

Consultation and Collaboration

An Action Research Model for the Full-Service School

William L. Conwill *University of Tennessee, Knoxville*

Growing concerns with issues such as youth violence and delinquency have led to more investment in schools as points of human service delivery as well as education centers, especially in urban areas (L. Cuban, 1989; W. Damon, 1997; W. E. Davis, 1995a, 1995b). These "full-service schools"—also known as "community schools"—provide on-site medical, dental, psychological, social, and other services in partnership with community-based organizations (R. F. Kronick, 2000). This article describes an action research approach to a complex case study, demonstrating the application of innovative methods and strategies available to the mental health consultant in full-service school settings. It highlights critical issues such as forming alliances among parents, administrators, teachers, counselors, and other stakeholders and basing behavioral management team decisions on clearly explained data.

Introduction

The case study presented here used a collaborative (Erchul, 1999; Erchul, Raven, & Whichard, 2001; Gutkin, 1999; Truesdell & Lopez, 1995; Welch, 2000; West & Idol, 1993) action research (Lusky & Hayes, 2001; Melrose, 2001; Sandler & Chassin, 2002) approach to help the teachers manage the extremely disordered behavior of an 8-year-old boy in a classroom setting. My intervention included baseline data collection on videotape, a functional analysis of a 20-min period of observation, and consultation and collaboration with school personnel, institute staff, and parents to alter their way of perceiving the child's disruptions in the classroom and to modify the child's unruly conduct.

After consultation and collaboration (Boytim, 1996; Dougherty, 2000; Erchul, 1993; Erchul & Martens, 2002; Powers,

2001; Rappaport, 2001), the research participants (school staff and the child's parents) interpreted the child's behavior as deliberate strategies for attaining his goals rather than intermittent explosions of temper randomly triggered by internal events. Once they changed their assumptions about the cause of his outbursts, the participants were able to modify the antecedents and consequences of the child's behavior. These procedures, described in detail below, are easily adaptable to full-service school settings by mental health consultants.

The Full-Service School as a Practice Setting

A growing trend over the past two decades has been to bring needed services into the school rather than to treat the health and social needs of children as distinct from their educational needs (Ascher, 1988, 1990; Kraemer, Lopez, & Lucas, 1992). Consultation and collaboration among administrators, teachers, parents, school staff, human service professionals, and other community stakeholders are necessary processes in this endeavor (Boytim, 1996; Dougherty, 2000; Powers, 2001; Quirk, 1997; Rappaport, 2001). According to education critic Peter Schrag (2000), schools do not necessarily shrug off their central mission to teach all children the basic academic subjects by our making them centers of youngsters' social

Correspondence concerning this article should be addressed to William L. Conwill, Educational Psychology and Counseling, University of Tennessee, Knoxville, TN 37996. E-mail: wconwill@utk.edu

life and, for lack of better alternatives, delivery points for meals, health care, and other social services (Tyack, 1992).

Behavioral consultation and collaboration in schools is becoming an increasingly popular way for mental health professionals to assist in these efforts (MacKenzie & Rogers, 1997; Reeder et al., 1997). Consultants, usually working with Schein's (1990) purchase of expertise model, help school personnel to develop preventive strategies for use with at-risk students and their parents (Holtzman, 1997). The movement toward full-service schools literally opens the doors of primary, middle, and high schools to communities' mental health consultants to work collaboratively with other professionals, including school personnel, and to respond to requests to help with children with disordered conduct (Ascher, 1988, 1990; Dryfoos, 1994, 1996; Kronick, 2000). To paraphrase a famous bank robber's answer as to why he robbed banks, mental health consultants are gravitating toward schools "because that's where the kids are."

Specializations and Practice Areas

The single most probable motivating factor pushing mental health professionals and school, community agency, industry, and neighborhood association personnel to collaborate on behalf of needy children and families is the perception of scarce resources (Levitan, Mangum, & Pines, 1989). No one group can see itself getting the lion's share of its community's resources to achieve all its objectives, but each can quickly recognize the advantages of involvement and collaboration in the schools (McChesney, 1996). Health and social service agencies gain easier access to clients, colleges and universities look forward to better trained students in the future, parents feel more assured of a wider range of occupational possibilities for children, businesses get a more competitive workforce, and communities achieve a greater sense of cohesion.

