A Center Report . . .

About Connecting Students with the Right Forms of Mental Health Assistance

(November, 2021)

School systems are not responsible for meeting every need of their students.
But when the need directly affects learning, the school must meet the challenge.
Carnegie Council on Education Task Force

Broadly conceived, mental health in schools focuses on (1) promoting social-emotional development, (2) preventing mental health and psychosocial problems, (3) enhancing resiliency and protective buffers, (4) intervening as early after the onset of behavior, learning, and emotional problems as is feasible, and (5) addressing the needs of students with chronic and severe problems. Based on our Center's work with schools, this report begins by highlighting that mental health assistance at schools can take the form of (a) open-enrollment programs, (b) direct instruction, (c) psychosocial counseling, and when problems are severe,(d) highly specialized interventions. Then, we delineate processes for connecting students with the right assistance (i.e., identifying and clarifying need, triage, consultation, referral, and monitoring/managing care). We also highlight the mental health dilemma that arises in responding to schoolwide crises and end with a note about diversity.

The Center for MH in Schools & Student/Learning Supports is co-directed by
Howard Adelman and Linda Taylor, Dept. of Psychology, UCLA.
Website: http://smhp.psych.ucla.edu
Contact: adelman@psych.ucla.edu or Ltaylor@ucla.edu

Contents

About Connecting Students with the Right Forms of Mental Health Assistance

No one is certain of the exact number of students whose behavior, learning, and emotional problems could benefit from mental health assistance. There is consensus, however, that many need such supports, and the problem has been compounded by the COVID-19 and social injustice crises.

And schools are being called on to help meet the need.

While the need is clear, there is no consensus when it comes to the question:

What should schools do in addressing mental health concerns?

Focusing only on the problems of specific students and pursuing clinical interventions tends to limit thinking about this question. In particular, such a narrow focus biases perceptions and attributions of what has caused the problems and what needs to change.

When a student is identified as having a problem, the first question is **not** necessarily:

What's wrong with the youngster?

Rather, an equally justifiable first question is:

Are external factors causing the problem?

Asking that question encourages assessment of conditions in the environment that need attention in correcting the problem of the student and other students as well. For a significant number of problems, changing environments and improving intervention are necessary and sometimes sufficient steps in preventing and correcting a problem at school. Of course, whether or not a problem resides with the environment, students may require some special assistance. Such practices and processes are outlined in this report with an emphasis on students at school and those who are in some phase of transitioning back after the COVID-19 school closures.

Schools offer a particularly good venue for students to find help. A challenge for school staff is how to encourage students (and families) to do so. This involves more than outreaching and ensuring students receive and understand information about what assistance is available and how to access it. School personnel must build student and family confidence and trust and guarantee privacy and confidentiality.

In reporting on school laws and policies, before the COVID-19 pandemic, the Centers for Disease Control and Prevention (CDC) noted the following about mental health assistance provided by schools:

> All states allow for the provision of counseling, psychological, and social services in school settings, but the scope and content of these services vary across states, school districts, and individual schools. State laws do not typically require that all students have access to specific services at school or outline how services should be provided. Nevertheless, access to and eligibility for mental health services in schools are widespread. A recent report by SAMHSA concluded that all students were eligible to receive mental health services in 87% of schools surveyed. ... These services include individual and group assessments, interventions, and referrals. ...
>
> Students may need treatment for mental health conditions ranging from depression and suicidality to attention deficit/hyperactivity disorder (ADHD) and stress. Schools may also provide a number of other counseling and social services, such as counseling and treatment for eating disorders, substance abuse, tobacco use, and physical, sexual, or emotional abuse. ...

Schools may facilitate counseling, psychological, and social services through multiple mechanisms, including on-site services by a variety of professionals employed by the school (e.g., school counselors, psychologists, nurses, and social workers), delivery of services by SBHCs, and referrals to off-site health providers (with appropriate prior written consent if personal information is disclosed). ...

Treatment services or referrals are widely available in schools. Some states have initiated proactive measures to expand access to school mental health services. ... Others mandate that schools implement programs to detect and treat substance abuse. ...

Recommending the use of psychotropic drugs has been a contentious issue at the state level. Several states, including Connecticut, Illinois, Texas, and Virginia, prohibit school officials from recommending that students use psychotropic drugs.

See the CDC website for updates on adolescent and school health policy
https://www.cdc.gov/healthyyouth/policy/index.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhealthyyouth%2Fabout%2Fpolicy.htm

Note that CDC stresses mental health interventions as *services*. However, in providing special assistance, schools offer more than services. Exhibit 1 outlines a flow chart to illustrate a broad range of interventions and a systematized set of processes that schools can (but don't always) use when addressing student problems.

Broadly conceived, mental health in schools focuses on:

>promoting social-emotional development

>preventing mental health and psychosocial problems

>enhancing resiliency and protective buffers

>intervening as early after the onset of behavior, learning, and emotional problems as is feasible

