Addressing Barriers to Student Learning

Continuing Education

Mental Health in Schools:
New Roles for School Nurses

Units

I. Placing Mental Health into the Context of Schools and the 21st Century

II. Mental Health Services and Instruction: What a School Nurse Can Do

III. Working with Others to Enhance Programs and Resources

Prepared by the School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- (310) 825-3634. Co-directors: Howard Adelman & Linda Taylor

Mental Health in Schools:
New Roles for School Nurses

This set of three continuing education units is part of a series developed by the UCLA Center for Mental Health in Schools focused on *addressing barriers to student learning.* Each unit consists of several sections designed to stand alone. Thus, the total set can be used and taught in a straight forward sequence, or one or more units and sections can be combined into a personalized course. This design also allows learners to approach the material as they would use an internet website (i.e., exploring specific topics of immediate interest and then going over the rest in any order that feels comfortable). The units are packaged in a sequence that reflects the developers' preference for starting with a big picture framework for understanding the context and emerging directions for mental health in schools.

Beginning each section are specific objectives and focusing questions to guide reading and review. Interspersed throughout each section are boxed material designed to help the learner think in greater depth about the material. Test questions are provided at the end of each section as an additional study aid.

CONTENTS

Preface

There is a simple truth that every professional working in schools knows: social, emotional, and physical health deficits and other persistent barriers to learning must be addressed if students are to learn effectively and schools are to accomplish their educational mission. It would be wonderful if the process of addressing such barriers could be handled solely by families or public and private community agencies. Unfortunately, these agencies are unable to do the job alone. Thus, if school reform is to be effective, schools must play a major role in easing problems, increasing opportunities, and enhancing the well-being of students and families.

It is clear that the success of any initiative focused on mental health in schools is dependent on the full involvement of school nurses. In the spring of 1996, Beverly Bradley and Keeta DeStefano Lewis representing the National Association of School Nurses (NASN) proposed that the UCLA Center prepare materials for continuing education of school nurses. The Center agreed to do so. The material contained in this document represents a timely and progressive approach to the topic. At the same time, the content, like the field itself, is seen as in a state of continuous evolution. Thus, we are extremely interested in receiving your feedback. Please send your comments to: Howard S. Adelman and Linda Taylor, Co-Directors, Center for Mental Health in Schools, UCLA, Department of Psychology, Los Angeles, CA 90095-1563.

*Under the auspices of the School Mental Health Project, the Center for Mental Health in Schools at UCLA pursues the need for better mental health interventions in the context of moving toward a comprehensive, integrated approach to addressing barriers to student learning. A comprehensive approach encompasses (a) prevention and prereferral interventions for mild problems, (b) high visibility programs for high-frequency psychosocial problems, and (c) strategies to assist with severe and pervasive mental health problems. A comprehensive approach recognizes the role school, home, and community life play in creating and correcting young people's problems, especially those who are under-served and hard-to-reach.

About Course Format

The continuing education module entitled *Mental Health in Schools: New Roles for School Nurses* consists of an evolving set of modular units focused on *addressing barriers to student learning.* Each unit consists of several sections designed to stand alone. Thus, the total set can be used and taught in a straight forward sequence, or one or more units and sections can be combined into a personalized course. This design also allows learners to approach the material as they would use an internet website (i.e., exploring specific topics of immediate interest and then going over the rest in any order that feels comfortable). The units are packaged in a sequence that reflects the designers' preference for starting with a big picture framework for understanding the context and emerging directions for mental health in schools.

To the Learner

Beginning each section are specific objectives and focusing questions meant to help guide reading and review. Interspersed throughout each section are boxed material designed to help you think in greater depth about the material. Test questions are provided at the end of each section as an additional study aid.

If feasible, establish a study group. Such a group not only can help facilitate the learning of new ideas and skills, it lays a great foundation for ongoing networking, social support, and team building. These, of course, are important ingredients in maintaining morale and minimizing burnout as you deal with difficult problems each day at your school.

***Under separate cover*, you will find a set of *Accompanying Materials* that can provide you with enrichment learning opportunities on key topics as well as with specific resource and technical aids to assist you in applying what you are learning.**

To Curriculum Designers Adopting this Material

The material can be incorporated into various formats:

(1) self-study (individual or group)

(2) participation in workshops (a half or full day continuing education workshop; a sequence of district-wide inservice workshops)

(3) media and computer courses (instructional television -- live, and if feasible, interactive; video or audiotaped courses; computer courses, an internet offering)

(4) a professional journal offering a continuing education series.

Introduction to a Continuing Education Module on
Mental Health In Schools: New Roles for School Nurses

Schools committed to the success of all children must have an array of activity designed to address barriers to learning. No one is certain of the exact number of students who require assistance in dealing with such barriers. There is consensus, however, that significant barriers are encountered by too many students. Among these barriers are a host of psychosocial and mental health concerns.

Each day school nurses are confronted with many students who are doing poorly in school as a result of health and psychosocial problems. Increasingly, school nurses find it necessary to do something more than their original training prepared them to do. At the same time, education reform and restructuring are changing the whole fabric of schools and calling upon all pupil services personnel to expand their roles and functions.

As a result, school nurses need to acquire new ways of thinking about how schools should address barriers to learning and they need additional skills to equip them for emerging new roles and functions. This continuing education module is designed to help meet these needs.

This set of three units focuses on the school nurse's role in addressing psychosocial and mental health problems that interfere with students' learning and performance.

Mental Health in Schools: New Roles for School Nurses

Contents of All Three Units

Mental Health in Schools: New Roles for School Nurses

Unit I:

Placing Mental Health into the Context of Schools and the 21st Century

Sections

A. Introductory Overview

B. The Need to Enhance Healthy Development and Address Barriers to Learning

C. Addressing the Need: Moving Toward a Comprehensive Approach

Do not follow where the path may lead. Go, instead, where there is no path and leave a trail.
Anonymous

This unit is one of a set of three focused on the school nurse's role in addressing psychosocial and mental health problems that interfere with students' learning and performance.

Schools of the 21st century will call upon us all to play new and expanding roles. Today's school nurses have both the opportunity and the responsibility to lead the way into the new century. To do so, they must become major participants in movements to reform and restructure schools, and they must help shape initiatives that are attempting to link community resources to schools.

Working closely with others who are concerned with psychosocial problems and healthy development, school nurses can broaden reform and restructuring in ways that truly address the barriers to student learning and enhance healthy development. In the process, they will continue to redefine their roles and functions and expand the ways in which nurses contribute to the well-being of young people and the society.

Mental Health in Schools: New Roles for School Nurses

Contents of All Three Units

Section A: Introductory Overview

Once upon a time, the animals decided that their lives and their society would be improved by establishing a school. The basics identified as necessary for survival in the animal world were swimming, running, climbing, jumping, and flying. Instructors were hired to teach these activities, and it was agreed that all the animals would take all the courses. this worked out well for the administrators, but it caused some problems for the students.

> The squirrel, for example, was an "A" student in running, jumping, and climbing but had trouble in the flying class -- not because of an inability to fly, for she could sail from the top of one tree to another with ease, but because the flying curriculum called for taking off from the ground. The squirrel was drilled in ground-to-air take-offs until she was exhausted and developed charley horses from overexertion. This caused her to perform poorly in her other classes, and her grades dropped to "D"s.

The duck was outstanding in swimming classes -- even better than the teacher. But she did so poorly in running that she was transferred to a remedial class. There she practiced running until her webbed feet were so badly damaged that she was only an average swimmer. But since average was acceptable, nobody saw this as a problem, except the duck.

> In contrast, the rabbit was excellent in running but, being terrified of water, he was an extremely poor swimmer. Despite a lot of makeup work in swimming class, he never could stay afloat. He soon became frustrated and uncooperative and was eventually expelled because of behavior problems.

The eagle naturally enough was a brilliant student in flying class and even did well in running and jumping. he had to be severely disciplined in climbing class, however, because he insisted that his way of getting to the top of the tree was faster and easier.

> It should be noted that the parents of the groundhog pulled him out of school because the administration would not add classes in digging and burrowing. The groundhogs, along with the gophers and badgers, got a prairie dog to start a private school. They all have become strong opponents of school taxes and proponents of voucher systems.

By graduation time, the student with the best grades in the animal school was a compulsive ostrich who could run superbly and also could swim, fly, and climb a little. She, of course, was made class valedictorian and received scholarship offers from all the best universities.

(George H. Reeves is credited with bringing this parable to America.)

Contents:

Objectives for Section A

After completing this section of the unit, your should be able to:

- identify a wide range of interveners who could play a role in counseling, psychological, and social service activity at a school
- enumerate, with respect to the activities carried out by such interveners, two specific functions related to (a) providing direct services and instruction, (b) coordinating, developing, and providing leadership for programs, services, and systems, (c) enhancing connections with community resources
- identify at least 2 major emerging trends related to health and psychosocial programs in schools
- explain why school nurses should play a role in addressing mental health and psychosocial concerns in schools and specify three related examples of possible new roles

A Few Focusing Questions

- *Who at a school might help students with psychosocial concerns?*
- *What factors put students "at risk?"*
- *How might a school nurse play a greater role in shaping a school's overall efforts to address barriers to learning and enhance healthy development?*

It is widely recognized that social, emotional, and physical health deficits and other persistent barriers to learning must be addressed if students are to benefit appropriately from their schooling.

Types of interveners who might play primary or secondary roles in counseling, psychological, and social service activity

Instructional professionals
(e.g., regular classroom teachers, special education staff, health educators, classroom resource staff and consultants)

Health office professionals
(e.g., nurses, physicians, health educators, consultants)

Counseling, psychological, and social work professionals
(e.g., counselors, health educators, psychologists, psychiatrists, psychiatric nurses, social workers, consultants)

Itinerant therapists
(e.g., art, dance, music, occupational, physical, speech-language-hearing, and recreation therapists; psychodramatists)

Personnel-in-training for the above roles

Others
- Aides
- Classified staff (e.g., clerical and cafeteria staff, custodians, bus drivers)
- Paraprofessionals
- Peers (e.g., peer/cross-age counselors and tutors, mutual support and self-help groups)
- Recreation personnel
- Volunteers (professional/paraprofessional/ nonprofessional)

This box outlines an array of interveners involved in schools who are concerned with mental health and psychosocial matters.

Many professionals struggle to

- ease problems
- increase opportunities
- enhance the well-being of students, families, and school staff.

While all students can benefit from interventions to enhance social and emotional development, such activity is essential for those manifesting severe and pervasive problems.

Some of the many important functions such personnel can carry out are listed below.

Types of functions provided

Direct services and instruction
(based on prevailing standards of practice and informed by research)

- Identifying and processing students in need of assistance (e.g., initial screening, gatekeeping and triage, client consultation, referral, initial monitoring of care)
- Indepth assessment (individuals, groups, classroom, school, and home environments)
- Crisis intervention and emergency assistance (e.g., psychological first-aid and follow-up; suicide prevention; emergency services, such as food, clothing, transportation)
- Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness (e.g., guidance counseling; contributing to development and implementation of health and violence reduction curricula; placement assistance; advocacy; liaison between school and home; gang, delinquency, and safe-school programs; conflict resolution)
- Transition and follow-up (e.g., orientations, social support for newcomers, follow-thru)
- Treatment/therapy/counseling, remediation, rehabilitation (incl. secondary prevention)
- Increasing the amount of direct service impact through ongoing management of care multidisciplinary teamwork, consultation, training, and supervision

Coordination, development, and leadership for programs, services, resources, systems

- Needs assessment
- Coordinating activities (e.g., participating on resource coordinating teams to enhance coordination across disciplines and components; with regular, special, and compensatory educ.; in and out of school)
- Mapping and enhancing resources and systems
- Developing new approaches (incl. facilitating systemic changes)
- Monitoring and evaluating intervention for quality improvement, cost-benefit accountability, research
- Advocacy for programs and services and for standards of care in the schools
- Pursuing strategies for public relations and for enhancing financial resources

Enhancing connections with community resources

- Strategies to increase responsiveness to referrals from the school
- Strategies to create formal linkages among programs and services

Few schools, of course, can afford the entire array of personnel and activity outlined. And, because so many young people experience serious problems that interfere with learning and performing in school, most schools indicate that *they need much more* than they have.

The problem of at risk students has grown so great that educators find they must hold special national summits where the emphasis is not only on the academic plight of students, but also on how to make schools safe.

- There is growing consensus about the *crisis* nature of the situation. And it is widely recognized that failure to address the problems of children and schools can only exacerbate the health and economic consequences for society.

- *New directions call for functions that go beyond direct service and traditional consultation.* All who work in the schools must be prepared not only to provide direct help but to act as advocates, catalysts, brokers, and facilitators of systemic reform. Particularly needed are efforts to improve intervention efficacy through integrating physical and mental health and social services.

- Ultimately, the need is for *systemic restructuring* of all support programs and services *into a comprehensive and cohesive set of programs.*

- Comprehensive approaches recognize the role school, home, and community life play in creating and correcting young people's problems. From such a perspective, schools must provide *interventions that address individual problems and system changes*. In this regard, there is renewed interest in the notion that school-based and linked services increase access to underserved and hard-to-reach populations.

State of the Art

An extensive literature reports positive outcomes for psychosocial interventions available to schools.

While many of the reports are from narrowly focused brief demonstrations, the research is promising. A significant number of appropriately developed and implemented programs demonstrate benefits for schools (e.g., better student functioning and attendance, less teacher frustration) and for society (e.g., reduced costs for welfare, unemployment, and use of emergency and adult services).

Thus, the literature is encouraging. It provides a menu of "best practices."

And the search for better practices remains a high priority and must be pursued with full consideration of the diverse demographics and conditions that exist in our changing society.

Data on diagnosable mental disorders (based on community samples) suggest that from 12% to 22% of all children suffer from mental, emotional or behavioral disorders, and relatively few receive mental health services. The picture is even bleaker when expanded beyond the limited perspective of *diagnosable* mental disorders to include all young people experiencing psychosocial problems and who Joy Dryfoos defines as "at risk of not maturing into responsible adults." The number "at risk" in many schools serving low-income populations has climbed over the 50% mark. Harold Hodgkinson , director of the Center for Demographic Policy, estimates across the nation 40% of students are in "very bad educational shape" and "at risk of failing to fulfill their physical and mental promise." Because so many live in inner cities and impoverished rural areas and are recently arrived immigrants, he attributes their school problems mainly to conditions they bring with them when they enter kindergarten. These are conditions associated with poverty, difficult and extremely diverse family circumstance, lack of English language skills, violent neighborhoods, physical and emotional problems, and lack of health care. One impact is that at least 12% fail to complete high school, which leads to extensive consequences for them, their families, and society.

School nurses are engaged in an increasingly wide array of activity, including promotion of social and emotional development, direct services, outreach to families, and various forms of support for teachers and other school personnel. There is enhanced emphasis on coordination and collaboration within a school and with community agencies to provide the "network of care" necessary to deal with complex problems over time. Thus, services in schools are expanding and changing rapidly. Schools' efforts to address health and psychosocial problems encompass

- prevention and prereferral interventions for mild problems
- high visibility programs for high-frequency problems
- strategies to address severe and pervasive problems.

Emerging Trends

Proliferation of health and psychosocial programs in schools tends to occur with little coordination of planning and implementation. As awareness of deficiencies has increased, major systemic changes have been proposed. Four emerging trends are

- the move *from* narrowly focused *to* comprehensive approaches
- the move *from* fragmentation *to* coordinated/integrated intervention
- the move *from* problem specific and discipline-oriented services *to* less categorical, cross-disciplinary programs
- the move *from* viewing health programs as "supplementary services" *to* policy changes that recognize physical and mental health services as an essential element in enabling learning.

Each trend has implications for what goes on in schools.

New Roles for School Nurses

In addition to the key role they play in promoting health and helping specific students with physical health problems, school nurses have always been called upon to deal with psychosocial and mental health concerns. In recent years, these calls have increased.

Moreover, emerging trends require that nurses and all pupil service personnel continue to expand their roles in advocating and facilitating systemic reforms so that they can be more effective in addressing barriers to student learning and promoting healthy development.

Through an expanded set of roles and functions, such personnel can play a potent role in creating a comprehensive, integrated approach to meeting the needs of the young by helping to weave together what schools can do with what the community offers.

The relatively small number of school nurses and other pupil service personnel available to schools can provide only a limited amount of direct services. Such personnel can have an impact on greater numbers of students if their expertise is used to a greater degree at the level of program organization, development, and maintenance than currently is the case.

With continuing education, school nurses can join other mental health professionals in bringing specialized understanding of cause (e.g., psychosocial factors and pathology) and intervention (e.g., approaching problem amelioration through attitude and motivation change and system strategies). This knowledge can have many benefits. For instance, mental health perspectives of "best fit" and "least intervention needed" strategies can contribute to reduced referrals and increased efficacy of mainstream and special education programs. With respect to pre and inservice staff development, such perspectives can expand educators' views of how to help students with everyday upsets as well as with crises and other serious problems -- in ways that contribute to positive growth. Specialized mental health understanding also can be translated into programs for targeted problems (e.g., depression, dropout prevention, drug abuse, gang activity, teen pregnancy).

Despite the range of knowledge and skills they bring to a setting, school nurses usually are able to see only a small proportion of the many students, families, and school staff who could benefit from their efforts. This is not surprising given the relatively few nurses most school districts employ and the many roles they are called on to assume in order to accommodate to changing models for delivering and financing health care.

This lamentable state of affairs raises several points for discussion. One often discussed idea is that greater dividends (in terms of helping more people) might be forthcoming if such personnel devoted their talents more to prevention. At an even more fundamental level, it seems likely that larger numbers would benefit if nurses devoted a greater portion of their expertise to creating a comprehensive, integrated approach for addressing barriers to learning and enhancing healthy development. For this to happen, however, there must be a shift in priorities with respect to how they use their time.

Specifically, this involves redeploying time to focus more on functions related to

(a) coordination, development, and leadership (e.g., to evolve and maintain resource integration) and

(b) evolving long-lasting collaborations with community resources.

Given the opportunity, school nurses can contribute greatly to creation of a comprehensive, integrated approach.

Concluding Comments

Emerging trends are reshaping the work of school nurses. New directions call for going beyond direct service and beyond traditional consultation. All who work in schools must be prepared not only to provide direct help but to act as advocates, catalysts, brokers, and facilitators of systemic reform. Particularly needed are efforts to improve intervention outcomes by integrating physical and mental health and social services. More comprehensively, the need is for systemic reform and restructuring of all education support programs and services to improve the state of the art and provide a safety net of care for generations to come.

This raises many questions. One you may want to think about and discuss at this point is:

How well integrated at my school are the programs to address barriers to learning and enhance healthy development?

The surprised principal, waving the achievement test scores, confronts Ms. Smith, the second grade teacher.
"How did you get these low IQ students to do so well?"
"Low IQ?" she repeats with equal surprise. "What do you mean, low IQ?"
"Well, didn't you see their IQ scores on the list I sent you last fall?"
"Oh no!" Ms. Smith exclaims, "I thought those were their locker numbers!"

Test Questions -- Unit I: Section A

(1) Which of the following were identified as potential interveners who could play a role could play a role in counseling, psychological, and social service activity at a school?

____(a) counselors
____(b) nurses
____(c) teachers
____(d) aides
____(e) students
____(f) a & b
____(g) a, b, & e
____(h) all the above

(2) With respect to the activities carried out by such interveners, enumerate two specific functions related to

(a) providing direct services and instruction
_____

_____

(b) coordinating, developing, and providing leadership for programs, services, and systems
_____

_____

(c) enhancing connections with community resources
_____

_____

(3) Which of the following is ***not*** an emerging trend related to health and psychosocial programs in schools?

___(a) the move *from* narrowly focused *to* comprehensive approaches

___(b) the move *from* fragmentation *to* coordinated/integrated intervention

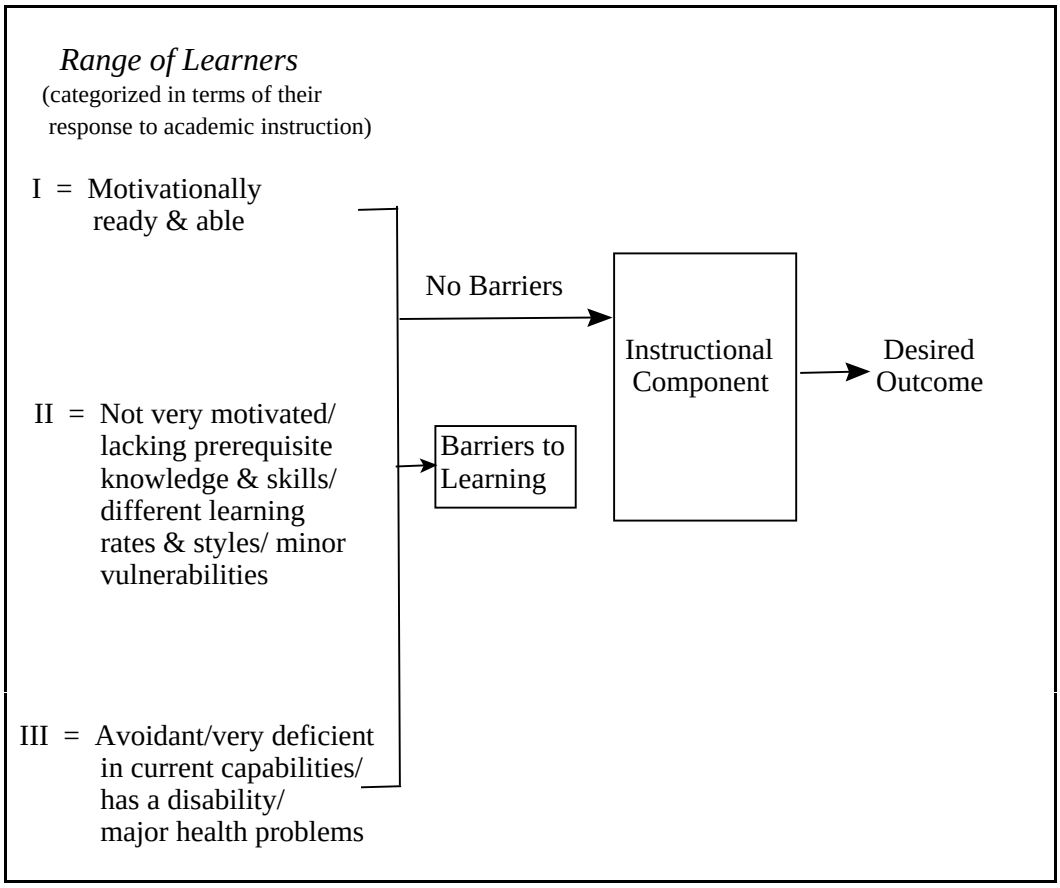
___(c) the move *from* problem specific and discipline-oriented services *to* less categorical, cross-disciplinary programs

___(d) the move *from* viewing health programs as "supplementary services" *to* policy changes that recognize physical and mental health services as an essential element in enabling learning

___(e) all are emerging trends

(4) Enumerate three possible new roles that school nurses might play in addressing mental health and psychosocial concerns in schools.
_____
_____
_____

Section B: The Need to Enhance Healthy Development and Address Barriers to Learning



Contents:

Objectives for Section B

After completing this section of the unit, your should be able to:

- discuss why providing health and social services is an insufficient strategy for addressing barriers to student learning
- identify at least five major areas of focus in enhancing healthy psychosocial development
- differentiate between personal and systemic barriers to student learning and understand the bias toward personal rather than social causation
- understand a range of family needs for social and emotional support and enumerate at least three characteristics of family-oriented interventions

A Few Focusing Questions

- *What are the major barriers that interfere with students learning and performing effectively at school?*
- *How can school staff build alliances with families?*
- *How do persons and environments interact to cause problems*

No one has to make the case that there are many factors interfering with students' learning and performance.

And the consensus is that there are many such barriers to learning in any school enrolling a high proportion of students who are poor or immigrants or both.

School policy makers also understand that poor health can be such a barrier and that healthy development is important to ongoing well-being.

At the same time, school policy makers are clear that health is not a school's primary mission. *Education* is.

Thus, the idea that schools should focus resources on physical and mental health must be advocated within the context of enabling schools to accomplish their primary mission.

The message that must be conveyed is that the mission of educating all students requires a comprehensive set of interventions that address barriers to learning in an integrated way.

Stop, Think, Discuss

What are some major barriers you think must be addressed so that students will learn and perform appropriately at school?

Outlined below are some common barriers usually identified as interfering with learning/ parenting/ teaching. Think about and perhaps discuss with your colleagues which of these you see everyday and what others you would add to the list.

