To some influential teachers who inspired us to dig deeper and reach higher:

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As considered here, consultation is an indirect model of delivering psychological and/or educational services. Within this model, a specialist (consultant) and staff member (consultee) work together to optimize the functioning of a client in the staff member’s setting and to increase the staff member’s capacity to deal with similar situations in the future. In schools, for example, a psychologist may consult with a teacher about a student in the teacher’s classroom. The practice of school consultation has burgeoned since its formal introduction into public education during the 1960s. Today, graduate training programs in various specialties of psychology and education require coursework in consultation, and many professionals in these areas spend some portion of their day engaged in consultation.

Consultation can be a powerful tool for delivering specialized services in schools, but only when the consultant possesses a requisite level of skill and sophistication. In preparing this volume, we envisioned its major purpose as reducing the level of naiveté typically experienced by the beginning school consultant. Toward that end, we offer a systematic approach to school consultation that targets much of the information needed for one to consult in a competent manner. The reader should note that our use of the somewhat ambiguous term school consultant is intentional and recognizes that consultants working in schools today represent a variety of professional disciplines. The primary intended audiences for this book, however, are school psychologists and clinical child psychologists, although psychologists having other specialties are likely to find its content useful. A clear secondary audience is educational specialists, including counselors, special educators, and school social workers. What the reader must have to benefit from our approach is a solid background in psychology, a content area of expertise from which to draw, and well-developed human relations skills.

We believe the overall method of school consultation detailed in this book is different from others that have been published previously. In stating that it is different, we are not claiming that it is wholly original. Our goal instead has been to incorporate the most useful conceptual and/or empirically supported principles of known consultation approaches into a single model that is particularly relevant to school-based practice. More specifically, the model of school consultation we promote attempts to integrate aspects of the historically separate models of mental health consultation and behavioral consultation, along with principles of interpersonal
influence, social support, and organizational psychology. In our model, the effective practice of school consultation is linked to the accomplishment of three interrelated tasks – the problem-solving, social influence, and support and development tasks.

Structurally, this volume is comprised of three major sections. The first of these consists of four chapters that describe foundational information, including historical and conceptual information (Chap. 1) as well as the contemporary context for school-based service delivery, including tiered systems of intervention and response to intervention (Chap. 2); using interpersonal influence in consultation (Chap. 3); and understanding the school as a setting for consultation (Chap. 4). The second section, comprised of Chaps. 5–8, documents important processes and outcomes of school consultation. Chapters 5 and 6 present our integrated model of consultation, focusing on elements of mental health consultation, behavioral consultation, professional support, problem solving, social influence, and the organizational context. Moving away somewhat from these core elements, Chap. 7 provides information on assessment issues and strategies of particular relevance to consultation, and Chap. 8 describes the importance of and provides practical models for selecting effective school-based interventions. Chapters 9 through 11 form the third section. Key participants in school consultation, teachers and students, are described in Chaps. 9 and 10, respectively. Chapter 11 contains a transcribed consultation case study that illustrates many aspects of school consultation in general and the integrated model in particular. Chapter 12 is an epilog that reviews important points and looks ahead to the future effective practice of school consultation. New to this third edition are Chaps. 2 and 7.

We have been very heartened by the positive reactions of students and colleagues to earlier editions of School Consultation: Conceptual and Empirical Bases of Practice. For example, Hintze (1998) wrote: “In reviewing the text, I found myself reflecting on what was being proposed from a variety of perspectives: ‘how much easier this is going to make my teaching,’ ‘this is just the type of book students have been asking for,’ ‘that’s exactly what I experienced as a practitioner,’ or ‘I wish I had a book like this when I was being trained.’” Meyers and Coleman (2004) noted: “Erchul and Martens offer an astute and scholarly discussion of school-based consultation…after reading this thought-provoking book, one is left with an enhanced theoretical understanding of consultation and is thus better prepared to practice with confidence and a clear sense of purpose.” We hope that readers of the third edition will find it just as useful.