>addressing the needs of students with chronic and severe problems

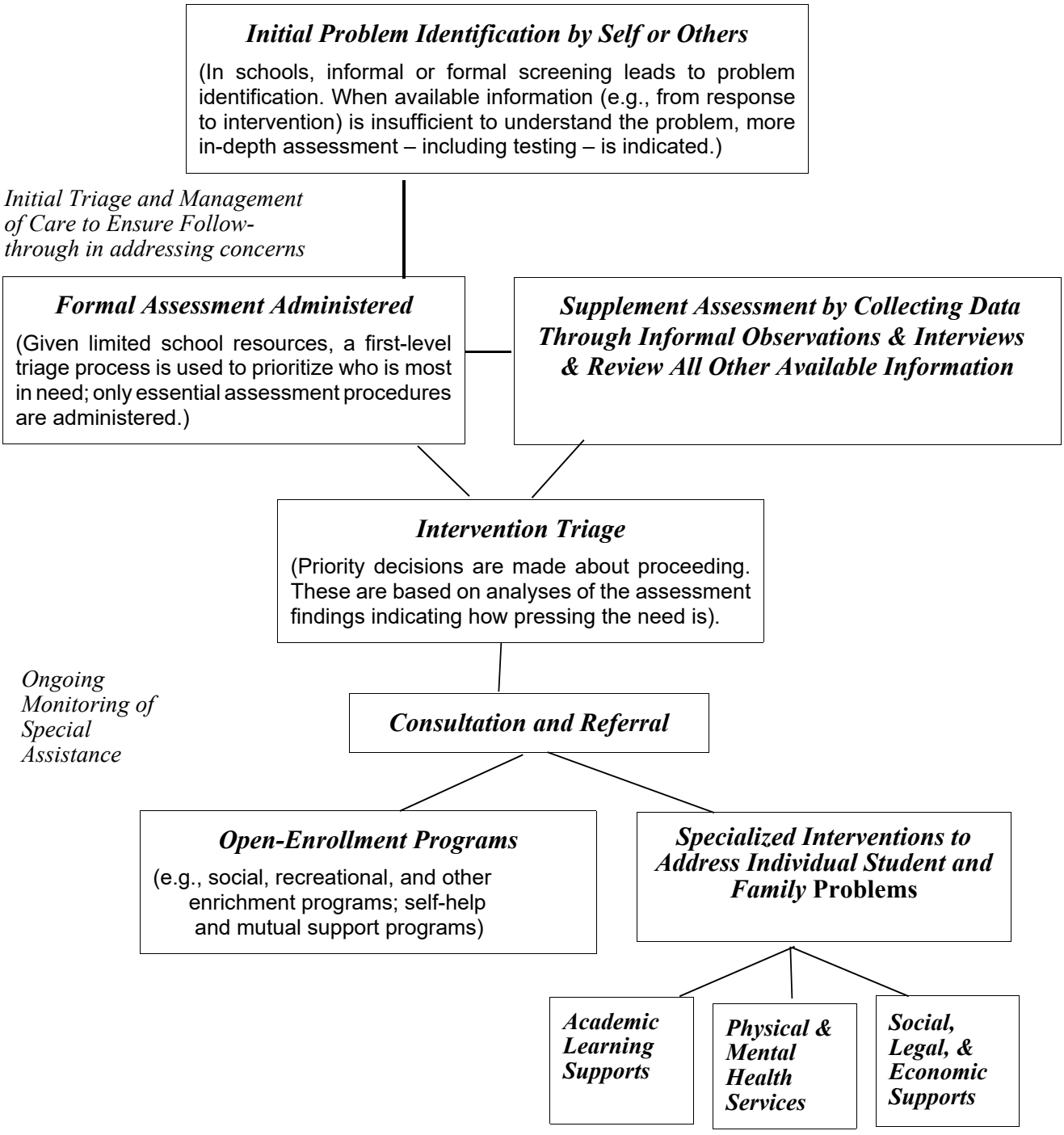
Forms of Mental Health Assistance at Schools

In providing the various forms of social, physical and mental health assistance, schools use a variety of personnel. Some are employed by the school district (e.g., school, psychologists, counselors, social workers, nurses) and some are from the community. At school, special assistance may be carried out in classrooms, school offices, or health/wellness centers; a few districts have centralized special mental health clinics. Schools also have pursued initiatives to establish formal connections with community agencies and their services.

(1) *Open-enrollment Programs.* Schools can use a variety of open-enrollment programs to foster and enhance positive mental health and social-emotional functioning. Examples are after school clubs and intramural sports; service learning and job shadowing programs; music, drama, art, and crafts classes. Other such opportunities include helping establish strategies to change the school environment in ways that make it safer, more inviting, and accommodating. And students can take leadership roles in welcoming programs for new students and families and in peer tutoring, mediation, counseling, and mentoring programs. Other examples are found among the many online activities that students pursue regularly, and those they accessed while at home during the COVID-19 crisis.

Exhibit 1

Processes for Problem Identification, Triage, Referral, & Management of Interventions



Note: Proper application of special assistance involves ongoing assessment, information sharing, and care monitoring and management. These processes can be facilitated by a computerized information management system (with effective privacy safeguards). 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.

(2) *Direct instruction*. This form of intervention can be used to enhance coping with mental health problems. Such interventions use didactic approaches to teach specific knowledge, skills, and attitudes and compensatory strategies. This work can be done individually or in a small group, in or out of classrooms.

While direct instruction tends to emphasize cognitive and metacognitive processes, we stress that it is essential to attend to emotional and motivational concerns. In this respect, the less one understands about a student's background and experiences and current states of being, the harder it may be to create a good intervention fit. This problem is at the root of concerns about working with students who come from different cultures. More broadly, it is the basic concern that arises in addressing a host of individual differences.

(3) *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. Personalized guidance and support is best provided on a regular basis in the classroom and at home. The COVID-19 crisis made this form of intervention especially important.

Guidance and support involves a range of potential activity:

>Advising
>Advocacy and protection
>Providing support for transitions (e.g., orienting students and connecting them with social support networks, phasing in returning students, 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

Self-determination theory suggests the importance of enhancing a student's feelings of competence, personal control, and self-direction

School staff can (a) directly provide support, (b) facilitate support through various activities and peer support strategies, and (b) mobilize and enhance support from those at home.

(4) *Psychosocial Counseling*. Most psychosocial counseling done by school staff is short-term. Some is informal – brief encounters with students who drop-in or are encountered on campus or have made telecommunication contact. While school counseling has some of the characteristics of psychotherapy, it is a less intensive form of a helping relationship. It requires the ability to carry on a productive dialogue and involves active listening, conveying empathy, warmth, nurturance, genuine regard and respect. It also requires conveying to the student that

>something of value can and will be gained from the experience

>the person doing the counseling is someone who can help and can be trusted and the situation is safe for saying what's on one's mind.

(5) *Highly Specialized Interventions for Severe Problems.* Any and all of the forms of special assistance can apply to students who have severe mental health problems. In addition, such students require *extensive accommodations and specialized, intensive help*.

Legislation spells out the rights and entitlements of such students to assure appropriate special assistance is provided them. For example, Section 504 of the 1973 Rehabilitation Act (anti-discrimination, civil rights legislation) provides a basis for a school to provide special accommodations for any student who (1) has or (2) has had a physical or mental impairment which substantially limits a major life activity or (3) is regarded as disabled by others. The disabling condition need only limit one major life activity in order for the student to be eligible. Children receiving special education services under the Individual's with Disabilities Education Improvement Act are also protected by Section 504.