Deficiencies in basic living resources and opportunities for development

- dearth of food in the home
- inadequate clothing
- substandard housing (incl. being homeless)
- lack of transportation
- income at or below the poverty level (e.g., due to unemployment or welfare status)
- lack of after-school supervision for child
- lack of youth recreation and enrichment
- immigration-related concerns (e.g., limited English proficiency, legal status)
- lack of home involvement in schooling
- lack of peer support
- lack of community involvement
- lack of school support services
- lack of social services
- lack of physical, dental, and mental health services

Psychosocial problems

- physical health problems
- school adjustment problems (incl. school avoidance, truancy, pregnancy, and dropouts)
- relationship difficulties (incl. dysfunctional family situations, insensitivity to others, social withdrawal, peers who are negative influences)
- deficiencies in necessary skills (e.g., reading problems, language difficulties, poor coordination, social skill deficits)
- abuse by others (physical and sexual)
- substance abuse
- Overreliance on psychological defense mechanisms (e.g., denial, distortion, projection, displacement)
- eating problems
- delinquency (incl. gang-related problems and community violence)
- psychosocial concerns stemming from sexual activity (e.g., prevention of and reactions to pregnancy or STDs)
- psychopathology/disabilities/disorders

General stressors and underlying psychological problems associated with

- external stressors (objective and perceived) and deficits in support systems
- competence deficits (low self-efficacy/self-esteem, skill deficits)
- threats to self-determination/autonomy/control
- feeling unrelated to others or perceiving threats to valued relationships
- emotional upsets, personality disorders, mood disorders and other psychopathology

Crises and emergencies

- personal/familial (incl. home violence)
- subgroup (e.g., death of a classmate or close colleague)
- school-wide (e.g., earthquake, floods, shooting on campus)

Difficult transitions

- associated with stages of schooling (e.g., entry, leaving)
- associated with stages of life (e.g., puberty, gender identity, job and career concerns)
- associated with changes in life circumstances (e.g., moving, death in the family)

Note: The severity and pervasiveness of all the problems addressed may be mild, moderate, or severe; they also may be narrow or pervasive in terms of how broadly they are manifested.

Schools clearly are involved in dealing with barriers to learning.

They hire pupil service professionals and institute services and programs aimed at such concerns as drug abuse, teen pregnancy, dropout prevention, and on and on. In addition, efforts increasingly are made to link with community health and social services.

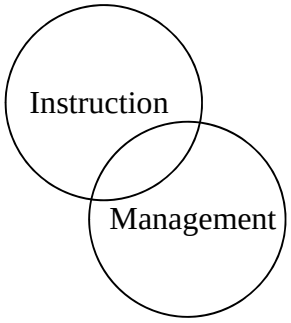
Unfortunately, the prevailing activity is not enough.

Even though poor health and other barriers to student learning are seen as directly related to poor educational outcomes, programs to address barriers to learning are treated as "add-ons." That is, in terms of policy and practice, they are not assigned top priority and often are among the first cut when budgets are tight.

As long as this is the case, many students will continue to encounter barriers that interfere with their benefiting from instructional reforms. And for schools serving large numbers of such students, this means continuation of the pattern of test score averages that do not rise substantially.

This is a central paradox of school reform. That is: school restructuring clearly is intended to enhance student achievement. To this end, reform efforts predominantly focus on improving instruction and school management, with little attention paid to *restructuring and enhancing resources that address barriers to learning*. Consequentially, too many students are unable to take advantage of improved teaching.

What is the solution to this paradox?



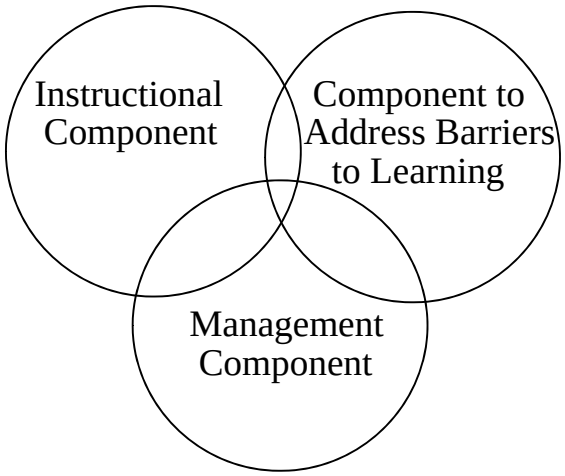
?

One strategy is to help policy makers understand that current *efforts to restructure schools are missing a major component*.

The missing component doesn't focus on health and social services per se, but it encompasses a strong emphasis on physical and mental health as one major facet of helping schools address barriers to student learning. Such a component is essential in any school committed to the success of *all*.

By themselves, *health and social services* are an insufficient strategy for addressing the biggest problems confronting schools. They are not, for example, designed to address a full range of factors that cause poor academic performance, dropouts, gang violence, teenage pregnancy, substance abuse, racial conflict, and so forth. This is not a criticism of the services per se. The point is that such services are only one facet of a comprehensive approach.

A broad perspective of what is needed emerges by conceiving the missing component for addressing barriers to learning as encompassing efforts to prevent and correct learning, behavior, emotional, and health problems. Such efforts include activity that fosters academic, social, emotional, and physical functioning.



Promoting Healthy Development

Promoting healthy development is one of the keys to preventing mental health and psychosocial problems. For schools, the need is to maintain and enhance health and safety and hopefully do more.

This requires programs that

inoculate through providing positive and negative information, skill instruction, and fostering attitudes (e.g., using facets of health education -- physical and mental -- to build resistance and resilience). Examples of problems addressed with a preventive focus are substance abuse, violence, pregnancy, school dropout, physical and sexual abuse, suicide

directly facilitate development in all areas (physical, social, emotional) and in ways that account for differences in levels of development and current developmental demands. Examples of arenas for activity are parent education and support, day care, preschool, early education, elementary classrooms, recreation and enrichment programs

identify, correct, or at least minimize physical and mental health and psychosocial problems as early after onset as is feasible

Areas of Focus in Enhancing Healthy Psychosocial Development

Responsibility and integrity
(e.g., understanding and valuing of societal expectations and moral courses of action)

Self-esteem
(e.g., feelings of competence, self-determination, and being connected to others)

Social and working relationships
(e.g., social awareness, empathy, respect, communication, interpersonal cooperation and problem solving, critical thinking, judgement, and decision making)

Self-evaluation/self-direction/self-regulation
(e.g., understanding of self and impact on others, development of personal goals, initiative, and functional autonomy)

Temperament
(e.g., emotional stability and responsiveness)

Personal safety and safe behavior
(e.g., understanding and valuing of ways to maintain safety, avoid violence, resist drug abuse, and prevent sexual abuse)

Health maintenance
(e.g., understanding and valuing of ways to maintain physical and mental health)

Effective physical functioning
(e.g., understanding and valuing of how to develop and maintain physical fitness)

Careers and life roles
(e.g., awareness of vocational options, changing nature of sex roles, stress management)

Creativity
(e.g., breaking set)

Appreciation of the developmental demands at different age levels is helpful, and awareness of an individual's current levels of development is essential. Basic textbooks provide guides to understanding developmental tasks.

Stop, Think, Discuss

For illustrative purposes, listed below are some major developmental tasks.

What are others you encounter frequently? What do the many developmental tasks suggest for what schools should be doing?

Examples of Major Developmental Tasks

Toddlers (2-4)	Locomotion and increasing control over gross motor skills Early speech Playing with others Beginning of impulse control
Early school age (4-6)	Sex-role identification Increasing control over fine motor skills Acquisition of basic language structure Beginning sense of morality Playing with others in groups
Middle school age (6-12)	Establishing close friendships Strengthening sense of morality Increasing listening skills Ability to use language in multifaceted and complex ways Academic achievement Teamwork Self-evaluation
Early adolescence (12-18)	Accepting one's physique Emotional development Lessening emotional dependence on parents Widening peer relationships Choosing and preparing for higher education/occupation Gender identity, sex role patterns, and sexual relationships Acquiring socially responsible values and behavior patterns

One way to think about all this is to remember that the normal trends are for school-age youngsters to strive toward feeling *competent, self-determining*, and *connected with others*. When youngsters experience the opposite of such feelings, the situation may arouse anxiety, fear, anger, alienation, a sense of losing control, a sense of impotence, hopelessness, powerlessness. In turn, this can lead to externalizing (aggressive, "acting out") or internalizing (withdrawal, self-punishing, delusional) behaviors.

While efforts to facilitate social and emotional development focus on enhancing knowledge, skills, and attitudes, from a mental health perspective the intent is to enhance an individual's feelings of competence, self-determination, and connectedness with others.

Personal and Systemic Barriers to Student Learning

*She's **depressed.***

*That kid's got an **attention deficit hyperactivity disorder**.*

*He's **learning disabled.***

In discussing mental health, it is easy to fall into the trap of thinking only in terms of psychopathology. As the noted anthropologist Ruth Benedict wisely noted:

> ***Normality and exceptionally (or deviance) are not absolutes; both are culturally defined by particular societies at particular times for particular purposes.***

What's in a name?

> Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

It is not surprising that debates about labeling young people are so heated. Differential diagnosis is difficult and fraught with complex issues.

> The thinking of those who study behavioral, emotional, and learning problems is dominated by models stressing *person* pathology.

Because of this, diagnostic systems do not adequately account for psychosocial problems.

> This is well-illustrated by the widely-used *Diagnostic and Statistical Manual of Mental Disorders* -- DSM V (American Psychiatric Association).

As a result, *formal* systems for classifying problems in human functioning convey the impression that all behavioral, emotional, or learning problems are due to internal *pathology*.

> Thus, most differential diagnoses of children's problems are made by focusing on identifying one or more disorders (e.g., oppositional defiant disorder, attention-deficit/hyperactivity disorder, or adjustment disorders), rather than first asking:

Is there a disorder?

Bias toward labeling problems in terms of *personal* rather than *social causation* is bolstered by factors such as

(a) *attributional bias* --a tendency for observers to perceive others' problems as rooted in stable personal dispositions

(b) *economic and political influences* -- whereby society's current priorities and other extrinsic forces shape professional practice

There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them.

"To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.

Nicholas Hobbs

Overemphasis on pathology skews theory, research, practice, and public policy away from environmentally caused problems and psychosocial problems. There is considerable irony in all this because practitioners understand that most problems in human functioning result from the interplay of person and environment. That is, it is not nature *versus* nurture, but nature transacting with nurture that determines human behavior.

Stop, Think, discuss

To illustrate, let's look at something every school nurse encounters everyday -- students who clearly have learning problems and whose misbehavior and various physical complaints seem very much connected to their negative experiences related to academic learning difficulties.

Of the many students who come to the see you with some problem, how many are doing poorly with their classwork? *Do you think some of their physical complaints are relate to their learning problems?*

As you know, not all learning problems stem from the same causes. *How do you understand the range of factors that cause such problems?*

In the classroom, it is evident that some students learn easily, and some do not; some misbehave, some do not. Even a good student may appear distracted on a given day. Everyone who wants to help students who manifest problems needs some basic understanding of

Why the differences?

A common sense answer suggests that each student brings something different to the situation and therefore experiences it differently. And that's a pretty good answer -- as far as it goes. What gets lost in this simple explanation is the reciprocal impact student and situation have on each other -- resulting in continuous change in both.

To clarify the point: a student brings to a situation *capacities and attitudes* accumulated over time, as well as *current states of being and behaving*. These "person" variables transact with each other and also with the environment.

> At the same time, any situation in which students are expected to function not only consists of *instructional processes and content*, but also the *physical and social context* in which instruction takes place. Each part of the environment also transacts with the others.

Obviously, transactions vary considerably and lead to a variety of outcomes. These outcomes may *primarily* reflect the impact of person variables, environmental variables, or both.

> Not all outcomes are desirable. Undesirable outcomes include *deviant, disrupted, and delayed functioning*.

Undesirable outcomes may be due to a dysfunction within the student such a *neurological dysfunction* interfering with effective processing of letters and numbers (a true learning disability) or *psychopathology* that preoccupies the student at the expense of school learning.

> However, as any school nurse will be quick to emphasize, the problem may also reflect any number of *physical health problems*.

It also may be related to a variety of *psychosocial factors* that are barriers to the student attending school regularly or functioning appropriately when at school (frequent school changes because of family mobility, factors related to poverty such as hunger, distractors such as gang affiliation and teen pregnancy, taking drugs, etc.).

> Then, there are the many *environmental stressors* that can negatively affect learning and behavior -- dysfunctional families, physical and sexual abuse, excessive pressure to achieve, etc.

Finally, it is important to remember that in some cases there is nothing objectively wrong with the student or the environment, but for various reasons a student may not mesh well with a given teacher, school, group of peers, and so forth. Common examples of s*tudent-environment mismatches* are seen in the many instances when a fine teacher and an able youngster find they rub each other the wrong way and thus have trouble working together.

Family Needs for Social and Emotional Support

School Nurse:

> *Cara showed up today bruised and battered. We think her dad is abusing her.*

A parent to a school nurse:

> *I don't know what to do with Matt. He always seems angry and won't do any school work. I'm so depressed, I can hardly deal with him any more.*

Home involvement is especially important when students have problems. Clearly, families play a key role in causing and sometimes maintaining a student's problems. They also can play a major role in correcting or at least minimizing problems. And, any family that has a youngster with a problem is likely to pay a price economically, psychologically, and socially.

In all cases, besides whatever direct health and human services the family requires, there may also be a need for social and emotional support.

Stop, Think, Discuss

Think about the families of the students who are referred to you because of problems.

How does the school interact with them? Do they see school staff as allies? If not, why not?

Parents and other caretakers find it difficult to attend to the needs of their children when their own pressing needs are not attended to. This may help account for why parents who are most receptive to efforts to involve them in schools and schooling are a relatively small group.

Parents and others in the home need to feel welcomed and appreciated by the school.

Parents and others in the home often need to have an opportunity to share concerns.

Parents and others in the home need good information when there are problems -- information about the problem and presentation of such information in a context that also recognizes assets.

Parents and others in the home need information and ready access to resources.

In situations where there are large numbers of students who are having problems, the need is for healthy families, healthy schools, and healthy communities.

It seems likely that efforts to involve increasing numbers of parents in improving the well-being of their children must include a focus on improving the well-being of the many parents who are struggling to meet their own basic personal and interpersonal needs.

Thus, schools must be prepared to add programs and services that address such basic needs and staff must reach out to parents with interventions that are welcoming and encourage use of such programs. At the same time, schools must resist the temptation to scold such parents.

Prevailing agendas for parent involvement emphasize meeting societal and school needs. It is not surprising, therefore, that little attention is paid to schools helping parents and caretakers meet their own needs. Schools do offer some activities, such as parent support groups and classes to teach them English as a second language, that may help parents and contribute to their well-being (e.g., by improving parenting or literacy skills). However, the rationale for expending resources on these activities usually is that they enhance parents' ability to play a greater role in improving schooling.

> Another reason for involving parents is to support their efforts to improve the quality of their lives. This includes the notion of the school providing a social setting for parents and, in the process, fostering a psychological sense of community.

If a school wants home involvement, it must create a setting where parents, others in the home, school staff, and students want to and are able to interact with each other in mutually beneficial ways that lead to a special feeling of connection. This encompasses finding ways to account for and celebrate cultural and individual diversity in the school community.

> To these ends, ways must be found to minimize transactions that make parents feel incompetent, blamed, or coerced. At the same time, procedures and settings must be designed to foster informal encounters, provide information and learning opportunities, enable social interactions, facilitate access to sources of social support (including linkage to local social services), encourage participation in decision making, and so forth.

Remember:

> *the primary intent is to improve the quality of life for the participants.*

> Although any impact on schooling is a secondary gain, it is encouraging to note that fostering such a climate is consistent with the school reform literature's focus on the importance of a school's climate/ethos/culture.

Barriers to Involving Parents/Home in Schools and Schooling

FORMS OF BARRIERS

TYPES OF BARRIERS	Negative Attitudes	Lack of Mechanisms/ Skills	Practical Deterrents
Institutional	e.g., school administration is hostile toward increasing home involvement	e.g., insufficient staff assigned to planning and implementing ways to enhance home involvement; no more than a token effort to accommodate different languages	e.g., low priority given to home involvement in allocating resources such as space, time, and money
Impersonal	e.g., home involvement suffers from benign neglect	e.g., rapid influx of immigrant families overwhelms school's ability to communicate and provide relevant home involvement activities	e.g., school lacks resources; majority in home have problems related to work schedules, childcare, transportation
Personal	e.g., specific teachers and parents feel home involvement is not worth the effort or feel threatened by such involvement	e.g., specific teachers and parents lack relevant language and interpersonal skills	e.g., specific teachers and parents are too busy or lack resources

Approaching the topic from a special education orientation, Dunst et al. (1991) differentiate family-oriented intervention policies and practices as

- family-centered,
- family-focused,
- family-allied, and
- professional-centered.

(Dunst, C.J., Trivette, C.M., & Deal, A.G. (1991). *Enabling and empowering families: Principles and guidelines for practice.* Cambridge, MA: Brookline Books)

They categorize the characteristics of family-oriented interventions in terms of those that focus on

(1) enhancing a sense of community (i.e., "promoting the coming together ofn people around shared values and common needs in ways that create mutually beneficial interdependencies"),

(2) mobilizing resources and supports (i.e., "building support systems that enhance the flow of resources in ways that assist families with parenting responsibilities),

(3) shared responsibility and collaboration (i.e., "sharing ideas and skills by parents and professionals in ways that build and strengthen collaborative arrangements"),

(4) protecting family integrity (i.e., "respecting the family beliefs and values and protecting the family from intrusion upon its beliefs by outsiders"),

(5) strengthening family functioning (i.e., "promoting the capabilities and competencies of families necessary to mobilize resources and perform parenting responsibilities in ways that have empowering consequences"), and

(6) proactive human service practices (i.e., "adoption of consumer-driven human service-delivery models and practices that support and strengthen family functioning").

The case of Jose and his family illustrates many of the complexities involved in working with families.

Jose's family had come to the U.S.A. four years ago. His father worked as a gardener; his mother worked in the garment district. Neither was fluent in English; mother less so than father.

Jose's parents were called to school because of his misbehavior in the classroom. The teacher (who did not speak Spanish) informed them that she was having to use a range of behavioral management strategies to control Jose. However, for the strategies to really work, she said it also was important for the parents to use the same procedures at home. To learn these "parenting skills," the parents both were to attend one of the 6 week evening workshops the school was starting. They were assured the workshop was free, was available in English or Spanish, and there would be child care at the school if they needed it.

After meeting with the teacher, Jose's father, who had reluctantly come to the conference, told his wife she should attend the workshop -- but he would not. She understood that he saw it as her role -- not his -- but she was frightened; they fought about it. They had been fighting about a lot of things recently. In the end, she went, but her resentment toward her husband grew with every evening she had to attend the training sessions.

Over the next few months, the mother attempted to apply what she was told to do at the workshop. She withheld privileges and confined Jose to periods of "time out" whenever he didn't toe the line. At the same time, she felt his conduct at home had not been and was not currently that bad -- it was just the same spirited behavior his older brothers had shown at his age. Moreover, she knew he was upset by the increasingly frequent arguments she and her husband were having. She would have liked some help to know what to do about his and her own distress, but she didn't know how to get such help.

Instead of improving the situation, the control strategies seemed to make Jose more upset; he "acted out" more frequently and with escalating force. Soon, his mother found he would not listen to her and would run off when she tried to do what she had been told to do. She complained to her husband. He said it was her fault for pampering Jose. His solution was to beat the youngster.

To make matters worse, the teacher called to say she now felt that Jose should be taken to the doctor to determine whether he was hyperactive and in need of medication. This was too much for Jose's mother. She did not take him to the doctor, and she no longer responded to most calls and letters from the school.

Jose continued to be a problem at school and now at home, and his mother did not know what to do about it or who to turn to for help. When asked, Jose's teacher describes the parents as "hard to reach."

Stop, Think, Discuss

You probably encounter many situations such as that described above. In reflecting on such cases: *What went well? What didn't? What would you do next time?*

The case of Jose and his family raises many issues.

> For example, involvement of the home in cases such as Jose's usually is justified by the school as "in the best interests of the student and the others in the class." However, clearly there are different ways to understand the causes of and appropriate responses to Jose's misbehavior.

By way of contrast, another analysis might suggest the problem lies in ill-conceived instructional practices and, therefore, might prescribe changing instruction rather than strategies focused on the misbehavior per se.

> Even given an evident need for home involvement, the way the mother was directed to parent training raises concerns about whether the processes were coercive.

Questions also arise about social class and race. For example, if the family had come from a middle or higher income background, would the same procedures have been used in discussing the problem, exploring alternative ways to solve it, and involving the mother in parent training? And, there is concern that overemphasis in parent workshops on strategies for controlling children's behavior leads participants such as Jose's mother to pursue practices that often do not address children's needs and may seriously exacerbate problems.

> All this reflects the fact that schools have different agendas related to parent involvement, and the different agendas determine the ways they interact with the home.

Agendas for Involving Homes

- socialization
- economics
- politics
- helping

Major Intervention Tasks

- Institutional organization for involvement
- Inviting involvement
- Facilitating early involvement
- Maintaining involvement

Continuum of Types of Home Involvement

- Meeting basic obligations toward student/ meeting own basic needs
- Communicating & making decisions regarding student
- Supporting student's *basic* learning & development at home
- Problem solving & providing support at home & school for student's *special* needs
- Working for school's improvement
- Working for improvement of all schools

Improve individual functioning <----------> Improve system functioning

Staff Needs for Social and Emotional Support

No one needs to tell a school nurse how stressful it is to come to work each day. Stress is the name of the game for all who work in school settings and, unfortunately, some working conditions are terribly stressful.

> Some of the stress comes from working with troubled and troubling youngsters. Some is the result of the frustration that arises when everyone works so hard and the results are not good enough. Over time, such stressors can lead to demoralization, exhaustion, and burnout.

The cost of ignoring staff stress is that the programs and services they offer suffer because of less than optimal performance by staff who stay and frequent personnel turnover. As with family members, school staff find it difficult to attend to thee needs of students when their own needs are going unattended.

> From this perspective, any discussion of mental health in schools should address ways to help the staff at a school reduce the sources of stress and establish essential social and emotional supports.

Such supports are essential to fostering awareness and validation, improving working conditions, developing effective attitudes and skills for coping, and maintaining balance, perspective, and hope.

Mother to son: *Time to get up and go to school.*

Son: *I don't want to go. It's too hard and the kids don't like me.*

Mother: *But you have to go -- you're the principal.*

Test Questions -- Unit I: Section B

(1) Which of the following can be barriers to student learning?

___(a) deficiencies in basic living resources
___(b) psychosocial problems
___(c) underlying psychological problems
___(d) family crises
___(e) transitions such as moving to a new school
___(f) all of the above

(2) Health and social services are designed to address the full range of factors that cause poor academic performance, dropouts, gang violence, teen pregnancy, substance abuse, and so forth.

____True ____False

(3) List five major areas of focus in enhancing healthy psychosocial development.

_____
_____
_____
_____
_____

(4) Current diagnostic systems such as the *Diagnostic and Statistical Manual of Mental Disorders -- DSM IV* do not adequately account for psychosocial problems>

____True ____False

(5) Formal systems for classifying problems in human functioning convey the impression that all behavioral, emotional, or learning problems are due to internal pathology.

____True ____False

(6) Most differential diagnoses of children's problems are made by focusing on identifying one of more internal disorders rather than first asking "Is there a disorder?".

____True ____False

(7) Attributional bias is a tendency for observers to perceive others' problems as rooted in stable personal dispositions.

____True ____False

(8) In the mental health field, the tendency is to see most student's problems as arising from environmental/social factors.

____True ____False

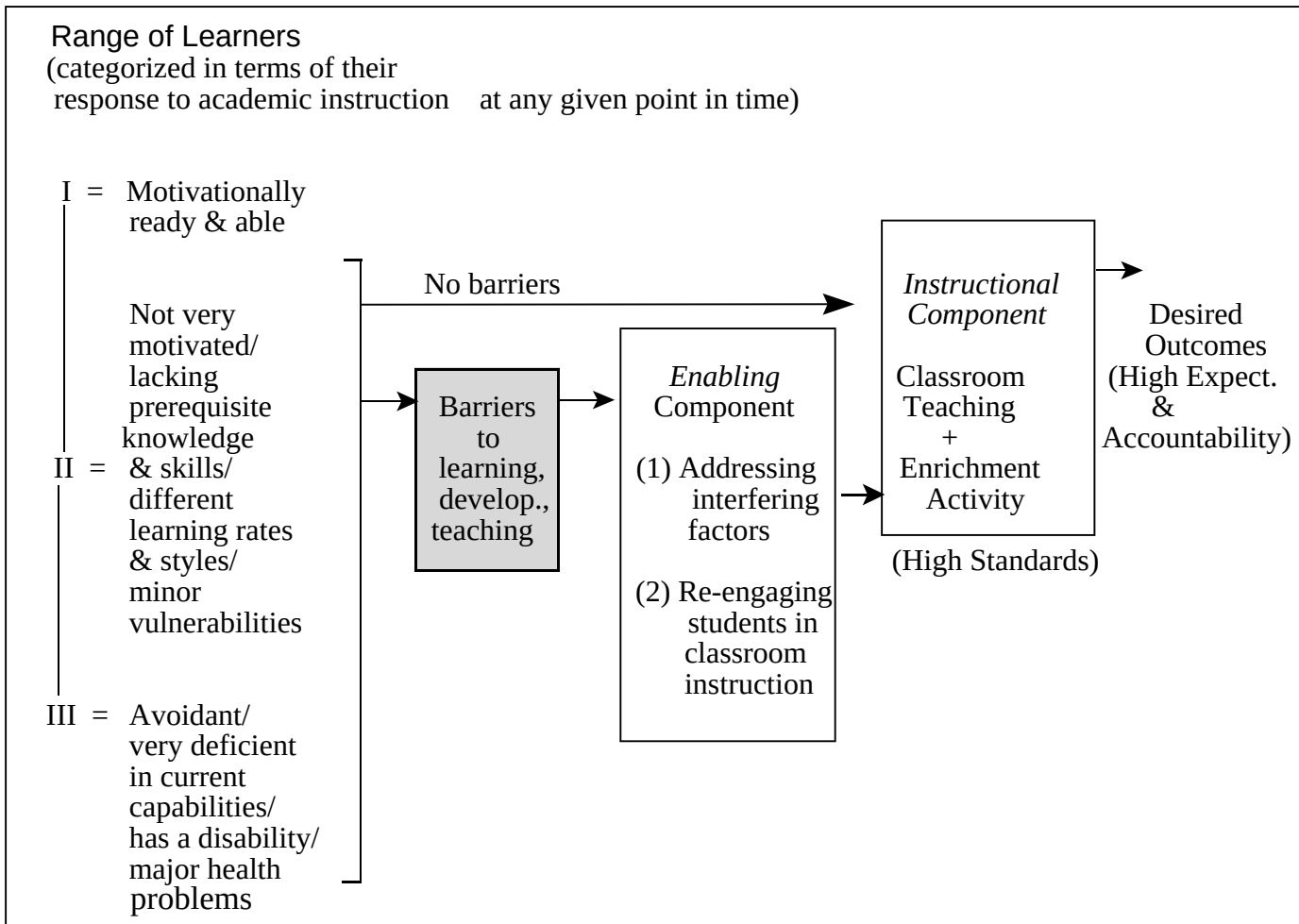
(9) List three characteristics of family-oriented interventions.