We have heard that one of the strengths of the earlier editions lay in its concise presentation of many topics germane to school consultation. That emphasis is retained here, but we also acknowledge there is much more to consultative practice than a single source can adequately cover. Therefore, instructors selecting this book for their graduate-level courses may wish to supplement it with others. We suggest the following sources for deeper coverage of indicated topics: Caplan and Caplan (1993/1999; mental health consultation); Kratochwill and Bergan (1990; behavioral consultation); Sheridan and Kratochwill (2007; conjoint behavioral consultation); Jimerson, Burns and VanDerHeyden (2007; response to intervention); Grigorenko (2008; Individuals with Disabilities Education Improvement Act of 2004); and Erchul and Sheridan (2008a; school consultation research).
Books are seldom the result only of their authors’ efforts, and with this in mind, we wish to express our gratitude to several individuals. Stephanie Asbeck, Priscilla Grissom, and Lynne Myers are thanked for their careful proofreading, editing, and indexing efforts. We also appreciate Blair Johnson’s help in preparing Fig. 6.1. We thank Judy Jones, Garth Haller, and other staff members at Springer for their considerable assistance in putting our ideas into print.

Throughout our careers we have been intellectually sparked by the scholarly contributions of Gerald Caplan (1917–2008) and Bertram H. Raven. Gerald Caplan, late Professor of Psychiatry at Harvard Medical School and originator of the modern practice of mental health consultation, has been a primary influence on our understanding of the interpersonal, organizational, and preventive aspects of consultation. Bert Raven, Professor of Psychology Emeritus at the University of California, Los Angeles, and renowned social psychologist, has greatly enhanced our view of the role that social influence plays in consultation. We are grateful to these gentlemen for both their kindness and insights into human behavior that led us to develop our integrated model of school consultation.

We also wish to acknowledge the many talented doctoral students – now our colleagues – with whom we have collaborated over the years. The diligent efforts and insights of Seth Aldrich, Scott Ardoin, John Begeny, Megan Bennett, Tracy Bradley, Sandy Chafouleas, Teri Chewning, Sheila Clonan, Edward Daly, Florence DiGennaro Reed, Kim Getty, Priscilla Grissom, Andrea Hiralall, Richard Hollings, Mary Cathryn Murray, Lynne Myers, Ami O’Neill, Derek Reed, Susan Smith Scott, Caryn Ward, Michelle Whichard, and Kristen Wilson have contributed immeasurably to the development of our model.

Finally, Bill Erchul would like to thank his wife, Ann Schulte, for the continued support of his many activities as well as for her clear-headed thinking on consultation, schools, and school psychology. Brian Martens would like to thank his wife, Rosemarie, for her continued help and support as well as her invaluable (and often humorous) insights as a master problem solver and enthusiastic life partner.

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Part I
Background
Consultation ... denote[s] the process of interaction between two professional persons – the consultant, who is a specialist, and the consultee, who invokes his help in regard to a current work problem with which the latter is having some difficulty, and which he has decided is within the former’s area of specialized competence. The work problem involves the management or treatment of one or more clients of the consultee, or the planning or implementation of a program to cater to such clients. (Caplan, 1963, p. 470)

The chapter begins with psychiatrist Gerald Caplan’s definition of consultation, not because it is the best definition for our purposes, rather because it provides a starting point, both historically and conceptually, from which to view the role of the school consultant. Historically speaking, perhaps the earliest systematic approach to human services consultation began in 1949 in Israel where Caplan and his small clinical staff were assigned the challenging task of attending to the mental health needs of 16,000 adolescent immigrants. Complicating this assignment were the facts that these adolescents were housed at more than 100 residential institutions, transportation within the country was often problematic, and there were about 1,000 initial requests for assistance. In confronting these obstacles to the traditional model of referral/diagnosis/psychotherapy of individual clients, Caplan reasoned that available professional resources would need to be used more effectively (Caplan, 1970).

