From the Center's Clearinghouse ...*

A Technical Aid Packet on

School-Based Client Consultation, Referral, and Management of Care

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School-Based Client Consultation, Referral, and Management of Care

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I. Connecting Students with the Right Help

It is easy to fall into the trap of thinking that interventions to address barriers to student learning and enhance healthy development should always be directed at the individual. This happens because problem definitions tend to be formulated in person-centered terms and because person-centered models of cause and correction dominate professional thinking. Consequently, most of what is written about such problems emphasizes person-focused intervention.

Focusing only on individuals tends to limit assumptions about what is wrong and what needs to change. Adopting a broader, transactional perspective of barriers to student learning suggests that intervention often should be directed at changing environments and programs as a necessary and sometimes sufficient step in working in the best interests of a youngster.

In the following work, we assume the first question that a professional asks should **not** be *What's wrong with this person?*

The first question should be

*What's making this person function like this?*

The answer may be that something's wrong with the way the person's environment is functioning, and therefore, it is the environment that really should be changed -- if feasible.

Of course, whether or not the problem resides with the environment, the person may require some special assistance.

The focus of this *technical aid packet* is on decisions about what assistance is needed, how serious the need is, where a student/family should go to get it, and how to ensure it is provided in coordinated and integrated ways.
A. Facets of Connecting a Student with the Right Help

School staff identify many mental health problems each day. Some students are best served by helping to ensure that appropriate pre-referral interventions are implemented; others require referrals. The process of connecting the student with appropriate help can be viewed as encompassing four facets: (1) screening/assessment, (2) client consultation and referral, (3) triage, and (4) monitoring/managing care. The following brief comments provides a bit more information about such matters.

Screening to Clarify Need

Most of the time it will not be immediately evident what the source of a student’s problems are or how severe or pervasive they are. As you know, the causes of behavior, learning, and emotional problems are hard to analyze. What look like a learning disability or an attentional problem may be emotionally-based; behavior problems and hyperactivity often arise in reaction to learning difficulties; problems with schooling may be due to problems at home, reactions to traumatic events, substance abuse, and so forth. It is especially hard to know the underlying cause of a problem at school when a student is unmotivated to learn and perform.

This, then, becomes the focus of initial assessment – which essentially is a screening process. Such screening can be used to clarify and validate the nature, extent, and severity of a problem. It also can determine the student’s motivation for working on the problem. If the problem involves significant others, such as family members, this also can be explored to determine the need for and feasibility of parental and family counseling.

In pursuing screening/assessment and diagnosis, the following points should be considered:

• When someone raises concerns about a student with you, one of the best tools you can have is a structured referral form for them to fill out. This encourages the referrer to provide you with some detailed information about the nature and scope of the problem. An example of such a form is provided at the end of this section.

• To expand your analysis of the problem, you will want to gather other available information. It is good practice to gather information from several sources – including the student. Useful sources are teachers, administrators, parents, home visit also may be of use. You will find some helpful tools in the accompanying materials.
• And you can do a screening interview. The nature of this interview will vary depending on the age of the student and whether concerns raised are general ones about misbehavior and poor school performance or specific concerns about lack of attention, overactivity, major learning problems, suicidal, or about physical, sexual, or substance abuse. To balance the picture, it is important to look for assets as well as weaknesses. (In this regard, because some students are reluctant to talk about their problems, it is useful to think about the matter of talking with and listening to students - see I B).

• In doing all this you will want to try to clarify the role of environmental factors in contributing to the student’s problems.

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**Screening: A Note of Caution**

Formal screening to identify students who have problems or who are "at risk" is accomplished through individual or group procedures. Most such procedures are first-level screens and are expected to over identify problems. That is, they identify many students who do not really have significant problems (false positive errors). This certainly is the case for screens used with infants and primary grade children, but false positives are not uncommon when adolescents are screened. Errors are supposed to be detected by follow-up assessments.

Because of the frequency of false positive errors, serious concerns arise when screening data are used to diagnose students and prescribe remediation and special treatment. Screening data primarily are meant to sensitize responsible professionals. No one wants to ignore indicators of significant problems. At the same time, there is a need to guard against tendencies to see normal variations in student's development and behavior as problems.

Screens do not allow for definitive statements about a student's problems and need. At best, most screening procedures provide a preliminary indication that something may be wrong. In considering formal diagnosis and prescriptions for how to correct the problem, one needs data from assessment procedures that have greater validity.

It is essential to remember that many factors found to be symptoms of problems also are common characteristics of young people, especially in adolescence. Cultural differences also can be misinterpreted as symptoms. To avoid misidentification that can inappropriately stigmatize a youngster, all screeners must take care not to overestimate the significance of a few indicators and must be sensitive to developmental, cultural, and other common individual differences.
Remember:

- Students often somaticize stress; and, of course, some behavioral and emotional symptoms stem from physical problems.
- Just because the student is having problems doesn’t mean that the student has a pathological disorder.
- The student may just be a bit immature or exhibiting behavior that is fairly common at a particular development stage. Moreover, age, severity, pervasiveness, and chronicity are important considerations in diagnosis of mental health and psychosocial problems. The following are a few examples to underscore these points.

<table>
<thead>
<tr>
<th>Common Transient Problem</th>
<th>Low Frequency Serious Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>0-3</td>
<td>Concern about monsters under the bed</td>
</tr>
<tr>
<td>3-5</td>
<td>Anxious about separating from parent</td>
</tr>
<tr>
<td>5-8</td>
<td>Shy and anxious with peers (Sometimes with somatic complaints)</td>
</tr>
<tr>
<td></td>
<td>Disobedient, temper outbursts</td>
</tr>
<tr>
<td></td>
<td>Very active and doesn’t follow directions</td>
</tr>
<tr>
<td></td>
<td>Has trouble learning at school</td>
</tr>
<tr>
<td>8-12</td>
<td>Low self-esteem</td>
</tr>
<tr>
<td>12-15</td>
<td>Defiant/reactive</td>
</tr>
<tr>
<td></td>
<td>Worries a lot</td>
</tr>
<tr>
<td>15-18</td>
<td>Experimental substance use</td>
</tr>
</tbody>
</table>

Note: The source of the problem may be stressors in the classroom, home, and/or neighborhood. (Has the student’s environment seriously been looked at as the possible culprit?)

Note: At this stage, assessment is really a screening process such as you do when you use an eye chart to screen for potential vision problems. If the screening suggests the need, the next step is referral to someone who can do in depth assessment to determine whether the problem is diagnosable for special education and perhaps as a mental disorder. To be of value, such an assessment should lead to some form of prescribed treatment, either at the school or in the community. In many cases, ongoing support will be indicated, and hopefully the school can play a meaningful role in this regard.
Family Consultation and Referral

When someone becomes concerned about a student's problems, one of the most important roles to play is assisting the individual in connecting directly with someone who can help. This involves more than referring the student or parents to a resource. The process is one of turning referral procedures into an effective intervention in and of itself.

Minimally, such an intervention encompasses consultation with the concerned parties, assisting them by detailing the steps involved in connecting with potential referral resources, and following-up to be certain of follow-through. It may also include cultivating referral resources so that you can maximize their responsiveness to your referrals.

Using all the information you have gathered, it is time to sit down with those concerned (student, family, other school staff) and explore what seems to be wrong and what to do about it.

Such consultation sessions are part of a shared problem solving process during which you provide support by assisting the involved parties in

• analyzing the problem (Are environmental factors a concern? Are there concerns about underlying disorders?)

• laying out alternatives (clarifying options/what's available)

• deciding on a course of action (evaluating costs vs. benefits of various alternatives for meeting needs)

Finally, it is essential to work out a sound plan for ensuring there is follow-through on decisions.

Because some facets of client consultation and referral may be new to you, a few more comments may be helpful here.

Referrals are relatively easy to make; appropriate referrals are harder; and ensuring follow-through is the most difficult thing of all. Appropriate referrals are made through a consultation process that is consumer oriented and user friendly. They also are designed as a transition-type intervention; that is, recognizing that many students/families are reluctant to follow-through on a referral, they include procedures that support follow-through.

A consumer oriented system is designed with full appreciation of the nature and scope of student problems as perceived by students, their families, and their teachers. Such problems range from minor ones that can be dealt with by providing direct information, perhaps accompanied by some instruction to severe/pervasive/chronic conditions that require intensive intervention.
The process must not ignore the social bases of a student's problems. This means attending to environmental concerns such as basic housing and daily survival needs, family and peer relations, and school experiences. A student's needs may range from accessing adequate clothes to acquiring protection from the harassment of gang members. In many instances, the need is not for a referral but for mobilizing the school staff to address how they might improve its programs to expand students' opportunities in ways that increase expectations about a positive future and thereby counter prevailing student frustration, unhappiness, apathy, and hopelessness.

A consumer oriented system should minimally

- provide readily accessible basic information about relevant resources
- help students/families appreciate the need for and value of a potential resource
- account for problems of access (e.g., cost, location, language and cultural sensitivity)
- aid students/families in reviewing their options and making decisions in their own best interests
- provide sufficient support and guidance to enable students/families to connect with a referral resource
- follow-up with students/families (and referrers) to determine whether referral decisions were appropriate.

Thinking in terms of intervention steps, a good consultation and referral process helps you do the following:

1) **Provide ways for students/families and school personnel to learn about existing resources**
   
   This entails widespread circulation of general information about on- and off-campus programs and services and ways to readily access such resources.

2) **Establish whether a referral is necessary**
   
   This requires an analysis of whether current resources can be modified to address the need.

3) **Identify potential referral options with the student/family**
   
   Review with the student/family how referral options can assist. A resource file and handouts can be developed to aid in identifying and providing information about appropriate services and programs -- on and off-campus -- for specific types of concerns (e.g., individual/group/family/professional or peer counseling for psychological, drug and alcohol problems, hospitalization for suicide prevention). Remember that many students benefit from group counseling. And, if a student's problems are based mainly in the home, one or both parents may need counseling -- with or without the student's involvement as appropriate. Of course, if the parents won't pursue counseling for themselves, the student may need help to cope with and minimize the impact of the negative home situation. Examples of materials
that can provide students, families, and staff with ready references to key resources are provided by the accompanying Resource Aids.

(4) **Analyze options with student/family and help with decision-making as to which are the most appropriate resources**

This involves evaluating the pros and cons of potential options (including location, fees, least restrictive and intrusive intervention needed) and, if more than one option emerges as promising, rank ordering them. For example, because students often are reluctant to follow-through with off-campus referrals, first consideration may be given to those on-campus, then to off-campus district programs, and finally to those offered by community agencies. Off-campus referrals are made with due recognition of school district policies.

(5) **Identify and explore with the student/family all factors that might be potential barriers to pursuing the most appropriate option**

Is there a financial problem? a transportation problem? a problem about parental consent? too much anxiety/fear/apathy? At this point, it is wise to be certain that the student (and where appropriate the family) truly feels an intervention will be a good way to meet her or his needs.

(6) **Work on strategies for dealing with barriers to follow-through**

This often overlooked step is essential to follow-through. It entails taking the time to clarify specific ways to deal with apparent barriers.

(7) **Send the student/family off with a written summary of what was decided including follow-through strategies**

A referral decision form can summarize (a) specific directions about enrolling in the first choice resource, (b) how to deal with problems that might interfere with successful enrollment, and (c) what to do if the first choice doesn't work out. A copy of a referral decision form can be given to the student/family as a reminder of decisions made; the original can be kept on file for purposes of case monitoring. Before a student leaves, it is essential to evaluate the likelihood of follow-through. (Does s/he have a sound plan for how to get from here to there?) If the likelihood is low, the above tasks bear repeating.

(8) **Also send them off with a follow-through status report form**

Such a form is intended to let the school know whether the referral worked out, and if not, whether additional help is called for in connecting the student/family to needed resources. Also, remember that teachers and other school staff who asked you to see a student will want to know that something was done. Without violating any confidentiality considerations, you can and should send them a quick response reassuring them that the process is proceeding.

(9) **Follow-through with student/family and other concerned parties to determine current status of needs and whether previous decision were appropriate**

This requires establishing a reminder (tickler) system so that a follow-up is made after an appropriate period of time.
Obviously, the above steps may require more than one session with a student/family and may have to be repeated if there is a problem with follow-through. In many cases, one must take specific steps to help with follow through, such as making direct connections (e.g., by phone) to the intake coordinator for a program. Extreme cases may require extreme measures such as arranging for transportation or for someone to actually go along to facilitate enrollment.

It is wise to do an immediate check on follow-through (e.g., within 1-2 weeks) to see if the student did connect with the referral. If the student hasn't, the contact can be used to find out what needs to be done next.

Increasingly, as a way to minimize the flood of referrals from teachers, what are called prerereferral interventions are being stressed. These represent efforts to help students whose problems are not too severe by improving how teachers, peers, and families provide support. A particular emphasis in enhancing prerereferral efforts is on providing staff support and consultation to help teachers and other staff learn new ways to work with students who manifest "garden variety" behavior, learning, and emotional problems. Over time, such a staff development emphasis can evolve into broader stakeholder development, in which all certificated and classified staff, family members, volunteers, and peer helpers are taught additional strategies for working with those who manifest problems.

**Triage**

Problems that are mild to moderate often can be addressed through participation in programs that do not require special referral for admission. Examples are regular curriculum programs designed to foster positive mental health and socio-emotional functioning; social, recreational, and other enrichment activities; and self-help and mutual support programs. Because anyone can apply directly, such interventions can be described as open-enrollment programs.

Given there are never enough resources to serve those with severe problems, it is inevitable that the processing of such students will involve a form of triage (or gatekeeping) at some point.

When referrals are made to on-site resources, it falls to the school to decide which cases need immediate attention and which can be put on a waiting list. Working alone or on a team, school nurses can play a key role in making this determination.

**Monitoring/Managing Care**

As indicated, it is wise to do an immediate check on follow-through (e.g., within 1-2 weeks) to see if the student did connect with the referral. Besides checking with the student/family, it is also a good idea to get a report on follow-through from those to whom referrals are made.

If there has been no follow-through, the contact can be used to clarify next steps. If there has been follow-through, the contact can be used to evaluate whether the resource is meeting the need. The opportunity also can be used to determine if there is a need for communication and coordination with others who are involved with the student’s welfare. This is the essence of case management which encompasses a constant focus to evaluate the appropriateness and effectiveness of the interventions.
Follow-up checks are indicated periodically. If the findings indicate the student did not successfully enroll or stay in a program or is not doing well, another consultation session can be scheduled to determine next steps.

Remember that from the time a student is first identified as having a problem, there is a need for someone to monitor/manage the case. Monitoring continues until the student's service needs are addressed. Monitoring takes the form of case management to ensure coordination with the efforts of others who are involved (e.g., other services and programs including the efforts of the classroom teacher and those at home). The process encompasses a constant focus to evaluate the appropriateness and effectiveness of the various efforts.

Systems of Care -- Prevention, Early Intervention, and Treatment

The concept of a "system of care" is an evolving idea that is applied in a variety of ways. While management of care is focused on a given client, the concept of systems of care emphasizes the importance of coordinating, integrating, and enhancing systems and resources to ensure that appropriate programs are available, accessible, and adaptable to the needs of the many clients who need help. Moreover, the aim is to ensure these resources are used effectively and efficiently.

A focus on system resources requires attending to various arenas and levels of potential support. A school has many programs and services that it owns and operates. A school district has additional resources. The surrounding community usually has public and private sector programs and a variety of other resources that may be of assistance. City, county, and state agencies also play a role in addressing certain needs.

In its initial application, the concept of systems of care focused on services to address clients with severe and well-established problems (e.g., youngsters with serious emotional disturbance). The intent of systems of care for such populations is to

- develop and provide a full array of community-based programs (including residential and non-residential alternatives to traditional inpatient and outpatient programs) to enhance what is available and reduce overreliance on out-of-home placements and overly restrictive treatment environments;
- increase interagency collaboration in planning, developing, and carrying out programs to enhance efficacy and reduce costly redundancy;
- establish ways that interventions can be effectively adapted to the individuals served.

To expand these goals to encompass prevention, there are increasing calls for incorporating primary and secondary prevention programs into all systems of care. We think in terms of three overlapping systems that encompass a continuum of caring: systems of prevention, systems of early intervention, and systems of treatment. The comprehensive nature of such a continuum requires concerted efforts to coordinate interventions at any given time as well as over the span of time (sometimes for many years) that students and their families are being assisted.
B. Developing Systems at a School for Problem Identification, Triage, Referral, and Management of Care

In responding to the mental health and psychosocial concerns of students, school staff make a variety of decisions. This figure and the outline on the following page highlight matters to be considered as a school develops its systems for problem identification, triage, referral, and management of care.

**Initial Problem Identification**

Is there enough available information to understand the problem? If not, you need to decide whether to gather additional data or make a referral for assessment.

**Initial Management of Care**

- **Screening/Assessment** (as appropriate)
- **Client Consultation and Referral**

**Note:** Some forms of screening do not require parental consent; most referrals do.

**Note:** Problems that are mild often can be addressed through participation in open-enrollment programs that do not require special referral and triage for admission.

**Ongoing monitoring**

- **Direct Instruction**
- **Psychosocial Guidance & Support**
- **Psychosocial Counseling**

**Open-Enrollment Programs** (e.g., social, recreational, and other enrichment programs; self-help and mutual support programs)

**Highly Specialized Interventions for Severe Problems** (e.g., special educ.)
C. Responding to Referrals in Ways that Can "Stem the Tide"

A supportive school has taken steps to welcome and provide social supports, to ensure that students have made a good adjustment to school, and to address initial adjustment problems as they arise.

When these prevention steps aren’t sufficient, school staff initiate the referrals for students who are manifesting behavior, learning, and emotional problems.

And these referrals bring with them a need to take steps to "stem the tide" through further enhancement of what takes place in the classroom and at school to prevent and address problems as soon as they arise.

If your school staff has developed a good referral system, it is essential to take steps to counter the "field of dreams" effect. (*Build it and they will come.*)

The key here is for the school team that processes referrals to do three things as they review each student:

• Determine the best course of action for helping the student
• Analyze the problem with a view to ways the classroom and school might change in order to minimize the need for similar referrals in the future
• Take steps to assist in implementing classroom and school changes that can prevent problems.

Doing all this requires staff development for the case review team, teachers, and other school staff. Student support staff need to play a major role in such staff development.

Improving the Referral System

Referral systems need to be designed in ways that stress the analysis of why problems are arising and not just to assess and funnel youngsters to services. And when services are needed, the referral must be designed as a transition intervention to ensure necessary services are appropriately accessed.

The following is a staff development tool for improving the system. Highlighted below are matters to be considered as a school develops its systems for problem identification, triage, referral, and management of care.

**Problem identification**

a. Problems may be identified by anyone (staff, parent, student).
b. There should be an Identification Form that anyone can access and fill out.
c. There must be an easily accessible place for people to turn in forms.
d. All stakeholders must be informed regarding the availability of forms, where to turn them in, and what will happen after they do so.

**Triage processing**

a. Each day the submitted forms must be reviewed, sorted, and directed to appropriate resources by a designated and trained triage processor. Several individuals can share this task; for example, different persons can do it on a specific day or for specified weeks.
b. After the sorting is done, the triage processor should send a Status Information Form to the person who identified the problem (assuming it was not a self-referral).
**Clients directed to resources or for further problem analysis and recommendations**

a. For basic necessities of daily living (e.g., food, clothing, etc.), the triage processor should provide information about resources either through the person who identified the problem or directly to the student/family in need.

b. If the problem requires a few sessions of immediate counseling to help a student/family through a crisis, the triage processor should send the form to the person who makes assignments to on-site counselors.

c. The forms for all others are directed to a small triage "team" (1-3 trained professionals) for further analysis and recommendations. (If there is a large case load, several teams might be put into operation.) Members of such a team may not have to meet on all cases; some could be reviewed independently with recommendations made and passed on the next reviewer for validation. In complex situations, however, not only might a team meeting be indicated, it may be necessary to gather more information from involved parties (e.g., teacher, parent, student).

**Interventions to ensure recommendations and referrals are pursued appropriately**

a. In many instances, prereferral interventions should be recommended. Some of these will reflect an analysis that suggests that the student's problem is really a system problem – the problem is more a function of the teacher or other environment factors. Other will reflect specific strategies that can address the students problem without referral for outside the class assistance. Such analyses indicate ways in which a site must be equipped to implement and monitor the impact of prereferral recommendations.

b. When students/families need referral for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Care management should be designed to determine follow-through, coordination, impact, and possible need for additional referrals.

c. Referrals to assess the need for special or compensatory education often are delayed because of a waiting list. Back logs should be monitored and arrangements made to catch-up (e.g., by organizing enough released time to do the assessments and reviews).

**Management of care (case monitoring and management)**

a. Some situations require only a limited form of monitoring (e.g., to ensure follow-through). A system must be developed for assigning care monitors as needed. Aides and paraprofessionals often can be trained to for this function.

b. Other situations require intensive management by specially trained professionals to (a) ensure interventions are coordinated/integrated and appropriate, (b) continue problem analysis and determine whether appropriate progress is made, (c) determine whether additional assistance is needed, and so forth. There are many models for intensive management of care. For example, one common approach is to assign the responsibility to the professional who has the greatest involvement (or best relationship) with the student/family.

c. One key and often neglected function of the care manager is to provide appropriate status updates to all parties who should be kept informed.
D. A Resource-Oriented Team

At school sites, one mechanism for focusing on enhancing the work is a resource-oriented team (e.g., a Learning Supports Resource Team). Such a team is designed to bring together representatives from all major programs and services addressing barriers to learning and promoting healthy development (e.g., pupils services personnel, a site administrator, special education staff, bilingual coordinators, health educators, noncredentialed staff, parents, older students). It also includes representatives from community agencies that are significantly involved at a school.

A Resource Team differs from teams created to review individual students (such as a student study team or a student success team) because it focuses on managing and enhancing systems to coordinate, integrate, and strengthen interventions. At the same time, many of the same staff usually are on both types of teams. Thus, initial creation of such a team often is best accomplished by broadening the scope of a student study team (or a teacher assistance team or a school crisis team). In doing so, however, it is essential to separate the agenda and have the members change "hats."

A Resource Team works toward weaving together all school and community programs and services. Among its activities, the team

- conducts resource mapping and analysis with a view to improving resource use and coordination
- ensures that effective systems are in place for triage, referral, management of care, and quality improvement
- establishes appropriate procedures for effective program management and for communication among school staff and with the home
- suggests ways to reallocate and enhance resources (e.g., clarifying how to better use staff and resources, which activities need revision or are not worth continuing).

Properly constituted, trained, and supported, a Resource Team can complement the work of the school's governance body through providing on-site overview, leadership, and advocacy for activities aimed at addressing barriers to learning and enhancing healthy development. To these ends, at least one team member should be designated as a liaison between the team and the school's governing and planning bodies to ensure the maintenance, improvement, and increased integration of essential programs and services with the total school program.