_____

_____

_____

Section C: Addressing The Need: Moving Toward a Comprehensive Approach



*In some places, an Enabling Component is called a Learning Supports Component. Whatever it is called, the component is to be developed as a comprehensive system of learning supports at the school site.

Contents:

Objectives for Section C

After completing this section of the unit, you should be able to:

- state several implications of understanding students' problems in terms of a causal continuum that ranges from internal to external causes
- identify two major reasons why school-based health centers have come to find it necessary to address mental health and psychosocial concerns
- understand the difference between a comprehensive school health program and a comprehensive approach for addressing barriers to learning

A Few Focusing Questions

- How do environments cause individuals to have problems?
- Why is it necessary to go beyond clinical interventions?
- What should a continuum of services and programs consist of in order to adequately address barriers to learning and promote healthy development?

Meeting Mandates: Necessary . . . but Insufficient and Often Unsatisfying

The following are some of the typical tasks assigned school nurses:

- health appraisal of new enrollees
- assessment and follow-up of state mandated immunization and Mantoux requirements
- vision screening as mandated (e.g., upon entry and every three years)
- physical health screening (including assessment of students referred for special education placement)
- screening and reporting for suspected child abuse
- screening and reporting for suspected substance abuse
- assessment and follow-up to control communicable (including sexually transmitted) diseases
- health education to prevent communicable (including sexually transmitted) diseases
- health appraisals related to activities such as interscholastic athletics and driver training
- dental health screening and consultation
- emergency care for *major* illness and injury
- participation in emergency and crisis planning (e.g., planning for how the school should respond to fires, floods, earthquakes, acts of violence and their aftermath)

And of course the ever present "Other tasks as assigned."

> These tasks require use of assessment, counseling, referral, consultation, monitoring, follow-up, information dissemination, and clerical skills related to remedial and preventive health concerns. They involve interactions with students, families, school staff, and professionals in the community.

Anyone seeing school nurses in action as they pursue their many tasks knows they are more than busy.

> Anyone who talks with enough school nurses also knows that they are inundated with referrals for students whose problems stem from more than physical health concerns.

Many school nurses want to redesign their roles so that much of the clerical and simple screening activity related to "mandates" can be streamlined. This would allow them to perform an array of other functions that their training and licenses indicate they are capable of doing. It would allow them to work more intensively with others at a school site to maximize the impact schools have on addressing the most profound barriers causing students to fall by the wayside. And all this has the potential not only to enhance the success of a great many more students, but also should prove more satisfying to nurses and their colleagues.

> How can this be done? "Not by working harder, but by working smarter."

One essential element in working smarter is to have an enhanced conceptual base that can increase effectiveness. And one of the essential elements of such a conceptual base is accounting for full range of factors that cause students to have problems.

Understanding What Causes Different Types of Problems

Before the 1920s, the tendency was to view human behavior as determined primarily by something within the person, especially inborn characteristics. As the psychological school of thought known as *behaviorism* gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

> Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment. However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables.

This is both unfortunate and unnecessary -- unfortunate because such a view limits progress in practice and research, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

The following is a way to think about the implications of a broad framework for understanding the causes of students' problems.

This way of thinking offers a useful *starting* place for classifying behavioral, emotional, and learning problems and helps avoid overdiagnosing internal pathology.

As illustrated below, such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)

E (E<--->p) E<--->P (e<--->P) P

|---|---|---|

Type I problems	Type II problems	Type III problems
•caused primarily by environments and systems that are deficient and/or hostile	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)	•caused primarily by person factors of a pathological nature
•problems are mild to moderately severe and narrow to moderately pervasive	•problems are mild to moderately severe and pervasive	•problems are moderate to profoundly severe and moderate to broadly pervasive

In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.

To highlight a few points about the illustration:

- Problems caused by the environment are placed at one end of the continuum and referred to as *Type I problems.*
- At the other end are problems caused primarily by pathology within the person; these are designated as *Type III problems.*
- In the middle are problems stemming from a relatively equal contribution of environmental and person sources, labelled *Type II problems.*

Also note that in this scheme, diagnostic labels denoting *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

> Obviously, some problems caused by pathological conditions within a person are not manifested in severe, pervasive ways, and there are persons without such pathology whose problems do become severe and pervasive. The intent is not to ignore these individuals. As a first categorization step, however, it is essential they not be confused with those seen as having Type III problems.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

> There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems.

Furthermore, some problems are not easily assessed or do not fall readily into a group due to a lack of information and comorbidity.

> Starting with a broad model of cause, however, helps practitioners counter tendencies to prematurely conclude that a problem is caused by pathology within the individual and thus helps avoid blaming the victim (Ryan, 1971).
>
> It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

Stop, Think, Discuss

Think about the last time you had a significant problem related to doing your work. *What caused it? Was it because of something wrong with you? the environment? the interaction between the two?*

Outlined on the next page is an aid for thinking about the many causes of learning, behavior, and emotional problems.

Factors Instigating Emotional, Behavioral, and Learning Problems

Environment (E)

(Type I problem)

1. Insufficient stimuli (e.g.,prolonged periods in impoverished environments; deprivation of learning opportunities at home or school such as lack of play and practice situations and poor instruction; inadequate diet)
2. Excessive stimuli (e.g., overly demanding home, school, or work experiences, such as overwhelming pressure to achieve and contradictory expectations; overcrowding)
3. Intrusive and hostile stimuli (e.g., medical practices, especially at birth, leading to physiological impairment; contaminated environments; conflict in home, school, workplace; faulty child-rearing practices, such as long-standing abuse and rejection; dysfunctional family; migratory family; language used is a second language; social prejudices related to race, sex, age, physical characteristics and behavior)

Person (P)

(Type III problems)

1. Physiological insult (e.g., cerebral trauma, such as accident or stroke, endocrine dysfunctions and chemical imbalances; illness affecting brain or sensory functioning)
2. Genetic anomaly (e.g., genes which limit, slow down, or lead to any atypical development)
3. Cognitive activity and affective states experienced by self as deviant (e.g., lack of knowledge or skills such as basic cognitive strategies; lack of ability to cope effectively with emotions, such as low self-esteem)
4. Physical characteristics shaping contact with environment and/or experienced by self as deviant (e.g., visual, auditory, or motoric deficits; excessive or reduced sensitivity to stimuli; easily fatigued; factors such as race, sex, age, or unusual appearance that produce stereotypical responses)
5. Deviant actions of the individual (e.g., performance problems, such as excessive errors in performing; high or low levels of activity)

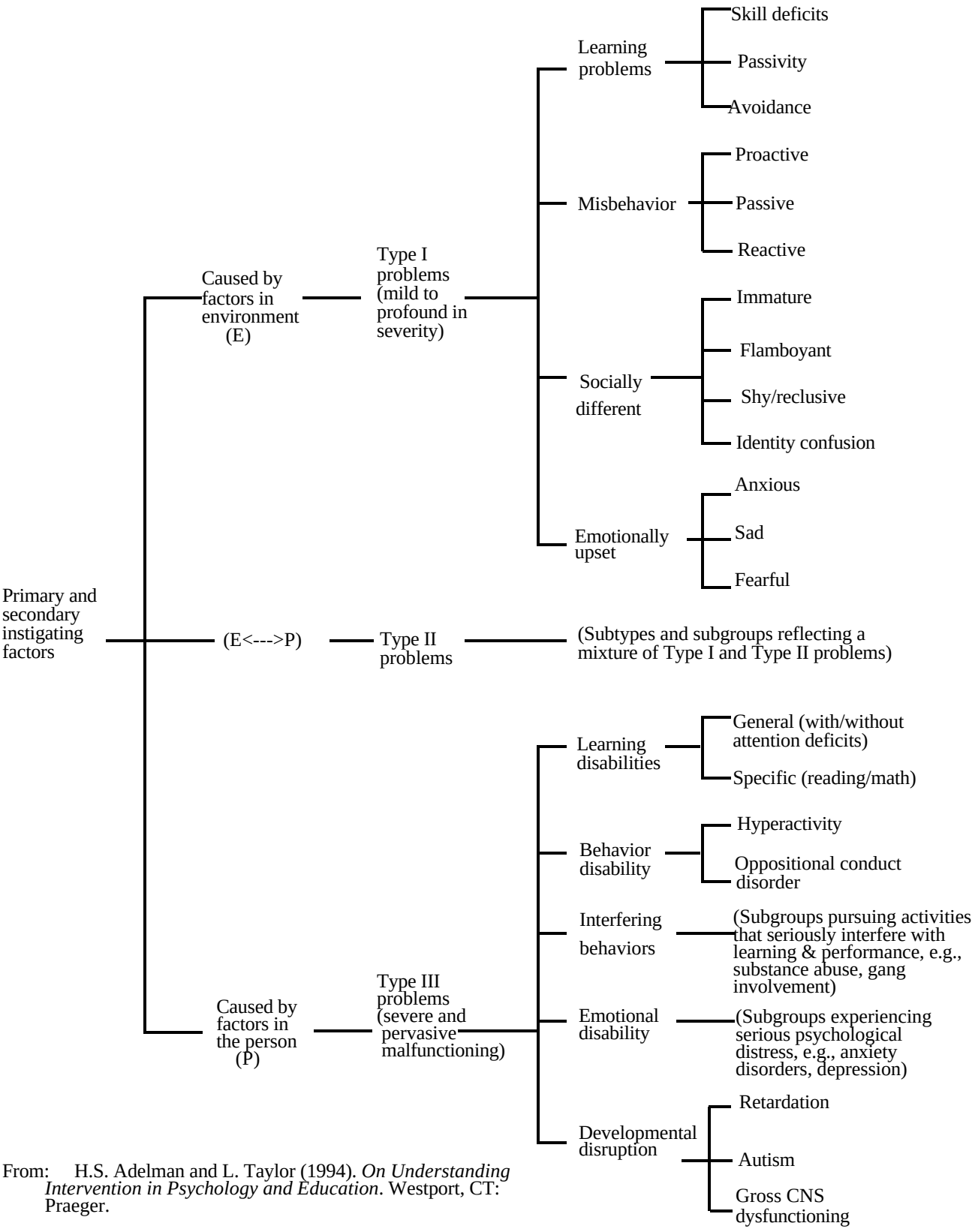
*Interactions and Transactions Between E and P**

(Type II problems)

1. Severe to moderate personal vulnerabilities and environmental defects and differences (e.g., person with extremely slow development in a highly demanding environment, all of which simultaneously and equally instigate the problem)
2. Minor personal vulnerabilities not accommodated by the situation (e.g., person with minimal CNS disorders resulting in auditory perceptual disability trying to do auditory-loaded tasks; very active person forced into situations at home, school, or work that do not tolerate this level of activity)
3. Minor environmental defects and differences not accommodated by the individual (e.g., person is in the minority racially or culturally and is not participating in many social activities because he or she thinks others may be unreceptive)

*May involve only one (P) and one (E) variable or may involve multiple combinations.

The following diagram uses an understanding of person, environment, and interactional causes to outline and differentiate among the types of problems seen among students.



From: H.S. Adelman and L. Taylor (1994). *On Understanding Intervention in Psychology and Education*. Westport, CT: Praeger.

Clinical Approaches at School Sites

All schools have and benefit from counseling, psychological, and social service interventions and want more.

Some of the services are provided by nurses and other student services professionals hired by the school district.

In addition, a few community services are appearing on campuses as part of the effort to base some of these at school sites.

For many years, clinical approaches in school settings were offered in a practitioner's office and carried out in relative isolation of other interventions aimed at a student and her or his family.

Recently, efforts to increase the range of services at school sites and to coordinate such efforts has led to an expanded number of school-based health centers and family service centers.

School-Based Health Centers

The school-based clinic movement was created in response to concerns about teen pregnancy and a desire to enhance access to physical health care for underserved youth. Soon after opening, most clinics find it essential also to address mental health and psychosocial concerns. The need to do so reflects two basic realities. One, some students' physical complaints are psychogenic, and thus, treatment of various medical problems is aided by psychological intervention. Two, in a large number of cases, students come to clinics primarily for help with no medical problems, such as personal adjustment and peer and family relationship problems, emotional distress, problems related to physical and sexual abuse, and concerns stemming from use of alcohol and other drugs. Indeed, up to 50% of clinic visits are for nonmedical concerns.

Thus, as these clinics evolve, so does the provision of counseling, psychological, and social services in the schools. At the same time, given the limited number of staff at such clinics, it is not surprising that the demand for psychosocial interventions quickly outstrips the resources available.

Without a massive infusion of money, school-based and linked health clinics can provide only a restricted range of interventions to a limited number of students. Thus, the desire of such clinics to be comprehensive centers in the full sense of the term remains thwarted.

Family Service Centers and Full Service Schools

Joy Dryfoos described the trend to develop school-based primary health clinics, youth service programs, community schools, and other similar activity under the rubric of *full service schools.* (She credited the term to Florida's comprehensive school-based legislation.)

As she noted in her review:

> Much of the rhetoric in support of the full service schools concept has been presented in the language of *systems change,* calling for radical reform of the way educational, health, and welfare agencies provide services. Consensus has formed around the goals of one stop, seamless service provision, whether in a school- or community-based agency, along with empowerment of the target population. ... most of the programs have moved services from one place to another; for example, a medical unit from a hospital or health department relocates into a school through a contractual agreement, or staff of a community mental health center is reassigned to a school, or a grant to a school creates a coordinator in a center. As the program expands, the center staff work with the school to draw in additional services, fostering more contracts between the schools and community agencies. But few of the school systems or the agencies have changed their governance. The outside agency is not involved in school restructuring or school policy, nor is the school system involved in the governance of the provider agency. The result is not yet a new organizational entity, but the school is an improved institution and on the path to becoming a different kind of institution that is significantly responsive to the needs of the community.

Full service schools reflect the desire for comprehensiveness; the reality remains much less than the vision. As long as such efforts are shaped primarily by a school-linked services model (i.e., initiatives to restructure to community health and human services), resources will remain too limited to allow for a comprehensive continuum of programs.

> And in their struggle to find ways to finance programs for troubled and troubling youth, community agencies and schools are forced to tap into resources that require assigning youngsters labels that convey severe pathology. Reimbursement for mental health and special education interventions is tied to such diagnoses. This fact dramatically illustrates how social policy shapes decisions about who receives assistance and the ways in which problems are addressed. It also represents a major ethical dilemma for practitioners. That dilemma is not whether to use labels, but rather how to resist the pressure to inappropriately use those labels that yield reimbursement from third party payers.

Programmatic Approaches: Going Beyond Clinical Interventions to Address the Full Range of Problems

A large number of young people are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters behave in ways that distress others; only a small percent have ADHD or a conduct disorder. In some schools, the majority of students have garden variety learning problems; only a few have learning disabilities. Thankfully, those suffering from true internal pathology (those referred to here as Type III problems) represent a relatively small segment of the population. Society must never stop providing the best services it can for such individuals and doing so means taking great care not to misdiagnose others whose "symptoms" may be similar but are caused to a significant degree by factors other than internal pathology (those referred to above as Type I and II problems). Such misdiagnoses lead to policies and practices that exhaust available resources in serving a relatively small percent of those in need. That is a major reason why there are so few resources to address the barriers interfering with the education and healthy development of so many youngsters who are seen as troubled and troubling.

> Because behavior, emotional, and learning problems usually are labelled in ways that overemphasize internal pathology, it is not surprising that helping strategies take the form of clinical/remedial intervention. And for the most part, such interventions are developed and function in relative isolation of each other.

Thus, they represent another instance of using piecemeal and fragmented strategies to address complex problems.

> One result is that an individual identified as having several problems may be involved in programs with several professionals working independently of each other. Similarly, a youngster identified and treated in special infant and pre-school programs who still requires special support may cease to receive appropriate help upon entering school. And so forth.

Dealing with the full continuum of Type I, II, and III problems requires a comprehensive and integrated programmatic approach. Such an approach may require one or more mental health, physical health, and social services. That is, any one of the problems may require the efforts of several programs, concurrently and over time. This is even more likely to be the case when an individual has more than one problem. And, in any instance where more than one program is indicated, it is evident that interventions should be coordinated and, if feasible, integrated.

Establishing a comprehensive, integrated approach is excruciatingly hard. Efforts to do so are handicapped by the way interventions are conceived and organized and the way professionals understand their functions. Conceptually, intervention rarely is envisioned comprehensively. Organizationally, the tendency is for policy makers to mandate and planners and developers to focus on specific programs. Functionally, most practitioners and researchers spend most of their time working directly with specific interventions and samples and give little thought or time to comprehensive models or mechanisms for program development and collaboration. Consequently, programs to address physical, mental health, and psychosocial problems rarely are coordinated with each other or with educational programs.

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 are underway designed to restructure community health and human services and the way schools operate.

Stop, Think, Discuss

Here's what one school-based psychiatrist has to say. *Do you agree or disagree with him?*

It happens several times a week in my practice of community child and adolescent psychiatry: Our society's overwhelming belief in medically controlling our kids' behavior finds expression in ever more Huxleyesque demands on the psychiatrist to prescribe. This week's winners are the school district, the juvenile court, and a religious shelter for homeless families with children. Their respective would-be victims are LaShondra, Trevor, and Jimmy.

Jimmy is a 9 year old boy with a long history of treatment for severe emotional disturbance. He's in a school-based day treatment program and seems to be making terrific progress on self-managing his behavior. This turnaround has occurred just in the past few weeks, following an acute psychiatric hospital stay during which the many psychotropic medications he'd been taking without apparent benefit were tapered and discontinued. He was discharged to the day treatment facility and is receiving case management and therapeutic services at home in the community. Unfortunately, the grandmother with whom he lives has been evicted from her residence, and has applied for assistance to a homeless family program. She and Jimmy are scheduled to be admitted to a shelter program next week, but the shelter has made it a condition of receiving services that Jimmy be on medication.

LaShondra is 14. She is in special education classes at her junior high school because of mild mental retardation and emotional disturbance. She bears both physical and psychic scars of early prolonged abuse, and has symptoms of borderline personality pathology and PTSD. She likes school and wants to learn, but keeps getting expelled for behavioral outbursts. The school, too, has made it a condition of her readmittance to classes that she be on medication. LaShondra experiences psychotropic medication as inimical to her emerging adolescent autonomy, and has had negative therapeutic effects during past trials of treatment.

Trevor, at 15, is incarcerated in the Juvenile Detention Center, awaiting a hearing on certification to stand trial as an adult on two charges of capital murder. We have evaluated him for fitness to proceed and determined that he's not mentally ill, but are involved in providing services to Trevor in consultation with the juvenile authorities because he is persistently threatening suicide. We think the best plan is to keep him closely supervised in detention, but the juvenile department is concerned about their liability and petition the court to transfer him to a psychiatric hospital. Two hearings are held on the same day. At the first hearing Trevor is committed to a private facility, on condition that the facility accepts the admission. The facility refuses. At the second hearing, Trevor is committed to the state hospital on condition that the hospital certifies that they can guarantee security. The hospital can't. The Court then orders that Trevor be involuntarily administered unspecified psychotropic agents by injection.

I am not making these things up. These three cases have so far occupied the last three days of my week, and I'm telling you about them not to garner sympathy for the kids (only two of whom have any sympathy coming in any case), or for me (despite my clearly deserving some), but to focus attention on the astonishing degree to which everyone in our society has come to believe in the prescribing of psychotropic medication as a cure, or at least a control, for disturbing behavior in kids.

How did we arrive at this state of affairs? Though a very complex interaction among a myriad of scientific, social, and historical factors, of which I want to mention just two of the scientific ones: progress in psychiatric nosology, and progress in biological psychiatry.

Since 1980, we've trained a generation or two of psychiatrists in the phenomenological approach to diagnosis. The last three editions of the DSM (III-R, and IV) are determinedly atheoretical and empirical in their approach (the majority of members of the Work Groups on Child and Adolescent Disorders for the last three DSM's have been pediatric psychopharmacology researchers), and I think we have long since abandoned trying to teach residents to think about the meanings of symptoms to patients (and ourselves), about the dynamics of intrapsychic structure and interpersonal process. During the same time, the explosive growth of neuroscience and pharmacology has given us many new tools with which to work (if only we knew how: my friend and teacher Bob Beavers used to say, "if the only tool you have is a hammer, everything looks like a nail to you!").

In short, I think we've unwittingly relinquished our most powerful and proven tool: appropriately affectionate, professionally respectful, intimate personal engagement of the patient in mutual exploration of inner meanings. We're frittering our therapeutic potency away on serial trials of psychotropic drugs, and we're prescribing for patients when we don't know the person. There are too many kids on too many drugs, and many of the kids have been given medication as a substitute for engagement and exploration of personal issues.

The point I'm trying to make is that every sector of today's society contributes to this pressure to prescribe. Parents believe medication will cure, schools believe it, courts believe it. even nonpsychiatric mental health professionals believe it. Well, I don't believe it, and it's been my experience with ASAP that most of our members don't believe it either. And, if not only do we not believe that medicine cures, but also we do believe that we have a more powerful and effective treatment which provides an essential context for medication to be helpful, let's stand up and say so. I look forward to hearing from y'all: agree or disagree.

Psychiatrist Glen Pearson is president of the American Society for Adolescent Psychiatry (ASAP). Reprinted with permission.

Needed: A Full Continuum of Programs and Services

School health programs always have been concerned with more than offering clinical services. And over the last decade, leaders in the field have advocated for an eight component model to ensure schools have a comprehensive focus on health. The components are (1) health education, (2) health services, (3) biophysical and psychosocial environments, (4) counseling, psychological, and social services, (5) integrated efforts of schools and communities to improve health, (6) food service, (7) physical education and physical activity, and (8) health programs for faculty and staff.

> The focus on comprehensive school health is admirable. It is not, of course, a comprehensive approach for addressing a full range of barriers to learning -- nor does it profess to be. Moreover, its restricted emphasis on health tends to engender resistance from school policy makers who do not think they can afford a comprehensive focus on health and still accomplish their primary mission to educate students.

Reform-minded policy makers may be more open to proposals encompassing a broad range of programs to enhance healthy development if such programs are part of a comprehensive approach for addressing barriers to learning.

> Some are suggesting that the *school-linked services* movement, especially in the form of full service schools is the answer. And each day brings additional reports from projects such as New Jersey's School-Based Youth Services Program, the Healthy Start Initiative in California, the Beacons Schools in New York, Cities-in-Schools, and the New Futures Initiative.

A review by Michael Knapp underscores the fact that the literature on school-linked services is heavy on advocacy and prescription and light on findings. Not surprisingly, findings primarily reflect how hard it is to institutionalize such approaches.

Keeping the difficulties in mind, a reasonable inference from available data is that school-community collaborations can be successful and cost effective over the long-run.

> Outstationing community agency staff at schools allows easier access for students and families -- especially in areas with underserved and hard to reach populations. Such efforts not only provide services, they seem to encourage schools to open their doors in ways that enhance family involvement. Analyses suggest better outcomes are associated with empowering children and families and having the capability to address diverse constituencies and contexts. Families using school-based centers are described as becoming interested in contributing to school and community by providing social support networks for new students and families, teaching each other coping skills, participating in school governance, and helping create a psychological sense of community.

At the same time, it is clear that initiatives for school-linked services produce tension between school district *pupil services personnel* and their counterparts in community-based organizations.

> When "outside" professionals are brought in, school specialist staff often view the move as discounting their skills and threatening their jobs. These concerns are aggravated whenever policy makers appear to overestimate the promise of school-linked services with regard to addressing the full range of barriers to learning. And, ironically, by downplaying school-owned resources, the school-linked services movement has allowed educators to ignore the need for restructuring the various education support programs and services that schools own and operate.

With respect to addressing barriers to learning, comprehensiveness requires more than

- *a focus on health and social services*
- *outreach to* link with *community* resources
- *coordination* of *school-owned* services
- *coordination* of *school and community* services.

Moving toward comprehensiveness in addressing barriers to learning encompasses restructuring, transforming, and enhancing

- all relevant school-owned programs and services
- community resources

and

- weaving these school and community resources together.

A continuum is outlined on the following page to illustrate the comprehensive range of programs needed to address Type I, II, and III problems.

> As can be seen, the continuum ranges from programs for primary prevention (including the promotion of mental health) and early-age intervention --through those for addressing problems soon after onset--on to treatments for severe and chronic problems.
>
> In doing so, it encompasses prevention and prereferral interventions for mild problems, high visibility programs for high-frequency psychosocial problems, and strategies to assist with severe and pervasive mental health problems.

