Addressing Barriers
to Learning

New ways to think . . .

Better ways to link

...consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one high school crisis is followed by another, we concentrate on the particular people involved -- their values, their character, their personal failings -- rather than asking whether something about the system in which these students find themselves might also need to be addressed.

Alfie Kohn, 1999

Youth Suicide/ Depression/Violence

"I am sad all the time."
"I do everything wrong."
"Nothing is fun at all."
items from the
"Children's Depression Inventory"

Too many young people are not very happy. This is quite understandable among those living in economically impoverished neighborhoods where daily living and school conditions frequently are horrendous. But even youngsters with economic advantages too often report feeling alienated and lacking a sense of purpose.

Youngsters who are unhappy usually act on such feelings. Some do so in "internalizing" ways; some "act out;" and some respond in both ways at different times. The variations can make matters a bit confusing. Is the youngster just sad? Is s/he

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depressed? Is this a case of ADHD? Individuals may display the same behavior and yet the causes may be different and vice versa. And, matters are further muddled by the reality that the causes vary.

The causes of negative feelings, thoughts, and behaviors range from environmental/system deficits to relatively minor group/individual vulnerabilities on to major biological disabilities (that affect only a small proportion of individuals). It is the full range of causes that account for the large number of children and adolescents who are reported as having psychosocial, mental health, or developmental problems. In the USA, estimates are approaching 20 percent (11 million).

Recent highly publicized events and related policy initiatives have focused renewed attention on youth suicide, depression, and violence. Unfortunately, such events and the initiatives that follow often narrow discussion of causes and how best to deal with problems.

Shootings on campus are indeed important reminders that schools must help address violence in the society. Such events, however, can draw attention away from the full nature and scope of violence done to and by young people. Similarly, renewed concern about youth suicide and depression are a welcome call to action. However, the actions must not simply reflect biological and psychopathological perspec- tives of cause and correction. The interventions must also involve schools and communities in approaches that counter the conditions that produce so much frustration, apathy, alienation, and hopelessness. This includes increasing the opportunities that can enhance the quality of youngsters' lives and their expectations for a positive future.

About Violence

Violence toward and by young people is a fact of life. And, it is not just about guns and killing. For schools, violent acts are multifaceted and usually constitute major barriers to student learning. As Curcio and First (1993) note:

Violence in schools is a complex issue. Students assault teachers, strangers harm

children, students hurt each other, and any one of the parties may come to school already damaged and violated [e.g., physically, sexually, emotionally, or negligently at home or on their way to or from school]. *The kind of violence an individual encounters varies also, ranging from mere bullying to rape or murder.*

Clearly, the nature and scope of the problem goes well beyond the widely-reported incidents that capture media attention. We don't really have good data on how many youngsters are affected by all the forms of violence or how many are debilitated by such experiences. But few who have good reason to know would deny that the numbers are large. Far too many youngsters are caught up in cycles where they are the recipient, perpetrator, and sometimes both with respect to physical and sexual harassment ranging from excessive teasing and bullying to mayhem and major criminal acts. Surveys show that in some schools over 50% of the students have had personal property taken (including money stolen or extorted). Before recent campaigns for safe schools, one survey of 6th and 8th graders in a poor urban school found over 32% reporting they had carried a weapon to school -- often because they felt unsafe.

About Suicide and Depression

In the Surgeon General's *Call to Action to Prevent Suicide 1999*, the rate of suicide among those 10-14 years of age is reported as having increased by 100% from 1980-1996, with a 14% increase for those 15-19. (In this latter age group, suicide is reported as the fourth leading cause of death.) Among African-American males in the 15-19 year age group, the rate of increase was 105%. And, of course, these figures don't include all those deaths classified as homicides or accidents that were in fact suicides.

Why would so many young people end their lives? The search for answers inevitably takes us into the realm of psychopathology and especially the arena of depression. But we must not only go in that direction. As we become sensitive to symptoms of depression, it is essential to differentiate common-place periods of unhappiness from the syndrome that indicates clinical depression. We must also remember that not all who commit suicide are clinically depressed and that most persons who are unhappy or even depressed do not commit suicide. As the National Mental Health Association cautions: "Clinical depression goes beyond sadness or having a bad day. It is a form of mental illness that affects the way one feels, thinks, and acts." And, it does so in profound and pervasive ways that can lead to school failure, substance abuse, and sometimes suicide.

