SCHOOL MENTAL HEALTH PROJECT UCLA

Addressing Barriers to Learning

New ways to think . . .

Better ways to link

Mental Health in Schools Center Training and Technical Assistance

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Scientific advances have contributed greatly to our understanding of drug use and addiction, but there will never be a 'magic bullet' capable of making these problems disappear. Drug use and addiction are complex social and public health issues, and they require multifaceted approaches.

Alan Lesher, Director
National Institute on Drug Abuse's
Report to Congress (1999)

Substance Abuse Prevention: Toward Comprehensive, Multifaceted Approaches

[Note: In the Winter, 2000 issue of this newsletter, we explored prevailing approaches to substance abuse prevention. Here, we revisit the topic with a view to discussing new directions.]

"Not another program!" That's the principal's lament in this era of high academic standards, high stakes accountability, eliminating social promotion, making schools safe and drug free, and on and on. Principals and school staff find themselves bombarded almost daily with more changes and more programs. However, the reality is that they can't adopt more and more – especially using the piecemeal approach that dominates school policy and practice.

Like many problems, student substance abuse is associated with poor school performance, interpersonal violence, and a variety of other negative activities. It also is associated with areas of life development in which schools play a major socialization role. For these and other reasons, substance abuse is a problem schools are expected to and should address. But not with a "let's add another program" mentality.

Contents

A Burgeoning Marketplace

Interventions for "safe and drug free schools" aim to (a) reduce risks, stressors, and other factors that interfere with positive functioning and (b) promote healthy development and enhance protective factors. The focus may be on

- primary prevention using "universal" or general population approaches (e.g., taking a school-wide or classroom-based approach)
- "selective" programs targeting specific groups seen as at risk
- "indicated" interventions to interrupt use (e.g., by ending drug experimentation, stopping a progression to drug abuse, minimizing the impact of abuse, and reducing future co-occurring problems or relapse for those who have stopped using).

The growing concern over making schools safe and drug free has made them an attractive marketplace for prevention programs. Many hundreds of packaged "curricula" and noncurricular approaches exist for use in: (1) education campaigns to enhance knowledge about substances and present a negative view about their impact, (2) skill training to enhance positive social coping, with a major emphasis on resisting peer pressure, and (3) multifaceted school programs (sometimes including the community). In an effort to bring coherence to the growing number of programs, lists of "research-based" or "evidence-based" approaches have been generated by public agencies and private groups. Different lists apply different criteria for what constitutes satisfactory empirical evidence. Unfortunately, the criteria often do not adhere to stringent research standards. Nevertheless, all this activity is resulting in more and more programs being identified as *exemplary or promising models*.*

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Limited Data, Limited Approaches

Few prevention program evaluations provide data on direct, long-term reduction of substance abuse. Most studies report short-term impact on specific knowledge, skills, and/or environmental supports, the absence of which might constitute risk factors.

Because most programs are carried out as projects or demonstrations, findings primarily constitute evidence of efficacy, not effectiveness. Moreover, those programs with sound evaluation data have focused mostly on elementary age children and young teens. The few for older teens have targeted specific subgroups and problems, such as high school athletes use of anabolic steroids.

Findings indicate information-oriented strategies alone have little impact. More promising is skill training focused on (a) enhancing a wide range of personal-social skills of relevance to curtailing substance use, (b) ensuring skills are learned, and (c) providing "booster inoculations." However, researchers stress that an emphasis on skills, per se, also is insufficient. (Clearly, lack of skills does not inevitably lead to drug abuse, and some very socially adept youngsters are drug abusers.)

Drops in incidence and prevalence of substance use also are used as evidence of prevention efficacy. And attempts are made to relate current use with past participation in prevention programs. The difficulties in making sound interpretations of such data are well-documented.

The intent here is not to denigrate the research on substance abuse prevention. Rather, the point is that the data are an insufficient basis for deciding how a school should proceed. Furthermore, if school decision makers only look at programs that are officially designated as promising or exemplary, they will continue to think mainly in terms of "add-on" programs. This perpetuates the tendency to address substance abuse, violence, dropping out, and many other problems in a narrow, problem-specific, and ad hoc fashion. The inevitable impact of this trend are fragmented and marginalized approaches and a continuation of an unhappy status quo with respect to results.

> Clearly, new directions are required if schools are to resolve the dilemma of *"We understand another program would help – but, we can't take on another thing."*

New Directions: Connecting Schools, Families, and Communities

With respect to substance abuse prevention, Schaps and Battistich (1991) have noted:

> "...prevention programs should attempt to create and maintain a positive social climate that facilitates socialization, rather than attempt to compensate for a prevailing negative social climate. This argues further that prevention programs should be a natural and important part of the school curriculum and, hence, be reflected in the overall organization, practices, and climate of the school. Under this conceptualization, the term 'prevention program' would be inappropriate. The program would disappear as a separate entity; it would be seen by both faculty and students as an integral, inseparable part of the school."