Such an approach recognizes the role school, home, and community life play in creating and correcting young people's problems, especially those who are under-served and hard-to-reach.

> With respect to *comprehensiveness*, the programs outlined highlight that many problems must be addressed developmentally and with a range of programs -- some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. With respect to concerns about *integrating* programs, the continuum underscores the need for concurrent interprogram linkages and for linkages over extended periods of time.

From such a perspective, schools must provide interventions that address individual problems and system changes. At the same time, schools must continue to explore formal and informal ways to link with public and private community agencies.

From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs to Address Barriers to Learning and Enhance Healthy Development

Intervention Continuum

Examples of Focus and Types of Intervention
(Programs and services aimed at system changes and individual needs)

Primary prevention

1. Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness
   - economic enhancement of those living in poverty (e.g., work/welfare programs)
   - safety (e.g., instruction, regulations, lead abatement programs)
   - physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)

2. Preschool-age support and assistance to enhance health and psychosocial development
   - systems' enhancement through multidisciplinary team work, consultation, and staff development
   - education and social support for parents of preschoolers
   - quality day care
   - quality early education
   - appropriate screening and amelioration of physical and mental health and psychosocial problems

Early-after-onset intervention

3. Early-schooling targeted interventions
   - orientations, welcoming and transition support into school and community life for students and their families (especially immigrants)
   - support and guidance to ameliorate school adjustment problems
   - personalized instruction in the primary grades
   - additional support to address specific learning problems
   - parent involvement in problem solving
   - comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)

4. Improvement and augmentation of ongoing regular support
   - enhance systems through multidisciplinary team work, consultation, and staff development
   - preparation and support for school and life transitions
   - teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support)
   - parent involvement in problem solving
   - resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth)
   - comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth)
   - Academic guidance and assistance
   - Emergency and crisis prevention and response mechanisms

5. Other interventions prior to referral for intensive and ongoing targeted treatments
   - enhance systems through multidisciplinary team work, consultation, and staff development
   - short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)

Treatment for severe/chronic problems

6. Intensive treatments
   - referral, triage, placement guidance and assistance, case management, and resource coordination
   - family preservation programs and services
   - special education and rehabilitation
   - dropout recovery and follow-up support
   - services for severe-chronic psychosocial/mental/physical health problems

Test Questions -- Unit I: Section C

(1) Which of the following are implications of understanding a student's problems in terms of a causal continuum that ranges from internal to external causes?

___(a) some problems primarily result from biological or psychological factors
___(b) some problems primarily result from environmental causes
___(c) some problems are caused by the environment not accommodating individual differences and vulnerabilities
___(d) a and b
___(e) all of the above
___(f) none of the above

(2) Improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

_____True _____False

(3) School-Based Health Centers have come to find it necessary to address mental health and psychosocial concerns because

___(a) mental health is more important than physical health
___(b) many students physical complaints are psychogenic
___(c) mental health services are less costly
___(d) many students come to the centers for help with psychosocial problems
___(e) a and b
___(f) a and c
___(g) b and d
___(h) all of the above

(4) With respect to addressing barriers to learning, a comprehensive approach requires more than a focus on health and social services.

_____True _____False

(5) A comprehensive approach to addressing barriers to learning is achieved by outreaching to link with community resources.

_____True _____False

(6) With respect to addressing barriers to learning, a comprehensive approach requires more than coordination of school and community services.

_____True _____False

(7) Moving toward comprehensiveness in addressing barriers to learning encompasses restructuring, transforming, and enhancing (a) relevant school-owned programs and services, (b) community resources, and (c) weaving these school and community resources together.

_____True _____False

Coda: A Wide Range of Responses for a Wide Range of Problems

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.

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.

Mental Health in Schools: New roles for school nurses

Unit II:

Mental Health Services & Instruction: What a School Nurse Can Do

Sections

A. Screening and Assessment

B. Problem Response and Prevention

C. Consent, Due Process, and Confidentiality

Deciding what is best for a child often poses a question no less ultimate than the purposes and values of life itself.

Robert Mnookin

This unit is one of a set of three focused on the school nurse's role in addressing psychosocial and mental health problems that interfere with students' learning and performance.

When it comes to mental health and psychosocial problems, a school nurse doesn't have to look very hard to find them. A school nurse's functions related to dealing with such problems begin with providing *direct services and instruction.*

Effective pursuit of such functions requires working with others to enhance services and programs. This encompasses efforts to *coordinate, develop, and provide leadership related to relevant programs, services, resources, and systems.* It also involves *enhancing connections with community resources.*

Because they are inundated with students who need assistance for mental health and psychosocial concerns, a key service many school nurses find themselves providing is the *identification and processing* of such students. Major tasks in carrying out this service are

- initial problem identification
- screening/assessment
- client consultation and referral
- triage
- initial case monitoring.

Nurses also must be prepared to *respond to students' psychological crises*. And with respect to *primary prevention and treatment*, they often find themselves providing

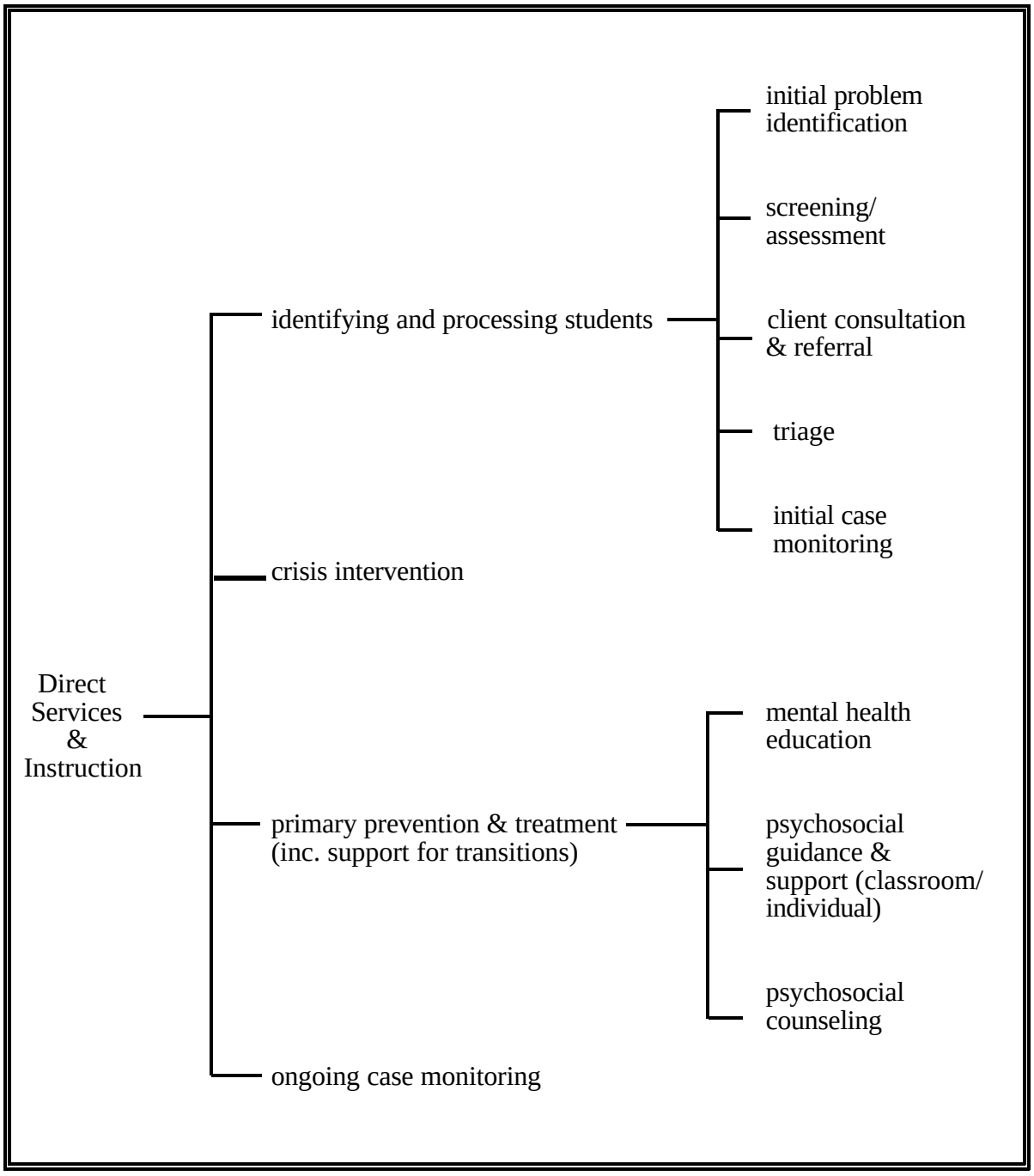
- mental health education
- psychosocial guidance and support (classroom/individual)
- psychosocial counseling.

They also are a valuable resource for *ongoing case monitoring.*

Mental Health in Schools: New Roles for School Nurses

Contents of All Three Units

Section A: Screening and Assessment



Contents:

Objectives for Section A

After completing this section of Unit II, you should be able to:

- explain what is involved in the process of identifying and processing students in need of assistance for mental health and psychosocial problems and identify five specific facets of the process

- know of and be able to use at least two instruments for screening psychosocial and mental health problems

A Few Focusing Questions

- *What is the school nurse's role in the initial identification of students who may have psychosocial and mental health problems?*
- *Once a student is identified as having problems, what screening activity can a school nurse do to help clarify the nature and severity of the problems?*
- *What are the purposes and processes of client consultation, referral, triage, and initial case monitoring?*

Initial Problem Identification

Nurses identify many mental health problems when students come to their office or in the process of screening for other health problems.

> Such problems also come to the nurses' attention during attendance and discipline reviews, assessments for special education placement, and related to crisis interventions, or as a result of others (staff, parents, students) raising concerns about a given youngster.

In this last respect, part of a nurse's job may be to educate teachers, peers, parents, and others about appropriately identifying and referring students.

And, of course, some students come seeking help for themselves.

How should you handle all this?

If there are accessible referral resources at the school (e.g., a school psychologist, a counselor, a social worker, a school-based health center with a mental health professional) or in the community, the answer *may* be to help a student connect with such an individual -- assuming it is not something you can handle without making a referral.

> Of course, when other professionals are not available or when a student will not follow-through, your only choice is to decide whether to do something more yourself.

If you decide to proceed, you will want to *assess* the problem for purposes of triage and consulting with the student and concerned others.

Stop, Think, Discuss

What's a nurse to do?

Joan, the nurse for Cates Elementary School, first encountered Matt Johnson when he was sent to her by his teacher because he said his stomach was upset. As best Joan could tell, there was no reason to think the problem was serious. She let the boy rest a while and then sent him back to class. Over the next two weeks, he was sent to her three more times with varying minor somatic complaints. At this point, she decided to call Matt's home.

Matt's mother was not surprised to hear from the school nurse. Mrs. Johnson had been to school for several teacher conferences during the month because of her son's poor classroom functioning and behavior. She told Joan she thought Matt's trips to the nurse's office probably were a way of getting out of class. It was a pattern the mother had seen before, both with Matt and her other child. Mrs. Johnson stressed that a recent doctor's exam had not turned up any physical problems. She also noted that Matt's teacher had told her to monitor his homework more closely and discipline him more consistently for misbehavior. But when she had tried to do so, Matt's rebellious behavior increased. She wasn't sure what to do. In a voice that was partially a plea and very much a challenge, she asked Joan: *Do you have any suggestions?*

What has been your experience with situations of this type?

What should a school nurse do in such circumstances?

Connecting a Student with the Right Help

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

(4) initial case monitoring.

TEACHER: *Yes, Chris, what is it?*
CHRIS: *I don't want to scare you, but my Dad says if I don't get better grades someone is due for a spanking.*

---

(1) *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 looks 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.

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 that are 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.

A Few Comments on Screening/Assessment and Diagnosis

- 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, sometimes peers, etc. If feasible and appropriate, a classroom observation and a 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, significant emotional problems such as appearing depressed and possibly 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 -- more on this in Section II-B.)

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

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.

Age	*Common Transient Problem*	*Low Frequency Serious Disorder*
0-3	Concern about monsters under the bed	Sleep Behavior Disorder
3-5	Anxious about separating from parent	Separation Anxiety Disorder (crying & clinging)
5-8	Shy and anxious with peers (sometimes with somatic complaints)	Reactive Attachment Disorder
	Disobedient, temper outbursts	Conduct Disorder Oppositional Defiant Disorder
	Very active and doesn't follow directions	Attention Deficit-Hyperactivity Disorder
	Has trouble learning at school	Learning Disabilities
8-12	Low self-esteem	Depression
12-15	Defiant/reactive	Oppositional Defiant Disorder
	Worries a lot	Depression
15-18	Experimental substance use	Substance Abuse

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

- 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 indepth 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.

Stop, Think, Discuss

What the nurse did.

Because of recent budget cut-backs, Joan knew she could not simply refer Matt and Mrs. Johnson to someone else at the school and count on them having time to help. And from her experiences with other similar situations, she knew the problem was starting to spin out of control and that something needed to be done right away.

Joan told Matt's mother she would be glad to talk with the teacher and others at the school and gather whatever information was available that might shed some light on the problem. Then, she said she wanted to meet with Matt to get his sense of what was going on. Mrs. Johnson thought all that was a good idea and agreed to come in to discuss things further after Joan had looked into the matter.

What do you think about a school nurse playing this role?

(2) *Client 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.

A Few Comments on Client Consultation and Referral

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 in the accompanying Resource Aid Packet on *Client Consultation and Referral: a Transition Intervention*.

(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 such a form can be kept on file for purposes of case monitoring.

(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.

Increasingly, as a way to minimize the flood of referrals from teachers, what are called *prereferral 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 prereferral 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.

(3) *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.

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 problem 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.

unfortunately, data suggest that follow-through rates for referrals made by staff at school sites are under 50%.

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 that 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)

(4) *Initial Case Monitoring*

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.

Stop, Think, Discuss

Gathering Some Assessment Data

Joan asked Mrs. Johnson to have the doctor send her a medical report. Although she was already convinced that Matt's problems were not physical, she wanted some validation.

To get a sense of his past experiences at school, she went to Matt's school records. It was clear from his grades and achievement test scores that the problems at school had not appeared until he entered 4th grade.

She talked with his teacher, Mr. Briggs. He didn't much like Matt but said the boy was smart and that his basic skills were pretty good. He also stressed that, because of the way Matt acted, none of the other students liked him. As far as the teacher was concerned, Matt just needed parents who could control him.

When she told Matt she wanted to talk with him, he wanted to know why. She explained her concerned that things weren't going well for him and that she thought he might have some ideas about how the school could help him make things better. She let him know that he didn't have to talk about anything he didn't want to discuss. She also said they could meet at a time that was good for him. Matt was skeptical, but he agreed to talk with her during math time.

When he appeared at her office, Joan put a "Conference in Progress" sign on the door and proceeded to engage Matt in a dialogue designed to find out what was wrong and what might be done to help him.

What types of things should a school nurse explore in interviewing a student about psychosocial and mental health concerns?

What is likely to facilitate and what can inhibit student talk during an interview?

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).

Exploring the Problem with the Student/Family

The following general guide is meant to provide an overview of the types of information you might pursue in order to learn a bit more about a student's problem.

In general, you will want to explore

What's *going well*?

What's *not going so well* and *how pervasive and serious* are the problems?

What seems to be the *causes* of the problems?

What's *already been tried* to correct the problems?

What *should be done* to make things better?

(What does the student/family think should be done? Do the causes shed any light on what needs to be done? Does what's already been tried shed any light? What are the student/family willing to try? How much do they truly think that things can be made better?)

The following pages outline specific areas and topics that might be explored in understanding the nature and scope of the problem(s). This is followed by a few examples of the many tools that are available to structure interviews.

Obviously, in a brief session, only a limited amount of information can be gathered. Choices must be made based upon your understanding of the problem(s) identified and the population you serve.

Remember, if you are going to do a formal interview with a student about psychosocial/mental health concerns, you usually will need both a signed informed consent from a parent or legal guardian. And, even if it is required, it is good practice to get the student's assent as well.*

*Your school may want to obtain a copy of the introductory packet on *Confidentiality and Informed Consent* -- available from the Center for Mental Health in Schools at UCLA.

SUICIDAL ASSESSMENT -- CHECKLIST*

Student's Name: _____ Date: _____ Interviewer: _____

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal Thoughts? *Y N*

Have there been suicide attempts by the student or significant others in his or her life? *Y N*

Does the student have a detailed, sophisticated plan? *Y N*

Has s/he made special arrangements to leave this world, such as giving away prized possessions? *Y N*

Does the student fantasize about suicide as a way to make others feel guilty or as a way lo get to a happier afterlife? *Y N*

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? *Y N*

Have there been major changes in recent behavior along with negative feelings and thoughts? *Y N*

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant others to help the student survive? *Y N*

Does the student feel alienated? *Y N*

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control? *Y N*

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises more concern, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk akso is asociated with very detailed plans (when, where, how) that specify a lethal abd easily available method, a specific time, and a location where it is unlikely the act would be disrupted. Because of the informal nature of this type assessment, it should not be filed as part of a student'thats regular school records.

Test Questions -- Unit II: Section A

(1) Which of the following were discussed as major facets of identifying and processing students in need of assistance for mental health and psychosocial problems?

___(a) initial problem identification
___(b) screening/assessment
___(c) client consultation and referral
___(d) triage
___(e) initial case monitoring
___(f) a, b, d
___(g) a, b, e
___(h) all the above

(2) It is especially hard to know the underlying cause of a problem when a student is not very motivated to learn and perform at school
.

___True ___False

(3) Screening can be used to help clarify the nature, extent, and severity of a problem?

___True ___False

(4) The instrument for screening suicidal risk doesn't ask about

___(a) past attempts, current plans, and view of death
___(b) reactions to precipitating events
___(c) available psychosocial support
___(d) attitudes toward school
___(e) history of risk-taking behavior

(5) Which of the following are a focus of the initial interview/questionnaire instruments

___(a) the student's perception of the problem
___(b) what has been tried previously to deal with the problem
___(c) motivation to do something about the problem
___(d) a, b
___(e) all the above

Section B: Problem Response and Prevention

The many pieces of the helping puzzle.
How do we put them together?

Initial Problem Identification

Screening/Assessment

Triage

Client Consultation and Referral

Guidance and Support

Direct Instruction

C o u n s e l i n g

Open-Enrollment Programs

Highly Specialized Interventions

Contents:

Objectives for Section B

After completing this section of Unit II, you should be able to:

- explain the immediate objective of psychological first aid.
- identify three phases of crisis intervention
- identify seven activities related to providing psychosocial guidance and support
- identify at least 5 specific things that can be done to facilitate student communication in a psychosocial counseling situation

A Few Focusing Questions

- *Besides providing immediate psychological first aid, what other concerns arise during crisis intervention?*
- *What is the potential scope of mental health education in schools?*
- *What can a school nurse do to provide additional guidance and support related to psychosocial concerns?*
- *How does one develop a psychosocial counseling relationship with a student?*
- *What is involved in providing ongoing case monitoring?*
- *What does the term informed consent really mean?*
- *What due process rights do parents have?*
- *When are the major exceptions to ensuring a student that what is said in counseling will be kept confidential?*

Psychological First Aid: Responding to a Student In Crisis

Pynoos and Nader (1988) discuss psychological first aid for use during and in the immediate aftermath of a crisis (providing a detailed outline of steps according to age). Their work helps all of us think about some general points about responding to a student who is emotionally upset.

Psychological first aid for students/staff/parents can be as important as medical aid. The immediate objective is to help individuals deal with the troubling psychological reactions.

(1) Managing the situation

A student who is upset can produce a form of *emotional contagion*.

To counter this, staff must

- present a calm, reassuring demeanor
- clarify for classmates and others that the student is upset
- if possible indicate why (correct rumors and distorted information)
- state what can and will be done to help the student.

(2) Mobilizing Support

The student needs *support and guidance*.

Ways in which staff can help are to

- try to engage the student in a problem-solving dialogue
  - >normalize the reaction as much as feasible
  - >facilitate emotional expression (e.g., through use of empathy, warmth, and genuineness)
  - >facilitate cognitive understanding by providing information
  - >facilitate personal action by the student
    (e.g., help the individual do something to reduce the emotional upset and minimize threats to competence, self-determination, and relatedness)
- encourage the student's buddies to provide social support
- contact the student's home to discuss what's wrong and what to do
- refer the student to a specific counseling resource.

(3) Following-up

Over the following days (sometimes longer), it is important to check on how things are progressing.

- Has the student gotten the necessary support and guidance?
- Does the student need help in connecting with a referral resource?
- Is the student feeling better? If not, what additional support is needed and how can you help make certain that the student receives it?

Another form of "first aid" involves helping needy students and families connect with emergency services. This includes connecting with agencies that can provide emergency food, clothing, housing, transportation, and so forth. Such basic needs constitute major crises for too many students and are fundamental barriers to learning and performing and even to getting to school.

The National Child Traumatic Stress Network and the National Center for PTSD have made the Psychological First Aid for Schools Field Operations Guide and accompanying handouts available online
http://www.nctsn.org/content/psychological-first-aid-schoolspfa

A Few General Principles Related to Responding to Crises

Immediate Response -- Focused on Restoring Equilibrium

In responding:

- Be calm, direct, informative, authoritative, nurturing, and problem-solving oriented.
- Counter denial, by encouraging students to deal with facts of the event; give accurate information and explanations of what happened and what to expect -- never give unrealistic or false assurances.
- Talk with students about their emotional reactions and encourage them to deal with such reactions as another facet of countering denial and other defenses that interfere with restoring equilibrium.
- Convey a sense hope and positive expectation -- that while crises change things, there are ways to deal with the impact.

Move the Student from Victim to Actor

- Plan with the student promising, realistic, and appropriate actions they will pursue when they leave you.
- Build on coping strategies the student has displayed.
- If feasible, involve the student in assisting with efforts to restore equilibrium.

Connect the Student with Immediate Social Support

- Peer buddies, other staff, family -- to provide immediate support, guidance, and other forms of immediate assistance.

Take Care of the Caretakers

- Be certain that support systems are in place for staff in general
- Be certain that support (debriefing) systems are in place for all crisis response personnel.

Provide for Aftermath Interventions

- Be certain that individuals needing follow-up assistance receive it.

Primary Prevention and Treatment

As already noted, many school nurses can and want to be more involved in programs to prevent and correct mental health and psychosocial problems. Among the functions some already are carrying out are

(1) mental health education

(2) psychosocial guidance and support

(3) psychosocial counseling

(1) *Mental Health Education*

Educative functions range from disseminating mental health information to actual course instruction related to positive social and emotional development and wellness.

Every school needs to disseminate information that helps protect, promote, and maintain the well-being of students with respect to both physical but mental health. School nurses already play a major role in disseminating health related information. It does not take much imagination to see how important it is that such activity encompass mental health. This includes providing highly visible information related to prevention and correction:

- positive opportunities for recreation and enrichment
- opportunities to earn money
- how to stay healthy -- physically and mentally (this includes instruction using curricula on special topics such as social skills and interpersonal relationships, substance abuse, violence prevention, physical and sexual abuse prevention, sex education, and so forth)
- early identification of problems
- what a student/parents should do when problems arise
- warm lines and hotlines
- services on- and off-campus.

During the instructional day, the curricula in many classes touches upon matters related to positive social and emotional development and wellness. In addition, some schools actually have incorporated mental health as a major facet of health education. And school staff are involved each day in dealing with matters related to mental health and psychosocial concerns.

> Related to these matters, efforts should be made to capitalize on the school nurse's strengths by facilitating ways for her or him to play a direct role with students as part of a school's efforts to provide comprehensive health education and an indirect role by participating in developing the capacity of other staff to address these matters.

In addition, nurses can play a role in a variety of open-enrollment programs designed to foster positive mental health and socio-emotional functioning. They can also help establish strategies to change the school environment in ways that make it more inviting and accommodating to students. This involves participation in staff development, but even more, it requires working with school staff to restructure the school so that it effectively promotes a sense of community. Examples include establishing welcoming programs for new students and families and strategies to support other transitions, developing *families* of students and teachers to create schools within schools, and teaching peers and volunteer adults to provide support and mentoring. Intervening at this environmental level also encompasses working with community agencies and businesses to enhance the range of opportunities students have with respect to recreation, work, and community service.

> Effective open-enrollment and prereferral intervention programs and environment change strategies can minimize the number of mild to moderate problems that develop into severe ones. This reduces the number in need of specialized interventions and helps reserve such help for those who inevitably require them.

(2) *Psychosocial Guidance and Support*

Each day many students require a small dose of personalized guidance and support to enhance their motivation and capability for coping with stressors. Others who are involved in therapeutic treatment (e.g., personal counseling, psychotherapy, psychotropic medication) need someone who understands the treatment and can deal with related concerns that arise at school.

Personalized guidance and support is best provided on a regular basis in the classroom and at home. There are great benefits to be gained from any role the nurse may play in helping teachers function in ways where they directly provide such support or do so through use of various activities and peer support strategies. Nurses also can play a role in mobilizing and enhancing support from those in the home.

The school nurse also is a logical person for a student to contact if something is amiss between what is happening at school and the student's therapeutic regimen. And s/he is a good person to interface with a student's personal counselor or therapist and to act as a school-site case manager so that there is coordination between the school's efforts to teach and treatment practices.