Numbers for depression vary. The National Institute of Mental Health's figure is 1.5 million children and adolescents. The American Academy of Child and Adolescent Psychiatry estimates 3.0 million. Variability in estimates contributes to appropriate concerns about the scope of misdiagnoses and misprescriptions. Such concerns increase with reports that, in 1998, children 2-18 years of age received 1.9 million prescriptions for six of the new antidepressants (an increase of 96% over a 4 year period) and about a third of these were written by nonpsychiatrists -- generally pediatricians and family physicians. This last fact raises the likelihood that prescriptions often are provided without the type of psychological assessment generally viewed as necessary in making a differential diagnosis of clinical depression. Instead, there is overreliance on observation of such symptoms as: *persistent sadness and hopelessness, withdrawal from friends and previously enjoyed activities, increased irritability or agitation, missed school or poor school performance, changes in eating and sleeping habits, indecision, lack of concentration or forgetfulness, poor self-esteem, guilt, frequent somatic complaints, lack of enthusiasm, low energy, low motivation, substance abuse, recurring thoughts of death or suicide.*

Clearly, any of the above indicators is a reason for concern. However, even well trained professionals using the best available assessment procedures find it challenging to determine in any specific case (a) the severity of each symptom (e.g., when a bout of sadness should be labeled as profoundly persistent, when negative expectations about one's future should be designated as "hopelessness"), (b) which and how many symptoms are transient responses to situational stress, and (c) which and how many must be assessed as severe enough to warrant a diagnosis of depression.

Linked Problems

Wisely, the Surgeon General's report on suicide stresses the linkage among various problems experienced by young people. This point has been made frequently over the years, and just as often, its implications are ignored.

One link is life dissatisfaction. For any youngster and among any group of youngsters, such a state can result from multiple factors. Moreover, the impact on behavior and the degree to which it is debilitating will vary considerably. And, when large numbers are affected at a school or in a neighborhood, the problem can profoundly exacerbate itself. In such cases, the need is not just to help specific individuals but to develop approaches that can break the vicious cycle. To do so, requires an appreciation of the overlapping nature of the many "risk" factors researchers find are associated with youngsters' behavior, emotional, and learning problems.

Center News
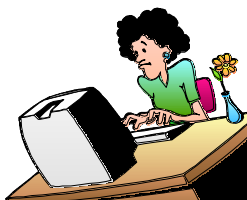
Last June we hosted a "mini-summit" focused on *Expanding Policy Leadership for Mental Health in Schools.* See pages 10 and 11 of this newsletter for excerpts from the report.

NEW ONLINE RESOURCES!

>>>Now Available for downloading:

- *AFFECT AND MOOD PROBLEMS RELATED TO SCHOOL AGED YOUTH*

This document provides an introduction to affect and mood problems. The discussion is framed within the classification scheme of the American Pediatric Association. Included is info on the symptoms and severity of a variety of affect and mood problems, as well as information on interventions -- ranging from environmental accommodation to behavior management to medication.

http://smhp.psych.ucla.edu/intropak.htm

- *PROTECTIVE FACTORS (RESILIENCY)*

This Technical Assistance aid contains a sample of diverse resources, as well as links to other resources. Included are: (1) Protective Factors and Resistance to Psychiatric Disorder; (2) Fostering Resiliency; and (3) Intervening in the School, Home, and Community. The work approaches the topic of fostering resilience as an inside-out, deep structure process of changing our own belief systems to see resources and not problems in youth, their families, and their cultures. Fostering resilience also is seen as requiring a focus on policy.

http://smhp.psych.ucla.edu/techpak.htm#sampler

>>>Also on our Website:

QUICK FIND SEARCHES

As a way to provide rapid access to assistance, two quick find options on our website offer a growing list of (1) Center technical assistance responses to specific requests on topics of general interest and (2) Center prepared resources. These are intended to speed up access to a sampling of basic information and resources on a range of major topics. New topics that have just been added include: Suicide Prevention, Financing & Funding, and Mental Health Assessment & Screening.

From our home page, click on "Contents" to find the Quick Find search box. From there, you can access Center responses to specific technical assistance requests we've received in the past.

In need of 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 news (ENEWS), just 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 information for us to circulate, note them on the form inserted in this newsletter or contact us directly by mail, phone, or E-mail.

Can you define collaboration for me?

Sure! Collaboration is an unnatural act between nonconsenting adults.
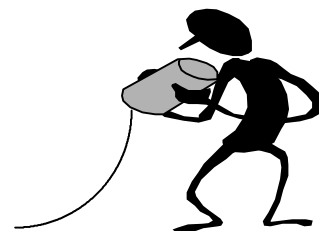
Stand still and silently wait for the world to go by -- & it certainly will!

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

Do You Know About?

In 1997, the American Youth Policy Forum published a compendium of evaluations of youth programs and practices entitled:

Some Things DO Make a Difference for Youth.

The work is a reader-friendly collection of summaries of 69 evaluations of 49 interventions focusing on youth development, mentoring, employment and training, and education.

Now, a second compendium has been produced.

More Things That DO Make a Difference for Youth.

This includes positive findings on an additional 46 interventions.

Contact: Donna Walker or Samuel Halperin
American Youth Policy Forum
1836 Jefferson Place, NW,
Washington, DC 20036-2505
Ph: 202/775-9731

Coalition for Cohesive Policy in Addressing Barriers to Development & Learning

The Center's parent organization, the UCLA School Mental Health Project, continues to facilitate the development and ongoing operation of this pioneering Coalition. Until the organization can establish its own infra-structure, the Center has organized a Listserv to facilitate participant communication and is hosting the beginnings of the Coalition's website. Click on "Contents" when you are next on the Center's web, and you will find two sites we are hosting. The Coalition site contains reports from its Steering Committee and a second draft of an organizational policy statement recently prepared and sent out to all Coalition participants. Organizations interested in the Coalition, its activities and products, can contact our Center.