Alliances founded on mutual sharing and trust among community agencies, parents, teachers, administrators, and mental health professionals involved in the educational process can have a positive impact on our level of awareness and our efforts to help solve children's problems at school (Comer, Haynes, Hamilton-Lee, Boger, & Joyner, 1986). In the educational setting, the outcomes of these alliances may focus on changes in knowledge, skills, attitudes, or behaviors at the levels of the child, adult, or system (West, 1990).

In short, in today's discourse on service provision, educators, counselors, parents, administrators and researchers do not compartmentalize their thinking about institutions to fit artificial a priori disciplinary divisions of labor. Today, we realize that we *must* work across community, home, and school settings (Beloin & Peterson, 2000; McGivern & Marquart, 2000; Weist, Proesch, Prodent, Ambrose, & Waxman, 2001). Classroom, family, and school-level interventions require collaborative efforts from all stakeholders.

Typical Types of Cases and Assignments

Mental health professionals can play multiple roles in this endeavor. Chief among them is behavioral consultant. Careful observation-based analyses are key to avoiding the mistake of underestimating intervention effects and perhaps, as a result, prematurely abandoning fairly simple and cost-effective solutions to a child's problem behavior (Adelman & Taylor, 1997; Stoolmiller, Eddy, & Reid, 2000). Other roles may involve addressing school climate issues and examining programmatic approaches to discipline (Dellar, 1999; Griffith, 1999; Peterson & Skiba, 2000; Shore, 1997; Villani, 1999).

Although we may be more familiar with grants for mental health professionals working on problems more explicitly related to

violence and drug abuse prevention within schools, preventive approaches typically target lower levels of disordered behavior, such as aggressive arguments and power struggles with teachers and other students (Stoolmiller et al., 2000). The mental health consultant's success in solving behavior problems in school settings can generate a great deal of good will.

Description of the Client

As director of Child and Family Studies, chair of the Interventions Committee, and later chief psychologist in the Children & Youth Division of a state mental health institute in a medium-size (population about 370,000) city in the southeastern United States during the 1990s, I spent much of my time consulting and collaborating with other members of treatment teams and with school staff in the institute's classrooms. The institute's elementary school classroom staff called on me to help structure a special treatment for an 8-year-old White male child who had been in hospital settings for nearly 18 months. The child's treatment team had moved him recently from the ward to the classroom. The teacher was frustrated by her daily attempts to manage him in the classroom. She wanted relief immediately. I agreed to work with her if I could evaluate the results of our intervention in the classroom.

Major Problems and Issues

Despite the hierarchical structure and top-down decision making of the institute's typical multidisciplinary treatment team, I was working toward a more interdisciplinary collaborative model in which decision making truly was shared by those with responsibility for carrying out treatment team mandates. This approach militated against so-called hit-and-run interventions that simply structured guidelines or handed directions to teaching staff and left accountability for failure in their hands.

The young boy had been removed from his home setting because of highly oppositional behavior. His parents stated that he had always been a difficult child to manage, so much so that they were not able to keep babysitters and very seldom went anywhere without him. He had been transferred—after his insurance was depleted—from a private child psychiatric facility with a diagnosis of pervasive developmental disorder.

When the boy first arrived at the center, he assaulted other children and staff at a high rate—that is, more than 20 times a day—and used to run away from staff members whenever he was asked to do something he did not want to do. He exhibited tantrum outbursts of defiant aggression when provoked by requirements to perform age-appropriate developmental tasks. Although he loved learning long lists of detailed names and numbers, he was intolerant of demands made on him in the classroom.

His parents lived 90 miles away from the institute. They drove several hours every week to visit him for 4 hours on Sundays and whenever they came to the institute for treatment team meetings and family therapy. They brought toys and magazines whenever they came, and they called him by phone every night.

Major Steps in Developing the Consultation Relationship

As the psychologist on the boy's treatment team, I had already been successful in extinguishing some of his self-mutilative behavior (banging himself in the face to cause nosebleed to escape discipline and get attention) fairly early on. Within 2 months after his intake, I also had reduced the frequency and intensity of his aggressive episodes through consistent and strategic interactions with his parents and other institute staff.

