

Chapter 2

Creating At-Risk Children and Youth

She entered the room wearing a slightly soiled bulky winter coat with fake fur trim around the hood. The hood completely covered her face. She was much taller than I was and did not seem to be the least bit excited about my idea to organize a new group. As one of my University students told me later, "I thought she was going to hit you." I, too, was not entirely certain that she was not planning violence. Her body posture was definitely aggressive. Ignoring her obvious signs of hostility, I suggested that we all find a chair. Three teens, middle school and high school age, two of my university students, and myself were stuffed in an overly crowded computer lab at a local community center. I explained that the six of us would be meeting each week. Sometimes we would meet as a group, sometimes for one-on-one tutoring, but that every Thursday we would come to this room to work on reading. She sat defiant with her hood still pulled over her head hiding her face. We broke into one-on-one subgroups for testing and initial tutoring. She was 15 years of age, a freshman in high school, and reading at the pre-primer (below first grade) level. The school had placed her in a special education classroom and had designated that she was to be taught second grade course material. She had an extensive record of behavioral issues and had been removed from the school bus because of bad behavior. Her file was marked "will most likely drop out of school as soon as she is old enough." There was absolutely no way she could read the second grade material being given to her at school.

Six months later she was greeting me with a smile and a hug, reading first-grade material, and asking if I thought she'd be able to go to college, possibly a 2-year school, when she graduated from high school.

Four million children and teens between the ages of 9 and 17 years can be classified as suffering from a major mental illness and approximately 21% of school-age children and teens have a diagnosable mental illness or addictive disorder and are thereby labeled as being at-risk (US Public Health Service 2000). When counselors or psychologists use the term "at-risk," they typically are referring to someone who is suffering from an emotional or adjustment problem (McWhirter et al. 2007). When teachers and the schools use the term "at-risk," they are probably referring to students who are at risk of dropping out of school or at risk of failure, but academic failure always comes with adjustment problems (Flaherty and Osher 2003; Weist 1997). Academic failure and psychological adjustment go hand-in-hand, and academic failure in the classroom

can place any student in the psychological at-risk category, regardless of whether they come from an affluent neighborhood with well-funded schools or a poor neighborhood. For children who have been labeled at-risk, *the school-based mental health approach* can mean the difference between success and failure.

Academic failure is closely tied to psychological development because failure is a form of rejection. The classroom becomes one of the first social arenas beyond the family in which the child seeks membership. Learning in school takes place in front of peers. Being labeled as a failure in the classroom can be especially damaging to young students (Rudolph et al. 2001) because failure to obtain a classroom goal, such as reading, becomes a roadblock to acceptance. Peer group rejection becomes intertwined with the child's perception of themselves. Children often feel shunned, ostracized, or labeled. If classroom failure continues, then the child will internalize such failure as part of their self-concept. Students fear being different than other students; they fear not being able to fit in with the group. The inability to succeed in the classroom is perceived as the inability to acquire the skills necessary to join the classroom group—to be as good as others in the group.

The Role of Prevention

A growing body of evidence shows that prevention programs can improve a child's ability to learn and overall psychological wellness (Nelson et al. 2003). Therefore, the goal of the *school-based mental health approach* is to create group prevention programs which strengthen school-based mental health through rebuilding necessary skills. The group becomes an early prevention tool for improving psychological adjustment and mental well-being. The *school-based mental health approach* provides a step-by-step model for designing and developing group prevention programs in schools and community settings. The *school-based mental health approach* combines counseling and learning and makes full use of interaction and group process, stresses intrinsic (internal) motivation rather than extrinsic (rewards or prizes), and focuses on self-efficacy (belief that the student can accomplish a task) rather than self-esteem (feeling good about oneself). Group-centered prevention programs organized before school, during school, and after school can help today's children have a more successful life, today and tomorrow.

To undo the psychological damage caused by school failure, it is necessary to prevent and erase classroom failure (Brooks-Gunn 2003). Before we can organize groups to prevent academic and psychological failure, however, we need to understand what causes children to be labeled at-risk and in need of counseling.

How Families Help Create At-Risk Children and Youth

Unfortunately many children are at risk before they are even born. Risk begins at the moment of conception. The fertilized ovum carries the effects of the parents' life style within its DNA and cells, not only the inherited traits. Four weeks after

conception, the brain, heart, ears, eyes, nose, mouth, arms, and legs are beginning to form. Many women are not even fully aware that they are pregnant by the fourth week after conception, yet the brain is already developing and the head and brain will soon comprise 50% of the embryo's total size. The nervous system and brain waves are functioning by the fifth week, and as many as 100,000 neurons are produced every minute (Nelson and Bosquet 2000).