Coming Soon

♦ The Center is preparing a Technical Assistance Sampler to provide a sampling of outcome findings from interventions relevant to addressing barriers to learning. Watch for it!

♦ We also are starting to gather information to develop a *Sampler on Technology for Addressing Barriers to Learning.* With each passing day, the importance of technology to all our efforts is growing at an exponential rate. Please share with us any relevant information you have on this topic.

##

On thinking about incidence and prevalence statistics . . .

I'm overworked and fatigued! For a couple of years, I've been blaming it all on having a particularly demanding job. But now I've figured out the real reason why I'm overworked.

The population of this country is about 237 million. Since 104 million are retired, that leaves 85 million to do the work.

Of these, 29 million are employed by the federal government -- leaving 19 million to do the work.

Another 2.8 are in the military, which leaves 16.2 million to do the work.

Take away another 14.8 who work for states and cities and that leaves 1.4 to do the work.

At any given time, there are 188,000 people in hospitals -- leaving 1,212,000 to do the work.

With 1,211,998 people in prisons, that leaves just 2 people to do the work.

YOU AND ME! *And you're just sitting around reading this joke.*

##

Risk Factors

Based on a review of over 30 years of research, Hawkins and Catalano (1992) identify the following 19 common risk factors that reliably predict youth delinquency, violence, substance abuse, teen pregnancy, and school dropout:

A. Community Factors
  1. Availability of Drugs
  2. Availability of Firearms
  3. Community Laws and Norms Favorable
     Toward Drug Use, Firearms, and Crime
  4. Media Portrayals of Violence
  5. Transitions and Mobility
  6. Low Neighborhood Attachment and
     Community Disorganization
  7. Extreme Economic Deprivation

B. Family Factors
  8. Family History of the Problem Behavior
  9. Family Management Problems
  10. Family Conflict
  11. Favorable Parental Attitudes and
      Involvement in the Problem Behavior

C. School Factors
  12. Early and Persistent Antisocial Behavior
  13. Academic Failure Beginning in
      Late Elementary School
  14. Lack of Commitment to School

D. Individual / Peer Factors
  15. Alienation and Rebelliousness
  16. Friends Who Engage in the Problem Behavior
  17. Favorable Attitudes Toward the Problem Behavior
  18. Early Initiation of the Problem Behavior

E. 19. Constitutional Factors

Hawkins, J.D. & Catalano, R.F. (1992). *Communities That Care; Action for Drug Abuse Prevention*. Jossey-Bass.

General Guidelines for Prevention

Various efforts have been made to outline guidelines for both primary and secondary (indicated) prevention. A general synthesis might include:

•Systemic changes designed to both minimize threats to and enhance feelings of competence, connectedness, and self-determination (e.g., emphasizing a caring and supportive climate in class and school-wide, personalizing instruction). Such changes seem easier to accomplish when

smaller groupings of students are created by establishing smaller schools within larger ones and small cooperative groups in classrooms.

•Ensure a program is integrated into a comprehensive, multifaceted continuum of interventions.

•Build school, family, and community capacity for participation.

•Begin in the primary grades and maintain the whole continuum through high school.

•Adopt strategies to match the diversity of the consumers and interveners (e.g., age, socio economic status, ethnicity, gender, disabilities, motivation).

•Develop social, emotional, and cognitive assets and compensatory strategies for coping with deficit areas.

•Enhance efforts to clarify and communicate norms about appropriate and inappropriate behavior (e.g., clarity about rules, appropriate rule enforcement, positive "reinforcement" of appropriate behavior; campaigns against inappropriate behavior).

Suicide Prevention

With specific respect to suicide prevention programs, one synthesis from the U.S. Dept. of Health and Human Services delineates eight different strategies: (1) school gatekeeper training, (2) community gatekeeper training, (3) general suicide education, (4) screening, (5) peer support, (6) crisis centers and hotlines, (7) means restriction, and (8) intervention after a suicide (CDC, 1992). Analyses suggested the eight could be grouped into 2 sets -- those for enhancing identification and referral and those for directly addressing risk factors. And, recognizing the linkage among problems, the document notes:

Certainly potentially effective programs targeted to high-risk youth are not thought of as "youth suicide prevention" programs. Alcohol and drug abuse treatment programs and programs that provide help and services to runaways, pregnant teens, or school dropouts are examples of programs that address risk factors for suicide and yet are rarely considered to be suicide prevention programs.

