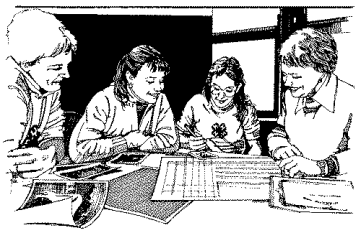
Introductory and Technical Aid Packet

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

(Updated 2016)



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

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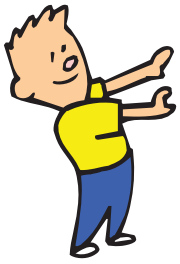


I. Connecting Students with the Right Help

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

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

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

The first question should be

What's making this person function like this?

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

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

The focus of this *technical aid packet* is on decisions about what assistance is needed, how serious the need is, where a student/ family should go to get it, and how to ensure it is provided in coordinated and integrated ways. Elsewhere we place such special assistance in the context of a unified, comprehensive system of student and learning supports (see *Transforming Student and Learning Supports: Developing a Unified, Comprehensive, and Equitable System* -- http://smhp.psych.ucla.edu/pdfdocs/book/book.pdf

I. Connecting Students with the Right Help

A. Facets of Connecting a Student with the Right Help

Only a small proportion of students requiring special assistance are candidates for special education

Before providing special assistance to a student, the logical first step is to address general factors that may be causing problems. In schools, this first step involves developing the five arenas of learning supports discussed in previous chapters. This can be sufficient for addressing conditions that are affecting a large proportion of students, and this reduces the need for further special attention. A few students, however, will continue to manifest learning, behavior, and emotional problems, and they and their families require extra assistance, perhaps including specialized interventions. Depending on problem severity and pervasiveness, such assistance involves pursuing the sequence and hierarchy of interventions highlighted in the Exhibit 1.

SPECIAL ASSISTANCE TO SUPPORT LEARNING AND TEACHING

Most school staff and parents have little difficulty identifying youngsters who manifest problems at school. Given that as much as feasible has been done to provide a range of general learning supports, such students require special assistance. Keep in mind, however, that only a small proportion of these students are candidates for special education diagnosis and programming. Indeed, properly designed and implemented special assistance is intended to reduce unnecessary referrals for special education.

Rethinking special assistance is fundamental in revamping school systems to address the needs of *all* learners and reduce learning problems, misbehavior, suspensions, expulsions, grade retention, and dropouts. As with the other elements of a learning supports system, the aim is to enable learning by improving the match between school interventions and a learner's motivation and capabilities.

Special assistance often is just an extension of general strategies; sometimes, however, more specialized interventions are needed. In either case, a school's process objective is to provide extra support as soon as a need is recognized and in ways that are least disruptive to the student's whole development. Done effectively, special assistance reduces misdiagnoses and unwarranted special education referrals. To these ends, the endeavor reflects aspects of what in the past has been referred to as prereferral intervention and uses Response to Intervention (RtI) as an authentic and multifaceted assessment process. These strategies improve screening and planning and facilitate appropriate decisions about referral for school-based, school-linked, and community-based specialized services. Exhibit 2 summarizes, with examples, the array of special assistance.

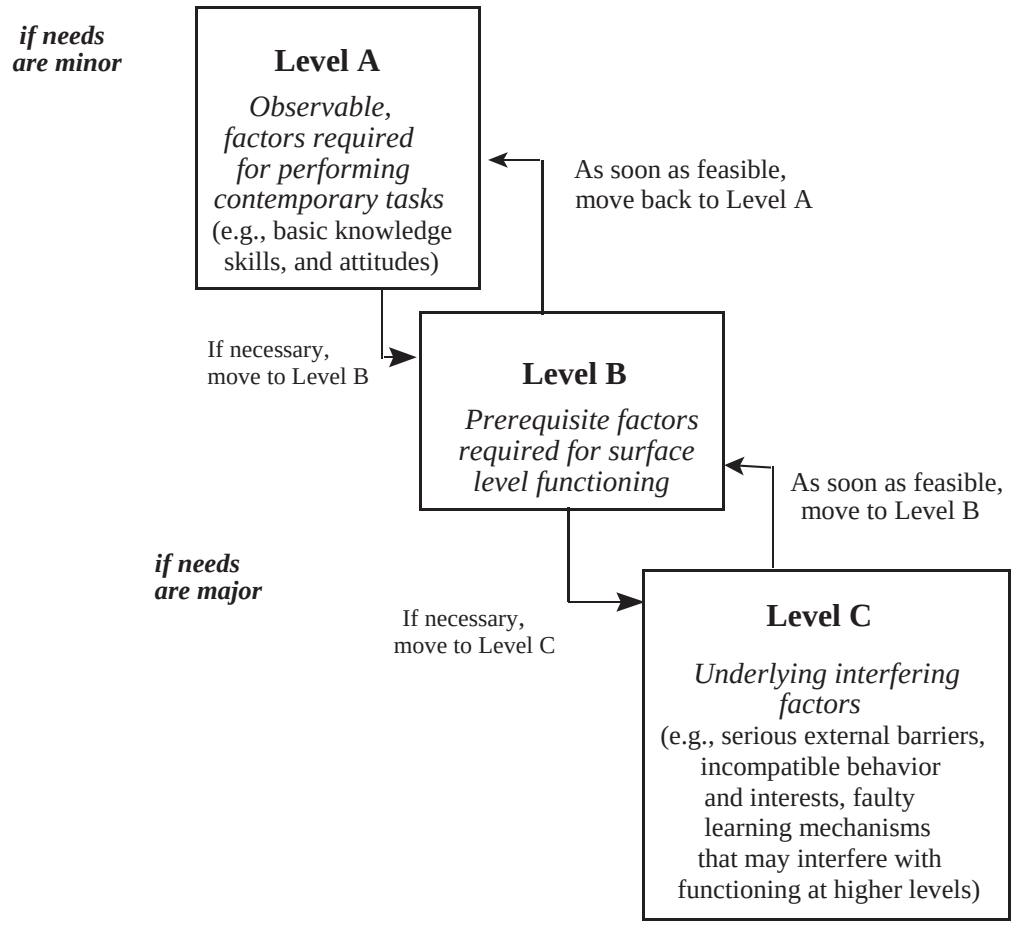
How is Special Assistance Provided Strategically?

Once it is clear that special assistance is required, the focus turns to determining what type of assistance to provide and how to provide it. In making such determinations, all who work with the youngster must take the time to develop (a) an understanding of why the student is having problems, (b) an analysis of the nature and scope of the problems (current weaknesses and limitations, including missing prerequisites and interfering behaviors and attitudes), and (c) an appreciation of his or her strengths (in terms of both motivation and capabilities).

Learning, behavior, and emotional difficulties are commonly associated with motivational problems. Thus, enhancing motivation is always a primary concern. To this end, intensive efforts are immediately required to ensure a student is mobilized to learn and perform. Such efforts include use of a wider range of learning and performance options, individual guidance and support, and appropriate accommodations. Particular attention is paid to minimizing threats to feelings of competence, self-determination, and relatedness to significant others and emphasizing ways to enhance such feelings.

Exhibit 1
Sequence and Hierarchy of Special Assistance

Step 2. *Best special practices* (special assistance, such as remediation, rehabilitation, treatment) are used differentially for minor and severe problems



Note: The concept of using the least intervention necessary to accomplish results applies to decisions about intervening at Levels A, B, or C. The point is to ensure the right amount of assistance is provided so that first and foremost students' needs are addressed. At the same time, the idea is to keep interventions from becoming too life-intrusive and to ensure the costs and benefits are appropriately balanced.

Responses to special assistance are a primary assessment strategy. When motivational considerations are given short shrift, assessments and diagnoses are confounded, and special assistance may just as readily exacerbate as correct a student's problems. When a student's motivation to learn and problem-solve is enhanced, a more valid assessment of special assistance needs and personal strengths is likely. Moreover, among the disengaged, re-engagement enables identification of students misdiagnosed as having internal dysfunctions (e.g., a learning disability, an attention deficit hyperactivity disorder).

Addressing motivational concerns can be sufficient for assisting a large proportion of students and reducing the need for further special attention. A few, however, may continue to manifest learning and behavior problems and require further special assistance, perhaps including specialized practices.

Exhibit 2
Array of Special Assistance

Concern	***In the Classroom***	***Outside the Classroom***
To provide student and learning supports as soon as a problem is recognized and to do so in the least disruptive way.	Where feasible, special assistance is implemented in the classroom. This is best accomplished by opening the door to invite in resource and student support staff and volunteers.	Outside assistance at school is provided as needed and available. Referrals elsewhere are made when necessary.
LEVELS		
Observable Factors Required for Effective Learning at School At this level, the focus remains on *directly* enabling acquisition of the basic knowledge, skills, and interests related to age-appropriate life and learning tasks (e.g., reading, inter- & intra-personal problem solving). It builds on personalized instruction, encompasses what often is called "prereferral" intervention, and uses accommodations and *responses to special assistance.*	A basic strategy at this level includes *reteaching* – but not with the same approach that has failed. Alternative strategies and modification of activities are used to improve the match with the learner's current levels of motivation and capability. To find the right match, a range of accommodations and technical moves are used to enhance motivation, sensory intake and processing, decision making, and output. Other strategies include problem solving conferences with parents and the student, expanding options and opportunities for decision making, and enhancing protective buffers and resilience.	Examples of interventions at this level include out-of-class tutoring, supportive and stress reduction counseling, parent training related to helping a student learn & perform, health and social services as needed for minor problems, enhancing protective buffers and resilience.
Missing Prerequisites **(i.e., the readiness gap)** Special assistance at this level focuses on identifying and *directly* enabling acquisition of developmental and motivational prerequisites (knowledge, skills, attitudes) in order to fill the readiness gap.	The more that a youngster has missed key learning opportunities, the more likely s/he has gaps in the knowledge, skills, and attitudes needed to succeed in the current grade. If the readiness gap is not filled, it grows. Where a readiness gap exists, teaching staff must be able to take the time to address the gap by identifying missing prerequisites and ensuring the student acquire them. Processes are the same as those used in facilitating learning related to current life tasks.	Examples at this level also include tutoring, supportive and stress reduction counseling, parent training, health and social services as needed for mild to moderate problems, and enhancing protective buffers and resilience. Students also may need special counseling to restore feelings of competence. self-determination, and relatedness to significant others.
Underlying Problems and Interfering Factors Special assistance at this level identifies severe and chronic problems (e.g., poor motivation, social and emotional dysfunctioning, faulty learning mechanisms). Then, the focus is on helping students overcome underlying deficiencies by correcting the problems (if feasible) or enabling learning and performance by providing accommodations and teaching strategies for coping and compensating.	Special assistance in the classroom at this level involves assessment of underlying problems and/or serious interfering factors and use of remedial, rehabilitative, and tertiary prevention strategies that are used in conjunction with ongoing personalized instruction.	At this level, the need is for intensive interventions designed to address barriers related to a host of external and internal risk factors and interventions for promoting healthy development (including a focus on resiliency and protective factors). In extreme cases, full time outside interventions may be required for a limited period of time.