While accommodations are appropriate for any student, they are especially important when

>a student shows a pattern of not benefitting from instruction
>retention is being considered
>a student exhibits a chronic health or mental health condition
>a student returns to school after being hospitalized
>long-tem suspension or expulsion is being considered
>a student is evaluated and found not eligible for Special Education services or is transitioning out of Special Education
>substance abuse is an issue
>a student is "at risk" for dropping out
>a student is taking medication at school

Current policy calls for ensuring that only those who cannot be helped effectively in the mainstream are referred to special settings such as remedial classrooms, "alternative" schools, and institutions

Accommodations to meet educational needs may focus on the curriculum, classroom and homework assignments, testing, grading, and so forth. Offering accommodations in regular classrooms can reduce unnecessary referrals for special assistance. (See examples of accommodations in Appendix A.)

Most mild to moderate problems belong in mainstream settings. This is feasible through modifying the physical setting, instituting special accommodations, and/or adding extra (ancillary) services. Ancillary assistance includes (1) extra instruction such as tutoring; (2) enrichment opportunities such as pursuit of hobbies, arts and crafts, and recreation; (3) psychologically oriented treatments such as individual and family therapy; and (4) biologically oriented treatments such as medication. When decisions are made to include such interventions, increasing attention is given to empirically supported treatments.

Even when special placements are made, it is expected that significant efforts will be made to engage these students part of the time in regular classrooms and other "mainstream" programs in which they are able to function with appropriate accommodations and special assistance.

Telemental Health and Psychological Tele-Assessment

In 2015, Gloff, LeNoue, Novins and Myers noted:

> Telemental health (TMH) offers one approach to increase access. TMH programmes serving young people are developing rapidly and available studies demonstrate that these services are feasible, acceptable, sustainable and likely as effective as in-person services. TMH services are utilized in clinical settings to provide direct care and consultation to primary care providers (PCPs), as well as in non-traditional settings, such as schools, correctional facilities and the home.[1]

While telemental health has been a focus by some schools (especially in rural areas), TMH became a major practice in responding to student needs when school closed because of the CODID-19. Federal and state legislation and regulation has rapidly changed in response to the pandemic in order to increase availability of such services.

Reviews of research on telemental health indicates efficacy for diagnosis and assessment across many populations (adult, child, geriatric, and ethnic) and in reducing pain, disability, depression, and anxiety comparable to traditional face-to-face encounters and without significant risks or adverse effects. Clients and practitioners are largely satisfied; concerns have focused on technological, quality, privacy, safety, and costs. Also referred to as online counseling or online therapy, telemental health is now on the agenda of more mental health licensure boards.[2]

While most distance psychological services during the COVID-19 crisis were focused on using online teleconferencing technology for face-to-face contact with students and parents, psychological tele-assessment also blossomed. Test publishers formulated remote testing options, and the American Psychological Association formulated a special set of guidance principles for doing assessments under physical distancing constraints.[3]

[1] Gloff, N.E., LeNoue, S.R., Novins, D.K., & Myers, K. (2015). Telemental health for children and adolescents. *International Review of Psychiatry,27*, 513–524. doi:10.3109/09540261.2015.1086322

[2] Abrams J, Sossong S, Schwamm LH, et al. (2017). Practical issues in delivery of clinician-to-patient telemental health in an academic medical center. *Harvard Review of Psychiatry, 25,* 135–145. doi:10.1097/HRP.0000000000000142

Conrad, R., Rayala, H., Diamond,R., et al., (2020). Expanding telemental health in response to the COVID-19 Pandemic. *Psychiatric Times.* https://www.psychiatrictimes.com/coronavirus/expanding-telemental-health-response-covid-19-pandemic

Cowan, K.E., McKean, A.J., Gentry, M.T., & Hilty, D.M. (2019). Barriers to use of telepsychiatry: Clinicians as gatekeepers. *Mayo Clinic Proceedings, 94*, 2510–2523. doi:10.1016/j.mayocp.2019.04.018

Hilty, D.M., Ferrer, D.C., Parish, M.B., et al., The effectiveness of telemental health: A 2013 review. *Telemedicine journal and e-health :The official journal of the American Telemedicine Association,* 19, 444–454. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662387/?fbclid=IwAR3xtzZHjb9PcMMo47PNehxsQMcb_CvEWAw2-e_5l9EOAjUOOCQxK6cfHJo

Kruse C. S., Karem, P., Shifflett, K., Vegi, L., Ravi, K., & Brooks, M. (2018). Evaluating barriers to adopting telemedicine worldwide: A systematic review. *Journal of Telemedicine and Telecare, 24,* 4–12. https://pubmed.ncbi.nlm.nih.gov/29320966/

Wiki guide to telepsychology https://en.wikiversity.org/wiki/Helping_Give_Away_Psychological_Science/Telepsychology

[3] Wright, A.J., Mihura, J.L., Pade, H., & McCord, D.M. (2020). *Guidance on psychological tele-assessment during the COVID-19 crisis*. Washington, D.C.: American Psychological Association. https://www.apaservices.org/practice/reimbursement/health-codes/testing/tele-assessment-covid-19

Connecting Students with the Right Mental Health Assistance

School personnel frequently identify mental health problems, and requests for specialized assistance to address such problems are common. As noted above, many problems can be prevented and corrected through classroom redesign that provides supports and accommodations.

When referral for specialized assistance is necessary, schools must have well-designed processes to connect them with the right help. The following discussion organizes such processes in terms of (1) identifying and clarifying need, (2) conducting triage, (3) providing client consultation and referral, and (4) monitoring and managing care. Exhibit 2 provides a resource outlining some specific practices for connecting a student with help and monitoring what happens. A toolbox of relevant resources is provided at http://smhp.psych.ucla.edu/summit2002/toolbox.htm .

Identifying and Clarifying Need

In many instances, the primary causes of a student's behavior, learning, and emotional problems cannot be determined. Is the problem the result of

>a central nervous dysfunction or some other biological disorder (e.g., true ADHD, LD, clinical depression)?

