Addressing Barriers to Learning

New ways to think . . .
Better ways to link

UCLA Mental Health in Schools Center Training and Technical Assistance

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So persuasive is the power of the institutions we have created that they shape not only our preferences, but actually our sense of possibilities.
Ivan Illich

Comprehensive Approaches & Mental Health in Schools

To address the needs of troubling and troubled youth, schools tend to overrely on narrowly focused and time intensive interventions. Given sparse resources, this means serving a small proportion of the many students who require assistance and doing so in a limited way. The deficiencies of prevailing approaches lead to calls for comprehensiveness -- both to better address the needs of those served and to serve greater numbers.

Comprehensiveness: A Term with Wide Appeal

Comprehensiveness is becoming a buzzword. Health providers pursue comprehensive systems of care; states establish initiatives for comprehensive school-linked services; school-based clinics aspire to become comprehensive health centers; and there is talk of comprehensive school health programs. Widespread use of the term masks the fact that comprehension is a vision for the future -- not a reality of the day.

Comprehensiveness requires developmental and holistic perspectives that are translated into an extensive continuum of programs focused on individuals, families, and the environment. Such a continuum ranges from primary prevention and early-age intervention -- through approaches for treating problems soon after onset -- to treatment for severe and chronic problems. Included are programs designed to promote and maintain safety at home and at school, programs to promote and maintain physical and mental health, preschool and early school adjustment programs, programs to improve and augment ongoing social and academic supports, programs to intervene prior to referral, and programs providing intensive treatment. This scope of activity underscores why mechanisms for ongoing interprogram collaboration are essential.

Schools are the focus of several initiatives aspiring to comprehensiveness. Key examples are (1) moves toward school-based health centers and full service schools and (2) the model for comprehensive school health.

Comprehensive School-Based Health Centers and Full Service Schools

Many of the over 700 school-based or linked health clinics are described as comprehensive centers. This reflects the fact that a large number of students want not only the medical services, but help with personal adjustment and peer/family relationship problems, emotional distress, problems related to physical and sexual abuse, and concerns stemming from use of alcohol and other drugs. Indeed, data indicate that up to 50% of clinic visits are for nonmedical concerns. Given the limited number of staff at such clinics, it is not surprising that the demand for psychosocial and mental health interventions quickly outstrips available resources. School-based and linked health clinics can provide only a restricted range of interventions to a limited number of students. Thus, the desire of such clinics to be comprehensive centers in the full sense of the term remains thwarted.

Joy Dryfoos encompasses the trend to develop school--based health clinics, youth service programs, community schools, and other similar activity under the rubric *of full service schools.* To date, the reality of

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this desire for comprehensiveness remains mostly a vision. And, as long as the vision is anchored in the school-linked services model (i.e., initiatives to restructure community health and human services), it is likely that resources will remain too limited to allow for a comprehensive continuum of programs.

Comprehensive School Health

Up until the 1980s, school health programs were seen as encompassing health education, health services, and health environments. Over the last decade, an eight component model for a comprehensive focus on health in schools has been advocated. The components are (1) health education, (2) health services, (3) biophys-ical and psychosocial environments, (4) counseling, psychological, and social services, (5) integrated efforts of schools and communities to improve health, (6) food service, (7) physical education and physical activity, and (8) health programs for staff.

To develop each states' capacity to move toward comprehensive school health programming, the Centers for Disease Control and Prevention (CDC) set in motion an initiative designed to increase state-level interagency coordination. Relatedly, the Educational Development Center with funding from CDC is in the midst of a project to clarify how national organizations and state and local education and health agencies can advance school health programs.

The focus on comprehensive school health is admirable. It is not, of course, a comprehensive approach for addressing a full range of barriers interfering with learning -- nor does it profess to be. Unfortunately, it's restricted emphasis on health tends to engender resistance from school policy makers who do not understand how they can afford a comprehen-sive focus on health and still accomplish their primary mission to educate students. Reform-minded policy makers may be more open to proposals encompassing a broad range of programs to enhance healthy devel-opment if such programs are part of a comprehensive approach for addressing barriers to learning.