Student Motivation Is a Major Consideration at All Times

- Motivation is an antecedent concern affecting intervention. Poor motivational readiness often is (a) a cause of inadequate and problem functioning, (b) a factor maintaining such problems, or (c) both. Thus, strategies are required that reduce avoidance motivation and enhance motivational readiness so that the student is mobilized to participate.
- Motivation is an ongoing process concern. Processes must elicit, enhance, and maintain motivation so that the student stays mobilized (e.g., strategies to counter boredom).
- Enhancing intrinsic motivation is a basic outcome concern. A student may be motivated to work on a problem during an intervention session 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.

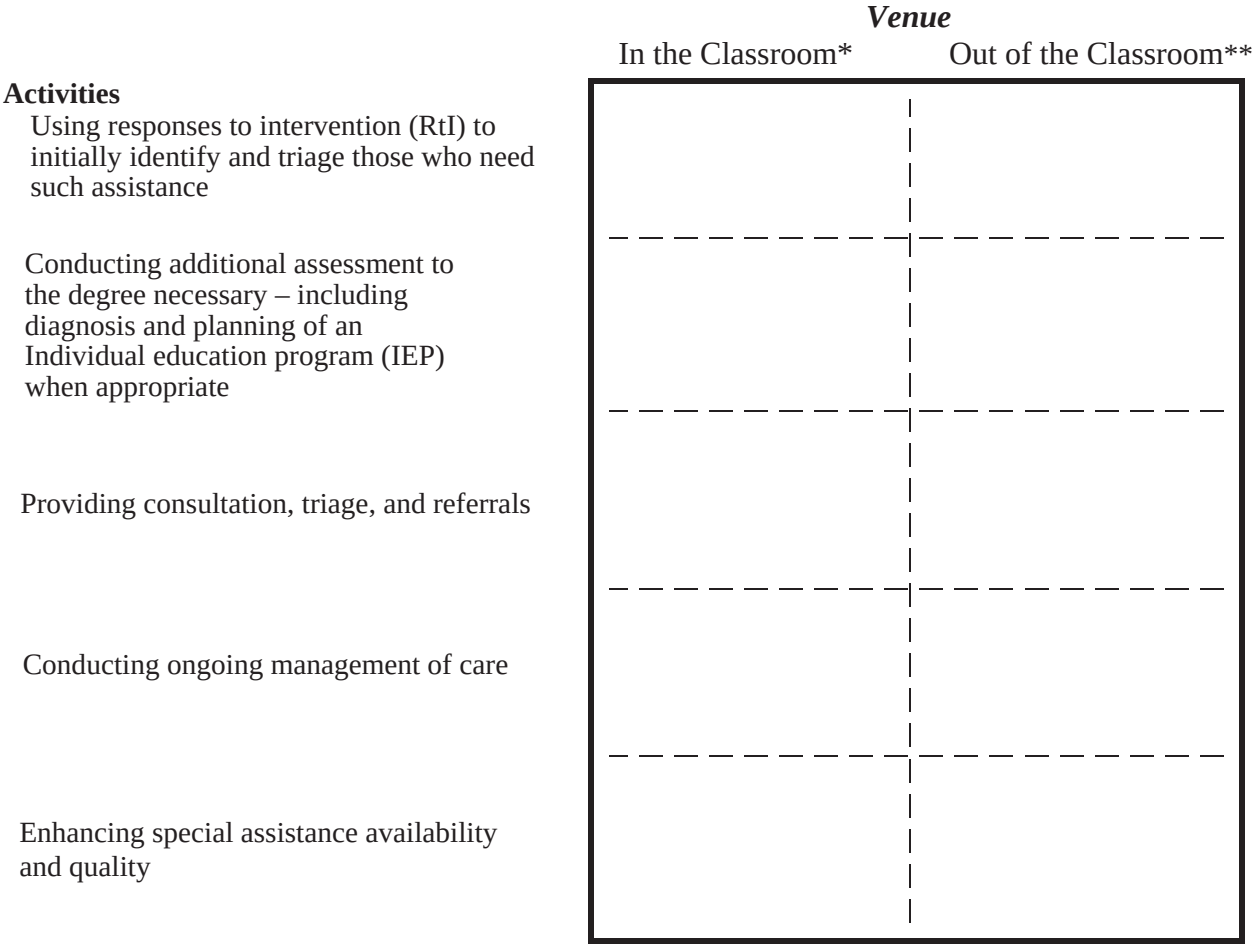
Similar motivational considerations arise in providing special assistance to a student's family. And, staff motivation warrants attention as well.

FRAMING AND DESIGNING INTERVENTIONS FOR STUDENT AND FAMILY SPECIAL ASSISTANCE

Exhibit 3 offers a prototype framework to help schools plan the many learning support activities related to special assistance. As the Exhibit highlights, special assistance in and out of classrooms encompasses processes for providing all stakeholders with information clarifying available assistance and how to access help, facilitating requests for assistance, identifying and assessing problems, triaging in making referrals, planning and providing direct services, monitoring and managing care, managing resources, and interfacing with community outreach to fill gaps. The work also includes ongoing formative evaluations designed to improve quality, effectiveness, and efficiency.

With specific respect to severe and chronic problems and students mandated for special education programs, special assistance includes connecting what the school offers with whatever is available in the community and facilitating access. In implementing the activity, the emphasis is on enhancing a "system of care" and ensuring the special assistance is integrated with the other facets of the comprehensive system of learning supports.

Exhibit 3
Framework for Student and Family Special Assistance

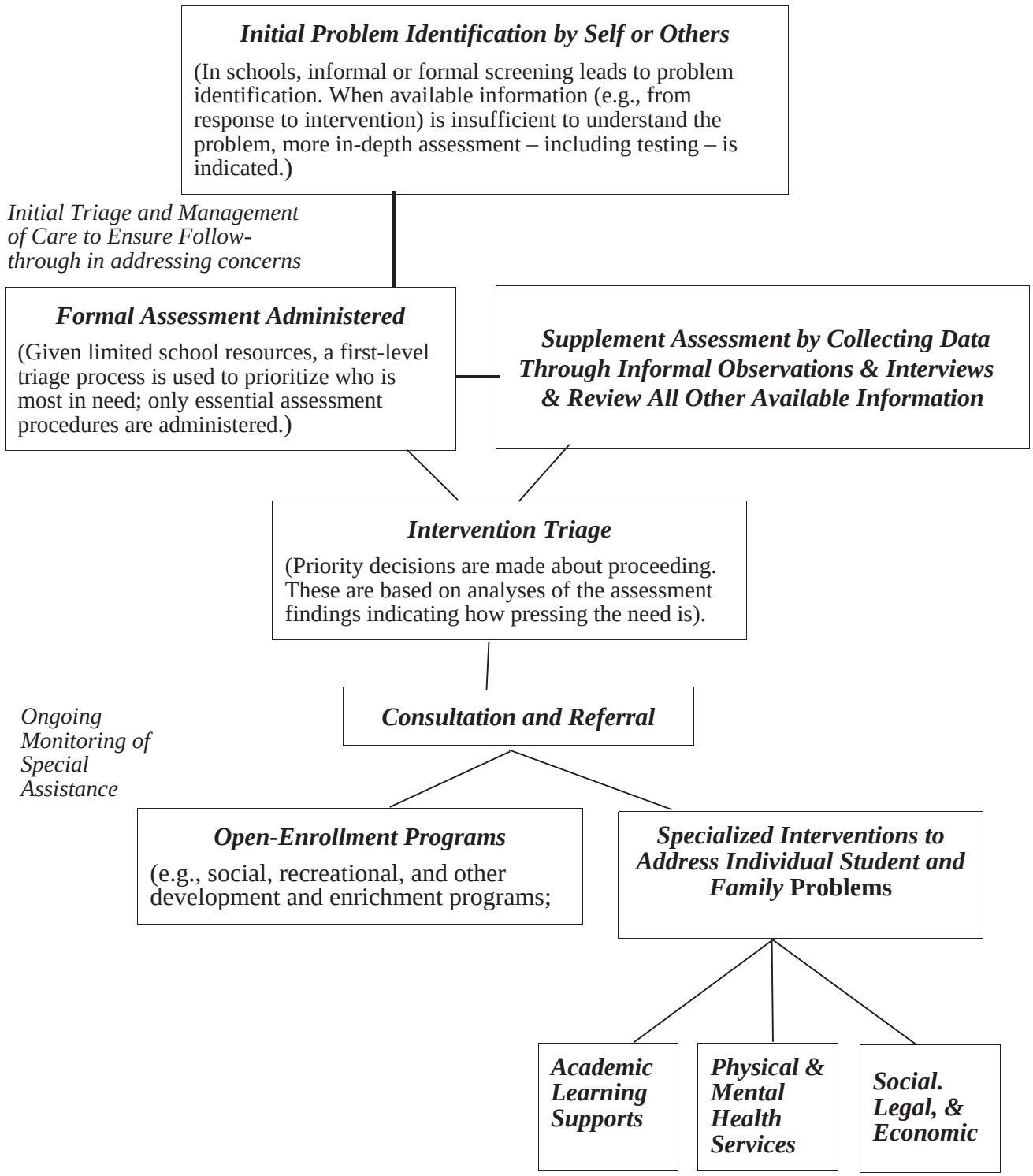


*Provided by the school's teaching and/or student support staff

**Out of class special assistance may be provided at the school, at a district facility, and/or at a community facility. In some schools, professionals from the community have connected with schools to co-locate their agency services.