Enhancing Protective Factors and Building Assets

Those concerned with countering the tendency to overemphasize individual pathology and deficits are stressing resilience and preventive factors and developing approaches designed to foster such factors. The type of factors receiving attention is exemplified by the following list:

Community and School Protective Factors

 •Clarity of norms/rules about behavior (e.g., drugs, violence)
 •Social organization (linkages among community members/capacity to solve community problems/ attachment to community)
 •Laws and consistency of enforcement of laws and rules about behavior (e.g., limiting ATOD, violent behavior)
 •Low residential mobility
 •Low exposure to violence in media
 •Not living in poverty

Family and Peer Protective Factors

 •Parental and/or sibling negative attitudes toward drug use
 •Family management practices (e.g., frequent monitoring & supervision/consistent discipline practices)
 •Attachment/bonding to family
 •Attachment to prosocial others

Individual Protective Factors

 •Social & emotional competency
 •Resilient temperament
 •Belief in societal rules
 •Religiosity
 •Negative attitudes toward delinquency
 •Negative attitudes toward drug use
 •Positive academic performance
 •Attachment & commitment to school
 •Negative expectations related to drug effects
 •Perceived norms regarding drug use and violence

Note: This list is extrapolated from guidelines for submitting Safe, Disciplined, and Drug-Free Schools Programs for review by an Expert Panel appointed by the U.S. Department of Education (1999). The list contains only factors whose predictive association with actual substance use, violence, or conduct disorders have been established in at least one empirical study. Other factors are likely to be established over time.

The focus on protective factors and assets reflects the long-standing concern about how schools should play a greater role in promoting socio-emotional development and is part of a renewed and growing focus on youth development. After reviewing the best programs focused on preventing and correcting social and emotional problems, a consortium of professionals created the following synthesis of fundamental areas of competence (W.T. Grant Consortium on the School-Based Promotion of Social Competence , 1992):

Emotional

 •identifying and labeling feelings
 •expressing feelings
 •assessing the intensity of feelings
 •managing feelings
 •delaying gratification
 •controlling impulses
 •reducing stress
 •knowing the difference between feelings and actions

Cognitive

 •self-talk -- conducting an "inner dialogue" as a way to cope with a topic or challenge or reinforce one's own behavior
 •reading and interpreting social cues -- for example, recognizing social influences on behavior and seeing oneself in the perspective of the larger community
 •using steps for problem-solving and decision-making -- for instance, controlling impulses, setting goals, identifying alternative actions, anticipating consequences
 •understanding the perspectives of others
 •understanding behavioral norms (what is and is not acceptable behavior)

 •a positive attitude toward life
 •self-awareness -- for example, developing realistic expectations about oneself

Behavioral

 •nonverbal -- communicating through eye contact, facial expressiveness, tone of voice, gestures, etc.
 •verbal -- making clear requests, responding effectively to criticism, resisting negative influences, listening to others, helping others, participating in positive peer groups

Note: With increasing interest in facilitating social and emotional development has come new opportunities for collaboration. A prominent example is the Collaborative for the Advancement of Social and Emotional Learning (CASEL) established by the Yale Child Study Center in 1994. CASEL's mission is to promote social and emotional learning as an integral part of education in schools around the world. Those interested in this work can contact Roger Weissberg, Executive Director, Dept. of Psychology, University of Illinois at Chicago, 1007 W. Harrison St., Chicago, IL 60607-7137. Ph. (312) 413-1008.

Initiatives focusing on resilience, protective factors, building assets, socio-emotional development, and youth development all are essential counter forces to tendencies to reduce the field of mental health to one that addresses only mental illness.

System Change

When it is evident that factors in the environment are major contributors to problems, such factors must be a primary focal point for intervention. Many aspects of schools and schooling have been so-identified. Therefore, sound approaches to youth suicide, depression, and violence must encompass extensive efforts aimed at systemic change. Of particular concern are changes that can enhance a caring and supportive climate and reduce unnecessary stress throughout a school. Such changes not only can have positive impact on current problems, they can prevent subsequent ones.

Caring has moral, social, and personal facets. From a psychological perspective, a classroom and school-wide atmosphere that encourages mutual support and caring and creates a sense of community is fundamental to preventing learning, behavior, emotional, and health problems. Learning and teaching are experienced most positively when the learner *cares* about learning, the teacher *cares* about teaching, and schools function better when all involved parties *care* about each other. This is a key reason why caring should be a major focus of what is taught and learned.

Caring begins when students first arrive at a school.

Schools do their job better when students feel truly welcome and have a range of social supports. A key facet of welcoming is to connect new students with peers and adults who will provide social support and advocacy. Over time, caring is best maintained through personalized instruction, regular student conferences, activity fostering social and emotional development, and opportunities for students to attain positive status. Efforts to create a caring classroom climate benefit from programs for cooperative learning, peer tutoring, mentoring, advocacy, peer counseling and mediation, human relations, and conflict resolution. Clearly, a myriad of strategies can contribute to students feeling positively connected to the classroom and school.

