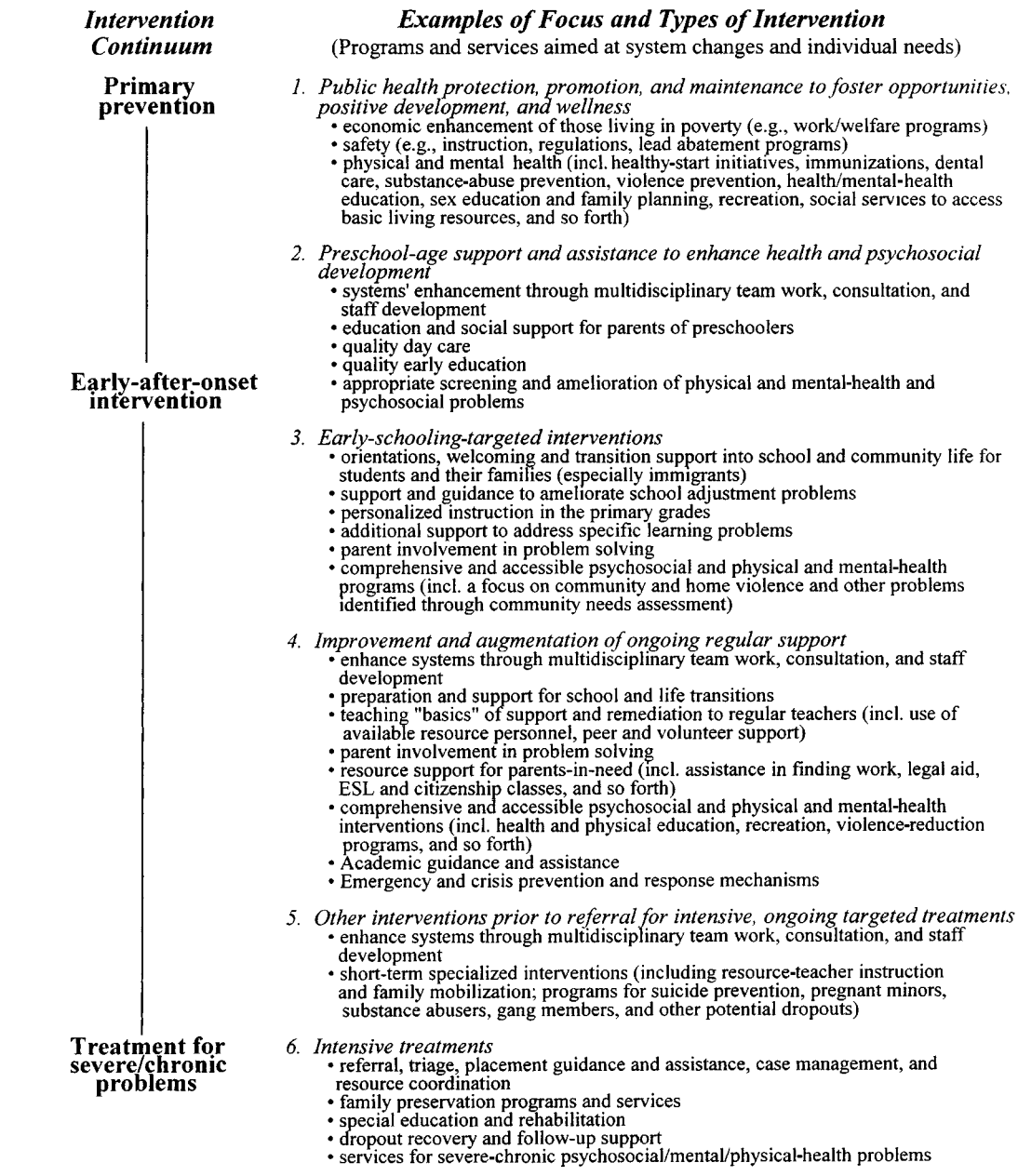
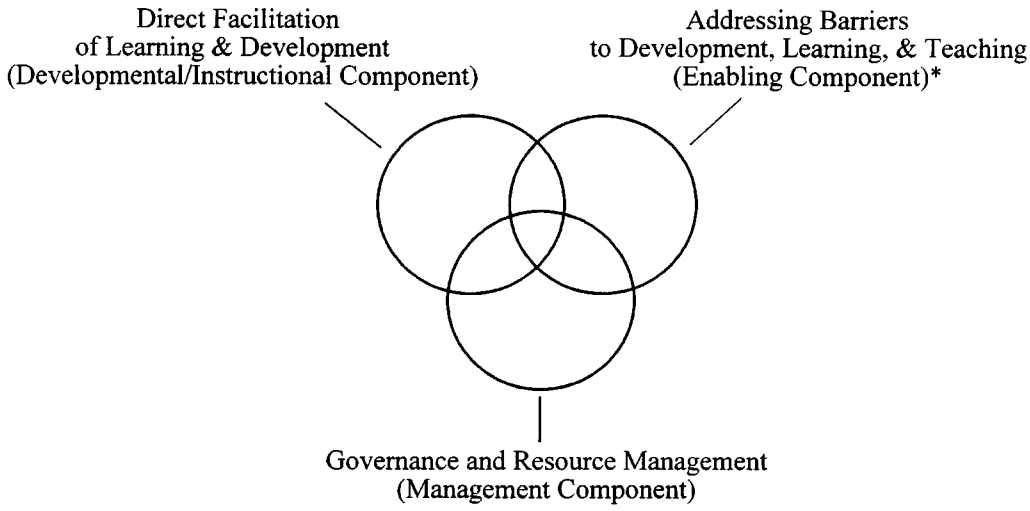