Efforts related to problem identification, triage, referral to and management of special assistance require developing and connecting each process systematically. Exhibit 4 highlights the connections.

Exhibit 4
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).

AN INITIAL LOOK AT KEY PROCESSES

School staff identify many mental health problems each day. Some students are best served by helping to ensure that appropriate pre-referral interventions are implemented; others require referrals. Here we provide an initial look at (1) screening/assessment, (2) client consultation and referral, (3) triage, and (4) monitoring/managing care. The material in Sections II and III provide more detail and links to tools.

Screening to Clarify Need

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

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

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

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

- To expand your analysis of the problem, you will want to gather other available information. It is good practice to gather information from several sources – including the student. Useful sources are teachers, administrators, parents, home visit also may be of use. You will find some helpful tools in the accompanying materials.

- And you can do a screening interview. The nature of this interview will vary depending on the age of the student and whether concerns raised are general ones about misbehavior and poor school performance or specific concerns about lack of attention, overactivity, major learning problems, suicidal, or about physical, sexual, or substance abuse. To balance the picture, it is important to look for assets as well as weaknesses. (In this regard, because some students are reluctant to talk about their problems, it is useful to think about the matter of talking with and listening to students - see the next section -- I B).

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

Screening: A Note of Caution

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

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

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

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

See http://smhp.psych.ucla.edu/pdfdocs/policyissues/mhscreeningissues.pdf

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 Appositional Defiant Disorder
	Very active and doesn't follow directions	Attention Deficit-Hyperactivity Disorder
	Has trouble learning at school	Learning Disorder
8-12	Low self-esteem	Depression
12-15	Defiant/reactive	Oppositional Defiant Disorder
	Worries a lot	Depression
15-18	Experimental substance use	Substance Abuse

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

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

Family Consultation and Referral

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

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

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

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

- analyzing the problem (Are environmental factors a concern? Are there concerns about underlying disorders?)
- laying out alternatives (clarifying options/what's available)
- deciding on a course of action (evaluating costs vs. benefits of various alternatives for meeting needs)

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

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

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

A consumer oriented system is designed with full appreciation of the nature and scope of student problems as perceived by students, their families, and their teachers. Such problems range from minor ones that can be dealt with by providing direct information, perhaps accompanied by some instruction to severe/pervasive/chronic conditions that require intensive intervention.

The process must not ignore the social bases of a student's problems. This means attending to environmental concerns such as basic housing and daily survival needs, family and peer relations, and school experiences. A student's needs may range from accessing adequate clothes to acquiring protection from the harassment of gang members. In many instances, the need is not for a referral but for mobilizing the school staff to address how they might improve its programs to expand students' opportunities in ways that increase expectations about a positive future and thereby counter prevailing student frustration, unhappiness, apathy, and hopelessness.

A consumer oriented system should minimally

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

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

(1) *Provide ways for students/families and school personnel to learn about existing resources*

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

(2) *Establish whether a referral is necessary*

This requires an analysis of whether current resources can be modified to address the need.

(3) *Identify potential referral options with the student/family*

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

that can provide students, families, and staff with ready references to key resources are provided by the accompanying Resource Aids.

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

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

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

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

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

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

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

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

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

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

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

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

Obviously, the above steps may require more than one session with a student/family and may have to be repeated if there is a problem with follow-through. In many cases, one must take specific steps to help with follow through, such as making direct connections (e.g., by phone) to the intake coordinator for a program. Extreme cases may require extreme measures such as arranging for transportation or for someone to actually go along to facilitate enrollment.

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

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

Triage

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

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

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

Monitoring/Managing Care

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

If there has been no follow-through, the contact can be used to clarify next steps. If there has been follow-through, the contact can be used to evaluate whether the resource is meeting the need. The opportunity also can be used to determine if there is a need for communication and coordination with others who are involved with the student's welfare. This is the essence of *case management* which encompasses a constant focus to evaluate the appropriateness and effectiveness of the interventions.

Follow-up checks are indicated periodically. If the findings indicate the student did not successfully enroll or stay in a program or is not doing well, another consultation session can be scheduled to determine next steps.

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

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

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

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

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

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

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

B. Responding to Referrals in Ways that Can "Stem the Tide"

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

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

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

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

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

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

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

Improving the Referral System

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

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

Problem identification

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

Triage processing

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

Clients directed to resources or for further problem analysis and recommendations

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

Interventions to ensure recommendations and referrals are pursued appropriately

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

Management of care (case monitoring and management)

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

More on this in Section IV.

C. System Building with a Resource-Oriented LeadershipTeam

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

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

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

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

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

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

Developing a Resource-Oriented Leadership Team

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

This team differs from Student Study, Student Success, and Student Guidance Teams. Its focus is not on individual students. Rather, it is oriented to clarifying resources and how they are best used. That is, it provides a necessary mechanism for developing fragmented and marginali ed programs and services into a unified and comprehensive *system* of student and learning supports.

For many support service personnel, their past experiences of working in isolation – and in competition – make this collaborative opportunity unusual and one which requires that they learn new ways of relating and functioning. For those concerned with school improvement, establishment of such a team is one facet of efforts designed to restructure school student and learning supports in ways that (a) weaves the supports together and (b) outreaches and links up with community resources in way that fills gaps and enhances programs and services.

Purposes

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

Major examples of the group's activity are

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

(cont.)

A *Learning Supports Leadership Team* -- an example of a resource-oriented team

Every school that wants to improve student and learning supports needs a mechanism specifically working on system *development* to enhance how schools address barriers to learning and teaching and re-engage disconnected students. The goal is to rework existing resources by establishing a unified and comprehensive approach. A *Learning Supports Leadership Team* is a vital mechanism for transforming current marginalized and fragmented interventions into a comprehensive, multifaceted, and cohesive *system* that enhances equity of opportunity for all students to succeed at school.

Most schools have teams that focus on individual student/family problems (e.g., a student support team, an IEP team). These teams pursue such functions as referral, triage, and care monitoring or management. In contrast to this case-by-case focus, a school's *Learning Supports Leadership Team*, along with an administrative leader, can take responsibility for developing a unified and comprehensive enabling or learning supports component at a school. In doing so, it ensures that the component is (1) fully integrated as a primary and essential facet of school improvement and (2) outreaches to the community to fill critical system gaps by weaving in human and financial resources from public and private sectors.

What Are the Functions of this Leadership Team?

A Learning Supports Leadership Team performs essential functions and tasks related to the implementation and ongoing development of a comprehensive, multifaceted, and cohesive system for addressing barriers to student learning and teaching.

Examples are:

- Aggregating data across students and from teachers to analyze school needs
- Mapping resources at school and in the community
- Analyzing resources & formulating priorities for system development (in keeping with the most pressing needs of the school)
- Recommending how resources should be deployed and redeployed
- Coordinating and integrating school resources & connecting with community resources
- Planning and facilitating ways to strengthen and develop new programs and systems
- Developing strategies for enhancing resources
- Establishing work groups as needed
- "Social marketing"

Related to the concept of an enabling/learning supports component, these functions and tasks are pursued within frameworks that outline six curriculum content arenas and the full continuum of interventions needed to develop a comprehensive, multifaceted approach to student and learning supports that is integrated fully into the fabric of school improvement policy and practice. (See http://smhp.psych.ucla.edu/pdfdocs/systemic/frameworksforsystemictransformation.pdf)

Who's on Such a Team?

A Learning Supports Leadership Team might begin with only a few people. Where feasible, it should expand into an inclusive group of informed, willing, and able stakeholders. This might include the following:

- Administrative Lead for the component
- School Psychologist
- Counselor
- School Nurse
- School Social Worker
- Behavioral Specialist
- Special education teacher
- Representatives of community agencies involved regularly with the school
- Student representation (when appropriate and feasible)
- Others who have a particular interest and ability to help with the functions

It is important to integrate this team with the infrastructure mechanisms at the school focused on instruction and management/governance. For example, the school administrator on the team needs to represent the team at administrative and governance meetings. A member also will need to represent the team when a Learning Supports Leadership *Council* is established for a family of schools (e.g., the feeder pattern).

For Related Center Resources, see the toolkit for *Rebuilding Student Supports into a Comprehensive System for Addressing Barriers to Learning and Teaching* – especially Section B on "Reworking Infrastructure" – http://smhp.psych.ucla.edu/summit2002/resourceaids.htm

Developing a Complex (Multisite) Resource-Oriented Leadership Council

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

Purpose

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

Some specific functions are

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

Membership

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

Facilitation

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

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

Location

Meeting at each school on a rotating basis can enhance understanding of the complex.

(cont.)

Developing a Complex (Multisite) Council (cont.)

Steps in Establishing a Complex Council

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

Accomplished through presentation and handouts.

b. Selection of representatives.

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

c. Task focus of initial meetings

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

d. General meeting format

- Updating on and introduction of council membership
- Reports from those who had between meeting assignments
- Current topic for discussion and planning
- Decision regarding between meeting assignments
- Ideas for next agenda

II. Student Clients as Consumers

A. Enhancing Understanding of the Motivational Bases for Problems

B. Talking with Kids about Problems

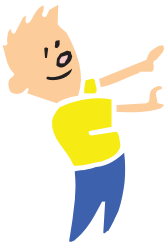
C. The Best Consumer Protection is a *Good* Professional

D. Referral: More than Giving a Name and Address

E. Help-Seeking Behavior and Follow Through on Referrals

F. Managing *Care*, Not *Cases*

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



II. Student Clients as Consumers

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

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

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

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

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

After adopting this principle, it is a short leap to adopting the stance that school-based assistance for students and families should be *consumer-oriented.*

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

Appropriately cautious information can

- put matters into proper perspective
- clarify general options for dealing with the problem
- ensure good decisions and follow through.