Guidance and support involves a range of potential activity:

- advising
- advocacy and protection
- providing support for transitions (e.g., orienting new students and connecting them with social support networks, facilitating students with special needs as they transition to and from programs and services)
- mediation and conflict resolution
- promoting and fostering opportunities for social and emotional development
- being a liaison between school and home.
- being a liaison between school and other professionals serving a student

(3) *Psychosocial Counseling*

Some student's problems will be more than you should try to handle and you will make the best effort you can to connect them with the right help.

There are many, however, who could benefit from your counseling -- once you have equipped yourself for the task and if you can create the time.

Good counseling builds on the type of caring which is fundamental to all nursing. It also encompasses the basics of any good working relationship -- and a bit more. Some basics are highlighted here. You will want to learn more and a good next step is to read some of the works referenced at the end of this unit.

In general, counseling 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. Some thoughts about engaging students in a productive dialogue are outlined on the following pages.

Counseling also requires the ability to create a working relationship that quickly conveys to the student

- *positive value and expectation* (that something of value can and will be gained from the experience)
- *personal credibility* (that the counselor is someone who can help and can be trusted to be keep his or her word, be fair, and be consistent, yet flexible)
- *permission and protection to engage in exploration and change* (that the situation is one where there are clear guidelines saying it is okay and safe to say what's on one's mind).

All this enables the counselor to elicit a student's concerns.

Then, the process requires the ability to 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)

- *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).

Stop, Think, Discuss

Think about the students you have found it easy to talk with.

What made the dialogue go so well?

Think about those students you found it difficult to engage in a dialogue.

What are some ideas that might help next time you encounter such a student?

A Few Thoughts About Engaging Students in a Productive Dialogue

A few are so nonverbal that referral probably is indicated. Many, however, are just reluctant to talk.

How to Facilitate "Talk"

Quite often, one has to start building a relationship around relatively nonverbal activities, such as responding to a structured set of interview questions dealing with common concerns. In some cases, having students draw themselves or significant others and telling a story about the picture can break the ice and provide some leads.

In general, the focus is on enhancing motivational readiness to dialogue by creating a sense of positive value and expectation for counseling, personal credibility for the counselor, and permission and protection for engaging in exploration for change.

Some specific things to do are

Create a private space and a climate where the student can feel it is safe to talk

Clarify the role and value of keeping things confidential

Avoid interruptions

Start slowly, avoid asking questions, and minimize pressure to talk (the emphasis should be more on conversation and less on questioning and on nonsensitive topics related to the student's main areas of personal interest)

Encourage the student to take the lead

Humor can open a dialogue; sarcasm usually has the opposite effect

Listen with interest

Respond with empathy, warmth, nurturance, and genuine regard and respect

Use indirect leading statement such as "Please tell me more about ...." or direct leading statements such as "You said that you were angry at your parents?"

If needed, use structured tools (surveys, sentence completion) to guide a student
(Examples of tools that may be useful are included in the accompanying materials resource packet entitled Screening/Assessing Students: Indicators and Tools.)

Sometimes a list of items (e.g., things that students generally like and dislike at school or after school) can help elicit a student's views and open-up a dialogue

When questions are asked, use open-ended, rather than yes/no questions

Appropriate self-disclosure by a counselor may disinhibit a reluctant student

In addition, for groups

Facilitate sharing through various activities (pairing a reluctant student with a supportive peer, having the group share backgrounds)

Clarify that trust, respect, confidentiality, etc. are a function of commitment to the group -- not a matter of stating rules

How to Keep Talk Going

In general, the focus is on maintaining motivation.

Some specific things to do are

Focus on areas of interest, strength, and self-esteem, as well as on analyzing problems

Build on previous discussions by referring to what has been shared

Continue to follow student's leads in analyzing problems and avoid procedures they may perceive as efforts to control them

Continue to convey that the intent is to help not socialize

In addition, for groups

Draw out similarities in experience and problems with a view to encouraging students to see the value of helping each other

Help students understand that giving advice usually is ineffective

Remember:

Short periods of silence are part of the process and should be accommodated.

A group of adolescents agreed to advise
school and community professionals
on what they and peers needed
in order to feel helped.
The most basic thing they stressed was:
"Let us talk about the things
that are really happening
in our lives -- friends, sex, drugs."
"We need people in schools
who care and will listen."

Some Points About Counseling and Student Motivation

Most counseling at a school site is short-term. Some will be informal -- brief encounters with students who drop-in or are encountered somewhere on campus. All encounters have the potential to be productive as long as one attends to student motivation as key antecedent and process conditions and as an important outcome concern.

(1) **Motivation is a key antecedent condition.** That is, it is a prerequisite to functioning. Poor motivational readiness may be (a) a cause of inadequate and problem functioning, (b) a factor maintaining such problems, or (c) both. Thus, strategies are called for that can result in enhanced motivational readiness (including reduction of avoidance motivation) -- so that the student we are trying to help is mobilized to participate.

(2) **Motivation is a key ongoing process concern.** Processes must elicit, enhance, and maintain motivation -- so that the student we are trying to help stays mobilized. For instance, a student may value a hoped for outcome but may get bored with the processes we tend to use.

With respect to both readiness and ongoing motivation, conditions likely to lead to negative motivation and avoidance reactions must be avoided or at least minimized. Of particular concern are activities students perceives as unchallenging/ uninteresting, overdemanding, or overwhelming and a structure that seriously limits their range of options or that is overcontrolling and coercive. Examples of conditions that can have a negative impact on a student's motivation are excessive rules, criticism, and confrontation.

(3) **Enhancing intrinsic motivation is a basic outcome concern.** A student may be motivated to work on a problem during counseling but not elsewhere. Responding to this concern requires strategies to enhance stable, positive attitudes that mobilize the student to act outside the intervention context and after the intervention is terminated.

Essentially, good counseling reflects the old maxim of "starting where the student is." But more is involved than matching the student's current capabilities. As suggested, attending to a student's motivational levels is also critical. Thus, it is the counselor's responsibility to create a process that will be a good fit with the student's capabilities *and* motivation.

> The less one understands the background and experiences that have shaped a student, the harder it may be to create a good fit. This problem is at the root of concerns about working with students who come from different cultures. It is, of course, a concern that arises around a host of individual differences.

As discussed in the unit on working with others, efforts to create effective working relationships require a breadth and depth of knowledge, skills, and positive attitudes.

Counseling aims at enabling students to increase their sense of competence, personal control, and self-direction -- all with a view to enhancing ability to relate better to others and perform better at school. When a counseling relationship is established with a student, care must be taken not to undermine these aims by allowing the student to become dependent and overrely on you. Ways to minimize such dependency include

- giving advice rarely, if at all
- ensuring that the student takes personal responsibility for her or his efforts to deal with problems and assumes credit for progress
- ensuring that the student doesn't misinterpret your efforts to help or lose sight of the limits on your relationship
- helping the student identify when it is appropriate to seek support and clarifying a wide range of ways to do so.
- planning a careful transition for termination

Regardless of how long you have seen a student for counseling, if a relationship has been established, you will need to deal with *termination.* This involves discussing the fact that the counseling is coming to an end, exploring any anxiety the student has about this, and reassuring the student about how s/he can deal with subsequent problems.

If the student is being referred for more counseling, you will want to provide support for a smooth transition, including clarifying what you should share with the new counselor. (This is a good reason for keeping a confidential Chart Record on the student.)

If the student will not be receiving additional support, you will want to try to connect her or him with an appropriate support network to draw upon (e.g., staff, peers, family).

If feasible, extend an invitation asking the student to let you know periodically how things are going.

Finally, a cautionary note about taking care of your own mental health:

In schools, the end of a school year may result in many students leaving all at the same time. For the counselor, this may produce a major sense of loss that adds to the frustrations of the job and contributes to feeling "burnt out." Burn out is a problem for all school staff.*

*Your school may want to obtain a copy of the introductory packet on *Understanding and Minimizing Burn Out* -- available from the Center for Mental Health in Schools at UCLA.

Ongoing Case Monitoring

Remember that from the time a student is first identified as having a problem, someone should be monitoring/managing the case. The process encompasses a constant focus to evaluate the appropriateness and effectiveness of the various efforts. That is, case monitoring is the process of checking regularly to ensure that a student's needs are being met so that appropriate steps can be taken if they are not. Such monitoring continues until the student service needs are addressed. It takes the form of case management when there must be coordination among the efforts of others who are involved (e.g., other services and programs including the efforts of the classroom teacher and those at home).

Case monitoring involves follow-ups with interveners and students/ families. This can take a variety of formats (e.g., written communications, phone conversations, electronic communications).

All case monitoring and case management require a system of record keeping designed to maintain an up-to-date record on the status of the student as of the last contact and that reminds you when a contact should be made. An example of a form used to facilitate follow-up on referrals is included on the following page.

Note: Other forms you can use to facilitate the processes described in this section are contained in a resource packet entitled *School-Based Client Consultation, Referral, and Management of Care* from by the UCLA Center as follow-up aids for you and your school.

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

Date of referral _____ Today's date_____
Immediate Follow up made by_____ Date_____
_____ Date_____
_____ Date_____

Service Need	Agency (name and address)	Phone	Contact person	Appt. time

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

Service Need	Agency (name and address)	Phone	Contact person	Appt. time

---

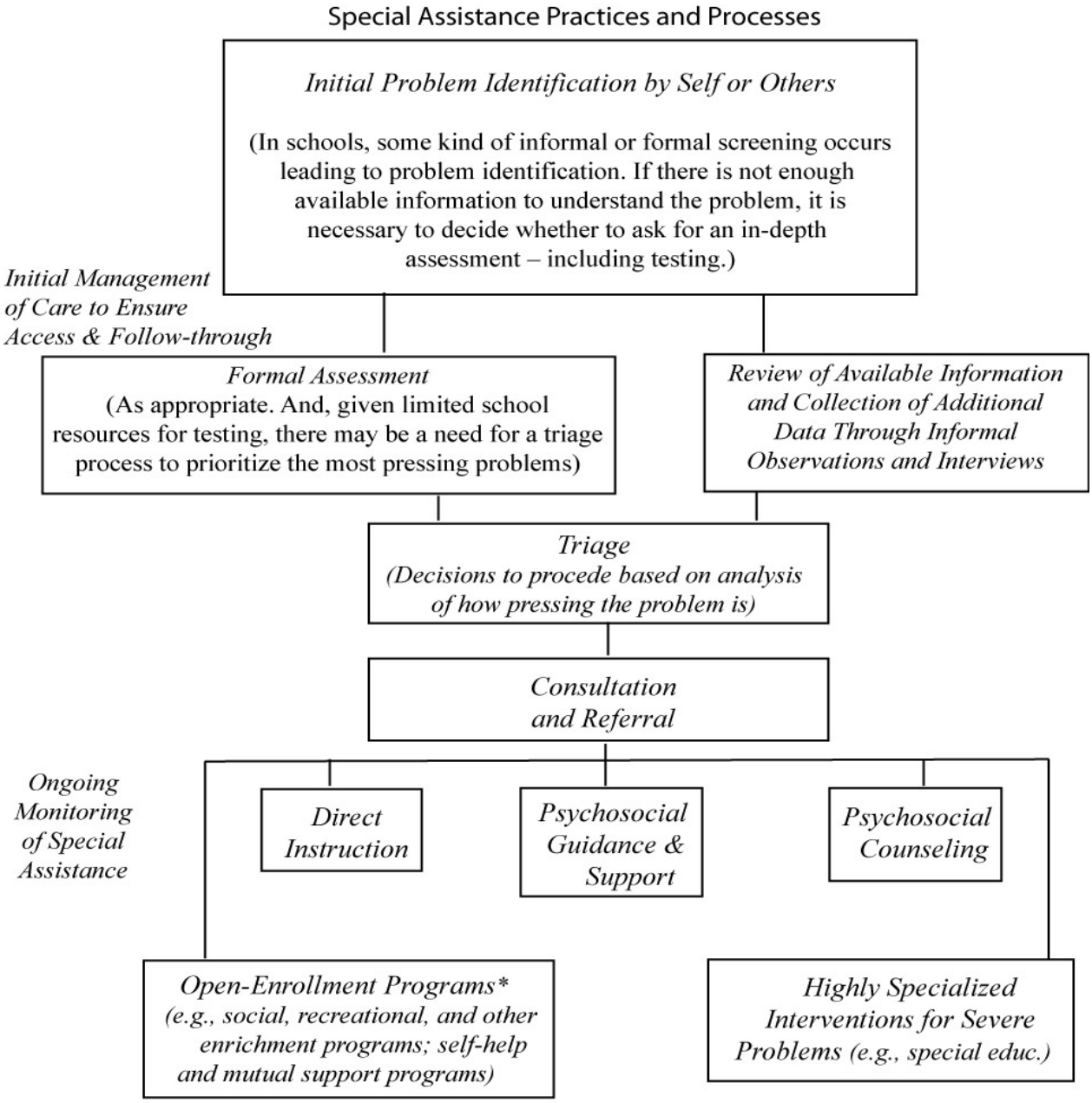
II. Long Term Referral Follow-Up Information

Have identified needs been met?

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

To review:

In responding to the mental health and psychosocial concerns of students, school nurses make a variety of decisions. For the nurse the process begins when the problem comes to her or his attention.



**The various types of special assistance are not mutually exclusive. Problems that are mild often can be addressed through participation in open-enrollment programs that do not require special referral and triage for admission.*

On the following page is an outline of matters to be considered as a school develops its systems for problem identification, triage, referral, and case monitoring and management.

Matters for a School to Consider in Developing its Systems for Problem Identification, Triage, Referral, and Case Management

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 cases, 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 cases, prereferral interventions should be recommended. This means a site must be equipped to implement and monitor the impact of such recommendations.
(b) When students/families are referred for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Case 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 case reviews).

Case monitoring/management

(a) Some situations require only a limited form of case monitoring (e.g., to ensure follow-through). A system must be developed for assigning case 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 case management. 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 case monitor/manager is to provide appropriate status updates to all parties who should be kept informed.

Examples of the Type of Facts Sheets that May be of Use in Your Work

Sample of a variety of fact sheets, descriptions of other related resources materials and mental health education curricula, and information on how to request the materials are included in an aid packet entitled Where to Get Resources (prepared by the Center for Mental Health in Schools at UCLA).

Mental, Emotional, and Behavior Disorders in Children and Adolescents

The Center for Menial Health Services extends appreciation to the National Institute of Mental Health. which is part of the National Institutes of Health, for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the CMHS National Mental Health Services Knowledge Exchange Network (KEN) - see contact information below.

Mental, Emotional, and Behavior Problems Are Real

Young people can have mental, emotional. and behavior problems that are real, painful, and costly. These problems, often called "disorders," are a source of stress for the child as well as the family, school, community, and larger society. The number of families who are affected by mental, emotional. and behavior disorders in young people is staggering. It is estimated that as many as one In five children or adolescents may have a mental health problem that can be identified and treated. At least I in 20--or as many as 3 million young people-may have a "serious emotiona disturbance." This term refers to a mental health problem that severely disrupts a person's ability to function socially, academically, and emotionally.

Mental health disorders in children and adolescents are caused by biology, environment, or a mix of both. Examples of biological factors are genetics, chemic imbalances in the body, and damage to the central nervous system, such as a head injury. Many factors in a young person's environment can affect his or her mental health, such as exposure to violence, extreme stress, and loss of an important person.

Caring families and communities working together can help children and adolescents with mental disorders. A broad range of services often is necessary to meet the needs of these young people and families.

The Disorders

Following are descriptions of some of the mental, emotional, and behavior problems that can occur during childhood and adolescence. All of these disorders can have a serious impact on a child's overall health.

Some disorders are more common than others, and conditions can range from mild to severe. Often, a child has more than one disorder.

> In this fact sheet. "Mental Health Problems" for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression. attention-deficit/ hyperactivity disorder. and anxiety. conduct. and eating disorders, among others. Mental health problems affect one in every five young people at any given time. “Serious Emotional Disturbances" for children and adolescents refers to the severely disrupt daily functioning in home. School, or community. Serious emotional disturbances affect 1 in every 20 young people at any given time.

**This fact sheet contains estimates of the prevalence (number of existing cases in a defined time period) of mental, emotional. and behavior disorders. These estimates are taken from several sources. most of which are small-scale studies that can Yield only a rough gauge of prevalence rates. The National Institute of Mental Health is currently engaged in a nationwide study to determine with greater accuracy * i the prevalence of mental disorders among children and adolescents. This information is needed to increase understanding of mental health problems and to improve the treatment and services that help young people who are affected by these conditions.*

U.S. **Department of Health and Human Services,** Substance Abuse and Mental Health Services Administration a Center for Mental Health Services 5600 Fishers Lane, Room 13-103 a Rockville. Maryland 20857 -Telephone 301.443.2792
CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together Campaign
For information about children’s mental health. contact the CMHS Knowledge Exchange Network PO Box 42490 - Washington, DC 20015 - Toll-free 1.800.789.2647 - E.4 X 302 6 56
FAX 301984 8796 . TTY 301443 9006 - CMHS Electronic Bulletin Board 1800.790.2647 4;4~ws4

Anxiety disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety disorders include:

- **phobia -** an unrealistic and overwhelming fear of some object or situation;
- **generalized anxiety disorder -** a pattern of excessive, unrealistic worry not attributable to any recent experience;
- **panic disorder -** terrifying panic attacks that include physical symptoms such as rapid heartbeat and dizziness;
- **obsessive-compulsive disorder** - being trapped in a pattern of repeated thoughts and behaviors such as counting or handwashing; and
- **post-traumatic stress disorder** - a pattern of flashbacks and other symptoms that occurs in children who have experienced a psychologically distressing event such as physical or sexual abuse, being a victim or witness of violence, or exposure to some other traumatic event such as a bombing or hurricane.

Major depression is recognized more and more in young people. Years ago, many people believed that major depression did not occur in childhood. But we now know that the disorder can occur at any age. Studies show that up to 6 out of every 100 children may have depression. The disorder is marked by changes in:

- emotion - the child often feels sad, cries, looks tearful, feels worthless;
- motivation - schoolwork declines. the child shows no interest in play;
- physical well-being - there may be changes in appetite or sleep patterns and vague physical complaints;
- thoughts - the child believes that he or she is ugly, that he or she is unable to do anything right, or that the world or life is hopeless.

Some adolescents or even elementary school children with depression may not place any value on their own lives, which may lead to suicide.

Bipolar disorder (manic-depressive illness) in children and adolescents is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). Periods of moderate mood occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as I in 100 adults, often experienced their first symptoms during teenage years.

Attention-deficit/hyperactivity disorder occurs in up to 5 of every 100 children. A young person with attention-deficit/hyperactivity disorder is unable to focus attention and is often impulsive and easily distracted. Most children with this disorder have great difficulty remaining still, taking turns, and keeping quiet. Symptoms must be evident in at least two settings (for instance, at home and at school) for attention-deficit/hyperactivity disorder to be diagnosed.

Learning disorders affect the ability of children and adolescents to receive or express information. These problems can show up as difficulties with spoken and written language, coordination, attention, or self-control. Such difficulties can make it harder for a child to learn to read, write, or do math. Approximately 5 of every 100 children in public schools are identified as having a learning disorder.

Conduct disorder causes children and adolescents to act out their feelings or impulses toward others in destructive ways. Young people with conduct disorder repeatedly violate the basic rights of others and the rules of society. The offenses that these children and adolescents commit often get more serious over time. Examples include lying, theft, aggression, truancy, firesetting, and vandalism. Children and adolescents with conduct disorder usually have little care or concern for others. Current research has yielded varying estimates of the number of young people with this disorder; most estimates range from 4 to 10 of every 100 children and adolescents.

Eating disorders can be life threatening. A young person with **anorexia nervosa,** for example, cannot be persuaded to maintain a minimally normal body weight. Ibis child or adolescent is intensely afraid of gaining weight and doesn't believe that he or she is underweight. Anorexia affects I in every 100 to 200 adolescent girls and a much smaller number of boys.

Youngsters with **bulimia nervosa** feel compelled to binge (eat huge amounts of food at a time). Afterward, to prevent weight gain, they rid their bodies of the food by vomiting, abusing laxatives, taking enemas, or exercising obsessively. Reported rates vary from I to 3 out of 100 young people.

Autism spectrum disorder or autism appears before a child's third birthday. Children with autism have problems interacting and communicating with others. They behave inappropriately, often repeating behaviors over long periods. For example, some children bang their heads, rock, or spin objects. The impairments range from mild to severe. Children with autistic disorder may have a very limited awareness of others and are at increased risk for other mental disorders. Studies suggest that autism spectrum disorder affects 7 to 14 of every 10,000 children.

Schizophrenia can be a devastating mental disorder. Young people with schizophrenia have psychotic periods when they may have hallucinations **(sense things that do not exist,** such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia is even **more rare than autism** in children under 12, but occurs in about 3 out of every 1000 adolescents.

Treatment, Support Services, and Research: Sources of Hope

Many of the symptoms and much of the distress associated with childhood and adolescent mental,or emotional, and behavior problems may be alleviated with timely and appropriate treatment and support services.

> In a "System of Care," local organizations work in teams--with families as critical partners--to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the seventy and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions.

Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life-at home, at school, and in the community. For a fact sheet on systems of care, call 1.800.789.2647.

Researchers are working to produce new knowledge and understanding about mental, emotional, and behavior disorders. Studies are also exploring ways to prevent and treat mental, emotional, and behavior problems, *including the* range of services that may be required.

Many of these studies are funded by Federal agencies within the Department of Health and Human Services, which include:

- the National Institutes of Health:
    - the National Institute of Mental Health
    - the National Institute of Child Health and Human Development
    - the National Institute for Drug Abuse
    - the National Institute on Alcoholism and Alcohol Abuse.

- the Substance Abuse and Mental Health Services Administration:
    - the Center for Mental Health Services
    - the Center for Substance Abuse Prevention
    - the Center for Substance Abuse Treatment.
- the Administration for Children and Families
- the Health Resources and Services Administration.

Related activities are taking place within:

- the Department of Education
- the Department of Justice.

There is now more reason than ever for youngsters with these problems and their families to lead normal, happy lives.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental jhealth problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available; call 1-800-789-2647

For free information about children's and adolescents' mental health-including publications, references, and referrals to local and national resources and organizations-call 1.800.789.2647; TTY 301-443-9006.

Test Questions -- Unit II: Section B

(1) The immediate objective of psychological first-aid is to

___(a) eliminate the fear individuals experience during and in the immediate aftermath of a crisis
___(b) help individuals deal with troubling psychological reactions during and in the immediate aftermath of a crisis
___(c) tell students counseling will be made available to them
___(d) all of the above

(2) Three phases of crisis intervention are (a) managing the situation, (b) mobilizing support, and (c) following-up.

___True ___False

(3) The following list mixes together general activities related to providing psychosocial guidance and support with specific things that can be done to facilitate student communication in a psychosocial counseling situation.

Put a + before the items that describe general activities related to providing psychosocial guidance and support.

___(a) advising
___(b) providing advocacy and protection
___(c) responding with empathy, warmth, nurturance, and positive regard
___(d) providing support for transitions
___(e) listening with interest
___(f) creating a private space and a climate where the student can feel it is safe to talk
___(g) clarifying the role and value of keeping things confidential
___(h) encouraging the student to take the lead
___(i) providing mediation and conflict resolution
___(j) promoting and fostering opportunities for social and emotional development
___(k) being a liaison between school and home
___(l) being a liaison between school and other professionals serving a student

Section C: Consent, Due Process, and Confidentiality

"Clearly, confidentiality mandates are very important and they need to be upheld. They have been developed to protect basic rights to privacy which all service providers must closely guard and carefully respect. Also, It must be recognized that in addition to governmental legal requirements, most professional disciplines have legal obligations or strong ethical standards that prohibit release of information about a client, patient, or student without consent.

> Confidentiality requirements involving interagency collaboration certainly are not new. ...what is new is that in the current environment there exists a growing expectation that organizations routinely will work together to help children and families. Put into practice, this expectation has several implications in the area of information sharing: it means that an exchange of information is likely to be sought in substantially more cases, that more organizations are likely to be involved in the exchange, and that more detailed information is likely to be desired. In brief, questions that once were rarely asked about vulnerable children and families are now far more likely to be commonplace.

As interagency collaboration efforts gain momentum, service providers from education, mental health, child welfare, and health agencies increasingly find themselves in a very delicate *dilemma*."

William Davis

Contents:

Objectives for Section C

After completing this section of Unit II, you should be able to:

- identify the three major aspects of the legal concept of consent
- identify at least two primary reasons for maintaining confidentiality in the delivery of mental health services
- identify two major exceptions to client confidentiality in a psychosocial counseling situation

A Few Focusing Questions

- *What does the term informed consent really mean?*
- *What due process rights do parents have?*
- *What are the primary reasons for ensuring confidentiality?*
- *What are the major exceptions to ensuring a student that what is said in counseling will be kept confidential?*

Before leaving the topic of mental health services and instruction, a few words are in order about some fundamental legal and ethical considerations.

Consent and Due Process

There was a time not so long ago when assessing students with problems and assigning them to special programs was done matter-of-factly. Most professionals believed they knew who needed help and what help was needed. It was a relatively simple matter to inform those involved that a problem existed and what was to be done. Growing awareness of rights and of the potentially harmful effects of treatment led to safeguards. Currently, consent is not taken for granted.

> Parent organizations and child advocates have insisted that parents be involved in any decision that might have a profound effect on the course of a child's life. This fact is reflected in the "procedural safeguards" enacted into federal law. These safeguards are rooted in the legal concept of due process as established in the Fourteenth Amendment to the federal constitution.