Because they often deal with the same families (e.g., families with children at each level of schooling) and link with the same community resources, complexes of schools (a high school and its feeder middle and elementary schools) should work collaboratively. A Complex Resource Council brings together representatives from each school's Resource Team to facilitate coordination and equity among schools in using school and community resources.
Developing a Resource Team

Creation of a School-site Resource Team provides a good starting place in efforts to enhance coordination and integration of services and programs. Such a team not only can begin the process of transforming what is already available, it can help reach out to District and community resources to enhance enabling activity.

A Resource Team differs from Student Study, Student Success, and Student Guidance Teams. The focus of a Resource Team is not on individual students. Rather, it is oriented to clarifying resources and how they are best used. That is, it provides a necessary mechanism for enhancing systems for communication and coordination.

For many support service personnel, their past experiences of working in isolation – and in competition – make this collaborative opportunity unusual and one which requires that they learn new ways of relating and functioning. For those concerned with school restructuring, establishment of such a team is one facet of efforts designed to restructure school support services in ways that (a) integrates them with school-based/linked support programs, special projects, and teams and (b) outreaches and links up with community health and social service resources.

**Purposes**

Such a team exemplifies the type of on-site organizational mechanism needed for overall cohesion and coordination of school support programs for students and families. Minimally, such a team can reduce fragmentation and enhance cost-efficacy by assisting in ways that encourage programs to function in a coordinated and increasingly integrated way. For example, the team can develop communication among school staff and to the home about available assistance and referral processes, coordinate resources, and monitor programs to be certain they are functioning effectively and efficiently. More generally, this group can provide leadership in guiding school personnel and clientele in evolving the school’s vision for its support program (e.g., as not only preventing and correcting learning, behavior, emotional, and health problems but as contributing to classroom efforts to foster academic, social, emotional, and physical functioning). The group also can help to identify ways to improve existing resources and acquire additional ones.

Major examples of the group's activity are

- preparing and circulating a list profiling available resources (programs, personnel, special projects, services, agencies) at the school, in the district, and in the community
- clarifying how school staff and families can access them
- refining and clarifying referral, triage, and case management processes to ensure resources are used appropriately (e.g., where needed most, in keeping with the principle of adopting the least intervention needed, with support for referral follow-through)
- mediating problems related to resource allocation and scheduling,
- ensuring sharing, coordination, and maintenance of needed resources,
- exploring ways to improve and augment existing resources to ensure a wider range are available (including encouraging preventive approaches, developing linkages with other district and community programs, and facilitating relevant staff development)
- evolving a site's enabling activity infrastructure by assisting in creation of area program teams and Family/Parent Centers as hubs for enabling activity

(cont.)
Developing a Resource Team (cont.)

Membership

Team membership typically includes representatives of all activity designed to support a school's teaching efforts (e.g., a school psychologist, nurse, counselor, social worker, key special education staff, etc.), along with someone representing the governance body (e.g., a site administrator such as an assistant principal). Also, included are representatives of community agencies already connected with the school, with others invited to join the team as they became involved.

The team meets as needed. Initially, this may mean once a week. Later, when meetings are scheduled for every 2-3 weeks, continuity and momentum are maintained through interim tasks performed by individuals or subgroups. Because some participants are at a school on a part-time basis, one of the problems that must be addressed is that of rescheduling personnel so that there is an overlapping time for meeting together. Of course, the reality is that not all team members will be able to attend every meeting, but a good approximation can be made at each meeting, with steps taken to keep others informed as to what was done.

Examples of Resource Team Initial and Ongoing Tasks

- Orientation for representatives to introduce each to the other and provide further clarity of Team's purposes and processes
- Review membership to determine if any group or major program is not represented; take steps to assure proper representation
- Share information regarding what exists at the site (programs, services, systems for triage, referral, case management)
- Share information about other resources at complex schools and in the immediate community and in the cluster and district-wide
- Analyze information on resources to identify important needs at the site
- Establish priorities for efforts to enhance resources and systems
- Formulate plans for pursuing priorities
- Discussion of the need to coordinate crisis response across the complex and to share complex resources for site specific crises (with conclusions to be share at Complex Resource Council)
- Discussion of staff (and other stakeholder) development activity
- Discussion of quality improvement and longer-term planning (e.g., efficacy, pooling of resources)

   General meeting format

- Updating on and introduction of team membership
- Reports from those who had between meeting assignments
- Current topic for discussion and planning
- Decision regarding between meeting assignments
- Ideas for next agenda
Developing a Complex (Multisite) Resource Council

Schools in the same geographic (catchment) area have a number of shared concerns, and feeder schools often are interacting with the same family. Furthermore, some programs and personnel are (or can be) shared by several neighboring schools, thus minimizing redundancy and reducing costs.

Purpose

In general, a group of sites can benefit from having a Resource Council as an ongoing mechanism that provides leadership, facilitates communication, and focuses on coordination, integration, and quality improvement of whatever range of activity the sites has for enabling activity.

Some specific functions are

- To share information about resource availability (at participating schools and in the immediate community and in geographically related schools and district-wide) with a view to enhancing coordination and integration
- To identify specific needs and problems and explore ways to address them (e.g., Can some needs be met by pooling certain resources? Can improved linkages and collaborations be created with community agencies? Can additional resources be acquired? Can some staff and other stakeholder development activity be combined?)
- To discuss and formulate longer-term plans and advocate for appropriate resource allocation related to enabling activities.

Membership

Each school can be represented on the Council by two members of its Resource Team. To assure a broad perspective, one of the two can be the site administrator responsible for enabling activity; the other can represent line staff.

Facilitation

Council facilitation involves responsibility for convening regular monthly (and other ad hoc) meetings, building the agenda, assuring that meetings stay task focused and that between meeting assignments will be carried out, and ensuring meeting summaries are circulated.

With a view to shared leadership and effective advocacy, an administrative leader and a council member elected by the group can co-facilitate meetings. Meetings can be rotated among schools to enhance understanding of each site in the council.

Location

Meeting at each school on a rotating basis can enhance understanding of the complex.
Developing a Complex (Multisite) Resource Council (cont.)

Steps in Establishing a Complex Council

a. Informing potential members about the Council's purpose and organization (e.g., functions, representation, time commitment).

   Accomplished through presentation and handouts.

b. Selection of representatives.

   Chosen at a meeting of a school's Resource Team. (If there is not yet an operational Team, the school's governance can choose acting representatives.)

c. Task focus of initial meetings

   • Orient representatives to introduce each to the other and provide further clarity of Council's purposes and processes
   • Review membership to determine if any group or major program is not represented; take steps to assure proper representation
   • Share information regarding what exists at each site
   • Share information about other resources at complex schools and in the immediate community and in the cluster and district-wide
   • Analyze information on resources to identify important needs at specific sites and for the complex as a whole
   • Establish priorities for efforts to enhance resources
   • Formulate plans for pursuing priorities
   • Discuss plan for coordinated crisis response across the complex and sharing of resources for site specific crises
   • Discuss combined staff (and other stakeholder) development activity
   • Discuss (and possibly visit) school-based centers (Family Service Center, Parent Center) with a view to best approach for the complex
   • Discuss quality improvement and longer-term planning (e.g., efficacy, pooling of resources)

d. General meeting format

   • Updating on and introduction of council membership
   • Reports from those who had between meeting assignments
   • Current topic for discussion and planning
   • Decision regarding between meeting assignments
   • Ideas for next agenda
II. Student Clients as Consumers

A. Enhancing Understanding of the Motivational Bases for Problems

B. Talking with Kids about Problems

C. The Best Consumer Protection is a Good Professional

D. Referral: More than Giving a Name and Address

E. Help-Seeking Behavior and Follow Through on Referrals

F. Managing Care, Not Cases

G. Accounting for Cultural, Racial, and Other Significant Individual and Group Differences
II. Student Clients as Consumers

In the helping professionals, there has long been concern about processes that inappropriately distance, depersonalize, and desensitize practitioners from those they serve. Professionals interested in the politics of institutionalized interventions (e.g., doctoring, counseling, educating) take the concern further and worry about power imbalances that disempower individuals and groups and increase dependency on professional interveners. The complexity of these matters becomes more so for those working with minors and in schools. Questions about *What is in a youngster's best interest?* and *Who should decide?* arise daily when a student is having difficulties.

In school settings, adults make many decisions for students, often without the involvement of the youngster's primary caregivers. As professionals know all too well, decisions made related to triage, referral, and "case" management often have profound, life-shaping effects. The intent, of course, is to benefit those involved. But decisions to delay assistance may exacerbate problems; referrals to unproven interventions are risky; and even the best interventions have potential negative "side effects" that lead to additional problems.

From another perspective, it is evident that decisions made about -- rather than with -- individuals often don't work out.

*Because of all this, a basic assumption underlying the following material is that students must be involved in decisions to assist them. Relatedly, except in rare instances, parents or guardians also must be involved.*

Obviously, there are significant exceptions to this principle. However, as a general guideline, the benefits of its application for most young people and for society are likely to far outweigh the costs involved.

After adopting this principle, it is a short leap to adopting the stance that school-based assistance for students and families should be *consumer-oriented.*
In a real sense, school personnel and the families and students they serve are all consumers. This is especially true for all those concerned about addressing barriers to student learning. What are they consuming? Information about causes and correction of learning, behavioral, emotional, and health problems. And, they want and deserve the best information available -- *information that clarifies rather than mystifies, information that empowers rather than increases dependency.*

Appropriately cautious information can

• put matters into proper perspective

• clarify general options for dealing with the problem

• ensure good decisions and follow through.

Unfortunately, the hardest time for people to get information and sort things out for themselves seems to be when there is a pressing concern. At such times, they often need help from others. For many parents and youngsters, public schools and related public agencies provide the most natural and ongoing contact point for discussing a youngster’s problems. Indeed, in the United States, federal guidelines stress the obligation of schools to identify certain problems, inform parents of their rights related to special programs, and ensure that proper assistance is provided. Among other practices, such mandates involve schools in a range of activity related to *triage, referral, and management of care.* Although not always discussed as such, they also involve schools in *client consultation* processes.
Processes related to triage, referral, and managing care often are carried out at school sites in ways that are not very consumer-oriented.

For example, professional referrals still tend to follow the practice of "Here are three names/places to contact." There is little or no sound evaluative information about the services of those to whom referrals are made; in particular, systematically gathered consumer feedback is virtually nonexistent. It should be clear that the appropriateness of a referral depends less on the referrer's perspective and preferences than on the match between the recommended service and the practical and psychological requirements of the client (financial costs, geographical location, program characteristics). Thus, even if professionals could (and they can't) adequately and objectively evaluate and ensure the quality of services to which they refer, they would still be confronted with the complex problem of determining that the service-client match will be a good one.

As a general guideline, all services should be based on the view that the more they reflect consumer-oriented considerations, the greater the likelihood of appropriate decisions.

For practices to be consumer-oriented, it is essential to clarify consumer needs as a group and as individuals. This requires gathering information about the nature and scope of problems in the immediate locale and for each given individual who is assisted. Also needed is good information clarifying the range of relevant intervention options and basic information about each (cost, location, program rationale and features, and, where feasible, previous consumer evaluations). And, it involves consultation processes that effectively involve clients in decisions.
A. Enhancing Understanding of the Motivational Bases for Problems

It is particularly important to address the reality that a few months into a school year positive motivational influences arising from the newness of the year (novelty, the "honeymoon" period, etc.) will have subsided. Many behavior, learning, and emotional problems arise at this time and could be countered by staff strategies designed to produce "motivational renewal."

For staff development to improve understanding of the motivational bases for many behavior, learning, and emotional problems and what to do about them, you can use the following Center resources:

- See Module II of the Continuing Education materials entitled: Enhancing Classroom Approaches for Addressing Barriers to Learning: Classroom Focused Enabling
- A Quick Training Aid on Re-engaging Students in Learning
- A Quick Training Aid on Behavior Problems at School
- An Intro Packet on Learning Problems and Learning Disabilities

One place to start is with staff development designed to increase the ability of school staff for talking with kids. The following is abstracted from the above materials. A simple strategy to stimulate staff interest might be to copy it and put it in the staff mailboxes (and/or post it) along with a note offering a study group for those who want to learn more about the motivational bases for many problems and about classroom and school changes that can minimize problems arising from low or negative motivation.
B. Talking with Kids about Problems

To help another, it is of great value and in many instances essential to know what the other is thinking and feeling. The most direct way to find this out is for the person to tell you. But, individuals probably won't tell you such things unless they think you will listen carefully. And the way to convince them of this is to listen carefully.

Of course, you won't always hear what you would like.

    Helper: Well, Jose, how do you like school?
    Jose: Closed!

In general, effective communication requires the ability to carry on a productive dialogue, that is, to talk with, not at, others. This begins with the ability to be an active (good) listener and to avoid prying and being judgmental. It also involves knowing when to share information and relate one's own experiences as appropriate and needed. The following are suggestions for engaging youngsters in productive dialogues.

1. Creating the Context for Dialogues
   - Create a private space and a climate where the youngster can feel it is safe to talk.
   - Clarify the value of keeping things confidential.
   - Pursue dialogues when the time, location, and conditions are right.
   - Utilize not just conferences and conversations, but interchanges when working together (e.g. exploring and sampling options for learning).

2. Establishing Credibility (as someone to whom it is worth talking)
   - Respond with empathy, warmth, and nurturance (e.g., the ability to understand and appreciate what others are thinking and feeling, transmit a sense of liking, express appropriate reassurance and praise, minimize criticism and confrontation).
   - Show genuine regard and respect (e.g., the ability to transmit real interest, acceptance, and validation of the other's feelings and to interact in a way that enables others to maintain a feeling of integrity and personal control.
   - Use active and undistracted listening.
   - Keep in mind that you want the student to feel more competent, self-determining, and related to you (and others) as a result of the interchange.

3. Facilitating Talk
   - Avoid interruptions.
   - Start slowly, avoid asking questions, and minimize pressure to talk (the emphasis should be more on conversation and less on questioning).
   - Encourage the youngster to take the lead.
   - Humor can open a dialogue; sarcasm usually has the opposite effect.
   - Listen with interest.
   - Convey the sense that you are providing an opportunity by extending an invitation to talk and avoiding the impression of another demanding situation (meeting them "where they are at" in terms of motivation and capability is critical in helping them develop positive attitudes and skills for oral communication).
   - Build on a base of natural, informal inter-changes throughout the day.
• When questions are asked, the emphasis should be on open-ended rather than Yes/No questions.
• Appropriate self-disclosure by another can disinhibit a reluctant youngster.
• Pairing a reluctant youngster with a supportive peer or small group can help.
• Train and use others (aides, volunteers, peers) to (1) enter into productive (nonconfidential) dialogues that help clarify the youngster's perceptions and then (2) share the information with you in the best interests of helping.
• For youngsters who can't seem to convey their thoughts and feelings in words, their behavior often says a lot about their views; based on your observations and with the idea of opening a dialogue, you can share your perceptions and ask if you are right.
• Sometimes a list of items (e.g. things that they like/don't like to do at school/after school) can help elicit views and open up a dialogue.
• When youngsters have learning, behavior, and emotional problems, find as many ways as feasible to have positive interchanges with them and make positive contacts outweigh the negatives.
• **Remember**: Short periods of silence are part of the process and should be accommodated.

Of course, other problems arise because of the way the system is operating. For example, analysis of behavior problems usually find that certain situations chronically contribute to problems (e.g., before school and lunch periods where youngsters do not have a good range of interesting recreational options leads some to get into trouble everyday).

A dramatic example comes from a district that found it had a significant increase in teen pregnancies among middle schoolers. Analyses traced the problem to too long a period of unsupervised time from when the school day ended until parents were home from work. To address the problem, the district moved the start of middle school later in the morning so the school day would end later, and with less time to fill, it was feasible to provide more after-school recreational opportunities. The number of teen pregnancies dropped.

For more materials on these topics, go to the Center Website and use the Quick Find Search to explore the following (among others) topics:

• Case and Care Management
• Motivation
• Enabling Component
• Classroom-focused Enabling
• Environments that Support Learning
• Classroom Management
• School Avoidance
• Dropout Prevention
• Transition Programs/Grade Articulation/Welcome
About Interviewing

1. Use a space that will allow privacy and let others know not to interrupt.
   - Clarify that you care by showing empathy, acceptance, and genuine regard.
   - Indicate clear guidelines about confidentiality so the student feels safe in confiding but understands that if danger to self or others is discussed, others must be involved.

2. Start out on a positive note and always convey a sense of respect.
   - Ask about things that are going well at school and outside of school
   - Use language that invites sharing and is more conversational than questioning.
   - If students are reluctant to talk you may need to start with nonverbal activity, such as drawing, or with semistructured surveys

3. Slowly transition to concerns
   - Ask about concerns the student has about school, outside school with friends or in the neighborhood
   - Explore what the student thinks may be causing the problem
   - What has the student done to solve the problem
   - What new things can you and the student think of that the student would be willing to try

4. As you follow the student’s lead, listen actively and encourage information through open ended questions that allow for exploration rather than closure.
   - This will lead to a broader range of concerns about school, home, relationships, self.
   - With other students you may find it helpful to explore more sensitive topics such as involvement substance use, gangs, sexuality.

5. It is very important to have a plan on how to end the interview. This includes
   - Clarifying it is time, not caring, that causes the need to stop at this point.
   - Summarize what has been shared with a sense of accomplishing at new ways to understand the problems and new plans to try in solving them
   - Plan the next step, such as the next appointment, a follow up time to check on progress, and open door if there is another need to talk, how to connect to others in the daily environment at school who may be of help.
C. The Best Consumer Protection Is a *Good* Professional

All professionals, of course, mean to do good. But what constitutes a "good" professional? For consumer advocates, a consumer orientation is at the heart of the matter. Indeed, such an orientation is found in a set of professional guidelines formulated by the American Psychological Association. These guidelines state that members of a good profession:

1. Guide their practices and policies by a sense of social responsibility;
2. Devote more of their energies to serving the public interest than to "guild" functions and to building ingroup strength;
3. Represent accurately to the public their demonstrable competence;
4. Develop and enforce a code of ethics primarily to protect the client and only secondarily to protect themselves;
5. Identify their unique pattern of competencies and focus their efforts to carrying out those functions for which they are best equipped;
6. Engage in cooperative relations with other professions having related or overlapping competencies and common purposes;
7. Seek an adaptive balance among efforts devoted to research, teaching, and application;
8. Maintain open channels of communication among "discoverers," teachers, and appliers of knowledge;
9. Avoid nonfunctional entrance requirements into the profession, such as those based on race, nationality, creed, or arbitrary personality considerations;
10. Insure that their training is meaningfully related to the subsequent functions of the members of the profession;
11. Guard against premature espousal of any technique or theory as a final solution to substantive problems;
12. Strive to make their services accessible to all persons seeking such services, regardless of social and financial considerations.
D. Referral: More than Giving a Name and Address

Referrals for service are commonplace at school sites.

And, for the most part,

referrals are relatively easy to make.

BUT,

because most students are reluctant to follow-through on a referral, the process needs to go beyond simply giving a student (or family) a name and address.

Schools must develop effective referral intervention strategies.

That is, it is essential to have referral procedures in place that

• provide ready reference to information about appropriate referrals,

• maximize follow-through by using a client consultation process that involves students and families in all decisions and helping them deal with potential barriers.

Referrals should be based on (1) sound assessment (information about the client's needs and resources available) and (2) consumer-oriented client consultation. Although most assessment and consultation can be seen as a form of problem solving, such problem solving may or may not be an activity professionals share with clients.

In developing a consumer-oriented system, the intent is twofold:

• to provide consumers with ready access to information on relevant services

• to minimize abuses often found in professional referral practices.

At the same time, the hope is that a positive side effect will be a higher degree of client self-reliance in problem solving, decision making, and consumer awareness.
Referrals are easy to make . . .

An old fable tells of an arthritic Bulgarian peasant and her encounter with a doctor. After an extensive examination, he diagnoses her problems and writes a prescription for medication, details a special diet, and recommends that she have hydrotherapy. The doctor's professional manner and his expert diagnosis and prescription naturally filled the woman with awe, and as she leaves his office, she is overcome with admiration and says the Bulgarian equivalent of "Gee, you're wonderful doctor!"

A few years pass before the doctor runs into the woman again. As soon as she sees him, she rushes up and kisses his hand and thanks him again for his marvelous help. The doctor, of course, is gratified. Indeed, he is so pleased that he fails to notice that she is as crippled as before.

The fact is that the woman never got the medication because she neither had the money nor access to an apothecary. Moreover, her village had no provision for hydrotherapy, and the prescribed diet included too many foods she either did not like or could not afford.

Nevertheless, despite her continuing pain, she remained full of awe for the wise doctor and praised him to everyone who would listen.

(Adapted from Berne, 1964)
To aid in reviewing client need and consideration of potential resources, information is presented in an organized and comprehensible manner. To facilitate decision making, guidance and support are provided in exploring the pros and cons of the most feasible alternatives. To encourage consumer self-protection, basic evaluative questions are outlined for consumers to ask of potential service providers before contracting for services.

Toward meeting all these ends, the process must be one of shared or guided problem solving with the objective of helping consumers (usually students and parents together) arrive at their own decisions rather than passively adopting the professional's recommendations and referrals.

A consumer-oriented, guided problem-solving approach eliminates a number of problems encountered in prevailing approaches. The process avoids making "expert" and detailed prescriptions that go beyond the validity of assessment procedures; and it avoids referrals based on "old boy" networks by ensuring clients have direct access to a well-developed community resource referral file.

As with all assessment involved in decision making, the assessment process has three major facets: (a) a rationale that determines what is assessed, (b) "measurement" or data gathering (in the form of analyses of records, observations, and personal perspectives, as well as tests when needed), and (c) judgments of the meaning of what has been "measured."

The consultation process also has three major facets: (a) a rationale that determines the focus of consultation activity, (b) exploration of relevant information (including "expert" information), and (c) decision making by the consumers.

An example of some specific steps used in an assessment and consultation process is provided on the next page.
Some Specific Steps in an Assessment and Consultation Process

(1) Initial screening of student/family (initial contacts with the home may be via phone conversations)

(2) Filling out of questionnaires by each concerned party (parents and student) regarding his or her perception of the cause of identified problems and their correction

(3) Gathering records and reports from other professionals or agencies when consumers agree it might be useful

(4) Brief, highly circumscribed testing, if necessary and desired by consumers

(5) Initial review of assessment findings to determine if enough information is available to proceed with client consultation

(6) Holding group conference(s) with immediately concerned parties to
   • analyze problems and in the process to review again whether other information is needed (and if so to arrange for gathering it)
   • arrive at an agreement about how a problem will be understood for purposes of generating alternatives
   • generate, evaluate, and make decisions about which alternatives to pursue
   • formulate plans for pursuing alternatives (designating support strategies to ensure follow-through)

(7) Follow-up via telephone or conference to evaluate the success of each pursued alternative and determine satisfaction with the process

Problem analysis and decision making can be accomplished in a session. However, if additional assessment data are needed, one or two assessment sessions and a subsequent conference are required.