Awareness of the limitations of prevailing approaches and an appreciation of the importance of context are giving rise to new directions. One emphasis is on multifaceted programs. Such approaches usually include strategies to develop cognitive and behavioral skills, change school and community norms and practices, and enhance social supports (e.g., families, schools, neighborhoods, the media).

Many problems are caused by the same factors and may be corrected through common pathways. At the same time, causal factors often are complex and require comprehensive, multifaceted solutions. The evidence indicates this is the case for substance abuse. Thus, we suggest that substance abuse prevention must be approached in a comprehensive, multifaceted manner – as part of a continuum of integrated interventions designed to address barriers to learning and promote healthy development. The nature and scope of such an approach precludes a school adopting programs in an ad hoc manner. Indeed, it precludes a school addressing such problems in isolation of students, families, and the surrounding community. Any truly comprehensive approach is only feasible if the resources of schools, families, and communities are woven together. (A corollary of this is that the committed involvement of school, family, and community can be essential in maximizing intervention implementation and effectiveness.)

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"...multiple and interrelated problems ... require multiple and interrelated solutions."

Schorr (1997)

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(cont. on page 5)

Center News

Report on Pioneer Initiatives to Reform Education Support Programs

On May 22, leaders involved in pioneer initiatives to reform and restructure education support programs participated in a day-long "summit" meeting at UCLA. A report is now available that extrapolates basic implications and lessons learned from such innovators. Interested parties across the country are being sent the report's Executive Summary. This summary, the report, and a collated set of materials describing each initiative also are available on our website or can be requested from the Center.

To download, go to http://smhp.psych.ucla.edu – click on Contents, scroll down to Center Hosted Sites, and click on *Pioneer Initiatives.*

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School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.

Carnegie Council Task Force (1989)

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Want resources? Need technical assistance?

Contact us at:
E-mail: **smhp@ucla.edu** Ph: **(310) 825-3634**
Write: Center for Mental Health in Schools
Department of Psychology, UCLA
Los Angeles, CA 90095-1563

Or use our website:
http://smhp.psych.ucla.edu

If you're not receiving our monthly electronic newsletter (ENEWS), send an E-mail request to:
listserv@listserv.ucla.edu
leave the subject line blank, and in the body of the message type: **subscribe mentalhealth-L**

Also, if you want to submit comments and info for us to circulate, use the form inserted in this newsletter or contact us directly by mail, phone, or E-mail.

Some New & Revised Resources

- ***News of the Week.*** Now on the *What's New?* page of our website, each week we feature 1-2 news items from around the country and offer links to sites providing mental health news items.
  Go to http://smhp.psych.ucla.edu – click on *What's New?*

- **New *Quick Finds*.** Recent additions to this easy access section of our website are sets of info on:
  - Emotionally Disturbed Children
  - Student Motivation
  - Standards of Model Programs
  - Discipline Codes and Policies
  - Dating Violence

  Go to http://smhp.psych.ucla.edu/websrch.htm.

- **Revised *Introductory Packet***

  Parent and Home Involvement in Schools
  Download from our website or request directly.
  http://smhp.psych.ucla.edu – click on *Center Materials*

- ***Other resources now downloadable from our website in PDF format:***

  Policymakers' Guide to Restructuring Student Support Resources to Address Barriers to Learning

  Common Psychosocial Problems of School Aged Youth: Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment

  Protective Factors (Resiliency)

  A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning

  Using Technology to Address Barriers to Learning

Just published journal article:

"Connecting schools, families, and communities." by Center co-directors Taylor & Adelman. *Professional School Counseling , 3,* 298-307.

If you can remain calm, you probably don't have all the facts.

Center Staff:
Howard Adelman, Co-Director
Linda Taylor, Co-Director
Perry Nelson, Coordinator
. . . and a host of graduate and undergraduate students

Q&A

Recently, we were asked:
What criteria are used to designate a school mental health model program?

In responding, we suggested that the question involves two parts. First comes the matter of:

What constitutes a school mental health program?

Our answer is that a wide range of school-based interventions to address barriers to student learning fits the category of mental health programs. This certainly includes counseling and psychotherapy activity carried out as part of special education services or as a facet of the work of school-based health centers. But the term also encompasses a host of other education support programs. For example, it includes violence prevention curricula, social support programs to meet the transitions needs of students and their families, and efforts to promote social and emotional development.

Now to the matter of:
What are the criteria for designating a program as a "model?"

