

The Recreation Mentoring Program: A Community Engagement Initiative for Children

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Abstract

Introduction: Approximately one in five Ontario children show symptoms of significant mental health problems. These children exhibit impairments at home, at school and in the community, often with long-lasting effects. Involvement in structured community-based recreation programs may be protective for these children; however, they often encounter multiple barriers to participation (e.g., facility fees, lack of family or peer support, and reluctance to try new activities). **Method:** The Recreation Mentoring Program is a community-wide program that reduces barriers to participation while providing an important relationship with a caring, young adult mentor. Trained volunteer mentors are matched with at-risk children, and meet regularly at a community recreation centre near the child's residence. The mentor's role is to: 1) stimulate participation in recreational programs, and 2) promote the child's continued participation after the mentorship ends. **Results:** Limited program evaluation suggests that the Recreation Mentoring Program engages at-risk children in community-based recreation, that it is operationally feasible, and that it produces high levels of client satisfaction. **Conclusion:** The Recreation Mentoring Program holds promise as an effective community-based intervention for children with mental health problems.

Key words: recreation, mentoring, children, prevention, mental health

Résumé

Introduction: En Ontario environ un enfant sur cinq souffre de graves problèmes de santé mentale. Ces enfants sont handicapés chez eux, à l'école et dans la communauté, et souvent pour longtemps. Participer à des programmes de loisirs communautaires structurés peut aider ces enfants. Toutefois, ils se heurtent souvent à de nombreux obstacles (frais de participation, manque d'appui de la famille ou des pairs, réticence à essayer de nouvelles activités etc.). **Méthode:** Le programme de loisirs avec mentor est un programme communautaire destiné à encourager la participation des enfants tout en leur offrant une relation significative avec un jeune adulte attentionné qui leur sert de mentor. Ces mentors bénévoles, spécialement formés, sont appariés à des enfants à risques qu'ils rencontrent régulièrement dans un centre communautaire de loisirs près du domicile de l'enfant. Le rôle du mentor consiste à encourager la participation aux programmes de loisirs et inciter l'enfant à continuer à y participer, une fois que le mentorat se termine. **Résultats:** Bien que limitée, l'évaluation du programme permet de conclure que le programme de loisirs avec mentor incite les enfants à participer à des activités communautaires, que le programme est facile à gérer et qu'il apporte beaucoup de satisfaction aux enfants. **Conclusion:** Le programme de loisirs avec mentor est un outil communautaire efficace pour les enfants souffrant de problèmes mentaux.

Mots-clés: loisirs, mentorat, enfants, prévention, santé mentale

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Background

The Ontario Child Health Study (Offord et al. 1987), a landmark study of children's mental health, found that approximately 18% of children in a community sample showed emotional-behavioural problems of sufficient severity to qualify for at least one psychiatric disorder. Other well-conducted community surveys find similar high rates of childhood psychiatric disorders (e.g., Offord & Lipman 1996, Breton et al. 1999, Costello 1989, U.S. Public Health Service 2000, Costello et al. 2005).

Children identified by these surveys commonly show concurrent impairments in family,

social, academic and community functioning. They have fewer pro-social supports and often show decreased engagement in school and community activities that might ameliorate their problems (Offord et al. 1992, Loeber et al. 1993, Beidel, 2001, Waddell et al. 2001, Heinze et al. 2004). Moreover, childhood mental health problems can herald problems in adulthood. For example, the U.S. Public Health Service (2000) found that 74% of young adults with mental health problems also had problems as children. Links with adult joblessness, substance abuse and criminality have long been identified (Kazdin 1992, Reid 1993). In a

recent review, Costello and colleagues (2005) concluded "There is mounting evidence that many, if not most, lifetime psychiatric disorders will first appear in childhood or adolescence." (p. 972). In summary, childhood mental health problems have high prevalence rates, and are often associated with serious, concurrent, and long-lasting impairments. The impact extends well beyond the affected children and their families, to include our schools, our communities and the quality of our shared future.

Community-Based Response

Recognizing the insufficiency of clinic-based, case-by-case service to address problems on this scale, Offord and colleagues (1987) argued "A major goal should be the development of effective interventions that can be launched for groups of children, for example, on a school-wide or community-wide basis, which we believe will reduce the incidence of these disorders..." (p. 836). Supervised, community-based recreation programs offer one means of achieving this goal. Recreation programs can help children to acquire special skills, to forge friendships, to learn to "get along" with others and to participate constructively in their community. Evidence suggests these skills and capacities are important protective factors that reduce risk for childhood mental health problems (Rae-Grant et.al. 1989). Recreational involvement is also developmentally appropriate, inherently rewarding, normalizing and non-stigmatizing. Jones and Offord (1989) showed that involving at-risk children in community-wide, supervised recreation programs was associated with a decrease in anti-social behaviour (e.g., vandalism and false fire calls) in the subsidized housing project where they lived. These authors suggest that participants developed a more positive attitude toward their community, resulting in a reduced tendency toward anti-social behaviour.

