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# MENTAL HEALTH IN SCHOOLS AND SYSTEM RESTRUCTURING

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**ABSTRACT.** *Because health is not the primary business of schools, a school's response to mental health and psychosocial concerns usually is limited to targeted problems seen as direct barriers to learning. And because resources are sparse, priority is given to problems defined in legislative mandates. As a result, school-based mental health services are available only to a small proportion of the many students who require assistance, and interventions generally are narrowly focused and short-term. To better meet the needs of those served and to serve greater numbers, emerging trends are pushing for restructuring of school-owned services and greater linkage with community resources to develop multifaceted, comprehensive, integrated approaches. This review (a) provides an overview of what schools currently do related to mental health and psychosocial concerns, (b) clarifies key emerging trends, and (c) explores implications for major systemic changes. © 1999 Elsevier Science Ltd*

WHILE PARTICIPATION OF clinical psychologists in schools is not extensive, the discipline of clinical psychology and the field of mental health have much to contribute to the success of schools. In addition, schools provide invaluable access to students and families in need of mental health services. Schools also offer unique opportunities for intensive, multifaceted approaches and are essential contexts for prevention and research activity. Over the years, schools have benefitted greatly from the work of exceptional leaders whose roots are in clinical psychology (e.g., Emory Cowen, Seymour Sarason, Ed Zigler). Renewed interest in school-based and school-linked mental health and psychosocial programs is seen in early intervention, various forms of counseling, crisis intervention, problem prevention, and promotion of health and social and emotional development (see Adelman & Taylor, 1993a; Comer, 1988; Day & Rob-

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erts, 1991; Goodwin, Goodwin, & Cantrill, 1988; Henggeler, 1995; Knitzer, Steinberg, & Fleisch, 1990; Sitwell, DeMers, & Niguette, 1985; Taylor & Adelman, 1996; Weist, 1997). Currently, most schools have at least a few programs and services that are highly relevant to mental health research and practice.

Why 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 (Duchnowski, 1994). In addition, school administrators, board members, teachers, parents, and students have long recognized that social, emotional, and physical health problems and other major barriers to learning must be addressed so that schools function satisfactorily and students learn and perform effectively (see Carlson, Paavola, & Talley, 1995; Dryfoos, 1994, 1998; Flaherty, Weist, & Warner, 1996; Tyack, 1992). This has led to a variety of student "support" services, including some designed to reach out to underserved and hard-to-reach individuals.

Our purpose here is to (a) provide an overview of what schools currently do related to mental health and psychosocial concerns, (b) clarify some emerging trends, and (c) explore implications for major systemic changes—implied throughout are roles for clinical psychology.

## HOW DO SCHOOLS ADDRESS MENTAL HEALTH?

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

Table 1 highlights the types of problems, as well as areas related to healthy development, that arise in the context of schools. Efforts to deal with these concerns have led to establishment of various school-owned services and programs and to initiatives for school-community collaborations.

An extensive literature reports positive outcomes for psychological interventions available to schools.[1] However, enthusiasm about positive findings is tempered by 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. With respect to individual treatments, most positive evidence comes from work done in tightly structured research situations; unfortunately, comparable results are

[1]Examples of the literature reporting positive outcomes include: Adelman & Taylor, 1993b; Albee & Gullotta, 1997; Anglin, Naylor, & Kaplan, 1996; Bond & Compas, 1989; Borders & Drury, 1992; Carnegie Council on Adolescent Development, 1988; Christopher, Kurtz, & Howing, 1989; Dryfoos, 1990, 1994, 1998; Duchnowski, 1994; Durlak, 1995; Duttweiler, 1995; Goleman, 1995; Hickey, Lockwood, Payzant, & Wenrich, 1990; Holtzman, 1992; Kazdin, 1993; Kirby et al., 1994; Knoff & Batsche, 1995; Larson, 1994; Mitchell, Seligson, & Marx, 1989; Price, Cowen, Lorion, Ramos-McKay, & Hutchins, 1988; Schorr, 1988, 1997; Slavin, Karweit, & Madden, 1989; Slavin, Karweit, & Wasik, 1994; Thomas & Grimes, 1995; U.S. Department of Health and Human Services, 1994; Weissberg, Caplan, & Harwood, 1991; Weissberg, Gullotta, Hamptom, Ryan, & Adams, 1997; Weisz & Weiss, 1993; Zigler, Kagan, & Hall, 1996.

**TABLE 1. Barriers to Learning and Areas for Enhancing Healthy Development**

## I. Barriers to Learning/Parenting/Teaching (beyond medical/dental needs)

*A. Deficiencies in basic living resources and opportunities for development*
- dearth of food in the home
- inadequate clothing
- substandard housing (incl. being homeless)
- lack of transportation
- income at or below the poverty level (e.g., due to unemployment or welfare status)
- lack of after-school supervision for child
- immigration-related concerns (e.g., limited English Proficiency, legal status)

*B. Observable problems*
- school adjustment problems (incl. prevention of truancy, pregnancy, and dropouts)
- relationship difficulties (incl. dysfunctional family situations, insensitivity to others)
- language difficulties
- abuse by others (physical and sexual)
- substance abuse
- emotional upset
- delinquency (incl. gang-related problems and community violence)
- psychosocial concerns stemming from sexual activity (e.g., prevention of and reactions to pregnancy or STDs)
- psychopathology

*C. General stressors and underlying psychological problems associated with*
- external stressors (objective and perceived) and deficits in support systems
- competence deficits (low self-efficacy/self-esteem, skill deficits)
- threats to self-determination/autonomy/control
- feeling unrelated to others or perceiving threats to valued relationships
- personality disorders or psychopathology

*D. Crises and emergencies*
- personal/familial (incl. home violence)
- subgroup (e.g., death of a classmate or close colleague)
- school-wide (e.g., earthquake, floods, shooting on campus)

*E. Difficult transitions*
- associated with stages of schooling (e.g., entry, leaving)
- associated with stages of life (e.g., puberty, job and career concerns)
- associated with changes in life circumstances (e.g., moving, death in the family)

## II. Areas of Focus in Enhancing Healthy Psychosocial Development

*A. Responsibility and integrity*
(e.g., understanding and valuing of societal expectations and moral courses of action)

*B. Self-esteem*
(e.g., feelings of competence, self-determination, and being connected to others)

*C. Social and working relationships*
(e.g., social awareness, empathy, respect, communication, interpersonal cooperation and problem solving, critical thinking, judgement, and decision making)

