

# Promoting Mental Health in Schools in the Midst of School Reform

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**ABSTRACT:** *Efforts to promote mental health in schools have encountered a variety of systemic problems. Of particular concern is that planning and implementing programs and services often occurs in an unsystematic and ad hoc fashion resulting in fragmented and piecemeal activities and an inefficient use of limited resources. Even more fundamental is the degree to which schools marginalize all efforts to address barriers to student learning. With a view to enhancing understanding and resolution of these problems, this paper explores the policy deficiencies that perpetuate the status quo and presents a framework for moving forward.* (J Sch Health. 2000;70(5):171-178)

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It is not a new insight that mental health and psychosocial problems must be addressed if schools are to function satisfactorily and if students are to learn and perform effectively. Everyday, teachers ask for help in dealing with problems; often they also would like support to facilitate their students' healthy social and emotional development and help in involving parents. Yet, despite long-standing and, widespread acknowledgment of need, relevant programs and services continue to be a supplementary item on a school's agenda. This is not surprising. After all, schools are not in the health or social service 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.

Nevertheless, over the years, schools have instituted programs designed with a range of health, mental health, and psychosocial problems in mind, such as school adjustment and attendance problems, dropouts, physical and sexual abuse, pregnancy prevention, substance abuse, relationship difficulties, emotional upset, delinquency and violence — including gang activity. School-based and school-linked programs were developed for purposes of early intervention, treatment, crisis intervention, and prevention, including programs to foster positive social and emotional development. A large body of research exists supporting the promise of such interventions. However, with expansion of school-based mental health and psychosocial interventions has come growing concerns about their effectiveness and place in schools.

Among some segments of the population, schools continue to be seen as an inappropriate venue for mental health interventions. The reasons vary from concern that such activity will take time away from the educational mission to fear that such interventions are another attempt by society to infringe on family rights and values. Further, with proliferation of school-based and linked services, a variety of systemic concerns has arisen. In particular, planning and implementing programs and services often occurs in an unsystematic and *ad hoc* fashion. As widely discussed, the ensuing fragmented and piecemeal activities are an inefficient use of limited resources. And even more fundamental is the degree to which schools marginalize all efforts to address barriers to student learning. With a view

to enhancing understanding and resolving these problems, this paper first explores the policy deficiencies that perpetuate the *status quo* and then offers a framework for moving forward. A second paper in this issue<sup>1</sup> amplifies on these matters and discusses specific mechanisms for systemic change.

## A POLICY PERSPECTIVE

If schools are to work effectively on mental health and psychosocial concerns, greater efforts must be made to develop comprehensive, multifaceted, and integrated intervention approaches. For greater efforts to be realized, initiatives for mental health in schools must be developed, coordinated, and fully integrated with each school site's school reform policy.

We begin with the fact that there is clear acknowledgment that some special programs and services may be needed to enable students to benefit from instruction. Prominent examples of how policymakers have responded to the need are seen in funding for pupil services personnel, compensatory and special education, safe and drug-free schools, dropout prevention, pregnancy prevention, and home involvement in schooling. Related policy initiatives designed to increase health and human service agency collaboration and program integration emphasize school-community partnerships to foster school-linked services. All these initiatives have relevance for mental health in schools.

At the same time, it is clear from analyses of current policy and practice that no cohesive policy vision exists, and pupil services and school health programs do not have high status in the educational hierarchy and in current health and education policy initiatives.<sup>2,6</sup> The continuing trend is for schools and districts to treat such activity, in policy and practice, as desirable but not essential. Since they are not seen as essential, programs and staff are marginalized. Planning programs, services, and delivery systems tends to be done on an *ad hoc* basis; interventions are referred to as "auxiliary" or "support" services. Specialist personnel almost never are a prominent part of a school's organizational structure. Even worse, pupil services personnel usually are among those deemed dispensable as budgets tighten.

Given the relatively low policy priority, it is not surprising so little has been done at any administrative level to create the type of vision, leadership, and organizational structure necessary for integrating pupil services into schools in a comprehensive way. At present, specialist

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personnel rarely are included on governance and planning bodies. As districts move to decentralize authority and empower stakeholders at the school level, and as managed care takes hold, a realignment is likely in how pupil service personnel are governed and involved in school governance and collective bargaining. Ultimately, this realignment and efforts to improve cost-effectiveness will play a major role in determining how many interveners there are at a school.

