

Addressing Barriers

to Learning

New ways to think . . .

Better ways to link

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*Of all the forms of injustice
discrimination in health care is the most cruel.*
Martin Luther King Jr.

Diversity and Professional Competence in Schools . . . *a mental health perspective*

Those who work in schools are a diverse group. So are the students and families who attend. Examples of diversity concerns identified in research include: age, gender, race, ethnicity, national origin, migration and refugee status and experiences, religion, spirituality, sexual orientation, disability, language, socioeconomic status, education, group identity, communication modality, developmental stages, level of acculturation/assimilation, stages of ethnic development, workplace culture, family and lifestyle, and popular culture.

Clearly, the topic of human diversity is fundamental to the processes, content, and outcomes of schooling. And, of course, diversity competence is central to any discussion of mental health in schools. Our concern in this article is with the competence of school personnel to account for human diversity in daily practice in ways that help to address barriers to learning and promote healthy development.

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Some Basics

"Human behavior is an interaction developed in the context of biological, psychological, sociopolitical, and socioeconomic realities. These realities are known as cultures which come together to create a pluralistic society. ...

Professionals are expected to be sensitive to individual differences as they practice their professions. Beyond that, it is imperative [to] acquire a knowledge base and an understanding of how attitudes, values, and behavior may be affected by cultural differences. This knowledge should be gained during ... formal educational preparation and should be enhanced as they continue in ... practice"

(Office of Professions, NY State Education Dept.

<http://www.op.nysed.gov/psychpluralguide.htm>).

All interventions to address barriers to learning and promote healthy development must consider significant individual and group differences. In this respect, discussions of diversity 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 baseline assumptions which can be broadened to read as follows:

- C 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.
- C 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 that the "problem is solved."

(cont. on p. 2)

- C 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.
- C 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.
- C 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 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 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.

An Introductory Outline for Continuing Education

In 2003, the California Board of Psychology decided to take another step in enhancing its focus on diversity competence. They established a volunteer work group of psychologists with relevant expertise. The Center for Mental Health in Schools at UCLA

In their discussion of "The Cultural Competence Model," Mason, Benjamin, and Lewis (1996)* outline five 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

provided support for the process and, in doing so, drew on the expertise of its various networks.

One of the work group's tasks was to clarify a framework outlining the content for a foundational module on human diversity that could guide development of continuing education courses. The aim was "to provide an overview of arenas for developing competence," with the final outline kept at a fairly abstract level. To this end, the group was instructed to think in terms of a course outline that provides a "big picture" introduction. The assumption was that in-depth learning related to any of the main points could be the focus of subsequent continuing education.

An adaptation of the resulting outline is presented on the following pages.

Outline

Diversity Competence Relevant to Mental Health in Schools: Eliminating Disparities in School Practices

Intro note: The following outline is meant to provide an overview of general arenas relevant to mental health practitioner competence in understanding and addressing human diversity among school populations. One way to think about the outline is in terms of a broad-focused, introductory course designed to provide a “big picture” perspective related to *human diversity* and daily practice for individuals whose previous courses may not have provided a *broad, foundational* introduction. The emphasis is on enhancing general awareness and knowledge and introducing foundational skills through a continuing education experience. Some items will not be relevant for those who are not involved in psychodiagnostic and psychotherapeutic interventions.

In-depth learning related to any of the main points is seen as a focus for *subsequent* continuing education. For example, practitioners working with a specific ethnic or socioeconomic group might pursue continuing education focused specifically on enhancing knowledge, skills, and attitudes/values related to that group.

I. Toward an Informed, Functional Understanding of the Impact of Diversity on Human Behavior and a Respect for Differences – in the Context of Professional Practice

- A. Diversity and Professional Competence: Definitional Considerations, Historical Perspectives, and Contemporary Impact (benefits and costs to individuals, groups, society)
- B. Enhanced Awareness of the Multiple Forms of Human Diversity* (including within group diversity) and How Such Factors Affect Consumer and Practitioner Attitudes, Values, Expectations, Belief Systems, World Views, Actions, and Mental Health
 - *Key examples of relevant forms of diversity identified in research include: age, gender, race, ethnicity, national origin, migration and refugee status and experiences, religion, spirituality, sexual orientation, disability, language, socioeconomic status, education, group identity, communication modality, level of acculturation/assimilation, developmental stages, stages of ethnic development, popular culture, family and lifestyle, workplace culture.
- C. How Consumer-Practitioner Contacts, Relationships, and Interactions are Affected by Diversity Concerns (e.g., stereotypes/biases, such as racism, sexism, gender bias, ethnocentrism, ageism, etc.; similarities and differences; oppression, marginalization, and victimization; blaming the victim)
- D. Mental Health (strengths/assets), Psychosocial Problems, Mental Illness, and School Interventions as Viewed by Diverse Groups
- E. How are Human Diversity and Related Power Differentials Accounted for in Intervention Theory and Research and What are the Prevailing Disciplinary and Field Biases?
- F. The Role Played by Public and Personal Teaching and Health Agenda, Political and Societal Agenda Related to Demographics and Equity, Cultural Beliefs, Religion, and Ethnocentrism