Risk factors during pregnancy. The brain will continue to develop throughout the fetal stage and be influenced by everything the mother consumes. Aspirin, ibuprofen, and even birth control pills taken by a woman before she realizes that she's pregnant affect the developing brain of the unborn child. Illicit drugs carry an even heavier risk. "Crack" cocaine use during pregnancy has been linked with lower IQ scores (Richardson et al. 2008), problems with language development, comprehension, verbal expression, and auditory attention (Lewis et al. 2004). Alcohol, nicotine, and caffeine all also affect brain development. As little as one ounce of alcohol can damage the brain of the unborn child and cause verbal learning deficits, attention difficulties, and below average mental development (Cornelius et al. 2002). Nicotine reduces the oxygen content of the mother's blood, thereby reducing the amount of oxygen available to the unborn child and the developing brain. Second-hand smoke may be even more damaging. Children whose mothers smoke marijuana during pregnancy often struggle more in spelling, reading, particularly reading comprehension, and may suffer from anxiety and depression (Goldschmidt et al. 2004). Smoking, alcohol, and drug use during pregnancy cause many other birth defects and physically debilitating problems (fetal alcohol syndrome, cleft palate, tremors, sleep disorders, and other emotional problems), but the focus here will be on academic at-risk problems. I call it simply SAD, because Smoking, Alcohol, and Drugs sentence many children to a lifetime of at-risk behaviors and problems before the child is even born, and some of these conditions can never be erased. This is true of children born to wealthy parents in affluent neighborhoods as well as children born in poverty.

Family risk factors after the child is born. A newborn is born with 100–200 billion basic brain cells or neurons, but these neurons have very few connections. In an adult, one neuron may have over 5,000 connections. These neuron connections are essential for the child to learn. Changes in the connections between neurons enable the child to learn and establishes a foundation for cognitive development (Merzenich 2001).

During the first 2 years of life the baby's brain is rapidly growing and developing. From birth to 1 year, the child begins to learn the language spoken by those with whom the child lives. By age 3 years, the child begins to assimilate the grammatical sentence structure of the language. If the parent reads books to the young child during the first few years of life, grammatical sentence structure is enhanced, but even if the child does not have the benefit of listening to stories or books, the child will learn to speak. Learning to speak is a natural process. All children, unless confronted with physical inability, learn to speak. This is not true of reading. Reading, spelling, and written grammatical sentence structure must be taught.

How Schools Help Create At-Risk Children and Youth

The guiding principle of any educational system should be: What is truly best for the students, both academically and psychologically? Cost, administrative concerns, mandated testing, classroom management, or the well-intended advice of others must not become the directing principles upon which programs are developed. If we are to create successful mental health programs, the primary concern must be based on the needs of the students. This is not always true in the public school system.

For instance, the U.S. Department of Education's *Blue Ribbon Schools Program*, part of the *No Child Left Behind* initiative vividly demonstrates an important lesson. Statistical standards, not student needs, are used to measure excellence in schools. The following is one example.

A blue ribbon school, considered to be the best school in its district, teaches through the use of video instruction and worksheets. Teachers are forbidden to introduce new ideas, or even to work out a math problem on the chalkboard; all instruction comes from the video. The administration maintains an iron grip on what is and is not taught each day. Everything is geared to mandated testing, state benchmark standards, and increasing test scores. There is no time for individualized instruction. If a student fails a test, the student forfeits recess to retake the test. The school does not re-teach the material, only retests and continues retesting. There is one method of instruction and only one method; children are taught through videos and a barrage of worksheets. Testing begins as the children enter the door each day and concludes with a daily minimum of 12 worksheets, quizzes, or tests before they leave their desks to go home. It is literally one worksheet after another. A child who falls behind is lost. Such "robotic-style teaching," as the teachers themselves refer to the approach with which they are required to teach, creates at-risk students and psychological adjustment problems.

Does this blue ribbon school meet the needs of its students? No, the needs of students are buried beneath mountains of worksheets and test data. The blue ribbon school does not have time to be concerned with the individual learning needs or psychological needs of students because the blue ribbon school must maintain test scores at all costs, even at the cost of the mental health needs of the students. This type of teaching approach has led many researchers to call for system-wide change (Greenberg et al. 2003; Weissberg et al. 2003). A year-long stream of stressful standardized tests or worksheets does not contribute to mental health and well-being (Sternberg et al. 1997). Standardized tests measure only a small fraction of the skills and expertise needed to be successful in life (Sternberg and Grigorenko 2002). Mandated testing and a never-ending sea of workbook pages are also not consistent with current educational research (Kaplan et al. 2009). While many call for change in our communities and in our schools, today's children cannot wait for tomorrow's changes. Children sitting in class today, need help today.

The *school-based mental health approach* combines academic and psychological needs through group-centered prevention programs which work directly with at-risk students; therefore, our focus in this book will be on developing intensive

group-centered prevention programs which can be used in school-based and community settings to foster psychological development and well-being as well as academic success.

How School Counselors and Psychologists Help Create At-Risk Children and Youth

Schools are the primary source for mental health services for children (Brown and Tracy 2008), and children only get one chance to be successful in the public school system (Weinstein 2006). Mandated testing and the all-encompassing quest for test scores have reduced mental health services in schools (Maras et al. 2008). There is also an ever-widening gap between research and practice in school-based mental health (Wandersman et al. 2008; Weist and Paternite 2006). Many complain that evidence-based results are not transferring to the real-world setting of the classroom which has led to a call for change in how we deliver mental health services in schools (Adelman and Taylor 2006; Wandersman and Florin 2003; Weisz et al. 2004).

Many school counselors believe that their counseling efforts have been compromised by budget cuts, extra job assignments, and mandated testing. As one counselor explained, “When am I supposed to pull students out for counseling sessions? I have bus duty before school, cafeteria duty and recess during lunch, bus duty after school, and in between I’m in charge of locker assignments and schedule changes. I gave six students a detention during lunch; it’s a safe bet those six are not coming to my office in search of counseling.” When counselors become disciplinarians or on-duty officers, they lose the opportunity to get to know students in a nonthreatening situation. Students rarely turn for help or disclose problems and fears to those who administer discipline. Such mandatory assignments in school settings destroy the counselor-client relationship.