Given the need schools have for home involvement, a caring atmosphere must also be created for family members. Increased home involvement is more likely if families feel welcome and have access to social support at school. Thus, teachers and other school staff need to establish a program that effectively welcomes and connects families with school staff and other families in ways that generate ongoing social support.

And, of course, school staff need to feel truly welcome and socially supported. Rather than leaving this to chance, a caring school develops and institutionalizes a program to welcome and connect new staff with those with whom they will be working.

What is a psychological sense of community?

People can be together without feeling connected or feeling they belong or feeling responsible for a collective vision or mission. At school and in class, a psychological sense of community exists when a critical mass of stakeholders are committed to each other *and* to the setting's goals and values *and* exert effort toward the goals and maintaining relationships with each other.

A perception of community is shaped by daily experiences and probably is best engendered when a person feels welcomed, supported, nurtured, respected, liked, connected in reciprocal relationships with others, and a valued member who is contributing to the collective identity, destiny, and vision. Practically speaking, such feelings seem to arise when a critical mass of participants not only are committed to a collective vision, but also are committed to being and working together in supportive and efficacious ways. That is, a conscientious effort by enough stakeholders associated with a school or class seems necessary for a sense of community to develop and be maintained. Such an effort must ensure effective mechanisms are in place to provide support, promote self-efficacy, and foster positive working relationships.

There is an clear relationship
between maintaining a sense of community

and countering alienation and violence at school. Conversely, as Alfie Kohn cautions:

The more that ... schools are transformed into test-prep centers -- fact factories, if you will -- the more alienated we can expect students to become.

Knowing What to Look For & What to Do

Of course, school staff must also be prepared to spot and respond to specific students who manifest worrisome behavior. Recently, the federal government circulated a list of "Early Warning Signs" that can signal a troubled child. Our Center also has put together some resources that help clarify what to look for and what to do. A sampling of aids from various sources is provided at the end of this article. In addition, see *Ideas into Practice* on p. 9.

Concluding Comments

In current practice, schools are aware that violence must be addressed with school-wide intervention strategies. Unfortunately, prevailing approaches are extremely limited, often cosmetic, and mostly ineffective in dealing with the real risk factors.

In addressing suicide, depression, and general life dissatisfaction, practices tend to overemphasize individual and small group interventions. Given the small number of "support" service personnel at a school and in poor communities, this means helping only a small proportion of those in need.

If schools are to do a better job in addressing problems ranging from interpersonal violence to suicide, they must adopt a model that encompasses a full continuum of interventions -- ranging from primary prevention through early-after-onset interventions to treatment of individuals with severe and pervasive problems. School policy makers must quickly move to embrace comprehensive, multi-faceted school-wide and community-wide models for dealing with factors that interfere with learning and teaching. Moreover, they must do so in a way that fully integrates the activity into school reform at every school site.

Then, schools must restructure how they use existing education support personnel and resources to ensure new models are carried out effectively. This restructuring will require *more than* outreach to link with community resources (and certainly *more than* adopting school-linked services), *more than* coordinating school-owned services with each other and with community services, and *more than* creating Family Resource Centers, Full Service Schools, and Community Schools.

Restructuring to develop truly comprehensive approaches requires a basic policy shift that moves schools from the inadequate two component model that dominates school reform to a three component framework that guides the weaving together of school and community resources to address barriers to development and learning. Such an expanded model of school reform is important not only for reducing suicide, depression, and violence among all children and adolescents, it is essential if schools are to achieve their stated goal of ensuring all students succeed.

Cited References and A Few Resource Aids

Curcio, J. & First, P. (1993). *Violence in the Schools: How to proactively prevent and defuse it.* Newbury Park, CA: Corwin Press.

Kohn, A. (Sept. 1999). Constant frustration and occasional violence: The legacy of American high schools. *American School Board Journal.* On the web at: http://www.asbj.com/current/coverstory/html

The Surgeon General's Call to Action to Prevent Suicide 1999. Available from the U.S. Dept. of Health & Human Services, Download-- http://www.mentalhealth.org/links/suicide.htm

Early Warning, Timely Response: A Guide to Safe Schools (1999). Printed version available from ED PUBS toll-free at 1-877-4ED-PUBS (1-877-433-7827) or by e-mail at edpuborders@aspensys.com. Can be downloaded from web. http://www.ed.gov/offices/OSERS/OSEP/earlywrn.html

Youth Suicide Prevention Programs: A Resource Guide (1992). Available from the U.S. Dept. of Health & Human Services, CDC. Can be downloaded from http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000024/p0000024.htm

The following are resources put together at our Center. All are available as described on p. 3 (*Center News*); most can be downloaded through our website: *http://smhp.psych.ucla.edu/*.