In response to these circumstances, a different model of delivering mental health services emerged. Rather than meeting individual clients at the clinic in Jerusalem, Caplan and his staff traveled to many institutions and met there with the referred teenagers and their caregivers (later termed consultees). Supportive, collegial discussions with the caregivers about the adolescents often resulted in the caregivers returning to work with a new, enhanced perspective that led to their more effective management of client problems. By concentrating his staff’s professional energies on consultative activities that improved the functioning of caregivers, Caplan believed that the mental health of many more clients could be positively affected than it was possible through traditional one-on-one therapy. He also found that much more pertinent information was obtained when meeting with caregivers on-site as opposed to a clinic (Caplan & Caplan, 1993/1999).

Conceptually, Caplan’s 1963 definition and later elaborations (Caplan, 1964, 1970; Caplan & Caplan, 1993/1999) specify the unique and essential features of the
mental health consultation relationship. These features distinguish consultation from the relationships and contracts inherent to other professional activities such as supervision, teaching, and psychotherapy. First, the consultative relationship is essentially triadic, with the involvement of a consultant and one or more consultees and clients. Consultees typically lack the training and experience that consultants possess, and they may be professionals or paraprofessionals representing various fields, including education, nursing, law, or medicine. Second, the optimal working relationship is coordinate and nonhierarchical; ideally, there is no power differential between consultant and consultee. Third, consultee work-related challenges rather than personal problems form the basis for consultative discussion. Fourth, the consultant has no administrative responsibility for or formal authority over the consultee. Thus, the ultimate professional responsibility for the client’s welfare remains with the consultee, not with the consultant. Fifth, the consultee retains the freedom to accept or reject whatever guidance the consultant may offer. In other words, consultation is considered to be a voluntary relationship. Sixth, messages exchanged between consultant and consultee are to be held in confidence, unless the consultant believes someone will be harmed if silence is maintained. Finally, consultation has a dual purpose – to help the consultee with a current professional problem and to equip the consultee with added insights and skills that will permit him or her to deal effectively with similar future problems, preferably without the consultant’s continuing assistance.

Gerald Caplan’s historical and conceptual contributions to mental health consultation are unprecedented (Erchul, 2009). Notwithstanding, it is also true that the field of consultation has progressed considerably from these early beginnings, benefiting along the way from the views of many other theorists, practitioners, and researchers. Today, consultation maintains a high profile within school, clinical, community, counseling, and organizational psychology, as well as within related mental health fields (e.g., social work, psychiatric nursing) and many areas of education (e.g., special education, school counseling). For example, a school psychologist may consult with teachers about effective management strategies in order to prevent classroom disruptions. A clinical psychologist may be contracted initially to conduct psychological testing in a school, but later may be asked to consult with special education teachers who instruct adolescents with impulse control problems. A community psychologist may consult with elected officials about the ways to reduce violent crime in the downtown area at night. A counseling psychologist employed at a university counseling center may consult with residence hall advisers to help them identify and assist those students who do not effectively handle the pressures of university life. A special educator may consult with a classroom teacher about how to instruct a student who has a moderate learning disability.

There are many external indicators of the growth and popularity of consultation in the human services. Searching the PsychINFO database (January 2000–January 2009) using the word consultation, we found 7,893 references in a keyword search, including 432 dissertations. Well over 100 books on human services consultation have been published since 1967, including about 20 since 2000. There are currently two professional journals that focus primarily on aspects of consultation: Consulting
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Psychology Journal: Practice and Research and Journal of Educational and Psychological Consultation. There are several other journals that routinely publish articles on human services consultation, including American Journal of Community Psychology, Journal of Primary Prevention, Journal of School Psychology, School Psychology Quarterly, and School Psychology Review (Zins, Kratochwill, & Elliott, 1993). With respect to practice issues, school psychologists typically spend about 20% of their time engaged in consultation and report that consultation is one of the most (if not the most) preferred of their service delivery activities (Fagan & Wise, 2007; Gutkin & Curtis, 2009).

This short introduction establishes a context for the rest of this chapter and foreshadows the content of chapters that follow. Other topics examined in Chap. I are the effectiveness of consultation, historical antecedents of the general human services consultant role and the specific school psychological consultant role, our definition of school consultation, and finally, our assumptions as authors.