With respect to addressing barriers to learning, comprehensiveness requires more than *outreach to* link with *community* resources, more than *coordination* of *school-owned* services, and more than *coordination* of *school and community* services. Moving toward comprehensiveness encompasses restructuring and enhancing (1) school-owned programs and services and (2) community resources; in the process, it is essential to (3) weave school and community resources together. The result is not simply a reallocation or relocation of resources; it is a total *transformation* of the approach to intervention. .

Toward a Comprehensive, Integrated Approach

Policy makers and reformers have not come to grips with the realities of addressing barriers to learning and fostering healthy development. A few preliminary steps have been taken toward reform, such as more flexibility in the use of categorical funds and waivers from regulatory restrictions. There also is renewed interest in cross-disciplinary and interprofessional collaboration training programs.

As our Center's 1996 policy report stresses, however:

> *For school reform to produce desired student outcomes, school and community reformers must expand their vision beyond restructuring instructional and management functions and recognize that there is a third primary and essential set of functions involved in enabling teaching and learning.*

The essential third facet of school and community restructuring encompasses integration of enabling programs and services with instructional and management components. For a cohesive "enabling component" to emerge requires (a) weaving together school-owned resources and (b) enhancing programs by integrating school and community resources (including increasing access to community programs and services by linking as many as feasible to programs at the school). This comprehensive, integrated approach is meant to *transform* how communities and their schools address barriers to learning and enhance healthy development.

The concept of an enabling component provides a unifying focus around which to formulate new policy. Adoption of an inclusive unifying concept is seen as pivotal in convincing policy makers to move to a position that recognizes enabling activity as essential if schools are to attain their goals.

Operationalizing an enabling component requires formulating a carefully delimited framework of basic programmatic areas and creating an infrastructure for restructuring enabling activity. Based on analyses of extant school and community activity, enabling activity can be clustered into six basic programmatic areas that address barriers to learning and enhance healthy development (all of which includes a focus on mental health).

The six areas encompass interventions to

- enhance classroom-based efforts to enable learning
- provide prescribed student and family assistance
- respond to and prevent crises
- support transitions
- increase home involvement in schooling
- outreach for greater community involvement and support -- including recruitment of volunteers.

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Center News

Recently we received the following from Joel Dansky:

> I just finished visiting your website. It was helpful to me in looking for resources. I expect that I will request some of your information packets by mail. I am a clinical social worker & supervisor at a school based health clinic in Holyoke, Mass. We have medical and mental health services available at two middle schools and one high school and mental health services available at another middle school and at an alternative program for students who have had major behavioral problems. I have mostly worked in the middle schools. When we started the middle school project six years ago, under the auspices of the local community mental health center which employs us, we struggled for referrals and to establish ourselves within the school community. Now the counseling side of the program is overwhelmed with referrals coming from school staff, from parents, and from some community agencies. We are also burdened by the paperwork involved in third party billing for our services. At this point we are looking to redesign the program to account for these factors and to avoid drowning. Until now, although we have operated inside the school and have worked closely with school staff, we have not been "integrated" in any systematic way to the system. Our CMHC sponsorship and not being school employees has, till now, helped establish us as somewhat independent of the school and in some ways more trustworthy to students and to parents. We get no financial support from the school system. Managed care is, as I am sure you know, ever more difficult to square with the exigencies of school based counseling. However, we are now feeling like we need to initiate discussions with the schools to reformulate the ways we can be more effective. I would be very interested in corresponding with others who are struggling with these issues. I can be reached via e-mail: jdansky@sophia.smith.edu or by mail Joel Dansky, Teen Clinic, Peck Middle School, 1916 Northampton St. Holyoke Mass. 01040.

We hope that many of you will take time to respond to Joel. What follows is our response:

> Joel: As you know, the matters you raise are being experienced across the country -- not only by those working in school-based/linked health centers, but by the many professionals schools employ to address psychosocial and mental health concerns Here's how our Center and others may be of assistance.

1) ***Improving Access to Resources***

> We are using our Clearinghouse as a context for organizing information on policy, system development, programs, and specific problems relevant to the topic of mental health in schools. To facilitate access, we are developing special resources and packaging them (e.g., Introductory Packets, Resource Aid Packets, Technical Aid Packets, Guidebooks, Continuing Education Units). A list of these resources is available on request. We also list them on our website and highlight them in this quarterly newsletter (see p. 12) and in our monthly electronic news (called *ENEWS*).