Because some people have come to overrely on experts, some clients may be a bit frustrated when they encounter an approach such as the one just described. They want professionals to give a battery of tests that will provide definitive answers, and they want decisions made for them. (They are convinced they cannot make good decisions for themselves.) These individuals often are a product of the negative side effects of professional practices that mystify consumers and make them feel totally dependent on professionals.
E. Help Seeking Behavior and Follow Through on Referrals

*Some Excerpts from the Journals*

Excerpt from

**Seeking Help From the Internet During Adolescence***

During the past decade there has been increased interest in help-seeking behavior among adolescents. This reflects the recognition that while many psychiatric problems, such as suicide and substance abuse, increase markedly during adolescence, the majority of disturbed teenagers do not receive mental health services. Research indicates that between 60% and 80% of disturbed children do not receive any kind of mental health care. The majority of those who do receive mental health care do so through their schools, while a minority (between 12% and 34%), receive services from a mental health professional (such as a psychiatrist, psychologist, or social worker). Of those who access mental health care, fewer still (20%) enter into treatment. These low assessment and treatment rates are especially disturbing in light of the poor prognoses for adolescents with untreated psychopathology.

Lack of help-seeking behavior from formal sources, such as mental health professionals, is one factor in the low rates of treatment among disturbed adolescents. Research suggests that when disturbed teenagers seek help, they prefer help from informal sources such as friends. In general, female adolescents have more positive attitudes about help-seeking and are more likely to seek both formal and informal support for emotional disturbances than are males.

Ethnic minority adolescents are more likely to approach informal sources such as family members and relatives. Adolescents' preference for informal sources of help seems to increase with age, and may, in turn, contribute to their low rate of formal mental health treatment.

Many disturbed adolescents who fail to seek treatment cite reluctance to approach others for help. They consistently cited four reasons for this reluctance: feeling that their help-seeking would not be kept confidential, feeling that no person or helping service could help, feeling that the problem was too personal to tell anyone, and feeling that they could handle the problem on their own.

Mental Health and Help-Seeking Among Ethnic Minority Adolescents*

Abstract

Survey data are reported on the mental health status and professional help-seeking behavior of adolescents predominantly representing a sample of lower SES, ethnic minority backgrounds. Contrary to popular stereotypes, the samples’s mental health status was found to be similar to findings from samples from non-minority backgrounds. Despite evident need for help, respondents indicated low utilization of services. Among those who did use professional help, school-based sources and medical personnel were used most often. Of factors examined as potential predictors of help-seeking, cognitive-affective factors were accounted for a small, yet significant amount of the variance. The findings highlight the importance of studying within-group differences to avoid perpetuating incorrect generalizations related to person from low SES and ethnic minority backgrounds.

Psychological Correlates of Help-seeking Attitudes among Children and Adolescent*

A self-report measure of attitudes about seeking help from adults for psychosocial problems was administered to approximately 200 children and adolescents. More negative help-seeking attitudes were associated with male gender, adolescence, depressive symptomology, and lower self-efficacy. Implications for effective delivery of mental health services to at-risk youth are discussed.

* by A. Garland & E. Zigler *Am J Orthopsychiatry* 1994 64,586-93

Adolescent Opinions About Reducing Help-seeking Barriers and Increasing Appropriate Help Engagement*

Relationship and trust were key approach factors for current help seeking. Memories of successful prior helping episodes were also important. Education about appropriate help seeking, presented in ways consistent with those currently used by adolescents (e.g., through peer networks), might reduce help-seeking barriers. Should include key adults who act as gatekeepers within adolescent networks (e.g., parents and teachers). Assertive outreach and follow-up might be important factors for continued help-source engagement. Themes provide a basis for suggestion about ways to facilitate adolescent help seeking and maintain appropriate help-source engagement.

F. Managing *Care*, Not *Cases*

Common terminology designates those whom professionals work with as "cases." Thus, considerations about making certain that clients connect with referral resources often are discussed as "case monitoring" and efforts to coordinate and integrate interventions for a client are designated "case management."

At the same time, efforts to ensure there are comprehensive and integrated resources to assist clients often refer to the expansion of "systems of care."

Given that words profoundly shape the way people think, feel, and act, some professionals are arguing for use of the term "care" in place of "case." Such a move is in keeping with the view that care is a core value of helping professionals. It also is consistent with the growing emphasis on ensuring that schools are "caring communities." For these reasons, it seems appropriate to replace the term case management with that of *management of care*. 


G. Accounting for Cultural, Racial, and Other Significant Individual and Group Differences

All interventions to address barriers to learning and promote healthy development must consider significant individual and group differences. In this respect, discussions of diversity and cultural competence offer some useful concerns to consider and explore. For example, in a document entitled *A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs* (by the Family Youth Services Bureau, DHHS), outlines some baseline assumptions which can be broadened to read as follows:

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.

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 of that the "problem is solved."

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.

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.

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.

(cont.)
Accounting for Cultural, Racial, and Other Significant Individual and Group Differences (cont.)

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, however, 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 throughout the country 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.

In their discussion of "The Cultural Competence Model," Mason, Benjamin, and Lewis* outline five cultural 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 to reflect the contextual realities of a given catchment area and the sociopolitical forces that may have shaped those who live in the area..

A Bit More on Diversity . . .

In most situations, direct or indirect accusations that "You don't understand" are valid. Indeed, they are givens. After all, it is usually the case that one does not fully understand complex situations or what others have experienced and are feeling.

With respect to efforts to build working relationships, accusing someone of not understanding tends to create major barriers. This is not surprising since the intent of such accusations generally is to make others uncomfortable and put them on the defensive.

It is hard to build positive connections with a defensive person. Avoidance of "You don't understand" accusations may be a productive way to reduce at least one set of major barriers to establishing working relationships.

Finally, it is essential to remember that individual differences are the most fundamental determinant of whether a good relationship is established. This point was poignantly illustrated by the recent experience of the staff at one school.

A Korean student who had been in the U.S.A. for several years and spoke comprehensible English came to the center seeking mental health help for a personal problem. The center's policy was to assign Korean students to Asian counselors whenever feasible. The student was so assigned, met with the counselor, but did not bring up his personal problem. This also happened at the second session, and then the student stopped coming.

In a follow-up interview conducted by a nonAsian staff member, the student explained that the idea of telling his personal problems to another Asian was too embarrassing.

Then, why had he come in the first place?

Well, when he signed up, he did not understand he would be assigned to an Asian; indeed, he had expected to work with the "blue-eyed counselor" a friend had told him about.

The focus in Section II of this technical resource aid is on principles and procedures to guide establishment of a comprehensive referral intervention. The perspective taken in developing such an intervention is that it should be consumer oriented and user friendly.

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III. Referral as an Intervention

A. The Pre-referral Process
   1. Response to Intervention
   2. Steps in the Pre-referral Process
   3. About Pre-referral Teams

B. The Referral Process: Some Guidelines and Steps

C. Providing Information About Services

D. Developing Ways to Facilitate Access to Service
   1. Highlighting the Most Accessible Referral Resources
   2. Referral Resource Files
   3. Support and Direction for Follow-through
   4. Personal Contact with Referral Resources
   5. Enhancing On-Campus Services

E. Following-up on Referrals (including consumer feedback)

F. Managing Care, Not Cares
   1. Initial Monitoring of Care
   2. Ongoing Management of Care
   3. System of Care
   4. More About Case Management
III. Referral as an Intervention

It is important to remember that referral is an intervention. Because it involves decisions about how to move from what is currently happening to a better state of affairs, it can be viewed as transition intervention.

The referral process begins when someone identifies a problem and asks for help. Sometimes assistance can be given at this point so that the student does not need referral to special services. This type of assistance is often called prereferral intervention. Actually, it is the first and sometimes a sufficient phase of the referral process. The assessment data generated during this process also is useful in making triage decisions.
A. The Pre-referral Process

When a student manifests a learning, behavior, or emotional problem, a major concern is to clarify why the problem has arisen. Often, this matter is not attended to until after a referral is made to someone outside the classroom. In recent years, there have been increasing numbers of such referrals (e.g., to student assistance teams and IEP teams). In turn, this has swollen the ranks of students who are diagnosed for special education and specialized interventions.

Efforts to stem the tide of unnecessary referrals have focused on what can be called “pre-referral” interventions. A prominent current version of such strategies is the move toward Response to Intervention (RTI). These strategies are meant to help reduce the number of referrals by providing effective classroom interventions; they are not meant to be another set of bureaucratic hurdles delaying appropriate referrals. That is, the hope of appropriately implemented pre-referral processes is to better address barriers to learning and teaching and not to further burden teachers.

With all this in mind, it will be increasingly important for student support staff to play a major role in the pre-referral process by working in the classroom alongside the teacher.

To guide school-based efforts to plan and implement a pre-referral process, the following pages include a brief discussion of the concept of Response to Intervention and a resource aid.
1. Response to Intervention

[This is from the Center’s quarterly newsletter, Addressing Barriers to Learning, Fall, 2006]

As Jeff Sprague noted in 2006, since the recent reauthorization of IDEA . . ., response to intervention (RTI) has become a major stimulus for discussion and action. ...schools are increasingly adopting an RTI logic to organize and deliver both academic and behavioral support for all students.

The concept of Response to Intervention is finding its way into schools with a significant push from the federal government and with a particular emphasis on reducing inappropriate diagnoses for special education. For example, as stated in the 4/20/06 U.S. Department of Education Request for Special Education Research Grants, “RTI holds significant promise when it is conceptualized as a multi-tiered (typically three-tiers) systems approach that integrates general and special education.”

Properly conceived and implemented, RTI is expected to improve the learning opportunities for many students and reduce the number who are diagnosed with learning disabilities and behavioral disorders. The intent is to use “well-designed and well-implemented early intervention” in the regular classroom as a way to deal with a student’s problems. The aim also is to improve assessment for determining whether more intensive and perhaps specialized assistance and diagnosis are required.

The process calls for making changes in the classroom to address learning and behavior as they are noted. Student responses are used as data to identify other in-classroom strategies as needed. The process continues until it is evident that a student’s problems cannot be resolved through classroom interventions alone.

A core difficulty involves mobilizing unmotivated students (and particularly those who have become actively disengaged from classroom instruction). If motivational considerations are not effectively addressed, there is no way to validly assess if a student has a true disability or disorder.

RTI is currently being operationalized across the country. While there will be variability in practice, the tendency is to proceed as if all that is needed is more and better instruction. Clearly, this is a necessary, but insufficient emphasis. Therefore, the following intervention concepts are proposed as guides in operationalizing RTI.

First, ensure an optimal teaching environment. This means personalized teaching. Then, the focus expands, if necessary, to meet needs for special assistance in the classroom.

When classroom interventions prove insufficient, some supportive assistance outside the classroom is added to the mix to help students remain in the regular program. Referral for special education assessment only comes after all this is found inadequate.

To spell this out a bit:

Step 1 involves personalizing instruction. The intent is to ensure a student perceives instructional processes, content, and outcomes as a good match with his or her interests and capabilities.

The first emphasis is on motivation. Thus:

Step 1a stresses use of motivation-oriented strategies to (re)engage the student in classroom instruction. This step draws on the broad science-base related to human motivation, with special attention paid to research on intrinsic motivation and psychological reactance. The aim is to enhance student perceptions of significant options and involvement in decision making.

The next concern is developmental capabilities. Thus:

Step 1b stresses use of teaching strategies that account for current knowledge and skills. In this respect, the emphasis on tutoring (designated as “Supplemental Services” in Title I) can be useful if the student perceives the tutoring as a good fit for learning.

Then, if necessary, the focus expands to encompass special assistance. Thus:

Step 2 stresses use of special assistance strategies to address any major barriers to learning and teaching, with an emphasis on the principle of using the least intervention needed (i.e., doing what is needed, but no more than that). In this respect, the range of strategies referred to as
“Prereferral Interventions” and the programs and services that constitute student/learning supports are of considerable importance. (Again, the impact depends on the student’s perception of how well an intervention fits his or her needs.)

Note: Prereferral interventions identify regular classroom problems, identify the source of the problems (student, teacher, curriculum, environment, etc.), and take steps to resolve the problems within the regular classroom.

Building Capacity for RTI

Implied in all this is capacity building. There must be a process that ensures teachers have or are learning how to implement “well-designed early interventions” in the classroom. And, support staff must learn how to play a role directly in the classroom to expand the nature and scope of interventions.

Two capacity building concerns are particularly essential. One is professional development on how to implement the Step 1 and 2 interventions described above; the other involves ensuring classrooms and student support programs are designed in ways that allow enough time for implementation.

Central to all this is learning how to create a positive classroom climate. One that uses practices that enhance motivation to learn and perform, while avoiding practices that decrease motivation and/or produce avoidance motivation. Such practices include:

- regular use of informal and formal conferences with students to discuss options, make decisions, explore learners’ perceptions, and mutually evaluate progress;

- a broad range of options from which learners can make choices about types of learning content, activities, and desired outcomes;

- a broad range of options from which learners can make choices about their need for support and guidance during decision making and learning processes;

- active decision making by learners in making choices and in evaluating how well the chosen options match their motivation and capability;

- establishment of program plans and mutual agreements about the ongoing relationships between the learners and program personnel;

- regular reevaluations and reformulation of plans, and renegotiation of agreements based on mutual evaluations of progress, problems, and learners’ perceptions of how well instruction matches his or her interests and capabilities.

Teachers and support staff also must learn how to approach special assistance in a sequential and hierarchical manner. First, they must be able to use reteaching strategies to better accommodate individual needs and differences. They also must be prepared to teach prerequisite knowledge, skills, and attitudes the student may not have learned along the way. Finally, they must be able to play a role in addressing major barriers that are interfering with student learning and performance.

And, to ensure RTI strategies can be implemented in a personalized way, schools must promote the type of collaborative classrooms and grouping strategies that have the effect of turning big classes into smaller units.

More Research Please!

As stated in the 4/20/06 U.S. Department of Education Request for applications (84.324) Special Education Research Grants, “Despite the preference for RTI, the empirical research to support its application to district and school practices and systems is very limited.” Nevertheless, the practice is seen as so important that the Department is investing significant resources to encourage the practice and to evaluate its impact.

Fortunately, the field doesn’t have to wait for evidence since the weight of available findings support the concepts underlying operationalization of a broad RTI approach. For example, there is an extensive literature supporting the application of intrinsic motivation theory to classroom instruction. And, with respect to special assistance, a broad range of supporting research has been culled from general and special education and the student support field.
Brief Commentary

If Response to Intervention (RTI) is treated simply as a problem of providing more and better instruction (e.g., the type of direct instruction described by the National Reading Panel sponsored by NICHD), it is unlikely to be effective for a great many students. However, if RTI is understood to be part and parcel of a comprehensive system of classroom and school-wide learning supports, schools will be in a position not only to address problems effectively early after their onset, but will prevent many from occurring.

By themselves, Response to Intervention strategies, especially if narrowly conceived, do not address major barriers to student learning. Such strategies must be broadly conceived and embedded in a comprehensive system of learning supports if they are to significantly reduce learning, behavior, and emotional problems, promote social/emotional development, and effectively reengage students in classroom learning. This will not only reduce the numbers who are inappropriately referred for special education or specialized services, it also will enhance attendance, reduce misbehavior, close the achievement gap, and enhance graduation rates.

A Few References

Tomlinson, C.A. (1999). The differentiated classroom: Responding to the needs of all learners. VA: ASCD.
2. Steps in the Pre-referral Process

When a student is seen as having problems, teachers and other school staff may find the following steps helpful.

Related guidelines and materials are attached.

Step 1: Based on your work with the student, formulate a description of the student's problem.

Step 2: Have a discussion to get the student's view. You may want to include the family.

Step 3: Try new strategies in the classroom based on your discussion.

Step 4: If the new strategies don't work, talk to others at school to learn about additional approaches they have found helpful.

Step 5: If necessary, use the school's referral processes to ask for additional support services.

Step 6: Work with referral resources to coordinate your efforts with theirs for classroom success.
**Step 1:** Based on your work with the student, *formulate a description* of the student's problem (use the checklist as an aid) and then request a Triage Review (see Appendix A).

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**A Checklist to Aid in Describing the Problem**

Teacher's Name: ____________________ Rm. _______ Date__________

Extensive assessment is not necessary in initially identifying a student about whom you are concerned. If a student is having a significant learning problem or is misbehaving or seems extremely disturbed, begin by checking off those items below that are concerning you.

<table>
<thead>
<tr>
<th>Student's name:________________</th>
<th>Birth date: _______</th>
<th>Grade: _____</th>
</tr>
</thead>
</table>

**Social Problems**
- ( ) Aggressive
- ( ) Shy
- ( ) Overactive
- ( ) _______________

**Achievement problems**
- ( ) Poor skills
- ( ) Low motivation
- ( ) _______________

**Overall academic performance**
- ( ) Above grade level
- ( ) At grade level
- ( ) Slightly below grade level
- ( ) Well below grade level
- ( ) _______________

**Absent from school**
- ( ) Less than once/month
- ( ) Once/month
- ( ) 2-3 times/month
- ( ) 4 or more times/month

**Other specific concerns:**

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**Comments:** If you have information about what is causing the problem, briefly note the specifics here.
Exploring the Problem with the Student and Family

As you know the causes of learning, behavior, and emotional problems are hard to analyze. What looks like a learning disability or an attentional problem may be an emotionally-based problem; behavior problems often arise in reaction to learning difficulties; what appears as a school problem may be the result of a problem at home.

It is particularly hard to know the underlying cause of a problem when the student is unmotivated to learn and perform. It will become clearer as you find ways to enhance the student's motivation to perform in class and talk more openly with you.

The following guide is to help you get a more information about a student's problem.

Make personal contact with student (and those in the home). Try to improve your understanding of why the student is having problems and see if you can build a positive working relationship. Special attention should be paid to understanding and addressing factors that may affect the student's intrinsic motivation to learn and perform.

1. Starting out on a positive note: Ask about what the student likes at school and in the class (if anything).
2. Ask about outside interests and "hobbies."
3. Ask about what the student doesn't like at school and in the class.
4. Explore with the student what it is that makes the things disliked (e.g., Are the assignments seen as too hard? Is the student embarrassed because others will think s/he does not have the ability to do assignments? Do others pick on the student? Are the assignments not seen as interesting?)
5. Explore what other factors the student and those in the home think may be causing the problem?
6. Explore what the student and those in the home think can be done to make things better (including extra support from a volunteer, a peer, etc.).
7. Discuss some new things the student and those in the home would be willing to try to make things better.

See student interview form in Appendix A.
**Step 3:** Try new strategies in the classroom based on your discussion. (See the preceding discussion of Response to Intervention.)

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**Some Things to Try**

The following list is meant as a stimulus to suggest specific strategies to try before referring a student for special help.

1. Make changes to (a) improve the match between a student's program and his/her interests and capabilities and (b) try to find ways for the student to have a special, positive status in the program, at the school, in the community. Talk and work with other staff in developing ideas along these lines.

2. Add resources for extra support (aide, volunteers, peer tutors) to help student's efforts to learn and perform. This includes having others cover your duties long enough for you to interact and relate with student as an individual.

3. Discuss with student (and those in the home) why the problems are occurring

4. Special exploration with student to find ways to enhance positive motivation

5. Change regular program/materials/environment to provide a better match with student's interests and skills

6. Provide enrichment options in class and as feasible elsewhere

7. Use volunteers/aide/peers to enhance the student's social support network

8. Special discussion with those in the home to elicit enhanced home involvement in solving the problem

9. Hold another special discussion with the student at which other staff (e.g., counselor, principal) join in to explore reasons for the problem and find ways to enhance positive motivation
Step 4: If the new strategies don't work, talk to others at school to learn about additional approaches they have found helpful.

- Reach out for support/mentoring/coaching
- Participate with others in clusters and teams
- Observe how others teach in ways that effectively address differences in student motivation and capability
- Request additional staff development on working with students who have learning, behavior, and emotional problems

With respect to staff development, there are a variety of topics that might be pursued. These include:

- addressing barriers to learning within the context of a caring, learning community
- ways to train aides, volunteers, and peers to help with targeted students
- specific strategies for mobilizing parent/home involvement in schooling
- using specialist staff for in-class and temporary out-of-class help
- addressing the many transition needs of students.

Step 5: If necessary, use the school's referral processes to ask for additional support services.

Step 6: Work with referral resources to coordinate your efforts with theirs for classroom success.
3. About Pre-referral Teams

Some Excerpts from the Journals

**A Meta-analysis of Pre-referral Intervention Teams: Student and Systemic Outcomes***

Although prereferral intervention teams (PIT) are common in public schools, there is little and conflicting research to support them. The current article conducted and empirical meta-analysis of research on PITs by reviewing 72 articles. Nine of the articles matched the inclusion criteria for the study and 57 effect size (ES) coefficients were computed, which resulted in a mean ES of 1.10. The studies were further broken down by category of dependent variable (DV), and resulted in a mean ES of 1.15 for student outcomes and 0.90 for systemic outcomes. PITs that were implemented by university faculty resulted in a mean ES of 1.32, but field based PITs resulted in a mean ES of only 0.54. Studies that used random assignment resulted in higher ES coefficients than those that used nonrandom assignment. Implications for research and cautious suggestions for practice are discussed.


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**Student Success Teams: A Blueprint for Building Student and School-wide Progress***

The Student Success Team, is a positive school-wide early identification and early intervention process. Working as a team, the student, parent, teachers and school administrator identify the student’s strength and assets upon which an involvement plan can be designed. Concerns are seen as obstacles to student success and not descriptors of the student’s character. As a regular school process, the SST intervenes with school and community support and a practical improvement plan that all team members agree to follow. Follow-up meetings are planned to provide a continuous casework strategy to maximize the students’ achievement and school experience.

*California Dropout Prevention Network (2000). CA Dept. of Education*
Teacher Assistance Teams

One prereferral method uses teacher assistance teams (TATs) which also go by such labels as staff support teams, intervention assistance teams, etc. Stokes (1982) defines a TAT as “a school based problem-solving group whose purpose is to provide a vehicle for discussion of issues related to specific needs of teachers or students and to offer consultation and follow-up assistance to staff...” TATs are typically comprised of regular classroom, teachers; however, in some settings, TATs also include representatives from multiple disciplines, such as psychology or special education. TATs focus on intervention planning, usually prior to referral and assessment, rather than on placement. The TAT and the referring teacher meet to discuss problems the student is having, think of possible solutions, and develop a plan of action to be implemented by the referring teacher. Assessment data are gathered by TATs for the purpose of planning and monitoring the effectiveness of interventions. Follow-up meetings are held to discuss the effectiveness of the proposed interventions, and to develop other strategies if necessary. Ultimately, the TAT decides whether the student should be referred to special education (Garcia & Ortiz, 1988).