II. Ethical and Legal Considerations

- A. Relevant Professional Guidelines (e.g., specific organization’s ethical guidelines; education code; *APA Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists; Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients*)
- B. Special Informed Consent Concerns
- C. Ensuring Use of Best Practices in Accounting for Diversity (including consideration of culturally meaningful alternatives, one’s limitations, and how to avoid and minimize iatrogenic effects related to diversity considerations)
- D. Reduction of Disparities in Care; Equity of Access
- E. Special Boundary, Transference, and Counter-transference Concerns
- F. Americans with Disabilities Act and Individuals with Disabilities Education Act
- G. Regulatory and Accreditation Issues (e.g., U.S. Dept. of Health and Human Services Recommended Standards for Culturally and Linguistically Appropriate Health Care Services; related state legislation and codes)

(cont.)

III. Enhancing General Competence Related to Diversity Considerations

- A. Strategies to Enhance Understanding/Awareness of and Address Personal and Professional Biases and Provide Appropriate Intervention
- B. Strategies for Creating an Environment Conducive to Addressing Diversity Concerns (including accounting for family and community context)
- C. Adapting Communication Strategies to Address Diversity (including use of interpreters) – see, for example, the U.S. DHHS’s National Standards for Culturally and Linguistically Appropriate Services in Health Care
- D. Identifying Student, Family, and Staff Preferences and Concerns (and Taboos) Related to Diversity
- E. Assessing Student and Family Perceptions of the Intervener and Intervention Approach and Enhancing Credibility
- F. Avoiding Misinterpretation of Behavior that is Normative for a Subgroup
- G. Strategies to Avoid Blaming the Victim and Perpetuating Inequities
- H. Understanding Conflict Stemming from Within Group Diversity and Relevant Strategies to Address Such Conflict
- I. Rebounding from Diversity Breaches

IV. Implications of Diversity for Assessing and Diagnosing Psychosocial Problems and Psychopathology

- A. Understanding of Referral Problems, Symptoms, Culture Bound Syndromes (as in Appendix of DSM-IV), Interaction of Physical and Mental Health Conditions, and Applicability of Prevailing Diagnostic Schemes and Classification Labels in Relation to Specific Groups (including clarification of prevailing biases)
- B. Concerns that Arise Across Groups and General Adaptations
- C. Specific Group and Intra-group Concerns and Specific Adaptations
- D. Importance of Prediagnosis Interventions
- E. Use of Responses to Intervention to Detect False Positives and False Negatives

V. Implications of Diversity for Intervention

- A. Prevention (protective buffers; resiliency; family and community collaboration)
- B. Concerns that Arise Across Groups and General Adaptations
- C. Specific Group and Intra-group Concerns and Specific Adaptations
- D. Negotiating Conflicts in the Practitioner-Consumer Relationship
- E. Referral and Pluralistic Intervention Considerations
- F. Care Monitoring and Management Considerations
- G. Identifying and Addressing Biases
- H. Quality Control and Evaluation of Progress

VI. Implications for Supervision/Mentoring

- A. Concerns that Arise Across Groups and General Adaptations
- B. Specific Group and Intra-group Concerns and Specific Adaptations
- C. Identifying and Addressing Biases and Conflicts in the Supervisor-Supervisee Relationship (and the Supervisee-Student/Family Relationship)
- D. Enhancing the Diversity of the Pool of Supervisors

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The process was facilitated by (1) CA Board of Psychology Exec. Officer Thomas O’Connor, Asst. Exec. Officer Jeff Thomas, and members of the CE committee and (2) staff of the Center for Mental Health in Schools at UCLA.