>early deprivation (e.g., a lack of school readiness opportunities, living in an unhappy home environment, the product of negative peer influences)?

Determining underlying cause is especially difficult after a student becomes unmotivated to perform.

Commonly, students are identified as candidates for special assistance through a formal or informal initial assessment which, in essence, is a first-level screening process. Formally done, such screening provides an initial set of data about the nature, extent, and severity of a problem. It also can help clarify the student's motivation for addressing the problem. The involvement of significant others, such as family members, also can be explored. First-level screening provides a foundation for more indepth assessment and if appropriate, a formal diagnosis.

At the same time, because of the deficiencies of first-level screening, a systematic process is required to ensure initial identification is done as validly as possible and with appropriate safeguards. To this end, those requesting special assistance for a student should provide a detailed description about the nature and scope of the identified problem. This includes any information on the contributing role of environmental factors. In addition, to create a balanced picture, information should be provided on a student's assets as well as weaknesses.

Once a request is made, several other sources of available information should be gathered. Useful sources are teachers, administrators, school support staff, recreation supervisors, parents, others who have made professional assessments, and of course, the student. Good practice calls for assessing the student's environment as a possible cause. The seeds of a problem may be stressors in the classroom, home, and/or neighborhood. A home visit is useful.

In gathering information from a student, a screening interview can be conducted. The nature of this interview varies depending on the age of the student and whether concerns raised are general ones about misbehavior and poor school performance or specific concerns about lack of attention; overactivity; major learning problems; suicidal ideation; or about physical, sexual, or substance abuse.

Some behavioral and emotional symptoms may stem from physical problems, and of course, a student may respond to stress with somatic symptoms. Some students are just a bit immature or exhibit behavior that is fairly common at a particular development stage.

Exhibit 2

Some Specific Practices Involved in Connecting a Student with the Right Help and Monitoring the Processes

Problem identification

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

Triage processing

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

Clients directed to resources or for further problem analysis and recommendations

a. For basic necessities of daily living (e.g., food, clothing, etc.), the triage processor should provide information about resources either through the person who identified the problem or directly to the student/family in need.
b. If the problem requires a few sessions of immediate counseling to help a student/ family through a crisis, the triage processor should send the form to the person who makes assignments to on-site counselors.
c. The forms for all others are directed to a small triage "team" (1-3 trained professionals) for further analysis and recommendations. (If there is a large case load, several teams might be put into operation.) Members of such a team may not have to meet on all cases; some could be reviewed independently with recommendations made and passed on the next reviewer for validation. In complex situations, however, not only might a team meeting be indicated, it may be necessary to gather more information from involved parties (e.g., teacher, parent, student).

Interventions to ensure recommendations and referrals are pursued appropriately

a. In many instances, additional prereferral interventions should be recommended. Some of these will reflect an analysis that suggests that the student's problem is really a system problem – the problem is more a function of the teacher or other environment factors. Other will reflect specific strategies that can address the students problem without referral for outside the class assistance. Such analyses indicate ways in which a site must be equipped to implement and monitor the impact of prereferral recommendations.
b. When students/families need referral for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Care management should be designed to determine follow-through, coordination, impact, and possible need for additional referrals.
c. Referrals to assess the need for special or compensatory education often are delayed because of a waiting list. Back logs should be monitored and arrangements made to catch-up (e.g., by organizing enough released time to do the assessments and reviews).

Management of care

a. Some situations require only a limited form of monitoring (e.g., to ensure follow-through). A system must be developed for assigning care monitors as needed. Aides and paraprofessionals often can be trained to for this function.
b. Other situations require intensive management by specially trained professionals to (1) ensure interventions are coordinated/integrated and appropriate, (2) continue problem analysis and determine whether appropriate progress is made, (3) determine whether additional assistance is needed, and so forth. There are many models for intensive management of care. For example, one common approach is to assign the responsibility to the professional who has the greatest involvement (or best relationship) with the student/family.
c. One key and often neglected function of the care manager is to provide appropriate status updates to all parties who should be kept informed.

As the examples outlined below indicate, age, severity, pervasiveness, and chronicity are important considerations in analyzing mental health problems. Depending on such matters, some problems are common and transient; others are low-frequency and serious disorders.

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	>Reactive Attachment Disorder
	(Sometimes with somatic complaints)	>Conduct Disorder
	>Disobedient, temper outbursts	>Attention Deficit-Hyperactivity Disorder
	>Very active; doesn't follow directions	>Learning Disorder
	>Has trouble learning at school	>Depression
8-12	>Low self-esteem	>Oppositional Defiant Disorder
12-15	>Defiant/reactive	>Substance Abuse
15-18	>Experimental substance use	

If screening suggests the need for more indepth assessment to prescribe specific forms of specialized assistance (either at the school or in the community), the next step is referral for such assessment. To be of value, such assessment must lead to help; in the process, a diagnosis and recommendation for special education services may be generated.

However, in analyzing assessment findings, we caution that a student's behavior, learning, and emotional problems are symptoms (i.e., correlates). Unless valid *signs* are present clarifying what is causing problems, prematurely concluding the student has a pathological disorder is unwarranted.

Triage

Given that schools never have enough resources for all the students who need special assistance, processing such students inevitably involves a form of gatekeeping – referred to in clinical circles as triage. A paradox related to this is that when a school develops efficient processes for problem identification and student review, the number of students sent for review tends to increase.

Ideally, a school will stem the tide of students sent for review by enhancing its prevention practices (e.g., welcoming and providing social supports and ensuring that students make a good adjustment to a new school and/or a new classroom). Also, increased emphasis on well-designed prereferral interventions and response to intervention (RtI) strategies can reduce the need for special assistance outside the classroom.

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

To further stem the tide of students sent for review, those who process the requests need to spend some time

>analyzing the general nature of the problems being sent with a view to identifying changes in the classroom and school that could minimize the need for similar requests in the future

>helping develop and implement the changes.

A Note About Mental Health Screening

The Centers for Law and the Public's Health reported in 2008:

State laws set up a framework within which schools may conduct screening for mental health conditions among students. Screening may occur for a number of conditions, including depression, suicide, substance abuse, eating disorders, ADHD, and physical and emotional abuse. Research indicates that assessment of mental health problems or disorders (including behavioral observation, psychosocial assessment, and psychological testing) is offered in nearly 90% of schools....