The Effectiveness of Human Services Consultation

As helping professionals, we live in an era that promotes “evidence-based practice” (Norcross, Beutler, & Levant, 2006) and the use of “evidence-based interventions” (Kratochwill et al., 2009). Thus, before investing the required time and energy in learning how to consult, the reader might ask, “Does consultation work?” In other words, is there empirical evidence indicating that positive effects accrue to clients and consultees when a specialist works directly with one or more consultees who in turn work directly with one or more clients? Before providing an answer, it is important to note first that conducting consultation research is difficult, and regrettably, many studies are flawed, both conceptually and methodologically (Erchul & Sheridan, 2008b; Gresham & Noell, 1993; Lewis & Newcomer, 2002; Reddy, Barboza-Whitehead, Files, & Rubel, 2000). As just one example, because consultation represents an attempt to benefit a third party (client) through change in a second party (consultee), one often cannot determine whether client change resulted from consultant effort or some other factor instead.

Accepting this less-than-ideal state of consultation outcome studies, however, there is ample evidence indicating that consultation is an effective treatment. Some of this evidence is based on meta-analysis, a statistical method for summarizing the effects of a treatment across large numbers of original research studies that investigated the treatment (Smith & Glass, 1977). For each study included in a meta-analysis, the change in performance due to a particular treatment is calculated as the mean of the treatment group minus the mean of the control group divided by the standard deviation of the control group. These effect size (ES) statistics are then averaged across studies examining a common treatment procedure to indicate the mean effectiveness of that procedure in standard score units. For example, an ES of 1.0 would indicate that the treatment group, on average, outperformed the control group by one standard deviation unit on whatever outcome measure was used.
Introduction to Consultation

e.g., teacher rating of student, achievement test score). Translating this  $ES = 1.0$ example to percentile ranks, the mean score of the treatment group could have fallen at the 84th percentile and that of the control group the 50th percentile. A negative $ES$ would indicate that the treatment group scored lower than the control group, whereas a zero $ES$ would indicate that there was no group difference.

Medway and Updyke (1985) examined the results of 54 controlled studies of psychological consultation published from 1958 to 1982 that were conducted in schools, clinics, and other organizations. These studies collectively reported 83 consultee outcome measures and 100 client outcome measures. Medway and Updyke’s key findings included: (1) the average $ES$ was 0.55 for consultees and 0.39 for clients; (2) consultees demonstrated functioning/satisfaction >71% of untreated controls; and (3) clients had outcome measure scores that were more favorable than 66% of their controls.

The effectiveness of consultation is arguably greater when one focuses on results obtained from school consultation research only. For example, Sibley (1986, reported in Gresham & Noell, 1993) found average $ES$s of 0.60 for consultees and 0.91 for clients across 63 studies of school consultation. Adapting meta-analytic procedures for single-case designs, Busse, Kratochwill, and Elliott (1995) reported an average client $ES$ of 0.95 for 23 cases of teacher consultation. Though not a meta-analysis, Sheridan, Welch, and Orme (1996) completed a comprehensive review of 46 school consultation outcome studies published from 1985 to 1995 and noted that 67% of all reported outcomes were positive, 28% were neutral, and only 5% were negative. Thus, outcome research on consultation published over a five-decade period has consistently documented the effectiveness of the approach.

Historical Influences on the Human Services Consultant Role

In order to understand the modern-day context for consultation within psychology and related fields, it is necessary to review some of the historical factors beginning in the 1950s that led to its acceptance and adoption as a significant role for many specialists. Here, we present some relevant and intertwined theoretical, professional, and pragmatic considerations.