Diversity Competence Online Resources

The workgroup drew on a variety of resources related to the topic of human diversity and professional competence. A sampling of these is provided below

- >American College of Mental Health Administration, Summit 2003 – Reducing Disparity: Achieving Equity in Behavioral Health Services. www.acmha.org/Summits/summit_2003.htm
- >American Psychological Assoc. (1998). *Expanding the Psychology Curriculum: An Annotated-Bibliography on Diversity in Psychology*. <http://www.apa.org/ed/biblio.html>
- >American Psychological Assoc. (2003) Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58, 377-402.
- >American Medical Student Association has a one year model curriculum entitled: *Promoting, Reinforcing and Improving Medical Education Culture and Diversity Curriculum* (Topics and Core Competencies). <http://www.amsa.org/programs/diversitycurriculum.cfm>
- >Center for Mental Health in Schools (2001) *Cultural concerns in addressing barriers to learning*. <http://smhp.psych.ucla.edu/pdfdocs/cultural/culture.pdf>
- >Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. SAMHSA. Available at: www.mentalhealth.org/publications/allpubs/SMA00-3457/
- >Diversity Central – <http://www.diversitycentral.com/>
- >Diversity content in the Accreditation Standards for Council of Social Work Education <http://cswe.org/>
- >Institute of Medicine (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. This work contains material relevant to training of healthcare professionals. <http://www.nap.edu/books/030908265X/html/>
- >National Association for School Psychologists website on Culturally Competent Practice <http://nasponline.org/Culturalcompetence/index.html>
- >National Center for Cultural Competence <http://www.georgetown.edu/research/gucdc/nccc/>
- >National Conference for Community and Justice <http://www.nccj.org/>
- >National Multicultural Institute <http://www.nmci.org/>
- >National Standards for Culturally and Linguistically Appropriate Services in Health Care from the U.S. Dept. of Health and Human Services' Office of Minority Health <http://www.omhrc.gov/CLAS/finalcultural1a.htm>
- >NASW Standards for Cultural Competence in Social Work Practice http://www.socialworkers.org/sections/credentials/cultural_comp.asp

- >Office of Professions, NY State Education Dept. *Guidelines Regarding the Education and Training of Psychologists for Practice in a Pluralistic Society*. <http://www.op.nysed.gov/psychpluralguide.htm>
- >U.S. Surgeon General's Office (2001). *Mental Health: Culture, Race, Ethnicity*. Supplement to Mental Health: Report of the Surgeon General. <http://www.mentalhealth.samhsa.gov/cre/default.asp>
- >Workgroup Summaries from "Competencies 2002" a competencies conference held by the Association of Psychology Postdoctoral and Internship Centers. www.APPIC.org/news/3_1_news_Competencies.htm

Some Recent Resource from The California Endowment:

Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals (2003). (http://www.calendow.org/reference/publications/pdf/cultural/principles_standards.pdf)

A Manager's Guide to Cultural Competence Education for Health Care Professionals (2003) (http://www.calendow.org/reference/publications/pdf/cultural/managers_guide.pdf)

Resources in Cultural Competence Education for Health Care Professionals (2003)

This resource document contains: policy statements and standards; cultural competence guidelines and curricula designed for health care professionals; models for culturally competent health care; a list of guidebooks and manuals; discussion of assessing the cultural competence of organizations and health care personnel, including personal assessments; lists of resource articles, books and reports, videos and CD-ROMs, journals, and web sites. (http://www.calendow.org/reference/publications/pdf/cultural/resources_book.pdf)

Almost all of the above provide reference lists to the key literature.

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Results! I have gotten a lot of results.

I know several thousand things that won't work.

Thomas Edison

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Center News



***NEW AND UPDATED RESOURCES

See the full list of Center resources online at – <http://smhp.psych.ucla.edu>. All the resources can be downloaded from the website at no cost. Hardcopies can be ordered for the cost of copying and mailing.

** *Integrating Agenda for Mental Health in Schools into the Recommendations of the President’s New Freedom Commission on Mental Health* – Prepared by the two national centers focused on mental health in schools, this brief now has been revised based on the feedback from the field. Our thanks to all who provided feedback. Feel free to copy and share this with others. Let us know if there are leaders to whom you want us to send a copy. Contact: ltaylor@ucla.edu

** *Resource Synthesis to Help Integrate Mental Health in Schools into the Recommendations of the President’s New Freedom Commission on Mental Health* – This synthesis highlights a set of readily accessed online resources. The document was just revised based on feedback from the field. (Thanks to all who responded.) Feel free to copy and share this with others.