>*Screening/Assessing Students: Indicators and Tools*
>*Responding to Crisis at a School*
>*Violence Prevention and Safe Schools*
>*Social and Interpersonal Problems Related to School Aged Youth*
>*Affect and Mood Problems Related to School Aged Youth*
>*Conduct and Behavior Problems in School Aged Youth*
>*What Schools Can Do to Welcome and Meet the Needs of All Students and Families*
>*Protective Factors (Resiliency)*

Some Websites:
Safe and Drug Free Schools Office, U.S. Dept. of Educ. http://www.ed.gov/offices/OESE/SDFS
National Institute of Mental Health http://www.nimh.nih.gov
National School Safety Center http://nssc1.org
Youth Suicide Prevention Program http://depts.washington.edu/ysp
Suicide Resources on the Internet http://psychcentral.com/helpme.htm

When a Student Seems Dangerous to Self or Others

Whhat should you do if you come upon a youngster who seems about to commit a violent act against self or others? The following points are extrapolated from guidelines usually suggested for responding when a student talks of suicide.

First, you must assess the situation and reduce the crisis state. (You can access assessment tools in the resources listed on p. 8.)

Then, here's some specific suggestions for

When a Student Talks of Suicide . . .

What to do:

• Send someone for help; you'll need back-up.
• Remain calm; remember the student is overwhelmed and confused as well as ambivalent.
• Get vital statistics, including student's name, address, home phone number and parent's work number.
• Encourage the student to talk. Listen! Listen! Listen! And when you respond, reflect back what you hear the student saying. Clarify, and help him/her define the problem, if you can.

Consider that the student is planning suicide. How does the student plan to do it, and how long has s/he been planning and thinking about it? What events motivated the student to take this step?

• Clarify some immediate options (e.g., school and/or community people who can help).
• If feasible, get an agreement to no-suicide ("No matter what, I will not kill myself.")
• Involve parents for decision making and follow-through and provide for ongoing support and management of care (including checking regularly with parents and teachers).

What to avoid:

• Don't leave the student alone and don't send the student away
• Don't minimize the student's concerns or make light of the threat
• Don't worry about silences; both you and the student need time to think
• Don't fall into the trap of thinking that all the student needs is reassurance
• Don't lose patience
• Don't promise confidentiality -- promise help and privacy
• Don't argue whether suicide is right or wrong

When a Student Attempts Suicide . . .

A student may make statements about suicide (in writing assignments, drawing, or indirect verbal expression). Another may make an actual attempt using any of a variety of means. In such situations, you must act promptly and decisively.

What to do:

• Be directive. Tell the student, "Don't do that; stand there and talk with me." "Put that down." "Hand me that." "I'm listening."
• Mobilize someone to inform an administrator and call 911; get others to help; you'll need back-up.
• Clear the scene of those who are not needed.
• An "administrator" should contact parents to advise them of the situation and that someone will call back immediately to direct the parent where to meet the youngster.
• Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings "You are really angry." "You must be feeling really hurt."
• Secure any weapon or pills; record the time any drugs were taken to provide this information to the emergency medical staff or police.
• Get the student's name, address and phone.
• Stay with the pupil; provide comfort.
• As soon as feasible, secure any suicide note, record when the incident occurred, what the pupil said and did, etc.

• Ask for a debriefing session as part of taking care of yourself after the event.

What to avoid:

• Don't moralize ("You're young, you have everything to live for.")
• Don't leave the student alone (even if the student has to go to the bathroom).
• Don't move the student.

In all cases, show concern and ask questions in a straightforward and calm manner. Show you are willing to discuss suicide and that you aren't appalled or disgusted by it. Open lines of communication. Get care for the student.

A Few References

Compas, B.E., Connor, J., & Wadsworth, M. (1997). Prevention of depression. In R.P. Weissberg, T. Gullota, et al., (Eds.), *Healthy children 2010: Enhancing children's wellness*. Thousand Oaks, CA: Sage

Fairchild, T., et al. (Eds.) (1997). *Crisis intervention strategies for school-based helpers* (2nd ed.) Springfield, IL: Charles Thomas Pub.

Seligman, M.E.P. (1995). *The optimistic child*. New York: Harper Perennial.

Weiner, M. (1989). Psychopathology reconsidered: Depression interpreted as psychosocial transactions. *Clinical Psych-ology Review, 9,* 295-321.

The next few years appear destined to produce major mental health policy initiatives. With a view to further enhancing initiatives specifically for mental health in schools, the *UCLA Center for Mental Health in Schools* hosted a "mini-summit" in June, 1999. The event was designed to bring together leaders for a relatively informal exchange on policy and infrastructure concerns affecting MH in schools. In addition to direct invitations, an open invitation was made through our electronic newsletter. The response was outstanding. We ended up with RSVPs from leaders across the country, including reps of key federal agencies such as HRSA, SAMHSA, the Dept. of Education's Office of Special Education and Safe and Drug Free Schools Program, and the Department of Justice.