Due process protects people's rights; procedural safeguards are meant to help guarantee that everyone is treated fairly. They are meant to ensure that parents are involved in decisions regarding testing and placement of their child. That is, such interventions are not supposed to take place without parental consent.

Some of the safeguards spelled out in law are:

1. Parents must be notified whenever the school plans to conduct a special evaluation of their child.

2. Parents have the right to refuse consent for such an evaluation. (However, the school district has the right to a legal hearing to prove it is needed. Should parents want a special evaluation and the school refuses to provide it, parents can seek a legal hearing.)

3. Parents have the right to

   - review the procedures and instruments to be used in any evaluation
   - be informed of the results and review all records
   - obtain an independent educational evaluation to be considered in any decisions.

4. Parents must be notified whenever the school wants to change their child's educational placement, and they have the right to refuse consent for such a change. (Again, the school district can ask for a legal hearing to overrule the parents' decision. And, parents who are unable to convince the school to provide the special placement they want can also seek such a hearing.)

All notifications and explanations are to be given in the parents' primary language or other primary mode of communication.

What basic information should be communicated and understood? It is important to clarify the purpose of all intervention activity (why the person is there; what the person will be doing), describe risks and benefits, spell out alternatives, assure the individual that participation is not required, and elicit and answer all questions.

To make sure information is understood, it may need to be presented in a variety of ways. Repeated verbal or written communications, translations, media presentations, question-and-answer follow-ups to evaluate how information was understood, feedback obtained from other consumers -- all may be relevant at various times.

The emphasis on information, and the very term *informed consent*, may sometimes lead to greater emphasis on giving information than on ensuring true consent. Consent is a legal concept that has three major aspects: *capacity, information*, and *voluntariness*.

All three elements are of equal importance. These elements can be captured by three questions: Does the person have the ability to consent? adequate information to do so knowledgeably? the freedom to decline?

Stop, Think, Discuss

Older students often want or need access to services without their parents knowing and with confidentiality protected.

When can students seek assistance without parent involvement?

Where the laws 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 emancipate 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. School 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 school 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-up support the school can provide. Some staff, however, believe it is essential for parents to take responsibility for student follow-through. Thus, parents are given referral information, asked to see that the student makes contact, and any needed follow-through support is directed at the parents.

Confidentiality

School Nurse Dilemma: *Matt told me in confidence that he is planning a wild weekend with his friends. Given his history of substance abuse and what I know about the friends he mentioned, I'm worried that things will get out of control. Should I warn his parents?*

Student to the School Nurse:

If I tell you something,
will you tell my parents?

Confidentiality is an ethical concern. The fundamental intent is to protect a student's/family's right to privacy by ensuring that matters disclosed are not relayed to others without informed consent. By ensuring confidentiality, professionals also hope to encourage communication.

Neither privacy nor confidentiality, however, are absolute rights, especially in the case of minors. There are fundamental exceptions, some involving ethical considerations and some involving legalities.

There are times when professionals would prefer to maintain confidences but cannot do so legally or ethically. Examples include instances when individuals being seen indicates an intention to harm themselves or someone else and when they have been abused. As a result of legislation, litigation, and ethical deliberations, professional guidelines call on interveners to breach the confidence and tell appropriate public authorities when there is a clear danger to the person or to others. Undoubtedly, breaking confidentiality in any case can interfere with the trust between you and a student and make it difficult to help. Prevailing standards, however, stress that this concern is outweighed by your responsibility to prevent various threats.

In this vein, but perhaps going a step further, the ethical guidelines for school counselors call for reporting instances when information provided by clients indicates circumstances likely to have a negative effect on others; that is, without revealing the identity of the client, the counselor is expected to report such circumstances "to the appropriate responsible authority." However, it is left to individual counselors to decide which circumstances are "likely" and what constitutes a "negative effect" that is serious enough to require reporting. One result of all this is to make the processes of ensuring privacy and building trust almost paradoxical.

Stop, Think, Discuss

What the primary reasons for ensuring the confidentiality of information about children and families.

Soler and Peters (1993) stress:

The fundamental right "to be let alone" is at the root of confidentiality protections. Confidentiality restrictions protect the privacy of individuals and insure that personal information is disclosed only when necessary. The reasons for respecting the privacy of children and families include the following:

a. Confidentiality restrictions protect embarrassing personal information from disclosure. This may include histories of emotional instability, marital conflicts, medical problems, physical or sexual abuse, alcoholism, drug use, limited education, or erratic employment.

b. Confidentiality provisions prevent improper dissemination of information about children and families that might increase the likelihood of discrimination or harm against them even if records show that the information is unproven or inaccurate. Such information includes HIV status, mental health history, use of illegal drugs or child abuse charges.

c. Protecting confidential information can be necessary to protect personal security. For instance, an abused woman in a domestic violence situation may be in great danger if law enforcers reveal her new location.

d. Confidentiality provisions also protect family security. For example, many immigrant families shy away from using public health clinics or other social services for that the Immigration and Naturalization Service (INS) will take action against them.

e. Restricting information disclosure may also protect job security. Information such as history of mental health treatment may bear no relation to job performance but could jeopardize the individual's position or ability to find employment.

f. Children and families want to avoid prejudice or differential treatment by people such as teachers, school administrators, and service providers.

g. Confidentiality provisions also may be necessary to encourage individuals to make use of services designed to help them. Adolescents may avoid seeking mental health services at a school-based clinic, for example, if they believe that information will get back to their teachers, parents or peers.

(From *Who should know what? Confidentiality and information sharing in service integration* published by the National Center for Service Integration).

States vary in the degree to which their laws specify limitations on privileged communication between counseling professionals and minor clients. Some protect only disclosures about problems related to alcohol and other drugs. Others give broad protection, specifying a few exceptions such as reporting child abuse and crime or potential criminal activity.

In order to adequately inform minors of exceptions to the promise of privacy, you can add a statement, such as

> Although most of what we talk about is private, there are three kinds of problems you might tell me about that we would have to talk about with other people. If I find out that someone has been seriously hurting or abusing you, I would have to tell the authorities about it. If you tell me you have made plan to seriously hurt yourself, I would have to let your parents know. If you tell me you have made a plan to seriously hurt someone else, I would have to warn that person. I would not be able to keep these problems just between you and me because the law says I can't. Do you understand that it's OK to talk about most things here but that these are three things we must talk about with other people?

Because youngsters may feel a bit overwhelmed about the exceptions to privacy and the serious problems described, they may simply nod their acquiescence or indicate that they are unsure about how to respond. To soften the impact, you may want to add statements, such as

> Fortunately, most of what we talk over is private. If you want to talk about any of the three problems that must be shared with others, we'll also talk about the best way for us to talk about the problem with others. I want to be sure I'm doing the best I can to help you.

There will be times when you find it in the best interest of a student for others to know something that he or she has disclosed. Most ethical guidelines on confidentiality recognize this. In doing so, guidelines stress that such sharing should occur "only with persons clearly concerned with the case." Given that teachers and parents are clearly connected and see themselves as also working in a student's best interests, some interveners feel it appropriate -- even essential -- to discuss information with them. In other words, there are times when keeping a specific confidence shared by a student works against the youngster's best interests. At such times, you may decide that the costs of not communicating the information to others outweighs the potential benefits of maintaining privacy. Obviously, the first step in such situations is to talk with the student and try to elicit consent for sharing. If you decide you must proceed without consent, you will want to inform the student of why you will be doing so and work to repair any damage to your relationship.

Note: For more on this topic, you may want to see the introductory packet on *Confidentiality and Informed Consent* from the Center at UCLA.

Finally, it should be noted that the sharing of confidential information within and across agencies can be facilitated through developing a *Consent to Exchange Confidential Information*. The forms on the following pages illustrate those that are being developed around the country to overcome the barriers to the type of sharing that is essential in coordinating services.

Note that the form is designed to meet the varying demands of federal and state laws and education codes.

CHILDREN'S INTERAGENCY

CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

PLEASE TYPE/PRINT ALL INFORMATION

Child's Name _____ Birth Date _____

Mother's Maiden Name_____ Father's Name_____

Social Security No_____ Record No. _____

I authorize_____
to exchange information with

_____
Agency/Person/Organization

_____
Address

about information obtained during the course of my/my child's treatment/case/service plan for

_____ .

The exchange of records authorized here is required for the following purpose:

_____ .

Restriction: Release or transfer of the specified information to any person or agency not named herein prohibited unless indicated below:

Such exchange shall be limited to the following specific types of information: _____

_____

_____ .

This consent is subject to revocation by the undersigned at any time. It shall terminate, without express revocation on:

_____
Date, Event, or Condition

I understand I am entitled to receive a copy of this consent._____ copy(ies) requested and received.
I have read this consent carefully and have had all my questions answered.

Date_____ Witness _____

Signed_____ Signed _____
Parent, Guardian, Conservator Case Manager/County Representative

Agency _____

Confidential Client Information

SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328 AND SECTION 10850. CIVIL CODE 34, 58 AND 1798. 42 C.F.R. SECTION 2.34 AND 2.35. EDUCATION CODE 49075. HEALTH AND SAFETY CODE 1795

RELEASED RECORDS

The following records and/or information was released to:

____ Summary of Record

____ Diagnosis / Assessment

____ Social History

____ Treatment Plan

____Financial Information

____Psychiatric Evaluation

____Medical Assessment, Lab, Test, etc.

____History of Drug / Alcohol Abuse

____Other Evaluation / Assessment (specify)

_____

_____

_____

_____

____

____Results ofPsychological/ Vocational Testing

____Other (specify)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

___

Released by:

SIGNATURE _____

TITLE _____ DATE _____

AUTHORIZATION FOR
RELEASE OF CONFIDENTIAL
INFORMATION

Citation Examples:

Health and Safety Code 5
W&I Code 10850 and 5328
Ed. Code 49075
Civil Code 56 and 1796
42 CFR Part 2

Case Name:

Case Record No.:

Date of Birth:

Test Questions -- Unit II: Section C

(1) Which of the following are major aspects of the legal concept of consent?

___(a) a person must have the capacity to consent
___(b) a person must have appropriate and sufficient information before being asked to consent
___(c) a person's consent must be given voluntarily
___(d) a and b
___(e) a and c
___(f) b and c
___(d) all of the above

(2) It is important to maintain a client's confidentiality to protect embarrassing information from disclosure.

___True ___False

(3) It is important to maintain a client's confidentiality to minimize the likelihood of discrimination against the person.

___True ___False

(4) It is important to be able to offer confidentiality to encourage individuals to use services.

___True ___False

(5) Identify two major exceptions to client confidentiality in a psychosocial counseling situation.

_____ _____

Coda: Networks of Care

Mental health services and instruction that fosters positive social and emotional development represent major facets of what must done to address barriers to student learning. Increasingly, it is evident that many staff members at a school can play an important role in these arenas. In doing so, they can demonstrate their ability to offer a wider range of services and can help ensure that students are approached in a holistic way.

Moreover, by working with colleagues both within the school and throughout the surrounding community, school staff can help enhance systems for referral, triage, and management of care and expand the available network of care. At the same time, they can help schools move toward more comprehensive, integrated approaches that can prevent as well as respond to problems. In the process, all school staff can take their place as leaders for the type of systemic reforms that are essential in providing a safety net of care for generations to come.

Mental Health in Schools: New roles for school nurses

Unit III

Working With Others to Enhance Programs and Resources

Sections

A. Working Relationships

B. Working to Enhance Existing Programs

C. Building a Comprehensive, Integrated Approach at Your School

We must indeed all hang together,
or most assuredly we shall
all hang separately.

Benjamin Franklin

This Unit is one of the set of three focused on school Nurse's role in addressing psychosocial and mental health problems that interfere with students' learning and performance.

Professionals devote a great deal of time and energy learning to carry out individual duties with competence. However, it is becoming increasingly evident that the type of comprehensive, integrated approach needed to address barriers to student learning requires systematic changes and programmic approaches that transcend what individuals can do themselves.

In general, enhancing services and programs requires a focus on policy change and improving systems of care. The goals are to improve availability, access, coordination, integration, and comprehensiveness. For individual clients, this means developing integrated systems to identify, assess, triage, monitor, manage, and evaluate care. For schools, it means developing integrated systems of map, analyze, and redeploy resources and to outreach to the surrounding community to encourage involvement and assistance.

None of this is likely to happen, of course, in the absence of staff development that fosters capacity building for dealing with mental health and [psychosocial problems through new ways ti work collaboratively. This is the focus of thus unit.

At the very foundation of all this
is working together
with others
in effective ways.

Mental Health in Schools:
New Roles for School Nurses

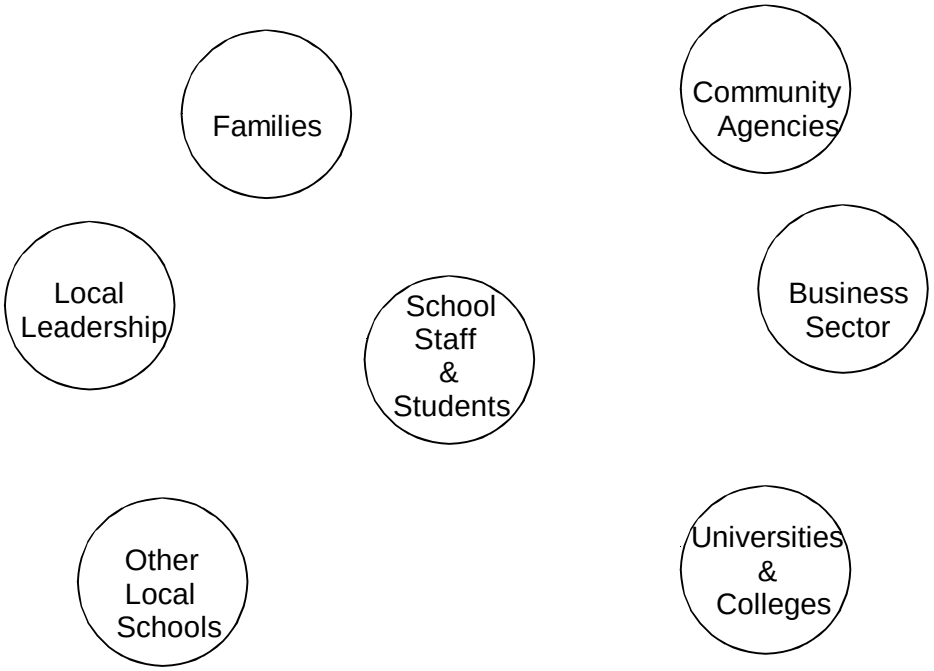
Contents of All Three Units

Section A: Working Relationships

Connecting the dots . . .

The many stakeholders who can work together to enhance programs and resources.

How many do you connect with?



Contents:

Objectives for Section A

After completing this section of the unit, you should be able to:

? identify at least three necessary ingredients in building positive working relationships

? identify at least three cultural competence values.

A Few Focusing Questions

? What types of differences might interfere with working relationships?

? How can barriers to working relationships be overcome?

? What is role might cultural competence and cultural values play in enhancing working relationships?

Treat people as if they were
what they ought to be
and you help them become
what they are capable of being.
Goethe

It's Not About Collaboration. It's About Being Effective

Most of us know how hard it is to work effectively with a group. Many staff members at a school site have jobs that allow them to carry out their duties each day in relative isolation of other staff. And despite various frustrations they encounter in doing so, they can see little to be gained through joining up with others. In fact, they often can point to many committees and teams that drained their time and energy to little avail.

Despite all this, the fact remains that no organization can be truly effective if everyone works in isolation. And it is a simple truth that there is no way for schools to play their role in addressing barriers to student learning and enhancing healthy development if a critical mass of stakeholders do not work together towards a shared vision. There are policies to advocate for, decisions to make, problems to solve, and interventions to plan, implement, and evaluate.

Obviously, true collaboration involves more than meeting and talking. The point is to work together in ways that produce the type of actions that result in effective programs. For this to happen, steps must be taken to ensure that committees, councils, and teams are formed in ways that ensure they can be effective. This includes providing them with the training, time, support, and authority to carry out their role and functions. It is when such matters are ignored that groups find themselves meeting and meeting, but going nowhere.

There are many committees and teams that those concerned with addressing barriers to learning and promoting healthy development can and should be part of. These include school-site shared decision making bodies, committees that plan programs, teams that review students referred because of problems and that manage care, quality review bodies, and program management teams.

Probably the most common, and ultimately the most damaging, mistake made by those eager to work together as a team or collaborative is moving to create a meeting structure before clearly specifying the ongoing functions that will guide the work.

For example, community collaboratives are a frequently formed structure that brings together leaders from school and community (e.g., public and private service and youth development programs). There is a hope that by having key people meet together significant program and systemic changes will be developed (e.g., changes that will enhance access and availability of services and improve coordination and integration).

Instead what often happens is the following . . .

Because they seldom have time to meet together, the leaders take the opportunity of the first couple of meetings to share what they are doing and to learn more about what others are doing. However, after the first meetings, it becomes evident that the group has no functions beyond communication and sharing. Having done their sharing, the leaders usually decide the meeting is not worth their time, and they begin sending their middle managers.

The middle managers usually are pleased for the chance to meet their counterparts and do some sharing. Again, this usually lasts for a couple of meetings before they decide to send line staff to represent them.

The line staff usually are pleased to come together to learn about each others work and often with a strong desire to see greater collaboration among schools and community institutions and agencies. However, as they discuss matters, it is painfully evident to them that nothing major can be changed because those with decision making power are no longer at the table.

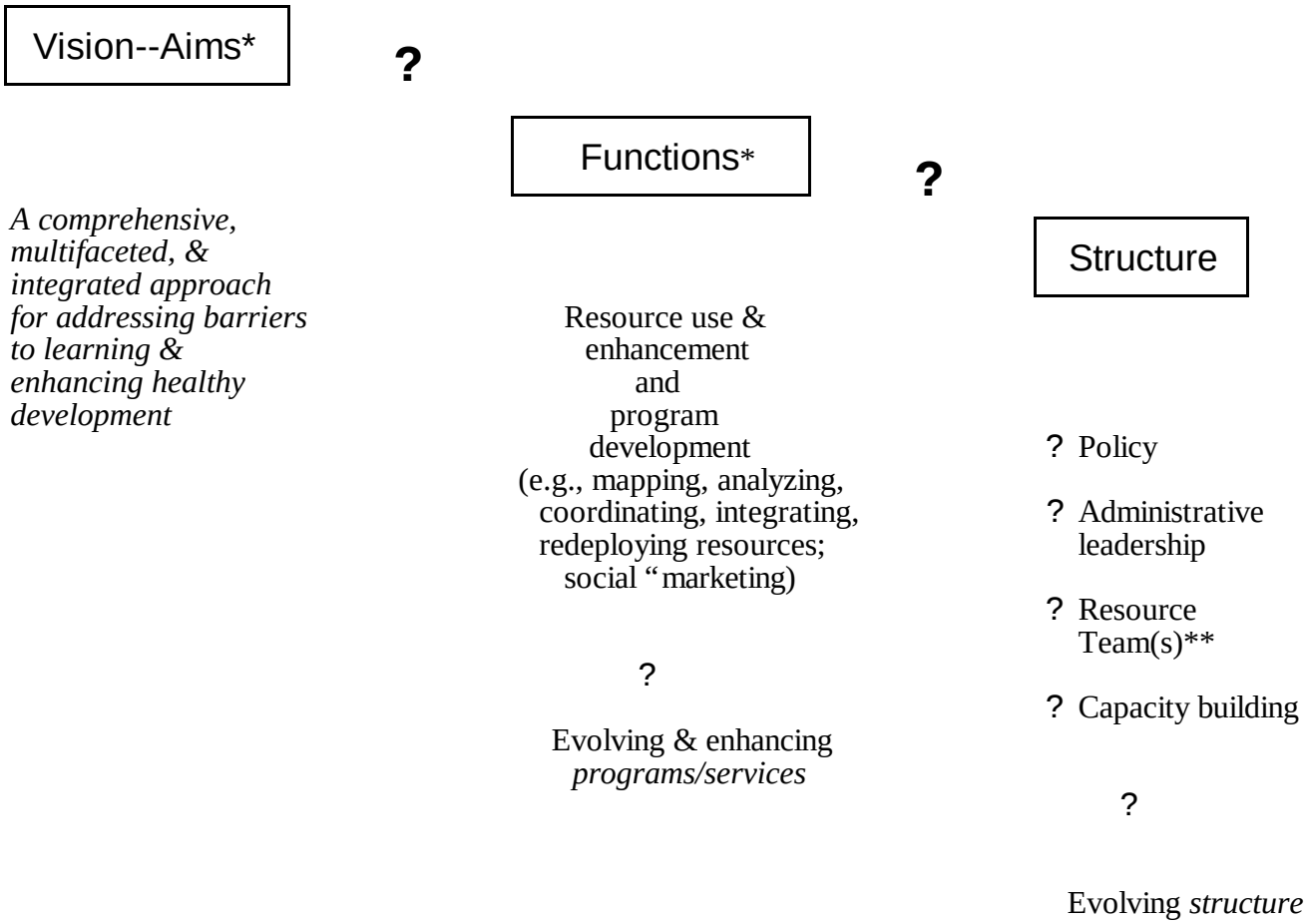
After several more meetings, the participants usually tire of "appreciating the problem" and describing possible solutions that are never heard by those in decision making roles. The result is that attendance drops or becomes sporadic – with new faces appearing as one line staff member fills in for another. Sometimes this results in outreach to a new set of institutions/agencies, but the process tends to repeat itself.

The problem arises from setting up structures before there is clarity about functions that require attention. It is the functions that should determine the mechanism (structure) that will be established to address them. The point to remember is that structure *follows* function. (And, functions should be generated in keeping with the vision that is being pursued. A successful structure is one that is designed to focus relentlessly on carrying out specific functions.

Take for example the need to identify and analyze the resources in the community to decide where the gaps are and how to fill them. This requires several mechanisms. The identification process involves the collection of existing information. This can be done quickly by assigning a couple of individuals to "jump start" the process by preparing a working document. Drafts can be widely circulated so that many stakeholders can review and add to the product. Then, a collaborative body of key leaders is ready to meet and begin the process of analysis and formulation of possible courses of action. The group's next functions would involve discussions with stakeholders to arrive at consensus about which courses of action will be taken.

The figure on the next page emphasizes the relationship between vision, functions, and structures with respect to efforts to develop comprehensive, multifaceted approaches for addressing barriers to learning and promoting healthy development.

Figure. From vision to function to structure.



*Answers the question: *Collaboration for what?*

**Focused mechanism(s) for operationalizing the collaborative vision and aims (e.g., mapping, analyzing, redeploying, and coordinating resources; ongoing advocacy; planning; guidance)

Planning and Facilitating Effective Meetings

Forming a Working Group

- There should be a clear statement about the group's mission.
- Be certain that 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..
- 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 record of decisions and planned actions (what, who, when).

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, eta. 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 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.

Some Group Dynamics to Anticipate

- *Hidden Agendas* – All members should agree to help keep hidden agendas in check and, when such items cannot be avoided, facilitate the rapid presentation of a point and indicate where the concern needs to be redirected.
- *A Need for Validation* – When members make the same point over and over, it usually indicates they feel an important point is not being validated. To counter such disruptive repetition, account for the item in a visible way so that members feel their contributions have been acknowledged. When the item warrants discussion at a later time, assign it to a future agenda.
- *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 with new ideas to offer; to deal with conflicts that arise over process, content, and power relationships employ problem solving and conflict management strategies (e.g., accommodation, negotiation, mediation).
- *Interpersonal Conflict and Inappropriate Competition* – These problems may be corrected by repeatedly bringing the focus back to the goal – improving outcomes for students/families; when this doesn't work; restructuring group membership may be necessary.
- *Ain't It Awful!* – Daily frustrations experienced by staff often lead them to turn meetings into gripe sessions. Outside team members (parents, agency staff, business and/or university partners) can influence school staff to exhibit their best behavior.

Differences as a Problem

In pursuing school-community partnerships, staff must be sensitive to a variety of human, school, community, and institutional differences and learn strategies for dealing with them. With respect to working with youngsters and their parents, staff members encounter differences in

- ? sociocultural and economic background and current lifestyle
- ? primary language spoken
- ? skin color
- ? sex
- ? motivation for help

and much more.

Comparable differences are found in working with each other.

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 staff, existing differences may make it difficult to establish effective working relationships with youngsters and others who effect the youngster. For example, many schools do not have staff who can reach out to those 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 and agencies cannot hire a separate specialist for all the major language, cultural, and skin color differences that exist in a school and community.

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; she expressed extreme resentment toward her father for 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

"You don't know what it's like to be poor."

"You're the wrong color to understand."

"You're being culturally insensitive."

"How can a woman understand a male student's problems?"

"Male therapists shouldn't work with girls who have been sexually abused."

"I never feel that young professionals can be trusted."

"Social workers (nurses/MDs/ psychologists/teachers) don't have the right training to help these kids."

"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

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.

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."

Exhibit

Understanding Barriers to Effective Working Relationships

Barriers to Motivational Readiness

Efforts to create readiness for change can build consensus but can't mobilize everyone. Some unmobilized individuals simply will not understand proposed changes. More often, those who do not support change are motivated by other considerations.

Individuals who value the current state of affairs and others who don't see the value of proposed changes can be expected to be apathetic and reluctant and perhaps actively resistant from the outset. The same is true for persons who expect that change will undermine their status or make unwanted demands on them. (And as the diffusion process proceeds, the positive motivation of others may subside or may even become negative if their hopes and positive expectations are frustrated or because they find they are unable to perform as other expect them to. This is especially apt to occur when unrealistic expectations have been engendered and not corrected.)