Theoretical Issues

Thomas Szasz’s (1960) conceptualization of psychopathology is often credited with challenging the assumptions of traditional psychological treatment, which was strongly aligned with the medical model (Hersch, 1968). In what Szasz termed the “myth of mental illness,” mental illness does not reflect an organic disease entity as much as problems with living that are psychosocial in nature. It is therefore important to assess behavior as normal or abnormal within a social, situational, and
moral context rather than only within an individual’s psyche. Importantly, this view suggests that normal and abnormal behavior share the same processes of development, maintenance, and change. On a broader level, Szasz’s revolutionary outlook demystified psychopathology and the role of the psychiatrist as well as emphasized the role of social institutions in the development of abnormal behavior.

A second, related issue concerns the rise of sociological and ecological models of abnormal behavior. The medical model, as applied to psychological treatment, began to lose support in the 1950s when sociological research substantiated clear linkages between the occurrence of mental illness and variables such as socioeconomic status, education, nutrition, and dysfunctional social networks. For example, Hollingshead and Redlich (1958) documented that aggressive, rebellious, and psychotic behavior was much more prevalent in the lower socioeconomic classes than in the middle and upper classes. These developments drew attention to variables outside the traditional individual-centered realm of mental health professionals, and provided credibility to nontraditional intervention programs by allied health professionals.

A third theoretical issue that facilitated the development of the human service consultant role was the rise of behavioral psychology. By the mid-1960s, psychoanalysis had begun to decline and behavior therapy was on the upswing. The behavioral perspective, in contrast to psychodynamic thought, views abnormal behavior as a function of environmental events and emphasizes learning and learning-based therapies. These therapeutic processes are specific, and mental health paraprofessionals (e.g., teachers, parents) can be trained to use many of them. Furthermore, behavioral treatments demonstrate relatively large, positive treatment effects. Very importantly, the emergence of behavioral psychology brought therapy out of the clinic setting, making possible the closer monitoring of treatment implementation and outcome. It also broadened the scope of potential clients and potential change agents (Gutkin & Curtis, 1982; Hersch, 1968; Tharp & Wetzel, 1969).

**Professional Issues**

There are at least three professional issues relevant to the emergence of the human services consultant role. The first is the problem with the clinical diagnosis of psychopathology, stemming from the early demonstrations that client assignment to specific DSM I and II diagnostic categories was generally unreliable (e.g., Zubin, 1967), and that symptomatology often failed to discriminate among diagnostic categories (e.g., Zigler & Phillips, 1961). Also, because the client’s socioeconomic status rather than his or her diagnosis was shown to be the best predictor of the type of treatment received (Hollingshead & Redlich, 1958), many began to question the utility of diagnosis by highly trained mental health professionals prior to treatment (Hobbs, 1964).

Second, there was a failure on the part of mental health professionals to specify therapeutic goals and processes. As more therapies became available in the 1960s,
it became less clear whether the overriding goal of psychological treatment was to reduce inner stress, cure mental illness, reorganize the patient’s personality, remove symptoms, or promote mental health. With respect to therapeutic processes, active treatment components often were not identified or, in the case of behavior therapy and existentialism, polar opposite concepts were advanced as critical for treating mental illness (Hersch, 1968). Confusion for the field and the public ensued, with one result being the greater acceptance of nontraditional forms of therapy, such as encounter groups (Lieberman, Yalom, & Miles, 1973).

Third, the lack of demonstrated therapeutic outcomes for psychotherapy (Eysenck, 1952) led some to question its value and, in some cases, pursue other treatment options. One impact of Eysenck’s findings, then, was to legitimize other forms of helping relationships, including basic human relations training (Carkhuff, 1969) and mutual help groups (Caplan & Killilea, 1976). Eysenck’s classic study also focused psychology’s efforts on demonstrating the benefits of psychotherapy, which others later documented (e.g., Smith & Glass, 1977).

Pragmatic Issues

One might specify three pragmatic reasons why the consultant role emerged in psychology and allied fields. First, there was the realization that there were insufficient numbers of trained mental health professionals to implement the medical model on a large scale (Albee, 1959). Even if there had been adequate personnel, there was the concern that psychotherapy as a means of addressing widespread mental health problems was ineffective and inefficient. As Hobbs (1963) stated, “A profession that is built on a 50-minute hour of a one-to-one relationship between therapist and client...is living on borrowed time” (p. 3). Complicating this situation was the discovery that the majority of individuals who needed help often failed to contact service providers (Hersch, 1968).