There are various answers to this. While some folks are still making judgments based simply on how well a program compares to prevailing standards for practice, the demand for research-based and empirically supported interventions is raising the standard. Some "models" have been so-designated based on criteria used in meta-analytic reviews. Increasingly, however, the emphasis is on "promising" and "exemplary" interventions reporting positive results from appropriately designed evaluation studies. Examples of specific criteria are available from (a) journals discussing "empirically supported interventions," (b) reports of the federally-funded project "Blueprints for Violence Prevention," and (c) guidelines set forth by the U.S. Office of Education's Expert Panel to identify the best Safe and Drug Free School Programs.

How would you have answered?

You can share your views/ideas/programs/ concerns, or dialogue with colleagues on our website. Go to http://smhp.psych.ucla.edu – click on Net Exchange.

Do You Know About?

More on *threat profiling:* The following are in: *Children's Services: Social Policy, Research, and Practice,* Volume 3, Number 3. (2000).

"Profiling potentially violent youth: Statistical and conceptual problems."
By K. Sewell & M. Mendelsohn.

"Profiling potentially violent youth: Comments and observations."
By E. Vernberg & S. Twemlow.

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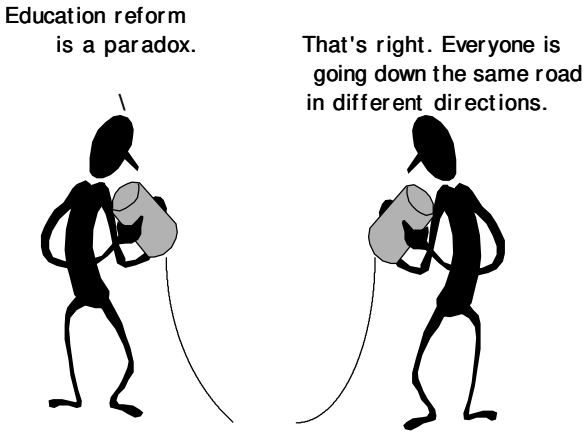
MH and substance abuse treatment spending is shrinking as a percentage of national health care expenditures. A SAMHSA news release reports:

"A new analysis . . . reveals that expenditures for mental health and substance abuse treatment represented 7.8 percent of the more than one trillion dollars in all U.S. health care expenditures in 1997, down from 8.8 percent of the total in 1987. This decline occurred despite the persistent gap between the prevalence of mental and addictive illnesses and treatment utilization documented in the Surgeon General's Report on Mental Health and the National Household Survey on Drug Abuse.

. . . public payers (government agencies) fund the majority of mental health and substance abuse treatment spending – the opposite of all health care funding. While public sources provided 58 percent of mental health and substance abuse treatment services dollars in 1997, they supply only 46 percent of all health spending. For all health care services, including mental health and substance abuse treatment, public sector spending has increased since 1987. This trend is primarily due to slower growth in private sector spending and rapid growth of Medicare and Medicaid.

Overall national expenditures for treatment of mental illness and abuse of alcohol and illicit drugs totaled $82.2 billion in 1997. Of this total, eighty-six percent ($70.8 billion) was for treatment of mental illness, fourteen percent ($11.4 billion) was for treatment of alcohol and drug abuse."



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A Full Continuum of Interventions

Awareness of the full range of causal factors supports the view that substance abuse prevention must be comprehensive and multifaceted. The interventions are conceived along a continuum. The continuum ranges from universal primary prevention (including a focus on wellness or competence enhancement) through approaches for treating problems early-after-onset (selective and indicated programs), and extending on to narrowly focused treatments for severe/ chronic problems. Besides spanning primary, secondary, and tertiary prevention, the continuum incorporates a holistic, developmental focus. It envelops individuals, families, and the contexts in which they live, work, and play. It also provides a framework for using the least restrictive and nonintrusive forms of intervention necessary for appropriately handling problems and accommodating diversity.

Moreover, given that many problems are not discrete, the continuum can be designed to address root causes, thereby minimizing tendencies to develop separate programs for each observed problem. In turn, this enables increased coordination and integration of resources which can improve impact and cost-effectiveness. Over time, the continuum can be evolved into integrated *systems* by enhancing the way interventions are connected. Such connections may involve horizontal and vertical restructuring of programs and services (a) within jurisdictions, school districts, and community agencies and (b) between jurisdictions, school and community agencies, public and private sectors, among clusters of schools, and among community agencies.