FIGURE 1. From primary prevention to treatment of serious problems: A continuum of community–school programs to address barriers to learning and enhance healthy development.



*Moving from a two-to a three-component model for school reform and restructuring calls for establishing a component for addressing barriers to learning and development. Such a component is treated as primary and essential and is developed into a comprehensive continuum of interventions by weaving together school and community resources.

Adapted from: Adelman & Taylor (1998)

FIGURE 2. A three-component model for reform and restructuring.

1994, 1998; Center for Mental Health in Schools, 1998). The continued failure of current models for school reform suggests that better achievement surely requires more than good instruction and well-managed schools (Tyack & Cuban, 1995).

As highlighted in Figure 2, a three-component model not only emphasizes a focus on reforming instruction and how schools are governed/managed, but that such a model calls for a component that comprehensively enables learning by addressing barriers to learning, development, and teaching. Moreover, it views such a component as a fundamental and essential facet of educational reform and thus calls for elevating efforts for addressing barriers to a high level of policy focus. When policy and practice are viewed through the lens of this third component, it becomes evident how much is missing in current efforts to enable all students to learn and develop.

The concept of an enabling component was formulated to encompass such a third component (see references cited above). It provides a basis for combating marginalization and a focal point for developing a comprehensive framework for policy and practice. It also can help address fragmentation by providing a unifying term for disparate approaches to preventing and ameliorating psychosocial problems and promoting wellness. The usefulness of the concept of an enabling component as a broad unifying focal point for policy and practice is evidenced in its adoption by the California Department of Education (whose version is called *Learning Supports*) and by one of the New American School's design teams (i.e., Urban Learning Center). It also is attracting attention in various states and localities around the country (e.g., Memphis, Oahu).

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, and doing so in ways that fully integrate the enabling, instructional, and management components. In the process, mechanisms must be developed to coordinate and eventually integrate school-owned enabling activity with community-owned resources (e.g., formally connecting school programs with assets at home, in the business and faith communities, and neighborhood enrichment, recreation, and service resources).

Analyses suggest that existing student-support services and programs cluster rather naturally into six general functional areas and that schools can build an enabling component by developing programs in these six areas (e.g., see Adelman & Taylor, 1998). The six interrelated areas encompass interventions to (1) enhance classroom-based efforts to enable learning, (2) provide prescribed student and family assistance, (3) respond to and prevent crises, (4) support transitions, (5) increase home involvement in schooling, and (6) outreach to develop greater community involvement and support—including recruitment of volunteers. Work carried out in the context of school reform indicates that delineating these six areas for schools can foster comprehensive, multifaceted approaches that encompass school–community partnerships (Urban Learning Center, 1995).