*D. Self-evaluation and self direction/regulation*
(e.g., understanding of self and impact on others, development of personal goals, initiative, and functional autonomy)

*E. Temperament*
(e.g., emotional stability and responsiveness)

*F. Personal safety and safe behavior*
(e.g., understanding and valuing of ways to maintain safety, avoid violence, resist drug abuse, and prevent sexual abuse)

*G. Health maintenance*
(e.g., understanding and valuing of ways to maintain physical and mental health)

*H. Effective physical functioning*
(e.g., understanding and valuing of how to develop and maintain physical fitness)

*I. Careers and life roles*
(e.g., awareness of vocational options, changing nature of sex roles, stress management)

*J. Talents and creativity*
(e.g., artistic and intellectual inventiveness)

not found when prototype treatments are institutionalized in school and clinic settings (see Weisz, Donenberg, Han, & Kauneckis, 1995, and Weisz, Donenberg, Han, & Weiss, 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 (see Adelman & Taylor, 1997a; Elias, 1997). And the evidence clearly is insufficient to support any policy restricting schools to use of empirically supported interventions. Still, there is a menu of promising practices, with benefits not only for schools (e.g., better student functioning, increased attendance, and less teacher frustration), but 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.

### *Interveners and Their Functions*

In schools, efforts to address barriers to learning and enhance healthy development are not the sole province of professionals/specialists. Professionals trained to provide mental health interventions play special roles with respect to preventing and correcting problems and enhancing the well-being of students, families, and school staff. But family members, students, nonprofessional school staff, and many individuals and groups in a community also can help address the concerns outlined in Table 1. Table 2 lists types of interveners and specific functions related to meeting psychosocial and mental health needs found in schools.

***Interveners.*** As noted in Table 2, the range of persons who may carry out functions related to mental health activity in schools encompasses all who are hired by a school, as well as students, family members, community agency personnel, volunteers, and others. With respect to school specialists, there is no typical pattern of staffing. In most states, elementary schools may only receive support 1 day a week from a couple of professionals, such as a school counselor, nurse, psychologist, or social worker. Middle and high schools usually are assigned support for more days and from diverse practitioners. Schools with funding for compensatory interventions, special education, and other categorical programs can afford more services. Additional resources also are available at the small number of schools where health clinics, service centers, or school-community collaborations have been established.

Taken as a whole, one finds in schools an extensive range of preventive and corrective activity oriented to student's problems. Some programs are provided throughout 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, or to those identified as "at risk," and may be designed for delivery to entire classes, small groups, or individuals. Activities may be implemented in regular or special education classrooms or as programs that pull students out of class for part of a period or day to work on designated problems. 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 for seriously emotionally disturbed youngsters. 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 problems—nevermind mounting a potent approach to address the wider range of psychosocial barriers interfering with the learning and performance of so many. Various types of personnel and forms of intervention simply are not available to students. Most schools offer only bare essentials. Too many schools cannot even meet basic needs. Primary prevention often is only a dream.

**TABLE 2. Types of Interveners and Functions**

***I. Interveners Who May Play Primary or Secondary Roles in Carrying Out Functions Relevant to Mental Health and Psychosocial Concerns***

**Instructional Professionals**
(e.g., regular classroom teachers, special education staff, health educators, classroom resource staff, and consultants)

**Administrative Staff**
(e.g., principals, assistant principals, deans)

**Health Office Professionals**
(e.g., nurses, physicians, health educators, consultants)

**Counseling, Psychological, and Social Work Professionals**
(e.g., counselors, health educators, psychologists, psychiatrists, psychiatric nurses, social workers, consultants)

**Itinerant Therapists**
(e.g., art, dance, music, occupational, physical, speech-language-hearing, and recreation therapists; psychodramatists)

**Personnel-In-Training**

**Others**
- Aides
- Classified staff (e.g., clerical and cafeteria staff, custodians, bus drivers)
- Paraprofessionals
- Peers (e.g., peer/cross-age counselors and tutors, mutual support and self-help groups)
- Recreation personnel
- Volunteers (professional/paraprofessional/nonprofessional -- including parents)

***II. Functions Related to Addressing Mental Health and Psychosocial Needs at the School and District Level***

**Direct Services and Instruction**
(based on prevailing standards of practice and informed by research)
- 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 (incl. secondary prevention)
- Accomodations to allow for differences and disabilities
- Transition and follow-up (e.g., orientations, social support for newcomers, follow-thru)
- 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)
- Multidisciplinary teamwork, consultation, training, and supervision to increase the amount of direct service impact

**Coordination, Development, and Leadership Related to Programs, Services, Resources, and Systems**
- Needs assessment, gatekeeping, referral, triage, and case monitoring/management (e.g., participating on student study/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 (incl. 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

Most school-owned and operated services are offered as part of what are called pupil personnel services. Federal and state mandates tend to determine how many pupil services professionals are employed, and states regulate compliance with mandates. Governance of daily practice usually is centralized at the school district level, often un-

der a director or assistant superintendent. In large districts, counselors, psychologists, social workers, and other specialists may be organized into separate units. Such units straddle regular and special education. 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 professionals are governed and how they are 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 of such personnel there are at a school (Hill & Bonan, 1991; Streeter & Franklin, 1993).

Currently, schools employ or contract with relatively few mental health practitioners. Based on a sample of 482 districts of varying sizes in 45 states, recent survey data indicate that 55% report having counselors; 40.5% have psychologists; 21% have social workers; and 2.1% have psychiatrists (Davis, Fryer, White, & Igoe, 1995). Another recent survey found that 84% of middle/junior high schools and 89% of high schools report providing individual counseling, and 61% of middle/junior high schools and 59% of high schools report that they provide some type of group counseling (Small et al., 1995). These figures are somewhat surprising in light of the estimated ratio of students to practitioners; for example, the ratio for school psychologists or school social workers averages 1 to 2500 students; for school counselors, the ratio is about 1 to 1000 (Carlson et al., 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 needed help (Knitzer et al., 1990).

***Functions.*** Specialists oriented to mental health and psychosocial concerns tend to focus on students who are seen as problems or as having problems. Prevailing approaches identify the needs of targeted individuals and prescribe one or more interventions. Activity encompasses direct interventions, brief consultation, and gatekeeping procedures (such as referral for assessment, corrective services, triage, and diagnosis). In some situations, however, resources are so limited that specialists do little more than offer brief consultations and make referrals to special education and/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; however, relatively few resources are allocated for such activity.