The continuum of interventions described can be fleshed out to provide a template for assessing the nature and scope of programs in local geographic or catchment areas. Unfortunately, when such a template is applied to communities that must rely on underwriting from public funds and private philanthropic groups, many essential programs and services are not found. For schools, this is certainly the case. In particular, prevention efforts, if present, usually are funded as discrete projects, often with "soft" money. Moreover, where prevention efforts are in place, they are seldom integrated with related programs and services. Thus, the type of approach necessary to deal with a wide range of problems is missing. A major breakthrough in the battle against substance abuse

(cont. on page 6)

A Comprehensive, Multifaceted Continuum

Youth Development & Primary Prevention

**Promoting Readiness for School -- everyday*

(e.g., home and community-oriented programs to foster healthy social-emotional-cognitive development; quality day care programs; quality Head Start and other preschool programs; health and human services)

**In-service for teachers*

(e.g., school-based in-service programs so that teachers can enhance strategies for preventing and minimizing barriers to learning and promoting intrinsic motivation for learning at school. A key aspect involves enhancing daily on-the-job learning for teachers through strong mentoring and increased collegial teaming and assistance.)

**Home Involvement*

(e.g., programs addressing specific learning & support needs of adults in the home, mobilizing them as problem solvers, and helping them meet basic obligations to youngsters)

**Support for Transitions*

(e.g., school-wide approaches for welcoming, orienting, and providing social supports for new students and families; articulation programs; enhanced home involvement in problem solving; ESL classes for students and those caretakers in the home who need them)

**School-Wide Programs Designed to Enhance Caring and Supportive School Environments*

(e.g., increasing curricular & extra-curricular enrichment & recreation programs; increasing the range of opportunities for students to assume positive roles)

Early-After-Onset Intervention

**Improving and Augmenting Regular Supports as Soon as a Student is Seen to Have a Problem*

(e.g., personalizing instruction; tutoring; using aides and volunteers to enhance student support and direction; mentoring for regular teachers regarding basic strategies for enhancing student support, introducing appropriate accommodations and compensatory strategies, and remedying mild-moderate learning problems; extended-day, after-school/ Saturday/summer school programs)

**Interventions for Mild-Moderate Physical & Mental Health and Psychosocial Problems*

(e.g., school-wide approaches and school-community partnerships to address these needs among the student body)

Provision for Severe and Chronic Problems

**Enhancing Availability & Access to Specialized Assistance for Persisting Problems*

(e.g., school-based and linked student and family assistance interventions, including special education)

**Alternative Placements*

(e.g., options that really offer supportive and promising approaches for the future)

probably can be achieved only when such a comprehensive, multifaceted, and integrated approach is in place.

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One of the most effective ways to reduce children's risk of developing problem behaviors is to strengthen their bonds with family members, teachers, and other socially responsible adults.

SAMHSA, 1999

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Integrating with School Reform

It is one thing to stress the desirability of framing primary prevention as one end of a continuum of intervention; it is quite another to argue that schools should pursue the type of comprehensive approach outlined above. In the long-run, the success of such proposals probably depends on anchoring them in the context of the mission of schools. That is, the recommendations must be rooted in the reality that schools are first and foremost accountable for educating the young. More specifically, the proposals must reflect an appreciation that schools are concerned about addressing a problem primarily when it is a barrier to student *learning*. Even then, schools are so enmeshed in instructional and management reforms that all other agendas are marginalized. Therefore, efforts to enhance school participation in evolving comprehensive approaches, including substance abuse prevention initiatives, must work to expand the school reform agenda.

To these ends, we have proposed that policy makers move from the dominant two component model of school reform to a three component framework. Such a model calls for elevating the policy priority for addressing factors interfering with learning. That is, a component is conceived for enabling learning by addressing barriers. This comprehensive "enabling" component is viewed as a fundamental and essential facet of educational reform. Such a concept provides a basis for both combating marginalization and developing a broad framework for policy and practice. It addresses fragmentation by unifying approaches to preventing/ameliorating problems and promoting wellness. From this perspective, safe and drug free school programs and all categorical programs can be integrated into one comprehensive component. When policy, practice, and research are looked at through the lens of this third component, it is evident just how much is missing in efforts to provide all students with an equal opportunity for success at school.

Connecting School-Community-Home

Initiatives to link community resources with each other and with schools are underway across the country. Along with such initiatives has come an increasing emphasis on establishing *collaboratives* involving school, home, and community. Such collaboratives are sprouting in a dramatic and ad hoc manner. In moving toward comprehensive, multi-faceted approaches, there is much to learn from these efforts. They have the potential for improving schools, strengthening neighborhoods, and markedly reducing young people's problems. Or, such "collaborations" can end up being another reform effort that promised a lot, but did little.

While it is relatively simple to make informal link-ages, establishing major long-term collaborations is complicated. They require vision, cohesive policy, and basic systemic reforms. The complications are readily seen in efforts to evolve a comprehensive continuum of interventions. Such a continuum clearly involves much more than linking some services, recreation, and enrichment activities to schools. It involves weaving together a critical mass of resources and strategies to enhance caring communities that support all youth and their families and enable success at school and beyond. Major processes are required to develop and evolve formal and institutionalized sharing of a wide spectrum of responsibilities and resources. And, the intent must be to sustain such “partnerships” over time.