Other counselors complain that teachers are so pressured by mandated testing that they will no longer allow students to attend counseling sessions during class time. Parents are reluctant to sign their children up for counseling because they, too, do not want to see children miss classroom material which might be covered on end-of-the-year tests. School counselors have been reduced to giving short talks to classes, sorting out class schedules, and meeting with students only after they have been identified as major discipline problems. Preventive counseling is almost non-existent in today’s schools. As Martin Seligman points out in his book, *The Optimistic Child* (2007), counselors need to spend as much time, if not more, on prevention rather than waiting until treatment is critical.

Counseling in public school settings must change. Our approach to counseling in schools is not working. Yet, over 70% of children’s counseling groups take place in the school (Hoag and Burlingame 1997). A new approach is needed. The *school-based mental health approach* offers a new method for working with at-risk students which addresses the academic needs and the psychological needs of the student who has been labeled at-risk.

Schools blame children when they fail to learn. In the example of the 15-year-old high school freshman at the beginning of the chapter, the young teen had learned most of her consonant sounds but virtually none of her vowel sounds, not even the long vowel sounds. The school's approach to teaching her to read was to give her short word lists to memorize, such as the days of the week on flash cards. The school's rationale for using second grade reading instructional material, when the student could not even read at the pre-primer level (below first grade), was that they wanted to challenge the student. Over and over the 15-year-old had been told that she was "lazy" and "not trying," or that "she is a slow learner but could read if she would just apply herself to the task." Unfortunately, she could not read because she bore the residual effects of her mother using "crack" cocaine during pregnancy and the fact that the school which she attended was still hanging on to a whole language approach to reading. Whole language has created more at-risk readers than probably any other method ever developed (Foorman et al. 2003). As soon as I started teaching *vowel clustering* (Clanton Harpine 2010b), a method for teaching phonics to at-risk readers, the young teen began to read. Progress has been slow, but she is reading, and she is so very excited to be able to do so. She has even agreed to work with me over the summer. During the fall, we selected a first-grade level book as our goal. She said, "that's a book I've always wanted to read." She hopes to be able to read the book to her little brother by Christmas. As her self-efficacy improved (belief that she could learn to read), and she saw herself actually reading, the anger, the aggression, and the threat of violence melted away. Even her behavior at school improved. Learning to read has truly changed her life, her psychological well-being, and her prospects for the future, which is what we strive for in counseling. When we addressed the root cause of her behavior problem, her behavior was no longer a problem. She is still terrified that one of the members of her peer group will find out that she cannot read, or that she's reading "baby" books, as she calls the early reading material we are working with, but her joy and excitement from being able to read are so strong that she comes back week after week just so that she can learn to read.

Reading failure fuels mental health problems. As many as one fourth of all public school students suffer from some form of psychological adjustment problem (Satcher 2000); many of these adjustment problems stem from academic failure. Weak reading skills contribute to many mental health problems that counselors, teachers, and parents encounter among school children. Learning to read is essential to healthy early child development. In 2009, approximately 40% of fourth-grade children were unable to read at grade level (National Assessment of Educational Progress 2009). Seventy-five percent of children who do not learn to read by the end of third grade never learn to read at grade level (Lyon 2002; Lyon 1998). Reading failure leads to frustration, anger, aggression, bullying, and even violence (Bryant et al. 2003).

Reading failure is at the center of most mental health at-risk problems found in the schools. Reading failure can lead to aggressive school violence (Catalano et al. 2003), dropping out of school before graduation (Nastasi et al. 2004), adolescent substance abuse (Sussman et al. 2004), negative self-evaluations (Berking et al. 2008),

anxiety, and even depression (Herman et al. 2008). Interventions which reduce reading failure have been shown to also reduce the risk of depression and other psychological at-risk behaviors (Fleming et al. 2004; Keller and Just 2009). Erasing reading failure should therefore become one of our earliest school-based mental health preventive concerns because reading failure causes lifelong psychological damage (Criss et al. 2002).

How Communities Help Create At-Risk Children and Youth

The community's involvement in school-based mental health has been steadily growing over the past 10 years. After-school programs, sometimes at the school, sometimes at community centers, are becoming more prevalent. After-school community programs have the potential to provide mental health services in a troubled community. Community programs can fill the gap between school and home with something more than just child care. Community programs can serve as vital school-based mental health prevention centers.

All too often, though, in school-based mental health, we design programs in schools and in the community to fit the needs of the adults who are conducting the program rather than the needs of the students who are participating in the program. An example from a community-based after-school group highlights the danger of such an approach. When the group met to decide how to organize their program, they did not consider what would work best with at-risk children; instead, they proposed formats that echoed their own personal beliefs. (1) A former school teacher wanted to have the children sitting in rows silently working on worksheets; (2) another teacher wanted direct instruction by a qualified teacher and homework assignments; (3) a retired businessman suggested just sitting and listening to the children read; and (4) another well-intended worker said, "All of this stuff is just a waste of time; children need to sit down and do as they are told." The group finally sought the advice of someone who worked with at-risk children and organized their program along the guidelines given by their at-risk advisor. The group then spent the entire 2 months of their program's existence trying to reshape and undo everything the outside advisor had taught them. They spent every day trying to restore their original concept: sitting in rows doing homework pages. The needs of the children were never discussed during the actual implementation of the program. The program format chosen and the at-risk expert were wasted because the directors were unwilling to deviate from their personal beliefs. The focus was on them, not the needs of the children.

