The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to the column editor, Francine Cournos, M.D., at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032.

A Volunteer Community Mental Health Clinic

Psychotherapy is largely unavailable for persons with low or no income. Clinicians have a moral and fiduciary responsibility—not only to the individual or family but also to the general population—to give back, having received a unique and specialized education largely provided by the community at large. The community mental health clinic in Raleigh, North Carolina, is based on clinical and moral principles. Our hypothesis was that a high-quality clinic of volunteer staff offering high-quality psychotherapy to motivated people who cannot afford existing resources could be implemented in an environment free of monetary considerations and constraints. The clinic is beginning its seventh year of operation; data presented here are for the first five years.

We accepted an invitation to use classroom space at the Edenton Street United Methodist Church, which is conveniently and centrally located and is a sponsor of many community service projects. We contacted clinicians and started with word-of-mouth publicity. The clinic is open every Thursday evening. All staff at the clinic are volunteers. One of the authors (CB) provides telephone screening contact, informing callers of the clinic's functions and ground rules. Services are free and are provided only to persons who are unable to pay and lack Medicare, Medicaid, or other insurance. Treatment is provided by a therapist-psychiatrist team and is based on an initial evaluation. Patients are expected to keep their appointments and to be active and committed. Treatment is goal oriented and time limited. Medications are prescribed only in conjunction with active psychotherapy. The clinic cannot respond to crises and does not accept persons who are actively abusing substances or who are psychotic, suicidal, or homicidal, although a number of clients have a history of such behaviors and characteristics.

A volunteer board evolved from an initial steering committee, meeting quarterly and including a representative from the National Alliance for the Mentally Ill, two clergy, an attorney, a representative from the church board, a representative from the free medical clinic, a community advocate, the clinic coordinator, and the medical director.

During the first five years of the clinic's operation, a total of 423 patients were given appointments. For many other patients we serve a triage function, referring them elsewhere because of such problems as active psychosis, desire for medication or evaluation only, lack of motivation, availability of insurance coverage, or active substance abuse. Referrals come from throughout the community, including the local private psychiatric hospital, vocational rehabilitation programs, employee assistance programs, private and public psychiatrists, school counselors, and patient word of mouth. Presenting problems included losses, relationship conflicts, disruptive behavior, anger, anxiety, depression, joblessness, low energy levels, sleep disturbances, and traumatic memories. Diagnostic categories included mood, anxiety, adjustment, posttraumatic stress, and personality disorders, frequently comorbid with one another. Some patients had a history of psychosis, substance abuse, or suicide attempts. At any one time, 30 to 35 active patients were in therapy. The patients received high-quality, timely services, approximately 90 percent with medication, primarily antidepressants and mood stabilizers.

Volunteers currently include four administrative staff, seven psychiatrists, and 14 therapists, who together contribute 20 to 30 hours for 16 to 22 individuals, couples, or families each Thursday. In most cases we can achieve the goal of helping patients become more self-sufficient through the attainment of employment, benefits, or insurance. We can then link them to other community resources in the private or public system.

Supports and links initially included the Urban Ministries of Raleigh, which operates a free medical clinic. We had access to its pharmacy while preserving our self-determination. When this pharmacy service was withdrawn—our first crisis—we contracted with a downtown pharmacy to dispense samples or provide medications at Medicaid prices by drawing on unsolicited donations. This approach worked for two years until the pharmacy board forbade dispensing of samples by retail pharmacies. This was our second crisis and the only time that lack of money became a barrier to some of our services. By obtaining medication samples for the clinic, using pharmaceutical company patient assistance programs, and undertaking limited fundraising, we were able to obtain the needed medications.

In January 2001, Urban Ministries announced that they were discontinuing the organizational connection after our rejection of their plan to integrate our clinic into the medical clinic and to assume administrative and hiring responsibility, which we believed would jeopardize the primary psychotherapeutic purpose. Our board expanded and restructured as an autonomous not-for-profit clinic, still operating at the church with sanction and approval of its board, which has been most supportive and a true partner.