Currently, several policy initiatives are under way at national, state, and local levels that may enhance the status of mental health in schools. For example, over the last decade, leaders concerned with school health have stressed the combination of counseling, psychological, and social services as one of eight components that comprise a school health program. To foster development of each states' capacity to improve school health programs, the Centers for

Figure 1  
**A Continuum of Community-School Programs**  
**Ranging From Primary Prevention to Treatment of Serious Problems**

<b>Intervention Continuum</b>	<b>Examples of Focus and Types of Intervention</b> (Programs and services aimed at system changes and individual needs)
<b>Primary Prevention</b>	<ol style="list-style-type: none"> <li>1. <b>Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness.</b> <ul style="list-style-type: none"> <li>• economic enhancement of those living in poverty, eg, work/welfare programs</li> <li>• safety, eg, instruction, regulations, lead abatement programs</li> <li>• physical and mental health, including healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth.</li> </ul> </li> <li>2. <b>Preschool-age support and assistance to enhance health and psychosocial development.</b> <ul style="list-style-type: none"> <li>• systems' enhancement through multidisciplinary team work, consultation, and staff development</li> <li>• education and social support for parents of preschoolers</li> <li>• quality day care</li> <li>• quality early education</li> <li>• appropriate screening and amelioration of physical and mental health and psychosocial problems</li> </ul> </li> </ol>
<b>Early-After-Onset Intervention</b>	<ol style="list-style-type: none"> <li>3. <b>Early-schooling targeted interventions.</b> <ul style="list-style-type: none"> <li>• orientations, welcoming and transition support into school and community life for students and their families, especially immigrants</li> <li>• support and guidance to ameliorate school adjustment problems</li> <li>• personalized instruction in the primary grades</li> <li>• additional support to address specific learning problems</li> <li>• parent involvement in problem solving</li> <li>• comprehensive and accessible psychosocial and physical and mental health programs, including a focus on community and home violence and other problems identified through community needs assessment</li> </ul> </li> <li>4. <b>Improvement and augmentation of ongoing regular support.</b> <ul style="list-style-type: none"> <li>• enhance systems through multidisciplinary team work, consultation, and staff development</li> <li>• preparation and support for school and life transitions</li> <li>• teaching "basics" of support and remediation to regular teachers, including use of available resource personnel, peer, and volunteer support</li> <li>• parent involvement in problem solving</li> <li>• resource support for parents-in-need, including, assistance in finding work, legal aid, ESL and citizenship classes, and so forth</li> <li>• comprehensive and accessible psychosocial and physical and mental health interventions, including health and physical education, recreation, violence reduction programs, and so forth</li> <li>• academic guidance and assistance</li> <li>• emergency and crisis prevention and response mechanisms</li> </ul> </li> <li>5. <b>Other interventions prior to referral for intensive, ongoing targeted treatments.</b> <ul style="list-style-type: none"> <li>• enhance systems through multidisciplinary team work, consultation, and staff development</li> <li>• short-term specialized interventions, including resource teacher instruction and family mobilization, and programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts</li> </ul> </li> </ol>
<b>Treatment for Severe/Chronic Problems</b>	<ol style="list-style-type: none"> <li>6. <b>Intensive treatments.</b> <ul style="list-style-type: none"> <li>• referral, triage, placement guidance and assistance, case management, and resource coordination</li> <li>• family preservation programs and services</li> <li>• special education and rehabilitation</li> <li>• dropout recovery and follow-up support</li> <li>• services for severe-chronic psychosocial/mental/physical health problems</li> </ul> </li> </ol>

Adapted from Adelman HS, Taylor L. **Learning Problems and Learning Disabilities: Moving Forward**. Pacific Grove, Calif: Brooks/Cole; 1993.