He had responded to a variety of interventions, including negative reinforcement and positive reinforcement. Examples of negative reinforcement were as follows: (a)

time out from group activities for noncompliance, (b) time away from peer interaction for oppositional behavior, (c) isolation from peer attention when his behavior was disruptive, and (d) seclusion from peer contact when he tried to assault others. Examples of positive reinforcement were as follows: (a) praise and special staff attention for compliant behavior, (b) tokens for compliant behavior, (c) pleasant outings for maintenance of compliance, and (d) awards for sustained compliance. The teaching staff were aware that my work with the child in a ward setting had resulted in enough progress to place him in a classroom setting.

Description of the Consultation Project

Although I listened intently as teachers expressed their frustration with any delays in alleviating their problems in the classroom, my first objective was to find out what was going on in the classroom from an observational point of view. As noted above, we already had agreed that I would gather baseline data before we devised a treatment strategy.

Relevant Dynamics and Relationships: Action Research and the Case Study (n = 1)

By the time the mental health consultant is called for assistance at school, the behavior problem may be well out of control. Parents and teachers may feel exhausted, with a sense that they are working in isolation from one another. Other children in the classroom and school may be angered by the “target” child’s behavior. The school administrators may complain about the amount of personnel currently dumped into the fray to solve the problem.

Depending on the complexity of the problem behavior, the consultant may find the need to wear several hats, including those of mental health expert and group process facilitator. Demonstrating and facilitating trust and always

working toward consensus thus become paramount activities for the consultant.

The initial impetus for calling in the consultant can often be the disruptive behavior of an individual youngster, more so than a request for programmatic solutions (Blader & Gallagher, 2001). This calls for the case study approach. The consultant providing services to schools often has to operate quickly and efficiently when called in to assist. In this situation, well-collected behavioral data in a case study ($n = 1$) format permits rapid problem solving in an action research mode.

Action research is a form of inquiry that allocates participants a research role based on their sharing the vision of committed professionals critically investigating their own practice (Carr & Kemmis, 1986). In the action research approach, consultants can focus on the actual quandary of school personnel while grounding themselves in the research-based literature that addresses these predicaments (Carter, 1994; Dryfoos, 1993; Holtzman, 1997). Working collaboratively to establish the antecedents and the setting events through functional behavioral assessment, the stakeholders then brainstorm both to generate one or more strategies, such as teaching alternative skills or notifying the child of consequences, and to set up evaluation procedures.

Cottone and Claus’s (2000) review of ethical decision-making models provides schemata for consultants working with other stakeholders in this fashion. Although Cottone and Claus listed process-oriented models primarily, they included theoretically and philosophically based commentary. Their social constructionist approach to ethical decision making acknowledges that principled management of problems is a social process that always involves interaction with others. The consultant should also be aware of informed consent and confidentiality issues (Quirk, 1997).

Knoster and Tilly’s (1999) format for generating plans for children with behavior prob-

lems in school is also especially useful in that it prompts a multifaceted analysis of the problem, with examination of the potential impact of biological, personological, and social factors related to the problem behavior. Their model, like Cottone and Claus's (2000), encourages the stakeholders to work together for common ends.

With treatment team approval, I obtained permission from the child's parents to videotape his disruptive behavior in the classroom so I could examine his behavior more systematically. On the day of filming, I discreetly mounted a videotape recorder in an adjoining room at the back of the classroom for unobtrusive observation. I began filming when the children entered the classroom and took their places. Once they entered the classroom, students and teaching staff carried on in their usual fashion.

The teacher, a nurturing, patient, and engaging woman, gave the children work assignments and instructions. Her assistant, a fairly directive man, left the room once the children began working. The teacher worked with the students, with her assistant absent.

During the time the teacher directed the class, the boy progressively signaled his desire for attention by raising his hand forcefully, waving it wildly, grunting, clearing his throat, dropping his books on the floor, rattling his desk, and finally turning his desk over with a crash. A time-out procedure (placing him in a corner for a few minutes) did not result in cessation of his disturbances. During the observation period, he managed to draw the teacher to his desk several times until she began to respond slowly enough to provoke him to toss his desk to the floor. At that point, about halfway through the classroom observation period, the teacher's assistant came back to relieve her.