All the efforts are meant to contribute to a reduction in problem referrals for special assistance, an increase in the efficacy of mainstream and special education programs, and enhanced instruction and guidance that fosters healthy development. In addition, it should be noted that personnel dealing with mental health and psychosocial concerns may also play a role in facilitating program development and system reform, as well as helping enhance school-community collaborations.

Professionals with psychological training bring to schools an understanding of psychosocial, developmental, and cultural factors that facilitate or interfere with positive functioning. They also are expected to bring perspectives of intervention that emphasize attitude and motivation change, system strategies, use of "best fit" and "least intervention needed" approaches, and more (see Table 3). 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

**TABLE 3. Some Key Intervention Considerations Related to Personnel Working in Schools**

**Timing of interventions**

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

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

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

**Scope of interventions**

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

**Contexts for intervention**

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

**Some basic intervention guidelines**

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

Note: The important contribution of advanced technology is beginning to be appreciated but yet be realized.

dropout, substance abuse, gang activity, teen pregnancy, and depression). Such a range of expertise also is essential in working with the diversity of backgrounds and the wide range of individual and group differences found among students, their families, and school staff.

### *School-Community Collaborations*

Concern about the fragmented way *community* health and human services are planned and implemented has led to renewal of the 1960s human service integration move-

**TABLE 4. Key Dimensions Relevant to School-Community Collaborative Arrangements**

**I. Focus**

*A. Improvement of program and service provision*
- for enhancing case management
- for enhancing use of resources

*B. Major systemic reform*
- to enhance coordination
- for organizational restructuring
- for transforming system structure and function

**II. Scope of Collaboration**

*A. Number of programs and services involved*

*B. Horizontal collaboration*
- within a school/agency
- among schools/agencies

*C. Vertical collaboration*
- within a catchment area (e.g., school and community agency, family of schools, two or more agencies)
- among different levels of jurisdictions (e.g., community, city, county, state, federal)

**III. Ownership of Programs and Services**

*A. Owned by school*

*B. Owned by community*

*C. Shared ownership*

*D. Public-private*

**IV. Location of Programs and Services**

*A. School-linked*

*B. School-based*

**V. Degree of Cohesiveness among Multiple Interventions Serving the Same Student/Family**

*A. Unconnected*

*B. Communicating*

*C. Cooperating*

*D. Coordinated*

*E. Integrated*

ment (see annotated bibliography by Walsh, Chastenay-Simpson, Craigie, & Holmes, 1997). 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 relationships between school sites and public and private community agencies. As a result, a variety of forms of school-community collaborations are being tested, including statewide initiatives in California, Florida, Kentucky, Missouri, New Jersey, and Oregon (First, Curcio, & Young, 1994; Palaich, Whitney, & Paolino, 1991). Table 4 outlines key dimensions relevant to such collaborative arrangements.

***School-linked services.*** Initiatives to restructure community health and human services have fostered the concept of *school-linked services* and contributed to the burgeoning of school-based and linked health clinics (U.S. Department of Education, 1995). It should be noted that the terms school-*linked* and school-*based* encompass two separate dimensions: (1) where programs/services are *located* and (b) who *owns* them. Literally, school-based indicates activity carried out on a campus, and school-linked refers to off-campus activity with formal connections to a school site. In either case, services may be owned by a specific school, the school district at large, or a community-based organization or in some cases are co-owned. (It also should be noted, however, that the term *school-linked* is commonly used to denote only community owned on- and off-campus services and is strongly associated with the notion of coordinated services.)

As discussed later, other related concepts that are widely used include *wrap-around services, one-stop shopping, full service schools*, and *community schools*. Also related is the notion of *systems of care*, but this concept usually is reserved for the set of services provided to individual's who have been designated as emotionally disturbed (Bickman, 1997; Day & Roberts, 1991; Duchnowski & Friedman, 1990; Hoagwood, 1997). Adoption of these concepts 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 concept of school-linked services spreads, the terms *services* and *programs* are often used interchangeably. This leads to confusion, especially since addressing a full range of barriers to learning requires going beyond a focus on *services*. The term *services* tends to denote special assistance provided to specific clients individually or in small groups (e.g., clinical interventions) or to the public at large (e.g., ad hoc public service announcements related to mental health). And given this range, such activity should be differentiated at least to distinguish between narrow-band, personal/clinical services and broad-band, public health and social services (Adelman, 1995). However, even this distinction is not sufficient. It is important to recognize that, although services often are provided as part of a program, not all are. For example, counseling to ameliorate mental health problems can be offered on an ad hoc basis or may be offered as one element of a multifaceted program. Programs characteristically involve a range of activity that are part of a systemic approach and are programmatically designed to meet the broad aims of an organization or society. Pervasive and severe psychosocial problems, such as substance abuse, teen pregnancy, physical and sexual abuse, gang violence, and delinquency, require multifaceted, programmatic interventions. Beside providing services to correct existing problems of individuals, such interventions encompass primary prevention activity (e.g., public health policies and practices that target groups seen as "at risk") and a broad range of open enrollment didactic, enrichment, and recreational activities. Differentiating services and programs helps mediate against tendencies to limit the range of interventions for addressing barriers to learning. The distinction also underscores the breadth of activity that requires coordination and integration.

In analyzing school-linked service initiatives, Franklin and Streeter (1995) categorize five approaches—informal, coordinated, partnerships, collaborations, and integrated services. These are seen as differing in terms of the degree of system change required. As would be anticipated, most initial efforts focus on developing informal relationships and beginning to coordinate services.

As Knapp's (1995) review notes, the contemporary literature on school-linked services is heavy on advocacy and prescription and light on data. Each day brings more reports from projects such as New Jersey's School-Based Youth Services Program, the Healthy Start Initiative in California, the Beacons Schools in New York, Communities-in-Schools, and the New Futures Initiative. Not surprisingly, the reports 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 underserved and hard to reach. 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, as well as the capability

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

***Systems of care.*** Properly developed, a system of care is a special form of school-community collaboration designed to provide comprehensive services for youth with serious emotional problems. The concept also is becoming a popular way to talk about any effort to provide cohesive assistance to clients. Thus, recent research on systems of care is likely to find its way into discussions of the value of collaborative efforts among services. Based on their evaluation of a major system of care demonstration project in Fort Bragg, Salzer and Bickman (1997) conclude that while systems of care produce important system-level changes, early results suggest these system changes do not enhance clinical outcomes. They argue that the primary direction to improving children's mental health services should be through effectiveness research, in contrast to continued large-scale investments in system research and development. In response, others have interpreted the findings from the Fort Bragg study as supportive of the concept of systems of care, because participants in both the elaborate system of care model and the more simplified continuum of services comparison model showed improvements (Hoagwood, 1997). For example, Hoagwood's interpretation is that the more elaborate model did not improve upon the already adequate interventions provided in the comparison sites.