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 overidentify 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.

Minimal controversy exists about one form of first-level screening. Each year a great many parents and teachers identify significant numbers of children soon after the onset of a problem. This natural screening can be helpful in initiating supportive accommodations that can be incorporated into regular school and home practice. Then, by assessing the response of these children to such interventions (e.g., RtI), it can be determined whether more specialized intervention is needed to overcome a problem.

Whether formal or natural, first-level screening primarily is meant to sensitize responsible professionals. No one wants to ignore indicators of significant problems. At the same time, constant vigilance is necessary to guard against tendencies to see normal variations in students' development and behavior and other facets of human diversity as problems. First-level screens do not allow for definitive statements about a student's problems and need. At best, most such screen- ing procedures provide a preliminary indication that something may be wrong. In considering for- mal diagnosis and prescriptions for how to correct the problem, one needs data from assessment procedures that have greater validity. Remember that many symptoms of problems also are com mon characteristics of young people, especially in adolescence.

Extreme caution clearly must be exercised to avoid misidentifying and inappropriately stigmatizing children and adolescents. Overestimating the significance of a few indicators is a common error. Moreover, many formal screening instruments add little predictive validity to natural screening.

At best, first-level screening procedures provide a preliminary indication that something may be wrong

Consultation and Referral

Using all information gathered, the next step is to sit down with concerned parties (student, family, other school staff) to explore what's wrong and what to do about it. This intervention is a consultation and referral process. The objective is to assist family and school staff with problem solving and decision making in ways that lead to appropriate forms of help.

Referrals for special assistance are commonplace at school sites and relatively easy to make; the process of arriving at *appropriate* referrals is harder. And, ensuring *access and follow-through* is the most difficult process. To these ends, schools can

>provide ready reference to information about appropriate school- or community-based referrals

>maximize follow-through by using a *consumer oriented consultation process* that involves students and families in all decisions and helps them deal with potential barriers.

Referrals are easy to make . . . unfortunately, data suggest follow-through rates of less than 50% for referrals made by schools

Ensuring the process is consumer oriented begins with full appreciation of the nature and scope of a student's problems as perceived by the student, the family, and school staff. Then, the consultation process is designed as a shared problem-solving approach with the final decisions controlled by the student and family. The steps in the problem-solving process are:

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

>clarifying possible alternative ways to proceed given what's available

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

>detailing the steps involved in connecting with potential resources and formulating a sound plan for access ands follow-through on decisions

>following-up to be certain of access and follow-through.

The focus is on both external and internal factors related to the problem. This includes environmental concerns such as basic housing and daily survival needs, family and peer relations, and school experiences. For example, a student's needs may range from not having adequate clothes to requiring protection from the harassment of gang members.

In many instances, a referral is not really needed. What is called for is mobilizing the school staff to address how they might improve programs. Key is expanding students' opportunities in ways that increase expectations about a positive future as a basis for countering student frustration, unhappiness, apathy, and hopelessness.

Obviously, the above processes can take more than one session and may require repeating if follow-through is a problem. In many cases, one must take specific actions to help with follow through, such as making direct connections (e.g., by phone) to the intake coordinator for a program.

Extreme cases may require extreme measures such as arranging for transportation or for someone to actually go along to facilitate enrollment. It is important to do an immediate check about follow-through (e.g., within 1-2 weeks) to see how well a student has connected with help. If the student hasn't, the contact can be used to find out what needs to be done next.

Exhibit 3 provides a resource tool that briefly summarizes steps in the assessment and consultation process.

Appendix B provides a benchmark checklist for a consumer-oriented, problem-solving consultation process.

Exhibit 3

Examples of Some Specific Steps in Assessment and Consultation Processes

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

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

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

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

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

(6) Holding problem solving conference(s) with immediately concerned parties to

- analyze problems and in the process review again whether other information is needed (and if so arranging to gather it)
- arrive at an agreement about how a problem will be understood for purposes of generating alternatives
- generate, evaluate, and make decisions about which alternatives to pursue
- formulate plans for pursuing alternatives (designating support strategies to ensure access and follow-through)

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

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

In supporting the process, school staff can cultivate referral resources to maximize their responsiveness to school referrals.

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

Monitoring/ Managing Care

Common professional terminology designates student with problems as "cases." Thus, processes for making certain that students connect with special assistance often are discussed as "case monitoring" and efforts to coordinate and integrate interventions for a student are designated "case management."

Given that words profoundly shape the way people think, feel, and act, some professionals want to replace *case* with *care.* Such a move is in keeping with the view that care is a core value of helping professionals. The change also is consistent with moves to ensure that schools are "caring communities." For these reasons, it seems appropriate to replace the term case management with *management of care*. Management of care involves

From the time a student is first identified as having a problem, someone must monitor/manage efforts to ensure the student gets appropriate help

(1) initial monitoring, (2) ongoing management of the individual's care, and (3) management within and across systems of care. The intent, as with any intervention, is to implement the work in ways that are developmentally and motivationally appropriate, as well as culturally sensitive.

(1) *Initial Monitoring of Care*. Stated simply, monitoring of care is the process by which it is determined whether a student is appropriately involved in needed special programs and services. Initial monitoring by school staff focuses on whether a student/family has connected with the program and/or service. Monitoring of care gathers information about follow-through and appropriateness.

An immediate check on referral follow-through (e.g., within 1-2 weeks) should be done to see if the student did connect effectively with help. Besides checking with the student and family, a follow-through report from those pro- viding interventions is helpful. If there has been follow-through, initial contacts are used to evaluate whether the resource is meeting the need. The opportunity also can be used to establish communication and coordina tion with others involved with the student's welfare. Where follow-through has not occurred, the process can determine why and offer additional consultation.

(2) *Ongoing Management of Care*. When a student is working with more than one intervener, management of care becomes a consideration. Monitoring can lead to ways to coordinate interventions, improve quality (including revising interventions as appropriate), and enhance cost-efficacy. Continuing evaluation of intervention appropriateness and effectiveness is the essence of care management.