2) ***Clarifying New Frameworks for Practice***

> As you indicate and as is stressed in the lead article to our current newsletter and in our 1996 policy report, the field must begin to pursue new approaches. The concerns you raise require weaving a clinic's focus on health into a school/community wide comprehensive, integrated approach for addressing barriers to learning (which includes enhancing healthy development).

3) ***Developing Support Networks and Clarifying Policy Needs***

> Our summer conferences bring together key leaders to encourage enhancement and development of local support infrastructures and to stimulate efforts to enhance current policy and practice. This summer we hope to bring together federal and state leaders to look at existing policy through the lens of how schools/ communities address barriers to learning. We think this will help further clarify to the need for major policy rethinking at all levels.

4) ***Providing Other Training & Technical Assistance***

> **Ask and we will discuss ways to help.** As a major technical assistance tool, we continue to recruit professionals in all parts of the country who are willing to share their expertise without fees. This growing cadre provides you access to a large network of colleagues who you can contact about the types of concerns you raise. In addition, you can ask for assistance from our Center staff by contacting us (see the box below). If we can't be of direct assistance, we will help you connect with someone who can.

Center For Mental Health In Schools at UCLA

For those of you who have not yet visited our website, please take a look: **http://www.lifesci.ucla.edu/psych/mh/**

Also, if you aren't receiving *ENEWS,* add yourself to the list: send an email request to: **maiser@bulletin.psych.ucla.edu** leave subject line blank, and in the body of the message type: **subscribe mentalhealth**

To contribute to ENEWS or the website, you can send us an Email at: **smhp@ucla.edu**

or send us a FAX (310) 206-8716
or phone (310) 825-3634
or write to us c/o the return address on this newsletter.

And please tell others about us.

Emerging Issue

Challenge to the concept of SYSTEMS OF CARE

The term *system of care* has become popular in discussing comprehensive and collaborative approaches for serving youth with serious emotional problems. It also has relevance to any effort to provide cohesive assistance to clients. In a journal article entitled "Delivering effective children's services in the community: Reconsidering the benefits of system interventions" in *Applied & Preventive Psychology* (v. 6, 1997), Mark Salzer and Leonard Bickman examine research on systems of care. They conclude that while systems of care produce important system-level changes, early results suggest these systems changes do not impact clinical outcomes. They argue that the primary direction to improving children's mental health services should be through effectiveness research, in contrast to continued large-scale investments in systems research and development.

We noted their argument in the last edition of our Center's *ENEWS*. Given the status of these authors and the nature of the data they muster to support their position, their views are likely to receive considerable attention from policy makers. We think it essential that this issue be discussed widely and all positions aired. Let us know your thoughts, and we will try to synthesize and report back the responses. (If you want to communicate directly with the authors, contact Mark Salzer at the Center for Mental Health Policy, Vanderbilt Institute for Public Policy Studies, 1207 18th Avenue South, Nashville, TN 37212.)

Among the responses we have already received are the following:

From **Albert J. Duchnowski,** Ph.D., Deputy Director and Professor of Special Education, Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, Fl 33612

It is important to discuss the results of the Fort Bragg study and their implications for the system of care model. Interested readers are referred to a special issue of *The Journal of Mental Health Administration,* Winter 1996, Volume 28/Number 1. This issue has 16 articles describing the study, one of which challenges the interpretation of the results offered by Leonard Bickman and his colleagues. This article "The Evaluation of the Fort Bragg Demonstration Project: An Alternative Interpretation of the Findings" was authored by Robert Friedman, Director of the Center for Children's Mental Health at the University of South Florida and Barbara Burns of Duke University. Both are prominent researchers in the field of mental health services. In their article, Friedman and Burns point out problems with the program theory as well as with specific procedures in the study that may lead to a different interpretation of results that are more favorable to the system of care. For example, there were significant differences in favor of the model when results from children who were severely emotionally disturbed were analyzed, there was a low level of parent involvement which is a basic principle of the system of care model, and the manner in which participants paid for services differed at the Demonstration site and the comparison site making a comparison of costs difficult. While the Fort Bragg study is important, it is not a conclusive study and the results are probably best described as mixed. More interpretation of these results are being published by other researchers.

From **Mike Furlong,** UCSB, School Psychology, Santa Barbara, CA 93106-9490.