Another example of good intentions that did not work comes from an after-school program for children and teens from a drug-infested neighborhood. The group was based at a local church; the volunteers worked hard and were sincere, and their enthusiasm within the group was contagious. Research indicates that religiosity works as a deterrent to alcohol and substance abuse as well as risky sexual behavior with teens (Wills et al. 2003), and more and more churches are developing prevention programs.

At one session, a short middle-aged woman dressed in blue jeans and a T-shirt shouted, “Get back, Satan!” As she spoke to the group of 45 children and youth ranging from kindergarten age to high school age, she demanded that the children and teens resist temptation and walk away from drugs and alcohol. Religious zeal and fear comprised her prevention technique. She even invited volunteers to come forward and demonstrate how to turn away from the temptation of drugs. Her demonstration consisted of teaching the youth to point and repeat the phrase: “Get back, Satan! I’m not following you.” The session was lively; no one dozed off. Her desire to prevent drug use was unquestionable, but was her group prevention approach effective? No, adolescents stayed in the program, enjoying the free dinner and activities offered each afternoon and evening until they were old enough to drop out; at that point, street life prevailed. Drugs took over their lives, most dropped out of school, and virtually no one from the group went on to college or to find full-time employment.

Does that mean that community organizations such as churches should not be used for after school prevention programs? Absolutely not, I personally work hand-in-hand with many community church-sponsored groups in providing after-school programs for at-risk children and youth. Churches can provide a wonderful family support structure and an ongoing preventive atmosphere. Spirituality adds an additional deterring effect to prevention programs, but spirituality alone is not enough (Wills et al. 2003) to bring about mental health change and well-being.

How Evidence-Based Programs Help Create At-Risk Children and Youth

Most schools currently require or strongly suggest using evidence-based programs. If such evidence-based programs are not being used as designed, however, then the research evidence which supports the evidence-based program is worthless to the school that is using it (McHugh and Barlow 2010).

As one well-intended program director told me, “I really like your new program; we’re going to use bits and pieces of it.” We cannot continue to take programs apart, use bits and pieces, and expect positive results. Evidence-based programs only produce the evidence-based results if they are implemented as designed and used in the research setting (McHugh et al. 2009). If an evidence-based program is redesigned to fit their philosophy of what a program should be, then they are no longer running an evidenced-based program. The person is running bits and pieces of an evidence-based program, and the results will not be the same.

Programs often become distorted when implemented by well-intended but confused school personnel or community group leaders. Let’s use a very popular school concept which vividly demonstrates this principle: the open classroom concept.

The evidence-based program. The open classroom concept originated in the 1960s and was originally put forth as a theory of curriculum development.

The open classroom concept built upon Dewey's theories of learning-by-doing and working in small cooperative groups (Dewey 1997) as well as the concept of interdisciplinary learning and engaging the whole child in the task of learning (Taba 1962). The original open classroom concept never discussed physically taking down walls or doors or building schools without walls. The original concept was for curriculum development, suggesting hands-on learning techniques, and working with curriculum that engaged children in cooperative small groups, particularly learning centers within the classroom where children could go together, work, and solve a problem and engage in critical thinking. In short, the original open classroom concept wanted teachers to get rid of worksheets and allow children to move around the room working in small groups at learning centers—hence, a “classroom without walls.”

Distorting an evidence-based program through implementation. Yet, in the 1970s, the open classroom concept was distorted into a massive building campaign which saw school districts building schools without walls, without doors, and in some instances without classrooms. The results were disastrous, which led many to state that the open classroom concept was a failure. Actually, it was the well-intended but distorted implementation of the open classroom concept that had failed (Stenhouse 1975). The most ironic result of building classrooms without walls is that students who still attend class in “buildings without walls” from the 1970s spend more hours in quiet seat work working on worksheets than they do in traditional schools. Extensive seat work is deemed necessary in order to control noise levels.

Buying an evidence-based program does not guarantee evidence-based implementation. Schools, after-school programs, and other school-based community organizations working with children and teens genuinely want to provide effective programs, but if the programs offered do not actually end up helping students, then such good intentions are wasted (Kazak et al. 2010). Therefore, simply buying an evidence-based program does not ensure evidence-based implementation or evidence-based results. So, when we organize and plan for a new group, it is not enough to merely have good intentions or say that we are using an evidence-based program. Effective programs must be designed which incorporate the evidence-based design, not just on paper or in a manual, but in the actual implementation of the program. We need a way to guarantee that evidence-based programs are being used as designed and tested.

As long as implementers are free to decide how they should implement, adapt, or change an evidence-based program, evidence-based programs are worthless. Often when groups select bits and pieces of an evidence-based program to add to their own approach, schools or community groups blame the evidence-based program rather than their implementation of the program when research promised results are not forthcoming. There is no way to ensure that a school or community organization will actually use an evidence-based program as it was written and designed to be implemented (Kratochwill 2007). We cannot assume that good intentions will guarantee an effective program, because they do not.