The agenda was shaped by two general questions about MH in schools: *Where are we currently? Where are we going?* A special focus was on clarifying key concerns that must be addressed in order to enhance policy. Participants also outlined some recent policy activity and explored the need to expand the pool of policy leaders. SAMHSA reps stressed the importance of connecting efforts to enhance policy for MH in schools with upcoming *Policy Academies* on developing systems of care.**

Enhancing a Policy Focus Relevant to Mental Health in Schools: Some Key Concerns

Leaders for MH in schools suggest that the well-being of youngsters can be substantially enhanced by addressing key policy concerns in this arena. They recognize that policy must be developed around well-conceived models and best available information. Policy must be realigned horizontally and vertically to create a cohesive framework and must connect in major ways with the mission of schools. Attention must be directed at restructuring the education support programs and services that schools own and operate and weave school owned and community owned resources together into comprehensive, mulitfaceted, integrated approaches for addressing problems and enhancing healthy development. Policy makers also must deal with the problems of "scale-up" (e.g., underwriting model development and capacity building for system-wide replication of promising models and institution-alization of systemic changes). And, in doing all this, more must be done to involve families and to connect the resources of schools, neighborhoods, and institutions of higher education.

What concerns must be addressed to enhance the policy context for MH in schools? The following synthesis provides a sense of agenda for the coming years.

•There is confusion about what constitutes MH in schools -- including disagreement regarding emphasis and breadth, and there is a dearth of unifying concepts, frameworks, and models.

> (Is the focus on specific services for emotional problems? Does the term encompass programs responding to psychosocial problems? prevention? affective education? wellness? school climate? How should families be involved?)

•There is no provision for an evolving synthesis, analysis, translation, and diffusion of research findings that have direct relevance to MH in schools.

> (What data support the value *to schools* of including a focus on mental health? What interventions look promising? What are the gaps in our knowledge base about interventions schools might find useful?)

•There is no ongoing synthesis and analyses of existing policy (federal, state, local) relevant to MH in schools. This deficiency exists with respect to clarifying

> how existing policies affect relevant practices at the school level (including analyses of how funding is shaping the nature and scope of what does and doesn't happen each day at school sites)

> how existing policies affect development of effective large-scale systems (e.g., district-wide approaches, school district and community-wide partnerships)

> how gaps in existing policy limit MH in schools

•Related to a lack of policy analyses is failure to confront the *policy marginalization and fragmentation* that hinders attempts to improve how schools address mental health and psychosocial concerns. In addition to addressing the above concerns, efforts to change this state of affairs must move rapidly to counter prevailing trends that continue to marginalize the focus in schools on mental health and psychosocial concerns. These trends include:

> the skewed focus that equates MH with severe and profound problems and minimizes prevention (including promotion of healthy social and emotional development) and early-after-onset interventions

> the lack of a significant integration with school reform of efforts to address barriers to learning

> the lack of a significant connection between initiatives for MH in schools and managed care/health reform

> the tendency not to map and analyze current resources used for psychosocial and mental health activity at school sites

> the dearth of attention given to enhancing policy cohesion in ways that minimize "silos" or "stovepipes" (redundancy, waste), maximize use of resources, and foster integrated school-community partnerships

> the failure to develop effective infrastructures to ensure development and maintenance of comprehensive, multifaceted, integrated approaches and related accountability procedures to clarify what's working

•The above matters tend not to be a significant focus in programs preparing MH professionals or in general courses offered to the citizenry.

>>>Those involved in school and community reforms recognize that institutions of higher education currently are part of the problem (e.g., because of the inadequacy of professional preparation and continuing education pro-grams; because of what higher education doesn't focus on in research and doesn't teach undergraduates). To achieve more than a marginal involvement of these mega-resource institutions requires policy, models, and structural changes that ensure truly reciprocal relationships designed to effectively address the pressing educational, social, and health concerns confronting our society. (Attention to professional preparation is especially important now given the "graying" of current support services personnel in schools and the need for such personnel to assume rapidly changing roles and functions and to enhance their cultural competency.)<<<

*Next Steps Toward an
Expanded Leadership Cadre*

Clearly, there is a great deal of work to be done in enhancing policy for mental health in schools. Key to the success of this work is increasing the pool of leadership and enhancing infrastructure capacity. Our Center plans to continue to play both a direct and a catalytic role in helping with ongoing leadership and infrastructure development.

In this respect, a policy leadership cadre represents a key infrastructure component. Such a group can become a direct force for advocacy and action, a catalyst, a focus for capacity building, and provide a critical mass for mentoring. Thus, our center will work to expand the policy leadership pool focused specifically on MH in schools.

We will also continue to amass policy-relevant information, develop frameworks for analysis, and facilitate the *Coalition for Cohesive Policy in Addressing Barriers to Development & Learning.****

The plan is to focus on each of the key concerns listed above. Taking one at a time, Cadre members will be asked to share information they already have or can readily access with respect to a given concern. Our Center will amass and analyze the various pieces of data and circulate the work as a stimulus to elicit additional information and analyses.

As a substantial analysis emerges and implications for policy action are clarified, specific recommendations will be formulated, as will strategies for pursuing them.

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*Are You Interested in
Expanding the Leadership Pool?*

Cadre members are now being recruited through self- and other-nominations. Our Center, in conjunction with other interested groups, will plan periodic capacity building sessions for the Leadership Cadre. However, much of the capacity building and regular communication will be accomplished through a computer Listserv.