References


B. The Referral Process: Some Guidelines and Steps

Everyone would do well to gain a bit of consumer savvy before contacting a professional resource -- not because professionals are out to rip people off (although there are a few shady practitioners in any profession) but because the majority of professional services by their very nature have built-in biases and usually reflect prevailing treatment dogma.

Practitioners often promote only one view of a problem and the needed treatment, and may also use confusing jargon or perhaps overly complex or unproven theories and practices.

In looking for help the consumer's problem is twofold:

- to identify feasible resources
- to evaluate their appropriateness.

Effective referral intervention strategies involve procedures that

- provide ready reference to information about appropriate referrals
- maximize follow-through by helping students and families make good decisions and plan ways to deal with potential barriers.

A client oriented, user friendly referral intervention is built around recognition of the specific needs of those served and involves clients in every step of the process. That is, the intervention is designed with an appreciation of

- the nature and scope of student problems as perceived by students and their family
- differences among clients in terms of background and resources
- the ethical and motivational importance of client participation and choice.

Moreover, given that many clients are reluctant to ask for or follow-through with a referral, particular attention is paid to ways to overcome factors that produce reluctance.
Referral Intervention Guidelines

A referral intervention should minimally

• provide readily accessible basic information about all relevant sources of help

• help the student/family appreciate the need for and value of referral

• account for problems of access (e.g., cost, location, language and cultural sensitivity)

• aid students/families to review their options and make decisions in their own best interests

• provide sufficient support and direction to enable the student/family to connect with an appropriate referral resource

• follow-up with students (and with those to whom referrals are made) to determine whether referral decisions were appropriate.

These guidelines can be translated into a 9 step intervention designed to facilitate the referral process and maximize follow-through.
Referral Steps*

Step 1
Provide ways for students and school personnel to learn about sources of help without having to contact you

This entails widespread circulation to students/families and staff of general information about available services on- and off-campus and ways students can readily access services.

Step 2
For those who contact you, establish whether referral is necessary

It is necessary if school policy or lack of resources prevent the student's problem from being handled at school.

Step 3
Identify potential referral options with the client

If the school cannot provide the service, the focus is on reviewing with the student/family the value and nature of referral options. Some form of a referral resource file is indispensable (see Appendix B for more on the idea of a Referral Resource File).

Step 4
Analyze options with client and help client choose the most appropriate ones

This mainly involves evaluating the pros and cons of potential options (including location and fees), and if more than one option emerges as promising, rank ordering them.

Step 5
Identify and explore with the client all factors that might be potential barriers to pursuing the most appropriate option

Is there a financial problem? a transportation problem? a parental or peer problem? too much anxiety/fear/apathy?

(cont.)
Referral Steps (cont.)

Step 6

Work on strategies for overcoming barriers

This often overlooked step is essential if referral is to be viable. It entails taking time to clarify specific ways the student/family can deal with factors likely to interfere with follow-through.

Step 7

Send clients away with a written summary of what was decided*

That is, summarize
*specific information on the chosen referral,
*planned strategies for overcoming barriers,
*other options identified as back-ups in case the first choice doesn't work out.

Step 8

Provide client with follow-through status forms
(See Appendix C for examples of tools to aid these steps.)

These are designed to let the school know whether the referral worked out, and if not, whether additional help is needed in connecting with a service.

Step 9

Follow-up with students/families (and referrers) to determine status and whether referral decisions were appropriate
(See Appendix C for examples of tools to aid these steps.)

This requires establishing a reminder system to initiate a follow-up interview after an appropriate time period.

Obviously, the above steps may require one or more sessions.

If follow-up indicates that the client hasn't followed-through and there remains a need, the referral intervention can be repeated, with particular attention to barriers and strategies for overcoming them. Extreme cases may require extreme measures such as helping a family overcome transportation problems or offering to go with a family to help them connect with a referral.

*Before pursuing such steps, be certain to review school district policies regarding referral (see Appendix B).
C. Providing Information about Services

Whether you are in a situation with few or many referral options, it is essential to compile and share basic information about all potential services (see Appendix B). A prerequisite for establishing and updating a good referral information system is to identify a staff member who will accept ongoing responsibility for the system.

Initially, such activity may take 3-4 hours a week. Maintaining the system probably requires only 1-2 hours per month. The staff member in charge of the system does not need to carry out all the tasks. Much of the activity can be done by a student or community volunteer or an aide.

In gathering information about services, the focus is on clarifying what is offered

• at the school site,
• elsewhere by school district personnel,
• in the local community,
• outside the immediate community.

If the school does not have a list of on-campus resources, a first step is to survey school staff and prepare a list of on-campus services dealing with psychosocial and mental health concerns (see Appendix B).

Similarly, information about other services offered by the school district can be gathered by calling relevant district personnel (e.g., administrators in charge of school psychologists, social workers, health services, special education, counseling).

In some geographic areas, public agencies (e.g., department of social services, libraries, universities) publish resource guidebooks which list major helplines, crises centers, mental health clinics, drug abuse programs, social service agencies, organizations offering special programs such as weight management, and so forth. Also, in some areas, telephone directories contain special sections on local Human Services.
D. Developing Ways to Facilitate Access to Service

In carrying out referral interventions to facilitate access to services, it is useful to develop

- materials listing the most accessible referrals and ways to circulate such materials widely,
- a comprehensive referral resource file,
- an array of procedures to support and direct students in following-through on referrals.
- And, it also may be useful to make personal contact with individuals at various agencies and programs as a way of opening doors for students referred from the school.

1. Highlighting the Most Accessible Referral Resources

Once the most accessible referrals are identified, they can be listed and the lists can be widely circulated (see Appendix H for examples). Such listings might take the form of

- 1-2 page handouts,
- wallet-size handouts,
- program description flyers & posters.

To ensure widespread circulation, information on services first can be distributed to all school staff (preferably with a memo from the school administration clarifying the purposes and importance of referring students in need). A follow-up presentation at a school staff meeting is highly desirable.

For older students, staff can offer to make direct presentations -- at least in classrooms of teachers who play a key role in distributing such information to students (e.g., homeroom or health teachers).

Because of staff changes, new enrollments, and the need for reminders, service information materials might be circulated at least three times during the school year. If the school has a health fair, this provides an excellent opportunity for disseminating service information material along with other relevant pamphlets. Such information also might be published in student newspapers and parent newsletters and as part of periodic health exhibits in school display cases and in health, counseling, and other offices.
2. **Referral Resource Files**

A referral resource filing system is intended to contain a comprehensive compilation of basic information on available services (see Appendix B).

Sources for this information are published directories or material gathered directly from programs and agencies. For example, once identified, each service can be asked to provide all relevant program descriptions and information which can be filed alphabetically in separate folders.

Referral files are most useful when the basic information on available services also is categorized. Minimally, categorization should be by location and by the type of problems for which the service can provide help.

To further facilitate access, the information on each program can be briefly summarized and placed in a binder "Resource Notebook" for easy reference. Minimally, a program summary might itemize

- service fees (if any) and hours
- whether provision is made for clients who do not speak English
- specific directions to locations (if off-campus, it is helpful to specify public transportation directions).

Referral resource files should be located where interested students can use them on their own if they so desire. To facilitate unaided use, a set of simple directions should be provided, and files and "Resource Notebooks" need to be clearly labeled.
3. Support and Direction for Follow-through

Many students are uncertain or not highly motivated to follow-through with a referral; others are motivated to avoid doing so. If we are to move beyond the ritual of providing referrals which students ignore, time and effort must be devoted to procedures that increase the likelihood of follow-through.

This involves finding out:

*Does the student agree that a referral is necessary?* (See student interview form in Appendix A.)

If not, additional time is required to help the student explore the matter. Uncertain students often need more information and should be offered the opportunity to meet with someone (e.g., school counselor, nurse, psychologist) who can explain about available programs. This includes discussing concerns about parental involvement. If such exploration does not result in the student really wanting to pursue a referral, follow-through on her or his own is unlikely. The problem then is whether the student's problem warrants coercive action (e.g., recruiting parents to take the student to the service).

For students who do agree that referral is appropriate but still are not highly motivated to follow-through, intervention focuses on increasing their motivation and providing support as they proceed.

Student participation in the process of identifying and choosing referral options is seen as one key to increasing motivation for follow-through. Students who feel the choice of where to go is theirs are likely to feel more committed. This is a good reason for working closely with a student at each step in identifying referral options.

Another aspect of enhancing a student's resolve to pursue a referral involves clarifying and addressing any reluctance, concern, and barriers through

- careful exploration of such factors
- specification of strategies to deal with them.
At the conclusion of the referral session(s), a potential enabling device is to provide the student with

- a written summary of referral recommendations and strategies for overcoming barriers
- two follow-up feedback forms -- one for the student to return to the school and one for the referral agency to send back.

See Appendix C for examples.

Other major supports that might be offered students include

- helping them make initial phone contacts and appointments (including having the student talk directly with the person to be seen)
- providing specific directions and even transportation to the first appointment
- parents or staff accompanying a student to the first appointment
- following-up (as described in a subsequent section).

4. **Personal Contact with Referral Resources**

Some staff have found that their referrals receive better attention after they have established a personal relationship with someone in a program or at an agency.

They accomplish this by periodically phoning and visiting or inviting selected individuals to visit.

In addition to helping establish special relationships that can facilitate access for students referred by the school, these contacts also provide additional information for referral resource files.
When Can Students Seek Assistance without Parent Involvement?

Older students often want or need to access services without their parents knowing and with confidentiality protected. Where the law allows, licensed professionals can offer some sensitive services without parent consent. School-based health centers allow for open access once parents have signed an initial consent form that allows the student to use designated services.

In many instances, however, students are not in a position or motivated to follow-through with a referral -- even though their problems may be severe. Thus, more often than not, parent involvement is needed to facilitate follow-through. For example, students may need parents to pay fees and for transportation. If a student is not an emancipated minor, the referral resource will probably require parental consent.

When parent involvement is indicated, the referral intervention includes efforts to help students understand the benefits of such involvement and encourage them to discuss the matter with their parents. Staff can play a major role in facilitating and perhaps mediating a student-parent discussion for students who see the need but are fearful of approaching their parents without support.

What if a student is determined not to involve parents? Except when inaction would place the student or others in extreme danger, some staff prefer to honor a student's desire to maintain confidentiality. In such instances, the only course of action open is to offer whatever referral follow-through support the school can provide. Some staff, however, believe it essential for parents to take responsibility for student follow-through. Thus, parents are given referral information and asked to see that the student makes contact. Any needed follow-through support is directed at the parents.

5. Enhancing On-Campus Services

It is given that referral to services offered on-campus ensures accessibility and generally increases follow-through. Therefore, efforts to expand on-campus resources are important to improving follow-through.

Additional on-campus resources can be accomplished by

• recruiting and training interested school personnel and students to offer appropriate services (e.g., mediating, mentoring, counseling)

• outreaching to convince appropriate agencies and professionals to offer certain services on-campus (e.g., arranging for on-campus substance abuse counseling by personnel from county mental health or a local community mental health clinic)

• outreaching to recruit professionals-in-training and professional and lay volunteers

• helping create new programs (e.g., stimulating interest in starting a suicide prevention program and helping train school staff to run it).
Case Example

A 10th grader comes to see you because her home situation has become so distressful she cannot concentrate on her school work, and she is feeling overwhelmed. It's evident she needs support and counseling. Because the school cannot currently provide such services, she has to be referred elsewhere. Thus, it falls to someone at the school to implement a referral intervention. The immediate intervention might be conducted over two sessions, with a follow-up interview done 2 weeks later. The gist of the intervention might take the following form.

Session 1: Sara, you've been very open in talking with me about the problems you're having at home. It sounds like some regular counseling appointments might help you sort things out.

Right now, we can't provide what you need. Because it's important to take care of the problems you've told me about, I want to help you find someone who can offer what you need.

Let's look over what's available. (Referral Resource Files are used -- see Appendix B) We have this information about local counseling resources. The first lists services provided by neighborhood agencies. There are two that might work for you. You said one of the problems is that your father drinks too much. As you can see, one local counseling center is doing a weekly group for Children of Alcoholics who want to talk about their troubles at home. And, on Wednesday afternoons, a social worker from a community center comes to the school to offer individual counseling.

Not too far away is a counseling program offered by the school district. What might work for you is one of their counseling groups. These are offered on either Tuesday or Thursday after school at a place which is about 3 miles from here.

The program offered here at the school and the one provided by the school district are free; the one at the local counseling center charges a fee of $5 for each session. Both the school district's program and the local counseling center are on the bus line so you could get there on your own.

Why don't you take tonight to think about what might work best for you and maybe make a list of concerns you have that we should talk about. Think about how you feel about meeting with a counselor alone or working with other students in a support group. You may want to talk to your parents before you decide, but you don't have to. However, if you do want counseling, your parents will have to give their consent.

Let's meet again tomorrow to discuss your options and how I can help you make your decision.  

(cont. on next page)
Case Example (cont.)

The second session focuses on Sara's (a) anxiety about telling her father she wants to sign up for counseling, (b) concerns about whether to join a group, and (c) preference not to go to an off-campus service. Any other barriers that might hinder follow-through also are worked on.

[After the various pros and cons are discussed and Sara seems to be favoring a particular option . . .]  

**Session 2:** So it sounds as if you’d like to see the social worker who comes to campus every Wednesday. We should put that down as your first choice. You also said the Children of Alcoholics group might be worth checking out -- let's put that down as a second choice. . . . And as we agreed, I'll be glad to meet with you and your parents to help you explain that such counseling will be a good thing for you.

Let's call your parents now and set up an appointment. . . . Tomorrow, you can call the social worker and make an appointment to talk about signing up for a regular counseling time. . . . If you have trouble with any of this, remember to come back to see me for help.

I've written all this down; here's your copy. (See Appendix A.) I'd also like you to let me know how our plans work out. Here's a form for you to return to me; all you have to do is put a check mark to let me know what happened and then drop the form in the school mail box sometime next week. (See Appendix C.)

Also, unless you need to come see me before then, I'll be checking with you in two weeks to see how things worked out.

**Follow-up Interview:** A "tickler" system (e.g., a notation on a calendar) is set up to provide a daily case monitoring reminder of who is due for a Follow-up Interview (discussed on the next page). The interview explores:

Has Sara been able to connect with her first or second choices?

If not, why not? And, how can she be helped to do so?

If she has made contact, does it now seem like the right choice was made? If not, the reasons why need to be clarified and additional options explored.
E. Following-Up on Referrals (including consumer feedback)

Follow-through for most referrals is meant to occur within a two week period. Thus, a good referral system should have a process in place that regularly reviews the status of students who were given referrals three weeks earlier.

The elements of such a system might include

- feedback forms given to clients for themselves and the referral agency (see Appendix D)
- a feedback form sent directly to the referral of first choice
- a procedure for daily identification of students due for referral follow-up
- analysis of follow-through status based on feedback
- follow-up interviews with students/families for whom there is no feedback information (See Appendix D).

For example:

As part of referral intervention, students/families can be given two types of feedback follow-up forms. In addition, a "back-up" feedback form can be sent directly to the service the student has identified as a first choice.

The client is to return a form to the school to show that contact was made with the referral agency or to clarify why such contact was not made. In either instance, the form reminds the student/family to return for additional referral help if needed.

If contact was made, the student/family might be asked to indicate whether the service seems satisfactory. For anyone who indicates dissatisfaction, the school may want to discuss the matter to determine whether another option should be pursued. If many clients indicate dissatisfaction with a particular agency, it becomes clear that it is not a good resource and should be removed from the referral listings.

The feedback form sent directly to the chosen service simply calls for a confirmation of follow-through. (With on-campus referrals, it has been found useful to establish a reciprocal feedback system. (See Appendix D.)

If no feedback forms are returned, the student can be invited to explore what happened and whether additional support and direction might help.
Evidence-based Treatments Must Have a Referral and Case Management Context*

Twenty years ago several randomized clinical trials found that interventions limited to screening primary care patients for depression did not substantially improve care for depression or outcomes (Attkisson & Yager, 1982; Mugrader-Habib, Zung, & Feussner, 1990; Shapira, 1996). Similarly, recent interventions limited to training of primary care physicians without providing additional resources in caring for patients had very limited success (Thompson et al., 2000). These experiences led to interventions designed to incorporate more of the components of comprehensive chronic disease management models (Von Korff, & Tiemens, 2000; Wagner, Austin, & Von Korff, 1996). The key components are (1) case finding and outreach to persons at risk for chronic disease; (2) consumer activation and self-management support, to achieve sustainable, appropriate care; (3) provider education and decision support based on evidence-based practice guidelines; (4) structural changes in the delivery of care that facilitate fulfilling roles and accountabilities for a collaborative team, and that support care for the disease at each essential step in care; (5) use of information system to support follow-up and tracking outcomes; (6) care management to link services and support initiation of and adherence to evidence-based treatments; (7) consultation from specialists for more complex patients, that is, “stepped care”; and (8) effective linkages with community agencies.

Evaluations of interventions based on this model have usually been conducted in staff model managed care organizations and have been shown to consistently decrease depressive symptoms, whether relying on underlying improvement in medication management or psychotherapy provision (Katon et al., 1995, 1996).

*NIMH Affective Disorders Workgroup (2002). Mental Health Services Research, 4, No. 4.
F. Managing Care, Not Cases

Common terminology designates those whom professionals work with as “cases.” Thus, considerations about making certain that clients connect with referral resources often are discussed as “case monitoring” and efforts to coordinate and integrate interventions for a client are designated “case management.”

Given that words profoundly shape the way people think, feel, and act, some professionals are arguing for use of the term “care” in place of “case.” Such a move is in keeping with the view that care is a core value of helping professionals. It also is consistent with the growing emphasis on ensuring that schools are “caring communities.” For these reasons, it seems appropriate to replace the term case management with that of management of care.

Management of care involves (1) initial monitoring, (2) ongoing management of an individual's prescribed assistance, and (3) system's management. As with any intervention, these activities must be implemented in ways that are developmentally and motivationally appropriate, as well as culturally sensitive.

1. Initial Monitoring of Care

Stated simply, monitoring of care is the process by which it is determined whether a client is appropriately involved in prescribed programs and services. Initial monitoring by school staff focuses on whether a student/family has connected with a referral resource. All monitoring of care requires systems that are designed to gather information about follow-through and that the referral resource is indeed turning out to be an appropriate way for to meet client needs. When a client is involved with more than one intervener, management of care becomes a concern. This clearly is always the situation when a student is referred for help over and above that which her/his teacher(s) can provide.

Subsequent monitoring as part of the ongoing management of client care focuses on coordinating interventions, improving quality of care (including revising intervention plans as appropriate), and enhancing cost-efficacy.

2. Ongoing Management of Care

At the core of the on-going process of care management are the following considerations:

- Enhanced monitoring of care with a specific focus on the appropriateness of the chosen interventions,
- Adequacy of client involvement;
- Appropriateness of intervention planning and implementation, and progress.

Such ongoing monitoring requires systems for:

- Tracking client involvement in interventions
- Amassing and analyzing data on intervention planning and implementation
- Amassing and analyzing progress data
- Recommending changes

(cont.)
Effective Care Management is based upon:

- Monitoring processes and outcomes using information systems that enable those involved with clients to regularly gather, store, and retrieve data.
- The ability to produce changes as necessary to improve quality of processes.
- Assembling a “management team” of interveners and clients, and assigning primary responsibility for management of care to one staff member or to several staff who share the role.
- Assuming a role that always conveys a sense of caring and a problem-solving orientation, and involves families as empowered partners.
- Facilitation of self-determination in clients by encouraging participation in decision-making and team reviews (particularly when clients are mandated or forced to enroll in treatment)
- Meeting as a management teams need to meet whenever analysis of monitoring information suggests a need for program changes or at designated review periods.

A few basic guidelines for primary managers of care are:

- Write up analyses of monitoring findings and recommendations to share with management team;
- Immediately after a team meeting, write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks by when;
- Set-up a "tickler" system (e.g., a notation on a calendar) to remind you when to check on whether tasks have been accomplished;
- Follow-up with team members who have not accomplished agreed upon tasks to see what assistance they need.

3. Systems of Care

The concept of a "system of care" is an evolving idea that is applied in a variety of ways. While management of care is focused on a given client, the concept of systems of care emphasizes the importance of coordinating, integrating, and enhancing systems and resources to ensure that appropriate programs are available, accessible, and adaptable to the needs of the many clients who need help. Moreover, the aim is to ensure these resources are used effectively and efficiently.

A focus on system resources requires attending to various arenas and levels of potential support. A school has many programs and services that it owns and operates. A school district has additional resources. The surrounding community usually has public and private sector programs and a variety of other resources that may be of assistance. City, county, and state agencies also play a role in addressing certain needs.

In its initial application, the concept of systems of care focused on services to address clients with severe and well-established problems (e.g., youngsters with serious emotional disturbance). The intent of systems of care for such populations is to:

- develop and provide a full array of community-based programs (including residential and non-residential alternatives to traditional inpatient and outpatient programs) to enhance what is available and reduce overreliance on out-of-home placements and overly restrictive treatment environments;
- increase interagency collaboration in planning, developing, and carrying out programs to enhance efficacy and reduce costly redundancy;
- establish ways that interventions can be effectively adapted to the individuals served.

(cont.)
To expand these goals to encompass prevention, there are increasing calls for incorporating primary and secondary prevention programs into all systems of care. At school sites, one mechanism for focusing on enhancing systems of care is a resource-oriented team. Such a team is designed to bring together representatives from all major programs and services addressing barriers to learning and promoting healthy development (e.g., pupils services personnel, a site administrator, special education staff, bilingual coordinators, health educators, noncredentialed staff, parents, older students). It also includes representatives from community agencies that are significantly involved at a school.

A resource team differs from teams created to review individual students (such as a student study team) because it focuses on managing and enhancing systems to coordinate, integrate, and strengthen interventions. At the same time, many of the same staff usually are on both types of teams. Thus, initial creation of a resource team often is best accomplished by broadening the scope of a student study team (or a teacher assistance team or a school crisis team). In doing so, however, it is essential to separate the agenda and have the members change "hats."

A resource team works toward weaving together all school and community programs and services. Among its activities, the team:

- Conducts resource mapping and analysis with a view to improving resource use and coordination
- Ensures that effective systems are in place for triage, referral, management of care, and quality improvement
- Establishes appropriate procedures for effective program management and for communication among school staff and with the home
- Suggests ways to reallocate and enhance resources (e.g., clarifying how to better use staff and resources, which activities need revision or are not worth continuing).

Properly constituted, trained, and supported, a resource team can complement the work of the school's governance body through providing on-site overview, leadership, and advocacy for activities aimed at addressing barriers to learning and enhancing healthy development. To these ends, at least one team member should be designated as a liaison between the team and the school's governing and planning bodies to ensure the maintenance, improvement, and increased integration of essential programs and services with the total school program.