Recreational programs hold promise, but children with mental health problems (like other disadvantaged children) tend to be under-involved (Offord et.al. 1998). Many face barriers to participation that are not encountered by "mainstream" children. Barriers may include low self-esteem, specific behavioural challenges, a reluctance to explore new activities and settings, below-average competence and

skill, and a lack of parental and peer support to participate in recreation. Systemic barriers include cost, transportation, and the tendency of some recreation programs to "screen out" children who show emotional-behavioural problems or below-average skills. Such barriers exclude at-risk children from one of the few resources available in most urban communities shown to improve their outcome.

The Recreation Mentoring Program

The Recreation Mentoring Program (RMP) targets children showing moderate emotional-behavioural difficulties, typical of referrals to children's mental health services. The primary objectives of the RMP are to increase involvement in community-based recreation programs, to teach recreational skills and to enable longer-term participation. By relying heavily upon existing community programs, the RMP can be offered on a community-wide basis at low cost.

Program Model

The RMP evolved in partnership with several agencies in Hamilton Ontario, principally, McMaster Children's Hospital (MCH), Big Brothers Big Sisters of Hamilton and Burlington (BBBS), the Hamilton YWCA and YMCA, the Hamilton East Kiwanis Boys and Girls Club, the city of Hamilton Department of Culture and Recreation, the Hamilton-Wentworth District School Board, and the Hamilton-Wentworth Catholic District School Board. The program has operated since 1996, and currently serves 40-50 children annually.

The RMP recruits young adult volunteer mentors, of whom most are senior secondary-level or first-year post-secondary students. Each volunteer receives a screening interview (by BBBS); in addition, a police record check and satisfactory references are mandatory. Successful volunteers receive a two-hour training session, which orients them to the program and their obligations. They learn the characteristics of good mentors and basic child management strategies (e.g., "Getting to Know You" games, redirection strategies, limit-setting and time-outs, rewarding positive participation, and active listening). They are also familiarized with child safety principles, and their obligation to report suspicions that a particular child may have been abused. Volunteers are then

matched on a 1:1 basis with a referred child (the "mentee"), aged 6-12.

Mentees are referred by a (mental) health professional, school personnel or child-welfare worker, who remains involved as a "backup", should the child require additional intervention during the mentorship (e.g. the child experiences a family crisis). Mentees comprise a mixed population of children who exhibit mental health problems, and who are under-involved in community recreational activities. Most receive concurrent service from a children's mental health service, or similar agency. Because the volunteer mentors usually lack experience managing high-risk behaviours, children who demonstrate frequent violence, running away or suicidality are excluded.

Parents/caregivers and mentees must attend an orientation session, where the program is discussed, and the value of recreation is emphasized. Parents are discouraged from making their child's participation in the RMP contingent on good behaviour at home or school. Parents must also arrange their child's transportation to and from the recreation centre. If transportation is a significant barrier, other arrangements are made (e.g. involving extended family members or, in rare cases, providing free bus tickets through RMP operating funds).

The mentor and mentee meet for about 90 minutes weekly, for 20 weeks, at a recreation center (preferably one near the mentee's residence). They participate in programs offered regularly at the facility and which interest the child. Activities that involve same-aged peers and offer the possibility of longer-term supervised participation are especially encouraged (e.g. karate, swimming, dance, gymnastics, court games). The mentor's role is to motivate the mentee to attend, to boost self-esteem, to participate with the mentee in recreational programs, and to encourage continued participation after the mentorship ends.

Financial subsidies are arranged when needed, usually through the recreation centres partnering in this project. Occasionally, a membership subsidy is provided through the RMP operating budget.

Small Group Alternative

The RMP is also offered twice yearly in a

12-week small group format, for children requiring social skills training, or supervision by a more highly-trained adult. Small groups have 6-10 participants, led by experienced staff with a diploma in Child and Youth Work (or similar qualification), assisted by two or three college students on field placement. The specific activities offered are gymnastics and swimming, but the most important component of the program is the interpersonal skills learned during these activities (e.g. following group norms, demonstrating respect, participating in group decision-making, and compromising). At the conclusion of the program, group leaders meet each mentee at a recreation centre close to their home, to arrange enrolment in a program of interest.