Second, during the 1960s there was a growing awareness of the differential delivery of mental health services among the rich and poor. Sociological research indicated that more serious mental health problems and risk factors were significantly overrepresented in the lower classes, but irrespective of diagnosis, the poor client received a quick treatment such as electric shock and the rich client received extended (and often costly) psychotherapy (Hollingshead & Redlich, 1958). During this time it seemed as though psychotherapy was appropriate only for a circumscribed client population – one that was young, attractive, verbal, intelligent, and successful (YAVIS).

Third, there were demonstrations of the successful use of paraprofessionals in various studies, suggesting that less formally trained individuals could contribute meaningfully to the prevention and treatment of mental disorders. In particular, researchers showed that parents, teachers, and teacher assistants could be trained to modify children’s behavior in specific settings (e.g., Cowen et al., 1975; Hobbs, 1966).
The culmination of all the above factors, which illustrate dissatisfaction with the traditional means of delivering mental health services, was a revolution termed the community mental health movement. This movement was officially sanctioned in 1963 when President John Kennedy signed into law the Community Mental Health Centers Act (P.L. 88-164) and continued until federal funds were reduced or reallocated in the early 1980s. Most importantly for our purposes, P.L. 88-164 specified consultation as one of five essential services that community mental health centers had to provide in order to receive federal monies. This provision gave consultation formal recognition and legitimized the placement of consultants in mental health agencies and schools. The community mental health movement also is acknowledged for its emphasis on: (1) population-oriented prevention (i.e., primary, secondary, and tertiary); (2) social support systems, which can lessen the risk of mental illness through the sharing of tasks and mobilization of resources; and (3) crisis intervention, which establishes a brief timeframe for action (Erchul & Schulte, 1993; Gallessich, 1982; Schulberg & Killilea, 1982).

Historical Influences on the School Consultant Role

Other notable trends occurred within public education and school psychology from the 1940s to the present. Many of these reflect changes in federal law and the resulting changes in school-based service delivery. In general, these trends have served to increase the need for psychologists and other professionals who consult with school personnel about educational and psychological issues.

Developments from the 1940s Through the 1970s

Seventy years ago, children with disabilities generally were excluded from education, as there was no mandate to serve this population. During the 1940s and 1950s, school psychology was viewed as the attempt to apply concepts and methods from clinical psychology to school adjustment problems. Beginning in the 1960s, state and federal funding became available to support special education programs, and school psychologists assumed the role of diagnostician. The passage of several states’ laws that protected the educational rights of children with disabilities led to the authorization in 1975 of P.L. 94-142, the Education for All Handicapped Children Act (renamed the Individuals with Disabilities Education Act [IDEA], P.L. 102-119, in 1990). This law increased the number of children to be served and required multidisciplinary team evaluation procedures as well as a continuum of services to be provided in schools. Although many of these services were of a pull-out variety (where students with disabilities were sent to special classrooms), through its “least restrictive environment” provision, the law did provide the impetus
for mainstreaming efforts. *Mainstreaming* refers to the integration of children with disabilities into regular education classes. P.L. 94142/IDEA broadened the potential role of school psychologists to include consultation, but at the same time established the school psychologist’s primary role as “gatekeeper” for special education (Fagan & Wise, 2007).

As an aside, it must be stated that there have been numerous problems associated with the school psychologist’s traditional role as gatekeeper. Practical and logistical issues have included increased caseloads and backlogs of outstanding assessments; lengthy delays for receipt of services; the likelihood of students in need of services deemed ineligible for them; and the high cost of evaluation-placement relative to other available services, such as the Title I reading program. It also has been acknowledged that the commonly used standardized tests have poor psychometric properties, and the results obtained from them are often of little use in making programming decisions and monitoring student progress. Within the ranks of school psychologists, there has been dissatisfaction over the reality that most are trained broadly but used narrowly. With the effectiveness of special education placements being questioned for some time, it is understandable that organizations such as the National Association of School Psychologists have pressed for an expanded role for school psychologists. Much more positively, there is a growing body of research demonstrating the manipulable influences on academic achievement and the educational applications of behavior analysis and intervention. This type of research certainly holds promise for the even greater involvement of school psychologists as consultants (Fagan & Wise, 2007; Martens, Witt, Daly, & Vollmer, 1999; Reschly, 1988; Tindall, 1979).

