ADVANCES IN SCHOOL-BASED MENTAL HEALTH INTERVENTIONS

BEST PRACTICES AND PROGRAM MODELS

Edited by
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Preface

The U.S. educational system has historically provided a range of benefits outside the definition of academic instruction. Schools have typically employed multidisciplinary personnel, such as nurses to provide on-site health care and psychologists to complete assessments. Some children receive the majority of their meals at school. The National School Lunch program was implemented in 1946, breakfast has been served since 1966, and after-school snacks were added in 1998. So the concept of a "full-service school" was in effect long before it was given a name.

It has been almost ten years (Dryfoos, 1994) since Joy Dryfoos introduced the term "full-service schools" to describe a more effective means of service delivery to our nation's youth and their families. And today, as every generation before, youth confront a landscape of unique challenges, the gravity of which is evident in our recent history. When we entered the 1990s we were engaged in the Gulf War conflict. Internal discord resulted in turmoil within our own national borders, reflected in civil rights riots in California, an internal bombing in Oklahoma, and unprecedented school violence around the nation. International conflict spilled into our country. As we turned the corner to a new millennium, we suffered the loss of over 3,000 lives in the attack on the World Trade Center and the Pentagon. Today's youth are facing challenges we could not have imagined when we were attending their schools—including a steadily increasing incidence of drug use, violence, and emotional disorders—underscoring the need to provide mental health services to our young people, who often are most effectively reached through school-based programs.

NEGATIVE PSYCHOSOCIAL FACTORS IN SCHOOL CHILDREN'S ENVIRONMENTS

Drug Use

Wide declines in drug use among youth were evident during the 1980s, but the national trend was reversed in the 1990's. The percentage of high school seniors who reported using illicit drugs "during the past year" increased from 22 percent in 1992, to 35 percent in 1995 (Johnston, O'Malley, & Bachman, 1996; 2002). The trend worsened with younger children. The number of eighth graders who reported using marijuana during their lifetime jumped from 10.2 percent in 1991 to 19.9 percent in 1995—a 92 percent increase. Alcohol and tobacco use followed similar trends among youth (Johnston, O'Malley, & Bachman, 2002). By the time they are high school seniors, more than 80 percent of youth have used alcohol and approximately 64 percent have been drunk. By 2001, there were more current daily users of cigarettes than of any other drug class: 5.5 percent, 12 percent, and 19 percent in grades eight, ten, and twelve, respectively.

Potent new club drugs have proliferated among youth, including MDMA ("ecstasy"), Rohypnol® (flunitrazepam), GHB, and Ketamine ("special K"). The long-term effects of these drugs will only be evident after several more years of observation. And in the midst of this new drug traffic, the nation's favorite prevention program

failed. A ten-year evaluation study of the DARE (Drug Abuse Resistance Education) program found no empirical evidence for its ability to curb youth drug use or attitudes about drugs (Lynam et al., 1999).

Domestic Violence

Approximately 1.5 million women and 834,700 men are physically assaulted by an intimate partner each year (Tjaden & Thoennes, 2000). Every year, 3 to 10 million children witness domestic violence (Carter, Weithorn, & Behrman, 1999). Witnessing violence is a risk factor for long-term physical and mental health problems, including alcohol and substance abuse, being a victim of abuse, and perpetrating violence (Felitti et al., 1998). Child abuse occurs in 30 to 60 percent of family violence cases that involve families with children (Carter, Weithorn, & Behrman, 1999).

Children are increasingly the victims of violence in our society. The United States has the highest rates of childhood homicide, suicide, and firearm-related death among industrialized countries (Centers for Disease Control & Prevention, 1997). In 1994, homicide was the third leading cause of death, and suicide was the sixth, among children aged five to fourteen years (Singh, Kochanek, & MacDorman, 1996). During adolescence, the risk of suffering domestic violence increases. Data from a study of eighth and ninth grade male and female students indicated that 25 percent had been victims of nonsexual dating violence and 8 percent had been victims of sexual dating violence (Foshee et al., 1996). Summarizing many studies, the average prevalence rate for nonsexual dating violence is 22 percent among male and female high school students and 32 percent among college students. (Sugarman & Hotaling, 1989).