Monitoring can use a variety of formats (e.g., written communications, phone conversations, electronic communications). All intervention monitoring and 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 remind staff when the next contact is scheduled.

If the student has not successfully connected with help or if the help isn't satisfactory, another consultation can be scheduled to determine next steps. Exhibit 4 provides a resource tool for management of care.

(3) *Systems of Care*. The concept of a system of care is an evolving idea that is applied in a variety of ways. While management of care is focused on a given client, the concept of systems of care emphasizes the value of coordinating, integrating, and enhancing systems and resources. One goal is to ensure that appropriate programs are available, accessible, and adaptable to the needs of those who need help. Another is to ensure resources are used effectively and efficiently.

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

From its initial application, the concept of systems of care emphasized services for clients with severe and well-established problems (e.g., youngsters with serious emotional disturbance).

The intent for such populations is to

>develop and provide a full array of community-based programs (including residential and non-residential alternatives to traditional inpatient and outpatient programs) to enhance what is available and reduce overreliance on out-of-home placements and overly restrictive treatment environments;

>increase interagency collaboration in planning, developing, and carrying out programs to enhance efficacy and reduce costly redundancy;

>establish ways that interventions can be effectively adapted to the individuals served.

To expand these goals to encompass prevention, there are increasing calls for incorporating a focus on primary and secondary prevention into all systems of care.

Exhibit 4

Ongoing Management of Care

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

- Enhanced monitoring of care with a specific focus on the appropriateness of 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 Care Management is based upon the ability to do the following:

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

A few basic guidelines for primary managers of care are as follows:

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

About the Dilemma of Responding to Schoolwide Crises: Mental Health Considerations

Before schools respond to an individual student after a crisis that affects the whole school, there must a school-wide response. And, with respect to events such as a school shooting, schools must enhance security and violence prevention efforts. As a result, every school is confronted with the dilemma of how to do all this without too much cost to a positive school climate and to the mental health of students.

One facet of this dilemma is reflected in a request sent to our Center:

> *I am the coordinator of all crisis work in our school district. As part of this responsibility I am charged with making sure that all of our school continue to practice the districts crisis plans and procedures during our various and state required drills. We have a number of drills during our school year that consist but are not limited to:lock-down, lock-out, severe weather, fire, emergency evacuation etc. We have been doing both announced and unannounced drills to prepare students and staff in the event a crisis occurs. I am seeking information, research and advice on psychological effect, if any, these drills have on children and adolescents.*

This as a true dilemma (i.e., no win-win answer is likely, only strategies to balance costs and benefits). Research on the matter is sparse. The evidence is that much more attention is paid to school safety and security (e.g., metal detectors, uniformed security officers, crisis response drills) than to minimizing negative consequences. Significant research is not available on the effectiveness and possible unintended negative effects on students and on school climate.

The dearth of research, of course, is no excuse for not considering matters such as the psychological effects of multiple emergency drills. Indeed, crisis response planners must reflect on such questions as the following:

>Do the frequent drills set a tone in the school of heightened concern about personal safety for some students? Raise anxiety?
>Do frequent drills produce complacency on the part of some staff and students?
>Is there resentment on the part of the teaching staff because of the loss of time for instruction?
>Does the "excitement" of a drill disinhibit some students and result in deviant behaviors?
>Do some student view drills as an opportunity for disrupting the school day and thus initiate false fire alarms, hoax phone calls regarding bombs, and so on?

See Appendix C for an introduction to Psychological First Aid in Responding to a Student in Crisis For more on *Crisis Assistance and Prevention*, see Ch. 17 in *Embedding Mental Health in Schools as Schools Change* http://smhp.psych.ucla.edu/improving_school_improvement.html. Also, see our Center's online clearinghouse Quick Find on *Safe Schools and Violence Prevention* at http://smhp.psych.ucla.edu/qf/p2108_03.htm

A Note on Accounting for Diversity

> Racism, bigotry, sexism, religious discrimination, homophobia, and lack of sensitivity to the needs of special populations continue to affect the lives of each new generation. Powerful leaders and organizations throughout the country continue to promote the exclusion of people who are "different," resulting in the disabling by-products of hatred, fear, and unrealized potential. ... We will not move toward diversity until we promote inclusion ... Programs will not accomplish any of (their) central missions unless ... (their approach reflects) knowledge, sensitivity, and a willingness to learn.
>
> U.S. Department of Health and Human Services

As is the case for so many other countries, the United States continues to grow in diversity. Our history is one of both embracing diversity and fighting against it. Embracing diversity on school campuses requires creating and supporting values that encourage students and staff of all backgrounds to value each other, interact with mutual respect and support, and develop authentic relationships. This calls for avoiding practices that work against equity of opportunity for all.

Examples of diversity concerns identified in research include: age, gender, race, ethnicity, national origin, migration and refugee status and experiences, religion, spirituality, sexual orientation, disability, language, socioeconomic status, education, group identity, position in the social hierarchy, communication modality, level of acculturation/assimilation, developmental stages, stages of ethnic development, level of acculturation/assimilation, individual preferences, popular culture, family and lifestyle, workplace culture, intersectionality, and more.

Addressing diversity at schools involves considerations of significant individual and inter- and intra-group differences. Developing diversity competence is a dynamic, on-going learning process. In the end, of course, it is accounting for *individual differences* that is fundamental in establishing intervention fit and effective working relationships.

The reality of schools is that direct or indirect accusations that *"You don't understand"* are common and 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.

For more on this, see the resource links on our Center's Quick Find on *Diversity, Disparities, and Promoting Equity* – http://www.smhp.psych.ucla.edu/qf/diversity.htm

Concluding Comments

Without a systematic approach to special assistance, referral processes at schools become flooded, and the capability of facilitating access to effective help for many students with learning, behavior, and emotional problems is undermined. By refining their approach to special assistance, schools can increase the likelihood that students will be more successful at school, while also reducing the need for teachers to seek special programs and services.

Schools that focus on mental health concerns show they care about all students. Providing effective special assistance helps enhance equity of opportunity and a positive school climate.