** *Youngsters’ Mental Health and Psychosocial Problems: What are the Data?* – A common request to Centers such as ours is for info about the prevalence and incidence of youngsters’ problems. This report provides a synthesis of the best data and clarifies the limitations of what has been gathered so far.

** *Mental Health of Children and Youth: The Important Role of Primary Care Health Professionals* – This brief report is intended for primary care health providers. Specifically, it underscores why MH is a basic concern in the practice of all health professionals, sketches a broad definition of MH that focuses on strengths as well as problems, outlines a continuum of interventions, and highlights considerations related to working with families, schools, and communities.

Change is inevitable, progress is optional.

** *Mental Health of Children and Youth and the Role of Public Health Professionals* – This brief report highlights: a) why the mental health of children and youth is a major public health concern, b) the importance of viewing causal factors from a broad perspective, c) a continuum of intervention strategies for addressing the full range of problems, d) some considerations related to mental health promotion and prevention, e) a note about screening, and f) the value of connecting with schools.

** *Addressing Barriers to Learning: A Comprehensive Approach to Mental Health in Schools* – This continuing education module is designed as a direct aid for training leaders and staff and as a resource that can be used by them to train others. While accounting for individual case-oriented approaches to providing services, the emphasis is on a *systems* approach to enhancing mental health in schools. In particular, the focus is on pursuing the need for better mental health interventions within the context of moving toward a comprehensive, integrated approach to addressing barriers to student learning and promoting healthy development.

** *Revisiting Learning & Behavior Problems: Moving Schools Forward* – Between the covers of this book, you will find a big picture overview of what’s wrong with the way schools address learning and behavior problems, frameworks for rethinking current policy and practice and for moving in new directions, and specific practices for making schools more effective. Along the way, we stress how schools, families, and communities must collaborate to get there from here. Our approach involves analyses, commentary, conceptualizations, examples, and opinions.

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Let us know what you need. New resources can be developed and best practices identified. Also, let us know about the latest and greatest you encounter so we can update our resources and our colleagues across the country.

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Education is a method whereby one acquires a higher grade of prejudices.
Laurence J. Peter

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

Want resources?
Need technical assistance?

Contact us at:

E-mail: smhp@ucla.edu Ph: (310) 825-3634
Toll Free Ph: (866) 846-4843

Write: Center for Mental Health in Schools
Department of Psychology, UCLA
Los Angeles, CA 90095-1563

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

If you're not receiving our monthly electronic newsletter (ENEWS), send an E-mail request to:

smhp@ucla.edu

or subscribe online @ – <http://lists.ucla.edu/cgi-bin/mailman/listinfo/mentalhealth-L>

**FOR THOSE WITHOUT INTERNET ACCESS,
ALL RESOURCES ARE AVAILABLE
BY CONTACTING THE CENTER.**

Exchange info on MH practices in school and network with colleagues across the country by joining (1) the **Weekly Listserv for School MH Practitioners** and/or (2) the **Center's Consultation Cadre**. Sign up by email at smhp@ucla.edu or by phone (toll Free (866) 846-4843)

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

Interested in a Statewide Summit on *New Directions for Student Support?*

Building on the National and regional summits, we are now working toward a summit in every state. The *New Directions for Student Support* initiative is proving to be a powerful strategy for pursuing efforts to change (e.g., rethink, reframe, reform, restructure) the way student supports are conceived at schools – with MH in schools solidly embedded. Discussions are underway about convening planning groups in RI, TN, TX, CT, and NJ.

See the info at <http://smhp.psych.ucla.edu/> and let us know about your interest. (Click on the green button labeled Summits on New Directions). Interested parties can contact: ltaylor@ucla.edu.

>Feel free to download and share info with others. See *Guidelines for a Student Support Component*. This document should be shared widely as a basis for a school's learning supports and a stimulus for advancing the work (e.g., developing standards and quality indicators). Various other documents can be used for policy, capacity building, training, and research.

>Follow-up efforts are underway stemming from the Summits Initiative in Wisconsin, California, Minnesota, and Indiana. In each of these states, a group of Summit participants and other state leaders form a Steering Group to follow up on the momentum and plans made at their state Summit. A major focus of the steering groups is to set priorities about next steps. If you live in ones of these states and are interested in being part of the Steering or work groups, contact: ltaylor@ucla.edu

The first step is to measure whatever can be easily measured.
That's okay as far as it goes.

The second step is to disregard what can't be measured.
That's artificial and misleading.

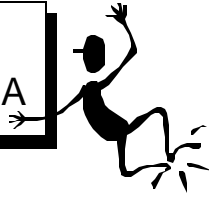
The third step is to presume that what can't be measured easily isn't very important.
That's blindness.

