

EMERGING MODELS

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Approximately 8 million children in America's schools are in need of mental health services. According to best estimates fewer than 2 million of these children receive the needed services, and the treatment they receive is often inadequate.^{18, 19} Child psychiatrists should be working with schools to meet the unmet needs of these millions of school children. This article describes seven programs that have shifted from the traditional approach of providing mental health consultation services to school personnel to procedures that include more interventive approaches. Such a shift has the potential to increase the psychiatrist's role in America's schools by maximizing limited resources in the profession, offering the ability to tap into new funding mandates, and capitalizing on the continuity of services offered by schools.

PSYCHIATRIC CONSULTATION

The 1950s saw the advent of community psychiatry and the expansion of mental consultation to many agencies. Caplan,⁷ Berlin,⁴ and others defined consultation as an indirect process with the goal of providing insight to school personnel about how to manage mental health issues especially for students' behavioral challenges in the classroom. Since 1975 and the passage of Public Law 94-142, consultation to schools has become more interventive, often providing direct service to students. Child psychiatrists who consult in schools often spend most of their time considering the needs of children assigned to special

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education services. In this work with special education students, there is a large range of tasks that psychiatrists are asked to provide when approached by a school district for help. These can include identifying learning barriers, assessing students for medication, helping an administrator or an education team determine if the school setting is appropriate for individual students, and even helping to design successful alternative programs.¹⁷ This is a departure from previous consultation models, but it became necessary to serve the thousands of needy children and adolescents in schools.

It has been estimated that 10% to 20% of US students could benefit from mental health services. Up to 10% of students are enrolled in special education programs, and one in five to one in ten of these students are receiving mental health attention; however, there is evidence that these students are not necessarily receiving adequate services such as psychologic treatment or medication assessment.¹⁸

There is no consensus or strong evidence of how to best serve children with learning and emotional disabilities in the school setting. The most recent trend is inclusion or the integration of special education students into the regular classroom. It is not clear whether children with special needs who are placed in mainstream settings receive the services they need to reach their potential or if inclusion is primarily a cost-saving measure for the districts. The pressure for inclusion frequently comes from parents of children with disabilities who see inclusion as an opportunity for their child to be positively challenged by high-functioning peers. They hope that their child may then model more age-appropriate behavior.²⁴ This may be the result for some children, but the implementation of inclusion often has added to the stress of regular education classroom teachers and deprived some students of the support available in smaller classes. Teachers also are under increasing pressure by states to cover large amounts of content and raise the performance of students despite large class sizes and little or no meaningful planning time during the school day. Many of these teachers do not have the necessary understanding of the special education children's difficulties. Mental health consultation to these teachers is crucial in expanding their repertoire.

Other Paradigms

Adelman and Taylor¹ point out that education system resources are sparse and that frequently those students who require legislatively mandated services receive short-term interventions that are usually narrowly focused and ineffective. They encourage consultants to help school systems map and analyze their utilization of personnel to eliminate fragmentation, increase efficacy, and minimize redundancy. Many mental health professionals now recognize the need for changing the nature of our involvement with children who need our services, specifically providing services where the children are—in school, 35 hours a week.

They also realize that acting alone as psychiatrists limits our impact, whereas working as a larger mental health "team" along with teachers, administrators, school counselors, and so forth dramatically improves our efficacy in addressing the mental health needs of America's children. Although traditional consultations do provide needed services and support to many school personnel and children, the task is daunting.

Emerging Paradigm

Dryfoos¹² provides a comprehensive review of prevention programs in elementary and high schools. She identified those successful programs that share a number of common elements despite differences in program size, complexity, goals, and level of documentation. In effective programs, high-risk children are connected to a responsible adult. The other common aspect of successful programs is their efforts to access and coordinate a number of programs and services, with an emphasis on early identification and intervention.

In reviewing the lessons learned from the models, the experts agree that there is no one solution to providing mental health services for high-risk children. They agree that a package of services is required, and special attention to the training, timing of the intervention, and the sustainability or continuity of effort is needed.

In traditional consultations, most consultants are called upon to provide a circumscribed role to a designated consultee group (e.g. special education, teachers, administrators, and so forth). Some consultants achieve a broader systemic focus. Jellinek,¹⁷ in a small district, was able to offer consultative services to all levels of the school personnel in the district on an ad hoc basis. In other districts, consultation to key administrators was effective in improving performance of a larger number of personnel.⁵ Other consultant groups offer system-wide programs such as behavioral programs to reduce bullying behavior (see article by Gault elsewhere in this issue).