Regarding Bickman. One needs to examine his methods very carefully. They are not without some serious questions (for example using T-scores from the CBCL instead of raw scores). While we need to take the outcome of the Fort Bragg study into account, there are some very fundamental issues regarding systems of care that need to be resolved before one jumps to the conclusion that Bickman has. In the Santa Barbara County System of Care, we are trying to play a small part by examining the outcome for our data in a couple of ways:

1. We have conducted cluster analyses of our early cases and found four distinguishable clusters of youths who have entered our system: Troubled, Troubling, Troubled and Troubling, and At-risk. This paper has just been accepted for publication in the *Journal of Emotional and Behavioral Disorders*. Next, at the U of South Florida conference, we will report on preliminary outcomes (6 months) for these clusters of youths. Our logic is that Bickman grouped all youths together in examining outcomes. We have found some evidence of different outcomes by cluster. In addition, one obviously needs to conduct analyses that examine if (a) services were provided that address the specific needs of each youth and (b) if the outcomes show improvement in the targeted areas.

2. In addition, before one concludes that systems of care do not work, one needs to show that the treatment provided for each client had fidelity with the tenets of the system of care change theory. Bickman has not done this. We are conducting studies now to help understand these issues. His work is analogous to the early work that declared psychotherapy or personal counseling ineffective. All types of theory were co-mingled with all types of client presenting problems and needs. What Bickman has done is only a first step in evaluating the conditions under which systems of care are and are not effective.

****

Some wag has defined collaboration

as an unnatural act

between nonconsenting adults.

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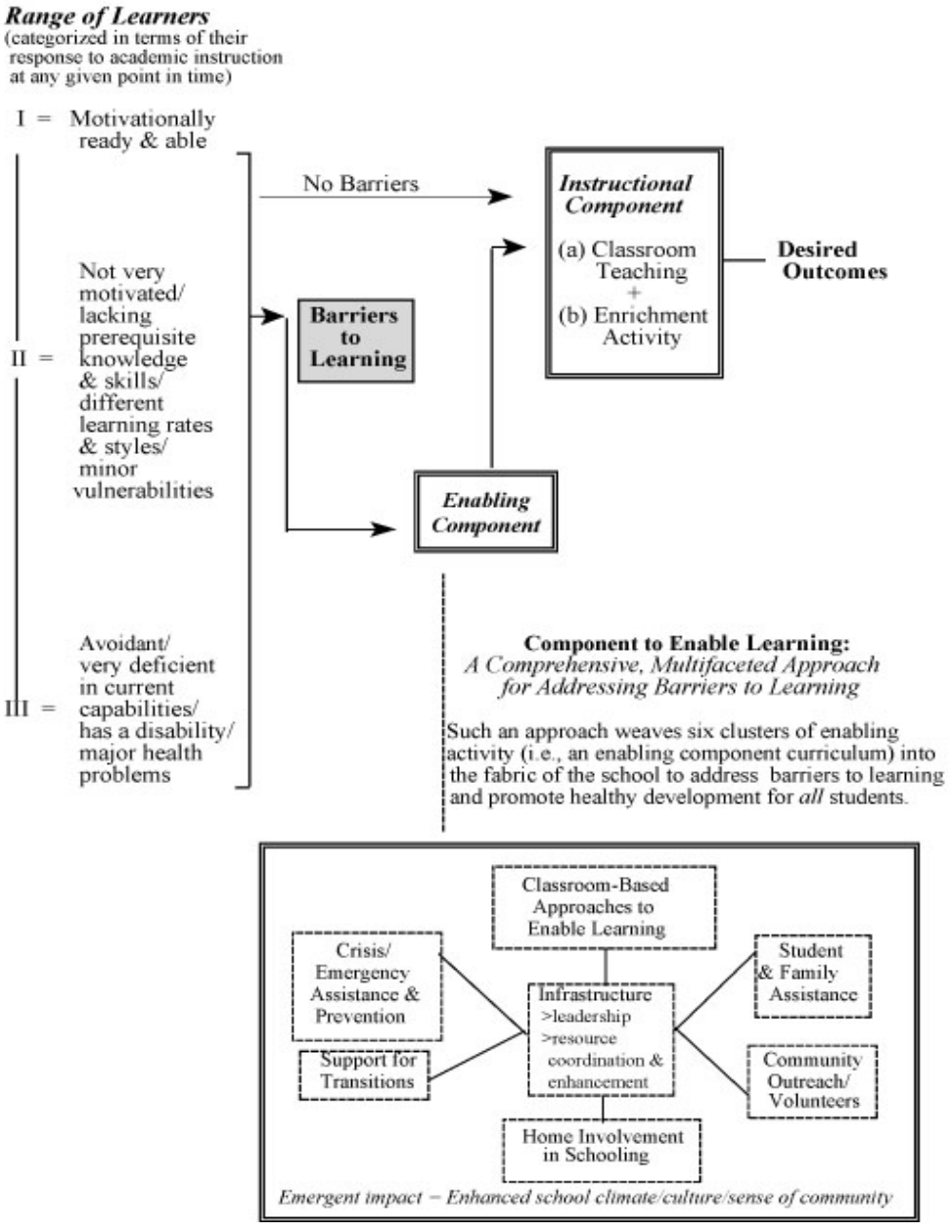
The following diagram highlights the rationale for and nature of an enabling component.