From a local perspective, there are three overlapping challenges in developing partnerships for comprehensive, multifaceted programs to address matters such as substance abuse prevention. One involves weaving existing school resources together. A second entails evolving programs so they are more effective. The third challenge is broadening the range of partnerships by reaching out to other resources.

Comprehensive school-home-community partnerships represent a rationale direction for efforts to generate essential interventions to prevent substance abuse, address other barriers to learning, enhance healthy development, and strengthen families and neighborhoods. Such a direction will enable schools to address many problems in a cohesive, multifaceted manner.

This is not to say that getting from here to there will be easy. Take the matter of blending resources as an example. This entails formally connecting school programs with assets at home and in the business and faith communities, as well as collaborating with enrichment, recreation, and service resources in the neighborhood – and more. For this to happen in optimal ways, there must be an extensive restructuring of all school-owned activity, such as pupil services,

safe and drug free school efforts, and special and

compensatory education programs. There also must be full integration of such activity with the instructional and management components. And, the allocation and use of community resources must be rethought. All this means policy and practice must undergo a radical transformation, and mechanisms must be developed to move toward appropriate integration of school-home-community resources.

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Protective Processes

- *Opportunities for involvement*
- *Skills for successful involvement*
- *Recognition for involvement*

Hawkins & Catalano (1998)

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Concluding Comments

Abatement of widespread abuse of substances and other psychosocial problems is unlikely without comprehensive, multifaceted approaches that mesh together the resources of school, home, and community. Such a broadened focus must be based on an understanding of psychological and socio-cultural factors motivating youth behavior. This includes appreciating the degree to which, for some youngsters, substance use represents the type of experimentation and risk taking that is part of the individuation process and development toward independence. Consistent with this developmental phase is skepticism about warnings and advice and psychological reactance to rules and authority. Thus, the very fact that substance use is illegal and forbidden can add to the allure. Countering all this requires ensuring there are good alternative ways for youngsters to feel competent, self-determining, and connected to others.

Clearly there is still a lot to learn about how to prevent substance abuse on a large-scale. It is also clear that more of the same probably won't do the trick. It is time for bold new directions.

Note:

*In recent years, support for the positive impact and future potential of prevention programs has been extrapolated from literature reviews, including meta-analyses. A different sense is garnered from the Center for the Study and Prevention of Violence's *Blueprint* project, which has used the most stringent criteria to date (albeit still rather minimal by research standards). Initially, the criteria generated a list of only 10 model programs. By reducing the criteria to encompass programs using a single site, those that were unreplicated, or those having a small effect on outcome measures, 13 additional programs were designated as promising. However, only a few of the 23 provide evidence of direct impact on preventing substance abuse.

As an aid to the field, SAMHSA's Knowledge Exchange Network (KEN) has combined several prominent program compilations under the heading "Examples of Exemplary/ Promising Programs." This list offers about 125 different programs relevant to violence and substance abuse prevention. Most of the programs address some or all of the 19 common risk factors identified through research as associated with problems such as youth delinquency, violence, substance abuse, teen pregnancy, and school dropout. In keeping with the growing interest in protective factors, some of the programs reframe risk factors into an approach that stresses strengthening protective factors and building assets. The list can be downloaded from www.mental health.org/specials/school violence/irenelis.htm

A Few Related References

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Also, see our Center's resource aid packet on *Substance Abuse* and other materials in the Center Clearinghouse.

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Most Teens expect to live forever
and experience each moment as
"So far, so good!"

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Ideas into Practice
Grief and Loss

Schools must be prepared to respond to those experiencing grief and loss. Students and staff die. There are deaths in the family. Pets die. Parents divorce. Friends move away. And on and on.

Many useful "what to do" resources are available. Ideas culled from various sources are offered below. More help on this topic can be found by using the Quick Find search on our website: http://smhp.psych.ucla.edu

Stages of Grieving

Grieving disrupts normal functioning, but it need not be a long lasting problem. "Working" through grief can help restore emotional health. Although grief stages may not occur in order, they are described as follows:

- *Shock* – usually the first reaction – often experienced as numbness or physical pain and withdrawal.
- *Denial* – acting as if no loss has occurred
- *Depression* – feeling pain, despair, emptiness – may not be accompanied by an emotional release such as crying
- *Guilt* – self-blame for not having expressed more caring or belief the loss was his/her fault
- *Anxiety* – panic reactions as reality sets in
- *Aggression* – toward those who might have prevented the loss and sometimes toward the lost object (may have trouble acknowledging anger toward the object of loss, but expressing such anger is seen as helping recovery)
- *Reintegration* – loss is accepted (although there may be periods of relapse).