The fourth step is to say what can't
be measured really doesn't exist.



Attributed to Yankelovich

Where it's Happening Legislation Introduced in CA



California's Assembly Speaker Pro Tem, Leland Yee, has introduced a bill (AB 2569) to include the concept of a "**Comprehensive Pupil Learning Support System**" in the state's Education Code. The current version of the bill can be accessed online at http://www.leginfo.ca.gov/pub/bill/asm/ab_2551-2600/ab_2569_bill_20040220_introduced.pdf

Why Such Legislation is Needed

- C To date, the manner in which state law (in every state but Hawaii) addresses learning supports has resulted in a marginalized and fragmented set of activities at school sites (e.g., see the many categorical programs and related personnel and the multiple categories of pupil personnel services).
- C The problem has been compounded by legislation to connect community resources to schools.
- C In terms of resource use at the school level and at all other system levels, the result is gross inefficiencies in organization and daily operations (e.g., redundancy in resource use, poor coordination, failure to achieve economies of scale, counterproductive competition for sparse resources, and almost no accountability for the direct outcomes the resources are allocated to achieve). The problem is recognized but not effectively addressed by efforts to enhance program and service coordination.
- C In terms of impact on students, the result has been to limit effectiveness significantly in addressing barriers to learning and teaching – especially for students with learning, behavior, and emotional problems.

What the Legislation Intends

“CHAPTER 6.4. **Comprehensive Pupil Learning Support System** 52060. (a) There is hereby established the Comprehensive Pupil Learning Support System (CPLSS). The CPLSS shall be implemented and administered by the department through existing resources that are available to the department for those purposes. (b) It is the intent of

the Legislature in establishing the CPLSS to provide all pupils with a support system to ensure that they will be productive and responsible learners and citizens. It is further the intent of the Legislature that the CPLSS ensure that pupils have an equal opportunity to succeed at school and to do so in a supportive, caring, respectful, and safe learning environment. (c) These goals shall be accomplished by involving pupils, teachers, pupil support professionals, family members, and other school and community stakeholders in the development, daily implementation, monitoring, and maintenance of a learning support system at every school and by braiding together the human and financial resources of relevant public and private agencies.”

Where's the Money?

First steps in developing a comprehensive learning support system would be made by reworking how current student support resources are used. This would encompass:

- C reframing the roles and functions of existing student support staff
- C reducing fragmentation and redundancy
- C reducing the overemphasis on expensive services. (As the in-classroom and school-wide approaches emerge, the need for out-of-classroom referrals will decline. This allows for rapid and early response when a student is having problems, and it enables student support staff to work more effectively in linking students up with community services.)

The systemic changes needed can be underwritten in many districts through the provisions in the *No Child Left Behind Act* and in the *Individuals with Disabilities Education Act* that allow use of some allocated funds to integrate programs and services. For example, funds can be used for a facilitator to enhance systems for student support in ways that lead to a comprehensive, integrated, and cohesive component at school, cluster, and district levels.

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The bill's author, Assembly Speaker Pro Tem Leland Yee, has asked that letters of support be sent to him at the following address:

Assemblymember Leland Yee
State Capitol, Room 3173
Sacramento, CA 95822

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Ideas into Practice

Obesity and Mental Health



We note that requests from schools for info on the relationship between mental health and obesity are increasing. From all indications, concern about this is going to be a controversial topic for the next couple of years. What's the controversy? What's good practice? Here's part of a response given recently on the Center's Practitioner Listserv.

First, Who Are We Talking About?

Children are considered obese when their weight is at least 10 percent higher than recommended for their age and height. Such children in the age range of 10 and 13 have an 80 percent chance of fitting this criterion as adults. (See: American Academy of Child and Adolescent Psychiatry

http://www.psych.org/news_room/press_releases/childrenobesity92903.pdf)

What's the Relationship to Mental Health?