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

Processes related to triage, referral, and managing care often are carried out at school sites in ways that are not very consumer-oriented.

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

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

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

II. Student Clients as Consumers

A. Enhancing Understanding of the Motivational Bases for Problems

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

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

See the Center Onlne Clearinghouse Quick Find entitled:
Motivation, Engagement, Re-engagement --
http://smhp.psych.ucla.edu/qf/motiv.htm

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

B. Talking with Kids about Problems

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

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

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

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

1. Creating the Context for Dialogues

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

2. Establishing Credibility (as someone to whom it is worth talking)

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

3. Facilitating Talk

- Avoid interruptions.
- Start slowly, avoid asking questions, and minimize pressure to talk (the emphasis should be more on conversation and less on questioning).
- Encourage the youngster to take the lead.
- Humor can open a dialogue; sarcasm usually has the opposite effect.
- Listen with interest.
- Convey the sense that you are providing an opportunity by extending an invitation to talk and avoiding the impression of another demanding situation (meeting them "where they are at" in terms of motivation and capability is critical in helping them develop positive attitudes and skills for oral communication).
- Build on a base of natural, informal inter-changes throughout the day.

- When questions are asked, the emphasis should be on open-ended rather than Yes/No questions.
- Appropriate self-disclosure by another can disinhibit a reluctant youngster.
- Pairing a reluctant youngster with a supportive peer or small group can help.
- Train and use others (aides, volunteers, peers) to (1) enter into productive (nonconfidential) dialogues that help clarify the youngster's perceptions and then (2) share the information with you in the best interests of helping.
- For youngsters who can't seem to convey their thoughts and feelings in words, their behavior often says a lot about their views; based on your observations and with the idea of opening a dialogue, you can share your perceptions and ask if you are right.
- Sometimes a list of items (e.g. things that they like/don't like to do at school/after school) can help elicit views and open up a dialogue.
- When youngsters have learning, behavior, and emotional problems, find as many ways as feasible to have positive interchanges with them and make positive contacts outweigh the negatives.
- **Remember**: Short periods of silence are part of the process and should be accommodated.

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

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

For more materials on these topics, go to the Center Website and use the Quick Find to go to the following and other relevant topics:

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

About Interviewing

1. Use a space that will allow privacy and let others know not to interrupt.

- Clarify that you care by showing empathy, acceptance, and genuine regard.
- Indicate clear guidelines about confidentiality so the student feels safe in confiding but understands that if danger to self or others is discussed, others must be involved.

2. Start out on a positive note and always covey a sense of respect.

- Ask about things that are going well at school and outside of school
- Use language that invites sharing and is more conversational than questioning.
- If students are reluctant to talk you may need to start with nonverbal activity, such as drawing, or with semistructured surveys

3. Slowly transition to concerns

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

4. As you follow the student's lead, listen actively and encourage information through open ended questions that allow for exploration rather than closure.

- This will lead to a broader range of concerns about school, home, relationships, self.
- With other students you may find it helpful to explore more sensitive topics such as involvement substance use, gangs, sexuality.

5.It is very important to have a plan on how to end the interview. This includes

- Clarifying it is time, not caring, that causes the need to stop at this point.
- Summarize what has been shared with a sense of accomplishing at new ways to understand the problems and new plans to try in solving them
- Plan the next step, such as the next appointment, a follow up time to check on progress, and open door if there is another need to talk, how to connect to others in the daily environment at school who may be of help.

II. Student Clients as Consumers

C. The Best Consumer Protection Is a Good Professional

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

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

II. Student Clients as Consumers

D. Referral: More than Giving a Name and Address

Referrals for service are commonplace at school sites.

And, for the most part,

referrals are relatively easy to make.

BUT,

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

Schools must develop effective referral *intervention* strategies.

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

- provide ready reference to information about appropriate referrals,
- maximize follow-through by using a *client consultation process* that involves students and families in all decisions and helping them deal with potential barriers.

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

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

- to provide consumers with ready access to information on relevant services
- to minimize abuses often found in professional referral practices.

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

Referrals are easy to make . . .

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

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

unfortunately, data suggest that follow-through rates for referrals made by staff at schools 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 she either did not like or could not afford.

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

(Adapted from Berne, 1964)

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

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

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

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

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

An example of some specific steps used in an assessment and consultation process is provided on the next page.

Some Specific Steps in an Assessment and Consultation Process

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

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

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

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

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

(6) Holding group conference(s) with immediately concerned parties to

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

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

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

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

II. Student Clients as Consumers

E. Help Seeking Behavior and Follow Through on Referrals

Some Excerpts from the Journals

Excerpt from

Seeking Help From the Internet During Adolescence*

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

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

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

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

*by M.S. Gould, J.L. Harris Munfakh, K. Lubell, M. Kleinman, & S. Parker in the *Journal of the American Academy of Child & Adolescent Psychiatry 2002; 41(10):1182-1189*

Mental Health and Help-Seeking Among Ethnic Minority Adolescents*

Abstract

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

*by L. Barker & H. Adelman in the *Journal of Adolescence 1994, 17, 251-263*

II. Student Clients as Consumers

F. Managing Care, Not Cases

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

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

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

Improving help-seeking among adolescents: A school-based intervention

Article *in* Australian and New Zealand Journal of Psychiatry 49(10) · August 2015
Impact Factor: 3.41 · DOI: 10.1177/0004867415598847 · Source: PubMed
https://www.researchgate.net/publication/280997927_Improving_help-seeking_among_adolescents_A_school-based_intervention

To the Editor: Champion et al. (2015) recently reported findings supporting an Internet-based prevention programme targeting alcohol and cannabis use in early adolescence. They found increased alcohol and cannabis knowledge among 13-year-old students who completed the programme, as well as decreased intentions to use alcohol. Such prevention programmes are critical given high rates of risky drinking among young people, and the wide range of harms associated with early onset and/or regular drinking during adolescence (Lubman et al., 2007). Similarly, intervention efforts promoting help-seeking during this period are paramount, as many adolescents are reluctant to seek help for substance use problems despite the benefits of early treatment.

Research examining help-seeking for mental health problems during adolescence has identified attitudes and beliefs that can act as barriers, including perceptions of stigma, fears about confidentiality, poor problem recognition and a belief that one should be able to sort out one's own problems. Consequentially, many young people keep their problems to themselves, or turn to peers or key adults (e.g., parents) for help, despite evidence of poor mental health literacy among these groups (Gulliver et al., 2010). Developing programmes that address these barriers is therefore an important component of broader prevention efforts that aim to minimise the harms associated with adolescent drinking (Lubman et al., 2007).

The MAKINGtheLINK: Seeking Help for Risky Drinking programme is a school-based intervention designed to address barriers and enablers to adolescent help-seeking, in order to promote help-seeking for alcohol-related problems before they reach clinical significance. The programme draws upon two well-validated models of behaviour change (the Information-Motivation-Behavioural Skills Model and Theory of Planned Behaviour) that have been previously utilised in school-based prevention programmes. We recently trialled the programme with 297 Grade 8 (aged 13–15) students from three Victorian schools. The programme was delivered over two sessions (3 hours total) during one week by an experienced teacher external to the school.

An evaluation of the programme identified high levels of satisfaction. Preliminary results demonstrated increased knowledge, awareness of help-seeking options and confidence to seek help for alcohol problems (see Table 1). These data support the feasibility and acceptability of the MAKINGtheLINK programme within a school environment, and add to the evidence supporting early intervention within this context (Champion et al., 2015). Further research is needed to determine whether these findings translate into actual help-seeking behaviours, or whether the effects of the programme generalise to help-seeking for other disorders.

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>Champion KE, Newton NC, Stapinski L, et al. (2015) A cross-validation trial of an Internet-based prevention program for alcohol and cannabis: Preliminary results from a cluster randomised controlled trial. Australian and New Zealand Journal of Psychiatry. Epub ahead of print 23 March. DOI: 10.1177/0004867415577435.
>Gulliver A, Griffiths KM and Christensen H (2010) Perceived barriers and facilitators to mental health help-seeking in young people: A system-atic review. BMC Psychiatry 10: 113.
>Lubman DI, Hides L, Yücel M, et al. (2007) Intervening early to reduce developmentally harmful substance use among youth popula-tions. Medical Journal of Australia 187: S22–S25.

When Ideals Get in the Way of Self-Care: Perfectionism and Self-Stigma for Seeking Psychological Help Among High School Students

R.J. Zeifman, S.K. Atkey, R.E. Young, G.L. Flett, P.L. Hewitt, & J.O. Goldberg (2015). *Canadian Journal of School Psychology, 30*, 273–287. http://cjs.sagepub.com/content/30/4/273.full.pdf+html

Abstract. In the current study, we investigated whether adolescents high in perfectionism are prone to experiencing self-stigma for seeking psychological help. This work is based on the premise that the need to seek help for psychological difficulties is not consistent with idealistic personal goals of perfectionistic young people and their desire to retain an idealistic self-image. A sample of 85 high school students completed the Child and Adolescent Perfectionism Scale, the Self-Stigma of Seeking Help Scale, and a measure of contact with individuals with mental illness. Results indicated that perfectionism was associated with self-stigma among those students with little to no experience with people with a history of mental illness. These findings suggest that certain perfectionistic students have a propensity toward low self-acceptance and judge themselves negatively for needing help. Implications are discussed for prevention and intervention programs that emphasize contact and experiential opportunities with individuals who have mental illness.