It is a given that individuals who are not highly motivated to work productively with others do not perform as well as they might. This is even more true of individuals with negative attitudes. The latter, of course, are prime candidates for creating and exacerbating problems. It is self-defeating when barriers arise that hinder stakeholders from working together effectively. And conflicts contribute to collaborative failure and burn out.

In encounters with others in an organization, a variety of human, community, and institutional *differences* usually can be expected. Moreover, organizational settings foster an extensive range of interpersonal *dynamics*. Certain dynamics and differences motivate patterns of poor communication, avoidance, and conflict.

Differences & Dynamics

Differences that may become sources of unproductive working relationships include variations in sociocultural and economic background, current lifestyle, primary language spoken, skin color, gender, power, status, intervention orientation, and on and on. Many individuals (students, parents, staff) who have been treated unfairly, discriminated against, or 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 individuals may promote conflict in hopes of correcting long-standing power imbalances or to call attention to other problems. And even when this is not so and even when there are no other serious barriers initially, common dynamics arise as people work together. Examples of interfering dynamics include excessive dependency and approval seeking, competition, stereotypical thinking and judgmental bias, transference and counter-transference, rescue-persecution cycles, resistance, reluctance, and psychological withdrawal.

Differences and dynamics become barriers to effective working relationships with colleagues and clients when they generate negative attitudes that are allowed to prevail. Fortunately, many barriers are preventable and others can be dealt with quickly if appropriate problem solving mechanisms are in place. Thus, a central focus in designing strategies to counter problems involves identifying how to address the motivational barriers to establishing and maintaining productive working relationships.

Reactions to Shifts in Power

In discussing power, theoreticians distinguish "power over" from "power to" and "power from." *Power over* involves explicit or implicit dominance over others and events; *power to* is seen as increased opportunities to act; *power from* implies ability to resist the power of others.*

(cont.)

Exhibit (cont.)
Understanding Barriers to Effective Working Relationships

Efforts to restructure schools often are designed to extend the idea of "power to" by "empowering" all stakeholders.

Unfortunately, the complexities of *empowerment* have not been well addressed (e.g., distinctions related to its personal and political facets). As practiced, empowerment of some seems to disempower others. That is, empowering one group of stakeholders usually reduces the political power of another. On a personal level, empowering some persons seems to result in others *feeling* disempowered (and thus feeling threatened and pushed or left out). For example, individuals whose position or personal status in an organization has endowed them with power are likely to feel disempowered if their control or influence over activities and information is reduced; others feel disempowered simply by no longer being an "insider" with direct connections to key decision makers. And often, individuals who express honest concerns or doubts about how power is being redistributed may be written off as resistant.**

Another concern arises from the fact that the acquisition of power may precede the ability to use it effectively and wisely. To counter this, stakeholder development is an essential component of empowerment during the diffusion process.

Problems stemming from power shifts may be minimized. The time to begin is during the readiness phase of the diffusion process. Those who are to share power must be engaged in negotiations designed to ease the transition; at the same time, those who will be assuming power must be engaged in specific developmental activity. Ultimately, however, success in countering negative reactions to shifts in power may depend on whether the changes help or interfere with building a sense of community (a sense of relatedness and interdependence).

Faulty Infrastructure Mechanisms

Most models for restructuring education call for revamping existing organizational and programmatic infrastructures (e.g., mechanisms for governance, planning and implementation, coordination). Temporary mechanisms also are established to facilitate diffusion (e.g., steering and change teams). A well functioning infrastructure prevents many problems and responds effectively to those that do arise. An early focus of diffusion is on ensuring that the institutionalized and temporary infrastructure mechanisms are appropriately designed and functioning. The work of the change team and those who implement stakeholder development is essential in this regard. Each infrastructure mechanism has a role in building positive working relationships and in anticipating, identifying, and responding to problems quickly. Persons staffing the infrastructure must learn to perform specific functions related to these concerns. Members of the change team must monitor how well the infrastructure is functioning with regard to these concerns and take steps to address deficiencies.

*

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

(1) prejudgments that a person is bad because of an observed difference

and

(2) 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

(1) to counter negative prejudgments (e.g., to establish the credibility of those who have been prejudged)

and

(2) 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

* 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.

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

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.

*I*n *Families and the Mental Health System for Children and Adolescence*, edited by C.A. Heflinger & C.T. Nixon (1996). CA: Sage Publications.

Stop, Think. Discuss

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.

At this point, what are you ideas about how to maximize good working relationships at your school?

One Other Observation

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.

Test Questions -- Unit III: Section A

(1) Of the various necessary ingredients in building positive working relationships, list three of those covered in this unit.

_____

_____

_____

(2) Enumerate three of the five cultural competence values as defined by Mason, Benjamin, & Lewis (1996).

_____

_____

_____

(3) There is a danger inherent in making prejudgments based on apparent cultural awareness.

True ____ False____

(4) Poor working relationships arise whenever there are individual, racial, or cultural differences.

True ____ False____

(5) Which of the following are things to do to help build working relationships and effective communication?

____ (a) convey empathy and warmth

____ (b) convey genuine regard and respect

____ (c) talk with, not at, others

____ (d) a & b

____ (e) all the above

Section B: *Working to Enhance Existing Programs*

Contents:

Objectives for Section B

After completing this section of the unit, you should be able to:

- identify at least two basic tasks for primary managers of care
- identify at least two major functions of a school-based team designed to manage resources

A Few Focusing Questions

- *What is to be gained through collaborating with others at the school and in the community?*
- *What is the difference between monitoring care and managing care?*
- *Why is it important to map and analyze existing resources at a school site?*

For any school program to improve, there must be both individual and group efforts. Group efforts may focus on planning, implementation, evaluation, advocacy, and involvement in shared decision making related to policy and resource deployment.

In working together to enhance existing programs, group members look for ways to improve communication, cooperation, coordination, and integration within and among programs. Through such collaborative efforts, they seek to (a) enhance program availability, access, and management of care, (b) reduce waste stemming from fragmentation and redundancy, (c) redeploy the resources saved, and (d) improve program results.

Formal opportunities for working together at schools often take the form of committees or councils and teams. To be effective, such collaborative efforts require thoughtful and skillful facilitation. Without careful planning and implementation, collaborative efforts rarely can live up to the initial hope. Even when they begin with great enthusiasm, poorly facilitated working sessions quickly degenerate into another ho-hum meeting, more talk but little action, another burden, and a waste of time. This is particularly likely to happen when the emphasis is mainly on the unfocused mandate to "collaborate," rather than on moving an important vision and mission forward through effective working relationships.

Stop, Think. Discuss

Think about the last collaborative meeting you attended.

What was the purpose of the meeting?

How well did the various participants work together?

Did it produce more effective results than would have arisen without a formal collaborative effort?

How might the process have been improved?

It's Not About Collaboration. It's About Being Effective.

Most of us know how hard it is to work effectively with a group. Many staff members at a school site have jobs that allow them to carry out their duties each day in relative isolation of other staff. And despite various frustrations they encounter in doing so, they can see little to be gained through joining up with others. In fact, they often can point to many committees and teams that drained their time and energy to little avail.

> Despite all this, the fact remains that no organization can be truly effective if everyone works in isolation. And it is a simple truth that there is no way for schools to play their role in addressing barriers to student learning and enhancing healthy development if a critical mass of stakeholders do not work together towards a shared vision. There are policies to advocate for, decisions to make, problems to solve, and interventions to plan, implement, and evaluate.

Obviously, true collaboration involves more than meeting and talking. The point is to work together in ways that produce the type of actions that result in effective programs. For this to happen, steps must be taken to ensure that committees, councils, and teams are formed in ways that ensure they can be effective. This includes providing them with the training, time, support, and authority to carry out their role and functions. It is when such matters are ignored that groups find themselves meeting and meeting, but going nowhere.

> There are many committees and teams that those concerned with addressing barriers to learning and promoting healthy development can and should be part of. These include school-site shared decision making bodies, committees that plan programs, teams that review students referred because of problems and that manage care, quality review bodies, and program management teams.

Two key teams are highlighted here because or the essential role they play in enhancing program effectiveness (a) a team to manage client care and (b) a team to manage program and service resources.

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 what 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

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 a person is task-focused, s/he may seem to be making the same point over and over. This usually is an indication that s/he feels s/he is making 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 an "agenda bin" to be addressed 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 -- Some people find it hard to like each other. Sometimes the dislike is so strong that they simply can't work closely together. If there is no mechanism to help them minimize their interpersonal conflict, the group needs to find a way to restructure its membership.

Two References

Rees, F. (1993). *25 Activities for Teams.* San Diego CA: Pfeiffer & Co.

Brilhart, J.K. & Galanes, G.J. (1995). *Effective Group Discussion* (8th ed.). Madison, WI: WCB Brown & Benchmark.

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.

* Examples of such forms and related resources are provided in the accompanying aid packet on *School-Based Client Consultation, Referral, and Management of Care* -- prepared by the Center for Mental Health in Schools at UCLA..

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 caregivers 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 that addresses her/him as a 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.

A few basic tasks 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 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.

Stop, Think. Discuss

When there are many students receiving various types of assistance, it is imperative that a school have an effective system in place to manage care.

What is the nature of the system at you school?

Who is responsible for being certain that it is working well?

Who shares the load as primary managers of care?

A Team to Manage Resources

As discussed in another unit, most school health and human service programs (as well as compensatory and special education programs) are developed and function in relative isolation of each other. Available evidence suggests this produces fragmentation which, in turn, results in waste and limited efficacy. National, state, and local initiatives aimed at increasing coordination and integration of community services are just beginning to direct school policy makers to a closer look at school-owned services. At the same time, school practitioners are realizing that since they can't work any harder, they must work smarter. For some, working smarter translates into new strategies for coordinating, integrating, and redeploying resources. Such efforts are reflected in new (a) processes for mapping and matching resources and needs and (b) mechanisms for resource coordination and enhancement. (Space precludes discussing the topic here, but all efforts to work smarter obviously can be enhanced through appropriate use of advanced technology.)

Mapping and matching resources and needs. The literature on resource coordination 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?*

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 coordinating team*. Creation of such a school-based team provides 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.

> *A resource coordinating team differs from teams created to review individual students* (such as a student study team or a teacher assistance 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 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.

Although a resource coordinating 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 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, noncertificated 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 focus to resource coordination.

Some General Guidelines for Establishing School-Site Collaborative Teams Focused on Addressing Barriers to Learning

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. Group 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), 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 mail, 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.

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.

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.

Test Questions -- Unit III: Section B

(1) Enumerate two of the basis tasks for primary managers of care as discussed in this unit.

_____

_____

(2) Enumerate two of the major functions of a school-based team designed to manage resources as discussed in this unit.

_____

_____

(3) Parents can be part of a management of care team.

True ____ False____

(4) Perhaps the most valuable aspect of mapping and analyzing a school's resources for addressing barriers to learning and promoting healthy development is that the products provide a sound basis for improving cost-effectiveness.

True ____ False____

(5) A school-based Resource Coordinating Team has the same functions as a team created to review individual students.

True ____ False____

***Coda**: Roles for the School Nurse: A Multifaceted Focus*

Obviously, school nurses have always played a key role in promoting health and helping students. Now, along with other school professionals, they have the opportunity and the responsibility to play an expanded and essential role in moving schools toward a comprehensive, integrated approach for dealing with barriers to learning, and in the process, they can enhance efforts to promote healthy development.

> Emerging reforms are reshaping the work of all school professionals. Pupil services in schools are expanding and changing rapidly. Pupil services professionals are engaged in an increasingly wide array of activity, including promotion of health and social and emotional development, direct services, outreach to families, and various forms of support for teachers and other school personnel. There is enhanced emphasis on coordination and collaboration within a school and with community agencies to provide the "network of care" necessary to deal with complex problems over time.

New directions call for functions that go beyond direct service and traditional consultation. All who work in the schools must be prepared not only to provide direct help but to act as advocates, catalysts, brokers, and facilitators of systemic reform. Particularly needed are efforts to improve intervention efficacy through integrating physical and mental health and social services. More extensively, the need is for systemic restructuring of all support programs and services into a comprehensive and cohesive set of programs.

> It seems evident that the relatively small number of pupil service personnel available to schools can provide only a small proportion of the direct services needed by students. The more their expertise is used at the level of program organization, development, and maintenance, the greater the number students who will benefit.

Section C: Building a Comprehensive, Integrated Approach at Your School

See

Addressing Barriers to Learning: In the Classroom and Schoolwide –

Available at this time as a free resource
http://smhp.psych.ucla.edu/pdfdocs/barriersbook.pdf

Contents:

Objectives for Section C

After completing this section of the unit, your should be able to:

- identify three components that need to be addressed in school and community efforts for systemic reform
- identify six program areas of an enabling component

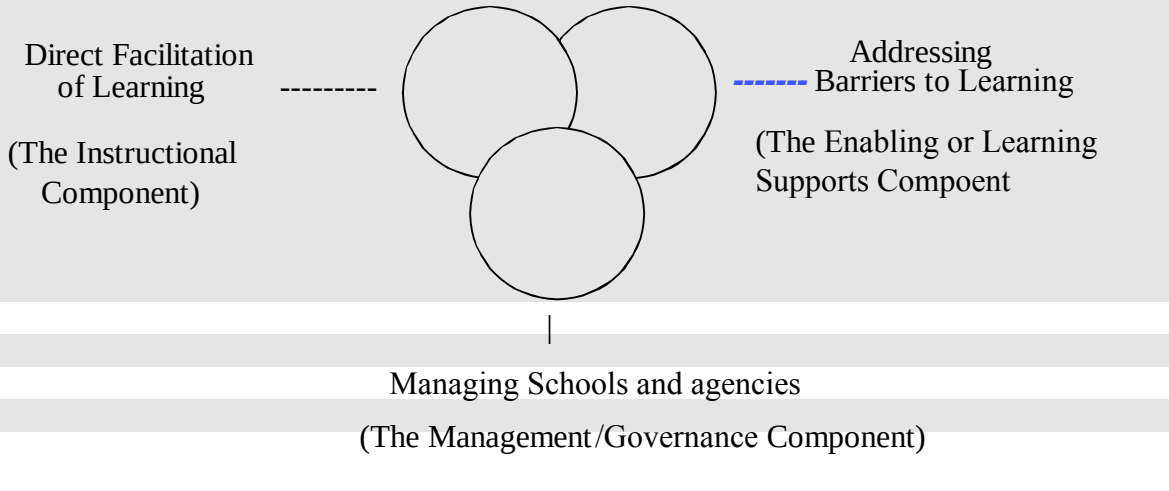
A Few Focusing Questions

- *What is an enabling component?*
- *To which of the six areas of an enabling component can a school nurse make a significant contribution?*

Even more fundamentally than establishing *linkages* between community agencies and school sites, school and community policy must start to reflect the reality that there are three primary and essential components to be addressed in systemic reform and restructuring of schools and community agencies.

As illustrated below, these are the *instructional, enabling*, and *management* components.

Three Components to be Addressed in Systemic Reform



Central to an effective *enabling component* is activity to address health and psychosocial problems.

School-owned enabling activity -- such as pupil services and the multi-components of a school health program -- must be coordinated and integrated not only with each other but with community-owned resources.

> And the overlapping enabling, instructional, and management components must be carried out as a cohesive whole if we are to effectively address the many barriers interfering with the appropriate and effective functioning of students.

Emergence of a cohesive Enabling Component requires (1) weaving together what is available at a school, (2) expanding what exists by integrating school and community resources, and (3) enhancing access to community programs and services by linking as many as feasible to programs at school sites in ways that can serve a complex of schools.

> Based on analyses of what schools and communities already are doing, enabling activity can be clustered into six program areas. These encompass interventions to

- work with teachers to enhance classroom based efforts to enable learning
- provide prescribed student and family assistance
- respond to and prevent crises
- support student and family transitions
- mobilize parent/home involvement in schooling and health promotion
- outreach to develop greater community involvement and support (including recruitment of volunteers).

A brief sketch of each of these programmatic areas follows.

Classroom Focused Enabling

When a teacher encounters difficulty in working with a youngster, the first step is to see whether there are ways to address the problem within the regular classroom and perhaps with added home involvement. Thus the emphasis here is on enhancing classroom-based efforts to enable learning by increasing teacher effectiveness for preventing and handling problems in the classroom. This is accomplished by providing personalized help to increase a teacher's array of strategies for working with a wider range of individual differences. For example, teachers learn to use peer tutoring and volunteers to enhance social and academic support and to increase their range of accommodative strategies and their ability to teach students compensatory strategies; and as appropriate, they are provided support in the classroom from resource and itinerant teachers and counselors. Two aims of all this are to increase mainstreaming efficacy and reduce the need for special services.

Work in this area requires

- ? programs for personalized professional development (for teachers and aides)
- ? systems to expand resources
- ? programs for temporary out of class help
- ? programs to develop aides, volunteers, and any others who help in classrooms or who work with teachers to enable learning.

Through classroom-focused enabling programs, teachers are better prepared to address similar problems when they arise in the future.

(The classroom curriculum, of course, already should encompass a focus on fostering socio-emotional and physical development. Such a focus is seen as an essential element in preventing learning, behavior, emotional, and health problems.)

Student and Family Assistance

Some problems cannot be handled without special interventions, thus the need for student and family assistance. The emphasis here is on providing special services in a personalized way to assist with a broad-range of needs. To begin with, available social, physical and mental health programs in the school and community are used. As community outreach brings in other resources, they are linked to existing activity in an integrated manner. Special attention is paid to enhancing systems for triage, case and resource management, direct services to meet immediate needs, and referral for special services and special education resources and placements as appropriate. Ongoing efforts are made to expand and enhance resources. As major outcomes, the intent is to ensure special assistance is provided when necessary and appropriate and that such assistance is effective.

Work in this area requires

- programs designed to support classroom focused enabling -- with specific emphasis on reducing the need for teachers to seek special programs and services
- a stakeholder information program to clarify available assistance and how to access help
- systems to facilitate requests for assistance and strategies to evaluate the requests (including use of strategies designed to reduce the need for special intervention)
- a programmatic approach for handling referrals
- programs providing direct service
- programmatic approaches for effective case and resource management
- interface with community outreach to assimilate additional resources into current service delivery.

Crisis Assistance and Prevention

The intent here is to respond to, minimize the impact of, and prevent crises. Desired outcomes of crisis assistance include ensuring immediate emergency and follow-up care is provided so students are able to resume learning without undue delay. Prevention activity outcomes are reflected in measures showing there is a safe and productive environment and that students and their families have the type of attitudes and capacities needed to deal with violence and other threats to safety.

Work in this area requires

- ? systems and programs for emergency/crisis response at a site, throughout a school complex, and community-wide (including a program to ensure follow-up care)
- ? prevention programs for school and community to address school safety and violence reduction, suicide prevention, child abuse prevention and so forth.

Support for Transitions

This area involves planning, developing, and maintaining a comprehensive focus on the variety of transitions concerns confronting students and their families. Anticipated outcomes are reduced alienation and increased positive attitudes toward and involvement in school and learning activities.

Work in this area requires

- ? programs creating a welcoming and socially supportive school community, especially for new arrivals
- ? counseling and articulation programs to support grade-to-grade and school-to-school transitions, moving to and from special education, going to college, moving to post school living and work
- ? before, after-school, and intersession programs to enrich learning and provide safe recreation.

Home Involvement in Schooling

The emphasis and work in this area includes

- programs to address specific learning and support needs of adults in the home, such as English as a Second Language (ESL) classes and mutual support groups
- programs to help those in the home meet their basic obligations to the student, such as instruction for parenting and for helping with schoolwork
- systems to improve communication about matters essential to the student and family
- programs to enhance the home-school connection and sense of community
- interventions to enhance participation in making decisions that are essential to the student
- programs to enhance home support related to the student's basic learning and development
- interventions to mobilize those at home to problem solve related to student needs
- intervention to elicit help (support, collaborations, and partnerships) from those at home with respect to meeting classroom, school, and community needs.

The context for some of this activity may be a *parent center* (which may be part of a *Family Service Center* facility if one has been established at the site).

Outcomes include measures of parent learning, student progress, and community enhancement specifically related to home involvement.

Community Outreach for Involvement and Support
(including a focus on volunteers)

Outreach to the community is used to build linkages and collaborations, develop greater involvement in schooling, and enhance support for efforts to enable learning. Outreach is made to (1) public and private community agencies, universities, colleges, organizations, and facilities, (2) businesses and professional organizations and groups, and (3) volunteer service programs, organizations, and clubs. Outcomes include measures of community participation, student progress, and community enhancement.

Work in this area requires

- ? programs to recruit community involvement and support (e.g., linkages and integration with community health and social services; cadres of volunteers, mentors, and individuals with special expertise and resources; local businesses to adopt-a-school and provide resources, awards, incentives, and jobs; formal partnership arrangements)

- ? systems and programs specifically designed to train, screen, and maintain volunteers (e.g., parents, college students, senior citizens, peer and cross-age tutors and counselors, and professionals-in-training to provide direct help for staff and students -- especially targeted students)

- ? programs outreaching to hard to involve students and families (those who don't come to school regularly -- including truants and dropouts)

- ? programs to enhance community-school connections and sense of community (e.g., orientations, open houses, performances and cultural and sports events, festivals and celebrations, workshops and fairs).

Stop, Think. Discuss

Every school has programs and services that are meant to address barriers to student learning and enhance healthy development.

Make a list of the ones that are currently in place at your school.

If you were to ask most of the teachers at the school, would they know that these interventions are available and understand how to arrange for students to access them?

What other programs and services do you think the school needs to better address mental health and psychosocial problems?

In organizing an enabling component, it is the content of each of the basic areas that guides program planning, implementation, evaluation, personnel development, and stakeholder involvement.

The intent is to blend a *continuum of programs* -- from primary prevention to treatment of chronic problems -- and a *continuum of interveners, advocates*, and *sources of support* (e.g., peers, parents, volunteers, nonprofessional staff, professionals-in-training, professionals).

Thus, the emphasis throughout is on *collaboration* -- cooperation, coordination, and, where viable, integration -- among all enabling activities, as well as with the instructional and management components.

If feasible, a *Center* facility provides a useful focal point and hub for enabling component operations.

Also as feasible, integrated use of advanced *technology* is highly desirable (e.g., a computerized system to organize information, aid case management, and link students and families to referrals).

It is clear that there is a long way to go before, a comprehensive, integrated approach to addressing barriers to learning and promoting healthy development is in place. Nevertheless, as we move into the next millennium, it seems wise to work within a context that has promise for truly meeting the needs of society rather than continuing to pursue fragmented strategies that have proven ineffective.

Test Questions -- Unit III: Section C

(1) Indicate three primary and essential components discussed in this unit that need to be addressed in reform efforts by schools/communities.

_____

_____

_____

(2) Enumerate six program areas of an Enabling Component.

_____

_____

_____

_____

_____

_____

(3) The concepts of (a) an Enabling Component and (b) School linked services are different terms for the same approach to addressing barriers to learning and enhancing healthy development.

True ____ False____

(4) School-owned enabling activity -- such as pupil services and the multi-components of a school health program -- must be coordinated and integrated not only with each other but with community-owned resources.

True ____ False____

***Coda**: Roles for the School Nurse: A Multifaceted Focus*

Obviously, school nurses have always played a key role in promoting health and helping students. Now, along with other school professionals, they have the opportunity and the responsibility to play an expanded and essential role in moving schools toward a comprehensive, integrated approach for dealing with barriers to learning, and in the process, they can enhance efforts to promote healthy development.

> Emerging reforms are reshaping the work of all school professionals. Pupil services in schools are expanding and changing rapidly. Pupil services professionals are engaged in an increasingly wide array of activity, including promotion of health and social and emotional development, direct services, outreach to families, and various forms of support for teachers and other school personnel. There is enhanced emphasis on coordination and collaboration within a school and with community agencies to provide the "network of care" necessary to deal with complex problems over time.

New directions call for functions that go beyond direct service and traditional consultation. All who work in the schools must be prepared not only to provide direct help but to act as advocates, catalysts, brokers, and facilitators of systemic reform. Particularly needed are efforts to improve intervention efficacy through integrating physical and mental health and social services. More extensively, the need is for systemic restructuring of all support programs and services into a comprehensive and cohesive set of programs.

> It seems evident that the relatively small number of pupil service personnel available to schools can provide only a small proportion of the direct services needed by students. The more their expertise is used at the level of program organization, development, and maintenance, the greater the number students who will benefit.

This leads to the view that the range of functions nurses and other pupil service specialists should perform for schools are

- Direct service activity (e.g., crisis intervention in emergency situations; short-term assessment and treatment, including facilitating referral and case management; prevention through promotion of physical and mental health and enhancing resources through supervising professionals-in-training and volunteers),

- Resource coordination and development (e.g., organizing existing programs; integrating with instruction through inservice mentoring and consultation; interfacing with community agencies to create formal linkages; preparing proposals and developing new programs; acting as an agent of change to create readiness for systemic reform and facilitating development of mechanisms for collaboration and integration; providing support for maintenance of reforms; participation on school governance and planning bodies),

- Enhancing access to community resources (e.g., identifying community resources; assisting families to connect with services; working with community resources to be more responsive to the needs of a district's students; community coalition building).

Furthermore, these three areas of function should be prioritized so school-based professionals can use their time to produce the broadest impact.

Used properly, pupil service personnel can play a potent role in creating a comprehensive, integrated approach to meeting the needs of the young by interweaving what schools can do with what the community offers.