Disease Control and Prevention (CDC) set in motion an initiative to support an administrative arrangement designed to enhance interagency coordination.<sup>7</sup> Relatedly, the Educational Development Center, Inc., with funding from a cooperative agreement with CDC's Division of Adolescent and School Health, initiated a large-scale project to clarify how national organizations and state and local education and health agencies can advance school health programs.<sup>7</sup> Another example is seen in activity by the US Department of Education. Recognizing a lack of integrated effort across various federal agencies concerned with health and social services, in 1995 the department initiated a working group to focus on the problem. The department also included provision under the Improving America's Schools Act for school districts to divert a portion of their federal funding to organize service coordination. In addition, several branches of the US Department

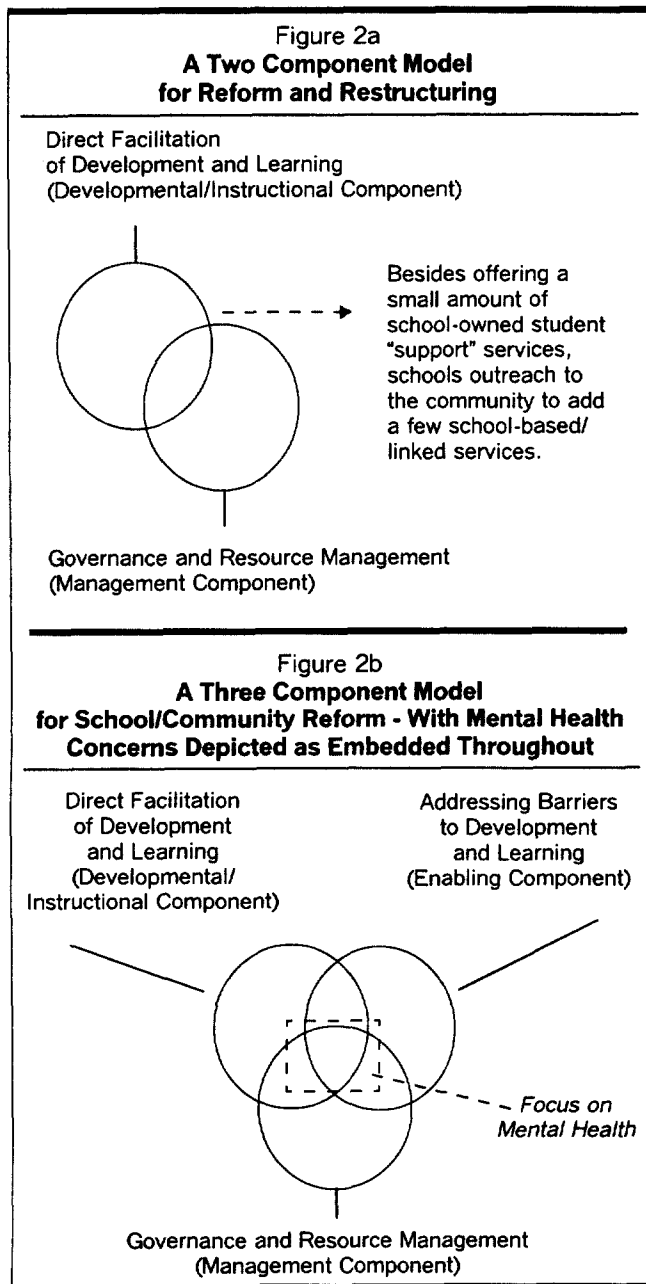
of Health and Human Services are involved in research and practice that benefits mental health in schools. For example, in 1995, the Office of Adolescent Health (Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau) undertook a major initiative to enhance mental health in schools. As a first step, two national training and technical assistance centers and five state projects were established and are already pursuing a wide range of activities designed to improve how schools address mental health concerns.<sup>9</sup> Other examples of policy movement are seen in the increasing number of initiatives by states, counties, and philanthropic foundations to stimulate school-community collaborations and enhance service integration.

### School-Community Collaborations

Concern about the fragmented way in which community health, including mental health, and human services are planned and implemented has renewed the 1960s human service integration movement. The hope is to better meet the needs of those served and use existing resources to serve greater numbers and to do so in a more comprehensive, accessible, and cost-effective manner. To these ends, considerable interest exists 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 around the country, including many statewide initiatives. In most cases, the focus is on serving families, which 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.