Because they often deal with the same families (e.g., families with children at each level of schooling) and link with the same community resources, complexes of schools (a high school and its feeder middle and elementary schools) should work collaboratively. A Complex Resource Council brings together representatives from each school's resource team to facilitate coordination and equity among schools in using school and community resources.

For more on this, see Appendix D and Center documents on the topic..
4. More About Case Management

On the following pages is a sampling of discussions from the literature on this topic. Specifically, the focus is on:

- Case Management: Concepts and Skills
- Curriculum for Community-Based Child/Adolescent Case Management Training
- Building Scaffolds of Support: Case Management in Schools
- Case Management with At-Risk Youth
- Advanced Technology to Assist with Student Care
What is Case Management?

"Case management as a way of helping people has a long and rich history."

"While the focus of case management is linking a client to needed services, other elements involve advocacy and social action"

"If the goal is service access and coordination, the case manager's efforts are designed to alleviate or counter the fragmentation of services and the natural tendency of bureaucratic organizations toward disorganization. For the case manager to achieve this goal, the following elements or conditions must be present:

- An accurate assessment and ongoing evaluation of client needs;
- The ability to link clients to resources appropriate to their needs;
- The power to ensure that appropriate and needed services are actually delivered;
- The capacity to see that services are utilized"

Case Management Tasks

"Probably the most comprehensive listing of tasks required of and performed by case managers was developed by Bertsche and Horejsi in 1980. The thirteen basic tasks provide a clear and concise description of case management responsibilities:

1. Complete the initial interviews with the client and his or her family to assess the client's eligibility for services.

2. Gather relevant and useful data from the client, family, or other agencies, and so on to formulate a psychosocial assessment of the client and his or her family.

3. Assemble and guide group discussions and decision-making sessions among relevant professionals and program representatives, the client and his or her family, and significant others to formulate goals and design an integrated intervention plan.

4. Monitor adherence to the plan and manage the flow of accurate information within the action system to maintain a goal orientation and coordination momentum.

5. Provide 'follow-along' to the client and his or her family to speed identification of unexpected problems in service delivery and to serve as a general troubleshooter on behalf of the client."
6. Provide counseling and information to help the client and his or her family in situations of crisis and conflict with service providers.

7. Provide ongoing emotional support to the client and his or her family so they can cope better with problems and utilize professionals and complex services.

8. Complete the necessary paperwork to maintain documentation of client progress and adherence to the plan by all concerned.

9. Act as a liaison between the client and his or her family and all relevant professionals, programs, and informal resources involved in the overall intervention plan to help the client make his or her preferences known and secure the services needed.

10. Act as a liaison between programs, providing services to the client to ensure the smooth flow of information and minimize the conflict between the subsystems.

11. Establish and maintain credibility and good public relations with significant formal and informal resource systems to mobilize resources for current and future clients.

12. Perform effectively and as a 'good bureaucrat' within the organization to be in a position to develop and modify policies and procedures affecting clients and the effectiveness of the service delivery system.

13. Secure and maintain the respect and support of those in positions of authority so their influence can be enlisted on behalf of the client and used, when necessary, to encourage other individuals and agencies to participate in the coordination effort.

A Final Word

"The potential of case management to help people solve their problems, make better use of the available community and governmental resources, and work together to advocate and develop new and better resources is tremendous…. Case management programs can give their clients fish, fishing poles, and guidance to the lakes where the fish are. "

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Summary of
Curriculum for Community-Based Child and Adolescent
Case Management Training

Norma Radol Raiff (December, 1992). Developed under contract with the South Carolina Department of Mental Health for the Southern Human Resources Development Consortium for Mental Health, 2414 Bull Street, P.O. Box 485, Columbia, South Carolina 29202.

The curriculum was developed to help states and local programs to prepare specialized community-based case managers to work with seriously emotionally disturbed children and adolescents.

Includes Units on the following topics:

- **Why is children's case management different from adult case management? Public, clinical, and parent perspectives.** This unit introduces participants to the philosophy of "a system of care." Objectives include describing the state or program's eligibility criteria and identifying five differences between child and adult mental health case management.

- **Families as allies: Empowerment perspectives.** This unit helps participants identify and reinforce skills and attitudes associated with successful family collaboration. Sensitivity to the cultural diversity of families and techniques for a more responsive practice will be discussed. Objectives include describing why collaboration is essential, identifying barriers, and discussing family empowerment strategies.

- **Consultative case management: Team building and beyond.** In this unit participants learn the philosophy of case management as consultation with parents and other team members. Objectives include defining what consultation means, identifying the dynamics and process of team meetings, and describing how case managers can be consultants with others.

- **Monitoring and quality assurance: Standards of documentation.** This unit describes the process of setting goals for a service plan, and monitoring based on quality assurance and quality improvement standards. Objectives include describing an assessment process that recognizes both strengths and needs, developing a working service plan, defining standards of documentation, and suggesting steps for improving practice.

- **Resource acquisition.** In this unit, participants learn about collaborative structures which are vehicles for resource acquisition and the development of individualized services. Objectives include describing the local (State) "system of care," describing the resources and procedures for accessing these resources.

- **Putting it together: A guided role play.** This unit gives participants an opportunity to apply case management skills in three different practice situations: referral, strengths interviewing, and negotiation. Objectives include understanding and working with common issues in child team settings, proficiency in initiating contact with a parent/child, and proficiency in negotiating systems in partnership with a parent/child.

- **Advocacy for children with serious emotional disturbance/behavioral disorders.** This additional unit provides an overview of the role of advocacy in child case management.

- **Appendices with optional assessments and masters for overheads.**
Excerpts from:

**Building Scaffolds of Support:**

**Case Management in Schools**


**Key Features of Individual Case Management:**

The key features of case management were identified initially as mainly welfare related and included:

- A trusting and enabling relationship between the young person and worker,
- A focus on understanding the young person in the context of the social and emotional environment in which the young person is located,
- Ensuring continuing care where there are complex and/or multiple problems, and
- Ameliorating the emotional problems accompanying issues the young person may face (family conflict, homelessness, loss of income or economic support, poverty).

Activities undertaken in case management are wide ranging and include assisting young people with study skills (sometimes this was done individually or at other times collectively). The most common activity through the schools was work placement. At times the worker would meet with the young people's families. Sometimes the worker would meet with the teachers the young person did not get on with, and also meet with those with whom the young person liked to mediate and discuss issues. Workers also connected the young people to youth groups and to counselling.

For some workers, casework embraced mediation between one young person and his/her peers. Some workers acted as advocates on behalf of the young person for housing. Mentoring was provided as an individual approach. Typically this took place in conjunction with outside agencies.

The implementation of an effective school model of case management should take into account a wide range of considerations, including the following strategies:

**Develop a clearly articulated philosophy and theoretical framework:**

Critical concepts include:

- recognizing that all young people are potentially at risk
- developing engagement (how to involve young people in learning)
• developing membership (developing all young people’s sense of being a part of the school)
• developing community (developing a culture of shared concern)
• building effective networks.

**Identify a designated person and join a network:**
As a first step in building scaffolds of support, there needs to be a designated person in conjunction with a team or network, who plans, coordinates and liaises within and outside the school.

**Develop a process to identify the needs of all young people in the school:**
This might include developing a formal relationship between each student and a staff member. It could involve developing a more formal assessment process.

**Establish a comprehensive work experience program:**
The value of strong work experience or vocational learning programs is emphasized in other sections of the report.

**Develop a process to identify and address systemic risk factors in the school:**
Identify ways of removing barriers which inhibit any young person=s opportunity to succeed educationally, socially and interpersonally within the school environment.

**Develop a process to identify and respond to risk in the community:**
Recognise the risk factors in the local community, for example unemployment, drug issues, violence, racism, family issues and lack of community networking. Establish means within the school of increasing awareness of and building proactive responses in young people to these issues. Establish strong collaborative community networks to provide effective support for young people.

**Establish strong school and community networks:**
Networks with parents, school and other education providers, and with other agencies and the broader community greatly enhance the education, training and employment opportunities available to all young people.

**Evaluation of practice**
Ongoing formative and summative evaluation is essential in determining the extent to which the support needs of young people are being met. The focus needs to be on addressing and improving the scaffolds of support for all young people in schools through identification and response to individual employment, education and training needs. The purpose of valuation should be to refine and develop successful initiatives while recognising the lessons from unsuccessful initiatives.
Case Management with At-Risk Youth


Why is Case Management Needed?

At-risk youth have needs that are often complex and intertwined. They require help determining which among a variety of services they need, when, and in what order. They require assistance finding and accessing those services, and support to successfully complete those services.

Human service institutions, on the other hand, are often one-dimensional and specialized. They typically offer services that are funded and provided as separate entities: housing is the niche of one agency, education that of another, and job training that of a third.

The result is that there is often a mismatch between the behavior of the helping-professions and the needs of the youth whom those services intend to help. Without case management, interventions are often uncoordinated and scarce resources squandered. A young person can easily fall through the cracks or give up trying to navigate what is, in most locales, a disjointed multi-institutional "non-system." The function of case management is to overcome the mismatch between institutions and client needs and to provide the continuity of services that is critical for at-risk youth.

Effective Case Management

In order to locate and walk a young person through a sequence of services, the typical case management system has the following components:

- Finding and attracting appropriate clients;
- Intake and assessment;
- Designing a service plan;
- Intervening in the community: broke ring, advocating, and linking;
- Implementing and monitoring the service plan;
- Evaluating the effectiveness of case management.
What makes these activities effective, however, is the philosophy or approach that guides them. As we reviewed the literature and talked with practitioners, four major themes stood out as central to almost every aspect of the case management process:

**Case Management Requires Partnership.** Case management is, first and foremost, a system of partnerships: between case manager and client, and between organizations. In an effective case management system, the case manager works in partnership with the client, sharing responsibility, rather than working on the client. There is a division, rather than a substitution, of labor. Case management also involves partnerships among institutions. At some level, each must be willing to be flexible and to share access to services or resources. In that context, the case manager works for all the partners, helping institutions access clients, and linking clients with those institutions that offer the services young people need.

**Intervening in the Community: Brokering, Advocating, and Linking.** For a case manager to make effective referrals, institutions at the receiving end must have slots available on an needed basis. They must be willing to grant timely admission to their programs, rather than placing the client on a waiting list. Ideally, the case manager can say: "I need my client enrolled in your program this week," and have it happen. Persuading institutions to do this is not easy.

Agencies providing case management have taken a variety of approaches to the referral process. Some place primary responsibility for identifying and securing services with the case manager, who works to develop needed slots on a case by case basis. Other agencies have organized the referral process more formally by assigning the task to a "resource developer" who secures service slots from agencies in the same manner as job developers have traditionally obtained employment slots from businesses.

The basic principles of case management point to a multifaceted role for the case manager. In essence, case managers are "jacks of all trades." They stimulate, coordinate, and monitor service delivery so that youth do not fall through cracks. They do whatever is necessary to remove barriers hindering a client's advance towards self-sufficiency.
Advanced Technology to Assist with Student Care

School sites with health or family service centers already have entered the age of computer assistance in providing care for students and their families. Constantly evolving systems are available not only to facilitate record keeping and reporting, but to aid with assessment and consultation, referrals, program planning, and ongoing management of care. As schools and other agencies move to computerized information systems, the capacity for integration and networking will be greatly enhanced.

For example, schools and community agencies will have the opportunity to share relevant information in ways that protect client privacy and enhance collaborative intervention. The advanced technology will also allow for rapid updating of information about available services, and school staff will be able to help students/families sign-up on-line. Computer technology also can be used as another modality to enhance counseling and therapy.

Beyond enhancing efforts to treat problems, the advanced technology opens up new avenues for students and parents to seek out information for themselves and connect with others for support.

Of course, as with any tool, computer software varies in quality and can be misused. For instance, reliance on computer programs to generate diagnoses will predictably exacerbate current trends to overuse psychopathological diagnoses in identifying mild-to-moderate emotional, learning, and behavior problems.

Similarly, there is a danger that schools will develop their computerized information and computer-assisted intervention systems in a fragmented and piecemeal manner. This will result in a waste of scarce resources and will reduce the usefulness of what is potentially an extremely powerful aid in efforts to address barriers to student learning and enhance healthy development.

References
IV. Other Related Resources and References

A. References

B. Related Quick Find Resource

C. Consultation Cadre
A. References


Mamlin, N., & Harris, K.R. (1998). Elementary teachers’ referral to special education in light of inclusion and prereferral: “Every child is here to learn...but some of these children are in real trouble”. Journal of Educational Psychology, 90, 385-396.


Ortega, A.N. & Rosenheck R.. (2002). Hispanic client-case manager matching: Differences in outcomes and services use in a program for homeless persons with sever mental illness. Journal of Nervous and Mental Disorders, 190, 315-23


*Resources from our Center and others who have relevant aids are included in the Quick Find on the next pages.*
TOPIC: Case/Care Management

The following reflects our most recent response for technical assistance related to this topic. This list represents a sample of information to get you started and is not meant to be exhaustive.
(Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one).

Center Developed Documents, Resources and Tools

Continuing Education Modules
- Addressing Barriers to Learning: New Directions for Mental Health in Schools (Continuing Education Modules)

Quick Training Aids
- Case Management in the School Context (Quick Training Aid)

Technical Aid Packet
- School-Based Client Consultation, Referral, and Management of Care (Technical Aid Packet)

Other Relevant Documents, Resources, and Tools on the Internet

- Accessing Resources for Community and Faith-based Organizations, Federal Funding Toolkit
- Bias in problem solving and the social process of student teams: a qualitative investigation
- Building Scaffolds of Support: Case Management in Schools
- CARAS: A School-Based, Case Management System for At-Risk Students
- Caring for Kids brochure. School-based Mental Health Services: Meeting the Needs of Children
- Children's Mental Health Case Management
- Children's Mental Health: Current Challenges and a Future Direction by Sarah Olbrich, MPH, GWU.
- Conflict Resolution Education: A Guide to Implementing Programs in Schools, Youth Serving Organizations, and Community and Juvenile Justice Settings
- Current applications of case management in schools to improve children's readiness to learn
- Effective Public Management of Mental Health Care: Views from States on Medicaid Reforms That Enhance Service Integration and Accountability
- Elements of Case Management: A Roadmap from the Healthy Start Field Office, UCD
- Guidelines & Benchmarks for Prevention Program Planning: Implementation Guide
- Health-related case management
- How to Develop a Statewide system to Link Families with Community Resources

(To access this quick find go to: http://smhp.psych.ucla.edu/qf/casemanagement.htm)
Integrating Mental Health Services into Primary Care Settings
Knowledge Path: Locating community-based services to support children and families
Mental Health Case Manager
Northeast CAPT FAQs on Program Design, Implementation, and Adaptation
Predicting Teachers’ and Schools’ Implementation of the Olweus Bullying Prevention Program: A Multilevel Study
Promoting Accountability Through Methods and Tools for Planning, Implementation, and Evaluation
Services for African American Children and Families
Services for Hispanic Children and Families
Services for Asian and Pacific Islander Children and Families
Services for Youth from Military Families
Services for Youth in Kinship Care
Services in Urban Communities
Student Assistance Teams
Student Assistance Teams (SAT)
Student Support Teams - Department of Education
Integrated Services: A Summary for Rural Educators
NASW Standards for Social Work Case Management
Student Assistance - North Central Regional Educational Laboratory
The Provider System for Children's Mental Health: Workforce Capacity and Effective Treatment
The Road Ahead: Research Partnerships to Transform Services

Clearinghouse Archived Materials

Packet of Case Management Models
School-Based Case Management: An Integrated Service Model for Early Intervention with Potential Dropouts

Related Agencies and Websites

American Case Management Association
Building a Successful Prevention Program
Case Management Society
Case Management Resource Guide
Community Toolbox
Implementing Research-Based Prevention Programs in Schools
National Center for Mental Health Promotion and Youth Violence Prevention
The National Student Assistance Association
State of California Child Welfare Services/Case Management System

Relevant Publications That Can Be Obtained through Libraries

Beyond child development centres: Care coordination for children with disabilities. Appleton, P. L.; Boell, V.; Everett, J. M.; Kelly, A. M.; and others. Child: Care, Health &


- Coordinated case management through the child protection system. Parnell, Teresa F. In: Teresa F. Parnell, Ed; Deborah O. Day, Ed.


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We hope these resources met your needs. If not, feel free to contact us for further assistance. For additional resources related to this topic, use our search page to find people, organizations, websites and documents. You may also go to our technical assistance page for more specific technical assistance requests.

If you haven't done so, you may want to contact our sister center, the Center for School Mental Health at the University of Maryland at Baltimore.

If our website has been helpful, we are pleased and encourage you to use our site or contact our Center in the future. At the same time, you can do your own technical assistance with "The fine Art of Fishing" which we have developed as an aid for do-it-yourself technical assistance.
C. Consultation Cadre

School-Based Client Consultation Referral and Management Care Consultation

Cadre List

Professional across the country volunteer to network with others to share what they know. Some cadre members run programs, many work directly with youngsters in a variety of settings and focus on a wide range of psychosocial problems. Others are ready to share their expertise on policy, funding, and major system concerns. The group encompasses professionals working in schools, agencies, community organizations, resource centers, clinics and health centers, teaching hospitals, universities, and so forth.

People ask how we screen cadre members. We don’t! It’s not our role to endorse anyone. We think it’s wonderful that so many professionals want to help their colleagues, and our role is to facilitate the networking. If you are willing to offer informal consultation at no charge to colleagues trying to improve systems, programs, and services for addressing barriers to learning, let us know. Our list is growing each day; the following are those currently on file related to this topic. Note: the list is alphabetized by Region and State as an aid in finding a nearby resource. Updated 9/07

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Appendix A

Tools to Facilitate Triage

Info Aid: Helping Students with Psychosocial Problems Seek Help

Triage Review Request Form

Info Aid: Being Alert to Indicators of Psychosocial and Mental Health Problems

Info Aid: Being Specifically Alert to Substance Abuse Indicators

Initial Interview Forms: Student’s View of the Problem (age appropriate versions)

Note: The Center’s Resource Aid Packet on Screening/Assessment: Indicators and Tools contains related materials such as aids for initial problem identification and guides to understanding the screening process. Other Center resources explore issues related to screening.
Helping Students With Psychosocial Problems Seek Help

Students with mental health needs are identified by

- self
- center medical staff
- counselors, school nurse, psychologist, or other school personnel
- family
- peers

*If a student indicates s/he has a problem and you think it should be screened by a mental health professional, you can help by doing the following:*

**Inform and Reassure**

Uncertain students often need more information; they also may need reassurance that they won't be coerced into doing something they don't want to do.

(a) Tell the student that the center (e.g., mental health professional) or other school personnel (e.g., counselors, nurse, psychologist) will be glad to explain about available programs that can help.

(b) Stress that no one will try to pressure the student to do anything s/he doesn't want to do. No one will try to make her or him participate in any mental health service. The decision is always the students.

**Guide Students to Help**

(a) If the student doesn't have parental consent to use the center, explain how s/he should go about getting consent. (Consent forms are available at the health center office.)

**OR**

If the student doesn't want to go to the center or says s/he can't get consent to do so, explain that other school personnel (such as counselors, the school nurse or psychologist) can provide information about services.

(a) Explain to the student how to go about initiating contact (with the center or other school personnel) for a screening interview. Provide as much support and direction as the student appears to need to initiate this contact (including making certain they know the way to the right office, hours of service, arranging for a summons or a pass, and so forth).

(b) If feasible, follow-up with the student to see whether a contact was made. If contact was not made, try to determine whether additional support and direction is needed to help the student make the contact. (For some students, you might ask if they would like you to make the initial contact and have an appointment arranged for them.)

*If the student is not ready to self-initiate contact and you feel s/he should be*
interviewed anyway, inform the appropriate professional at the school.

Triage Review Request Form
(Request for Assistance in Addressing Concerns about a Student/Family)

Extensive assessment is not necessary in initially identifying a student about whom you are concerned. Use this form if a student is having a significant learning problem, a major behavior problem, or seems extremely disturbed or disabled.

Student’s Name _______________________________________ Date:_______

To: _________________________________ Title: ___________________

From: _________________________________ Title: ___________________

Apparent problem (check all that apply):

___ physical health problem (specify) _______________________________

___ difficulty in making a transition
( ) newcomer having trouble with school adjustment   ( ) trouble adjusting to new program

___ social problems
( ) aggressive   ( ) shy   ( ) overactive   ( ) other _________________

___ achievement problems
( ) poor grades   ( ) poor skills   ( ) low motivation   ( ) other _____________

___ major psychosocial or mental health concern
( ) drug/alcoh. abuse   ( ) pregnancy prevention/support   ( ) self esteem
( ) depression/suicide   ( ) eating problems (anorexia, bulim.)   ( ) relationship problems
( ) grief   ( ) physical/sexual abuse   ( ) anxiety/phobia
( ) dropout prevention   ( ) neglect   ( ) disabilities
( ) gang involvement   ( ) reactions to chronic illness

Other specific concerns

Current school functioning and desire for assistance

Overall academic performance
( ) above grade level   ( ) at grade level   ( ) slightly below grade level   ( ) well below grade level

Absent from school
( ) less than once/month   ( ) once/month   ( ) 2-3 times/ month   ( ) 4 or more times/month

Has the student/family asked for:
information about service Y N
an appointment to initiate help Y N
someone to contact them to offer help Y N
If you have information about the cause of a problem or other important factors related to the situation, briefly note the specifics here (use the back of the sheet if necessary).

Information Aid

**Being Alert to Indicators of Psychosocial and Mental Health Problems***

No one should be overzealous in seeing normal variations in student's development and behavior as problems. At the same time, school professionals don't want to ignore indicators of significant problems. The following are meant only to sensitize responsible professionals. They should not be seen as a check list.

If a student is of significant concern, a request should be made to an appropriate person on the school staff who can do some further screening/assessment.

*If they occur frequently and in a variety of situations and appear rather serious when you compare the behavior with other students the same age*, the following behaviors may be symptomatic of significant problems.

**Emotional appearance**
(Emotions seem excessive. Displays little affect. Very rapid shifts in emotional state.)

<table>
<thead>
<tr>
<th>very unhappy, sad, teary, depressed, indicates a sense of worthlessness, hopelessness, helplessness</th>
<th>very afraid, fearful can't seem to control emotions doesn't seem to have feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>very anxious, shy</td>
<td></td>
</tr>
</tbody>
</table>

**Personal Actions**
(Acts in ways that are troublesome or troubling)

speech patterns

<table>
<thead>
<tr>
<th>very immature</th>
<th>frequent outbursts/temper tantrums, violent</th>
</tr>
</thead>
<tbody>
<tr>
<td>often angry</td>
<td>cruel to animals</td>
</tr>
<tr>
<td>sleep problems and/or nightmares</td>
<td>wetting/soiling at school</td>
</tr>
<tr>
<td>easily distracted</td>
<td>impulsive</td>
</tr>
<tr>
<td>steals</td>
<td>lies often</td>
</tr>
<tr>
<td>cheats often</td>
<td>destroys things</td>
</tr>
<tr>
<td>accident prone</td>
<td>unusual, strange, or immature</td>
</tr>
</tbody>
</table>
often doesn't seem to hear
hurts self, self-abusive
easily becomes overexcited
truancy, school avoidance
trouble learning and performing
eating problems
sets fires
ritualistic behavior
seizures
isolates self from others
complains often about physical aches and pains
unaccounted for weight loss
substance abuse
runs away
Interactions with others
(Doesn't seem interested in others. Can't interact appropriately or effectively with others.)