The teacher went to restrain the child, grabbing him around his waist from the rear and sitting on the floor with her arms around him. Whereas she thought she was controlling his flailing, he was luxuriously nestling against her, an intent she became aware of

only after viewing the videotape later. When he had "calmed" sufficiently, she moved him back to his desk and, after a few minutes, took a break.

Her assistant then took over monitoring the assignments in the classroom. After a couple of responses to the child's raised hand, the assistant gave instructions for the child to work alone and made no more trips to his desk. The child quit raising his hand after a couple of minutes and went to work on his assignment, with little disruption.

The fortuitous switch between the teacher and her assistant allowed us a comparison of the child's behavior under more than one condition. After the class, I removed the recording equipment from the school area and viewed the tape in order to develop observational categories for analysis.

Method for Managing the Problem: Functional Analysis of Child's Behavior

After the recording, I viewed the tape to analyze the contents. I timed 53 separate highlights, that is, occurrences of discretely observable salient behaviors, over a 23-min period of recording, noting the conditions for the behaviors (e.g., teacher or assistant response). I was alert to any circumstances preceding the child's disruptive behaviors that may have acted as stimuli (Patterson, 1982; Patterson & Cobb, 1973) or as reinforcers for acting out (Skinner, 1969).

I then sorted these 53 highlights into eight categories:

1. The boy complies with 1:1 interaction.
2. He complies without 1:1 interaction.
3. He receives instructional assistance.
4. He resists instructions through direct noncompliance.
5. He engages in self-stimulating play.
6. He engages in disruptive behavior.
7. He taunts staff.
8. He leaves the classroom.

Examples of disruptive behavior were getting out of his seat and walking around,

wrinkling and tearing papers, whining, protesting work assignments, and tantrum behavior (screaming, flailing about, lying on the floor and kicking about). Examples of self-stimulating play included gazing intently at his fingers while bending them and lightly bumping his head against a wall when on time away. Examples of taunting staff included affecting nonchalance while receiving instructions, forcefully shaking his desk, making obscene gestures and epithets toward staff, making loud noises while confronting staff with a direct gaze, and finally, throwing books to the floor while looking directly at staff.

Results of the Functional Analysis

Table 1 shows the percentage of time the child engaged in certain categories of behavior over a 23-min period. The categories are arranged generally from most to least preferred behavior.

I met with the teaching staff to show them that the child used exactly 41% of the observation period receiving staff attention for acting out and noncompliance. In addition, he spent nearly 20% of the time obtaining intense (1:1) staff interaction in the form of "listening to individual instructions," with a trade-off of only 6.6% of the observation period in compliance under this condition. The child was able to generate a 3:1 exchange of teacher interaction (individual instruction) for performance of desired activities (on-task behavior). Alternatively, his on-task behavior (working quietly on an assignment) increased dramatically when he did not receive intense 1:1 interaction from the male assistant.

The school staff and treatment team members were intrigued by these findings. They agreed with my suspicion that there was a "method to the madness": If the teacher did not respond to a lower level of attention-seeking activity, he would escalate to the next higher level of disruptive behavior.

Table 1
Percentages of Time for Categories of Behavior

Cate- gory	Name of category	% time
1	Complies without 1:1 interaction	14.5
2	Complies with 1:1 interaction	6.6
3	Receives individual instructional attention/direction	17.4
4	Engages in direct noncompliance and resistance	18.3
5	Engages in self-stimulating play	4.4
6	Engages in disruptive behavior	22.6
7	Taunts staff	10.8
8	Leaves the arena of the classroom	5.4

The school staff dropped their prior notion that the child was driven by sudden uncontrollable and unpredictable bouts of rage. We acknowledged his stages of engagement for gaining attention in the classroom: seeking individual instruction, passive resistance and direct noncompliance, disrupting the classroom environment by acting out (e.g., making noise until the teacher approached him), taunting, and forcing the issue by leaving the classroom. He was fairly sophisticated in getting attention. The data showed that the intense 1:1 interaction his teacher had described as essential for his proper comportment in the classroom was in fact inversely related to compliance. Indeed, he controlled large amounts of his teacher's time through noncompliance (see Patterson, 1982). Individualized instruction did not produce as much conformity as receiving a general instruction directed to the class as a whole. The classroom staff's present interaction pattern with him limited his compliance rate (time in compliance/total time) to perhaps 20%. Under the teacher's present schedule of reinforcement, he was likely to continue his high levels of tantrum, aggressive, and noncompliant behavior. We used the data in Table 1 as a baseline from which to plot our progress.