Not surprisingly, a literature review reveals there is not a strong science-base on the relationship, and there is controversy. The prevailing view presents obesity as a MH problem. It is commonplace to read that there is "a clear association between obesity and depression and anxiety disorders among children and teens" and "untreated depression is both the cause and effect of obesity." Here's a sampling of this view:

(1) The American Psychiatric Association sees the mental health impact of childhood obesity as a burgeoning public health crisis in the U.S. An online article entitled: "Obesity can be Harmful to your child's Mental Health" states that obese children are at increased risk for emotional problems that last well into adulthood. The article concludes that obesity and the mental disorders to which it contributes are as serious as other medical illnesses. (See: http://www.psych.org/news_room/press_releases/childrenobesity92903.pdf)

(2) Investigators at the University of Medicine and Dentistry of New Jersey report that obese girls ages 13 to 14 were four times more likely to experience low self-esteem than non-obese girls. They also report that obese boys and girls with low self-esteem had higher rates of loneliness, sadness and nervousness and were more likely to smoke and drink alcohol. They note that depression, often an

outcome of low self-esteem, affects as many as 750,000 teens in the U.S. (Source: Pediatrics, "Childhood Obesity and Self-Esteem" Jan., 2000.)

(3) A University of Minnesota study reports that children teased about being overweight were more likely to have poor body image, low self-esteem, and symptoms of depression. The study found that 26 percent of teens who were teased at school and home reported they had considered suicide, and 9 percent had attempted it. (Source: Archives of Pediatrics and Adolescent Medicine, "Associations of Weight-Based Teasing and Emotional Well-being Among Adolescents," August 2003)

Concern about Unintended Negative Effects of Campaigns Against Obesity

Concern is growing that the new "campaign against obesity" may have unintended negative effects. These include amplifying youngsters' self-consciousness and embarrassment about their body size, possible increased harassment by peers, heightened pressures to reach an "ideal" weight despite genetic predispositions, and growing rates of eating disorders.

Those expressing concerns suggest there is an alternative to stigmatizing campaigns. They call for approaches that focus on a healthy lifestyle and physical fitness for all children and youth.

Still others argue for greater acceptability of those who weigh more than others. For example, see the positions advocated by groups such as the American Obesity Association (www.obesity.org) and the National Association to Advance Fat Acceptance (www.NAAFA.org).

What Practices Are Recommended?

Depending on whose agenda is on the table, recommended practices encompass advocacy for acceptance, greater attention to promoting healthy behaviors, dieting, and various treatment strategies (e.g., medication, psychological treatment, surgery).

The Centers for Disease Control and Prevention (CDC) emphasizes a host of prevention approaches for schools and communities— see

><http://www.cdc.gov/nccdphp/dash/shi/>

><http://www.cdc.gov/nccdphp/dash/physicalactivity/guidelines/index.htm>

><http://www.cdc.gov/nccdphp/dnpa/npa-proj.htm>

(cont. on page 10)

From the perspective of obesity as related to mental health problems, the American Academy of Child and Adolescent Psychiatry offers the following advice:

- C Help children understand that being overweight can undermine physical and mental health and is more than an appearance issue;
- C Talk to children about why they overeat and how they feel about themselves. Identify feelings and situations that cause them to overeat and discuss coping strategies;
- C Criticizing an obese child or trying to humiliate them into losing weight will increase the child's emotional difficulties. The child may become lonelier, more depressed, and less likely to make changes that might help;
- C Praise your child's strengths and accomplishments;
- C Help children gain control over their weight by discussing and encouraging healthy food choices and exercising regularly with them. Individualize food and exercise plans according to the child's interests and your commitment level;
- C Set an example – make healthy eating and exercise a family affair;
- C Encourage children to make smart choices and understand the benefits of feeling better and being healthier. Explain the long-term medical impacts of a healthy lifestyle;
- C Limit access to high-calorie, high-fat and sugary foods, including soda and juices – especially at home;
- C Limit sedentary activities including television and computer time; and
- C Do not use food to reward or punish children. Establish a system to reward weight goals and help the child get back on track when they fall off.

Source: American Academy of Child and Adolescent Psychiatry
http://www.psych.org/news_room/press_releases/childrenobesity92903.pdf

Readers: What are your concerns about obesity and mental health? Are you involved in activities to promote healthy behaviors? Let us know what works. Contact: ltaylor@ucla.edu

#####

In this context, we are reminded of a lament we heard in Iowa about the overemphasis on achievement testing as a strategy for improving student learning:

**Weighing the pig
 does little to fatten it up.**

#####

*****JOIN: Practitioners' Listserv** – Every Monday a large group of folks involved with schools are part of a practitioner listserv. The email deals with concerns, questions, and responses from the field and facilitates sharing of experiences and resources. To join, email smhp@ucla.edu and ask to be added to the Practitioner Listserv. Send questions and topics for discussion to ltaylor@ucla.edu.