- doesn't pay attention
- cruel and bullying
- highly manipulative
- alienates others
- has no friends
- refuses to talk
- promiscuous
- excessively reactive and resistant to authority
- highly aggressive to others -- physically, sexually

Indicators of Unusual Thinking
(Has difficulty concentrating. May express very strange thoughts and ideas.)

- worries a lot
- doesn't stay focused on matters
- can't seem to concentrate on much
- preoccupied with death
- seems to hear or see things, delusional

*Additional indicators for problems (such as depression in young people) are available through a variety of resources – for example, see the various gateways available on the website of the Center for Mental Health in Schools at UCLA.  http://smhp.psych.ucla.edu
Information Aid – Being Specifically Alert to Substance Abuse Indicators

It is essential to remember that many of the symptoms of substance abuse are common characteristics of young people, especially in adolescence. This means extreme caution must be exercised to avoid misidentifying and inappropriately stigmatizing a youngster. Never overestimate the significance of a few indicators.

The type of indicators usually identified are

- a prevailing pattern of unusual and excessive behaviors and moods
- recent dramatic changes in behavior and mood.

School staff and those in the home need to watch for

- poor school performance; skipping or ditching school
- inability to cope well with daily events
- lack of attention to hygiene, grooming, and dress
- long periods alone in bedroom/bathroom apparently doing nothing
- extreme defensiveness; negative attitudes; dissatisfied about most things; argumentative
- frequent conflicts with others; verbally/physically abusive
- withdrawal from long-time friends/family/activities
- disregard for others; extreme egocentricity
- taking up with new friends who may be drug users
- unusual tension or depressed states
- seems frequently confused and "spacey"
- often drowsy
- general unresponsiveness to what's going on (seems "turned off")
- increasing need for money; disappearance of possessions (e.g., perhaps sold to
- buy drugs); stealing/shoplifting
- excessive efforts to mislead (lying, conning, untrustworthy, insincere)
- stooped appearance and posture
- dull or watery eyes; dilated or pinpoint pupils
- sniffles; runny nose
- overt indicators of substance abuse (e.g., drug equipment, needle marks)

In the period just after an individual has used drugs, one might notice mood and behavioral swings – first euphoria, perhaps some unusual activity and/or excessive talking, sometimes a tendency to appear serene, after a while there may be a swing toward a depressed state and withdrawal. Sometimes the individual will stare, glassy-like at one thing for a long time.

To be more specific about a few indicators of abuse categorized by some common substances that are abused:

**Amphetamines (stimulants)**

- excessive activity
- rapid speech
- irritability
- appetite loss
- anxiety
- extreme moods and shifts
- erratic eating and sleeping patterns

**Cocaine (stimulant, anesthetic)**

- short-lived euphoria followed by depression
- nervousness and anxiety
- irritability
- shallow breathing
- fatigue
- disorientation and confusion
- increased blood pressure and body temp.
- increased respiration
- increased and irregular pulse
- tremors
- fever
- tremors
- tightening muscles
Inhalants  
euphoria  
intoxicated look  
odors  
nausea  
drowsiness  
stupor  
headaches  
fainting  
poor muscle control  
rapid heartbeat  
anemia  
choking  
Cannabinoids (e.g., marijuana, hash, THC)  
increased appetite initially  
decreased appetite with chronic use  
euphoria  
decreased motivation for many activities  
apathy, passivity  
decreased concentration  
altered sense of time and space  
inappropriate laughter  
rapid flow of ideas  
anxiety; panic  
irritability, restlessness  
decreased motor skill coordination  
characteristic odor on breath and clothes  
increased pulse rate  
droopy, bloodshot eyes  
irregular menses  
Narcotics (e.g., opium, heroin, morphine, codeine, methadone, and other pain killers)  
extreme mood swings  
poor concentration  
confusion  
insensitivity to pain  
drowsiness/decreased respiration  
slow, sallow breathing  
decreased motor coordination  
watery eyes/pinpoint pupils  
lethargy  
weight loss  
decreased blood pressure  
possible needle marks  
as drug wears off nausea & runny nose  
itchiness  
Barbiturates, sedatives, tranquilizers (CNS depressants)  
decreased alertness  
intoxicated look  
drowsy  
decreased motor coordination  
slurred speech  
confused  
extreme mood swings  
erratic eating and sleeping patterns  
dizzy  
cold, clammy skin  
decreased respiration and pulse  
dilated pupils  
depressed mood state  
disinhibition  
Hallucinogens (effecting perceptions; e.g., PCP, LSD, mescaline)  
extreme mood alteration and intensification  
altered perceptions of time, space, sights, sounds, colors  
loss of sense of time, place, person  
decreased communication  
panic and anxiety  
paranoia  
extreme, unstable behaviors  
restlessness  
tremors  
nausea  
flashbacks  
increased blood pressure  
impaired speech  
impaired motor coordination  
motor agitation  
decreased response to pain  
watery eyes
(For use with all but very young students)

**Student's View of the Problem -- Initial Interview Form**

Interviewer ______________________ Date______________

Note the identified problem:

Is the student seeking help?  Yes  No

If not, what were the circumstances that brought the student to the interview?

Questions for student to answer:

Student's Name _______________________________ Age _____   Birthdate ___________

Sex:  M  F  Grade ________       Current Placement ______________________

Ethnicity __________Primary Language ____________________

We are concerned about how things are going for you.  Our talk today will help us to discuss what's going O.K. and what's not going so well.  If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

   (1) How would you describe your current situation?  What problems are you experiencing?  What are your main concerns?

   (2) How serious are these matters for you at this time?

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<tr>
<th>1</th>
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<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>very serious</td>
<td>serious</td>
<td>Not too serious</td>
<td>Not at all serious</td>
</tr>
</tbody>
</table>

   (3) How long have these been problems?

   ___ 0-3 months    ___4 months to a year    ___more than a year
(4) What do you think originally caused these problems?

(5) Do others (parents, teachers, friends) think there were other causes? If so, what they say they were?

(6) What other things are currently making it hard to deal with the problems?

(7) What have you already tried in order to deal with the problems?

(8) Why do you think these things didn't work?

(9) What have others advised you to do?
(10) What do you think would help solve the problems?

(11) How much time and effort do you want to put into solving the problems?

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<th>4</th>
<th>5</th>
<th>6</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>not at all</td>
<td>not much</td>
<td>only a little bit</td>
<td>more than a little bit</td>
<td>quite a bit</td>
<td>very much</td>
</tr>
</tbody>
</table>

If you answered 1, 2, or 3, why don't you want to put much time and effort into solving problems?

(12) What type of help do you want?

(13) What changes are you hoping for?

(14) How hopeful are you about solving the problems?

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<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>very hopeful</td>
<td>somewhat</td>
<td>not too hopeful</td>
<td>not at all hopeful</td>
</tr>
</tbody>
</table>

If you're not hopeful, why not?

(15) What else should we know so that we can help?

Are there any other matters you want to discuss?
(For use with very young students)

Student's View of the Problem -- Initial Interview Form

Interviewer ______________________ Date______________

Note the identified problem:

Is the student seeking help?   Yes   No

If not, what were the circumstances that brought the student to the interview?

__________________________________________________________

Questions for student to answer:

Student's Name _______________________________ Age _____   Birthdate ___________

Sex:  M  F   Grade ________       Current Placement ______________________

Ethnicity __________Primary Language ________________

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) Are you having problems at school? ___Yes   ___No
If yes, what's wrong?

What seems to be causing these problems?
(2) How much do you like school?

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<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>not much</td>
<td>only a little bit</td>
<td>more than a little bit</td>
<td>Quite a bit</td>
<td>Very much</td>
</tr>
</tbody>
</table>

What about school don't you like?

What can we do to make it better for you?

(3) Are you having problems at home?  ____Yes  ____No

If yes, what's wrong?

What seems to be causing these problems?

(4) How much do you like things at home?

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<th>5</th>
<th>6</th>
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</thead>
<tbody>
<tr>
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<td>only a little bit</td>
<td>more than a little bit</td>
<td>Quite a bit</td>
<td>Very much</td>
</tr>
</tbody>
</table>

What about things at home don't you like?

What can we do to make it better for you?
(5) Are you having problems with other kids?  ___Yes  ___No
If yes, what's wrong?

What seems to be causing these problems?

(6) How much do you like being with other kids?

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<th>6</th>
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<td>more than a little bit</td>
<td>quite a bit</td>
<td>very much</td>
</tr>
</tbody>
</table>

What about other kids don't you like?

What can we do to make it better for you?

(7) What type of help do you want?

(8) How hopeful are you about solving the problems?

<table>
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<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>very hopeful</td>
<td>somewhat</td>
<td>not too</td>
<td>not at all hopeful</td>
</tr>
</tbody>
</table>

If you're not hopeful, why not?

(9) What else should we know so that we can help?

Are there any other things you want to tell me or talk about?
Appendix B

*Tools to Enhance*

*Client Access to Information on Referral Resources*

Three aids are provided here:

1. *Examples of Resource Information Handouts for Students/Families*

2. *Description of Referral Resource Files*

3. *Example of One District's Referral Policy*
Examples of Resource Information Handouts for Students/Families

This and the following pages offer format examples of materials developed to provide students, families, and staff with ready references to key referral resources. It is best if these references are backed up with a Referral Resource File containing summary descriptions and other information on the various services.

ON-CAMPUS MENTAL HEALTH RESOURCES

GENERAL PSYCHOSOCIAL PROBLEMS

Clinic Mental Health Professional -- (name)
  information, screening, referral, individual and group therapy, crises, consultation,
  supervises interns and volunteer professionals offering individual and group
  psychotherapy

School Nurse -- (name)
  information, screening, referral, consultation, supervises interns and volunteer
  professionals offering individual and group counseling

Clinic Nurse Practitioner -- (name)
  information, screening, referral, consultation

School Psychologist -- (name)
  information, screening, assessment, referral, individual and group counseling, crises,
  consultation -- primary focus on special education but available on a limited basis for
  regular education students

School Counselors
  information, screening, and referral

Student Assistance Center -- (name)
  information, screening, referral, coordination and facilitation of counseling and self-help
  groups, training and coordination of peer counselors, consultation

SPECIAL PROBLEM FOCUS

Substance Abuse
  Counselor -- (names)
  information, screening, referral, treatment, consultation

Psychosocial Problems Resulting from Pregnancy
  Counselors from an outside agency who come to the school -- (names)
  individual and group counseling, consultation

  Teacher for pregnant minors class -- (name)
  education, support, consultation

  Infant Center -- (name)
  education, support, consultation

Dropout Prevention
  Advisor -- (name)
  individual and group counseling, consultation

RELATED CONCERNS

Clinic Health Educator -- (name)
  offers and educational focus in dealing with various problems (e.g., weight problems)

Vocational Educational Advisor -- (name)
  job counseling and finding for special education students
COMMUNITY COUNSELING RESOURCES

The community resources listed below are provided to assist in finding community services. The School District does not assume responsibility for the services provided nor for the fees that may be charged.

### Individual, Group, and Family Counseling

<table>
<thead>
<tr>
<th>Service</th>
<th>Address</th>
<th>Contact Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hathaway Childrens Serv.</td>
<td>11600 Eldridge Ave.</td>
<td>(818) 896-1161 Ext. 231</td>
</tr>
<tr>
<td>Manos Esperanza</td>
<td>14412 Hamlin</td>
<td>(818) 376-0028</td>
</tr>
<tr>
<td>North Valley Family Counseling Center</td>
<td>661 S. Workman St.</td>
<td>(818) 365-5320</td>
</tr>
<tr>
<td>Van Nuys, 91405</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling Center</td>
<td>661 S. Workman St.</td>
<td>(818) 365-5320</td>
</tr>
<tr>
<td>Van Nuys, 91405</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Fernando Valley</td>
<td>14412 Hamlin</td>
<td>(818) 376-0028</td>
</tr>
<tr>
<td>Boys &amp; Girls Club of San Fernando</td>
<td>11251 Glenoaks Blvd</td>
<td>(818) 365-5320</td>
</tr>
<tr>
<td>Because I Love You</td>
<td>Pacoima, 91331</td>
<td></td>
</tr>
<tr>
<td>General Information Line</td>
<td>Pacoima, 91331</td>
<td></td>
</tr>
<tr>
<td>Pacoima, 91331</td>
<td>(818) 993-9311</td>
<td>(818) 896-5261</td>
</tr>
<tr>
<td>El Nido Services</td>
<td>12502 Van Nuys Blvd</td>
<td>(818) 989-7841</td>
</tr>
<tr>
<td>Families Anonymous</td>
<td>9650 Zelzah</td>
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<tr>
<td>Sons &amp; Daughters United/Parents United</td>
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<td>Sexually Abused Children (13-18)</td>
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<tr>
<td>General Information Line</td>
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<tr>
<td>Pacoima, 91331</td>
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</tr>
<tr>
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<td>12502 Van Nuys Blvd</td>
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</tr>
<tr>
<td>Boys &amp; Girls Club of San Fernando</td>
<td>9650 Zelzah</td>
<td></td>
</tr>
<tr>
<td>Because I Love You</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Information Line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacoima, 91331</td>
<td>(818) 993-9311</td>
<td>(818) 896-5261</td>
</tr>
<tr>
<td>Life-Plus</td>
<td>6421 Coldwater Canyon</td>
<td>(818) 989-7841</td>
</tr>
<tr>
<td>ASAP - Panorama City Hosp.</td>
<td></td>
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<tr>
<td>North Hollywood, 91606</td>
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<tr>
<td>Phone Counseling</td>
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</tr>
<tr>
<td>Valley Hotline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(818) 989-5463</td>
<td></td>
<td></td>
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<tr>
<td>Helpline Youth Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(213) 864-3722</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Abuse Hotline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dial 0 -- Ask for Zenith 2-1234</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td>(813) 501-4447</td>
<td></td>
</tr>
<tr>
<td>Spanish Bilingual Helpline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(818) 780-9727</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape Hotline</td>
<td>(818) 708-1700</td>
<td></td>
</tr>
<tr>
<td>Alateen</td>
<td>(213) 387-3158</td>
<td></td>
</tr>
<tr>
<td>Info Line</td>
<td>(818) 989-5463</td>
<td></td>
</tr>
<tr>
<td>Runaway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(213) 387-3158</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(818) 989-5463</td>
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<tr>
<td>Emergency Counseling</td>
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<tr>
<td>Crisis Management Center</td>
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<td></td>
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<tr>
<td>Olive View Mid-Valley Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same day appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olive View Mid-Valley Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8101 Sepulveda Blvd.</td>
<td>14445 Olive Drive</td>
<td>(818) 364-4340 24 hours</td>
</tr>
<tr>
<td>Van Nuys, 91402</td>
<td>8101 Sepulveda Blvd.</td>
<td>(818) 364-4340 24 hours</td>
</tr>
<tr>
<td>(818) 901-0327 or 782-1985</td>
<td>8101 Sepulveda Blvd.</td>
<td>(818) 364-4340 24 hours</td>
</tr>
<tr>
<td>FOR ADDITIONAL RESOURCES, SEE THE SCHOOL'S RESOURCE REFERENCE FILE.</td>
<td></td>
<td></td>
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</table>
## Example of a Wallet-Card Developed at a School Site for Students to Carry with Them

### Front

<table>
<thead>
<tr>
<th>San Fernando High School</th>
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<tbody>
<tr>
<td>Community Resources</td>
</tr>
<tr>
<td>Alcohol &amp; Other Drugs</td>
</tr>
<tr>
<td>Alcoholics Anonymous ... 1-800-252-6465</td>
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<tr>
<td>Be Sober (24 hr. hotline)...1-800-Be Sober</td>
</tr>
<tr>
<td>Cocaine Anonymous ...... (818) 988-1777</td>
</tr>
<tr>
<td>Narcotics Anonymous ..... (818) 750-3951</td>
</tr>
<tr>
<td>El Proyecto del Barrio ...... (818) 896-1135</td>
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<tr>
<td>Suicide Prevention</td>
</tr>
<tr>
<td>Hotline for Teens ........ 1-800-621-4000</td>
</tr>
<tr>
<td>24 hour Crisis............. (213)-381-5111</td>
</tr>
<tr>
<td>Child Abuse</td>
</tr>
<tr>
<td>Hotline......................1-800-272-6699</td>
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<tr>
<td>Family 24 hour</td>
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<tr>
<td>Crisis Center...........(818) 989-3157</td>
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<td>Rape</td>
</tr>
<tr>
<td>Rape Hotline..............(818) 793-3385</td>
</tr>
<tr>
<td>Victims Anonymous....(818) 993-1139</td>
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</table>

### Back

<table>
<thead>
<tr>
<th>Run Away</th>
</tr>
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<tbody>
<tr>
<td>Run Away Hotline..........1-800-621-4000</td>
</tr>
<tr>
<td>L.A. Youth Network.......(213) 466-6200</td>
</tr>
<tr>
<td>Stepping Stone............(213) 450-7839</td>
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<tr>
<td>Pregnancy/Family Planning</td>
</tr>
<tr>
<td>Pregnancy Testing........(818) 365-8086</td>
</tr>
<tr>
<td>El Nido Services.........(818) 896-7776</td>
</tr>
<tr>
<td>County Health Dept....... (818) 896-1903</td>
</tr>
<tr>
<td>Other Resources</td>
</tr>
<tr>
<td>School Team...............Ext. 15</td>
</tr>
<tr>
<td>School Health Center.....(818) 365-7517</td>
</tr>
<tr>
<td>Teenline ................1-800-TLC-TEEN</td>
</tr>
<tr>
<td>AIDS Hotline.............1-800-922-2437</td>
</tr>
<tr>
<td>Spanish Bilingual Helpline (818) 780-9727</td>
</tr>
<tr>
<td>Family Problems Group...(818) 882-4881</td>
</tr>
</tbody>
</table>

App B-4
Description of Referral Resource Files

A comprehensive referral resource filing system is built up in stages. The first stage involves a focus on a few key referrals. Each week, time can be devoted to adding a few more possible services. Once the main services are catalogued, only a little time each week is required to update the system (e.g., adding new services, deleting those that are not proving useful, updating information).

The tasks involved in establishing and maintaining the system can be described as follows:

1. Use available resource systems and directories and contact knowledgeable persons at the school and in the community to identify all possible services.

2. If sufficient information is available from directories and other systems, it can simply be photocopied. In cases where there is insufficient or no information, contact the service (preferably by mail) to request brochures and other materials that describe available services.

3. Use a standard format to summarize basic information for quick review (see attached form). The summary can be done by someone at the center abstracting information that has been gathered about a service or the form itself can be sent to be filled out by someone at the agency and returned.

4. Put the information gathered about each service into a separate folder and label the folder appropriately (e.g., name of agency or program).

5. Sort folders into categories reflecting (a) their location (e.g., on-campus, community-based) and (b) the type of service provided (e.g., counseling/psychotherapy, substance abuse, vocational guidance, tutoring). File the folders alphabetically, by category in a filing cabinet that can be made accessible to clients.

6. Summaries can be exhibited in binder notebooks for quick review. Using separate binder "Resource Notebooks" for each location (e.g., on-campus, community-based), alphabetically insert the summaries into sections labeled for each category of service. There are computerized systems that can be used to store the information for easy access.

7. Files and Resource Notebooks should be put in an area where anyone interested in using them can have ready access. A poster might be hung over the file to call attention to this service information system and how to use it.

8. Listings of the most accessible services can be compiled and widely distributed to all school staff and students.

9. Consumer feedback can be elicited in a variety of ways from student users (e.g., as part of referral follow-through interviews or periodic consumer feedback questionnaires). If clients provide positive feedback on services, their comments can be included in the folders as an encouragement to others. If a number of clients indicate negative experiences with a service, it can be removed from the files.

10. Service listings and filed information and summaries regarding services probably should be updated yearly.
SUMMARY SHEET ON AN AVAILABLE REFERRAL RESOURCE

The following is basic information provided by an agency and summarized here as a quick overview for anyone interested in the service.

How to contact the service

Name: ________________________ Phone: ____________
Address: _______________________ City _______________

Person to contact for additional information or to enroll in the service:
Name: ________________________ Title: __________

Clients served

Age range: Youngest _____ Oldest ________
Sex: Males _______ Females ________

Type of problems for which services are offered:
(please briefly list)

Ability to serve clients who do not speak English. YES NO
If so, which languages?

If there are any limitations or restrictions related to clients served, please note (e.g., no individuals who are on drugs; only Spanish speaking).

Type of services
(please check services offered)

Assessment
Counseling/psychotherapy
substance abuse treatment
sexual abuse support groups
vocational guidance
tutoring
other (specify)

Fees:

Sliding Scale? YES NO

If there are any other sources that underwrite fees for the above services, please indicate them (e.g., public agencies, insurance).
SUPPLEMENT TO BROCHURE AND OTHER PRINTED MATERIAL

Along with whatever brochures and printed material that is available, it is
helpful to have a summary statement highlighting the following matters.

1. What is the particular philosophical or theoretical orientation underlying the
   service(s) provided?

2. Please describe the nature of what a client can expect to experience (e.g.,
   time involvement, activities; if groups are involved, indicate typical group size
   and composition).

3. Specific directions for traveling to the service provider (e.g., using public
   transportation if off-campus).

4. If there is any other information that should be highlighted for a potential
   client, please provide it here.

Date this form was filled out: ________________________
Example of One School District's Referral Policy

INTRODUCTION

It is the policy of the District to initiate the referral of parents and pupils to appropriate agencies when a pupil's needs are beyond the scope and/or responsibility of school and District resources. School staff members cooperate with agency personnel in effecting timely and suitable referrals and work together on a continuing basis regarding aspects of the pupils problems which may relate to school adjustment. The following guidelines are to be followed in making such referrals.

I. SCHOOL PERSONNEL RESPONSIBLE FOR REFERRALS

A. The school principal or designee assumes administrative responsibility for the coordination of efforts to help a pupil in the school and for the delegation of community agency referrals to appropriate personnel.

B. Pupil services personnel are trained specifically to assist school staff and parents in the selection and contact of approved community resources providing counseling, health, mental health, and related services.

C. School staff and parents are encouraged to consult with the pupil services personnel assigned to the school for information and assistance in processing referrals (e.g., nurses, counselors, school physicians, psychologists, social workers).