Needed: a comprehensive integrated programmatic approach

An enabling component to address barriers to learning and enhance healthy development at a school site.



To clarify each area a bit.

(1) Classroom focused enabling. In this area, the idea is to enhance classroom-based efforts to enable learning and productive classroom functioning by increasing teacher effectiveness for preventing and handling problems. This is done by providing personalized professional develop-ment and enhanced resources to expand a teacher's array of strategies for working with a wider range of individual differences. For example, teachers learn to use peer tutoring and volunteers (as well as home involvement) toenhance social and academic support; they learn to increase their accommodative strategies and their ability to teach students compensatory strategies; and as appropriate, they are provided support in the classroom by resource teachers and counselors. Only when necessary is temporary out of class help provided. In addition, programs are directed at developing the capabilities of aides, volunteers, and any others helping in classrooms or working with teachers to enable learning. To further prevent learning, behavior, emotional, and health problems, there is also an effort to enhance facets of classroom curricula designed to foster socio-emotional and physical development.

(2) Student and family assistance. Some problems cannot be handled without a few special interventions; thus the need for student and family assistance. The emphasis is on providing ancillary services in a personalized way to assist with a broad-range of needs. To begin with, available social, physical and mental health programs in the school and community are used. As community outreach brings in other resources, they are linked to existing activity in an integrated manner. Particular attention is paid to enhancing systems for prereferral intervention, triage, case and resource management, direct services to meet immediate needs, and referral for special services and special education resources and placements as appropriate. Ongoing efforts are made to expand and enhance resources.

3) Crisis assistance and prevention. The intent is to respond to, minimize the impact of, and prevent crises. This requires systems and programs for emergency/crisis response at a site, throughout a school complex, and community-wide (including a program to ensure follow-up care); it also encompasses prevention programs for school and community to address school safety and violence reduction, suicide, child abuse, and so forth. Crisis assistance includes ensuring immediate emergency and follow-up care is provided so students are able to resume learning without undue delay. Prevention activity creates a safe and productive environment and develops the type of attitudes and capacities that
students and their families need to deal with violence and other threats to safety.

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(4) *Support for transitions.* This area involves a programmatic focus on the many transition concerns confronting students and their families. Such efforts aim at reducing alienation and increasing positive attitudes and involvement related to school and various learning activities. Examples of interventions include (a) programs to establish a welcoming and socially supportive school community, especially for new arrivals, (b) counseling and articulation programs to support grade-to-grade and school-to-school transitions, moving to and from special education, going to college, moving to post school living and work, and (c) programs for before and after-school and intersession to enrich learning and provide recreation in a safe environment.

(5) Home involvement in schooling. Efforts to enhance home involvement must range from programs to address specific learning and support needs of adults in the home to approaches that empower sanctioned parent representatives to become full partners in governance. Examples include (a) programs to address adult learning and support needs, such as ESL classes and mutual support groups, (b) helping those in the home meet their basic obligations to the student, such as programs on parenting and helping with schoolwork, (c) systems to improve communication about matters essential to student and family, (d) programs to enhance the home-school connection and sense of community, (e) interventions to enhance participation in decisions essential to the student, (f) programs to enhance home support for student's basic learning and development, (g) interventions to mobilize those at home to problem solve related to student needs, and (h) intervention to elicit help (support, collaborations, and partnerships) from those at home in order to meet classroom, school, and community needs. The context for some of this activity may be a *parent center* (which may be part of a *Family Service Center* facility if one has been established at the site).