Helping Students/Staff Deal with Loss

One of the most difficult losses is the death of someone who was loved. As in all loss situations, those grieving need to experience school as a safe place to think about and express their loss. To this end, anyone doing counseling needs to:

(1) Recognize loss; encourage students/staff to talk about what happened and how they feel. ("Tell me what happened." "I'm so sorry.")

(2) Tell others as a group what happened and respond emotionally. Directly relate the facts. Let them know how you feel. ("It hurts to know your mother died.")

(3) Allow students/staff to express their reactions and then validate the emotions that emerge at each grief stage. Offer time for them to share feelings and facilitate the process with warmth and understanding. For groups, validate the feelings expressed – even if they seem harsh. (There will be expressions of anger, fear, guilt, and so forth. Some will even indicate relief that what happened to someone else didn't happen to them. Others may find it hard to express anything.) All need to be told it is O.K. to cry.

(4) Answer questions directly and sensitively. Relate the facts of an event as best you can. In discussing death, recognize its finality – don't compare it with sleeping (that can lead to sleep problems).

(5) In a situation where someone returns to school after experiencing a cherished other's death, be sure that students and staff are prepared for what to say and how to act. It is critical that they welcome the person and not shy away ("Glad you're back, sorry about your brother." "When you feel like it, let's talk about it.").

(6) Don't forget to take care of yourself – especially if the loss is one for you too.

Helping the Bereaved Return to School

Individuals experiencing loss sometimes don't want to return to school. There are many reasons for this. Crisis response plans should address what to do to maximize someone's return after a loss.

Outreach. A home visit can help assess needs and how to address them. A step-by-step plan can be made with the individual's family.

Special support and accommodations at school. Inform teachers and other staff about plans and specific ways to help a student or colleague readjust. Connect the person to special friends and counselors who will be especially supportive. Ensure that everyone understands grief reactions and is ready to be appropriately responsive. Add support around classroom learning activities and job functions to help if someone is having trouble focusing.

Counseling to help the person through the stages of grief. In general, the individual needs to have prompt and accurate information about what happened, honest answers to questions, an opportunity to work through the grief, and lots of good support.

Lessons Learned

Volunteers: A Multifaceted Resource

Everyone knows schools have a big job to do and too few resources to do it. Volunteers are not *the* answer, but they can play a role in helping schools do much more in addressing barriers to learning. From the front office to the classroom, before school, after school, and on weekends – volunteers can assist. And in doing so, they ease the burden on staff, improve the status of students and their families, and reap a host of benefits to themselves.

Schools have always used volunteer help. However, they do not always use such resources in a multifaceted way. This is unfortunate because, with relatively little expense, volunteers can (a) be the backbone of newcomer welcoming and social support programs, (b) assist with specific students in ways that minimize class disruptions and facilitate positive performance, enabling teachers to personalize instruction, (c) help with school recreational, enrichment, and tutorial programs, (d) provide general assistance to staff on countless everyday tasks that must be done, freeing other school personnel to meet students' needs more effectively, (e) broaden students' experiences through inter-action with volunteers, and (f) strengthen school-community understanding and relations.

With the renewed interest in "volunteerism" and "service learning," schools have a wonderful chance to capitalize on what will be an increasing pool of talent. The key to doing so effectively is making recruitment, training, and daily maintenance of a volunteer force part of a school's everyday agenda.

Using Volunteers in Many Roles

I. Welcoming and Social Support

- A. In the Front Office
  - 1. Greeting and welcoming
  - 2. Providing information to those who come to the front desk
  - 3. Escorting guests, new students/families to destinations on the campus
  - 4. Orienting newcomers
- B. Staffing a Welcoming Club
  - 1. Connecting newly arrived parents with peer buddies
  - 2. Helping develop orientation and other information resources for newcomers
  - 3. Helping establish newcomer support groups

II. Working with Designated Students in the Classroom

- A. Helping to orient new students
- B. Engaging disinterested, distracted, and distracting students
- C. Providing personal guidance and support for specific students in class to help them stay focused and engaged

III. Providing Additional Opportunities and Support in Class and on the Campus as a Whole by Helping Develop and Staff

- A. Recreational and enrichment activity
- B. Tutoring
- C. Mentoring

IV. Helping Enhance a Positive Climate Throughout the School (including assisting with "chores")

- A. Assisting with Supervision in Class and Throughout the Campus
- B. Contributing to Campus "Beautification"
- C. Helping Get Materials Ready