Relevant Dynamics of the Consultation and the Relationships Involved in the Project

I began working with the child's teachers and treatment team members to explain the findings from the observation period. We developed a common framework for a plan. We adopted the following interventions. He was called to the teacher's desk to receive a token for on-task behavior. He was redirected to carry on by himself if he sought assistance and was negatively reinforced for noncompliance (time out) or disruptive behavior (removed from the audience of teachers and classmates). We reported his progress to his parents weekly.

Prior to intervention, his parents had been allowed to call to speak to him daily and to visit with him after their counseling session in addition to during the institute's regular Sunday visiting period, when they brought him toys and other objects he had ordered. On Sundays, they had visited with him for the whole afternoon, whereas most visiting parents and family members stayed for only an hour or so. His parents agreed to skip their post-counseling visit, to curtail their Sunday visits to one hour, and to refrain from asking to speak with him every night over the telephone. We also took away access to his toys during periods of discipline and sent most of them home with his parents. Although these agreements were difficult for his parents, they felt that we were on their side and agreed to these restrictions.

Description of the Outcomes and Impacts of the Consultation Assignment

We had recognized the problem. Individual attention had served as his reward for noncompliance. Our goal was to have him exhibit sustained compliance in the classroom in preparation for his discharge and return to a community school. Our objec-

tives were as follows: (a) to increase his on-task and compliance rates without 1:1 interaction, up from its baseline of 14.5%; (b) to increase his tolerance for working alone by giving him token reinforcement for 5-min periods without seeking 1:1 staff attention through asking for instructions, up from our baseline of 17.4%; and finally (c) to increase his instances of following initial directions from staff without seeking additional attention, without passive noncompliance, and without disruptive behavior.

This regimen produced improvements in the areas of school attendance, task completion, and classroom etiquette, with a marked reduction in the boy's solicitation and the teachers' provision of 1:1 interaction. I also continued to monitor staff interactions with the boy in other settings, for example, living ward, playground, and lunchroom. We reviewed intervention outcomes during weekly treatment planning sessions.

The boy's progress continued. Gradually, we began his transition from the institute to home and to community school, first over weekends, and then during the week. In only a few months, he returned home full-time. He is now attending a public school in his own community.

Key Learning for the Consultant

We can glean several lessons from this consultation. First, all the stakeholders should have a voice in decision making. This helps avoid sabotage of intervention efforts by unwitting counterproductive interactions with the child. Second, assessment should include an observational analysis based on sound theoretical grounds, for example, coercion theory (Patterson, 1982) or reinforcement theory (Skinner, 1969). Third, the consultant should be able to explain the significance of complex interactional sequences to stakeholders in a way that informs their cooperation. Finally, the consultant should see the process through and follow up on the outcome of the intervention.

Summary

The consultant's invitation to join in the effort to improve conditions at schools generally follows the school staff's failed attempts to manage a child's disordered behavior. Mental health consultation and collaboration are useful means of joining colleagues and other human service professionals in addressing problems in the school setting. A collective problem-solving approach assures better chances of success. After formulating and agreeing on a plan of action, the consultant and collaborators attend to salient observations that might unlock the solution to the problems confronting them.

By serving as a consultant and collaborator, the mental health professional can help develop the ability of schools to do their jobs better. The consultant has to generate some consensus among the collaborative stakeholders concerning problem conceptualization, help develop a plan, and assess the intervention. The plan is then further refined until the stakeholders achieve the objectives of the intervention.

This article demonstrated consultation and collaboration processes applied to a complex case study of family intervention in a specialized school setting using an action research approach. An analysis of a video recording of classroom interactions between the teaching staff and the child led to the discovery that the means thought by the lead teacher to control disruptive behavior actually positively reinforced and elicited it. The steps taken to bring all the stakeholders together to work in unison to create behavioral change in the system (child, teachers, team, parents, community school) were described in detail.

The consultant can help the collaborators understand how to handle problems of this sort in the future. Although this particular case is complex, the processes for aligning all the stakeholders, deciding on a plan, and executing and evaluating it can be widely applied in the full-service school setting.