**Developments During the 1980s and 1990s**

Many changes were observed in public education in the 1980s. Perhaps as a result of state and federal cuts in the education budget, there emerged a greater focus on teacher accountability and a major rethinking of national educational goals, with a decided emphasis on outcomes. Within special education, there was rapid growth evidenced in mildly handicapped populations, particularly in the specific learning disability category. Responses to this trend included increased mainstreaming efforts as well as the initiation of prereferral intervention and prereferral intervention teams. The major purpose of prereferral intervention (also known as intervention assistance) was to promote mainstreaming by offering greater professional support to the classroom teacher. Also noticeable during the 1980s was the *Regular Education Initiative* (REI), a movement whose adherents believed that most mildly disabled students can and should receive instruction in the regular classroom. It should be clear that the concepts of mainstreaming, prereferral intervention, and REI emphasize the provision of consultative support to regular education teachers (Lloyd, Singh, & Repp, 1991; Reschly, Tilly, & Grimes, 1999; Zins, Curtis, Graden, & Ponti, 1988).
During the 1990s, seeds were sown for additional educational reforms. The 1997 amendments to IDEA (P.L. 105-17; IDEA 1997) helped to legitimize a consulting role for school psychologists, in that the amendments defined “psychological services” as including the development and implementation of positive behavioral supports and behavior intervention plans for students. The 1997 amendments also specified that triennial reevaluations of students in special education could be based on existing information and previous evaluations, if deemed appropriate by school personnel and parents. This provision theoretically served to decrease the time spent in formal psychoeducational assessment and thereby potentially increase the time spent in intervention and consultation activities (Fagan & Wise, 2007; Hoff & Zirkel, 1999).

**Contemporary Developments**

Since 2001, two very important acts of federal legislation concerning public education have been enacted. The first, the No Child Left Behind Act (NCLB; P.L. 107–110), specifies that the educational skills and progress of all children – regardless of disability status – be measured annually, with performance-based rewards and punishments issued to teachers and schools. It is clear that NCLB has institutionalized data-based decision-making and has raised the stakes for accountability in US public schools. The second, the Individuals with Disabilities Education Improvement Act (IDEIA 2004; P.L. 108-446), has opened the door to reconceptualizing the category of specific learning disability. IDEIA 2004 Part B regulations allow a response-to-intervention (RTI) approach to take the place of the traditional IQ/achievement discrepancy for eligibility determination. Briefly, RTI is a series of steps/tiers: (1) the classroom teacher implements scientific, research-based instruction/intervention with the student; (2) the student’s academic progress is measured; (3) if the student does not show improvement, the intervention is intensified; (4) the student’s progress is measured again; and (5) if the student still has not improved (i.e., responded), then he/she is eligible for special education services or a formal psychoeducational assessment that may result in special education placement (Burns & Gibbons, 2008; Fuchs, Mock, Morgan, & Young, 2003; Kratochwill, Clements, & Kalymon, 2007). Although we shall elaborate on this issue in Chap. 2, at this juncture it can be readily seen how the success of RTI depends on the skill of the specialist who consults with a classroom teacher.