II. SELECTION OF AGENCIES

A. Referrals may be made to:
   1. Public tax supported agencies
   2. Charitable support based agencies such as those funded under United Way
   3. Voluntary non-profit agencies meeting the following criteria:
      a. Directed by a rotating board broadly representative of the community
      b. Not operated on fees alone
      c. Available on a sliding-scale cost to patients
      d. Open to the public without regard to color, race, religion ancestry, or country of natural origin
      e. Licensed by the State Department of Health when mental health services are involved.

B. Referrals shall not be made to:
   1. A profit or non-profit proprietary agency. (proprietary: "held in private ownership")
   2. Private practitioners or groups of private practitioners.

C. Since the District does not have staff resources to investigate the status or otherwise evaluate community agencies, school personnel should limit referrals to agencies listed by (designated resource book or public information phone or on-line service).
III. PROCESSING OF REFERRALS

A. Most health, counseling and related social service agencies require that the pupil, parent, or guardian make direct application for service. This does not preclude school personnel from assisting in the application process nor from presenting pertinent information to the agency in support of the applicant's request, when authorized by the parent.

B. Complete information about a recommended agency should be given to prospective clients by support services personnel. Such information should include agency program, application procedures, intake process, location, agency hours, telephone number, fees, and other pertinent data.

C. In all agency referrals, consideration should be given to family factors such as:
   1. Geographical area
   2. Determined needs and services
   3. Religious preference
   4. Ethnic and/or language factors
   5. Financial capability

D. A family's financial resources should be explored discreetly prior to making an appropriate agency referral. A family which has the financial ability to secure private services should consult with the family physician or the referral services provided by professional associations. A family which has its own insurance plan should confer with the plan's insurance consultant.

IV. RELEASE OF PUPIL INFORMATION

Written authorization from parent, guardian, or student (if student is eighteen [18] years of age and living independently of parents, or is an emancipated minor) must be obtained before any school information is released to a community agency regarding a pupil. The same such authorization is required for a community agency to release information to school personnel.
Appendix C

Tools to Assist Clients with Referrals

• Referral Decisions -- Summary Form

• Guidelines and Follow-up Forms to Aid Referral Follow-through
Referral Decisions – Summary Form

Student's Name or ID # ________________________ Birthdate _______
Date of Request _____________

Interviewed by___________________ Date___________

Referred to:

1. On-campus program/resource:  ________________________________________

2. Off-campus district resource (e.g., Counseling Center): _______________________

3. Off-campus community agency  _________________________________________

4. No referral _________(please indicate why)

_____________________________________________________________________________

PLANS FOR ENROLLMENT

Person to contact________________________ Phone__________
Location_____________________________________________

Appointment time____________________________

Plans for making initial contact (anticipate any problems):

Back up plans:

If the above plan doesn't work out or if you need additional information or help, contact
____________________________________ at___________________.

In a week or two, you will be contacted to see if everything worked out as planned.
GUIDELINES FOR ACKNOWLEDGING STATUS OF REFERRAL

Rationale:

The referrer and the person to whom an individual is referred both have an ethical responsibility to take steps to ensure the referred individual has been able to make an appropriate contact for needed services.

Thus, the referrer follows-up, if feasible, with the individual or, if necessary, with the person to whom the referral was made.

Similarly, the professional receiving a referral should take steps to inform the referrer whether or not the referred individual has been provided with the recommended services.

Procedures for Communicating Referral Status and Preserving Confidentiality:

Given the intent is to clarify referral status while preserving confidentiality about matters the client does not want others to know, the process of communication is designed to be simple and direct. For instance, in responding to an inquiry from the referrer, one of the following five responses should suffice.

1. The individual that you indicate having referred has contacted me, and I am providing the services for which you referred her/him. Thanks.

2. I had an exploratory session with the individual and referred her/him to __________. I will be following-up to see if the referral worked out.

3. The individual that you indicate having referred to me has not contacted me.

4. I have tried to make contact with the individual you referred but s/he has not responded to my messages.

5. I had an exploratory session with the individual, but s/he chose not to pursue the services I offer and was not interested in another referral. You may want to recontact her/him.

To facilitate such communication, a form such as the one attached may be useful.

Information Beyond Acknowledging Referral Status:

Except where legal reporting requirements prevail, communications about the nature of the individual's problems and matters discussed require client consent. When communication about such matters may serve the individual's best interests, it is important to convey the matter to the client and to seek a signed release.
Examples of Forms to Aid Referral Follow-Through

School's Record of Response to Request for Assistance in Addressing Concerns about a Student/Family

Name of student _________________________________

Name of staff member who made contact with student ________________________________

Date of contact with student ____________________________.

The following are the results of the contact:

Follow-up needed?   Yes ___       No ___

________________________________________________________________________

If follow-up:

Carried out by ________________________________ on ________________

(name of staff member)

Results of follow-up:

Was permission given to share information with referrer?  Yes ___    No ___

If yes, note the date when the information was shared. ___________

If no, note date that the referrer was informed that her/his request was attended to. ___________
Form Used to Aid Follow-Up on Referral Follow-Through

The following form should be used in conjunction with a general calendar system (a "tickler" system) that alerts staff to students who are due for some follow-up activity.

**Student's Name: ___________________ Today's Date:_____**

**DATES FOR FOLLOW-THROUGH MONITORING**

- Scheduled date for Immediate Follow up_______ (about 2 weeks after referral)
- Scheduled date for Long-term first Follow up_______
- Schedule for Subsequent Long-term Follow ups _______ _______ _______

**I. Immediate Referral Follow up Information**

<table>
<thead>
<tr>
<th>Date of referral</th>
<th>Today's date</th>
<th>Immediate Follow up made by</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Need</th>
<th>Agency (name and address)</th>
<th>Phone</th>
<th>Contact person</th>
<th>Appt. time</th>
</tr>
</thead>
</table>

A. Put a check mark next to those agencies with which contact was made;
B. Put a line through agencies that didn't work out;
C. Put a circle next to agencies still to be contacted.

Indicate any new referrals recommended

<table>
<thead>
<tr>
<th>Service Need</th>
<th>Agency (name and address)</th>
<th>Phone</th>
<th>Contact person</th>
<th>Appt. time</th>
</tr>
</thead>
</table>

**II. Long Term Referral Follow-Up Information**

Have identified needs been met?

Contact the student at appropriate intervals (beginning three months after referral) and administer "Follow-up Interview Form -- Service Status."
Client's Response

Status of Referral Follow-Through

Student's Name: ___________________ Today's Date:_____

_____ I was unable to connect with any of the services we discussed.

_____ I did connect with (write in the name of the service)

______________________________________.

__________________________________________________________________________

Whether or not you connected with a service, you may want an additional session to discuss your service needs. If so, let us know by checking the following. We will then set up an appointment for you.

_____ I would like another session to discuss my needs.
Agency's Response

Status of Referral Follow-Through

TO:

FROM:

We recently referred ___________________ to you.

As part of our case monitoring, we would appreciate your letting us know that this student connected with you.

__________________________________________________________________________

Name of person responding: _______________________________

Today's Date:____________

_____ The above named student/family contacted us on ____________ and was provided appropriate services.

_____ We have no record of this student/family making contact with us.

__________________________________________________________________________

Please return this form to:

Mrs. Benson
Smith High School
1340 S. Highland Ave.
Johnston, Missouri   90005
Record of Contact with Referrer

Date: __________

To:

From:

Thank you for your request for assistance for __________________________.

(name)

A contact was made on ____________.

Comments:
Appendix D

Tools to Aid in Assuring Quality of Care

• *Follow-up Rating Forms -- Service Status*

• *Management of Care Review Form*

• *Outline of Key Steps and Tasks in Problem Solving Intervention*

• *Survey of System Status*

• *Working Together with School and Community*
Follow-up Rating Form -- Service Status (Intervener Form)
(To be filled out periodically by interveners)

To: _____________________ (Intervener's name)

From: _____________________, Primary Care Manager

Re: Current Status of a client referred to you by _________________ school.

Student’s Name or ID # ________________________ Birthdate _______ Date _________

Number of sessions seen:   Ind. ___  Group _____

What problems were worked on?

Current status of problems worked on: (Severity at this time)

<table>
<thead>
<tr>
<th></th>
<th>1 very severe</th>
<th>2 severe</th>
<th>3 not too severe</th>
<th>4 not at all severe</th>
</tr>
</thead>
</table>

If the problems worked on differ from the "presenting" problems (e.g., referral problem), also indicate the current status of the presenting problems.

<table>
<thead>
<tr>
<th></th>
<th>1 very severe</th>
<th>2 severe</th>
<th>3 not too severe</th>
<th>4 not at all severe</th>
</tr>
</thead>
</table>

Recommendations made for further action:

Are the recommendations being followed?   YES   NO
If no, why not?

How much did the intervention help the student in better understanding his/her problems?

<table>
<thead>
<tr>
<th></th>
<th>1 not at all</th>
<th>2 not much</th>
<th>3 only a little bit</th>
<th>4 more than a little bit</th>
<th>5 quite a bit</th>
<th>6 very much</th>
</tr>
</thead>
</table>

How much did the intervention help the student to deal with her/his problems in a better way?

<table>
<thead>
<tr>
<th></th>
<th>1 not at all</th>
<th>2 not much</th>
<th>3 only a little bit</th>
<th>4 more than a little bit</th>
<th>5 quite a bit</th>
<th>6 very much</th>
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</thead>
</table>

Prognosis

<table>
<thead>
<tr>
<th></th>
<th>1 very positive</th>
<th>2 positive</th>
<th>3 negative</th>
<th>4 very negative</th>
</tr>
</thead>
</table>
Follow-up Rating Form -- Service Status         (Client Form)
(To be filled out periodically by the clients)

Student's Name or ID # ________________________ Birthdate _______ Date___________

1. How worthwhile do you feel it was for you to have worked with the counselor?

   1. not at all
   2. not much
   3. only a little bit
   4. more than a little bit
   5. quite a bit
   6. very much

2. How much did the counseling help you better understand your problems?

   1. not at all
   2. not much
   3. only a little bit
   4. more than a little bit
   5. quite a bit
   6. very much

3. How much did the counseling help you deal with your problems in a better way?

   1. not at all
   2. not much
   3. only a little bit
   4. more than a little bit
   5. quite a bit
   6. very much

4. At this time, how serious are the problems for you?

   1. very severe
   2. severe
   3. not too severe
   4. not at all severe

5. How hopeful are you about solving your problems?

   1. very hopeful
   2. somewhat hopeful
   3. not too hopeful
   4. not at all hopeful

If not hopeful, why not?

6. If you need help in the future, how likely are you to contact the counselor?

   1. not at all
   2. not too likely
   3. likely to
   4. definitely will
Management of Care Review Form

Student's Name or ID # ________________________ Birthdate _______

Primary Manager of Care ________________________________________

Management of Care Team (including student/family members):
____________________________________________________________________________

____________________________________________________________________________

Initial Plan

Date management of care file opened: ___________

Student Lives with: __________________________ Relationship _________________
Address _____________________________ Phone ___________________________

Home language ________________________________

Type of concern initially presented (briefly describe for each applicable area)

<table>
<thead>
<tr>
<th>How serious are the problems?</th>
</tr>
</thead>
<tbody>
<tr>
<td>not too serious</td>
</tr>
<tr>
<td>Learning:</td>
</tr>
<tr>
<td>Behavior:</td>
</tr>
<tr>
<td>Emotional:</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

Problem Identified and Referred by: ________________________________ date _______

Initial client consultation done with: ________________________________ date _______
Conducted by: ________________________________

Indicate diagnosis (if any): ________________________________

Recommendations/Decisions/consents:

Planned Date for Immediate Follow-up: ___________
(2 weeks after recommended action)
**Immediate Follow-up**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate client follow-through?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, why not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the original plan still appropriate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, why not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What changes are needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any problems with coordination of interventions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What needs to be done? By Who? When? Monitoring Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SYSTEMS OF CARE REVIEW**: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for first team review: ____________________
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.
First Team Review

Date: ______________________

Team members present:
______________________ _____________________ _____________________
______________________ _____________________ _____________________

General Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented, at this time –

<table>
<thead>
<tr>
<th></th>
<th>Amount of Improvement Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not too much</td>
</tr>
<tr>
<td>Learning:</td>
<td>1  2  3  4  5  6</td>
</tr>
<tr>
<td>Behavior:</td>
<td>1  2  3  4  5  6</td>
</tr>
<tr>
<td>Emotional:</td>
<td>1  2  3  4  5  6</td>
</tr>
<tr>
<td>Other:</td>
<td>1  2  3  4  5  6</td>
</tr>
</tbody>
</table>

Appropriate client follow-through? Yes  No

If no, why not?
Is the current plan still appropriate?  Yes  No

If no, why not?

What changes are needed?

Any problems with coordination of interventions?  Yes  No

If yes:

What needs to be done?  By Who?  When?  Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

**SYSTEMS OF CARE REVIEW:** Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for next team review: ____________________
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.
**Ongoing Team Review**

Date: ________________

Team members present:

________________________________________

________________________________________

________________________________________

________________________________________

General Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented, at this time –

<table>
<thead>
<tr>
<th></th>
<th>not too severe</th>
<th>How Severe?</th>
<th>very severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning:</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior:</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional:</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appropriate client follow-through? Yes No

If no, why not?
Is the current plan still appropriate?  Yes  No

If no, why not?

What changes are needed?

Any problems with coordination of interventions?  Yes  No

If yes:

What needs to be done?  By Who?  When?  Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies?  If so, these implications should be directed to those responsible for enhancing the system.

Planned date for next team review: ____________________
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.
End of Intervention  

Date: ____________________

Final Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented, at this time –

<table>
<thead>
<tr>
<th></th>
<th>How Severe?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not too severe</td>
</tr>
<tr>
<td>Learning:</td>
<td>1  2  3  4  5  6</td>
</tr>
<tr>
<td>Behavior:</td>
<td>1  2  3  4  5  6</td>
</tr>
<tr>
<td>Emotional:</td>
<td>1  2  3  4  5  6</td>
</tr>
<tr>
<td>Other:</td>
<td>1  2  3  4  5  6</td>
</tr>
</tbody>
</table>

Why is the intervention ending?

If the client still needs assistance, what are the ongoing needs?

What plans are there for meeting these needs?

If there are no plans, why not?

App D-10
SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

With intervention ending, the primary manager must be certain that (1) everyone who should be informed is provided relevant information and (2) evaluation data are entered into the appropriate systems.
### Outline of Key Steps and Tasks in Problem Solving Intervention

<table>
<thead>
<tr>
<th>Steps</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Rationale and general plan of action related to problem solving as an intervention model</strong>&lt;br&gt;<strong>1</strong> Recognize problem; initiate intervention&lt;br&gt;<strong>2</strong> Analyze problems; establish working agreement&lt;br&gt;<strong>3</strong> Generate possible solutions; evaluate alternatives&lt;br&gt;<strong>4</strong> Select initial solution and backups; clarify ways to carry out alternatives&lt;br&gt;<strong>5</strong> Support implementation of alternatives; evaluate progress&lt;br&gt;<strong>6a</strong> Alternative not satisfactory&lt;br&gt;<strong>6b</strong> Problem solved (outcome)</td>
</tr>
</tbody>
</table>
Survey of System Status

The following pages contain the self-study survey designed to provide an overview of system status at a school. This survey is part of a set developed to focus on six major intervention arenas that provide a fundamental framework for developing a comprehensive system of learning supports. All six arenas are essential for a school’s component to address barriers to learning and teaching (e.g., an enabling or learning supports component).

The emphasis in the following survey is on

- *clarifying what resources already are available*
- *how the resources are organized to work in a coordinated way*
- *what procedures are in place for enhancing resource usefulness*

Working with a group to review the survey is a good way to understand what parent/home involvement might look like.
A tool for mapping and planning

**Survey of Learning Supports System Status**

As a school sets out to enhance the usefulness of learning supports designed to address barriers to learning, it helps to clarify what you have in place as a basis for determining what needs to be done. You will want to pay special attention to

- clarifying what resources already are available
- how the resources are organized to work in a coordinated way
- what procedures are in place for enhancing resource usefulness

This survey provides a starting point.

The first form provides a template which you can fill in to clarify the people and their positions at your school who provide services and programs related to addressing barriers to learning. This also is a logical group of people to bring together in establishing a resource-oriented team for learning supports at the school.

Following this is a survey designed to help you review how well systems for Learning Supports have been developed and are functioning.

**Learning Supports Staff at the School**
In a sense, each staff member is a special resource for each other. A few individuals are highlighted here to underscore some special functions.

**Administrative Leader for Learning Supports**

- **School Psychologist**
  - times at the school ________________
  - Provides assessment and testing of students for special services. Counseling for students and parents. Support services for teachers. Prevention, crisis, conflict resolution, program modification for special learning and/or behavioral needs.

**School Nurse**

- times at the school ________________
  - Provides immunizations, follow-up, communicable disease control, vision and hearing screening and follow-up, health assessments and referrals, health counseling and information for students and families.

**Pupil Services & Attendance Counselor**

- times at the school ________________
  - Provides a liaison between school and home to maximize school attendance, transition counseling for returnees, enhancing attendance improvement activities.

**Social Worker**

- times at the school ________________
  - Assists in identifying at-risk students and provides follow-up counseling for students and parents. Refers families for additional services if needed.

**Counselors**

- times at the school ________________
  - General and special counseling/guidance services. Consultation with parents and school staff.

**Dropout Prevention Program Coordination**

- times at the school ________________
  - Coordinates activity designed to promote dropout prevention.

**Title I and Bilingual Coordinators**

- **Title I and Bilingual Coordinators**
  - Coordinates categorical programs, provides services to identified Title I students, implements Bilingual Master Plan (supervising the curriculum, testing, and so forth)

**Resource and Special Education Teachers**

- times at the school ________________
  - Provides information on program modifications for students in regular classrooms as well as providing services for special education.

**Other important resources:**

**School-based Crisis Team (list by name/title)**

- ________________
- ________________
- ________________
- ________________
- ________________
- ________________

**School Improvement Program Planners**

- ________________
- ________________

**Community Resources**

- Providing school-linked or school-based interventions and resources

<table>
<thead>
<tr>
<th>Who</th>
<th>What they do</th>
<th>When</th>
</tr>
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<tbody>
<tr>
<td>________________</td>
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</tr>
</tbody>
</table>
Survey of Learning Supports System Status

Items 1-9 ask about what processes are in place.

Use the following ratings in responding to these items.

DK = don't know
1 = not yet
2 = planned
3 = just recently initiated
4 = has been functional for a while
5 = well institutionalized (well established with a commitment to maintenance)

1. Is someone at the school designated as the administrative leader for activity designed to address barriers to learning (e.g., learning supports, health and social services, the Enabling Component)?

2. Is there a time and place when personnel involved in activity designed to address barriers to learning meet together?

3. Is there a resource-oriented team (e.g., a Learning Supports Resource Team) – as contrasted to a case-oriented team?

(a) Does the team analyze data trends at the school with respect to

> attendance
> drop outs
> achievement

(b) Does the team map learning supports programs to determine whether

> identified priorities are being addressed adequately
> program quality is up to standards
> gaps have been identified and priorities for the future are set

(c) Which of the following areas of learning support are reviewed regularly?

> Classroom-based Approaches to Enable and Re-engage Students in Classroom Learning
> Crisis Assistance and Prevention
> Support for Transitions
> Home Involvement in Schooling
> Community Outreach for Involvement and Support
> Student and Family Assistance

DK 1 2 3 4 5

DK 1 2 3 4 5

DK 1 2 3 4 5

DK 1 2 3 4 5

DK 1 2 3 4 5

DK 1 2 3 4 5
Survey of Learning Supports System Status (cont.)

4. Are there written descriptions of learning supports programs available to give

  >staff
  >families
  >students
  >community stakeholders

5. Are there a case-oriented systems in place for

  (a) concerned parties to use in making referrals?
  (b) triage (to decide how to respond when a referral is made)?
  (c) case monitoring and management?
  (d) a student review team?
  (e) a crisis team?

6. Are there written descriptions available to give to staff and others about

  >how to make referrals
  >the triage process
  >the process for case monitoring and management
  >the process for student review

7. Are there systems in place to support staff wellness?

8. Are there processes by which staff and families learn

  (a) What is available in the way of programs/services at school?
  (b) What is available in the way of programs/services in the community?
  (c) How to access programs/services they need?

9. Has someone at the school been designated as a representative to meet with the other schools in the feeder pattern to enhance coordination and integration of learning supports among the schools and with community resources?
Survey of Learning Supports System Status (cont.)

The following items ask about effectiveness of existing processes.

Use the following ratings in responding to these items.

DK = don’t know
1 = hardly ever effective
2 = effective about 25% of the time
3 = effective about half the time
4 = effective about 75% of the time
5 = almost always effective

10. How effective are the processes for

(a) planning, implementing, and evaluating learning supports system improvements?

(b) enhancing learning supports resources (e.g., through budget decisions, staff development; developing or bringing new programs/services to the site; making formal linkages with programs/services in the community)?

11. How effective are the processes for ensuring that

(a) resources are properly allocated and coordinated?

(b) community resources linked with the school are effectively coordinated/integrated with related school activities?

12. How effective are the processes for ensuring that resources available to the whole feeder pattern of schools are properly allocated and shared/coordinated?

13. How effective is the

(a) referral system?

(b) triage system?

(c) case monitoring and management system?

(d) student review team?

(e) crisis team?

14. List community resources with which you have formal relationships.

(a) Those that bring program(s) to the school site

(b) Those not at the school site but which have made a special commitment to respond to the school’s referrals and needs.
Working Together with School and Community

Every program designed to assist students and their families must consistently be working toward integration with (1) other programs and services at a school and (2) community resources. Efforts to integrate can be viewed in terms of phases of collaboration.

Ultimately, addressing barriers to learning and enhancing healthy development for all students in the school is through

- coordination and integration among all programs at the school
- expanding the range of intervention options

These objectives are only possible through establishment of a close working relationship with school staff who are responsible for and interested in psychosocial programs. A key procedure in stimulating such integration is a Resource Team (discussed later). Another approach is to identify ongoing programs and then establish personal working relationships with the staff involved.

Working Together?

Two best friends were taking a walk in the woods when they saw a giant grizzly bear approaching them, erect, claws bared. Being the best of friends, they clung to one another for dear life. But then one of the two disengaged, knelt to unlace his hiking boots, and hurriedly put on his running shoes.

I don’t get it, his best friend said. What can you hope to achieve? You and I both know there’s no way you can outrun a grizzly bear.

Silly, said his friend, I don’t have to outrun the bear. I only have to outrun you.
Some General Guidelines for Establishing School-Site Collaborative Teams

Two basic problems in forming collaborative teams at school-sites are (a) identifying and deploying committed and able personnel and (b) establishing an organizational structure that provides sufficient time and nurtures the competence and commitment of team members. The following are some suggestions that can help in dealing with these problems.