How Reliance on Manualized Programs Helps Create At-Risk Children and Youth

Many researchers call for more reliance on manuals, but a manual does not guarantee that a program will be implemented using the evidence-based design, because manuals do not guarantee evidence-based practices. This is exemplified by a school which uses the STEMS Word Study Program (Thompson 2000). The STEMS manual discusses teaching “word attack” skills for prefixes, suffixes, and word roots. The manual also emphasizes spelling instruction focused on “word chunks” and looking at how words are related in order to enhance long-term memory. Yet, the school using the program merely distributes a list of STEMS every week for the students to memorize for a test on Friday. The school does not include the instruction, just a list of STEMS on Monday, and a test on Friday. Also, the school does not emphasize spelling. One teacher complained, “I was criticized for trying to correct a student’s spelling of the word *government*. The school classified this student as being an ‘A’ student; yet the student had written ‘gov4ment.’ I was told that spelling could only be corrected during spelling lessons; for other class work, spelling doesn’t matter.” The STEMS program and manual was attempting to teach an approach in which spelling could be integrated into every subject and become part of the student’s way of thinking. The school’s implementation of the program was the use of memorization to raise test scores, but then for anything other than mandated testing, spelling really didn’t matter. The school could advertise to parents that they were using an evidence-based program which would result in higher SAT scores, but the school’s incorrect use of the program actually rendered the program ineffective, specifically because the school did not use the program as described in the manual.

Good Intentions Are Not Enough

Manuals, evidence-based programs, research, and good intentions do not help if personnel conducting the program ignore the manual and the research. Therefore, good intentions are not always effective.

How should counselors, psychologists, teachers, parents, community workers, and others approach these school-based mental health problems? Can we as mental health professionals, teachers, parents, and community workers enact changes which will help students? I believe that we can.

In school-based mental health, we need (1) to remind all well-intentioned adults that the needs of students must come first; (2) to ensure that evidence-based programs are used in school and community-based prevention and treatment; and (3) to make sure that evidence-based programs are used correctly, not simply in bits and pieces. Ready-to-use program packets could be one solution which might solve this problem in school-based settings. One of our goals throughout this book will be to discuss designing and implementing group-centered prevention programs using program packets.

Developing Group-Centered Program Packets

A group-centered program packet is a ready-to-use program which has an educational as well as a counseling or mental health component (Clanton Harpine 2006). The programs are usually interactive and often use hands-on learning techniques. Group-centered program packets are complete and ready to use.

Some program packets, such as the *Reading Orienteering Club* (Clanton Harpine 2011), are year-long programs designed to be used in a public school classroom or community center after school with virtually no prior setup. All the group leader must do is provide paper, pencils, and other basic supplies. The program is divided into ongoing sessions which may be used once a week, twice a week, or even four times a week. The program is presented through hands-on learning center workstations where children work together in small groups or individually. The program is designed to be flexible to the needs of the school or community group without changing the program. Flexibility is built into the program packet.

Another example of a group-centered program packet is the *Camp Sharigan* program (Clanton Harpine 2010a). *Camp Sharigan* is a 10-hour, week-long motivational group-centered prevention program for children in first through third grades. The *Camp Sharigan* program packet utilizes 10 hands-on learning centers set in the atmosphere of a portable summer camp scene. Instructions are given for creating a make-believe portable camp with trees, waterfalls, and even a rainbow which can be taken from school to school to motivate and encourage children to erase reading failure.

The *Camp Sharigan* and *Reading Orienteering Club* packets incorporate hands-on remedial reading teaching techniques and group counseling motivational techniques; therefore, they combine both the educational needs and the counseling needs of at-risk children (Clanton Harpine 2007c). The program packet is a ready-to-use set of hands-on booklets which provide step-by-step learning center instructions – not a manual, but the actual program. The teacher or counselor at the school need only to open the packet and lay out the booklets when they're ready to utilize the program. The packet includes game cards, stories, and puppet plays, as well as all learning center instructional materials (including the step-by-step learning center instructions for the children).

Using a ready-to-use program packet ensures that the hands-on, at-risk teaching methods and the motivational group counseling techniques are used correctly because both techniques are written into the learning center workstation booklets. Therefore, evidence-based programs can be used as intended and the local schools can receive the same evidence-based results as the researcher who developed the program.

Both of these program packets stress erasing reading failure as a means of preventing depressive symptoms, at-risk behaviors, and other mental health concerns. Research shows that improving reading skills does in fact improve mental health and wellness (Maugban et al. 2003). Groups are one of the best preventive techniques in mental health because groups enable children and teens to experience change in a group setting which translates back to the classroom better than one-on-one tutoring (Cleary and Zimmerman 2004).

Benefits of School Mental Health

Program packets reduce preparation time for school personnel conducting the programs. Program packets will enable psychologists to develop evidence-based programs and ensure that the program will be used as intended, thereby allowing evidence-based results from research to benefit a larger number of children and teens at the local school level. Learning centers allow for individualized, self-paced learning so that the needs of all students can be met. Program packets are one method for bridging the gap between research and practice.

Because an evidence-based program packet may not be available for the particular group you are organizing, it may fall upon you to develop your own program packet. This book provides a step-by-step outline for developing group-centered program packets. Throughout each chapter, you will be given a question-response set of worksheets. Starting with Step 2 in this chapter, work through the series of worksheets and follow the steps to organizing an effective group-centered prevention program.