***Some concerns.*** Research issues aside, initiatives for school–community collaborations raise various concerns (see Adelman, 1996b; Lawson & Briar-Lawson, 1997; Smrekar, 1994). They may enhance access to services, reduce redundancy, improve case management, coordinate resources, and increase efficacy—all of which clearly 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 has produced tension between school district service personnel and their counterparts in community-based organizations. When "outside" professionals are brought into a school, school specialists often view it as discounting their skills and threatening their jobs. Moreover, the emphasis on school-linked services downplays the need for restructuring the various education support programs and services schools own and operate. Initiatives for school-linked services also lead some policy makers to the mistaken impression that such an approach can effectively meet the needs of schools in addressing barriers to learning. In turn, this leads some legislators to view school-linked services as a replacement for school-owned services. The reality is that even when one combines community and school assets, the total set of services in economically impoverished locales is woefully inadequate (Koyanagi & Gaines, 1993).

### *Current Policy Status*

With respect to policy, national and state legislation and statements by education agencies, school administrators' associations (e.g., Council of Chief State School Officers), and school boards clearly acknowledge that services are needed to enable students to benefit from instruction. At the same time, despite the existence of a variety of counseling, psychological, and social interventions in schools, it is evident that pu-

pil services and school health programs do not have high status in the educational hierarchy and in current health and education policy initiatives (Allensworth, Wyche, Lawson, & Nicholson, 1997; Dryfoos, 1998; Zigler, Kagan, & Hall, 1996). The continuing trend is for schools and districts to treat such activity, in policy and practice, as desirable, but not essential. The efforts are frequently referred to as "auxiliary" or "support" services. Because of this devalued status, there is no cohesive policy vision for addressing barriers to learning and enhancing healthy development. Relatedly, pupil services personnel too often are among those deemed dispensable as budgets tighten. For example, although some groups have increased their numbers (e.g., school social workers), overall staffing of pupil services in most districts has been significantly cut back in recent years (Gibelman, 1993). All this results in disjointed advocacy and planning and inevitable fragmentation in providing services and programs (Adelman, 1995, 1996a, 1996b; Adelman & Taylor, 1993b, 1997b; Adler & Gardner, 1994; Carnegie Council on Adolescent Development, 1988; Dryfoos, 1993, 1994, 1995; Hickey, Lockwood, Payzant, & Wenrich, 1990; Hodgkinson, 1989; Lawson & Briar-Lawson, 1997; Melaville, Blank, & Asayesh, 1993; White & Wehlage, 1995).

Funding policies also contribute to intervention fragmentation. Funds are often earmarked for use only in treating narrowly defined problems, and budget cuts tend to increase competition for resources and work against collaboration. And the expanding managed-care environment and changes in the welfare system are exacerbating the situation (Brellochs, Zimmerman, Zink, & English, 1996; DeGraw, Park, & Hudman, 1995; DeMers & Bricklin, 1995; Lourie, Howe, & Roebuck, 1996; Rand Corporation, 1996; Twentieth Century Fund, 1995a, 1995b). It should be noted also that the emphasis on entrepreneurship in public education has resulted in schools seeking more and more specially funded projects. Obviously, schools need more resources. However, such projects—including those connected with university faculty research—tend to shift time and energy away from other programs and from efforts to build infrastructure for comprehensive, integrated approaches to address barriers to learning and enhance healthy development. The trend is for special projects to operate as ad hoc programs, and they almost always disappear once the funding period ends. The phenomenon is so prevalent that the term *projectitis* has been coined to raise consciousness about the dangers inherent in pursuing grants that distract and fragment staff and create programs that cannot be sustained after the grant ends.

Given the policy context, it is not surprising that so little is done at any administrative level to create the necessary leadership and organizational structure for establishing a potent approach to address barriers to learning and enhance student's healthy development. Mental health and other specialist personnel are almost never a prominent part of a school's organizational structure. As schools move toward school-based management and shared decision-making, such personnel are rarely included in new shared governance and planning bodies. One result is that the planning of programs, services, and delivery systems often is done on an ad hoc basis. Service personnel tend to operate in relative isolation of each other and other stakeholders, with a great deal of the work oriented to discrete problems and with an overreliance on specialized services for individuals and small groups.

With respect to the organization of services and programs offered at schools, 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, rather than integrating such services with the ongoing efforts of school staff. Fragmentation also reflects the failure of educational re-

form to restructure the work of school professionals who carry out psychosocial and health programs, as well as the dearth of policy establishing effective mechanisms for coordination and integration. In some schools, the deficiencies of current policies give rise to such aberrant practices as the involvement of a student identified as at risk for dropout, suicide, and substance abuse in three counseling programs operating independently of each other.

With respect to on-the-job education, policy makers allocate few resources to considerations related to addressing barriers to learning and enhancing healthy development. Almost none of a teacher's inservice training focuses on improving classroom approaches for dealing effectively with mild-to-moderate behavior, learning, and emotional problems. Paraprofessionals, aides, and volunteers working in classrooms and in the area of pupil services still receive little or no formal training/supervision before or after they are assigned duties. And little or no attention is paid to cross-disciplinary training.

## EMERGING TRENDS

Efforts underway to refine existing reforms and fill major policy gaps are expected to produce fundamental shifts in thinking about mental health in schools and about the personnel who provide such services. Two emerging trends are discussed here: (a) the move *from* fragmentation *to* cohesive intervention and (b) the move *from* narrowly focused, problem specific, and specialist-oriented services *to* comprehensive general programmatic approaches.

### *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 that this produces fragmentation which, 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; Kahn & Kamerman, 1992; Los Angeles Unified School District, 1995; U.S. General Accounting Office, 1993). This is leading to new strategies for coordinating, integrating, and redeploying resources (Tharinger, 1995). Of particular relevance are (a) processes for mapping and matching resources and needs and (b) mechanisms for resource coordination and enhancement.