As more students require comprehensive, costly services to progress in school, effective on-site alternative educational programs have become more attractive. In 1996, Andover, a suburban Boston school district, launched the Andover Seaport Program in one middle school to assist nine children with severe emotional or behavioral impediments to learning.⁶ Based on a resilience paradigm, the program attempted to develop positive school functioning by cultivating a surrogate family atmosphere by using community resources to provide indirect instruction and by providing teachers weekly collaborative consultation with mental health clinicians to optimize instruction. While an educational psychologist worked with students' families biweekly to ally school and home efforts, a psychiatric consultant spent 1 hour per week with school staff addressing emerging problems. At the discretion of the teachers, the psychiatric consultant would sometimes, with proper consent, interact directly with students or family members, although no formal treatment

(medication or psychotherapy) was provided. The consultant did, however, assist school staff in accessing relevant resources, such as recreational, treatment, or community supports, contingent on student's needs. The consultation techniques used in this program are described elsewhere in this volume (see article by Bostic and Bagnell). Although psychiatric consultation is only one small component responsible for the benefits obtained in this program, if only one student is prevented from requiring outside placement, the system can use this money to cover a contract for 5 years of psychiatrist consultation.

Outcomes from the Andover Seaport Program are encouraging. During the first year, student grades improved 66%, absenteeism decreased 62%, tardiness and dismissals each decreased 88%, and 43% of students mainstreamed half the school day after 1 year. Parent satisfaction with the program was high, and the program saved the school district approximately \$15,000 per student in the program. The program expanded to the high school the following year, and the psychiatric consultant's paid time was increased.

The Andover Seaport Program suggests that psychiatric consultation can benefit students and improve staff morale as well as teaching options and still be cost-effective for school districts. Perhaps more telling, neighboring school districts purchased and implemented the Andover Seaport Program and similarly expanded the program each year to additional schools within their districts. This model, however, has been limited to suburban areas where additional (treating) child psychiatrists are available; in more rural areas, psychiatric consultants might not have the option of referring students to other providers. Indeed, as more schools are included, time spent driving between sites has increased, essentially decreasing staff-consultant time, so that video conferencing alternatives are now being considered.¹⁶ In addition, many school districts only rarely send students to out-of-district placements; thus, cost benefits might differ. Finally, the program has been implemented only in relatively small school districts for approximately 10 carefully selected students at each school site and where personnel turnover is low, allowing the psychiatric consultant to become a familiar "ally."

Systemic Interventions

One of the earliest and more comprehensive approaches to the use of more interventive psychiatric consultation was developed by James Comer during the last 30 years.⁹ The "Comer Process" dramatically bridges child psychiatry and education by providing a method for reforming educational systems to promote learning in a developmental context that highlights the needs of the students. Comer advocated the perspective that schools can provide pivotal protective roles by fostering children's development through positive relationship with teachers and administrators who could have a direct impact on the students' capacity to learn. He encouraged schools to include parents in substantive ways

such as participating in school governance. He suggested that a consulting psychiatrist could catalyze needed change by (1) providing feedback and coaching necessary for new behaviors, (2) providing valuable process consultation to a team with well-established internal dynamics, (3) and offering help to establish meaningful benchmarks of student/system progress.

In his book, *Waiting for a Miracle: Why Schools Can't Solve Our Problems and How We Can*, he emphasizes that, "for the common good, society needs to systematically promote adequate development and create a system of schooling that can begin to help us solve societal and cultural problems rather than simply reflect them."¹⁰ In answer to this challenge, he implemented the School Development Program that is used in more than 450 schools in 17 states and several foreign countries. In his comprehensive structural changes, Comer addresses school climate, curriculum alignment, and efficiency. His focus is on consensus, collaboration, and a no-fault stance. He advocates that "rebuilding the learning community is critical to the growth of its children and relationships are at the core of that rebuilding." He recognizes that "strong relationships are prerequisites for growth and learning and that the relationships between students and teachers must be supported by strong relationships among adults."¹¹ Comer pays particular attention to the entry process and taking the time for the stakeholders to agree with the necessary changes.