One of the first steps in designing a group-centered program packet is to analyze the group. When we organize a group, we typically organize a group in response to a particular problem. Note the difference between *what* not *who* is the cause of the problem. All too often we identify students as the problem instead of *what* caused students to have a problem.

Step 2: Identify the Problem

What problem would you like to work on or change?

What (not who) is the primary cause of the problem?

Why is there a need for a change? How will a change benefit the group?

Each worksheet will be accompanied by a design example. For each design step presented throughout the book, an example is presented after the worksheet. Examples will help you understand how to use the design worksheet pages and give suggestions for designing your own program. The design examples come from the *Camp Sharigan* week-long motivational group-centered prevention program, but the principles can be applied in any number of different ways.

Step 2, Design Example

Because *Camp Sharigan* is our example, our problem is reading failure or inability to read at grade level. The cause of the problem lies with the methods being used in the classroom to teach reading—notice we did not say the problem is the student or the teacher. The cause of the problem is (1) classroom approach does not allow for individuality and the individual learning needs of at-risk students; (2) reading instruction often is taught too early, many kindergarteners are expected to memorize 50 or 60 words and/or begin reading; (3) only one method is used to teach reading at most schools, if the student cannot learn by the prescribed method, then there is something wrong with the student—not the method; and (4) extrinsic rewards are used to motivate young readers instead of using intrinsic motivation. A change is needed because children are failing, being labeled as slow readers, reading two and three grade levels below their age, and being retained because of failing reading scores. A successful approach to teaching reading will enable all students to be successful academically and thereby happier and better adjusted psychologically.

Correcting At-Risk Problems in the Schools

A well-designed, well-implemented program can make the difference between offering true success or a well-intentioned but ineffective program. If we care about our children and youth, then we owe it to them to change how we teach and provide counseling in the schools because the approach we use in schools today will affect mental health and wellness for the remainder of life.

Real-World Applications

Observational Extensions

Go to the classroom, if possible, and observe the students who you wish to include in your new group.

- How do these students interact with the teacher and with their peers in the classroom?
- What needs do your group members display in the classroom?

- How will you change the learning environment in your new group intervention to enable these students to learn effectively?

Troubleshooting Checklists for Organizing a New Group

1. How will you adjust for diversity among the members of your group?
2. Are there language barriers or cultural differences?
3. Are special needs accommodated?

A Ready-to-Use Group-Centered Intervention: “Captain A and His Hot Air Balloon”

Age level: Kindergarten through 2nd Grade

Learning Objective: To increase word recognition skills for the letter A through hands-on activities.

Counseling Objective: To rebuild self-efficacy by teaching the beginning word decoding skills necessary to learn to read.

Time needed: 2 hours

Tips for Using this Group-Centered Intervention: This group-centered intervention works well with children, kindergarten through second grade, or any at-risk children reading at the first grade level. This is a great hands-on group intervention which helps children who struggle to learn and understand the many phonetic sounds of the letter A. This group-centered intervention illustrates *vowel clustering* (Clanton Harpine 2010b) and how vowel clustering teaches a vowel sound. Please note that we are only including *a* sounds for the letter A with this exercise. AL, AU, AW, and other sounds used by the letter A are not included. We are clustering vowels together by sound, not letter.

How to Expand into a Group-Centered Prevention Program: You can expand this intervention by substituting any vowel sound into the same activity (Captain E, Captain I, etc.) and clustering vowel sounds (Clanton Harpine 2010b). The initial activity takes approximately 2 hours, but can be expanded by repeating the intervention with different vowel clustered sounds into a month-long prevention program stressing vowel sounds. You may keep the hot air balloons posted on the wall or bulletin board for review and as a reminder of how vowel sounds are not always comprised from the same letters or letter combinations. If children meet only once a week, use a different vowel sound each week.

Supplies Needed: construction paper, 1-in. wide colorful paper strips (thin photocopy paper curls easier; pre-cut if desired—10 strips per student), yarn, scissors,

pencils, crayons or markers, hole punch, and a picture of a hot air balloon if desired.