Emotionally Troubled Teens' Help-Seeking Behaviors: An Evaluation of Surviving the Teens® Suicide Prevention and Depression Awareness Program

C.M. Strunk, M.T. Sorter, J. Ossege, & K.A. King (2014). *Journal of School Nursing, 30*, 366-375. http://jsn.sagepub.com/content/30/5/366

Abstract. Many school-based suicide prevention programs do not show a positive impact on help-seeking behaviors among emotionally troubled teens despite their being at high risk for suicide. This study is a secondary analysis of the Surviving the Teens® program evaluation to determine its effect on help-seeking behaviors among troubled youth. Results showed significant increases in mean scores of the Behavioral Intent to Communicate with Important Others Regarding Emotional Health Issues subscale ($p < 0.0005$) from pretest to 3-month follow-up. There was a significant increase ($p = 0.006$) in mean scores of the Behavioral Intent Regarding Help-Seeking Behaviors when Suicidal subscale from pretest to posttest, but not at 3-month follow-up. Also, there was a significant increase ($p = 0.016$) in mean scores in the item "I would tell an adult if I was suicidal" from pretest to 3-month follow-up. These findings suggest that the Surviving the Teens program has a positive effect on help-seeking behaviors in troubled youth.

Teen Dating Violence Outcomes and Help-Seeking

U.S. Department of Justice, Office of Justice Programs, National Institute of Justice - NIJ.gov

http://nij.gov/topics/crime/intimate-partner-violence/teen-dating-violence/Pages/outcomes.aspx

Ideally, teens will seek help when dating violence occurs. Researchers and service providers are working to better understand how many teens seek help, from whom they seek it, and what factors encourage or deter help-seeking after violence or abuse.

An NIJ-funded study of teens from 10 middle schools and high schools throughout New York, New Jersey and Pennsylvania examined help-seeking rates among teens. The prevalence of help-seeking among teens who reported at least one form of psychological, physical, sexual or cyber abuse was fairly low: 8.6 percent of all victims, 5.7 percent of male victims and 11.0 percent of female victims.

Female teens were more likely than male teens to seek help. The majority (77.2 percent; 69.2 percent of males and 82.0 percent of females) of those who sought help turned to friends. In addition, about half of the teens (48.5 percent overall; 44.2 percent of males and 50.5 percent of females) sought help from a parent.

Learn more from the following (go online to for the links):

- An abstract and access the final report, *Technology, Teen Dating Violence and Abuse, and Bullying*.
- A research summary by the grantees, *Teen Dating Abuse and Harassment in the Digital World: Implications for Prevention and Intervention*.

In a national study of Latino teens, help-seeking was examined among those who experienced physical or sexual dating violence or stalking:

- Only 15.6 percent of Latino dating abuse victims sought formal help (e.g., from teachers, counselors, case workers or police). The most common reason given for not seeking formal help was "I didn't think of it."
- In contrast, 60.7 percent of Latino dating abuse victims sought informal help, most often from friends (42.9 percent) but also from family members (15.5 percent).
- Male and female victims sought informal help at similar rates (43.6 percent and 41.4 percent, respectively), but Latino female teens (35.5 percent) were more likely than Latino male teens (5.1 percent) to seek formal help.

In addition, the higher the Latino teens scored on a measure of familism (e.g., putting the family above individual interests), the more likely they were to seek formal help.

Learn more from the following (go online to for the links):

- An abstract and access the final report, *Dating Violence Among Latino Adolescents (DAVILA) Study*.
- A research summary by the grantees, *Experience of Dating Violence Among Latino Adolescents*.

Overall, results from NIJ-funded studies suggest that many teens never seek help after experiencing dating violence. When they do seek help, they most commonly seek help from their friends. Very few teens seek formal help from an adult service provider.

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II. Student Clients as Consumers

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

COMMUNITY INTEGRATION TOOLS

Cultural Competence in Mental Health

http://www.tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/community_inclusion/Cultural_Competence_in_MH.pdf

What Is Culture?

Culture may be defined as the behaviors, values and beliefs shared by a group of people, such as an ethnic, racial, geographical, religious, gender, class or age group. Everyone belongs to multiple cultural groups, so that each individual is a blend of many influences.

Culture includes or influences dress, language, religion, customs, food, laws, codes of manners, behavioral standards or patterns, and beliefs. It plays an important role in how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. Culture affects every aspect of an individual's life, including how we experience, understand, express, and address emotional and mental distress.

What Is Cultural Competence?

Cultural competence is the ability to relate effectively to individuals from various groups and backgrounds. Culturally competent services respond to the unique needs of members of minority populations and are also sensitive to the ways in which people with disabilities experience the world. Within the behavioral health system (which addresses both mental illnesses and substance abuse), cultural competence must be a guiding principle, so that services are culturally sensitive and provide culturally appropriate prevention, outreach, assessment and intervention.

Cultural competence recognizes the broad scope of the dimensions that influence an individual's personal identity. Mental health professionals and service providers should be familiar with how these areas interact within, between and among individuals. These dimensions include:

- race
- ethnicity
- language
- sexual orientation
- gender
- age
- disability
- class/socioeconomic status
- education
- religious/spiritual orientation

Diversity in the United States

The U.S. population is rapidly diversifying:

- The decade between 1990 and 2000 saw the largest increase – from 20 percent to 25 percent – in population growth of persons of color.
- According to the 1990 census, the number of persons who speak a language other than English rose 43 percent, to 28.3 million, compared with 1980 census figures.
- Nearly 45 percent of these 28.3 million people indicated having trouble speaking English.
- One in 10 Americans are now foreign-born.
- One in three Americans belongs to a group or groups identified as minorities.

Cultural Competence in Mental Health

The diversity that exists within groups is often overlooked. For example:

- The term *Asian American* includes people from a variety of nations, such as Afghanistan, China, India, Syria and Japan. It includes both immigrants and those whose families have lived in the United States for generations.
- The term *African American* implies that 33.9 million people share certain characteristics because of their ties with some of the 797 million people in Africa, who live in 54 different countries and speak some two thousand different languages.
- The term *Native American* includes people who may be of unmixed ancestry or whose Native American lineage is only a fraction of their backgrounds, who may trace their roots to any of more than 500 different tribes, and who may or may not identify with tribal culture.
- According to 2006 Census Bureau estimates, some 44.3 million Americans were identified as Hispanic. Within this "group," 64 percent were of Mexican background, 9 percent were of Puerto Rican background, 3.5 percent Cuban, 3 percent Salvadoran and 2.7 percent Dominican. The remainder are of some other Central American, South American, or other Hispanic or Latino origin.

With the increasing diversity of the U.S. population, mental health service providers must be aware of the influences that culture has on psychological processes, mental illnesses, and the ways that people seek help. They must also be aware of the variety within groups.

Disparities in Mental Health Services

The Surgeon General's report *Mental Health: Culture, Race and Ethnicity* discusses disparities in behavioral health services for members of racial and ethnic minority populations. People in these populations:

- are less likely to have access to available mental health services;
- are less likely to receive necessary mental health care;
- often receive a poorer quality of treatment; and
- are significantly underrepresented in mental health research.

Members of racial minority groups, including African Americans and Latinos, underuse mental health services and are more likely to delay seeking treatment. Consequently, in most cases, when such individuals seek mental health services they are at an acute stage of illness. This delay can result in a worsening of untreated illness and an increase in involuntary services.

Generally, rates of mental disorders among people in most ethnic minority groups are similar to rates for Caucasians. However, members of minority populations are more likely to experience factors – such as racism, discrimination, violence and poverty – that may exacerbate mental illnesses.

Cultural Competence in Mental Health

Cultural disparities include the following:

- For decades, studies have shown that African Americans are more likely to be misdiagnosed with schizophrenia than any other ethnic group. Reasons for this remain unclear.
- A protein that metabolizes several antidepressant medications is less active in East Asians. This increases the risk of higher blood levels of medication and more side effects within members of this population, indicating that everyone doesn't respond to and metabolize medication in the same way and at the same rate.
- Research on Native Americans and Alaskan Natives is limited, but existing studies suggest that members of these populations experience a disproportionate percentage of mental health problems and disorders. For example, the suicide rate among Native Americans and Alaskan Natives is 50 percent higher than the national rate.

Cultural Barriers to Mental Health Care

Cultural barriers that prevent members of minority populations from receiving appropriate care include:

- mistrust and fear of treatment;
- alternative ideas about what constitutes illness and health;
- language barriers and ineffective communication;
- access barriers, such as inadequate insurance coverage; and
- a lack of diversity in the mental health workforce.

Cultural Biases and Stereotypes

In general, discrimination refers to the hostile or negative feelings of one group of people toward another. It can cause bias in service provision and can prevent people from seeking help. Cultural competency must address the biases and stereotypes that are associated with an individual's culture and various identities.

Forms of discrimination include:

racism: prejudice or discrimination based on a person's race, or on the belief that one race is superior to another;

ageism: bias toward an individual or group based on age. For example, young people may be stereotyped as immature and irresponsible; older adults may be called slow, weak, dependent and senile;

sexism: discrimination or prejudice based on gender;

heterosexism: prejudice against people who are gay, lesbian, bisexual, transgender, or intersex. It is also the assumption that all people are heterosexual and that heterosexuality is correct and normal;

homophobia: the fear and/or dislike of homosexual people or homosexuality;

classism: any form of prejudice or oppression against people who are members of (or who are perceived as being similar to those who are members of) a lower social class; and

religious intolerance: an inability or unwillingness to tolerate another's beliefs or practices.

Mental health professionals and service providers must be aware of how stereotypes and stigma influence not only their clients but also their own thoughts and views of others.

How to Incorporate Cultural Competency Standards into Practice

Mental health professionals and service providers can improve their cultural competence by taking the following steps:

- Use open-ended questions to identify each person's unique cultural outlook.
- Re-evaluate intake and assessment documentation, as well as policies and procedures, to be more inclusive.
- Employ qualified mental health workers who are fluent in the languages of the groups being served.
- Understand the cultural biases of staff and provide training to address educational needs.
- Understand the cultural biases in program design.
- Identify resources, such as natural supports, within the community that will help an individual recover.
- Design and implement culturally sensitive treatment plans.
- Evaluate procedures and programs for cultural sensitivity and effectiveness.
- Survey clients and workers to elicit their understanding of cultural competence and culturally competent practice.

An Example of Cultural Competence in Practice: A Community-Based Intervention for Elderly Chinese Americans

Depression and dementia are the most common forms of mental illness in older adults. Depression, often associated with physical illness or disability, increases health care costs and can lead to suicide.