Comer's model for school reform takes into consideration the fact that programs need to be tailored to the school's needs. Of the schools that have used the Comer process, one third have had dramatic results, one third showed some moderate improvement, and one third were little changed. He acknowledges that efforts to improve academic and social outcomes take significant time to develop and that often these processes have multiple unanticipated influences. Rigorous scientific protocols are difficult in school environments where there is often a lot of change.

Prevention Practitioners

Several other programs have emerged that are more interventive in entering classrooms and changing school structure. One modest program is the Harvard RALLY project (Responsive Advocacy for Learning and Life in Youth).²¹ It is primarily a program that invests resources early on but will not make extensive changes in the school structure. This program attempts a new kind of intervention using prevention practitioners who bridge health and mental health services and other community resources in response to the needs of at-risk youths in schools. The model is to build a relationship between the student and a committed adult who helps the student achieve higher yet still realistic expectations that are aligned with concrete skills. Students are paired with prevention practitioners who help them with their academic, social, and emotional performances within the classroom and school setting. They also help

dents spend one morning a week at the school providing evaluation, consultation, and short-term counseling services. The prevention practitioners provide comprehensive referral information.

The RALLY program is unique in that it has been successful primarily with students who have needed only moderate support. Its advantage is that the practitioners' presence in the regular classroom in effect provides services to all the children in the classroom, not just individuals identified as special needs students. They are therefore better able to identify problems early on. Noam et al²¹ support the concept of "pulling in" services to the classroom as a means to better monitor students' progress and tailor appropriate interventions. Currently, the program is funded in part through local grants and collaborative institutions and relies on the practitioners who are in training. There is a yearly turnover.

The program has been evaluated both qualitatively and with developmental and baseline measures. Although students apparently benefited from improved relationship building, skill training, and service and resource linkage, Noam et al²¹ admit that it has been challenging to integrate the prevention practitioner's approach into the classroom. This approach clearly has appealed to the more receptive teachers. One inherent flaw in the design is that the annual turnover of the prevention practitioners and the rotation of the child psychiatry fellows hamper continuity of care.

Advising Programs

Recognizing the critical need for continuity of constructive relationships with students as a way of encouraging adolescents to engage in academics and achieve their potential, this author has focused on the evolution of an advising program. In small alternative high schools and private schools, well-planned advising programs have made a difference in outcomes for at-risk students.²³ In larger public high schools, however, advising programs are not consistently executed or sufficiently evaluated if tried at all.

Like many other urban high schools, Cambridge Rindge and Latin High School (CRLS) in Cambridge, MA, is a challenging environment in which to implement a program. Of its population of roughly 2000 students, approximately 60% are racial or ethnic minorities, more than half are eligible to receive free lunches, and one third speak a first language other than English. At CRLS, many students do not have the grades to have a realistic chance of going to a good college. At CRLS, 30% of all students fail at least one class every semester. The percentages for minorities are even higher: 47% for African-American students and 38% for Latino students.

In this advising program, rather than pulling in resources as the RALLY project does, the program emphasizes protected time for teachers to build constructive relationships that allow for reflection as a vehicle

for learning. Groups are led by teachers who, in exchange for a lighter course load, meet weekly with students. There is an effort to have each advisor also have the students in daily homeroom and an academic class. The meetings are held during the regular school day and last for a typical class period. There is a specific curriculum that covers such areas as orientation, study skills, negotiating conflict, and identifying learning skills. There is also plenty of room for advisors to adapt to the needs of the students.

There are systemic obstacles that are necessary to overcome when implementing the advising program, such as scheduling, student participation, teacher buy-in, teacher compensation for participation, and the historical propensity to shift commitment. Despite these obstacles, the advising program at CRLS is expanding for the student's 4-year high school experience. This program is a unique opportunity to understand the impact longitudinally on adolescent development (on self-concept and higher rate of engagement) if a public school system develops its capacity to provide access to a consistent, positive adult. The advising program evaluations show that a majority of advisors say that this is a powerful way to build a positive connection with their students.

State-Wide School Coordination of School Mental Health

A largely rural state, New Mexico has one of the largest rates of uninsured children in the United States and some of the highest rates of poverty, substance abuse, suicide, and school dropout. In an effort to provide critical additional support, New Mexico has designed a comprehensive approach to build capacity by developing state-wide schools' mental health infrastructure. Adelsheim,² a child psychiatrist in New Mexico, initiated a state-wide coordinated response to school mental health. By forging partnerships with government, school mental health, and university-based residencies, there is an impressive coordinated package of services to support students with multiple problems.