Overcoming today's limitations and meeting tomorrow's challenges requires a clear picture of where we want to go and how we can get there. Over the next few years, there will be fundamental changes in the ways in which the needs of young people are addressed. We all have the opportunity to play key roles in redesigning schools internally and in terms of how they work with others in the surrounding community to better address barriers to learning and enhance healthy development. Our hope is that the material presented in this set of continuing education units has provided you not only with some new skills, but with a picture of emerging trends and their implications for new roles for school nurses.

Addressing Barriers to Student Learning

Continuing Education

Mental Health in Schools:
New roles for school nurses

Instructor's Guide
and
Test Questions & Answers

Prepared by the School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- (310) 825-3634. Co-directors: Howard Adelman & Linda Taylor

Preface

There is a simple truth that every professional working in schools knows: social, emotional, and physical health deficits and other persistent barriers to learning must be addressed if students are to learn effectively and schools are to accomplish their educational mission. It would be wonderful if the process of addressing such barriers could be handled solely by families or public and private community agencies. Unfortunately, these agencies are unable to do the job alone. Thus, if school reform is to be effective, schools must play a major role in easing problems, increasing opportunities, and enhancing the well-being of students and families.

It is clear that the success of any initiative focused on mental health in schools is dependent on the full involvement of school nurses. In the spring of 1996, Beverly Bradley and Keeta DeStefano Lewis representing the National Association of School Nurses (NASN) proposed that the UCLA Center prepare materials for continuing education of school nurses. The Center agreed to do so. The material contained in this document represents a timely and progressive approach to the topic. At the same time, the content, like the field itself, is seen as in a state of continuous evolution. Thus, we are extremely interested in receiving your feedback. Please send your comments to: Howard S. Adelman and Linda Taylor, Co-Directors, Center for Mental Health in Schools, UCLA, Department of Psychology, Los Angeles, CA 90095-1563.

*Under the auspices of the School Mental Health Project, the Center for Mental Health in Schools at UCLA pursues the need for better mental health interventions in the context of moving toward a comprehensive, integrated approach to addressing barriers to student learning. A comprehensive approach encompasses (a) prevention and prereferral interventions for mild problems, (b) high visibility programs for high-frequency psychosocial problems, and (c) strategies to assist with severe and pervasive mental health problems. A comprehensive approach recognizes the role school, home, and community life play in creating and correcting young people's problems, especially those who are under-served and hard-to-reach.

Introduction

To Curriculum Designers Adopting this Material

The material in the continuing education module entitled *Mental Health in Schools: New Roles for School* Nurses can be incorporated into various formats:

(1) self-study (individual or group)

(2) participation in workshops (a half or full day continuing education workshop; a sequence of district-wide inservice workshops)

(3) media and computer courses (instructional television -- live, and if feasible, interactive; video or audiotaped courses; computer courses, an internet offering)

(4) a professional journal offering a continuing education series.

The content is designed as an evolving set of modular units. Each unit consists of several sections conceived to stand alone. Thus, the total set can be used and taught in a straight forward sequence, or one or more units and sections can be combined into a personalized course. This design also allows learners to approach the material as they would use an internet website (i.e., exploring specific topics of immediate interest and then going over the rest in any order that feels comfortable). The units are packaged in a sequence that reflects the designers' preference for starting with a big picture framework for understanding the context and emerging directions for mental health in schools.

Beginning each section are specific objectives and focusing questions meant to help guide reading and review. Interspersed throughout each section are boxed material designed to help learners think in greater depth about the material. Test questions are provided at the end of each section as an additional study aid.

If the materials are used in a self-study format, instructors should encourage learners to survey and browse through the material and then read in greater depth. If feasible, learners should be encouraged to establish a study group. Such a group not only can help facilitate the learning of new ideas and skills, it lays a great foundation for ongoing networking, social support, and team building.

Contents of the Instructor's Guide

Continuing Education for School Nurses

Topic: *Mental Health in Schools: New Roles for School Nurses*

Content:

I. Placing Mental Health into the Context of Schools and the 21st Century
- A. Introductory Overview
- B. The Need to Enhance Healthy Development and Address Barriers to Learning
- C. Addressing the Need: Moving Toward a Comprehensive Approach
- Coda: A Wide Range of Responses for a Wide Range of Problems

II. Mental Health Services & Instruction: What a School Nurse Can Do
- A. Screening and Assessment
- B. Problem Response and Prevention
- C. Consent, Due Process, and Confidentiality
- Coda: Networks of Care
- Follow-Up Reading
  - *ABCs of Assessment*
  - *Managing and Preventing School Misbehavior and School Avoidance*

III. Working with Others to Enhance Programs and Resources
- A. Working Relationships
- B. Working to Enhance Existing Programs
- C. Building a Comprehensive, Integrated Approach at Your School
- Coda: Roles for the School Nurse: A Multifaceted Focus

Expanded Content Outlines:

I. Placing Mental Health into the Context of Schools and the 21st Century
- A. Introductory Overview
  - State of the Art
  - Emerging Trends
  - New Roles for Nurses
- B. The Need to Enhance Healthy Development and Address Barriers to Learning
  - Promoting Healthy Development
  - Personal and Systemic Barriers to Student Learning
  - Family Needs for Social and Emotional Support
  - Staff Needs for Social and Emotional Support
- C. Addressing the Need: Moving Toward a Comprehensive Approach
  - Meeting Mandates: Necessary . . . but Insufficient and Often Unsatisfying
  - Understanding What Causes Different Types of Problems
  - Clinical Approaches at School Sites
  - School-Based Health Centers, Family Service Centers, and Full Service Schools
  - Programmatic Approaches: Going Beyond Clinical Interventions to Address the Full Range of Problems
  - Needed: A Full Continuum of Programs and Services
- Coda: A Wide Range of Responses for a Wide Range of Problems

II. Mental Health Services & Instruction: What a School Nurse Can Do
- A. Screening and Assessment
  - Initial Problem Identification
  - Connecting a Student with the Right Help
    - Screening to Clarify Need
    - Client Consultation and Referral
    - Triage
    - Initial Case Monitoring
- B. Problem Response and Prevention
  - Psychological First Aid: Responding to a Student in Crisis
  - Primary Prevention and Treatment
    - Mental Health Education
    - Psychosocial Guidance and Support
    - Psychosocial Counseling
  - Ongoing Case Monitoring
  - To Review
- C. Consent, Due Process, and Confidentiality
- Coda: Networks of Care

III. Working with Others to Enhance Programs and Resources
- A. Working Relationships
  - Differences as a Problem
  - Differences as a Barrier
  - Overcoming Barriers Related to Differences
  - Building Rapport and Connection
  - One Other Observation
- B. Working to Enhance Existing Programs
  - It's Not About Collaboration. It's About Being Effective
  - A Team to Manage Care
  - A Team to Manage Resources
- C. Building a Comprehensive, Integrated Approach at Your School
  - Classroom-Focused Enabling
  - Crisis Assistance and Prevention
  - Support for Transitions
  - Student and Family Assistance
  - Home Involvement in Schooling
  - Community Outreach for Involvement and Support (including a focus on volunteers)

Coda: Roles for the School Nurse: A Multifaceted Focus

Sample "Lesson Plan" for Offering the Curriculum in a Workshop Format

Topic: *Mental Health in Schools: New Roles for School Nurses*

Unit II: Mental Health Services & Instruction: What a School Nurse Can Do

I. Assignment to Prepare Participants for a Session

Prior to the workshop, do any of the following activities -- with a view to sharing a bit of what you learned from the experience with others at the workshop.

1. In journal form, briefly describe a student who you are having difficulty helping -- note a few things you have tried to do and why you think they haven't worked.

2. Reflect on and write-up a brief description of your efforts to help students who come to you about psychosocial and mental health concerns. If you can, write this in terms of how you think the students experience it.

3. Read something recent about improving school nursing and decide what changes, if any, you would want to make in your school to improve the way it addresses students' problems.

4. In journal form, briefly reflect on what you were like when you were the age of your students. Think of both a positive and negative incident and of something you needed from the school that you got and something that you didn't get.

5. Any other activity you would like to do and share at the session.

II. Warm-up Activity

Small Group Sharing of What Participants Learned from the Presession Assignment (20 minutes).

Create and guide small groups to share and discuss -- briefly -- the presession activity that each member chose.

(A set of "Group Guidelines" is attached for use as is or for adaptation.)

III. Introduction to the Unit

Overview of what the unit covers (10 minutes)

Mental Health Services & Instruction: What a School Nurse Can Do

Points for emphasis:

The unit will cover

- identifying and processing students in need of assistance
  for mental health and psychosocial problems
  >initial problem identification
  >connecting a student with the right help
  screening to clarify need
  client consultation and referral
  triage
  initial case monitoring

- problem response and prevention
  >psychological first aid: responding to a student in crisis
  >primary prevention and treatment
  mental health education
  psychosocial guidance and support
  psychosocial counseling
  >ongoing case monitoring

- consent, due process, and confidentiality

IV. Topic Exploration

A. *Identifying and Processing Students who Need Assistance*

1. Brainstorming in small groups (15 minutes)

   What role and functions can a school nurse play in identifying and screening mental health and psychosocial problems?

   (See the set of "Group Guidelines" included in this guide and use as is or adapt.)

2. Presentation (35-40 minutes)

   (See the unit's text and choose points to highlight.)

   The intent of the presentation is to enhance knowledge and skills about

   a. Initial identification of mental health and psychosocial problems.

   b. Connecting a student with the right help

   - screening/assessment
   - client consultation and referral
   - triage
   - initial case monitoring

Sample "Lesson Plan" (cont.)

B. *Psychosocial Helping Intervention*

1. Brainstorming in small groups (15 minutes)

   Think about the last school crisis event. What was done to deal with students experiencing immediate and subsequent psychological trauma?

   (Again refer to the "Group Guidelines.")

2. Two Presentations (35-40 minutes each)

   (See the unit's text and choose points to highlight.)

   The intent of the presentations are to enhance knowledge and skills about

   a. Psychological first aid.

   b. Mental health education

   c. Psychosocial guidance and support

   d. Psychosocial counseling

   e. Ongoing case monitoring

   f. Consent and confidentiality

Provide follow-up packet -- copies of the written version of the content covered, other follow-up readings, and related resource and technical aids.

V. Explanation of Assignments for Follow-up of this Session (5 minutes)

(See section in Instructor's Guide on *Activity and Materials for Follow-up Learning*)

Some Guidelines for Facilitating Small Groups in Workshops

*(*The following guidelines can be adapted and copied for use as a handout.)

Sharing and Discussion of the Activity You Pursued in Preparing for this Session

Group Guidelines

(1) Form small groups to briefly and informally share and discuss the presession activity that each member chose. The objective is simply to set the tone for what will be explored as part of this unit.

(2) Someone in the group should volunteer to facilitate an "on task" focus.

(3) Someone else in the group should volunteer to be time keeper. There is only 20 minutes for this activity.

(4) Start with volunteers. As a first round, each member should just share a bit of what they learned from her/his chosen activity.

(5) If there is time after each person has shared, begin a discussion of what you see as the major barriers experienced in the classroom that interfere with students' learning.

(The following guidelines can be adapted and copied for use as a handout.)

Brainstorming: What role and functions can a school nurse play in identifying and screening mental health and psychosocial problems?

Group Guidelines

(1) You have 15 minutes for this activity.

(2) Form small groups.

(3) Someone in the group should volunteer to facilitate an "on task" focus.

(4) Someone else should volunteer to "chart" the ideas.

(5) Begin brainstorming -- remember not to criticize any contribution.

(6) If there is time categorize the ideas and rank them according to which seem like the most promising.

Activity and Materials for Follow-up Learning

(The following description can be adapted and copied use as a handout.)

Follow-up Activity

Self-learning

The website at the UCLA Center has many relevant resources for self-learning. Browse the website at http://smhp.psych.ucla.edu/

See, for example, the Virtual Toolbox for Mental Health in Schools. The toolbox reflects a broad view of mental health in schools and of the role mental health plays in the well-being of students, their families, and their teachers. Also stressed is the value of embedding mental health into a comprehensive classroom and school-wide system for addressing barriers to learning and teaching and re-engaging disconnected students as an essential facet of ensuring all students have an equal opportunity to succeed at school. Each section of the toolbox is under continuous development.

While this toolbox is intended as an adjunct to the book Mental Health in Schools: Engaging Learners, Preventing Problems, and Improving Schools (Corwin Press), its contents should be useful to any school practitioner and those involved in pre-and inservice professional development programs.

Work with others

- Reach out for support/mentoring/coaching from:
- Participate with others in clusters and teams
- Request additional staff development on these topics

Use the Center's Self-study Surveys to nap and plan ways to improve how the school addresses mental health concerns in classrooms and school-wide. These are online at http://smhp.psych.ucla.edu/pdfdocs/surveys/set1.pdf

See especially

General Overview of Student & Learning Supports Activity, Processes, and Mechanisms at a School -- to clarify the current situation at a school site with respect to leadership, planning and implementation teams, processes for referral, triage, case management, and so forth

Student and Family Special Assistance -- to clarify thecurrent situation with respect to specific programs and the processes used to build capacity.

Surveys for Use in Follow-up Learning (cont.)

The other 5 Surveys are:

- **classroom-based efforts** to enhance learning and performance of students with mild-moderate learning, behavior, and emotional problems
- support for **transitions**
- **crisis assistance and prevention**
- **home involvement in schooling**
- outreaching to develop greater **community involvement** and support -- including recruitment of volunteers

*

Mental Health in Schools: New roles for school nurses

Test Questions and Answers

Questions

Unit I: Section A

(1) Which of the following were identified as potential interveners who could play a role could play a role in counseling, psychological, and social service activity at a school?

____(a) counselors
____(b) nurses
____(c) teachers
____(d) aides
____(e) students
____(f) a & b
____(g) a, b, & e
____(h) all the above

(2) With respect to the activities carried out by such interveners, enumerate two specific functions related to

(a) providing direct services and instruction

_____

_____

(b) coordinating, developing, and providing leadership for programs, services, and systems

_____

_____

(c) enhancing connections with community resources

_____

_____

(3) Which of the following is ***not*** an emerging trend related to health and psychosocial programs in schools?

___(a) the move *from* narrowly focused *to* comprehensive approaches

___(b) the move *from* fragmentation *to* coordinated/integrated intervention

___(c) the move *from* problem specific and discipline-oriented services *to* less categorical, cross-disciplinary programs

___(d) the move *from* viewing health programs as "supplementary services" *to* policy changes that recognize physical and mental health services as an essential element in enabling learning

___(e) all are emerging trends

(4) Enumerate three possible new roles that school nurses might play in addressing mental health and psychosocial concerns in schools.

_____

_____

_____

Unit I: Section B

(1) Which of the following can be barriers to student learning?

___(a) deficiencies in basic living resources
___(b) psychosocial problems
___(c) underlying psychological problems
___(d) family crises
___(e) transitions such as moving to a new school
___(f) all of the above

(2) Health and social services are designed to address the full range of factors that cause poor academic performance, dropouts, gang violence, teen pregnancy, substance abuse, and so forth.

____True ____False

(3) List five major areas of focus in enhancing healthy psychosocial development.

_____

_____

_____

_____

_____

(4) Current diagnostic systems such as the *Diagnostic and Statistical Manual of Mental Disorders -- DSM IV* do not adequately account for psychosocial problems>

____True ____False

(5) Formal systems for classifying problems in human functioning convey the impression that all behavioral, emotional, or learning problems are due to internal pathology.

____True ____False

(6) Most differential diagnoses of children's problems are made by focusing on identifying one of more internal disorders rather than first asking "Is there a disorder?".

____True ____False

(7) Attributional bias is a tendency for observers to perceive others' problems as rooted in stable personal dispositions.

____True ____False

(8) In the mental health field, the tendency is to see most student's problems as arising from environmental/social factors.

____True ____False

(9) List three characteristics of family-oriented interventions.

Unit I: Section C

(1) Which of the following are implications of understanding a student's problems in terms of a causal continuum that ranges from internal to external causes?

___(a) some problems primarily result from biological or psychological factors
___(b) some problems primarily result from environmental causes
___(c) some problems are caused by the environment not accommodating individual differences and vulnerabilities
___(d) a and b
___(e) all of the above
___(f) none of the above

(2) Improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

_____True _____False

(3) School-Based Health Centers have come to find it necessary to address mental health and psychosocial concerns because

___(a) mental health is more important than physical health
___(b) many students physical complaints are psychogenic
___(c) mental health services are less costly
___(d) many students come to the centers for help with psychosocial problems
___(e) a and b
___(f) a and c
___(g) b and d
___(h) all of the above

(4) With respect to addressing barriers to learning, a comprehensive approach requires more than a focus on health and social services.

_____True _____False

(5) A comprehensive approach to addressing barriers to learning is achieved by outreaching to link with community resources.

_____True _____False

(6) With respect to addressing barriers to learning, a comprehensive approach requires more than coordination of school and community services.

_____True _____False

(7) Moving toward comprehensiveness in addressing barriers to learning encompasses restructuring, transforming, and enhancing (a) relevant school-owned programs and services, (b) community resources, and (c) weaving these school and community resources together.

_____True _____False

Unit II: Section A

(1) Which of the following were discussed as major facets of identifying and processing students in need of assistance for mental health and psychosocial problems?

___(a) initial problem identification
___(b) screening/assessment
___(c) client consultation and referral
___(d) triage
___(e) initial case monitoring
___(f) a, b, d
___(g) a, b, e
___(h) all the above

(2) It is especially hard to know the underlying cause of a problem when a student is not very motivated to learn and perform at school

.

___True ___False

(3) Screening can be used to help clarify the nature, extent, and severity of a problem?

___True ___False

(4) The instrument for screening suicidal risk doesn't ask about

___(a) past attempts, current plans, and view of death
___(b) reactions to precipitating events
___(c) available psychosocial support
___(d) attitudes toward school
___(e) history of risk-taking behavior

(5) Which of the following are a focus of the initial interview/questionnaire instruments

___(a) the student's perception of the problem
___(b) what has been tried previously to deal with the problem
___(c) motivation to do something about the problem
___(d) a, b
___(e) all the above

Unit II: Section B

(1) The immediate objective of psychological first-aid is to

___(a) eliminate the fear individuals experience during and in the immediate aftermath of a crisis
___(b) help individuals deal with troubling psychological reactions during and in the immediate aftermath of a crisis
___(c) tell students counseling will be made available to them
___(d) all of the above

(2) Three phases of crisis intervention are (a) managing the situation, (b) mobilizing support, and (c) following-up.

___True ___False

(3) The following list mixes together general activities related to providing psychosocial guidance and support with specific things that can be done to facilitate student communication in a psychosocial counseling situation.

Put a + before the items that describe general activities related to providing psychosocial guidance and support.

___(a) advising
___(b) providing advocacy and protection
___(c) responding with empathy, warmth, nurturance, and positive regard
___(d) providing support for transitions
___(e) listening with interest
___(f) creating a private space and a climate where the student can feel it is safe to talk
___(g) clarifying the role and value of keeping things confidential
___(h) encouraging the student to take the lead
___(i) providing mediation and conflict resolution
___(j) promoting and fostering opportunities for social and emotional development
___(k) being a liaison between school and home
___(l) being a liaison between school and other professionals serving a student

Unit II: Section C

(1) Which of the following are major aspects of the legal concept of consent?

___(a) a person must have the capacity to consent
___(b) a person must have appropriate and sufficient information before being asked to consent
___(c) a person's consent must be given voluntarily
___(d) a and b
___(e) a and c
___(f) b and c
___(d) all of the above

(2) It is important to maintain a client's confidentiality to protect embarrassing information from disclosure.

___True ___False

(3) It is important to maintain a client's confidentiality to minimize the likelihood of discrimination against the person.

___True ___False

(4) It is important to be able to offer confidentiality to encourage individuals to use services.

___True ___False

(5) Identify two major exceptions to client confidentiality in a psychosocial counseling situation.

_____ _____

Unit III: Section A

(1) Of the various necessary ingredients in building positive working relationships, list three of those covered in this unit.

_____

_____

_____

(2) Enumerate three of the five cultural competence values as defined by Mason, Benjamin, & Lewis (1996).

_____

_____

_____

(3) There is a danger inherent in making prejudgments based on apparent cultural awareness.

True ____ False____

(4) Poor working relationships arise whenever there are individual, racial, or cultural differences.

True ____ False____

(5) Which of the following are things to do to help build working relationships and effective communication?

____ (a) convey empathy and warmth

____ (b) convey genuine regard and respect

____ (c) talk with, not at, others

____ (d) a & b

____ (e) all the above

Unit III: Section B

(1) Enumerate two of the basis tasks for primary managers of care as discussed in this unit.

_____

_____

(2) Enumerate two of the major functions of a school-based team designed to manage resources as discussed in this unit.

_____

_____

(3) Parents can be part of a management of care team.

True ____ False____

(4) Perhaps the most valuable aspect of mapping and analyzing a school's resources for addressing barriers to learning and promoting healthy development is that the products provide a sound basis for improving cost-effectiveness.

True ____ False____

(5) A school-based Resource Coordinating Team has the same functions as a team created to review individual students.

True ____ False____

Unit III: Section C

(1) Indicate three primary and essential components discussed in this unit that need to be addressed in reform efforts by schools/communities.

_____

_____

_____

(2) Enumerate six program areas of an Enabling Component.

_____

_____

_____

_____

_____

_____

(3) The concepts of (a) an Enabling Component and (b) School linked services are different terms for the same approach to addressing barriers to learning and enhancing healthy development.

True ____ False____

(4) School-owned enabling activity -- such as pupil services and the multi-components of a school health program -- must be coordinated and integrated not only with each other but with community-owned resources.

True ____ False____

Answers

Unit I: Section A

(1) h
(2) Two from each of the following three categories:

Direct services and instruction

- Identifying and processing students in need of assistance (e.g., initial screening, gatekeeping and triage, client consultation, referral, initial monitoring of care)
- Indepth assessment (individuals, groups, classroom, school, and home environments)
- Crisis intervention and emergency assistance (e.g., psychological first-aid and follow-up; suicide prevention; emergency services, such as food, clothing, transportation)
- Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness (e.g., guidance counseling; contributing to development and implementation of health and violence reduction curricula; placement assistance; advocacy; liaison between school and home; gang, delinquency, and safe-school programs; conflict resolution)
- Transition and follow-up (e.g., orientations, social support for newcomers, follow-thru)
- Treatment/therapy/counseling, remediation, rehabilitation (incl. secondary prevention)
- Increasing the amount of direct service impact through ongoing management of care multidisciplinary teamwork, consultation, training, and supervision

Coordination, development, and leadership for programs, services, resources, systems

- Needs assessment
- Coordinating activities (e.g., participating on resource coordinating teams to enhance coordination across disciplines and components; with regular, special, and compensatory educ.; in and out of school)
- Mapping and enhancing resources and systems
- Developing new approaches (incl. facilitating systemic changes)
- Monitoring and evaluating intervention for quality improvement, cost-benefit accountability, research
- Advocacy for programs and services and for standards of care in the schools
- Pursuing strategies for public relations and for enhancing financial resources

Enhancing connections with community resources

- Strategies to increase responsiveness to referrals from the school
- Strategies to create formal linkages among programs and services

(3) e
(4) Any of the following:

- providing direct services and instruction related to mental health and psychosocial concerns
- consulting with teachers and others at the school regarding how to better address mental health and psychosocial concerns
- advocating for school-based programs and services to address mental health and psychosocial concerns
- facilitating system reforms to ensure that mental health and psychosocial concerns are addressed
- coordinating resource integration related to mental health and psychosocial concerns
- outreaching to increase collaboration with relevant community resources

Unit I: Section B

(1) f
(2) False
(3) Five of the following:
- Responsibility and integrity
- Self-esteem
- Social and working relationships
- Self-evaluation/self-direction/self-regulation
- Temperament
- Personal safety and safe behavior
- Health maintenance
- Effective physical functioning
- Careers and life roles
- Creativity

(Credit may be given if a specific example of any category given in text is listed.)
(4) True
(5) True
(6) True
(7) True
(8) False
(9) Three of the following:
- Enhancing a sense of community
- Mobilizing resources and supports
- Shared responsibility and collaboration
- Protecting family integrity
- Strengthening family functioning
- Proactive human service practices

Unit I: Section C

(1) e
(2) True
(3) g
(4) True
(5) False
(6) True
(7) True

Unit II: Section A

(1) h
(2) True
(3) True
(4) d
(5) e

Unit II: Section B

(1) b
(2) True
(3) + for items a, b, d, i, j, k, l

Unit II: Section C

(1) d
(2) True
(3) True
(4) True
(5) Two of the following
- student is being abused
- student has a plan to seriously hurt someone else
- student has a plan to seriously hurt self

Unit III: Section A

(1) Three of the following:
- minimizing negative prejudgments about those with whom you will be working
- 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

(2) Three of the following:
- Valuing Diversity
- Conducting Cultural Self-Assessment
- Understanding the Dynamics of Difference
- Incorporating Cultural Knowledge
- Adapting to Diversity

(3) True
(4) False
(5) e

Unit III: Section B

(1) Two of the following:
- 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 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.

(2) Two of the following:
- assessing needs
- mapping resources
- coordinating resources
- analyzing resources
- enhancing resources

(3) True
(4) True
(5) False

Unit III: Section C

(1) The 3 components are:
- Instructional Component
- Enabling Component
- Management Component.

(2) The six program areas are:
- Classroom-Focused Enabling
- Student and Family Assistance
- Crisis Assistance and Prevention
- Support for Transitions
- Home Involvement in Schooling
- Community Outreach for Involvement and Support

(3) False
(4) True