***Mapping and matching resources and needs.*** The literature on resource coordination makes it clear that a first step in countering fragmentation involves "mapping" resources (e.g., clarifying existing programs and services that support students, families, and staff; delineating referral and case management procedures). A comprehensive form of need and asset assessment is generated when resource mapping is paired with surveys of unmet needs and existing strengths of students, their families, and school staff. Analyses of these data allow for systematic formulation of strategies for resource enhancement, including (a) outreach to link with additional resources at other schools, district sites, and in the community and (b) establishing better ways to use existing resources.

For both the school and community agencies, mapping and analyzing resources provides a basis for redeploying and improving cost-effectiveness. In some schools, about 40% of the resources are assigned to functions other than regular instruction (Tyack, 1992), but, as yet, little attention has been paid to analyzing and restructuring such resources. Among community agencies, there is acknowledged redundancy stemming from ill-conceived policies and lack of coordination (Hodgkinson, 1989). These facts do not translate into evidence that there are pools of unneeded personnel; they simply suggest there are resources that can be used in different ways to address unmet needs. Given that additional funding for reform is hard to obtain, such redeployment of resources is the primary answer to the ubiquitous question: *Where will we find the funds?*

***Mechanisms for resource coordination and enhancement.*** An example of a mechanism designed to reduce fragmentation and enhance resource availability and use (with a view to enhancing cost-effectiveness) is seen in the concept of a *Resource Coordinating Team* (Adelman, 1993; Rosenblum, DiCecco, Taylor, & Adelman, 1995). Such a mechanism is used to weave together existing school and community resources and encourage cohesive functioning of services and programs.

A resource-oriented team *differs* from teams created to review individual students (such as a student study or a teacher assistance team). That is, its focus is not on specific cases, but on clarifying resources and their best use. In doing so, it provides what is often a missing mechanism for managing and enhancing *systems* to coordinate, integrate, and strengthen interventions. Such a team is assigned responsibility for (a) mapping and analyzing activity and resources with a view to improving coordination, (b) ensuring that there are effective systems for referral, case management, and quality assurance, (c) guaranteeing that there are sound procedures for management of programs and information 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.

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

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

To facilitate resource coordination and enhancement among a complex of schools (e.g., a high school and its feeder schools), the mechanism of a Resource Coordinating *Council* brings together representatives of each school's resource *team*. Schools in a given locale usually try to link with the same set of community resources, and a resource council can help ensure cohesive and equitable deployment of available resources. A complex of schools working together also can achieve economies of scale. Moreover, since many families have children at different levels of schooling, a high school and its feeder schools often are dealing with the same family and can both enhance consistency of effort and reduce redundancy through coordination and integration of effort.

### *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 better address 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. Another response is seen in efforts to balance generalist and specialist approaches. Ultimately, the need is for a full continuum of prevention and corrective programs that are integrated with each other and with instruction.

***Schools as service centers.*** Over the last decade, many of the now over 1000 school-based or linked *health clinics* have been described as comprehensive centers (Advocates for Youth, 1994; Dryfoos, 1994; Robert Wood Johnson Foundation, 1993). 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: (a) the physical complaints of some students are psychogenic, and thus, treatment of various medical problems may be aided by psychological intervention, and (b) in a large number of cases, students come to clinics primarily for help with nonmedical problems related to peer and family relationships, emotional distress, physical and sexual abuse, and abuse of alcohol and other drugs. Indeed, up to 50% of visits may be for nonmedical concerns (Adelman, Barker, & Nelson, 1993; Anglin, Naylor, & Kaplan, 1996; Center for Reproductive Health Policy Research, 1989; Robert Wood Johnson Foundation, 1989). Thus, as clinics evolve, so does provision of 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 available resources, and the problem is compounded if the staff overrelies on a clinical model (Adelman, 1996b).

Relatedly, as noted above, policy initiatives in an increasing number of states encourage linkages between schools and community agencies to enhance comprehen-

siveness, 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 relationships between schools and such community agencies as county public health, mental health, and child and family services. Dryfoos (1994, 1995) encompasses the trends to develop family service centers, school-based primary health clinics, youth service programs, community schools, and other similar activity under the rubric of *full service schools.* (She credits the term to Florida's comprehensive school-based legislation.) As she notes in her review:

> Much of the rhetoric in support of the full service schools concept has been presented in the language of *systems change*, calling for radical reform of the way educational, health, and welfare agencies provide services. Consensus has formed around the goals of one-stop, seamless service provision, whether in a school- or community-based agency, along with empowerment of the target population . . . most of the programs have moved services from one place to another; for example, a medical unit from a hospital or health department relocates into a school through a contractual agreement, or staff of a community mental health center is reassigned to a school, or a grant to a school creates a coordinator in a center. As the program expands, the center staff work with the school to draw in additional services, fostering more contracts between the schools and community agencies. But few of the school systems or the agencies have changed their governance. The outside agency is not involved in school restructuring or school policy, nor is the school system involved in the governance of the provider agency. The result is not yet a new organizational entity, but the school is an improved institution and on the path to becoming a different kind of institution that is significantly responsive to the needs of the community. (p. 169)

***Balancing specialist and generalist perspectives.*** Another response to the call for comprehensiveness is a quest to balance problem-specific and specialist-oriented services with a generalist perspective, including less categorical, cross disciplinary programs (e.g., Henggeler, Schoenwald, Pickrel, & Rowland, 1994). Specialized approaches currently dominating psychosocial interventions in schools are shaped primarily by two factors. One is funding agency regulations and guidelines, for example, those related to legislatively mandated compensatory and special education programs and to categorical programs for addressing social problems, such as substance abuse, gang and on-campus violence, and teen pregnancy. The other shaping force is the prevailing intervention models taught by various fields of professional specialization, such as school counseling, school and clinical psychology and social work, and other specialty areas of therapeutic intervention.

To counter what some describe as "hardening of the categories," the trends are toward granting (a) flexible use of categorical funds and (b) temporary waivers from regulatory restrictions. There is also renewed interest in cross-disciplinary training—with several universities already testing interprofessional collaboration programs. These trends 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, 1996a, 1996b; Adelman & Taylor, 1994, 1997b; Dryfoos, 1998; Lawson & Briar-Lawson, 1997; Lawson & Hooper-Briar, 1994; Lipsky & Gartner, 1996; Meyers, 1995; Young, Gardner, Coley, Schorr, & Bruner, 1994).