As the notion of school-community collaboration spreads, the terms services and programs are used interchangeably and the adjective comprehensive often is appended. This leads to confusion, especially since addressing a full range of factors affecting young people's development and learning requires going beyond services to utilize an extensive continuum of programmatic interventions. Services themselves should be differentiated to distinguish between narrow-band, personal/clinical services and broad-band, public health and social services.<sup>10</sup>

Further, although services can be provided as part of a program, not all are. For example, counseling to ameliorate a mental health problem can be offered on an *ad hoc* basis or may be one element of a multifaceted program to facilitate healthy social and emotional development. Pervasive and severe psychosocial problems, such as substance abuse, teen pregnancy, physical and sexual abuse, gang violence, and delinquency, require multifaceted, programmatic interventions. Besides providing services to correct existing problems, such interventions encompass primary prevention (eg, public health programs that target groups seen as "at risk") and a broad range of open enrollment didactic, enrichment, and recreation programs. As Schorr's recent analysis indicates, "multiple and interrelated problems...require multiple and interrelated solutions."<sup>11</sup> Differentiating services and programs and taking care in using the term comprehensive can help mediate against tendencies to limit the range of interventions and under-



scores the breadth of activity requiring coordination and integration.

### **School-Linked and School-Based Services**

The various initiatives for enhancing school-community collaboration have fostered the concept of school-linked services.<sup>12</sup> In analyzing school-linked service initiatives, Franklin and Streeter group them as — informal, coordinated, partnerships, collaborations, and integrated services.<sup>13</sup> These categories 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.

In practice, the terms school-linked and school-based encompass two separate dimensions: 1) where programs/services are located, and 2) who owns them. Taken literally, school-based should indicate activity carried out on a campus, and school-linked should refer to off-campus activity with formal connections to a school site. In either case, services may be owned by schools or community-based organizations, or in some cases, are co-owned. As commonly used, however, the term school-linked refers to community owned on- and off-campus services and is strongly associated with the notion of coordinated services. Relatedly, additional terms exist: wrap-around services, one-stop shopping, full-service schools, and community schools. The concept of systems of care also encompasses concern for coordination of community and school services, but usually this term is reserved for individuals designated as emotionally disturbed.<sup>14,15</sup> Adoption of these terms reflects the desire to develop a sufficient range of accessible interventions to meet the needs of those served. Many projects illustrating such concepts offer an array of medical, mental health, and social services housed in a Family Service or Resource Center established at or near a school.<sup>16</sup>

School health centers represent a new form of service provision. In the last decade, the number of health clinics has grown to more than 1,000. Most of these began as school-linked services in that they were established by community agencies. Initially, school-based clinics were created in response to concerns about teen pregnancy and a desire to enhance access to physical health care for underserved youth. Soon after opening, such clinics found it essential also to address mental health and psychosocial concerns. The need to do so reflects two basic realities. One, some students' physical complaints are psychogenic, and thus, treatment of various medical problems is aided by psychological intervention. Two, in a large number of cases, students come to clinics primarily for help with nonmedical problems, such as peer and family relationship problems, emotional distress, problems related to physical and sexual abuse, and concerns stemming from use of alcohol and other drugs. Indeed, up to 50%, and in some cases more, of clinic visits are for nonmedical concerns.<sup>17-19</sup> Thus, as these clinics evolve, so does the provision of counseling, psychological, and social services in the schools. At the same time, given the limited number of staff at such clinics and in the schools, it is not surprising that the demand for psychosocial interventions quickly outstrips the resources available, and the problem is compounded if the staff over-relies on a clinical model of direct services.

### **Needed: Better Connections**

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

Relatedly, tension has increased between school district service personnel and their counterparts in community-based organizations. When "outside" professionals are brought in, school specialists often view it as discounting their skills and threatening their jobs. The "outsiders" often feel unappreciated and may be rather naive about the culture of schools.<sup>20</sup> Conflicts arise over "turf," use of space, confidentiality, and liability.