1. Ask children to describe a hot air balloon or show a picture of a hot air balloon to the children. Then, have children draw a large hot air balloon on their paper or have hot air balloon pictures prepared ahead of time [You may make a pattern for younger children to trace or photocopy balloon pictures]. Have each child decorate their hot air balloon.
2. Have children cut a square from brown construction paper to make a basket for their hot air balloon. This is Captain A's balloon. Have children draw a picture of Captain A to place in the basket of their balloon. Punch holes with a hole punch and attach the basket to the balloon with yarn. Make sure the basket dangles and sways back and forth.
3. Explain that a hot air balloon may use sand bags to help it stay anchored on the ground. Explain that, "we're going to make letter strips to help anchor Captain A and his hot air balloon." For very young children, you may want to have the children write or copy only one word on each strip. If your idea is to introduce the sound, then one word is adequate. If you want to increase vocabulary and use of words, then have older children write as many words as possible on their strips. Copying words from the board can be effective if student spelling skills are weak. It is much better to copy a word correctly than to write it incorrectly. Spelling the word correctly is important. The idea is to match words to a letter sound. You will need 10 strips of paper for each student.
4. Start with the *ă* sound, as in *at*. Have the children practice the *ă* sound. Give each child a strip of paper. Say: "Make a letter strip with as many words as possible using the *ă* sound, such as *at*, *bat*, *map*, *fan*, *trap*. Write short *ă* sound at the top of the strip. Then, fill the strip with words." If students are too young to spell, write words on the board and have them copy words as you review each word.
5. Then tell students: "The short *ă* sound can be changed into the long *ā* sound by adding *silent e* to certain words. Make a second sand bag strip changing words from the short *ă* sound to long *ā* sound by simply adding *silent e*. Example: *fat* to *fate*; *fad*, to *fade*; *hat* to *hate*; *rat* to *rate*. Write *silent e* at the top of the strip. Can you think of enough words to fill the entire strip? Never fear, there are many words that use *silent e*. Finish the strip with other words that do not have a short *ă* sound base but simply use the long *ā* sound by adding *silent e*: *cake*, *bake*, *rake*."
6. Give students a third strip of paper, then say: "You can also change short *ă* sound to long *ā* sound with *AI*. The *I* becomes silent. Example: *man* to *main* or *ran* to *rain*. Take a third letter strip. Write *AI* at the top of the strip and see how many *AI* words you can create. Remember, there are also words which use the *AI* sound which do not have a short *ă* sound base but simply use the long *ā* sound. Example: *train*, *grain*, *stain*."

7. On the fourth strip of paper, have students write AY. “When the long \bar{a} sound appears at the end of a word, it is written as AY. The Y is silent, as in the words: bray, day, hay, say. Make a colorful word strip of AY words. Can you fill the entire strip?”
8. Remind students: “We must remember that word sounds can sometimes be tricky. AI and AY do not always have a long \bar{a} sound. For example, the word kayak. The AY uses the *I* sound, so, be careful of tricky words.”
9. Give students a fifth strip and say: “What about EI? Can E and I be combined to form the long \bar{a} sound? Yes, such as with the words: rein, freight, neighbor, reindeer. Take a word strip and see if you can think of more EI words? Be careful, EI can also use the sound for *I*.” (For young children, you may want to spell EI words on the board and have them copy words.)
10. On the sixth strip: “At the end of a word, use the EY combination, as with: obey or they. List as many words as you can remember. EI and EY are tricky. AI, AY, EI and EY can also use other vowel sounds; so, be careful. Sound the words out carefully and listen for that long \bar{a} sound.”
11. On a seventh strip of paper, have students write EA and say: “E and A combine together to use the long \bar{a} sound, as in the word: steak. But you want to watch out for the EA combination, because EA can also use the vowel sound for the letter E, as with: eat. Make a strip of EA words for the long \bar{a} sound. How many can you think of?”
12. Have students make an eighth strip by saying: “EIGH uses the long \bar{a} sound, as in: sleigh. Add the letter T to EIGH and you still have the long \bar{a} sound, as in: eight. Make a word strip for words using the EIGH sound for the long \bar{a} sound. EIGH is tricky too because EIGH can also be used for *I* as with: height. So be careful; words are tricky. Remember to use a dictionary if you need help.”
13. On the ninth strip, have students write: “When A combines with the letter R, the letter R takes control of the word and changes the sound of A, as in *car*. The A is silent; R is the only sound you hear. Try these words: far, large, star, tar. Make a word strip. How many words can you add to your strip?”
14. On the tenth strip, have students write: *air*. “When A and R are combined with a second vowel, such as in *air*, the sound changes again. Try these words: air, bare, care, fair, mare, pair, stairs, stare, wear. Make a word strip for Captain A using the *air* sound.”
15. Each student should have 10 strips of paper. Review strips to make sure everyone understands each sound correctly. Do not glue strips yet. The children will glue each strip to the hot air balloon basket as you read the story, just the top tip of the strip needs to be glued on. Let the strips dangle out of the basket. Instruct the students to “Listen to Captain A’s story and curl the correct strip on a pencil when Captain A calls for each letter to be raised for take-off.” Demonstrate how to curl strips on a pencil. If the students curl the strips tightly, thin strips will stay curled up in the basket at the end of the story as the students launch their balloons. Read the story as children curl and glue each strip in keeping with the story.

Story

Captain A and His Hot Air Balloon

Welcome friends. It's a wonderful day for a ride in my hot air balloon. Usually, I have lots of helpers, but today, I seem to be a bit shorthanded. Perhaps you will help? You see, because I'm Captain A, I have to make sure that I take all of the sounds for the letter A with me wherever I go. So, I have to check each sandbag, letter strip before I launch.

Let's start with the *ă* sound, as in *at*. We all know this sound. We find it in such words as cat, fat, rat, that. Check your letter strips. Find the strip for the short *ă* sound. Check your words, do you have only short *ă* sound words on your strip? Make sure that you have only short *ă* sound words because we do not have room for any extra passengers. If you're set, then take your pencil and curl the short *ă* sound strip tightly around your pencil. Glue just the top of your strip to the basket on your hot air balloon. We're getting ready to go. [Make sure everyone understands and has the task completed before you go to the next sound.]