At schools where existing interventions have been 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 basis for making priority decisions regarding redesigning interventions and enhancing outcome efficacy (Lim & Adelman, 1997; Rosenblum, DiCecco, Taylor, & Adelman, 1995).

What Might the Future Look Like? How Can Pupil-Service Professionals Shape It?

Our analyses envision schools and communities weaving together their resources to develop a comprehensive continuum of programs and services designed to address barriers to development, learning, parenting, and teaching. From a decentralized perspective, the primary focus in designing such an approach is on systemic changes at the school and neighborhood level. Then, based on understanding what is needed to facilitate and enhance local efforts, changes must be made for families of schools and wider communities. Finally, with clarity about what is needed to facilitate school and community-based efforts and school–community partnerships, appropriate centralized restructuring can be pursued.

Whether or not what we envision turns out to be the case, school psychologists and other pupil-service personnel must be proactive in shaping their future. In doing so, they must understand and take advantage of the windows of opportunity that currently are open as a result of major reform initiatives and the rapid advances in technology. We also think they need to adopt an expanded vision of mental health in schools. Politically, they must integrate themselves fully into school reform at all levels and especially at the school site, as decentralization makes local decision making the norm.

Windows of Opportunity Stemming from Reform Initiatives and Advanced Technology

There are presently several windows of opportunity for taking a leadership role in shaping the future. Among the most prominent are the major initiatives to reform schools and welfare and health services. Each reform initiative is shifting the ways in which children and their families interface with school and community. For example, among other things, school reform is eliminating social promotion, introducing zero-tolerance policies, and calling for inclusion of exceptional children in

regular programs. If such changes are to benefit the targeted students, current implementation strategies must be overhauled thoroughly, and well-designed interventions for prevention and early-after-onset correction of problems are essential. To these ends, pupil-service personnel must find their way to leadership tables so that effective system-wide changes are designed and implemented.

Similar opportunities arise around welfare reform. As the pool of working parents is increased, there is an expanding need for quality day care and preschool programs and programs to fill non-school hours for all youngsters. Health reforms also are beginning to stimulate renewed interest in primary and secondary prevention. As local schools and neighborhoods wrestle with the implications of all this, the result can be more fragmented and marginalized programs, or steps can be taken to weave changes into the fabric of a comprehensive approach for addressing barriers to development and learning. Pupil-service professionals have not, as yet, emerged as key participants in these arenas, but the opportunity for assuming a leadership role is there.

Another window of opportunity comes from the rapid expansion of technological applications. Although schools are just beginning to incorporate the many advances, technology, in the next few years, will provide major avenues for improving the way pupil-service personnel function. Now is the time to take the lead in planning how technology will be used in working with clients and in building capacity for more effective, less costly interventions. Tools already are available for empowering client self-help and self-sufficiency. Improved computer programs are emerging that systematically support many intervention activities (including assessment and management of care), and the internet offers amazing ways to increase access to information and resources, enhance collaborative efforts including consultation and networking, provide personalized continuing education, and distance learning, and on and on.

New Mechanisms

Fundamental policy and practice changes carry with them calls for restructuring systemic mechanisms and personnel roles and functions at schools, central offices, and school boards. With specific respect to improving how problems are prevented and ameliorated, all support staff need to lead the way in establishing well-redesigned organizational and operational mechanisms that can provide the means for schools to: (a) arrive at wise decisions about resource allocation; (b) maximize systematic and integrated planning, implementation, maintenance, and evaluation of enabling activity; (c) outreach to create formal working relationships with community resources to bring some to a school and establish special linkages with others; and (d) upgrade and modernize interventions to reflect the best models and use of technology. Implied in all this are new roles and functions for some staff and greater involvement of parents, students, and other representatives from the community. Also implied is redeployment of existing resources, as well as finding new ones. A few examples of related reforms we are pursuing in our work are offered below to highlight these matters. For a more detailed discussion, see the references cited.

Resource-oriented teams at schools, complexes, and system-wide. Many schools currently do not have mechanisms focused specifically on how to prevent and ameliorate barriers to learning and teaching. No administrator or team has responsibility for mapping existing efforts, analyzing how well resources are being used to meet needs, and planning how to enhance such efforts. An example of mechanisms designed for these purposes is seen in work related to building a resource-coordinating team into the structure of every school, creating a resource-coordinating council for a complex or "family" of schools, and creating a system-wide steering body (Adelman, 1993; Adelman & Taylor, 1998; Rosenblum et al., 1995).