In general, the movements toward integrated services and school-community collaboration aim at enhancing access to services by youth and their families, reducing redundancy, improving case management, coordinating resources, and increasing effectiveness. Obviously, these are desirable goals. In pursuing these ends, however, the tendency is to think mainly in terms of coordinating community services and putting some on school sites. This emphasis downplays the need for also restructuring the various education support programs and services that schools own and operate. Initiatives for school-community collaboration also have led some policymakers to the mistaken impression that community resources can effectively meet the needs of schools in addressing barriers to learning. In turn, this has led some legislators to view the linking of community services to schools as a way to free up the dollars underwriting school-owned services. The reality is that even when one adds together community and school assets, the total set of services in economically impoverished locales is woefully inadequate.<sup>21</sup> After the first few sites demonstrating school-community collaboration are in place, community agencies find they have stretched their resources to the limit.<sup>4</sup>

### **MOVING FROM A TWO TO A THREE COMPONENT MODEL TO CONNECT WITH SCHOOL REFORM**

Given that schools are not in the health business, initiatives aimed at directly and narrowly expanding physical and mental health activity in schools will continue to have a relatively low priority. Thus, in working with schools, we approach mental health and psychosocial concerns from the broader framework of addressing barriers to development, learning, and teaching. This broader approach allows us to encompass a range of policy concerns and strategies

designed to counter marginalization and enhance integrated collaboration between school and community resources.

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

Effectively addressing barriers to development, learning, and teaching requires a comprehensive, multifaceted continuum of community and school programs that encompasses a holistic and developmental emphasis and ranges from primary prevention and early-age intervention, through approaches for treating problems soon after onset, to treatment for severe and chronic problems (Figure 1). Moreover, the interventions need to focus on individuals, families, and the contexts in which they live, work, and play. Included are programs designed to promote and maintain safety at home and at school, programs to promote and maintain physical and mental health, preschool programs, early school-adjustment programs, programs to improve and augment ongoing social and academic supports, programs to intervene prior to referral for intensive treatments, and programs providing intensive treatments. A basic assumption is that the least-restrictive and nonintrusive forms of intervention required to address problems and accommodate diversity should be used. Another assumption is that many problems are not discrete, and therefore, interventions that address root causes can minimize the trend to develop separate programs for every observed problem.

With respect to concerns about integrating activity, the continuum of community and school interventions exemplified in Figure 1 underscores that systemic collaboration is essential to establishing interprogram connections on a daily basis and over time. The continuum must include systems of prevention, systems of early intervention to address problems as soon after onset as feasible, and systems of care for those with chronic and severe problems. And each of these systems must be connected effectively. Such connections may involve horizontal and vertical restructuring of programs and services: a) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies; and b) within jurisdictions, school districts, and community agencies (eg, among departments, divisions, units, schools, clusters of schools).

Currently, most reforms are not generating the type of comprehensive, multifaceted approach necessary to address the many overlapping barriers — including those factors that make schools and communities unsafe and lead to substance abuse, teen pregnancy, dropouts, and so forth. As discussed, developing such an approach requires more than outreach to link with community resources (and certainly more than adopting a school-linked services model), more than coordination of school-owned services, more than coordination of school and community services, and more than Family Resource Centers and Full-Service Schools.

### **The Concept of an Enabling Component**

Viewing school/community environments through the lens of addressing barriers to development, learning, and teaching suggests the need for a basic policy shift. The present situation is one where, despite awareness of the many barriers, school and community reformers continue to concentrate mainly on improving efforts to directly facilitate learning and development (instruction) and system

management (Figure 2a). In effect, current policy pursues school and community reforms using a two rather than a three component model. This ignores the need to fundamentally restructure school and community support programs and services and continues to marginalize efforts to design the type of environments essential to the success of school reforms (eg, environments designed to effectively address barriers to teaching and learning).

To address gaps in current reform and restructuring initiatives, the concept of the Enabling Component was introduced as a policy-oriented notion around which to unify efforts to address barriers to development, learning, and teaching.<sup>2,22-24</sup> The concept is intended to underscore that: a) current reforms are based on an inadequate two component model for restructuring school and community resources; and b) movement to a three component model is necessary if all young people are to benefit appropriately from their formal schooling.

A three component model calls for elevating efforts to address barriers to development, learning, and teaching to the level of one of three fundamental and essential facets of education reform and school and community agency restructuring (Figure 2b). To enable teachers to teach effectively, we suggest there must not only be effective instruction and well-managed schools, but that barriers must be handled in a comprehensive way. All three components are seen as essential, complementary, and overlapping.