Some Online Center Resources for MH Assistance for Students at School

Embedding Mental Health as Schools Change
http://smhp.psych.ucla.edu/improving_school_improvement.html
This free book provides a big picture and detailed discussion of how to fully embed mental health in schools.

A Self-study Survey focused on Student and Family Assistance
http://smhp.psych.ucla.edu/pdfdocs/toolsforpractice/studentfamilysurvey.pdf
This is one of a set of self-study aids developed by the Center for surveying what a school has in place and what it may want to enhance.

A Virtual Toolbox for Mental Health in School Practitioner
http://smhp.psych.ucla.edu/summit2002/toolbox.htm
This online toolbox provides brief resources developed by the national Center. The resources reflect the broad perspective of mental health in schools emphasized in this book, and the role mental health plays in the well-being of students, their families, and their teachers.

Clearinghouse Quick Finds
http://smhp.psych.ucla.edu/quicksearch.htm
The Center's website provides ready access to online Quick Find clearinghouse with a menu of over 130 specific topics. Among the topics covered are disaster response, classroom management, motivation (including engagement and re-engagement in classroom learning), social and emotional development, specific types of student problems, and much more. Quick Finds provide links directly to resources developed by the UCLA Center and to online resources across the country.

Appendix A

About Accommodations

Accommodations are intended not only to address differences in capability, but to affect students' motivation by involving them in activities they value and believe are attainable with appropriate effort. For example, classroom assignments and rules can be changed to better account for youngsters who are very active and/or distractable. For such students, this involves relaxing behavioral expectations and standards a bit, at least for a period of time (e.g., widening limits for them so that certain behaviors are not an infringement of the rules).

Accommodations help establish a good match for learning. For students with significant learning, behavior, and emotional problems, interveners use many special accommodations (see Exhibit A-1). School improvement plans need to ensure a full array of accommodations are used in personalizing instruction and providing special assistance.

Exhibit A-1

Accommodations

For easily distracted students:

- identify any specific environmental factors that distract students and make appropriate environmental changes
- have students work with a group that is highly task-focused
- let students work in a study carrel or in a space that is "private" and uncluttered
- designate a volunteer to help whenever students becomes distracted and/or start to misbehave, and if necessary, to help them make transitions
- allow for frequent "breaks"
- interact with students in ways that will minimize confusion and distractions (e.g., keep conversations relatively short; talk quietly and slowly; use concrete terms; express warmth and nurturance)

For students needing more support and guidance:

- develop and provide sets of specific prompts, multisensory cues, steps, etc. using oral, written, and perhaps pictorial and color-coded guides as organizational aids related to specific learning activities, materials, and daily schedules
- ensure someone checks with students frequently throughout an activity to provide additional support and guidance in concrete ways (e.g., model, demonstrate, coach)
- support student efforts related to self-monitoring and self-evaluation and provide nurturing feedback keyed to student progress and next steps

For students having difficulty finishing tasks as scheduled:

- modify the length and time demands of assignments and tests
- modify the nature of the process and products (e.g., allow use of technological tools and allow for oral, audio-visual, arts and crafts, graphic, and computer generated products)

See the following page for examples of the types of accommodations highlighted by federal law (Section 504 of the Rehabilitation Act of 1973).

Exhibit A-1 (cont.)

504 Accommodation Checklist

Various organizations concerned with special populations circulate lists of 504 accommodations. The following is one that was downloaded from website of a group concerned with Fetal Alcohol Syndrome (see http://www.come-over.to/FAS/IDEA504.htm).

Physical Arrangement of Room

- seating student near the teacher
- seating student near a positive role model
- standing near student when giving directions/presenting lessons
- avoiding distracting stimuli (air conditioner, high traffic area)
- increasing distance between desks

Lesson Presentation

- pairing students to check work
- writing key points on the board
- providing peer tutoring
- providing visual aids, large print, films
- providing peer notetaker
- making sure directions are understood
- including a variety of activities during each lesson
- repeating directions to student after they are given to the class: then have him/her repeat and explain directions to teacher providing written outline
- allowing student to tape record lessons
- having child review key points orally
- teaching through multi-sensory modes, visual, auditory, kinestetics, olfactory
- using computer-assisted instruction
- accompany oral directions with written directions for child to refer to blackboard or paper
- provide model to help students, post the model, refer to it often
- provide cross age peer tutoring
- to assist the student in finding the main idea underlying, highlighting, cue cards, etc.
- breaking longer presentations into shorter segments

Assignments/worksheets

- giving extra time to complete tasks
- simplifying complex directions
- handing worksheets out one at a time
- reducing the reading level of the assignments
- requiring fewer correct responses to achieve grade (quality vs. quantity)
- allowing student to tape record assignments/homework
- providing a structured routine in written form
- providing study skills training/learning strategies
- giving frequent short quizzes and avoiding long tests
- shortening assignments; breaking work into smaller segments
- allowing typewritten or computer printed assignments prepared by the student or dictated by the student and recorded by someone else if needed.
- using self-monitoring devices
- reducing homework assignments
- not grading handwriting
- student not be allowed to use cursive or manuscript writing
- reversals and transpositions of letters and numbers should not be marked wrong, reversals or transpositions should be pointed out for corrections
- do not require lengthy outside reading assignments
- teacher monitor students self-paced assignments (daily, weekly, bi-weekly)
- arrangements for homework assignments to reach home with clear, concise directions
- recognize and give credit for student's oral participation in class

Test Taking

- allowing open book exams
- giving exam orally
- giving take home tests
- using more objective items (fewer essay responses)
- allowing student to give test answers on tape recorder
- giving frequent short quizzes, not long exams
- allowing extra time for exam
- reading test item to student
- avoid placing student under pressure of time or competition

Organization

- providing peer assistance with organizational skills
- assigning volunteer homework buddy
- allowing student to have an extra set of books at home
- sending daily/weekly progress reports home
- developing a reward system for in-schoolwork and homework completion
- providing student with a homework assignment notebook

Behaviors

- use of timers to facilitate task completion
- structure transitional and unstructured times (recess, hallways, lunchroom, locker room, library, assembly, field trips, etc.)
- praising specific behaviors
- using self-monitoring strategies
- giving extra privileges and rewards
- keeping classroom rules simple and clear
- making "prudent use" of negative consequences
- allowing for short breaks between assignments
- cueing student to stay on task (nonverbal signal)
- marking student's correct answers, not his mistakes
- implementing a classroom behavior management system
- allowing student time out of seat to run errands, etc.
- ignoring inappropriate behaviors not drastically outside classroom limits
- allowing legitimate movement
- contracting with the student
- increasing the immediacy of rewards
- implementing time-out procedures

Given the intervention principle of placement in the least restrictive environment needed, a student may be assigned to a special classroom and school (e.g., special education classes, alternative public or private schools). While often a controversial move, such placements frequently are recommended as another form of accommodation.