Schools today face many challenges. There is increased concern over school violence and discipline problems, unprecedented diversity reflected within student populations, heightened accountability for both student and teacher performance, personnel shortages, and a substantial reduction in available funding. These and other emerging issues strongly suggest that there will be a need for school-based consultants for years to come (Erchul & Sheridan, 2008a; Esquivel, Lopez, & Nahari, 2007; Larson, 2008).
Reconceptualizing Consultation for Today’s Schools

Historical Summary

Some of the more critical developments distilled from the preceding historical review are summarized in the following 12 points:

1. Over time, there has been a greater emphasis placed on social and situational determinants of behavior.
2. There is often no clear connection between assessment and treatment, suggesting that formal diagnosis and classification are unnecessary for effective treatment.
3. Many traditional, commonly used standardized assessment instruments have been shown to lack adequate psychometric properties, and thus are of little value in deciding on programming options and in monitoring client progress.
4. There has been a growing reliance on therapeutic methods other than psychotherapy.
5. Human services have been delivered increasingly in naturalistic settings rather than in clinic settings.
6. Direct care providers, rather than highly trained specialists, increasingly have been viewed as primary change agents.
7. The aims of population-oriented prevention can be served well through the provision of social support.
8. Crisis intervention has shown that effective psychological services can be delivered within a short time frame.
9. Experience with IDEA’s multidisciplinary assessment teams and prereferral intervention teams suggests a clear benefit to sharing expertise and information among professionals representing different specialties.
10. The specification of treatment goals, procedures, and outcomes has become increasingly important as accountability for services looms larger in education and psychology.
11. The higher accountability for teacher performance, as reflected in NCLB, demands that consultants support teachers in their professional role.
12. The evolution of IDEA, from 1975 to the present, has served to institutionalize consultation as an essential service to be provided by school-based professionals.

Our Definition of School Consultation

These 12 points constitute a strong rationale for the delivery of psychological and educational services in schools via a consultation approach. As a step toward operationalizing this approach, we offer the following definition:

School consultation is a process for providing psychological and educational services in which a specialist (consultant) works cooperatively with a staff member (consultee) to improve the learning and adjustment of a student (client) or group of students. During face-to-face
interactions, the consultant helps the consultee through systematic problem solving, social influence, and professional support. In turn, the consultee helps the client(s) through selecting and implementing effective school-based interventions. In all cases, school consultation serves a remedial function and has the potential to serve a preventive function.

Assumptions of Our Approach to School Consultation

The approach to consulting in schools presented in this book draws on our experiences as practicing consultants and researchers of processes and outcomes associated with psychological consultation. In presenting this approach, we wish to alert readers to our biases:

1. We promote a scientist–practitioner viewpoint by providing guidance for consultative practice whenever possible that is based on research findings rather than conjecture (Erchul & Sheridan, 2008a). As the title of this book implies, we believe our approach is based on solid conceptual ground and, where possible, relevant empirical findings.
2. We view successful school consultation as involving a combination of social influence and professional support within a problem-solving context. We refer to the resulting approach as an “integrated model of school consultation.” What is specifically integrated in the model are two theoretically distinct approaches to consultation (i.e., Caplan’s mental health consultation (1970; Caplan & Caplan, 1993/1999) and Bergan’s behavioral consultation (1977; Bergan & Kratochwill, 1990)), as well as two general approaches to consultative practice (i.e., social influence and professional support) regarded by some as mutually exclusive concepts.
3. In contrast to a view taken in earlier editions of this volume, we believe that the integrated model of school consultation is highly appropriate for, and, in fact, intended for, internal consultants. An internal consultant is defined as one who spends most of his or her time working at a site that is the setting for consultation, although how consultees view the consultant frequently is a key factor as well (Brown, Pryzwansky, & Schulte, 2006). School psychologists, for instance, often are difficult to characterize strictly as internal or external consultants because they are more appropriately placed on an internal–external continuum (Alpert & Silverstein, 1985). For example, one school psychologist may be assigned full time to a single school (internal), but another may consult only 2 days each month with a particular school but has done so for 18 years, so is considered a regular staff member (external and internal). Particularly given this edition’s emphasis on social influence (Chap.3), problem-solving models and RTI (Chap. 2), and direct client assessment measures (Chap. 7) as well as a new case study (Chap. 11), the relevance of the integrated model to the internal consultant should be clear.
4. We believe the elements of Caplan’s mental health consultation approach are useful for understanding relationship and system-level issues within consultation.