A resource-oriented team differs from those created to review students (such as a student-study or success team, a teacher-assistance team, and a case-management team). That is, its focus is not on

specific cases but on clarifying resources and their best use. However, where creation of "another team" is seen as a burden, existing case-oriented teams can be asked to broaden their scope. Of course, in doing so, they must take great care to structure their agenda so that sufficient time is devoted to the additional tasks.

A resource-oriented team provides what often is a missing mechanism for managing and enhancing *systems* to coordinate, integrate, and strengthen interventions. For example, at a school site, a resource-coordinating team can be assigned responsibility for (a) identifying and analyzing activity and resources with a view to improving the school's efforts to prevent and ameliorate problems, (b) ensuring there are effective systems for pre-referral interventions, referral, case management, and quality assurance, (c) guaranteeing appropriate procedures for effective management of programs and for communication among school staff and with the home, and (d) exploring ways to redeploy and enhance resources—such as clarifying which activities are nonproductive and suggesting better uses for the resources, as well as reaching out to connect with additional resources in the school district and community.

Creation of resource-oriented teams provides essential mechanisms for starting to weave together existing school and community resources and encourage services and programs to function in an increasingly cohesive way. Such teams also are vehicles for building working relationships and can play a role in solving turf and operational problems, developing plans to ensure availability of a coordinated set of efforts, and generally improving the attention paid to developing a comprehensive, integrated approach for addressing barriers to student learning.

One of the primary and essential tasks a resource-oriented team undertakes is that of enumerating school and community programs and services that are in place to support students, families, and staff. A comprehensive form of "needs assessment" is generated as resource mapping is paired with surveys of the unmet needs of students, their families, and school staff. Analyses of what is available, effective, and needed provides a sound basis for formulating strategies to link with additional resources at other schools, district sites, and in the community and enhance use of existing resources. Such analyses also can guide efforts to improve cost effectiveness. In a similar fashion, a resource-oriented team for a complex or family of schools (e.g., a high school and its feeders) provides a mechanism for analyses that can lead to strategies for cross-school and community-wide cooperation and integration to enhance intervention effectiveness and garner economies of scale.

Although a resource-oriented team might be created solely around psychosocial programs, such a mechanism is meant to bring together representatives of all major programs and services supporting the instructional component. This includes, for example, guidance counselors, school psychologists, nurses, social workers, attendance and dropout counselors, health educators, special-education staff, after-school-program staff, bilingual- and Title I-program coordinators, health educators, and safe and drug-free school staff. It also includes representatives of any community agency that is significantly involved with schools. Beyond these "service" providers, such a team is well advised to add the energies and expertise of administrators, regular classroom teachers, non-certificated staff, parents, and older students.

School-site and central-office leadership. School and multisite resource-oriented teams are not sufficient; site- and system-wide policy guidance, leadership, and assistance are required. For example, it is unlikely that a school can create, institutionalize, and foster ongoing renewal of a comprehensive approach to addressing barriers to learning without someone who has the formal responsibility, time, and competence to lead the way and who sits at the administrative decision making table.

At the central-office level, leadership must focus on supporting school- and cluster-level activity. That is, such leadership must ensure that system-wide resources truly are designed to support the

work of school sites in the most effective and efficient ways. This role requires much more than distributing a "fair" share to everyone. It encompasses capacity-building strategies that facilitate school-site development of comprehensive approaches for preventing and ameliorating problems, including creating readiness for systemic change, leadership training, stake-holder development, and capitalizing on commonalities across sites to achieve economies of scale. Central district offices generally have not attended to establishing a cohesive infrastructure for supporting school-based efforts to develop and enhance comprehensive approaches. Many have quite independent units focused on related matters (e.g., school psychology, counseling, nursing, social work, special and compensatory education, school safety, and health education). There often is no overall administrative leader, such as an associate superintendent, who has the time and expertise to weave the parts together and ensure they are used effectively to support what must go on in each school. Such a leader is needed to (a) evolve the district-wide vision and strategic planning for preventing and ameliorating problems, (b) ensure coordination and integration of enabling activity among groups of schools and system wide, (c) establish linkages and integrated collaboration among system-wide programs and with those operated by community, city, and county agencies, and (d) ensure integration with instructional and management components. This leader's functions also encompass evaluation, including determination of the equity of various efforts, quality improvement reviews of all mechanisms and procedures, and, of course, ascertaining how well outcomes are achieved.