By calling for reforms that fully integrate a focus on addressing barriers, the concept of an Enabling Component provides a unifying framework for responding to a wide range of psychosocial factors interfering with young people's learning and performance and encompasses the type of models described as full-service schools — and goes beyond them. Adoption of such an inclusive unifying concept is seen as pivotal in convincing policymakers to move to a position that recognizes the essential nature of activity to enable learning. More specifically, the Enabling Component concept calls on reformers to expand the current emphasis on improving instruction and school management to include a comprehensive component for addressing barriers to learning.

Emergence of a cohesive Enabling Component requires policy reform and operational restructuring that allow for weaving together what is available at a school, expanding this through integrating school, community, and home resources, and enhancing access to community resources by linking as many as feasible to programs at school. This involves extensive restructuring of school-owned enabling activity, such as pupil services and special and compensatory education programs. In the process, mechanisms must be developed to coordinate and eventually integrate school-owned enabling activity and school and community-owned resources. Restructuring must also ensure that the enabling component is well-integrated with the developmental/instructional and management components. The importance of such integration, is to minimize fragmentation, avoid marginalization, and ensure that efforts to address problems (eg, learning and behavior problems) are implemented on a schoolwide basis and play out in classrooms.

Although some calls for comprehensive approaches are attracting attention, they do not convey the perspective that interventions addressing barriers to development, learning,

and teaching are essential to the success of school reform. The next step in moving toward a comprehensive approach is for school and community reformers to expand their vision beyond refining processes to facilitate instruction/development and improve system management. To this end, the following message must be brought home to policymakers at all levels: current reforms cannot produce desired outcomes as long as the third primary and essential set of functions related to enabling development, learning, and teaching is so marginalized. Evidence of the value of rallying around a broad unifying concept, such as an enabling component, is seen in the pioneering efforts underway in several school districts, such as the Los Angeles Unified School District, Memphis City Schools, Central O'ahu District, and in comprehensive school reform models, such as the New American Schools' Urban Learning Center Model.

### A Model for an Enabling Component at a School Site

An enabling component overlaps the instructional component (Figure 2b). The intent is to ensure a school-wide approach and one that enhances instructional processes in every classroom. Operationalizing an enabling component requires formulating a delimited framework of basic programmatic areas and creating an infrastructure to restructure enabling activity. Based on an extensive analysis of activity used to address barriers to learning, enabling activity is clustered into six interrelated areas: **Classroom-focused enabling** — stressing classroom reforms that help teachers enhance the way they assist students with “garden variety” learning, behavior, and emotional problems, including ways to enhance motivation, use prereferral interventions and special accommodations, etc. **Support for transitions** — encompassing such activity as welcoming and social support for new students and families, articulation, and before and after school programs. **Student and family assistance** — which provides health and human services, sometimes offered in the context of a family resource center and a school-based clinic. The remaining areas encompass **Crisis response and prevention, Home involvement in schooling, and Community outreach** — including an extensive focus on using volunteers. Detailed discussion of each area can be found in previous articles.<sup>25</sup>

Clearly, a well-designed and supported infrastructure is needed to establish, maintain, and evolve this type of a comprehensive, programmatic approach. Such an infrastructure includes mechanisms for governance, capacity building (including stakeholder development), coordination among enabling activity, enhancement of resources by developing direct linkages between school and community programs, movement toward increased integration of school and community resources, and integration of the developmental/instructional, enabling, and management components.<sup>24,26-28</sup> The infrastructure also benefits when multimedia advanced technology are incorporated to support all activity.