References

- Adelman, H. S., & Taylor, L. (1997). Addressing barriers to learning: Beyond school-linked services and full-service schools. *American Journal of Orthopsychiatry*, 67(3), 408–421.
- Ascher, C. (1988). *Urban school–community alliances*. Trends and issues no. 10. New York: ERIC Clearinghouse on Urban Education/Institute for Urban and Minority Education. (ERIC Document Reproduction Service No. ED306339)
- Ascher, C. (1990). *Linking schools with human service agencies*. ERIC Clearinghouse on Urban Education Digest, 62. Retrieved October 28, 2003, from <http://www.ericfacility.net/ericdigests/ed319877.html>
- Beloin, K., & Peterson, M. (2000). For richer or poorer: Building inclusive schools in poor urban and rural communities. *International Journal of Disability, Development and Education*, 47(1), 15–24.
- Blader, J. C., & Gallagher, R. (2001). Consultation to administrators. *Child and Adolescent Psychiatric Clinics of North America*, 10(1), 185–197.
- Boytim, J. A. (1996). The mental health counselor as consultant. In W. J. Weikel & A. J. Palmo (Eds.), *Foundations of mental health counseling* (2nd ed., pp. 242–248). Springfield, IL: Charles C Thomas.
- Carr, W., & Kemmis, S. (1986). *Becoming critical: Education, knowledge, and action research*. Philadelphia: Falmer Press.
- Carter, S. (1994). *Prevention. Organizing systems to support competent social behavior in children and youth*. Eugene, OR: Western Regional Resource Center.
- Comer, J., Haynes, N. M., Hamilton-Lee, M., Boger, J. M., & Joyner, E. (1986). *Yale Child Study Center school development program: Developmental history and long-term effects*. New Haven, CT: Yale University, Child Study Center.
- Cottone, R. R., & Claus, R. E. (2000). Ethical decision-making models: A review of the literature. *Journal of Counseling and Development*, 78, 275–283.
- Cuban, L. (1989). At-risk students: What teachers and principals can do. *Educational Leadership*, 46(5), 29–32.
- Damon, W. (1997). *The youth charter: How communities can work together to raise standards for all our children*. New York: Free Press.
- Davis, W. E. (1995a, August). *The full-service schools movement: Emerging opportunities—*