Lessons Learned

Implementing a Student Learning Support System



Note: Hawai'i's schools know that leaving no student behind requires a three component approach to school improvement: (1) strengthening instruction, (2) building a comprehensive student support system, and (3) redesigning management and governance practices. The state's policy commitment to develop a *systemic* and nonmarginalized approach to student support makes it a pioneer. A key facet of the work stresses introduction of a resource-oriented infrastructure mechanism called the CSSS Cadre. The following description is excerpted from a brief by Dr. Shannon Simonelli, entitled *The CSSS Cadre: A Vital Mechanism for Coordinating Resources to Implement a School's Comprehensive Student Support System*.

As part of its continuing commitment to help schools develop an effective Comprehensive Student Support System (CSSS), the Hawai'i Department of Education is encouraging establishment of a CSSS cadre at each school. A key step in helping schools do so has involved providing targeted training to eight model schools across the state. These sites provided others an opportunity to observe, discuss, and learn from their successes and challenges as they each strove to establish CSSS Cadres.

As part of its CSSS infrastructure, every school uses a team approach to focus on the needs of individual students/families (e.g., a student support team, an IEP team). These student-centered teams focus on such functions as referral, intervention, and care monitoring or management.

In contrast to this case-by-case focus, a school's CSSS cadre takes responsibility for coordinating resources on a school-wide level to address barriers to learning and promote healthy development. This includes analyzing how existing resources are used and clarifying how they can be used even more synergistically and effectively.

Who participates in the CSSS Cadre?

Theoretically, when there are two people, you have a group. The CSSS cadre can begin with only two people and expand into an inclusive group of informed stakeholders who are able and willing. An effective Cadre draws from various stakeholders.

These school-wide resource coordinating cadres may have a small core group with various others included as needed. As schools continue to build their CSSS cadre, they consider the following players:

Principal/VP; counselor; service coordinator; school nurse, psychologist, social worker; behavioral health therapist; School Renewal Specialist; literacy, special education, and regular education teachers; representatives of parents and community agencies involved regularly with the school; student representation (when appropriate and feasible); and others who have a particular interest and ability to help with the functions.

It is important to integrate the CSSS cadre with the existing school infrastructure. For example, the team must be represented at administrative . . . and governance meetings, at Quality Assurance meetings, and at other appropriate complex level meetings.

What are the functions of the CSSS Cadre?

The CSSS Cadre performs essential functions related to the implementation and ongoing development of a school's Comprehensive Student Support System. Examples of key functions are:

- C Mapping, identifying, and analyzing resources at the school and in the community
- C Coordinating and integrating school resources & connecting with community resources
- C Recommending how resources should be deployed and redeployed
- C Developing strategies for enhancing resources
- C Identifying the most pressing program development needs at the school
- C Establishing priorities, planning, and facilitating ways to strengthen programs and developing new ones
- C "Social marketing" (e.g., a brochure or fact sheet about parent involvement offerings)

These functions are pursued within the frameworks that outline the six curriculum content areas of CSSS (classroom-focused enabling, home involvement, student and family assistance, crisis assistance and prevention, community outreach, and support for transitions) and the five level continuum of care (basic, informal, individualized, specialized, and intensive supports). Both components are needed to develop a comprehensive continuum of multifaceted programs and services that are integrated fully into the fabric of the school.

The Parable of a Boy and a Bully

In a school where bullying was common, one ringleader and his followers set out to harass a student who was heavier than most. "We can have some fun by calling him "Fatso," he said.

Day after day in the schoolyard the gang sought the boy out. "Fatso! Fatso!" they hooted at him. The boy took the matter so much to heart that he began to brood and spent sleepless nights over it. Finally, out of desperation, he told his teacher about the problem, and together they evolved a plan.

The following day, when they jeered at him, he told them:

From today on I'll give any of you who calls me "fatso" a quarter.

Then he put his hand in his pocket and, indeed, gave each boy a quarter. Well, delighted with their booty, of course the youngsters sought him out the following day and began to shrill, *Fatso! Fatso!*

The boy smiled at them. He put his hand in his pocket and gave each of them a dime, saying, *A quarter is too much – I can only afford a dime today.*

Well, the boys went away satisfied because, after all, a dime was money too. However, when they came the next day to hoot, the boy gave them only a penny each.

Why do we get only a penny today? they yelled. . . . That's all I can afford, the boy said.

But two days ago you gave us a quarter, and yesterday we got a dime. It's not fair!

Take it or leave it. That's all you're going to get.

Do you think we're going to call you "Fatso" for one lousy penny?

So don't, the boy said. . . . And they didn't.