The state

- collects compelling data that demonstrate the critical need for services
- provides system-wide training for teachers in how to identify children's mental health issues and to provide adequate responses in the classroom
- expands school-community collaboration
- advocates for school mental health legislation
- develops school mental health assessments for at risk children.

As the child psychiatry director of New Mexico's school mental health initiative (SMHI), Adelsheim developed regional school mental health advocate positions that provide technical assistance to districts. An expanded state-wide insurance plan (state children's health insur-

ance plan) for uninsured children provides expanded wraparound services for indigent children. These wraparound services include more intensive services such as home visiting services for first-time mothers and behavioral health respite care.⁸ These active state-wide steps of increased assessment, collaboration, and early intervention alleviate the isolation of many schools.

SCHOOL-BASED MENTAL HEALTH CENTERS

The acme of school intervention measures has been the rise of school-based clinics in secondary and even some elementary schools. There are presently more than 1000 school-based health centers, with some centers located in almost every state.²³ School-based centers provide both a public health opportunity and a challenging clinical and administrative role for the child and adolescent psychiatrist working in schools.¹ Psychiatrists can collaboratively critically analyze techniques for screening of students at risk and evaluate efficacy of treatment.³ The advantages of school-based services over traditional services include greater access to children, adolescents, and families and less stigma being attached to receiving services as well as the opportunities for mental health professionals to observe students in multiple school settings and the possibility of early intervention.²⁰

In school-based mental health centers in Dallas, a child adolescent psychiatrist developed a collaborative, multidisciplinary mental health treatment team to initiate district-wide school-based mental health services.²² The program served 160,000 students in more than 200 schools. Initially, the program reported a nearly 100% compliance rate, although there has been a drop-off as the program expanded. Of note, however, is that the Youth Family Centers (YFC) service 20 to 25 school campuses. The design seems to have shifted from on-site school mental health centers to off-site liaison intervention. The evaluation conducted by Dallas public schools and independent evaluators included quantitative outcome evaluation, student school successes outcomes (grade, attendance, behavior), and qualitative measures (ratings of satisfaction). Despite impressive results, Dallas has faced significant challenges to this service delivery system, including decreased compliance rates and a shift in political climate, which has drastically reduced its funding sources. Thus, the expectation that a child can expect to receive services throughout his or her school life from preschool through grade 12 is questionable at this point.¹⁹ A modification of service delivery is required as Dallas encounters the vicissitudes and challenges of providing stable, consistent access and mental health care in the school setting.

In Charlotte, North Carolina, Casat et al⁶ have played a key role in designing a model for school-based services in an urban public school system of 90,000 students. Currently, the behavioral health center focuses on 24 elementary schools because of recognition by the schools that an early intervention program is a better allocation of resources than the more expensive later intervention. Casat's model uses school personnel

to identify students and families who may benefit from diagnostic assessment, aggression and socialization groups, parent training, and medication services. The team psychiatrist provides medical evaluation, staff training, and supervision. In Charlotte, group interventions use a formatted treatment plan to ensure treatment fidelity. The model has struggled with professional turnover and with determining how to best clarify agreements between school and clinical services.

Currently, there is no established best practices guideline or model for delivering cost-effective care to students and families that focuses on outcomes that demonstrates conclusively that school-based mental health centers are more effective than less interventive approaches. As school-based clinics expand, it is critical to pay attention to the obstacles. There are many potential areas of research, and presently two centers provide technical assistance nationally (Center for School Mental Health Assistance, Baltimore, and UCLA Center for Mental Health, Los Angeles). These centers are focusing on defining future data-based strategies for process- and outcome-focused evaluations on a multisite basis.²⁴

Prototypical school-based mental health programs need to address several challenges. Adelson³ outlines some of these: (1) Determination of what systems to use to identify students in need of school-based mental health services. (2) Once students are identified, ensuring that services are available. (3) In terms of establishing clinical treatment, there must be random and controlled treatment to assess the quality and consistency of the interventions.³ This is particularly challenging because of ethical and resource concerns.²⁴ It is challenging to document measurable outcomes in mental health (symptoms, adaptive behaviors) and improved classroom behavior (increased academic achievement, attendance. (4) Identification of the type of school-based mental health services that students are willing to utilize. (5) Identification of barriers to care and development of successful ways to overcome these barriers (i.e., financial, stigma, language, or cultural barrier). (6) Clarification of the best mechanisms for engaging students who are reluctant to seek help.