> "Chinese elders typically don't seek help for depression and other mental disorders," said Sandy Chen Stokes, a nurse and geriatric specialist at El Camino Hospital's Older Adult Transitions (OATS), an outpatient counseling service (in Mountain View, California). "…You go along with what your culture tells you: tough it out or let time heal the problem. … They don't know depression can be treated … (Some) end up as an inpatient or in a locked facility" (Cloutman, 2001).

Cultural Competence in Mental Health

Stokes began an outreach program by first disseminating information about depression in Chinese-language newspapers, radio and television programs. With a gift from an anonymous donor, Stokes purchased translation devices so that Chinese clients could be integrated into an English-speaking counseling group.

Conclusion

The mental health system is slowly improving, but large gaps in services still exist. When you are seeking and/or providing mental health services, it is good to understand that cultural differences influence every individual, both provider and client. With the proper training for mental health workers and educational materials for members of minority populations, culturally sensitive services can be effective in treating and possibly preventing episodes of acute mental illness.

E-Resources

American Psychological Association: Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists http://www.apa.org/pi/multiculturalguidelines/formats.html

Hogg Foundation for Mental Health: Cultural Competency: A Practical Guide for Mental Health Service Providers http://www.hogg.utexas.edu/PDF/Saldana.pdf

National Center for Cultural Competence: http://www11.georgetown.edu/research/gucchd/nccc/

National Mental Health Association (now Mental Health America): Cultural and Linguistic Competency in Mental Health Systems http://www1.nmha.org/position/ps38.cfm

New York City Department of Health and Mental Hygiene, Cultural Competence Websites – Mental Health: http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-ccpriority-resources.pdf

Rainbow Heights: Guidelines for effective and culturally competent treatment with lesbian, gay, bisexual, and transgender people living with mental illness: Excerpted from Rosenberg , S., Rosenberg, J., Huygen, C., and Klein, E. (2005). No need to hide: Out of the closet and mentally ill, Best practices in mental health: An international journal, 1, 72-85. http://www.rainbowheights.org/Guidelines.htm

Substance Abuse and Mental Health Services Administration: Factsheets on specific races and ethnicities: http://mentalhealth.samhsa.gov/cre/factsheet.asp

Substance Abuse and Mental Health Services Administration: Culturally specific mental health resources: http://mentalhealth.samhsa.gov/cre/resources.asp

Cultural Competence in Mental Health

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A Bit More on Diversity . . .

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

With respect to efforts to build working relationships, accusing someone of not understanding tends to create major barriers. This is not surprising since the intent of such accusations generally is to make others uncomfortable and put them on the defensive.
It is hard to build positive connections with a defensive person. Avoidance of *"You don't understand"* accusations may be a productive way to reduce at least one set of major barriers to establishing working relationships.

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

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

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

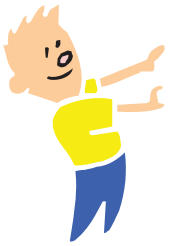
Then, why had he come in the first place?

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

III. Enhancing Student And Family Special Assistance

A. The Pre-referral Process

B. Response to Intervention



III. Enhancing Student and Family Special Assistance

A. Pre-referral Interventions

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

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

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

Doing Less Student and Family Special Assistance Outside the Classroom

Currently, most requests for special assistance outside the classroom ask student support staff (e.g., psychologists, counselors, social workers, nurses) to address specific problems related to individual students and/or their families. Usually, the request is stimulated because a student is manifesting significant learning, behavior, and emotional problems. In some instances, the request is intended to generate an evaluation leading to special education. Indeed, over the years, such requests have led to an exponential escalation in the number of students designated as having a learning disability (LD) or attention deficit hyperactivity disorder (ADHD).

As student and learning supports aim more at preventing and ameliorating many school-related learning, behavior, and emotional problems, greater emphasis is needed on bringing student support staff into classrooms for part of each day so they can play a greater role in limiting the need for out-of-class services. One aim is to reduce the number of students with commonplace problems who are misdiagnosed and assigned to the special education population.

This is not to say that added assistance outside class is unnecessary. The point is to reduce overuse and misuse of specialized services, while maximizing appropriate attention to both external and internal barriers to learning and performance. Examples of appropriate use were cited in Exhibit 2.

Doing More Student and Family Special Assistance in the Classroom

Common priorities in enhancing special assistance in classrooms are expanding options, broadening accommodations, taking a comprehensive approach to response to intervention, and enhancing remedial strategies. A few words about each follow.

About Adding Learning Options. Every teacher knows the value of variety. Varied options are especially important in engaging and finding ways to re-engage students with low motivation for or negative attitudes about classroom learning and performance. Before some students will decide to participate in a proactive way, they have to perceive the learning environment as positively different – and quite a bit so – from the one they dislike.

A valued set of options and the opportunity for involvement in decision making helps foster student perceptions of having real choices and being self-determining and can help counter perceptions of coercion and control. Shifting such perceptions can reduce reactive misbehavior and enhance engagement in classroom learning.

Broadening Accommodations. Besides adding options, it is imperative to accommodate a wider range of behavior than usually is tolerated. For instance, classroom environments can be altered to better account for youngsters who are very active and/or distractable. This includes initial easing of certain behavioral expectations and standards for some of these students (e.g., widening limits on acceptable behavior for a time to minimize rule infringement).

> *Accommodative strategies are intended to enable a student to participate successfully. Such strategies improve the fit between what is expected and what a student values and believes is attainable with appropriate effort* (see Exhibit 5).

Exhibit 5
Examples of Accommodation Recommendations

If students seem easily distracted, the following might be used:

- 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)

If students need more support and guidance, the following might be used:

- 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

If students have difficulty finishing tasks as scheduled, try the following:

- 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)

As noted, accommodations help establish a good match for learning. For students with significant learning, behavior, and emotional problems, interveners use many special accommodations. In fact, federal law (Section 504 of the Rehabilitation Act of 1973) encourages schools to pursue a range of such accommodations when students’ symptoms significantly interfere with school learning but are not severe enough to qualify them for special education. See the following page for examples of the types of accommodations offered.

(cont.)

Exhibit 9.5 (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

Besides individual accommodations, schools can make changes in how classrooms and instruction are organized. Looping is an example. This strategy involves the teacher moving with students from one grade to the next for one or more years. This accommodation can reduce student apprehension about a new school year and enables schools to provide more time for slower students. And, it ensures more time for relationship building and bonding between teachers and students and teachers and parents and among students. Other examples of procedural changes that can help accommodate a wider range of learner differences in motivation and development include blocking, blending, and flipping instruction and various uses of technology. Both academic and social benefits are reported for such practices.

To guide school-based efforts to plan and implement a pre-referral process, the following pages include a brief summary of and resource aid for prereferral interventions. This is followed bu a discussion of Response to Intervention (RtI) as a special assistance practice.

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

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

An Example of the Prereferral Process

School violence, poor academic performance, misbehavior in class -- with increasing numbers of students identified as troubled or in trouble, schools must design systems for intervening prior to referral for special assistance. Otherwise, the system will grind to a halt. A *prereferral intervention* process delineates steps and strategies to guide teachers. The following is one example:

(1) ***Formulate an initial description of the problem.***

(2) ***Get the youngster's view of what's wrong*** **and, as feasible,** ***explore the problem with the family***.

As every teacher knows, the causes of learning, behavior, and emotional problems are hard to analyze. What looks like a learning disability or an attentional problem may be emotionally-based. Misbehavior often arises in reaction to learning difficulties. What appears as a school problem may be the result of problems at home. The following are some things to consider in seeking more information about what may be causing a youngster's problem.

(a) Through enhanced personal contacts, build a positive working relationship with the youngster and family.

(b) Focus first on assets (e.g. positive attributes, outside interests, hobbies, what the youngster likes at school and in class).

(c) Ask about what the youngster doesn't like at school.

(d) Explore the reasons for "dislikes" (e.g., Are assignments seen as too hard? as uninteresting? Is the youngster embarrassed because others will think s/he does not have the ability to do assignments? Is the youngster picked on? rejected? alienated?)

(e) Explore other possible causal factors.

(f) Explore what the youngster and those in the home think can be done to make things better (including extra support from a volunteer, a peer, friend, etc.).

(g) Discuss some new things the youngster and those in the home would be *willing* to try to make the situation better.

(3) ***Try new strategies in the classroom*** -- based on the best information about what is causing the problem.

Prereferral Interventions Some Things to Try

- Make changes to (a) improve the match between a youngster's program and his/her interests and capabilities and (b) try to find ways for her/him to have a special, positive status in class, at the school, and in the community. Talk and work with other staff in developing ideas along these lines.
- Add resources for extra support (aide, volunteers, peer tutors) to help the youngster's efforts to learn and perform. Create time to interact and relate with the youngster as an individual.
- Discuss with the youngster (and those in the home) why the problems are occurring.
- Specifically focus on exploring matters with the youngster that will suggest ways to enhance positive motivation.
- Change aspects of the program (e.g.,materials, environment) to provide a better match with his/her interests and skills.
- Provide enrichment options (in and out of class).
- Use resources such as volunteers, aides, and peers to enhance the youngster's social support network.
- Specifically focus on exploring ways those in the home can enhance their problem-solving efforts.
- If necessary include other staff (e.g., counselor, principal) in a special discussion with the youngster exploring reasons for the problem and ways to enhance positive involvement at school and in class.

(4) If the new strategies don't work, ***talk to others*** at school to learn about approaches they find helpful (e.g., reach out for support/mentoring/coaching, participate with others in clusters and teams, observe how others teach in ways that effectively address differences in motivation and capability, request additional staff development on working with such youngsters).

(5) If necessary, use the ***school's referral processes*** to ask for additional support services.

(6) Work with referral resources to ***coordinate your efforts*** **with theirs** for classroom success.

Step 1: Based on your work with the student, *formulate a description* of the student's problem (use the checklist as an aid) and then request a Triage Review.