With respect to designing a comprehensive, integrated approach, the intent is to

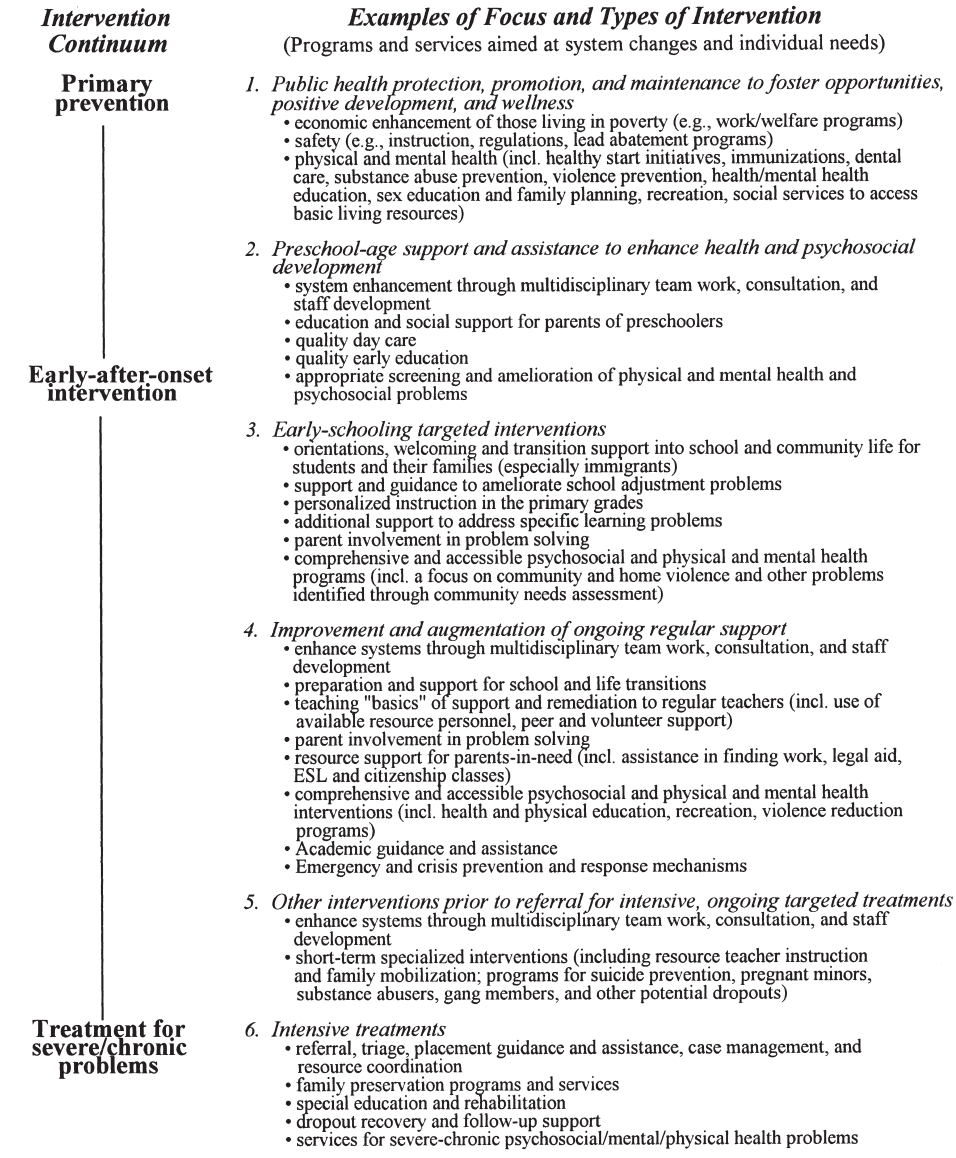
develop and evolve a continuum of programs and services encompassing instruction and guidance, primary prevention, early-age and early-after-onset interventions, and treatments for severe problems. To this end, the most radical proponents of a generalist orientation argue for a completely noncategorical 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.

Examples of a nonradical (moderate) generalist approach are seen in two extensive demonstrations, one of which is designed to restructure health and human services throughout a large urban school district (Los Angeles Unified School District, 1995). The other is part of one of the nine "break the mold" models funded by the New American Schools Development Corporation (Learning Center Model, 1995). Both drew on analyses that suggest that existing student support services and programs cluster rather naturally into six general programmatic areas. These six interrelated areas encompass interventions to (a) enhance classroom-based efforts to enable learning, (b) provide prescribed student and family assistance, (c) respond to and prevent crises, (d) support transitions, (e) increase home involvement in schooling, and (f) outreach to develop greater community involvement and support—including recruitment of volunteers (Adelman, 1996a; Adelman & Taylor, 1994). At schools where existing interventions were mapped and analyzed with reference to the six areas, the process quickly identified redundant and nonproductive programs. It also helped clarify the strengths and weaknesses in each area, including a variety of coordination and resource needs. The mapping and analyses then became the bases for making priority decisions regarding redesigning interventions and enhancing outcome efficacy.

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

***A full continuum of integrated interventions.*** Ultimately, addressing barriers to learning and enhancing healthy student development must be viewed from a societal perspective. From this viewpoint, the aim becomes that of developing a comprehensive, integrated continuum of community and school programs for local catchment areas. The framework for such a continuum emerges from analyses of social, economic, political, and cultural factors associated with the problems of youth and from reviews of promising practices.

Figure 1 illustrates such a continuum. The outlined examples highlight that a comprehensive approach is built with a holistic and developmental emphasis. Such an ap-




Adapted from Adelman & Taylor (1993a)

**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*, by H. S. Adelman and L. Taylor, 1993a, Forest Grove, CA: Brooks/Cole. Copyright 1993 by Brooks/Cole. Adapted with permission.**

proach 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.

## SYSTEM RESTRUCTURING

The prevailing state of affairs and emerging trends just described suggest the need for *fundamental* systemic reform. Central to such reform are policies and strategies that can counter fragmentation by integrating the efforts of school, home, and community. On a hopeful note, there is some evidence of favorable policy movement at national, state, and local levels. An example is the mental health in schools initiative begun in 1995 by the U.S. Department of Health and Human Service's Maternal and Child Health Bureau (Office of Adolescent Health). As a first step, five statewide, multiyear projects and two national training and technical assistance centers were established and already are pursuing a wide range of activity designed to improve how schools address barriers to learning and enhance healthy development. Another example is seen in support by the Centers for Disease Control and Prevention (CDC) of counseling, psychological, and social services as one of eight components of a school health program (e.g., Kolbe, 1986; see also the 1997 Institute of Medicine report edited by Allensworth et al. [1997]). To advance this model of school health programs, CDC has funded a large-scale, multiyear project (Marx & Wooley with Northrop, 1998). Relatedly, several years ago, CDC began supporting an administrative arrangement to enhance interagency collaboration between state health and education agencies to build each state's capacity to improve school health programs (Kolbe, 1993).