Moral: In the long run, bullying doesn't pay very well.

(Adapted from a fable presented by Ausubel, 1948)

Please see the insert and take a few minutes to help us with our yearly impact evaluation.

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Center for Mental Health in Schools
Department of Psychology, UCLA
Los Angeles, CA 90095-1563
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The Center for Mental Health in Schools is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project in the Dept. of Psychology, UCLA. Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration. Co-funding comes from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both HRSA and SAMHSA are agencies of the U.S. Dept. of Health and Human Services.

UCLA Center for Mental Health in Schools Impact Evaluation

The Center is trying to determine the impact of our work.

Please take a few minutes to help us out by providing us with feedback.

- >Send back your responses using this form OR
- >fill out the online version (<http://smhp.psych.ucla.edu/eval2002.htm>) OR
- >call Perry Nelson at 310/825-3634 and we will enter your responses directly OR
- >check here and we will give you a call. CALL ME_____.

EVEN PARTIAL RESPONSES WILL BE HELPFUL!

IF YOU CHOOSE NOT TO PROVIDE FEEDBACK, IT WILL STILL HELP US IF YOU SEND BACK THIS PAGE WITH THE FOLLOWING IDENTIFYING DATA FILLED OUT.

Date: _____	Your Name _____
Title _____	Role/Function _____
Agency _____	Private? _____ Public? _____
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City _____	State _____ Zip _____
Phone (____) _____	Fax (____) _____ E-Mail _____

Frequency and nature of contact with Center?

- My contact has been of a casual nature (e.g., receive newsletter)
- I have been in frequent contact (e.g., for TA, for resources, etc.)
- I use the Center for strategic assistance (e.g., to help improve programs, systems, etc.)

Do you want to be dropped from our mailing list? Yes No

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UCLA Center for Mental Health in Schools
(310) 825-3634 / smhp@ucla.edu
<http://smhp.psych.ucla.edu>



How useful were any of these resources to you?

	TA/ Consultation	Training	Resource Materials*	Electronic Newsletter (ENEWS)	Quarterly Hardcopy Newsletter	Practitioners Listserv	Leadership Summit on New Directions for Student Support	Other Networking Facilitation**	Support for Program/ Initiative Enhancement	Support for Systemic Changes
Not at all										
A Little										
Somewhat										
Quite a Bit										
Not Used										

Your Capability Related to:

What has been the short-term impact or what impact do you anticipate?

	TA/ Consultation	Program Development	Practice	Policy	Training	Research	Networking	Initiating New Approaches & Ideas	Infrastructure Development	General Capacity Building
None										
A Little										
Somewhat										
Quite a Bit										
Not Yet										

What has been the longer-term impact?

	TA/ Consultation	Program Development	Practice	Policy	Training	Research	Networking	Initiating New Approaches & Ideas	Infrastructure Development	General Capacity Building
None										
A Little										
Somewhat										
Quite a Bit										
Not Yet										

*Resource materials refers to resource packets and aids, fact sheets, practice notes, guidebooks, concept papers, statements of principles and guidelines, critical issue and policy reports, continuing education modules, special training aids, published articles, chapters, and books, products related to research and development
 **Networking facilitation refers to opportunities created by the Center for interacting at regional and national meetings, through participation in coalitions and special cadres, through Center operated listservs, through task workgroups and other collaborative connections, etc.

Ways in which you have had contact with the Center: *(check all that apply)*

- Website
- Listserv (e.g., ENEWS, MH Practitioners, Policy Makers)
- Received direct mail or email
- Had contact at a presentation or special meetings
- Center staff came to us
- Center materials, special reports, publications, etc. came to us indirectly (e.g., shared by a colleague)
- We visited Center and/or a site with which the Center works
- Other (specify) _____

Satisfaction with Center *(circle rating)*

How easy was it to access the Center's resources?	Not at all	Somewhat	Very	Extremely Easy
How timely and appropriate was the Center's response to your requests?	Not at all	Somewhat	Very	Extremely Responsive
How well did the Center meet your needs?	Not at all	Somewhat	Very	Extremely Well

Based on your experience with the Center, would you use it again and/or recommend that others make contact?

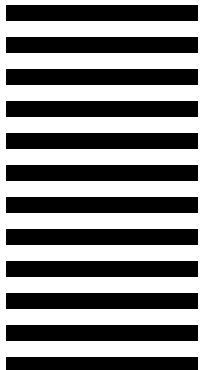
Yes No

Other comments?

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