School-board committee on addressing barriers to learning. As a policy report from the Center for Mental Health in Schools (1998) notes, most school boards do not have a standing committee that gives full attention to the problem of how schools address barriers to learning and teaching. This is not to suggest that boards are ignoring such matters. Indeed, items related to these concerns appear regularly on every school board's agenda. The problem is that each item tends to be handled in an ad hoc manner without sufficient attention to the "Big Picture." Given this, it is not surprising that the administrative structure in most districts is not organized in ways that coalesce various functions for preventing and ameliorating student problems. The piece-meal structure reflects the marginalized status of such functions, and both create and maintain fragmented policies and practices. Given that every school endeavors to address barriers to learning and teaching, school boards should analyze carefully the way they deal with these functions and consider whether they need to restructure themselves to enhance cohesion of policy and practice.

The above examples are only a few illustrations of arenas in which support-service personnel could play leadership roles. The need for change is evident, so is the pressure and opportunities for pursuing systemic reforms. Equally obvious is the fact that making fundamental changes is not a task for the timid.

Concluding Comments

Over the next decade, initiatives to restructure education, community health, and human services will reshape the work of all pupil-service professionals. Although some current roles and functions will continue, many will disappear, and others will emerge. Opportunities will arise not only to provide direct assistance, but also to play increasing roles as advocates, catalysts, brokers, and facilitators of reform and to provide various forms of consultation and in-service training. It also should be emphasized that these additional duties include participation on school and district governance, planning, and evaluation bodies. All who work to address barriers to student learning must participate in capacity-building activity that allows them to carry out effectively new roles and functions.

The new millennium will mark a turning point for how schools and communities address the problems of children and youth. Currently being determined is: In what direction should we go? And

who should decide this? If you are not yet shaping the answers to these questions, it is time to find a place at the relevant tables.

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

Adelman, H.S., & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. Educational Psychologist, 33, 135–152.

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

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

Center for Mental Health in Schools. (l998). Restructuring Boards of Education to enhance schools' effectiveness in addressing barriers to student learning. Los Angeles: Author.

Central Oahu District. (1999). Building resilience for learning: Central Oahu District's school-based comprehensive student support system. Oahu: Author.

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

Gitlin, M.J. (1996). The psychotherapist's guide to psychopharmacology (2nd ed.) New York: The Free Press.

Jenkins, J.R., Pious, C.G., & Peterson, D.L. (1988). Categorical programs for remedial and handicapped students: Issues of validity. Exceptional Children, 55, 147–158.

Kahn, A., & Kamerman, S. (1992). Integrating service integration: An overview of initiatives, issues, and possibilities. New York: National Center for Children in Poverty.

Lim, C., & Adelman, H.S. (1997). Establishing school-based collaborative teams to coordinate resources: A case study. Social Work in Education, 19, 266–277.

Los Angeles Unified School District. (1995). Plan for restructuring student health and human services. Los Angeles: Author.

Memphis City Schools. (1999). Draft plan from implementation of the Enabling Component. Memphis, TN: 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.

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

Slavin, R., Madden, N., Karweit, N., Dolan, L., Wasik, B., Shaw, A., Mainzer, K., & Huxby, B. (1991). Neverstreaming: Prevention and early intervention as an alternative to special education. Journal of Learning Disabilities, 24, 373–378.

Tyack, D., & Cuban, L. (1995). Tinkering toward Utopia: A century of public school reform. Cambridge, MA: Harvard University Press.

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

Weisz, J.R., Donenberg, G.R., Han, S.S., & Kauneckis, D. (1995). Child and adolescent psychotherapy outcomes in experiments versus clinics: Why the disparity? Journal of Abnormal and Clinical Psychology, 23, 83–106.

Young, N., Gardner, S., Coley, S., Schorr, L., & Bruner, C. (1994). Making a difference: Moving to outcome-based accountability for comprehensive services. Falls Church, VA: National Center for Service Integration.