VIDEO SCHOOL CONSULTATION

Innovative projects for providing psychiatric consultation to aid educators are being developed. One example is video school consultation. This has potential to expand the child psychiatrists' consistent availability to those schools most in need that have the least access to mental health services. Many school are simply too far away from psychiatrists to maintain regular consultation. Harper and Santos¹⁶ described a video consultation service with multiple schools in Houston, Texas, as well as with schools as far away as 400 miles away.

The University of Texas-Houston Medical School (UT-HMS) Tele-Education Project began in the fall of 1998 at Whittier Elementary School in the Houston Independent School District. This school of 600 students in grades K-5 is located in an urban low-to-middle socioeconomic area.

Initially, the school's needs were clarified. Then, the logistical availability of child psychiatrists in a tertiary care academic center, the school, and UT-HMS Department of Psychiatry was determined. UT-HMS devised a mental health consultation model using video conferencing based at the Harris County Psychiatric Center (HCPC), a freestanding psychiatric hospital operated by the department. Dedicated telephone lines connect UT psychiatrists and psychologists with 27 schools in the Houston area as well as with juvenile justice and child protective services facilities. Equipment at the hospital includes a desktop computer, camera, two monitors, and a document projector. The remote sites are equipped with a television and camera.

The video conferencing project was launched at an annual teacher in-service day held at HCPC. During this in-service day, Dr. Harper and other UT faculty met face-to-face with the faculty "consultees" for 1 day before shifting to video conferencing from remote locations. Teachers identified and prioritized topics (e.g., how to identify and educate students with various psychiatric disorders, what to do about suspicions of child abuse, etc.), so that UT-HMS psychiatrists and psychologists could provide specific information. A typical consultation of 1 hour consisted of a brief (20-minute) presentation, with the remaining time devoted to mental health consultation as needed by the school faculty. Faculty coverage of the sessions rotates among a group of interested psychiatrists and psychologists. The psychiatrists did not video conference with students or parents and did not provide treatment, although they recommended interventions for the classroom, connected school personnel with appropriate community service agencies, and helped school personnel determine appropriate steps to help individual students and families access appropriate resources. Faculty consistently attended and stayed "after school" for this service and described satisfaction with the video modality so that it was extended the following year to other schools. Teachers were comfortable with the remote video interactions and requested only that the same "consultant" be available for longer time blocks (4 weeks) so that problems might be "worked through" with psychiatrists familiar to a problem. Accordingly, Child Psychiatry Fellows now participate in these consultations for 3-month blocks, thereby providing continuity while clinical faculty provides more expertise about specific issues. In addition to improved teacher skills, Harper and Santos¹⁶ report improved teacher skills.

Telecommunications may allow redefinition of how psychiatric services can be provided to staff and potentially to parents and students, particularly in geographically isolated regions.

SUMMARY

In all these models, the potential of child psychiatrists and other mental health professionals in decreasing student barriers to learning is promising. While expanding the traditional client service model, child

psychiatrists can serve as advocates for identifying student's unmet mental health needs, encourage schools to build capacity for effective responses, be vigilant for quality assurance, develop and initiate new programs that systematically respond to needs of the school community, and provide training opportunities that demystify the psychiatric concepts that can help administrators and teachers.

Relatively few child psychiatrists are active in the school setting or have developed a presence in the national movement to provide mental health services in schools. In recognition of the fact that traditional models of psychiatric care such as outpatient clinics and hospital-based programs do not reach many children and adolescents, it is hoped that child psychiatrists will be more motivated to have a more active and rewarding presence in the school setting.³ Even with the variety of responses to the need for increasing mental health services to children, there are a lot of unanswered questions. With only 8000 child psychiatrists in the United States and 80,000 schools, it is clear that we need to be strategic about how best to utilize our resources.¹⁶ The big question is whether there are predictable and alterable characteristics, mechanisms, and interactive processes that enable high-risk students to attain educational and personal success, despite seemingly poor odds.¹⁰ Emerging models have the potential to begin answering this question.

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