Volunteers Helping with Targeted Students

Volunteers can be especially helpful working under the direction of the classroom teacher to establish a supportive relationship with students having trouble adjusting to school. Every teacher has had the experience of planning a wonderful lesson and having the class disrupted by one or two students. Properly trained volunteers can help minimize such disruptions by re-engaging an errant student. When a teacher has trained a volunteer to focus on designated students, the volunteer knows to watch for and move quickly at the first indication that a student needs special guidance and support. The strategy involves quickly sitting down next to and quietly engaging the youngster. If necessary, the volunteer takes the student to a quiet area in the classroom and initiates another activity or even goes out for a brief walk and talk if feasible. None of this is a matter of rewarding the student for bad behavior. Rather, it is a strategy for avoiding the tragedy of disrupting the whole class while the teacher reprimands the culprit and, in the process, increases that student's negative attitudes toward teaching and school. This use of a volunteer enables the teacher to continue teaching, and as soon as time permits, it allows the teacher to explore with the student ways to make the classroom a mutually satisfying place. Moreover, by handling the matter in this way, the teacher is likely to find the student more receptive to discussing matters than often is the case when the usual "logical consequences" are administered (e.g., loss of privileges, sending the student to time-out or to the office).

*For more on this topic, see the Center's TA Packet on Volunteers and the guidebook:
What Schools Can Do to Welcome and Meet the Needs of All Students And Families.

Commentary: Major Concerns in Enhancing MH in Schools

As you may know, the U.S. Surgeon General will hold a national conference on Children's Mental Health on September 18-19, 2000. In preparation for the conference, Dr. Satcher's office solicited a variety of input. That request paralleled inquiries that come to our Center asking:

> *What are the major concerns in enhancing mental health (MH) for school-age children, adolescents, and their families?*

Here is our answer.

Not surprisingly, we think about key concerns from the perspective of mental health *in schools.* And, we use the complementary lenses of addressing barriers to learning and promoting healthy development in analyzing what schools are doing and should do.

Our analyses lead us to suggest that those interested in improving the well-being of youngsters by enhancing MH in schools must strive to ensure

- mental *illness* is understood and addressed within the broader context of psychosocial problems and that mental *health* is understood in terms of strengths, as well as deficits
- the *respective roles of schools, communities, and homes* are enhanced and pursued in a collaborative manner
- critical *equity considerations* are addressed
- the prevailing *marginalization and fragmentation* of policy, organizational infrastructures, and daily practice are countered and result in increased financing
- the challenges of *evidence-based strategies* and *achieving results* are handled *in ways that enhance system-wide effectiveness.*

The challenge for those focused on MH *in schools* is not only to understand these matters, but to function on the cutting edge of change so that the concerns are well-addressed. A few thoughts about each may help clarify some points.

Defining MH: There are two key definitional problems. First is the tendency to define mental health as mental illness. Second is the tendency to define too many emotional and behavioral problems as disorders (e.g., translating commonplace behavior into "symptoms" and DSM-IV diagnoses). For youngsters, the most frequent problems are psychosocial, and for the majority, these problems stem from socio-cultural and economic factors. This in no way denies there are children for whom the primary factor instigating a problem is an internal disorder. We are simply recognizing that these youngsters constitute a relatively small group. Biases in definition that overemphasize this group lead to a narrowing of how problems are classified and assessed and a skewing of strategies for prevention and intervention early-after-onset. For example, each year a great many parents and teachers identify large numbers of children (e.g., of kindergarten age) soon after the onset of a problem. This "first level screen" bears little fruit because there are so few resources, especially school-based resources, for intervening early-after-onset – unless the problem is severe and pervasive.

Currently, not many youngsters can readily access help for emotional, behavioral, or learning problems unless the problem is severe or pervasive enough to warrant diagnosis as a disorder/disability. As long as this is the case, large numbers of misdiagnoses are inevitable and the response to problems often will be inappropriate and expensive. Furthermore, the amount of misdiagnoses will continue as a major contaminate in research and training.

To reduce misdiagnoses and misprescriptions, we must place mental illness in context with respect to psychosocial problems and broaden the definition of MH to encompass *positive* MH (e.g., promoting social and emotional development). Another way to improve the situation is to counter bias in training. A great deal of MH training focuses on mental illness, with little time devoted to psychosocial problems and their relationship to mental disorders. Positive MH receives little or no attention. The result is a person-pathology orientation to assess-ment and a clinical orientation to ameliorating problems. These trends contribute to the dearth of investment in research to develop (a) assessment practices and classification schemes that account for environmental causes and (b) school-wide and system-wide programs to prevent and correct psychosocial problems.

Obviously, we need to keep a strong and aggressive focus on mental illness. At the same time, it is essential to realize that *only* doing this is a self-defeating public policy agenda. The evidence indicates that efforts to deal with child/adolescent mental illness are hampered by the tendency to assign psychopathological labels to so many commonplace psychosocial problems. Appreciation of this fact has profound and fundamental implications for reshaping MH research, training, and practices.

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School-community-home collaborations: See the lead article in this issue.