A Checklist to Aid in Describing the Problem

Teacher's Name: _____ Rm. _____ Date_____

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

Student's name:_____ Birth date: _____ Grade: _____

Social Problems
( ) Aggressive
( ) Shy
( ) Overactive
( ) _____

Achievement problems
( ) Poor skills
( ) Low motivation
( ) _____

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

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

Other specific concerns:

Comments: If you have information about what is causing the problem, briefly note the specifics here.

Step 2: Have a discussion to get the student's view. You may want to include the family. (See suggestions below).

Exploring the Problem with the Student and Family

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

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

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

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

1. Starting out on a positive note: Ask about what the student likes at school and in the class (if anything).

2. Ask about outside interests and "hobbies."

3. Ask about what the student doesn't like at school and in the class.

4. Explore with the student what it is that makes the things disliked (e.g., Are the assignments seen as too hard? Is the student embarrassed because others will think s/he does not have the ability to do assignments? Do others pick on the student? Are the assignments not seen as interesting?)

5. Explore what other factors the student and those in the home think may be causing the problem?

6. Explore what the student and those in the home think can be done to make things better (including extra support from a volunteer, a peer, etc.).

7. Discuss some new things the student and those in the home would be *willing* to try to make things better.

See student interview form in the toolbox at

http://smhp.psych.ucla.edu/pdfdocs/triaging.pdf .

Step 3: Try new strategies in the classroom based on your discussion. (See the preceeding discussion of Response to Intervention.)

Some Things to Try

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

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

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

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

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

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

6. Provide enrichment options in class and as feasible elsewhere

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

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

9. Hold another special discussion with the student at which other staff (e.g., counselor, principal) join in to explore reasons for the problem and find ways to enhance positive motivation

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

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

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

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

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

Step 6: Work with referral resources to *coordinate your efforts* with theirs for classroom success.

For more aids for triage, see
http://smhp.psych.ucla.edu/pdfdocs/triaging.pdf

Research Highlights: The Prereferral Intervention Process

http://www.emstac.org/registered/topics/disproportionality/researchhighlights/prereferral.htm

From: EMSTAC Elementary & Middle Schools Technical Assistance Center

Disproportionality
The Disproportionate Representation of Racial and Ethnic Minorities in Special Education

- Prereferral interventions are primarily used to decrease the number of inappropriate referrals to special education.
- The purpose of the prereferral team is to empower teachers and to increase the skills and abilities of teachers to effectively meet the needs of students who may have learning problems, behavioral problems, or both.
- Prereferral teams engage in problem solving techniques to address student needs. These teams may include parents; general education classroom teachers; administrators; a consulting special education teacher; and special services personnel, such as a school psychologist, a guidance counselor, a nurse, a social worker, or a speech and language instructor.
- There are various models of prereferral interventions that have been identified and share some common goals: prereferral intervention teams, prereferral consultation teams, student assistance teams, student success committees, and school-based intervention assistance teams.
- Prereferral interventions require administrative support and funding for training, release time for consultations, planning, and communication between the participants.
- The prereferral intervention is often confused with the referral process defined in special education. Historically, the referral process initiates the myriad decisions that identify, assess, refer, and place students in special education on the basis of their academic and behavioral needs. However, despite similar terminology, in this document "prereferral intervention" does not imply special education. It simply represents a school-based intervention that allows educational professionals and stakeholders to brainstorm ways to have a positive impact on students who are experiencing difficulty in the general education classroom.

Typical Pre-Referral Team Members and Their Roles on the Team

http://iris.peabody.vanderbilt.edu/module/preref/cresource/q2/p06/preref_06_link_roster/

Standard Team Members	Role
General education teacher	May identify a student who is having academic or behavioral issues May implement the suggested intervention or consult with other staff members who might provide small-group or classroom assistance
Administrator	Provides the underlying support (e.g., collaboration, planning) and the organizational structure of the teams
School psychologist or educational assessor (diagnostician)	Conducts individual or small-group observations, screenings, and academic diagnostic assessments
Parents	Share knowledge about the student's strengths and needs Relate information about the family's cultural background Suggest strategies that have worked with the student in the past Implement strategies in the home and support the student

Optional Team Members	Role
Students	Share strengths, likes, dislikes, learning preferences, and other unique needs
Special education teacher	Assists the general education teacher in developing plans for individualization of instruction in the general education classroom
ESL teacher	Identifies the language needs of the student and works with the team to make sure all of those language needs are met
School counselor	Reviews student records with the team Plans with the classroom teacher and support staff to target the learning and behavioral needs of the student
Reading specialist	Provides instructional supports or individual or small-group instruction for reading May collaborate with the general education teacher on instructional methods
Grade-level teachers	May plan, share, or exchange methods, materials, and instructional practices that work among diverse learners in the general education classroom
Health professional	May be asked to determine whether sensory acuity or health difficulties are contributing to, or causing, the initial concern May provide health-related assistance to students who need it

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Models: Teacher Assistance Teams (TAT)

http://www.emstac.org/registered/topics/disproportionality/models/tat.htm

From: EMSTAC Elementary & Middle Schools Technical Assistance Center

Disproportionality
The Disproportionate Representation of Racial and Ethnic Minorities in Special Education

Teacher Assistance Teams (TAT) are designed to support the regular education teacher who needs strategies and support for students who exhibit academic, emotional, or behavioral difficulties. The goal of the TAT is to maximize the student's success in the regular education classroom thereby decreasing the probability that a student will be referred to special education. The TAT is a comprehensive approach that uses an interdisciplinary team consisting of teachers, psychologists, social workers, specialists, parents, and counselors to problem solve to improve students' academic and behavioral outcomes. The TAT team members meet, brainstorm strategies to meet identified goals, and develop an action plan that includes a time to reconvene to check the student's progress and evaluate the plan. The TAT meets regularly to assist classroom teachers in planning and implementing strategies that are designed to produce success for the referred student. The TAT is a compilation of all the supports available in a school to adapt programs to meet a student's needs instead of placing the child in pre-established models. In some instances, the TAT is viewed as a "push-in" model instead of a "pull-out" model because it gives the child greater access to the general education curriculum. The TAT takes into consideration the total school ecology and its impact on a student's teaching and learning. The TAT process comprises assessment and intervention procedures that ensure that the student receives an effective instructional program that will meet his or her learning needs.

TAT Process

- TAT is a multi-step process with guided time lines.
- Any staff member or parent may request TAT assistance for a child.
- After receiving the request for assistance, the referring teacher contacts the parent.
- The teacher meets with the requesting teacher to discuss concerns and make a plan for assessment.
- The TAT gathers data, conducts informal assessments such as curriculum-based assessments (CBAs), and analyzes the information.
- A goal is established for the student.

III.Enhancing Student and family Special Assistance

B. Response to Intervention

The concept:

Response to Intervention is finding its way into schools with a significant push from the federal government. Properly conceived and implemented, the strategy is expected to improve the learning opportunities for many students and reduce the number who are *inappropriately* diagnosed with learning disabilities and behavioral disorders.

The approach overlaps ideas about pre-referral interventions but is intended to be more systematically implemented with special attention to enhancing teacher capability to carry out "well-designed and well-implemented early intervention." The aim also is to improve assessment for determining whether more intensive and perhaps specialized assistance and diagnosis are required. (It is important to emphasize that the tactic involves specific and well-monitored plans for "identified" students and is not to be used as a delaying tactic related to getting students the interventions they need.)

Response to Intervention has the potential to build teacher capacity so that similar problems are prevented in the future. Implied in all this is that someone is working to ensure (1) classroom teachers have or are learning how to implement "well-designed early intervention" in the classroom, and (2) support staff are learning how to play a role, sometimes directly in the classroom, to expand the intervention strategies if needed.

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The process:

Response to Intervention calls for making changes in the classroom designed to improve the student's learning and behavior as soon as problems are noted and using the student's response to such modifications as info for making further changes if needed. The process continues until it is evident that it cannot be resolved through classroom changes alone.

Through this sequential approach, students who have not responded sufficiently to the regular classroom interventions would next receive supportive assistance designed to help them remain in the regular program, and only when all this is found not to be sufficiently effective would there be a referral for special education assessment. (If the problem proves to be severe and disruptive, an alternative setting may be necessary on a temporary basis to provide more intensive and specialized assessments and assistance.)

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

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The intervention context:

If Response to Intervention is treated simply as a matter of providing more and better instruction, it is unlikely to be effective for a great many students. However, if the strategies are understood broadly and as part and parcel of a comprehensive system of classroom and school-wide learning supports, schools will be in a position not only to address problems effectively early after their onset, but will prevent many from occurring. Such a broad-based system is needed to reduce learning, behavior, and emotional problems, promote social/emotional development, and effectively reengage students in classroom learning. This will not only reduce the numbers who are inappropriately referred for special education or specialized services, it also will enhance attendance, reduce misbehavior, close the achievement gap, and enhance graduation rates.

##########

Devising practices:

Response to Intervention is currently being operationalized across the country. While there will be variability in practice, the tendency is to proceed as if all that is needed is more and better instruction. Clearly, this is necessary. And, the emphasis needs to go beyond direct instruction. The key is truly personalized instruction (see below). And, because the context for this is a school,

instruction must be supported by school-wide interventions focusing on enhancing supports for transitions and crisis events and home and community involvement.

But, there will be students for whom all this is insufficient. In such cases, some other forms of supportive assistance must be added to the mix – inside and, as necessary, outside the classroom. Referral for special education assessment only comes after all this is found inadequate.

To spell out the classroom-based approach a bit:

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

The first emphasis is on *motivation*. Thus:

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

The next concern is *developmental capabilities*. Thus:

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

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

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

For a range of resources from our center and links to other resources, begin with the our online clearinghouse Quick Find on:

Response to Intervention –
http://smhp.psych.ucla.edu/qf/responsetointervention.htm

Also, take a look at the Quick Finds on ***Classroom Focused Enabling and **Motivation.**
http://smhp.psych.ucla.edu/websrch.htm

***And, if you would like to try a training tutorial, go to:

Classroom Changes to Enhance and Re-engage Students in Learning
http://smhp.psych.ucla.edu/qf/classchange_tt/index.htm

***And, for even more, go to our continuing education modules on:

Enhancing Classroom Approaches for Addressing Barriers to Learning: Classroom-Focused Enabling
http://smhp.psych.ucla.edu/pdfdocs/contedu/cfe.pdf

***Finally, note that several other of the Center's **Practice Notes** are relevant to this matter and refer to additional resources.