The U.S. Department of Education (DOE) is also concerned about countering service fragmentation. In 1995, DOE initiated a working group to address the lack of integrated effort across various federal agencies concerned with health and social services. DOE is also using the Improving America's Schools Act to encourage schools to develop schoolwide approaches (e.g., pulling together compensatory education, bilingual education, and safe and drug-free school programs) rather than continuing to pursue categorically oriented activities. Title XI of this act allows school districts to divert a portion of their federal funding to organize service coordination.

Many states, counties, and philanthropic foundations also have initiatives aimed at stimulating system reform and restructuring by enhancing school–community collaborations and service integration. Other forms of support for system change emanate from the many policy and research centers and the various associations that represent professionals and youngsters and their families (e.g., guilds and advocacy groups).

Although such efforts indicate recognition of the need for systemic change, the initiatives themselves are fragmented and marginal. And, there are a variety of other federal programs finding their way into schools that usually result in further fragmentation of intervention efforts (e.g., juvenile justice and delinquency prevention programs, abstinence education, and family preservation and support programs). It is ironic that some federal initiatives have been introduced to counter the extensive fragmentation that categorically funded programs have produced, and at the same time, new categorical programs are being propagated.

### *Policy Considerations*

In our work, we suggest a basic policy shift that elevates efforts to address barriers to learning, including social, emotional, and physical health problems, to the level of one of three fundamental and essential facets of education reform and school and community agency restructuring (see Figure 2). That is, to enable teachers to teach effectively, we suggest that there must not only be effective instruction and well-man-

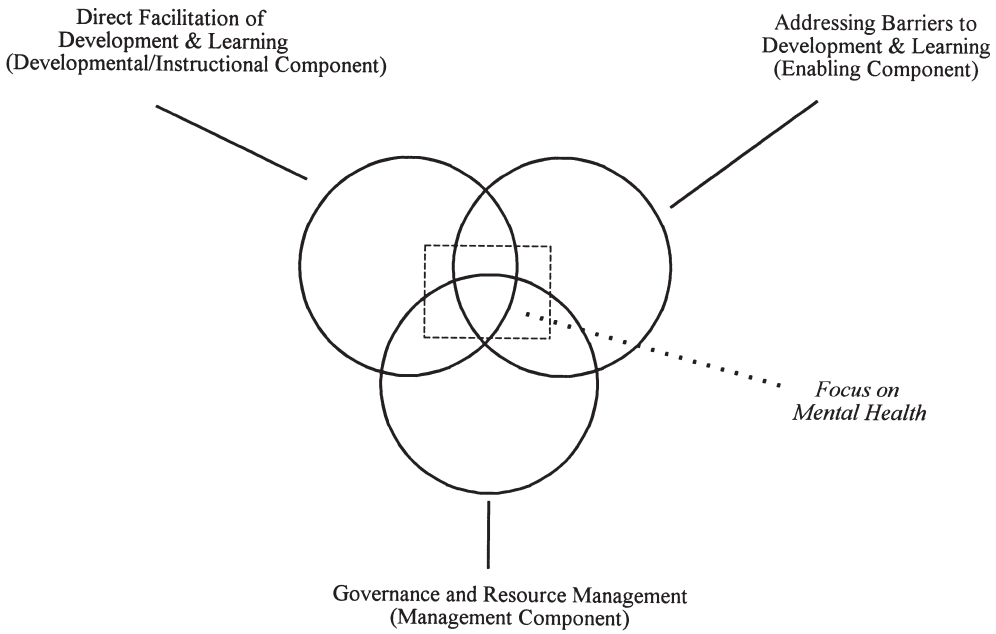



**FIGURE 2. Placing School Mental Health Interventions Within a Three-Component Model for School/Community Reform.**

aged schools, but that barriers to learning must be handled in a comprehensive way (Adelman, 1996a, 1996b; Adelman & Taylor, 1994, 1997b). The current situation is one where, despite awareness of the many barriers to learning, school reformers continue to concentrate mainly on improving instruction and school management. In effect, they pursue school reform using a two- rather than a three-component model. As a result, the need to restructure education support programs and services remains unmet, and this works against meshing school resources with initiatives to integrate community services and link them to schools. Comprehensive approaches to addressing barriers to learning and enhancing healthy development require weaving together programs to address mental health and psychosocial concerns and much more. In the process, there must be mechanisms to coordinate and eventually integrate (a) school-owned activity for addressing barriers to learning, (b) school- and community-owned resources, and (c) the enabling, instructional, and management components.

Although most educators are aware of the value of health (mental and physical) and psychosocial interventions in enabling students to become full participants in their own academic achievement and healthy development, efforts to create a comprehensive approach are not assigned a high priority. One way to understand this is to recognize that the primary and essential nature of relevant programs and services has not been thrust before policy makers and education reformers in an effective manner. Current demonstrations of "comprehensive" approaches are attracting some attention. However, they are not viewed as evidence that interventions addressing barriers to teaching and learning are *essential* to the success of school reform. The next step in moving toward a comprehensive approach is to bring the following message to policy makers at all levels. *For school reform to produce desired student outcomes, school and commu-*

*nity reformers must expand their vision beyond restructuring instructional and management functions and recognize that there is a third primary and essential set of functions involved in enabling teaching and learning.*

As illustrated in Figure 2, this third facet of school and community restructuring has been dubbed the Enabling Component. In a policy context, the concept of an enabling component is meant to provide a focal point around which policy for addressing barriers to development, learning, and teaching can be unified. By emphasizing the essential nature of this third facet of school and community reforms, the intent is to help elevate policy priorities related to addressing such barriers. For daily practice, the concept has been operationalized into the six general, interrelated, programmatic areas outlined in a preceding section of this review. (For a detailed discussion of the Enabling Component in terms of policy and practice, see Adelman, 1996a; Adelman & Taylor, 1997b; Center for Mental Health in Schools, 1997; Learning Center Model, 1995.)

By calling for reforms that enhance the focus on a wide range of psychosocial factors interfering with school learning and performance, the concept of an Enabling Component encompasses the type of models described as full-service schools—and goes beyond them (Adelman, 1996b). The concept calls on reformers to expand the current emphasis on improving instruction and management to include a comprehensive component for addressing barriers to learning. All three components are seen as essential, complementary, and overlapping. Emergence of a cohesive enabling component requires policy reform that facilitates weaving together what is available at a school, expanding this through integrating school, community, and home resources, and enhancing access to community programs and services by linking as 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. By offering a delimited set of program areas for restructuring school-owned enabling activity and blending school and community resources, the concept provides a much-needed intervention focus around which to formulate new policy.