We are reevaluating and planning for the future. The original conceptualization is sound and will be continued. Issues being explored include staff re-

cruitment, future leadership, expansion, development of the clinic as a training site for psychiatry and social work at the University of North Carolina, and any necessary fundraising.

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Positive Schools: An Approach to School Discipline

Student violence, vandalism, harassment, and disruptive classroom behavior are serious problems in our nation's schools. Chronic discipline problems create a threat to the school community, place excessive demands on teachers, and impede academic performance. In addition to reducing challenging behaviors, there is a need to assist at-risk students (secondary prevention) and to stop problems before they occur (primary prevention). A preventive focus is important because persistent maladjustment among school-age children and adolescents is linked to criminal behavior and incarceration in adult life.

Positive Schools is a prevention-focused, whole-school approach designed to promote student achievement by providing training to school personnel on effective instruction and discipline practices. Its primary objectives are to improve students' academic performance, social skills, and attention during instruction; to decrease student discipline referrals, detentions, suspensions, and attrition; and to increase the proficiencies, satisfaction, and retention of school personnel. Doctoral-level psychologists and postdoctoral fellows from Positive Schools deliver consultation through a coordinated system of service delivery. The Positive Schools model has been implemented in K–12 urban, rural, public, private, and charter schools in seven states for the past three years.

Positive Schools requires an average of 25 days of on-site consultation and training as well as external program evaluation, monitoring, and oversight. The program is funded through a variety of federal, state, and local sources, including Title I and Title II accountability funds, an Innovative Education Program Strategies grant (Title VI), the Comprehensive School Reform Demonstration Program, a Safe and Drug-Free Schools and Communities grant, professional development funds, and state school improvement initiatives.

The Positive Schools program first establishes an in-school team that is responsible for the development and implementation of behavior support policies—typically composed of administrators, teachers, and students. The team identifies and selects intervention objectives, such as strengthening instructional methods used by teachers, improving students' social skills, and overcoming specific discipline problems. Next, the existing school discipline program is reviewed to identify procedures that should be retained and those that should be eliminated in favor of more effective strategies. Before new or modified policies are considered, the Positive Schools consultant guides the school team in selecting evaluation measures—for example, academic productivity, attention during instruction, school attendance, detentions, and suspensions. Typically, there is a preintervention phase of evaluation that considers these and similar measures and serves as a benchmark by which to judge intervention efficacy.

The objective of Positive Schools is to establish systems of behavior support that incorporate positively oriented, skills-building, and preventive approaches to discipline. This objective is realized by having students, teachers, and administrators define school "rules" (behavioral expectations), rewarding students' successes through systematic positive reinforcement (prizes in a school lottery, recognition letters, and personal acknowledgments), training teachers to conduct more effective classroom instruction, enhancing students' social skills and problem-solving abilities, and, when necessary, instituting more intensive behavior-support interventions with "high-profile" students.

The effectiveness of Positive Schools is assessed by using multiple sources of data. Results show a substantial reduction in office discipline referrals, with corresponding increases in school attendance and academic achievement. Similar gains have been recorded with significantly fewer suspensions and expulsions. Beyond desirable changes in the classroom, the intervention has succeeded in decreasing disruptive and potentially dangerous behavior on school buses. Finally, teachers and school administrative personnel consistently give positive ratings to the training and consultation they receive.

In contrast with traditional mental health services, the Positive Schools model is implemented "in context" by individuals who are part of the students' daily life. Thus students receive therapeutic and preventive interventions in the same way that they are exposed to academic instruction, namely through daily, systematic, and predictable routines with teachers. We strive to equip school personnel with strategies for implementing positive discipline programs that can be maintained independently of additional consultation. In the future, we hope to address such research questions as the persistence of behavior change over time (for example, multiple school years), efficacy with the most at-risk students, and potential cost savings to school districts through the adoption of prevention strategies.

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