- emerging threats*. Paper presented at the 103rd Annual Convention of the American Psychological Association, New York, NY.
- Davis, W. E. (1995b). Full-service schools for youth at risk: Overcoming obstacles to effective implementation. *Journal of At Risk Issues*, 2(1), 11–17.
- Dellar, G. B. (1999). School climate, school improvement and site-based management. *Learning Environments Research*, 1(3), 353–367.
- Dougherty, A. M. (2000). *Psychological consultation and collaboration: A casebook* (3rd ed.). Belmont, CA: Wadsworth/Thomson Learning.
- Dryfoos, J. G. (1993). Full-service schools: What they are and how to get to be one. *NASSP Bulletin*, 77(557), 29–35.
- Dryfoos, J. G. (1994). Full-service schools: *A revolution in health and social services for children, youth, and families*. San Francisco, CA: Jossey-Bass.
- Dryfoos, J. G. (1996). Full-service schools. *Educational Leadership*, 53(7), 18–23.
- Erchul, W. P. (1993). Reflections on mental health consultation: An interview with Gerald Caplan. In W. P. Erchul (Ed.), *Consultation in community school, and organizational practice: Gerald Caplan's contributions to professional psychology* (pp. 57–72). Washington, DC: Taylor & Francis.
- Erchul, W. P. (1999). Two steps forward, one step back: Collaboration in school-based consultation. *Journal of School Psychology*, 37(2), 191–203.
- Erchul, W. P., & Martens, B. K. (2002). *School consultation: Conceptual and empirical bases of practice* (2nd ed.). New York: Plenum Press.
- Erchul, W. P., Raven, B. H., & Whichard, S. M. (2001). School psychologist and teacher perceptions of social power in consultation. *Journal of School Psychology*, 39(6), 483–497.
- Griffith, J. (1999). The school leadership/school climate relation: Identification of school configurations associated with change in principals. *Educational Administration Quarterly*, 35(2), 267–291.
- Gutkin, T. B. (1999). Collaborative versus directive/prescriptive/expert school-based consultation: Reviewing and resolving a false dichotomy. *Journal of School Psychology*, 37(2), 161–190.
- Holtzman, W. H. (1997). Community psychology and full-service schools in different cultures. *American Psychologist*, 52, 381–389.
- Knoster, T., & Tilly, D. (1999). *Designing effective behavior support plans for students with problem behavior* (1999–2000 NASDSE Satellite Conference Series: Creating School Environments Conducive to Learning). Retrieved October 28, 2003, from http://www.nasdse.org/national.NASDSE%2099-2000%20Conference/September_29_1999_.htm
- Kraemer, J. C., Lopez, M. E., & Lucas, C. (1992). *Building partnerships: Models of family support and education programs*. Cambridge, MA: Harvard Family Research Project.
- Kronick, R. F. (2000). *Human services and the full service school: The need for collaboration*. Springfield, IL: Charles C Thomas.
- Levitan, S. A., Mangum, G. L., & Pines, M. W. (1989, July). *A proper inheritance: Investing in the self-sufficiency of poor families*. Washington, DC: Center for Policy Studies.
- Lusky, M. B., & Hayes, R. L. (2001). Collaborative consultation and program evaluation. *Journal of Counseling and Development*, 79(1), 26–38.
- MacKenzie, D., & Rogers, V. (1997). The full service school: A management and organizational structure for 21st century schools. *Community Education Journal*, 25(3-4), 9–11.
- McChesney, J. (1996). Full-service schools. *Research Roundup*, 12(2), 5.
- McGivern, J. E., & Marquart, A. M. (2000). Legal and ethical issues in child and adolescent assessment. In E. S. Shapiro & T. R. Kratochwill (Eds.), *Behavioral assessment in schools: Theory, research and clinical foundations* (2nd ed., pp. 387–434). San Antonio, TX: Psychological Association.
- Melrose, M. J. (2001). Maximizing the rigor of action research: Why would you want to? How could you? *Field Methods*, 13(2), 160–180.
- Patterson, G. R. (1982). *Coercive family processes*. Eugene, OR: Castalia.
- Patterson, G. R., & Cobb, J. A. (1973). Stimulus control for classes of noxious behaviors. In J. F. Knutson (Ed.), *The control of aggression: Implications from basic research* (pp. 149–199). Chicago: Aldine Press.
- Peterson, R. L., & Skiba, R. (2000). Creating school climates that prevent school violence. *Preventing School Failure*, 44(3), 122–129.
- Powers, K. M. (2001). Problem solving student support teams. *California School Psychologist*, 6, 19–30.
- Quirk, J. P. (1997). Professional and ethical issues in family-school mental health interventions. In D. T. Marsh & R. D. Magee (Eds.), *Ethical and legal issues in professional practice with families* (pp. 161–179). New York: Wiley.
- Rappaport, N. (2001). Emerging models. *Child and Adolescent Psychiatric Clinics of North America*, 10(1), 13–24.

Reeder, G. D., Maccow, G. C., Shaw, S. R., Swerdlik, M. E., Horton, C. B., & Foster, P. (1997). School psychologist and full-service schools: Partnerships with medical, mental health, and social services. *School Psychology Review*, 26(4), 603-621.

Sandler, I., & Chassin, L. (2002). Training of prevention researchers: Perspectives from the Arizona State University Prevention Research Training Program. *Prevention and Treatment*, Volume 5, Article 6, posted January 15, 2002. Retrieved October 28, 2003, from <http://www.journals.apa.org/prevention/volume5/pre00500006a.html>

Schein, E. H. (1990). Models of consultation: What do organizations of the 1990s need? *Consultation*, 9, 261-275.

Schrag, P. (2000). The education of Diane Ravitch. *The Nation*, 271(9), 31-36.

Shore, R. (1997). *Creating a positive school climate*. Mt. Kisco, NY: Plan for Social Excellence.

Skinner, B. F. (1969). *Contingencies of reinforcement*. New York: Appleton-Century-Crofts.

Stoolmiller, M., Eddy, J. M., & Reid, J. (2000). Detecting and describing preventive intervention effects in a universal school-based randomized trial targeting delinquent and violent behavior. *Journal of Consulting and Clinical Psychology*, 68(2), 296-306.