(6) Community outreach for involvement and support (including a focus on volunteers). Outreach to the community is used to build linkages and collaborations, develop greater involvement in schooling, and enhance support for efforts to enable learning. Outreach is made to public and private community agencies, universities, colleges, organizations, and facilities; businesses and professional organizations and groups; and volunteer service programs, organizations, and clubs. Examples of activity include (a) programs to recruit community involvement and support (e.g., linkages and integration with community health and social services; volunteers, mentors, and individuals with expertise and resources; local businesses to adopt-a-school and provide resources, awards, incentives, and jobs; formal partnership arrangements), (b) systems and programs designed to train, screen, and maintain volunteer parents, college students, senior citizens, peer and cross-age tutors and counselors, and professionals-in-training who then provide direct help for staff and students -- especially targeted students, (c) programs outreaching to hard to involve students and families (those who don't come to school regularly -- including truants and dropouts), and (d) programs to enhance community-school connections and sense of community (e.g., orientations, open houses, performances and cultural and sports events, festivals and celebrations, workshops and fairs).

Ultimately, a comprehensive set of programs to address barriers and enhance healthy development must be woven into the fabric of every school. In addition, feeder schools need to link together to maximize use of limited school and community resources. By working to develop a comprehensive, integrated approach, every school can be seen, once more, as a key element of its community. When schools are seen as a valued and integrated part of every community, talk of school and community as separate entities can cease; talk of education as if it were the sole function of schools should end; and the major role schools can play in enhancing healthy development may be appreciated.

Encompassing the Concept of Comprehensive School Health into a Comprehensive Approach to Address Barriers to Student Learning

It has been our experience that schools respond better when proposals emphasize *a comprehensive approach to addressing barriers to learning,* rather than recommending a focus on specifically on physical and mental health. Given the thrust to enhance *Comprehensive School Health* in general and the eight "component" Comprehensive School Health model in particular, it is important to understand that the concept of the Enabling Component readily encompasses the eight components of comprehensive school health. That is, these eight components fit readily into the six areas of the Enabling Component with some of the eight components best understood as fitting more than one cluster of Enabling Component programming (see the Exhibit on the next page.)

Some Relevant References

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Kolbe, L. (1993). An essential strategy to improve the health and education of Americans. *Preventive Medicine, 22,* 544-560.

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Linking Models to Present a Unifying Approach for Policy Making

CDC "components"	Enabling Component Areas
(1) Health Education	The curricular facets of this CDC component fit into CLASSROOM-FOCUSED ENABLING.
(2) Health Services	Fits into STUDENT AND FAMILY ASSISTANCE.
(3) Biophysical/psychosocial Environments	Enhancing the environment emerges from the total programmatic effort (in all 6 areas) to address barriers to learning -- as integrated with the Instructional and Management Components at a school site. The resultant comprehensive and cohesive approach produces the type of structure that is essential for evolving and creating a healthy psychosocial and biophysical environment.
(4) Counseling, Psychological, & Social Services	Fits into STUDENT AND FAMILY ASSISTANCE.
(5) Food Services	We want to reconceptualize school breakfast and lunch services as another opportunity to offer essential programs providing SUPPORT FOR TRANSITIONS. In this respect, schools could pair breakfast time with structured before school recreation opportunities as ways to counter tardiness and enhance student readiness for the school day. The same goes for lunch and after school. Also fits in with programs related to HOME INVOLVEMENT IN SCHOOLING.
(6) P.E. and physical activity	Fits in SUPPORT FOR TRANSITIONS and also can play a role related to CLASSROOM-FOCUSED ENABLING and HOME INVOLVEMENT IN SCHOOLING.
(7) Health Programs for Faculty & Staff	In terms of providing direct health support to faculty and staff, schools will need to expand STUDENT AND FAMILY ASSISTANCE. Some of the best health benefits for faculty and staff would be related to enhancing the effectiveness of schools in Addressing Barriers to Student Learning by establishing the type of comprehensive, integrated approach called for by the Enabling Component concept. This will reduce degrees of stress and burnout.
(8) Integrated School/Community	COMMUNITY OUTREACH

Linking to Our Sister Center

The CENTER FOR SCHOOL MENTAL HEALTH ASSISTANCE (CSMHA)
at the University of Maryland at Baltimore is our sister center.