Some school organizational changes also are accommodation opportunities. “Looping” is an example (i.e., the teacher moving with students from one grade to the next for one or more years). Beside reducing student apprehension about a new school year and a new teacher, this allows for teacher continuity in providing special assistance and for relationship and community building and bonding between teachers and students and teachers and parents and among students.

Appendix B

A Benchmark Checklist for a Consumer-oriented, Problem-solving Consultation Process

__ *Provides readily accessible basic information about relevant resources to students, families, and school personnel*

Entails widespread circulation of general information about on- and off-campus programs and services and ways to readily access such resources.

__ *Helps students, families, and school personnel appreciate whether a referral is necessary and, if so, clarifies the value of a potential resource*

Involves reviewing with the student, family, staff 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). 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 require other forms of special assistance to cope with and minimize the impact of the negative home situation.

__ *Analyzes options with student, family, and staff and helps with decision making as to which are the most appropriate resources*

Involves evaluating the pros and cons of potential options (including location, fees, least restrictive and intrusive intervention) 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 on-campus. Off-campus district programs and those offered by community agencies can follow as needed. Off-campus referrals are made with due recognition of school district policies.

__ *Identifies and explores with the student/family/staff 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, and/or apathy? Concerns about language and cultural sensitivity? At this point, be certain that the student (and where appropriate the family) truly feels an intervention is a good way to meet her or his needs.

__ *Works on strategies for dealing with barriers to follow-through*

Strategies must provide sufficient support and guidance to enable students and families to connect with resources This often overlooked step is basic to follow-through and entails taking time to clarify specific ways to handle barriers to following through.

__ Sends the student, family, and staff off with a written summary of what was decided, including follow-through strategies

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

__ *Also sends 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 and family to needed resources. Also, remember that teachers and other school staff who asked for a student review will want to know that something was done. Without violating any confidentiality considerations, a quick response can be sent reassuring them that the process is proceeding.

__ *Follows through with student and family and other concerned parties to determine current status of needs and whether previous decisions were appropriate*

Requires establishing a reminder (tickler) system so that follow-up is made after an appropriate period of time.

Appendix C

About Psychological First Aid: Responding to a Student in Crisis

School and community shootings, natural disasters, death of a family member or a friend, bullying – students and their families (and school staff) clearly are exposed to traumatic events. As schools play their role, psychological first aid for students/staff/parents is as important as medical aid.

Psychological first aid is used during and in the immediate aftermath of a crisis. The immediate objective is to help individuals deal with troubling psychological reactions. Below we highlight steps in the process, and Exhibit C-1 outlines some general principles for crisis response.

First: *Manage 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.

Second: *Mobilize Support* – The student needs *support and guidance*. Staff can help by:

- Engaging 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 info
  >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)
- Encouraging the student's buddies to provide social support
- Contacting the student's home to discuss what's wrong and what to do
- Referring the student to a specific counseling resource.

Third: *Follow-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.

While the COVID-19 crisis was unlike any other schools have experienced, it is not difficult to extrapolate and adapt ways to help from what has been written about psychological first aid. Applications can be made to students and staff.

Exhibit C-1

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.

Exhibit C-2 highlights the *Psychological First Aid for Schools Field Operations Guide* developed by the National Child Traumatic Stress Network and the National Center for PTSD for assisting children, adolescents, adults, and families in the aftermath of a school crisis, disaster, or terrorism event.

Exhibit C-2

Psychological First Aid for Schools - Field Operations Guide

http://www.nctsn.org/content/psychological-first-aid-schoolspfa

From the National Child Traumatic Stress Network and the National Center for PTSD

As stated in the manual, *the basic objectives* of a Psychological First Aid provider in schools are:

- To establish a positive connection with students and staff members in a non-intrusive, compassionate manner
- To enhance immediate and ongoing safety and provide physical and emotional comfort
- To calm and orient emotionally overwhelmed or distraught students and staff
- To help students and staff members identify their immediate needs and concerns
- To offer practical assistance and information to help students and staff members address their immediate needs and concerns
- To connect students and staff members as soon as possible to social support networks, including family members, friends, coaches, and other school or community groups
- To empower students, staff, and families to take an active role in their recovery by acknowledging their coping efforts and strengths, and supporting adaptive coping
- To make clear your availability and (when appropriate) link the student and staff to other relevant school or community resources such as school counseling services, peer support programs, afterschool activities, tutoring, primary care physicians, local recovery systems, mental health services, employee assistance programs, public-sector services, and other relief organizations

Core actions are:

1. Contact and Engagement
   Goal: To initiate contacts or to respond to contacts by students and staff in a non-intrusive, compassionate, and helpful manner
2. Safety and Comfort
   Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort
3. Stabilization (if needed)
   Goal: To calm and orient emotionally overwhelmed or disoriented students and staff
4. Information Gathering: (Current Needs and Concerns)
   Goal: To identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid for Schools interventions to meet these needs
5. Practical Assistance
   Goal: To offer practical help to students and staff in addressing immediate needs and concerns
6. Connection with Social Supports
   Goal: To help establish brief or ongoing contacts with primary support persons or other sources of support, including family, friends, teachers, and other school and/or community resources
7. Information on Coping
   Goal: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning
8. Linkage with Collaborative Services
   Goal: To link students and staff with available services needed at the time or in the future

These core actions of Psychological First Aid for Schools constitute the basic objectives of providing early assistance within hours, days, or weeks following an event.

The manual stresses the importance of being flexible and devoting the amount of time spent on each core action based on the person's specific needs and concerns.