1. For staff, job descriptions and evaluations must reflect a policy that personnel are expected to work in a coordinated and increasingly integrated way with the aim of maximizing resource use and enhancing effectiveness.

2. To maximize resource coordination and enhancement at a school, every staff member must be encouraged to participate on some team designed to improve students' classroom functioning. The importance of such teams should be recognized through provision of time and resources that allow team members to build capacity and work effectively together.

3. Teams may consist of current resource staff, special project staff, teachers, site administrators, parents, older students, and others from the community. In this last regard, representatives of school-linked community services must be included. Individuals should be encouraged to choose a team whose work interests them.

4. Groups should vary in size -- from two to as many as are needed and interested. Major criteria used in determining size should be factors associated with efficient and effective functioning. The larger the group, the harder it is to find a meeting time and the longer each meeting tends to run. Frequency of meetings depends on the group's functions, time availability, and ambitions. Properly designed and trained teams can accomplish a great deal through informal communication and short meetings.

5. The core of a team is staff who have or will acquire the ability to carry out identified functions and make the mechanism work; others can be auxiliary members. All should be committed to the team's mission. Building team commitment and competence should be one major focus of school management policies and programs.

6. Because several teams require the expertise of the same staff (nurse, psychologist, counselor, resource teacher, social worker, administrator, teacher, parent), these individuals will necessarily be on more than one team.

7. Each team needs a dedicated leader/facilitator who has the ability to keep the group task-focused and productive and someone who records decisions and plans and reminds members of planned activity and products.

8. Team functioning is enhanced through use of computer technology (management systems, electronic bulletin boards and email, resource clearinghouses). Such technology facilitates communication, networking, program planning and implementation, linking activity, and a variety of budgeting, scheduling, and other management concerns.

9. Effective teams should be able to produce savings in terms of time and resources through appropriately addressing their areas of focus. In addition, by tapping into public health-care funds, a district may be able to underwrite some of the costs of those team members who also provide specific services.
Planning and Facilitating Effective Meetings

There are many fine resources that provide guidelines for conducting effective meetings. Some key points are synthesized below.

Forming a Working Group

- There should be a clear statement about the group's mission.
- Be certain that the members agree to pursue the stated mission and, for the most part, share a vision.
- Pick someone who the group will respect and who either already has good facilitation skills or will commit to learning those that are needed.
- Provide training for members so they understand their role in keeping a meeting on track and turning talk into effective action.
- Be certain to designate processes (a) for sending members information before a meeting regarding what is to be accomplished, specific agenda items, and individual assignments and (b) for maintaining and circulating a record of decisions and planned actions (what, who, when) formulated at the meeting.

Meeting Format

- Be certain there is a written agenda and that it clearly states the purpose of the meeting, specific topics, and desired outcomes for the session.
- Begin the meeting by reviewing purpose, topics, desired outcomes, etc. Until the group is functioning well, it may be necessary to review meeting ground rules.
- Facilitate the involvement of all members, and do so in ways that encourage them to focus specifically on the task. The facilitator remains neutral in discussion of issues.
- Try to maintain a comfortable pace (neither too rushed, nor too slow; try to start on time and end on time -- but don't be a slave to the clock).
- Periodically review what has been accomplished and move on to the next item.
- Leave time to sum up and celebrate accomplishment of outcomes and end by enumerating specific follow-up activity (what, who, when). End with a plan for the next meeting (date, time, tentative agenda). For a series of meetings, set the dates well in advance so members can plan their calendars.

(cont.)
Some Group Dynamics to Anticipate

Despite the best of intentions, group members sometimes find it difficult to stay on task. Some of the reasons are

Hidden Agendas -- A person may feel compelled to make some point that is not on the agenda. At any meeting, there may be a number of these hidden agenda items. There is no good way to deal with these. It is important that all members understand that hidden agendas are a problem, and there should be agreement that each member will take responsibility for keeping such items in check. However, there will be times when there is little choice other than to facilitate the rapid presentation of a point and indicate where the concern needs to be redirected.

A Need for Validation -- Even when people are task-focused, they may seem to be making the same point over and over. This usually is an indication that they feel it is an important point but no one seems to be accounting for it. To counter such disruptive repetition and related problems, it is helpful to use flipcharts or a writing board on which group member points are highlighted (hopefully with some form of organization to enhance coherence and facilitate summarizing). Accounting for what is said in this visible way helps members feel their contributions have been heard and validated. It also allows the facilitator to point to a matter as a visible reminder to a member that it has already been raised. When a matter is one that warrants discussion at a later time, it can be assigned to a future agenda or planning list to be addressed if time allows toward the end of the meeting or at a subsequent meeting.

Members are at an Impasse -- Two major reasons groups get stuck are: (a) some new ideas are needed to "get out of a box" and (b) differences in perspective need to be aired and resolved. The former problem usually can be dealt with through brainstorming or by bringing in someone who has some new alternatives to offer. The latter problem involves conflicts that arise over process, content, and power relationships and is dealt with through problem solving and conflict management strategies (e.g., accommodation, negotiation, mediation).

Interpersonal Conflict and Inappropriate Competition -- Some people find it hard to like each other or feel compelled to show others up. Sometimes the problem can be corrected by repeatedly bringing the focus back to the goal -- improving outcomes for students/families. Sometimes, however, the dislike or competitiveness is so strong that certain individuals simply can't work closely together. If there is no mechanism to help minimize such interpersonal dynamics, the group needs to find a way to restructure its membership.

Ain't It Awful! -- The many daily frustrations experienced by staff members each day often lead them to turn meetings into gripe sessions. One of the benefits of including parents and community members (agency staff, business and/or university partners) is that, like having company come to one's home, outside team members can influence school staff to exhibit their best behavior.

Two References
A Team to Manage Care

When a client is involved with more than one intervener, management of care becomes a concern. This clearly is always the situation when a student is referred for help over and above that which her/his teacher(s) can provide. Subsequent monitoring as part of the ongoing management of client care focuses on coordinating interventions, improving quality of care (including revising intervention plans as appropriate), and enhancing cost-efficacy.

Management of care involves a variety of activity all of which is designed to ensure that client interests are well-served. At the core of the process is enhanced monitoring of care with a specific focus on the appropriateness of the chosen interventions, adequacy of client involvement, appropriateness of intervention planning and implementation, and progress. Such ongoing monitoring requires systems for

- tracking client involvement in interventions
- amassing and analyzing data on intervention planning and implementation
- amassing and analyzing progress data
- recommending changes

Effective monitoring depends on information systems that enable those involved with clients to regularly gather, store, and retrieve data. Schools rely heavily on forms for gathering necessary information. In coming years, more and more of this information will be entered into computers to facilitate retrieval and assist in other ways with client care.

Management of care, of course, involves more than monitoring processes and outcomes. Management also calls for the ability to produce changes as necessary. Sometimes steps must be taken to improve the quality of processes, including at times enhancing coordination among several interveners. Sometimes intervention plans need to be revised to increase their efficacy and minimize their "costs" -- including addressing negative "side effects." Thus, management of care involves using the findings from ongoing monitoring to clarify if interventions need to be altered and then implements strategies to identify appropriate changes and ensure they are implemented with continued monitoring. Along the way, those involved in managing the client's care may have to advocate for and broker essential help and provide the linkage among services that ensures they are coordinated. They also must enhance coordinated intervener communication with the student's care givers at home.
Who does all this monitoring and management of care? Ideally, all involved parties -- interveners and clients -- assume these functions and become the management team. One member of such a team needs to take primary responsibility for management of care (a primary manager). Sites with sufficient resources often opt to employ one staff member to fill this role for all clients. However, given the limited resources available to schools, a more practical model is to train many staff to share such a role. Ultimately, with proper instruction, one or more family members might be able to assume this role.

All who become primary managers of care must approach the role in a way that respects the client and conveys a sense of caring. The process should be oriented to problem-solving but should not be limited to problem treatments (e.g., in working on their problems, young people should not be cut off from developmental and enrichment opportunities). In most instances, a youngster's family will be integrally involved and empowered as partners, as well as recipients of care. Well-implemented management of care can help ensure that clients are helped in a comprehensive, integrated manner designed to address the whole person. A positive side effect of all this can be enhancement of systems of care.

Management teams should meet whenever analysis of monitoring information suggests a need for program changes and at designated review periods. Between meetings, it is the responsibility of the primary manager to ensure that care is appropriately monitored, team meetings are called as changes are needed, and that changes are implemented. It is the team as a whole, however, that has responsibility for designating necessary changes and working to ensure the changes are made.

The following list itemizes a few basic tasks for primary managers of care:

- **Before a team meeting,** write up analyses of monitoring data and any recommendations to share with management team.
- **Immediately after a team meeting,** write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks and when.
- **Set-up a "tickler" system** to remind you when to check on whether tasks have been accomplished.
- **Follow-up with team members** who have not accomplished agreed upon tasks to see what assistance they need.
A Team to Manage Resources

School practitioners are realizing that since they can't work any harder, they must work smarter. For some, this translates into new strategies for coordinating, integrating, and redeploying resources. Such efforts start with new (a) processes for mapping and matching resources and needs and (b) mechanisms for resource coordination and enhancement.

An example of a mechanism designed to reduce fragmentation and enhance resource availability and use (with a view to enhancing cost-efficacy) is seen in the concept of a resource team. Creation of such a school-based team provides a vehicle for building working relationships and a good mechanism for starting to weave together existing school and community resources and encourage services and programs to function in an increasingly cohesive way.

Where such a team is created, it can be instrumental in integrating the center into the school's ongoing life. The team solves turf and operational problems, develops plans to ensure availability of a coordinated set of services, and generally improves the school's focus on addressing barriers to learning, including concerns for mental health.

A resource team differs from teams created to review individual students (such as a student study team, a student success team, a teacher assistance team, a case management team). That is, its focus is not on specific cases, but on clarifying resources and their best use. In doing so, it provides what often is a missing mechanism for managing and enhancing systems to coordinate, integrate, and strengthen interventions. For example, this type of mechanism can be used to weave together the eight components of school health programs to better address such problems as on-campus violence, substance abuse, depression, and eating disorders. Such a team can be assigned responsibility for (a) mapping and analyzing activity and resources with a view to improving coordination, (b) ensuring there are effective systems for referral, case management, and quality assurance, (c) guaranteeing appropriate procedures for effective management of programs and information and for communication among school staff and with the home, and (d) exploring ways to redeploy and enhance resources -- such as clarifying which activities are nonproductive and suggesting better uses for the resources, as well as reaching out to connect with additional resources in the school district and community.
Because of its potential value to schools, it is well worth staff time to help establish a resource team. A good way to start the process is to

1. survey key school staff members to identify and map existing school-based psychosocial programs and who runs them

2. invite key people from each program to a meeting to discuss how various school and community programs interface with each other (Note: Be certain to include some from the administrative staff and all other school personnel who might be supportive and interested in program enhancement.)

At the first meeting,

3. if the programs are not coordinated, discuss ways to work together; if some are coordinated with each other, discuss how to integrate all programs into the process

4. suggest the idea that the group constitute itself as a regular resource team and meet regularly (e.g., initially, every two weeks, then once a month)

For subsequent meetings,

5. be certain someone is designated to act as facilitator (e.g., to send out reminders about agenda, times, and places, circulate "minutes" after each meeting, help to ensure the meeting runs smoothly).

Once the team is established, it will raise concerns and ideas that require more time and follow-through than is possible during the meeting. To minimize frustration and maximize effectiveness,

6. set up a small subcommittee (e.g., 1-3 team members) which will take time between meetings to work out details of ideas, work on solving problems raised, and report back to the team.

Among the topics a resource team might address are ways to deal with crises and how to resolve dilemmas regarding consent, confidentiality, legal reporting requirements, and school district policies.
Mapping Resources

The literature on maximizing resources makes it clear that a first step in countering fragmentation involves "mapping" resources by identifying what exists at a site (e.g., enumerating programs and services that are in place to support students, families, and staff; outlining referral and case management procedures). A comprehensive form of "needs assessment" is generated as resource mapping is paired with surveys of the unmet needs of students, their families, and school staff.

Based on analyses of what is available, effective, and needed, strategies can be formulated for resource enhancement. These focus on (a) outreach to link with additional resources at other schools, district sites, and in the community and (b) better ways to use existing resources. (The process of outreach to community agencies is made easier where there is policy and organization supporting school-community collaboration. However, actual establishment of formal connections remains complex and is becoming more difficult as publicly-funded community resources dwindle.)

Perhaps the most valuable aspect of mapping and analyzing resources is that the products provide a sound basis for improving cost-effectiveness. In schools and community agencies, there is acknowledged redundancy stemming from ill-conceived policies and lack of coordination. These facts do not translate into evidence that there are pools of unneeded personnel; they simply suggest there are resources that can be used in different ways to address unmet needs. Given that additional funding for reform is hard to come by, such redeployment of resources is the primary answer to the ubiquitous question: Where will we find the funds?

See resource aids from the Center for a set of surveys designed to guide mapping of existing school-based and linked psychosocial and mental health programs and services.
Although a resource team might be created solely around psychosocial programs, such a mechanism is meant to bring together representatives of all major programs and services supporting a school's instructional component (e.g., guidance counselors, school psychologists, nurses, social workers, attendance and dropout counselors, health educators, special education staff, bilingual and Title I program coordinators). This includes representatives of any community agency that is significantly involved at the school. It also includes the energies and expertise of one of the site's administrators, regular classroom teachers, non-certificated staff, parents, and older students. Where creation of "another team" is seen as a burden, existing teams can be asked to broaden their scope. Teams that already have a core of relevant expertise, such as student study teams, teacher assistance teams, and school crisis teams, have demonstrated the ability to extend their functions to encompass resource coordination. To do so, however, they must take great care to structure their agenda so that sufficient time is devoted to the additional tasks.

Properly constituted, trained, and supported, a resource coordinating team can complement the work of the site's governance body through providing on-site overview, leadership, and advocacy for all activity aimed at addressing barriers to learning and enhancing healthy development. Having at least one representative from the resource coordinating team on the school's governing and planning bodies helps ensure that essential programs and services are maintained, improved, and increasingly integrated with classroom instruction (see Resource Aids).

**Local Schools Working Together**

To facilitate resource coordination and enhancement among a complex of schools (e.g., a high school and its feeder middle and elementary schools), a resource coordinating council can be established by bringing together representatives of each school's resource coordinating team. Such a complex of schools needs to work together because in many cases they are concerned with the same families (e.g., a family often has children at each level of schooling). Moreover, schools in a given locale try to establish linkages with the same community resources. A coordinating council for a complex of schools provides a mechanism to help ensure cohesive and equitable deployment of such resources.
Fully Integrating with School and Community Resources

Most schools and many community services use weak models in addressing barriers to learning. The primary emphasis in too many instances is to refer individuals to specific professionals, and this usually results in narrow and piecemeal approaches to complex problems, many of which find their roots in a student’s environment. Overreliance on referrals to professionals also inevitably overwhelms limited, public-funded resources. More ideal models emphasize the need for a comprehensive continuum of community and school interventions to ameliorate complex problems. Such a continuum ranges from programs for primary prevention and early-age intervention -- through those to treat problems soon after onset -- to treatments for severe and chronic problems. Thus, they emphasize that promoting healthy development and positive functioning are one of the best ways to prevent many problems, and they also address specific problems experienced by youth and their families.

Limited efficacy seems inevitable as long as the full continuum of necessary programs is unavailable; limited cost effectiveness seems inevitable as long as related interventions are carried out in isolation of each other. Given all this, it is not surprising that many in the field doubt that major breakthroughs can occur without a comprehensive and integrated programmatic thrust. Such views have added impetus to major initiatives designed to restructure community health and human services and the way schools operate.

To be most effective, such interventions are developmentally-oriented (i.e., beginning before birth and progressing through each level of schooling and beyond) and offer a range of activity -- some focused on individuals and some on environmental systems. Included are programs designed to promote and maintain safety at home and at school, programs to promote and maintain physical/mental health, preschool and early school adjustment programs, programs to improve and augment social and academic supports, programs to intervene prior to referral for intensive treatments, and intensive treatment programs. It should be evident that such a continuum requires meshing together school and community resources and, given the scope of activity, effectiveness and efficiency require formal and long-lasting interprogram collaboration.

One implication of all this is formulated as the proposition that *a comprehensive, integrated component to address barriers to learning and enhance healthy development is essential* in helping the many who are not benefitting satisfactorily from formal education. Schools and communities are beginning to sense the need to adopt such a perspective. As they do, we will become more effective in our efforts to enable schools to teach, students to learn, families to function constructively, and communities to serve and protect. Such efforts will no longer be treated as supplementary ("add-ons") that are carried out as fragmented and categorical services; indeed, they will be seen as a primary, essential, and integrated component of school reform and restructuring.
Overcoming Barriers to Working Together

Treat people as if they were what they ought to be and you help them become what they are capable of being.

Goethe

In pursuing their mission, a school's staff must be sensitive to a variety of human, community, and institutional differences and learn strategies for dealing with them. With respect to working with students and their parents, staff members encounter differences in

- sociocultural and economic background and current lifestyle
- primary language spoken
- skin color
- gender
- motivation for help

and much more.

Differences as a Problem

Comparable differences are found in working with school personnel (certificated and non certificated, line staff and administrators). In addition, there are differences related to power, status, and orientation. And, for many newcomers to a school, the culture of schools in general and that of a specific school and community may differ greatly from other settings where they have lived and worked.

For school staff, existing differences may make it difficult to establish effective working relationships with students and others who effect the student. For example, many schools do not have staff who can reach out to students whose primary language is Spanish, Korean, Tagalog, Vietnamese, Cambodian, Armenian, and so forth. And although workshops and presentations are offered in an effort to increase specific cultural awareness, what can be learned in this way is limited, especially when one is in a school of many cultures.
There also is a danger in prejudgments based on apparent cultural awareness. There are many reports of students who have been victimized by professionals who are so sensitized to cultural differences that they treat fourth generation Americans as if they had just migrated from their cultural homeland.

Obviously, it is desirable to hire staff who have the needed language skills and cultural awareness and who do not rush to prejudge. Given the realities of budgets and staff recruitment, however, schools cannot hire a separate specialist for all the major language, cultural, and skin color differences that exist in some schools. Nevertheless, the objectives of accounting for relevant differences while respecting individuality can be appreciated and addressed.

**Examples of Client Differences as a Problem**

"A 14 year old Filipino wanted help, but his mother told me her culture doesn't recognize the need for counseling."

"Despite the parents' resistance to accepting the need for treatment, we decided the student had to be sent to the emergency room after the suicide attempt."

"A 15 year old Vietnamese attempted suicide because her parents were forcing her into an arranged marriage."

"An 18 year old Latina student reported suicidal ideation; being so strict that he would not allow her to date."

As these cases illustrate, differences can result in problems for students, parents, and staff. Although such problems are not easily resolved, they are solvable as long as everyone works in the best interests of the student, and the differences are not allowed to become barriers to relating with others.

**Differences as a Barrier**

As part of a working relationship, differences can be complementary and helpful -- as when staff from different disciplines work with and learn from each other. Differences become a barrier to establishing effective working relationships when negative attitudes are allowed to prevail. Interpersonally, the result generally is conflict and poor communication. For example, differences in status, skin color, power, orientation, and so forth can cause one or more persons to enter the situation with negative (including competitive) feelings. And such feelings often motivate conflict.

Many individuals (students, staff) who have been treated unfairly, been discriminated against, been deprived of opportunity and status at school, on the job, and in society use whatever means they can to seek redress and sometimes to strike back. Such an individual may promote conflict in hopes of correcting power imbalances or at least to call attention to a problem. Often, however, power differentials are so institutionalized that individual action has little impact.
"You don't know what it's like to be poor."

"You're the wrong color to understand."

"You're being culturally insensitive."

"Male therapists shouldn't work with girls who have been sexually abused."

"How can a woman understand a male student's problems?"

"I never feel that young professionals can be trusted."

"How can you expect to work effectively with school personnel when you understand so little about the culture of schools and are so negative toward them and the people who staff them?"

"If you haven't had alcohol or other drug problems, you can't help students with such problems."

"If you don't have teenagers at home, you can't really understand them."

"You don't like sports! How can you expect to relate to teenagers?"

You know, it's a tragedy in a way that Americans are brought up to think that they cannot feel for other people and other beings just because they are different.

Alice Walker
It is hard and frustrating to fight an institution. It is much easier and immediately satisfying to fight with other individuals one sees as representing that institution. However, when this occurs where individuals are supposed to work together, those with negative feelings may act and say things in ways that produce significant barriers to establishing a working relationship. Often, the underlying message is "you don't understand," or worse yet "you probably don't want to understand." Or, even worse, "you are my enemy."

It is unfortunate when such barriers arise between students and those trying to help them; it is a travesty when such barriers interfere with the helpers working together effectively. Staff conflicts detract from accomplishing goals and contribute in a major way to "burn out."

**Overcoming Barriers Related to Differences**

When the problem is only one of poor skills, it is relatively easy to overcome. Most motivated professionals can be directly taught ways to improve communication and avoid or resolve conflicts that interfere with working relationships. There are, however, no easy solutions to overcoming deeply embedded negative attitudes. Certainly, a first step is to understand that the nature of the problem is not differences per se but negative perceptions stemming from the politics and psychology of the situation.

It is these perceptions that lead to

- prejudgments that a person is bad because of an observed difference

and

- the view that there is little to be gained from working with that person.

Thus, minimally, the task of overcoming negative attitudes interfering with a particular working relationship is twofold. To find ways

- to counter negative prejudgments (e.g., to establish the credibility of those who have been prejudged)

and

- to demonstrate there is something of value to be gained from working together.
Building Rapport and Connection

To be effective in working with another person (student, parent, staff), you need to build a positive relationship around the tasks at hand.

Necessary ingredients in building a working relationship are

* minimizing negative prejudgments about those with whom you will be working (see Exhibit 1)
* taking time to make connections
* identifying what will be gained from the collaboration in terms of mutually desired outcomes -- to clarify the value of working together
* enhancing expectations that the working relationship will be productive -- important here is establishing credibility with each other
* establishing a structure that provides support and guidance to aid task focus
* periodic reminders of the positive outcomes that have resulted from working together

With specific respect to building relationships and effective communication, three things you can do are:

* convey empathy and warmth (e.g., the ability to understand and appreciate what the individual is thinking and feeling and to transmit a sense of liking)
* convey genuine regard and respect (e.g., the ability to transmit real interest and to interact in a way that enables the individual to maintain a feeling of integrity and personal control)
* talk with, not at, others -- active listening and dialogue (e.g., being a good listener, not being judgmental, not prying, sharing your experiences as appropriate and needed)

Finally, watch out for ego-oriented behavior (yours and theirs) -- it tends to get in the way of accomplishing the task at hand.