Youthful Perpetrators

Youth have historically been both the victims and perpetrators of a rising degree of violence. Today more youth are committing violent acts, compared to their predecessors of fifteen years ago (Office of Juvenile Justice and Delinquency Prevention, 1997). Youth violence has also become more lethal, illustrated by the doubling of the juvenile arrest rate for murder between 1985 and 1995. Youth perpetrated violence includes a wide range of externalized and internalized aggression, with increasing numbers of victims.

Externalized aggression ranges from verbal harassment and bullying to physical assault and multiple homicide. Youth who are violent at school are often disenfranchised and face repeated ostracism and overt bullying by others (Anderson et al., 2001). The key to diverting lethal school violence may lie in prevention of lower-level aggression, such as bullying. School-wide programs addressing bullying have shown promise (National Resource Center for Safe Schools, 2001; Garrity et al., 1994; Thornton et al, 2002). Many states have adopted legislation requiring school districts to implement antibullying policies and procedures in the hopes of reversing the trend in school violence (Zehr, 2001).

Between 1994 and 1999, 220 events resulting in 253 deaths were studied; 202 events involved one death and eighteen involved multiple deaths (Anderson et al., 2001). Of the 220 events, 172 were homicides, thirty were suicides, and eleven were homicide-suicides. Although the incidence of such lethal school violence is rare—

estimated to be 0.068 per 100,000 students—this type of violence is unprecedented in previous generations. For 120 (54.5 percent) of the incidents, respondents reported that a note, threat, or other action potentially indicating risk for violence occurred prior to the event. Homicide offenders were more likely than homicide victims to have been bullied by their peers and had expressed some form of suicidal behavior prior to the event.

Suicide

Internalized violence is evident in the suicide rates of youth. Suicide is the third leading cause of death for both children ten to fourteen years old, and young adults fifteen to twenty-four years old (U.S. Department of Health and Human Services, 2001). Between 1952 and 1995, the incidence of suicide among adolescents and young adults nearly tripled. Recognition of this dangerous trend resulted in increased research and prevention programs. In 1999, the *Surgeon General's Call to Action to Prevent Suicide* (U.S. Public Health Service, 1999) outlined a national agenda for suicide prevention. Key people, such as parents, teachers, and school health staff, must be aware of the risk factors and warning signs for suicidal ideation among the youth they serve.

ADDRESSING EMOTIONAL AND BEHAVIORAL DISORDERS IN YOUTH

Approximately 9 to 13 percent of youth in the United States present with serious emotional or behavioral disorders (Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1996). However, only about 20 percent of youth in need receive mental health services (Burns et al., 1995). Youth today are challenged with a vast number of internal risk factors (e.g., cognitive and social skill deficits) and external risk factors (e.g., poverty, abuse, maladaptive modeling) that may interfere with healthy development, learning, and functioning. Schools are the center of youth life and serve to connect families to community resources. Mental health services can help youth face these challenges with resiliency and skill. Interest in school-based mental health (SBMH) has steadily increased in the past two decades. Professional organizations, such as the National Education Association, the American Psychological Association, and the National Association of Social Workers, have adopted guidelines supporting SBMH.

Today, there are several hundred programs, and many more adjunctive services, that identify as "school-based mental health." This book is not meant to be an exhaustive account; rather, it showcases best practices in the field and illustrates a sample of programs in operation. For our purposes, school-based mental health is broadly defined as mental health resources delivered within or linked to school settings. The chapter uthors represent a wide range of talent from across the nation and have published and practiced in the field. The program chapters were selected on the basis of how well each described the following: (1) program development and implementation—i.e., history and key events in the development of the model, funding strategies, administrative foundation, such as referral development and staffing, and interagency collaboration; (2) clinical foundation—theoretical foundation for the model and evi-

dence-based interventions utilized; and (3) outcomes—i.e., clinical outcomes, based on the utilization of repeated measures and research-supported instruments, consumer perspectives, and cost analysis. Our purpose is to inform stakeholders, including funding sources, families, and professionals, of the research basis and recent developments of SBMH across the nation.

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