Next, let's look for words which use the long *ā* sound by adding *silent e*, such as rate, cake, bake. Your letter strip should say *silent e* at the top. *Silent e* always makes the letter A say its name or use the long *ā* sound. Check your words, do you have only long *ā* sound words on your strip? Make sure that you have only long *ā* sound words which use *silent e* because we are going to be tight on space today. If your strip is ready, take your pencil and curl the long *ā* sound words which use *silent e* tightly around your pencil. Glue just the top of your strip to the basket on your hot air balloon. The way we're going we'll be in the air in no time. [Make sure everyone understands and has the task completed before you go to the next sound.]

There are seven different ways to make the long *ā* sound. Adding *silent e* is only one of the ways we have to make words use the long *ā* sound. For our next sandbag, look for the letter strip with AI written at the top. Words such as train and brain use the long *ā* sound with AI. Find the strip for the long *ā* sound with AI. Check your words, do you have only long *ā* sound with AI words on your strip? Make sure that you have only the long *ā* sound with AI words. If so, take your pencil and curl the long *ā* sound with AI strip tightly around your pencil. Glue just the top of your strip to the basket on your hot air balloon. You should now have three sandbag letter strips curled and ready to go. [Make sure everyone understands and has the task completed before you go to the next sound.]

Remember, there are seven different ways to make the long *ā* sound. AI and *silent e* are the first two ways. Now, let's add another way to make the long *ā* sound. Look for a strip marked AY at the top. When Y follows A, the Y is silent. AY is typically used at the end of a word, such as with: day, tray, say. Look for the letter strip with AY written at the top. Check your words, do you have only long *ā* sound with AY words on your strip? Make sure that you have only the long *ā* sound with AY words because we are running out of room and we do not have room for any extra passengers. Take your pencil and curl the long *ā* sound with AY strip tightly around your pencil. Glue just the top of your strip to the basket on your hot air balloon. You

should now have four sandbag letter strips curled and ready to go. [Make sure everyone understands and has the task completed before you go to the next sound.]

We have AI, AY, and *silent e*. We now add: EI? When E and I are combined they can use the long *ā* sound but be careful because EI can also use the long I sound. So check your letter strip carefully. Make sure that you have included only EI words which use the long *ā* sound, such as: rein, feign. Look for the letter strip with EI written at the top. Check your words, do you have only long *ā* sound with EI words on your strip? Make sure that you have only the long *ā* sound with EI words because we are really running out of room. Take your pencil and curl the long *ā* sound with EI strip tightly around your pencil. Glue just the top of your strip to the basket on your hot air balloon. You should now have five sandbag letter strips curled and ready to go. [Make sure everyone understands and has the task completed before you go to the next sound.]

So far, for the long *ā* sound, we have AI, AY, EI, and *silent e*. We now add: EY, as with: obey or they. EI and EY are tricky. EI and EY can also use other vowel sounds. So, be careful. You want to add only EY words which use the long *ā* sound. Once you are certain you have only EY words on your strip, take your pencil and curl the long *ā* sound with EY strip tightly around your pencil. Glue just the top of your strip to the basket on your hot air balloon. You should now have six sandbag letter strips curled and ready to go. [Make sure everyone understands and has the task completed before you go to the next sound.]

For the long *ā* sound, we have AI, AY, EI, EY, and *silent e*. We now add: EA. E and A combine together to use the long *ā* sound, as in the word: steak. Be careful, though, because EA can also use the long E sound. Check your word strip carefully. Make sure that you have only EA words which use the long *ā* sound. Then, take your pencil and curl the long *ā* sound with EA strip tightly around your pencil. Glue just the top of your strip to the basket on your hot air balloon. Squish everyone together because we still have more sounds to come. You should now have seven sandbag letter strips curled and ready to go. [Make sure everyone understands and has the task completed before you go to the next sound.]

There is one more vowel combination which uses the long *ā* sound. It is EIGH, as in: sleigh. Add the letter T to EIGH and you still have the long *ā* sound, as in: eight. Look for the letter strip labeled EIGH. Check your word strip carefully. Make sure that you have only EIGH words which use the long *ā* sound. Then, take your pencil and curl the EIGH strip tightly around your pencil. Glue, just the top, of your strip to the basket on your hot air balloon. Make room; we still have more sounds coming. You should now have eight sandbag letter strips curled and ready to go. [Make sure everyone understands and has the task completed before you go to the next sound.]

Hold on, we're almost ready to launch our balloons. We have two sounds remaining. When A combines with the letter R, the letter R takes control of the word and changes the sound of A, as in *car*. The A is silent; R is the only sound you hear. So, look for the AR letter strip. Make sure that you have only AR words which have the *silent a* sound, as in *car*. There are two sounds with A and R; so be careful. Then, take your pencil and curl the AR strip tightly around your pencil.

Glue just the top of your strip to the basket on your hot air balloon. Leave room for one more strip. You should now have nine sandbag letter strips curled and ready to go. [Make sure everyone understands and has the task completed before you go to the next sound.]

When A and R are combined with a second vowel, such as in *air*, the sound changes again, as in: *air*, *care*, *fair*. Look for the AIR letter strip. Make sure that you have only AR words which combine with a second vowel for the *air* sound, as in *stare*. There are two sounds with A and R; so be careful. Then, take your pencil and curl the AIR strip tightly around your pencil. Glue just the top of your strip to the basket on your hot air balloon. We're finally ready to go.

Lift your balloon slowly off the ground. Hot air balloons never move fast. They are slow and graceful, so lift your balloon up into the air gently. Have a great flight and thanks for flying along with me.

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Clanton Harpine, E.

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