Truesdell, L. A., & Lopez, E. C. (1995). Consultation models revisited: In conclusion. *Journal of Educational and Psychological Consultation*, 6(4), 385-395.

Tyack, D. (1992). Health & social services in public schools: Historical perspectives. *The Future of Children*, 2(1). Retrieved October 28, 2003, from http://futureofchildren.org/usr_doc/vol2no1ART2.pdf

Villani, C. J. (1999). Community culture and school climate. *School Community Journal*, 9(1), 103-105.

Weist, M. D., Proescher, E., Proedente, C., Ambrose, M. G., & Waxman, R. (2001). Mental health, health, and education staff working together in schools. *Child and Adolescent Psychiatric Clinics of North America*, 10(1), 33-43.

Welch, M. (2000). Collaboration as a tool for inclusion. In S. E. Wade (Ed.), *Inclusive education: A casebook and readings for prospective and practicing teachers* (pp. 71-96). Mahwah, NJ: Erlbaum.

West, J. F. (1990). Educational collaboration in the restructuring of schools. *Journal of Educational and Psychological Consultation*, 1(1), 23-40.

West, J. F., & Idol, L. (1993). The counselor as consultant in the collaborative school. *Journal of Counseling and Development*, 71(6), 678-683.

United States Postal Service
Statement of Ownership, Management, and Circulation

1. Publication Title: Consulting Psychology Journal: Practice and Research

2. Issue Frequency: Quarterly

3. Complete Mailing Address of Known Office of Publication (Street, city, county, state, and ZIP+4): 750 First Street, N.E., Washington, D.C. 20002-4242

4. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer): 750 First Street, N.E., Washington, D.C. 20002-4242

5. Full Name and Complete Mailing Address of Publisher, Editor, and Managing Editor (Do not leave blank): Educational Publishing Foundation/APA, 750 First Street, N.E., Washington, D.C. 20002-4242

6. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer): American Psychological Association, 750 First Street, N.E., Washington, D.C. 20002-4242

7. Publication Number: 0091-0715

8. Issue Date: October 2003

9. Annual Subscription Price: \$85

10. Number of Issues Published Annually: 4

11. Annual Circulation: 2306

12. Total Number of Copies (Net press run): 2306

13. Total Paid and/or Requested Circulation: 1530

14. Total Free Distribution: 776

15. Total (Sum of 13 and 14): 2306

16. Publication of Statement of Ownership: Yes

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: R. L. Meyers, Sr., Director, Publishing Services

18. Date: 10/16/03

13. Publication Title: Consulting Psychology Journal: Practice and Research

14. Issue Date for Circulation Data Below: June 2003

15. Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net press run)	2306	2286
b. Paid and/or Requested Circulation	1530	1397
(1) Paid and/or Requested Circulation Outside-County as Shaded on Form 3841	1530	1396
(2) In-County as Shaded on Form 3841	7	87
c. Free Distribution Outside the Mail (Carriers or other means)	7	87
d. Total Free Distribution (Sum of 15c and 15d)	7	87
e. Total Distribution (Sum of 15b and 15d)	1537	1483
f. Copies not Distributed	769	803
g. Total (Sum of 15e and 15f)	2306	2286
16. Payment of Postage and Postage Paid Circulation (PSI) (Not required for 1st class mail)	99.5	94.1
17. Publication of Statement of Ownership: Yes		
18. Publication required: Will be printed in the December 2003 issue of this publication. <input type="checkbox"/> Publication not required.		
19. Signature and Title of Editor, Publisher, Business Manager, or Owner: R. L. Meyers, Sr., Director, Publishing Services		Date: 10/16/03

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

Instructions to Publishers

- Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
- In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
- Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
- Item 15b, Copies not Distributed, must include (1) newspaper copies originally attached on Form 3841, and returned to the publisher; (2) additional sections from news agents, and (3) copies for office use, libraries, schools, and all other copies not distributed.
- If the publication has Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or, if the publication is not published during October, the first issue printed after October.
- In item 16, indicate the date of the issue in which this Statement of Ownership will be published.
- Item 17 must be signed.
- Failure to file or publish a statement of ownership may lead to suspension of Periodicals authorization.

PS Form 3826, October 1999 (See instructions on Reverse)