Adoption of an inclusive unifying concept is pivotal in convincing policy-makers to move to a position that recognizes the essential nature of activity to enable learning. Evidence of the value of rallying around a broad unifying concept is seen in the fact that in 1995 the state legislature in California considered the type of policy shift outlined here as part of a major urban education bill (AB 784). And in 1997, California's Department of Education included a version of such a concept (called Learning Supports) in their school program quality review guidelines.

### *Developing a Comprehensive Integrated Approach*

After policy-makers adopt a component for addressing barriers to learning as essential, it should be easier to blend all enabling activity together (including special and compensatory education) and elevate the status of programs to enhance healthy development. It also should be easier to gain acceptance of fundamental policy shifts to reshape pre- and in-service professional education.

***Changes in policy are necessary but insufficient.*** For significant systemic change to occur, new policies must be translated into appropriate daily practices. This is accomplished through organizational reform and/or restructuring—including allocation/redeploy-

ment of resources (e.g., finances, personnel, time, space, and equipment) and modification of existing organizational mechanisms. With respect to mechanism redesign, the focus is on at least five fundamental organizational concerns: (a) governance, (b) planning and implementation related to specific organizational and program objectives, (c) coordination and integration to ensure cohesive functioning, (d) daily leadership, and (e) communication and information management. Well-designed mechanisms must ensure local ownership, a critical mass of committed stakeholders, processes that can overcome barriers to stakeholders working together effectively, and strategies that can mobilize and maintain proactive effort so changes are properly implemented and systems are renewed over time. In terms of specific task focus, mechanisms must attend to (a) integrating resources related to the enabling, instructional, and management facets of school and community, (b) reframing inservice programs—including an emphasis on cross-training, and (c) establishing suitable forms of quality improvement, accountability, and ongoing systemic evolution and renewal.

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

Clearly, all this requires greater involvement of pupil service professionals in every facet and especially in the governance structure at the district level and at their schools. For this to happen, however, there must be a shift in roles as well as in priorities with respect to daily functions. Theirs must be a multifaceted role—providing services and much more. Jobs must be recast so that such personnel are not completely consumed by their caseloads and can focus more on functions related to coordination, development, and leadership and evolving long-lasting collaborations with community resources. And there must be guaranteed time and opportunity for representatives of enabling activity to serve on school and district governance, planning, and evaluation bodies.

***Changing systems.*** The type of institutional changes involved in moving toward a comprehensive, integrated approach cannot be achieved without a sophisticated and appropriately financed process for getting from here to there. Restructuring on a large scale involves substantive organizational and programmatic transformation at multiple jurisdictional levels. Although this seems self-evident, its profound implications are often ignored (e.g., see Adelman, 1993; Adelman & Taylor, 1997a; Argyris, 1993; Barth, 1990; Connor & Lake, 1988; Elias, 1997; Fullan & Stiegelbauer, 1991; Knoff, 1995; Replication and Program Services, Inc., 1993; Sarason, 1996).

At any site, key stakeholders and their leadership must understand and commit to restructuring existing activity. Commitment must be reflected in policy statements and an organizational structure that ensures effective leadership and resources. The process begins with activity designed to create readiness for the necessary changes by enhancing a climate/culture for change. Steps include creating readiness for systemic change by (a) building interest and consensus for developing a comprehensive approach to addressing barriers to learning and enhancing healthy development, (b) introducing basic concepts, especially basic program elements, to relevant groups of

stakeholders, (c) establishing a policy framework that recognizes the approach is a primary and essential facet of the school's activity, and (d) appointment of a site leader (of equivalent status to the leaders for the instructional and management facets) who can ensure implementation of policy commitments.

Creating the necessary readiness for systemic change overlaps development of a start-up and phase-in structure for implementing organizational change. Such a structure involves (a) establishing mechanisms and procedures, such as a steering group and leadership training, to guide development of reforms, (b) formulating specific start-up and phase-in plans, (c) establishing and training a resource coordinating team, (d) phasing-in reorganization of all activity for addressing barriers and enhancing healthy development, (e) forging linkages with other schools and with district and community resources, and (f) establishing systems to ensure quality improvement, momentum for reforms, and ongoing systemic renewal.

Use of pupil services personnel to facilitate systemic change has long been advocated. Recent work demonstrates the value of redeploying and training a cadre of such professionals as change agents in moving schools toward a comprehensive approach for addressing barriers to learning (Early Assistance for Students and Families Project, 1995). Designated as *organization facilitators*, such personnel start from a relevant base of knowledge and skills. In addition, because they are seen as internal agents for change, many of the negative reactions their colleagues direct at outside reformers are minimized. Specialized training gives them an understanding of specific activities and mechanisms for establishing and maintaining a comprehensive, integrated approach and increases their capacity for dealing with the processes and problems of organizational change.

## CONCLUDING COMMENTS

As many public schools struggle to deal with poor achievement and escalating psychosocial problems, concerns about addressing barriers to learning and enhancing healthy development warrant greater attention. Clearly, all this encompasses a variety of mental health considerations.

An extensive array of school-based and school-linked preventive and corrective activity already exists—some of which the data suggest should be part of any effort to establish comprehensive, integrated approaches to improve school effectiveness. There are, however, fundamental concerns that must be dealt with regarding how problems are understood and classified, what approaches are appropriate for different groups and individuals, how to plan and implement intervention so that it is most cost effective, and how to improve interventions and evaluate cost effectiveness. Clearly, these are areas to which clinical psychologists (and the mental health field as a whole) have contributed already and can continue to do so.

Although schools are not in the health business, it is clear that schools must address mental health and psychosocial concerns. As indicated by the Carnegie Council Task Force on Education of Young Adolescents (1989): "School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge" (p. 61). To meet this challenge, the search for better practices must be a high priority. The search must not be limited, however, to clinically oriented interventions. Those concerned with mental health in schools must pursue a full continuum of multifaceted programs and services. This requires weaving

together school and community resources to address barriers to learning and integrating these efforts with those designed to promote development and learning.

The need is evident; so are the opportunities for research, development, and practice. Clinical psychology has much to contribute to meeting the needs of schools and communities and much to gain in the process.

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