Like our center,
they offer a range of technical assistance and training resources.

They will hold their Second National Conference
in New Orleans, LA on Sept. 12 and 13, 1997.
Contact the center (toll-free) at (888) 706-0980.

Lessons Learned

Accounting for Cultural, Racial, and Other Significant Individual and Group Differences

All interventions to address barriers to learning and promote healthy development must consider significant individual and group differences. In this respect, discussions of diversity and cultural competence offer some useful concerns to consider and explore. For example, the Family and Youth Services Bureau of the U.S. Department of Health and Human Services, in a 1994 document entitled *A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs,* outlines some baseline assumptions which can be broadened to read as follows:

> Those who work with youngsters and their families can better meet the needs of their target population by enhancing their competence with respect to the group and its intragroup differences.
>
> Developing such competence is a dynamic, on-going process -- not a goal or outcome. That is, there is no single activity or event that will enhance such competence. In fact, use of a single activity reinforces a false sense of that the "problem is solved."
>
> Diversity training is widely viewed as important, but is not effective in isolation. Programs should avoid the "quick fix" theory of providing training without follow-up or more concrete management and programmatic changes.
>
> Hiring staff from the same background as the target population does not necessarily ensure the provision of appropriate services, especially if those staff are not in decision-making positions, *or* are not themselves appreciative of, or respectful to, group and intragroup differences.
>
> Establishing a process for enhancing a program's competence with respect to group and intragroup differences is an opportunity for positive organizational and individual growth.

The Bureau document goes on to state that programs:

> are moving from the individually-focused "medical model" to a clearer understanding of the many external causes of our social problems ... why young people growing up in intergenerational poverty amidst decaying buildings and failing inner-city infrastructures are likely to respond in rage or despair. It is no longer surprising that lesbian and gay youth growing up in communities that do not acknowledge their existence might surrender to suicide in greater numbers than their peers. We are beginning to accept that social problems are indeed more often the problems of society than the individual.
>
> These changes, however, have not occurred without some resistance and backlash, nor are they universal. Racism, bigotry, sexism, religious discrimination, homophobia, and lack of sensitivity to the needs of special populations continue to affect the lives of each new generation. Powerful leaders and organizations throughout the country continue to promote the exclusion of people who are "different," resulting in the disabling by-products of hatred, fear, and unrealized potential.
>
> ... We will not move toward diversity until we promote inclusion ... Programs will not accomplish any of (their) central missions unless ... (their approach reflects) knowledge, sensitivity, and a willingness to learn.

In their discussion of "The Cultural Competence Model," Mason, Benjamin, and Lewis* (1996) outline five cultural competence values which they stress are more concerned with behavior than awareness and sensitivity and should be reflected in staff attitude and practice and the organization's policy and structure. In essence, these five values are

> (1) *Valuing Diversity* -- which they suggest is a matter of framing cultural diversity as a strength in clients, line staff, administrative personnel, board membership, and volunteers.
>
> *(2) Conducting Cultural Self-Assessment* -- to be aware of cultural blind spots and ways in which one's values and assumptions may differ from those held by clients.
>
> (3) *Understanding the Dynamics of Difference* -- which they see as the ability to understand what happens when people of different cultural backgrounds interact.
>
> (4) *Incorporating Cultural Knowledge* -- seen as an ongoing process.
>
> (5) *Adapting to Diversity* -- described as modifying direct interventions and the way the organization is run so that they reflect the contextual realities of a given catchment area and the sociopolitical forces that may have shaped those who live in the area.

*In *Families and the Mental Health System for Children and Adolescents,* edited by C.A. Heflinger & C.T. Nixon. CA: Sage Publications.

Also see p. 12 for information about our Introductory Packet entitled *Cultural Concerns in Addressing Barriers to Learning.*

It is said that organizational change comes from gentle pressure relentlessly applied.