Equity, marginalization, and financing: As the Surgeon General's recent report underscores, the nation's response for MH is inadequately financed. This ensures that substantial numbers cannot access needed services and that there will continue to be sociocultural disparities related to access. (Given this state of affairs, it is hardly surprising there are so few funds for programs to foster social and emotional development and overall wellness.)

Despite limited data on financing, some points can be extrapolated from available studies. For one, the public sector does the greatest proportion of financing of MH services because insurance coverage is not on a par with coverage for physical health. A second point that emerges is that the vast proportion of public and private funding for MH is directed mainly at addressing severe, pervasive, and/or chronic psychosocial problems. For example, in the last decades of the 20th century, support for MH services came mainly from legislation designed for youngsters with diagnosed emotional and behavioral "disabilities" and "mental illnesses" or to address problems such as violence and substance abuse. On a lesser scale, legislation also provided for those living in poverty to access early periodic screening, diagnosis, and treatment for MH problems. However, as often has been the case related to public financing for MH, many states and localities have been reticent to underwrite and promote intervention activity. Consequently, passage of legislative mandates and monitoring to ensure full compliance still tend to be done reluctantly and frequently only in response to lawsuits. This is reflected in the growing body of case law that defines and expands MH services – especially for youngsters in special education. It is also reflected in the ad hoc, de facto nature of the "system" that has arisen to address MH and psychosocial concerns.

Given the limited financing and current ways funds are used, the high degree of competition seen among those seeking a share is hardly surprising. In many cases, the competition is producing more tension than productivity (e.g., advocates for the mentally ill compete with those seeking support for prevention; researchers want more money even if it means there is less for services). The competition is fueled by dependency on varied streams of funding and the lack of coherent connections and coordination among the host of public and private agents involved in addressing child/adolescent MH. This includes such professionals as pediatricians, primary care providers, and those dealing with education, social welfare, and criminal justice concerns.

A reasonable policy conclusion is that the current level of public funding and health plan coverage is grossly inadequate. In general, the nature and scope of financial support for MH and psychosocial concerns is marginalized in policy and practice, categorical in law and related regulations, fragmented in planning and implementation, and inequitable with respect to access. As a result, there are too few programs and services available to many youngsters, and what is available is too often inadequate in nature, scope, duration, intensity, quality, and impact. For those in crisis and those with severe mental impairments, financing is only sufficient to provide access to a modicum of treatment, and even this is not accomplished without creating major inequities of opportunity. For the large numbers of youngsters seen as "at risk," current financing does expose a significant number to a range of interventions, however, such exposure typically is rather superficial.

Evidence-based strategies: If the field is not careful, another and rather ironic barrier to moving forward may be the way we handle the complementary challenges surrounding the needs for *evidence-based strategies* and *demonstrating results*. These matters must be addressed in ways that enhance rather than hinder system-wide effectiveness.

The problem rests with the limited nature and scope of interventions that currently have strong research support. The best (not always to be equated with good) evidence-based strategies for identifying and working with children's mental health problems are for a small number of non-comorbid disorders. And, the data show efficacy – not effectiveness. Clearly, before these strategies are seen as the answer, they must be widely implemented in community and school settings, and they must generate data that demonstrate enhanced cost-effectiveness.

But it should be stressed that there is a bigger problem related to addressing the MH needs of children and adolescents. This involves investing in the development and evaluation of interventions that go beyond one-to-one and small group approaches and that incorporate public health and primary prevention initiatives. Such approaches must be comprehensive, multifaceted, and integrated and must encompass a full intervention continuum in the form of systems of prevention, systems of early intervention (early after the onset of problems), and systems of care. Development of such a continuum of overlapping systems requires major school-based programs and school-community collaborations.

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We must recognize that we do not have a strong evidence base for addressing many psychosocial problems. We must recognize that we are not moving in the direction of developing such a evidence base because (1) we do not support the type of research that must be carried out to determine the impact of comprehensive, multifaceted, and integrated approaches, and (2) we are falling into the trap of thinking we can solve large-scale problems by reifying a few evidence-based interventions. It is striking that there never has been a formal study of the impact on a catchment area (e.g., a neighborhood) of a comprehensive, multifaceted, and integrated approach that encompasses a full intervention continuum in the form of systems of prevention, early intervention, and care.

* * * * *

It is our hope that the Surgeon General's Conference in September will not reflect a definitional bias that approaches the topic of mental health as if it only encompassed mental illness and will take pains to place mental disorders into perspective vis-a-vis psychosocial problems and then clarify the implications of this broad perspective for classification schemes, assessment, prevention, corrective intervention, research, and training. Clearly, the conference represents an opportunity to advance the agenda related to children's MH. The temptation, at this stage, will be to keep the agenda rather narrow. Politically, this makes some sense. But in the long-run, it may be counterproductive to meeting the needs of the nation's youth.

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