Roles of the Primary Partners

RMP staff at MCH assume the overall program coordination responsibility, overseeing referrals of the mentees, liaising among RMP partners, and maintaining brief (approximately bi-weekly) telephone or email contact with the mentors. BBBS assumes responsibility for screening and supervising the mentors, and ensuring their adherence to agency standards of conduct. Our local school boards enable us to recruit mentors at their secondary schools, and act as the referral source for some of the mentees. Local recreation centres provide facilities and space, and often provide financial subsidies when warranted. Parents understand that they have a special responsibility to encourage consistent attendance, and to support continued participation after the mentorship ends. Finally, the mentors' responsibility is to meet consistently with their mentees, to stimulate and facilitate participation, and to have fun.

Costs

Costs relating to the above roles are largely supported through in-kind contributions by partner agencies. The only directly-funded hours (a Child and Youth Work position at 650 hr/yr) relate to program coordination, and include the leadership of the small group program. Based on annual service activity of 25 one-to-one matches and two small groups (n = 7 per group), mentees receive a total of approximately 1250 hrs. of direct service,

mentors approximately 750 hrs. of supervised volunteer experience, and CYW students 72 hrs. (each) of directly-supervised group experience. Thus, the RMP generates over 2000 service hours annually- a very significant return from an investment of only 650 directly-funded hours.

Evaluation of The RMP

During its early development, the RMP was funded by several community-development grants, which allowed for only a limited program evaluation. Evaluation focused on questions of feasibility rather than effectiveness, for example: 1) Can the necessary community partnerships be created and sustained?, 2) Can sufficient numbers of mentors and mentees be recruited?, 3) Will mentors and mentees complete the program?, 4) Will mentees adhere to behaviour codes?, and 5) Does the program have potential for significant growth while containing costs?

The simple answer to all these questions has been an unqualified "yes". Beginning as a small pilot project developed by MCH and BBBS, our partners now include approximately 25 recreation centres, our two local school boards and two private schools. Mentor recruitment, though challenging at first, became significantly easier as the program grew and became more widely known. Mentees rarely fail to complete the program, and there have been only two reports of behavioural problems during recreational activities. Apart from the anticipated "growing pains", we have encountered remarkably few problems over the history of this program.

Though we have not had dedicated research funding, we have attempted to measure outcomes of the 1:1 and small group program using client-completed standardized measures at three intervals: pre-participation, post-participation, and at two-month follow-up. Using recreational participation scales from the Ontario Child Health Study (revised) (Offord et.al., www.offordcentre.com), pre-participation vs. post-participation comparisons suggest mentees increase their participation in instructed recreational programs (e.g., lessons in swimming, gymnastics, karate), arts programs, clubs and "hobbies". Data from the Brief Child and Family Phone Interview

(Cunningham & Pettingill, www.bcfpi.com), a parent-completed, standardized measure of the six most prevalent children's mental health problems, suggest improvement in emotional-behavioural functioning at program completion, but results at the two-month follow-up are mixed. Program satisfaction ratings by parents and mentees (eight questions rated on a five-point Likert scale) averaged 4.4 out of 5.0. Two important caveats apply. First, lacking a comparison group, one cannot attribute differences at follow-up to participation in the RMP. Second, even though well over 90% of mentees complete their program, returns on the two-month follow-up questionnaires are below 50%, raising the possibility of sample bias.

In summary, the feasibility of the RMP as a community-wide intervention for children with mental health problems is clearly demonstrated. Data pertaining to program effectiveness are encouraging, but insufficient to support any conclusions. Our pilot studies have highlighted issues to be addressed for an improved evaluation of effectiveness of the 1:1 and small group program. Direct interviews of parents and children would likely decrease sample loss, and could add qualitative in addition to quantitative data. A wait-list control with delayed treatment offers a stronger research design, with the proviso that data for both groups should be collected at the same times of the year to control for seasonal fluctuations in recreational participation. A randomized-controlled-trial might offer the RMP to the treatment group, and a subsidized recreation membership (but no mentor) to the control group. A comprehensive study should also examine the benefits to partner agencies, and to mentors, who often comment that mentoring has enriched their lives.

Conclusions and Future Directions

The RMP is an intervention that can be mounted on a community-wide basis at low cost. Though we have examined only short-term effects, the RMP may stimulate long-term change in the lives of children with mental health problems. It appears to confer significant benefits to mentors, and is a resource for practical training of post-secondary students in the field of children's services (e.g. Child and Youth Work, Social Service Work, and

Recreational Leadership). The RMP has proven to be an excellent platform for inter-agency collaboration, where "everybody wins".

Two important objectives lie ahead. First, an improved evaluation of the program is needed, focusing on three questions: 1) does this program result in ongoing increased participation in recreational activity?, 2) does participation in the RMP reduce the risk for, or the severity of, childhood mental health problems?, and 3) over what time period can these effects be detected? Second, the RMP was designed as a "portable" intervention, which could be implemented in most urban communities. A future aim is to consolidate the program's operating procedures, implementation strategies, training manuals and publicity materials in a form that can be "exported" and tested in other communities.

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