Ideas into Practice

Suicidal Crisis

In developing our Center's Resource Aid Packet on *Responding to Crisis at a School,* we were impressed by the good work being done by so many people around the country. The unfortunate fact that so many students feel despair and consider suicide has resulted in important common practices at school sites.

Changing systems in schools to support students and reduce unnecessary stress is the first line of defense. However, when concerns arise about a specific student, school staff must be ready to respond. The suicide assessment and follow-through checklists on pages 10 and 11 are a compilation of best practices and offer tools to guide intervention.

When a Student Talks of Suicide . . .

You must assess the situation and reduce the crisis state (see accompanying Suicidal Assessment Checklist). The following are some specific suggestions.

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 or her to 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 happens, 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; 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 suicidal 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.

Read Some More

Adolescent Suicide: Assessment and Intervention by A.L. Berman & D.A. Jobes (1991). Washington, D.C.: American Psychological Association.

Youth Suicide: A Comprehensive Manual for Prevention and intervention by B.B. Hicks (1990). Bloomington, IN: National Educational Service.

Let us hear how you're handling such situations.

Center *Staff*:
Howard Adelman, Co-director
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. . . and a host of graduate and undergraduate students

SUICIDAL ASSESSMENT -- CHECKLIST*

Student's Name:_____ Date:_____ Interviewer: _____

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts? *Y N*

Have there been suicide attempts by the student or significant others in his or her life? *Y N*

Does the student have a detailed, feasible plan? *Y N*

Has s/he made special arrangements as giving away prized possessions? *Y N*

Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife? *Y N*

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? *Y N*

Have there been major changes in recent behavior along with negative feelings and thoughts? *Y N*

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive? *Y N*

Does the student feel alienated? *Y N*

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control? *Y N*

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.

FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK -- CHECKLIST

____(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.

___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.

___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.

___(4) Try to contact parents by phone to

a) inform about concern
b) gather additional information to assess risk
c) provide information about problem and available resources
d) offer help in connecting with appropriate resources

Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

____(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:

*student's name/address/birthdate/social security number
*data indicating student is a danger to self (see Suicide Assessment -- Checklist)
*stage of parent notification
*language spoken by parent/student
*health coverage plan if there is one
*where student is to be found

____(6) Follow-up with student and parents to determine what steps have been taken to minimize risk.

____(7) Document all steps taken and outcomes. Plan for aftermath intervention and support.

____(8) Report child endangerment if necessary.

More Introductory Packets and Resource Aids from the Center's Clearinghouse

Our Introductory Packets highlight key topics related to specific psychosocial problems, program and processes, and system concerns. Each has overview discussions, descriptions of model programs (where appropriate), reference to publications, information on other relevant centers, agencies, organizations, advocacy groups, Internet links, and lists of consultation cadre members ready to share expertise. The latest Introductory Packets are:

Assessing to Address Barriers to Learning -- discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on the types of procedures and instruments to measure psychosocial, as well as environmental barriers to learning.

Cultural Concerns in Addressing Barriers to Learning -- highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. This packet also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.

As aids in finding resources and contacting major organizations that have relevance to addressing barriers to learning and promoting mental health in the schools, the Center has also developed initial drafts of:

Where to Get Resource Materials to address barriers to learning -- includes a sampling of major clearinghouses, centers, organizations, and publishers that offer such resource materials and provides information on what they offer in terms of publications, brochures, fact sheets, audiovisual & multimedia tools.

Organizations with Resources Relevant to Addressing Barriers to Student Learning: A Catalogue of Clearinghouse, Technical Assistance Centers, and Other Agencies -- this catalogue groups organizations around five major categories: I. Children's Mental Health, II. Education and Schools, III. School-Based and School-Linked Centers, IV. Concerned with Youth, Family, and Community , and V. Health Related Concerns. An appendix provides concise descriptions of each organization, its mission, and types of assistance it provides and offers updated information on how to access the agency.

A free listing of our growing set of Introductory, Resource, and Technical Aid Packets and other special resources developed by the Center is available on request.
(To defer costs of copying, handling, and mailing, we currently must charge $3.50 for each.)
Eventually, we plan to put Center materials on line so those with Internet access will have free access.

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.

PLEASE FILL OUT THE INSERTED FORM AND SEND IT TO US.

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