If you are interested in seeing these matters pursued in a proactive way, we urge you to return the insert in the newsletter to nominate yourself, if appropriate, and anyone else who you think should become part of this leadership cadre. We also are interested in any reactions you wish to share regarding these matters.

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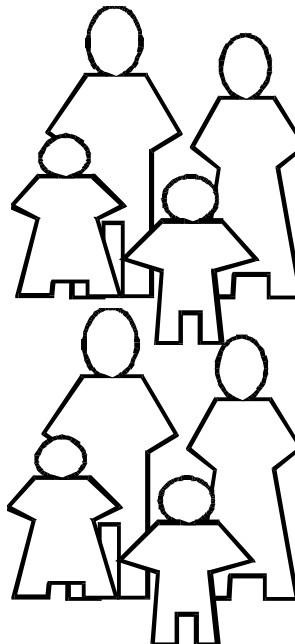
*The full report is available from our Center via mail or on our website.

**The Child, Adolescent, and Family Branch of the federal Center for Mental Health Services, SAMHSA, has funded the Georgetown University National Technical Assistance Center for Children's Mental Health to coordinate a series of these academies.

***The *Coalition for Cohesive Policy in Addressing Barriers to Development & Learning* was created to focus on the critical need to enhance policy cohesion (and fill policy gaps) related to addressing barriers to development and learning. The School Mental Health Project at UCLA is providing facilitation and support in the initial phases of the Coalition's development.

Should Schools Be Addressing Mental Health and Psychosocial Concerns?

The July 16th issue of the *CQ Researcher* (published by Congressional Quarterly Inc.) focuses on *Childhood Depression*. In that context, it addresses the pros and cons of pursuing mental health concerns at schools. They asked Center co-director, Howard Adelman, to prepare a statement expressing the pro-side of the issue. The following is what he wrote:

Every day too many youngsters encounter barriers that interfere with their healthy development. From an educational perspective, such barriers encompass any factor that interferes with academic performance -- including factors that make it difficult for teachers to teach effectively.

Among those living in poverty, major inequities of opportunity exist that interfere with school readi-ness, and this contributes to the large proportion of learning, behavior, and emotional problems found in urban and rural schools serving economically impoverished families.

How many youngsters are affected? Estimates vary, but the number is large and growing. With specific respect to mental health concerns, between 12 and 22 percent of all children are described as suffering from a diagnosable mental, emotional or behavioral disorder, with relatively few receiving mental health services anywhere. If one adds the many others experiencing significant psychosocial problems the numbers grow dramatically. The reality for many large urban and poor rural schools is that over half of their students manifest learning, behavior and emotional problems.

Clearly, young people are facing multiple barriers to their successful development and learning. It is critical to deal with these barriers in ways that enable more of them to achieve successfully in school. However, as is widely acknowledged, schools are not in the mental health business. Their primary mission is to educate. At the same time educators, policy-makers, families and communities have long recognized that schools must play an expanding role in addressing barriers to learning so that all students can learn and perform effectively. Thus, the question before policy-makers isn't whether schools should be involved in such matters. The real question is how to address the many barriers and promote healthy development most effectively.

Although mistakes have and will be made in finding better ways to do all this, such errors are not reasons for backing away from major efforts to ensure that schools address psychosocial and mental health concerns. If we back away from these responsibilities, we will surely jeopardize the futures of too many young people and ensure the failure of current policy initiatives for school reform and renewal. Schools can and must strive to do a better job in meeting their responsibilities to protect everyone's rights, and this especially includes ensuring that no young person is deprived of interventions that are essential to enabling them to benefit appropriately from the school's instructional program.

Please use the enclosed form to ask for what you need and to give us feedback.
Also, send us information, ideas, and materials for the Clearinghouse.

School Mental Health Project/
Center for Mental Health in Schools
Department of Psychology, UCLA
Los Angeles, CA 90095-1563
PX-94

Resources and Leadership

(1) We are starting to gather information to develop a *Sampler on Technology for Addressing Barriers to Learning.* If you have any information to share related to this topic, please indicate what and how we can gather it.

(2) If you have any resource requests, list them below.

(3) Are you interested in expanding the leadership pool for MH in School? If so, please list below and send the names of all individuals you recommend (including yourself, if appropriate).

Name   *Contact Info.*

(4) As always, we welcome your feedback on any facets of the Center's operations.

Your Name _____ Title _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone (____)_____ Fax (____)_____ E-Mail _____

Thanks for completing this form. Return it by FAX to (310) 206-8716 *or* in a separate envelope *or* by folding it in half to use the return address on the back as a mailing label.

------------------------------ (fold on the dashed line, and seal at bottom) ------------------------------

Return to: School Mental Health Project/
                                Center for Mental Health in Schools:
                                Training and Technical Assistance
                                UCLA/Department of Psychology
                                Los Angeles, CA 90095-1563