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

### Getting From Here to There

A policy shift and programmatic focus are necessary but insufficient. For significant systemic change to occur, policy and program commitments must be demonstrated through allocation/ redeployment of resources, such as finances, personnel, time, space, and equipment, that can adequately operationalize policy and promising practices. In particular, sufficient resources must exist to develop an effective structural foundation for system change. Existing infrastructure mechanisms must be modified in ways that guarantee new policy directions are translated into appropriate daily practices. Well-designed infrastructure mechanisms ensure there is local ownership, a critical mass of committed stakeholders, processes that can overcome barriers to stakeholders working together effectively, and strategies that can mobilize and maintain proactive effort so that changes are implemented and renewed over time.<sup>1</sup> Institutionalizing a cohesive and comprehensive approach requires redesigning mechanisms with respect to at least five basic infrastructure concerns: 1) governance; 2) planning implementation associated with specific organizational and program objectives; 3) coordination/ integration for cohesion; 4) daily leadership; and 5) communication and information management. In reforming mechanisms, new collaborative arrangements must be established, and authority (power) must be redistributed — all of which is easy to say and extremely hard to accomplish. Reform obviously requires providing adequate support (time, space, materials, equipment) — not just initially but over time — to those who operate the mechanisms. In addition, appropriate incentives and safeguards must exist for those undertaking the tasks.

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

Further, the institutional changes for moving toward comprehensive, integrated approaches cannot be achieved without sophisticated and appropriately financed systemic change processes. Restructuring on a large-scale involves substantive organizational and programmatic transformation at multiple jurisdictional levels. Although this seems self-evident, its profound implications are widely ignored.<sup>11,20,26,29-32</sup>

Elsewhere, we present the model we are evolving for the widespread diffusion of new approaches such as an enabling component.<sup>33</sup> The model draws on a diverse body of literature related to organizational change and community psychology, as well as practices evolved as part of several restructuring efforts. A few points are highlighted. At school and district levels, key stakeholders and their leadership must understand and commit to restructuring. Commitment must be reflected in policy statements and

creation of an organizational structure that ensures effective leadership and resources. The process begins with activity designed to create readiness for the necessary changes by enhancing a climate/culture for change. Steps involved include: 1) building interest and consensus for developing a comprehensive approach to addressing barriers to learning and enhancing healthy development; 2) introducing basic concepts to relevant groups of stakeholders; 3) establishing a policy framework that recognizes the approach is a primary and essential facet of the institution's activity; and 4) appointment of leaders (of equivalent status to the leaders for the instructional and management facets) at school and district levels who can ensure policy commitments are carried out.

Overlapping efforts to create readiness are processes to develop an organizational structure for start-up and phase-in. This involves: a) establishing mechanisms and procedures to guide reforms, such as a steering group and leadership training; b) formulating specific start-up and phase-in plans; c) establishing and training of a team that analyzes, restructures, and enhances resources with the aim of evolving a comprehensive, integrated approach; d) phasing in reorganization of all enabling activity; e) outreach to establish collaborative linkages among schools and district and community resources; and f) establishing systems to ensure quality improvement, momentum for reforms, and a sense of ongoing renewal.

Schools require assistance in establishing and maintaining an appropriate infrastructure for enabling activity. A specially trained organization facilitator represents a mechanism that embodies the necessary expertise to help: a) develop essential school-based leadership; b) establish program, coordinating, and resource teams; and c) clarify how to link up with community programs and enhance community involvement.<sup>23,24,26</sup> Work to date suggests that a relatively small cadre of organization facilitators should be able to phase-in desired mechanisms throughout a relatively large district over a period of about five to six years.

## CONCLUDING COMMENTS

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

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

Also needed is a program of policy research focused on

resource concerns. With respect to cost-effectiveness, school finance studies suggest that about 7% of school budgets formally goes to student support services.<sup>34</sup> However, it remains unclear how much additional money actually is used to address barriers to learning — drawing on funding for compensatory education, special education, and safe and drug-free schools, as well as various other resource pools. It seems likely that at many schools the percentage of the school budget spent on enabling activity is significantly greater than 7%. Studies are needed to answer the question: What percentage of a school's resources is expended on such activity? A related but more complex matter for study arises because of widespread complaints about the fragmentation produced by categorical funding. Research is needed to describe the impact and assess the cost-benefits of separate funding streams and the degree to which they contribute to a lack of cohesion in daily practice at school sites.

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

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

to study such matters is provided by the 1998 federal initiative to foster adoption of comprehensive school reform models by providing financial incentives to schools that are eligible for Title I basic grants. The legislation specifies 22 models from which schools can choose.

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

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

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

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

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