As a special assistance approach, RtI becomes a strategy for improving understanding of a student's problem and what to do about it (see Exhibit 6).

Exhibit 6
Example of Steps in a Special Assistance Approach to Response to Intervention

- Use individual conferences to find out more about the causes of a student's problems and what interventions to try.
- Keep the initial focus on building a positive working relationship with the youngster and family.
- Move on to ask about assets (e.g. positive attributes, outside interests, hobbies, what the student likes at school and in class).
- Ask about what the youngster doesn't like at school.
- Explore the reasons for "dislikes" (e.g., Are assignments seen as too hard? as uninteresting? Is the student embarrassed because others will think s/he doesn't have the ability to do assignments? Is the youngster picked on? rejected? alienated?)
- Clarify other likely causal factors.
- Explore what the youngster and those in the home think can be done to make things better (including extra support from a volunteer, a peer, friend, etc.).
- Discuss some new strategies the youngster and those in the home would be *willing* to try to make the situation better.
- Introduce some new learning and enrichment options with an emphasis on those that fit the student's specific interests and a deemphasis on areas that are not of interest. Analyze the response.
- If peers dislike the student, find ways for the youngster to have special, positive status in class and/or in others arenas around the school/community. (This not only can help counter a negative image among peers, but can reduce behavior problems and alleviate negative feelings about self and others.) Analyze the impact on learning and behavior.
- Enhance use of aides, volunteers, peer tutors/coaches, mentors, those in the home, etc. not only to help support student efforts to learn and perform, but to enhance the student's social support networks. Analyze the impact on learning and behavior.
- After trying all the above, add some tutoring specifically designed to enhance student engagement in learning and to facilitate learning of specific academic and social skills that are interfering with effective classroom performance and learning.

Over time, staff using RtI acquire an appreciation of what is likely to work with the student and what will not. Only after extensive efforts are pursued and proven unsuccessful in the classroom is it time to seek out-of-classroom support services. And, as such services are added, steps are required to ensure they are coordinated with what is going on in the classroom, school-wide, and at home.

About Remediation

Remediation generally is used when students have difficulty learning or retaining what they have learned. Techniques and materials designated as remedial often appear quite different from those used in regular teaching. However, many remedial practices are simply adaptations of regular procedures and draw on general intervention principles and models. This is even the case with some packaged programs and materials especially developed for problem populations.

So what makes remedial instruction different?

The answer involves the following factors:

- *Sequence of application.* Remedial practices are pursued after the best available nonremedial practices prove inadequate.
- *Level of intervention focus.* Specialized psychoeducational procedures to facilitate learning may be applied at any of three levels noted in Exhibit 9.1.
- *Staff competence and time.* Probably the most important feature differentiating remedial from regular practices is the need for a competent professional who has time to provide one-to-one intervention. While special training does not necessarily guarantee such competence, remediation usually is done by staff who have special training. Establishing an appropriate match for learners with problems is difficult and involves a great deal of trial and appraisal. Additional time is essential in developing an understanding of the learner (strengths, weaknesses, limitations, likes, dislikes).
- *Content and outcomes.* Remedial efforts often add other content and outcome objectives to address missing prerequisites, faulty learning mechanisms, or interfering behaviors and attitudes.
- *Instructional and other intervention processes.* Remediation usually stresses an extreme application of instructional principles. Such applications may include reductions in levels of abstraction, intensification of the way stimuli are presented and acted upon, and increases in the amount and consistency of direction and support – including added reliance on other resources in the clasroom (e.g., paid aides, resource personnel, volunteers, peer tutors). Use of special settings outside regular classrooms is a last resort.
- *Resource costs.* Because of the factors described above, remediation is more costly than regular teaching (allocations of time, personnel, materials, space, and so forth).
- *Psychological Impact.* The features of remediation are highly visible to students, teachers, and others. Chances are such features are seen as "different" and stigmatizing. Thus, the psychological impact of remediation can have a negative component. The sensitive nature of remediation is another reason it should be implemented only when necessary and in ways that strive to produce positive perceptions all around.

In sum, what makes remedial strategies different is their rationale, the extreme degree and consistency with which they must be applied, and their application on levels of functioning other than current life tasks. What may make a remedial procedure work is that it puts aside practices a student has experienced as ineffective and replaces them with strategies that enhance motivation and match current capabilities.

SPECIAL ASSISTANCE FOR ADDRESSING CHRONIC BEHAVIOR PROBLEMS

A comprehensive approach to addressing misbehavior encompasses:

- efforts to prevent and anticipate misbehavior
- actions taken during misbehavior
- steps taken afterwards

However, because of the frequency with which students may be misbehaving, a school's focus usually is on reacting to deviant and devious behavior and ensuring a safe environment. In doing so, teachers and other school staff increasingly have adopted *discipline* and *classroom management* strategies that model behaviors which foster (rather than counter) development of negative values.

With growing awareness of the lack of effectiveness and the negative effects associated with widely used discipline practices, many schools are moving beyond applications of direct punishment. The trend is toward using positive approaches and "logical" and "fair" consequences in dealing with behavior problems.

From both a prevention and correction perspective, advocates for more positive approaches have called for various forms of special student training programs (e.g., *character education*, *emotional "intelligence" training*, positive behavior support initiatives, social skills training, mindfulness training). Besides reducing misbehavior, some of these approaches aim at enhancing personal responsibility (social and moral), integrity, self-regulation/self-discipline, a work ethic, appreciation of diversity, and positive feelings about self and others. Embedded throughout are calls for more home involvement, with emphasis on enhanced parent responsibility for their children's behavior and learning.

Are Special Training Programs the Answer?

Poor social-emotional development clearly is a widely identified concern (a correlate) and contributing factor in a wide range of educational, psychosocial, and mental health problems. Training programs to improve social-emotional learning and interpersonal problem solving are described as having promise both for prevention and correction. Reviewers of research are cautiously optimistic. Conclusions stress that individual studies show effectiveness, but the range of skills acquired remain limited; and so does the generalizability and maintenance of outcomes. This is the case for training of specific skills (e.g., what to say and do in a specific situation), general strategies (e.g., how to generate a wider range of interpersonal problem-solving options), as well as efforts to develop cognitive-affective orientations (e.g., empathy training). What training programs tend to pay insufficient attention to is the role engagement in instruction plays in determining behavior at school.

Addressing Chronic Misbehavior and Engagement as a Special Assistance Priority

Specific discipline practices, training programs, and positive behavior initiatives usually stop short of ensuring the ongoing motivational engagement of students in classroom instruction. Engaging/re-engaging students productively in instruction is key not only to reducing misbehavior but to maintaining positive behavior. And the process requires understanding and addressing the causes of misbehavior, especially underlying motivation. Failure to attend effectively to underlying motivation leads to approaching passive and often hostile students with practices that can instigate and exacerbate problems.

Consider students who spend most of the day trying to avoid all or part of the instructional program. An intrinsic motivational interpretation of the avoidance behavior of many of these youngsters is that it reflects their perception that school is not a place they experience a sense of competence, self-determination, and/or relatedness to significant others. Indeed, too often, the experience results in feelings of incompetence, loss of autonomy, and adverse relationships. Over time, the negative perceptions develop into strong motivational dispositions and related patterns of misbehavior.

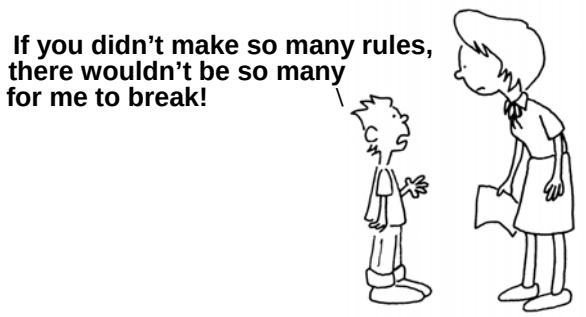
Analyses point to many school conditions that can have a negative impact on a student's motivation. Examples of such conditions include: excessive rules, criticism, and confrontation; processes that the student perceives as unchallenging, uninteresting, over-demanding, or overwhelming; structure that seriously limits options or that is over-controlling and coercive. Misbehavior at school often is reactive to such conditions. That is, individuals can be *expected* to react. This is particularly true for students with learning, behavior, and emotional problems.

So, a great deal of school misbehavior is motivated by students' efforts to cope, defend, avoid, and protest in reaction to aversive experiences (e.g., to protect themselves against situations in which they feel coerced to participate and/or cannot cope effectively). The actions may be direct or indirect and include defiance, physical and psychological withdrawal, and diversionary tactics.

Of course, misbehavior can also reflect *approach motivation*. Noncooperative, disruptive, and aggressive behavior patterns that are *proactive* can feel rewarding and satisfying to a youngster because the behavior itself is exciting or because the behavior leads to desired outcomes (e.g., peer recognition, feelings of competence or autonomy). Intentional negative behavior stemming from approach motivation can be viewed as *pursuit of deviance*.

In addressing students manifesting chronic misbehavior, intrinsic motivational theory suggests different approaches for reactive and proactive actions. In both instances, however, interventions to reduce reactive and proactive behavior problems generally begin with major changes in the school environment that minimize reactivity.

Special assistance for those misbehaving reactively require steps designed to reduce reactance and enhance positive motivation for participating in an intervention. For youngsters highly motivated to pursue deviance (e.g., those who proactively engage in criminal acts), even more is needed. Intervention might focus on helping these youngsters identify and follow through on a range of valued, socially appropriate alternatives to deviant activity. Such alternatives must be capable of producing greater feelings of self-determination, competence, and relatedness than usually result from the youngsters' deviant actions. To these ends, motivational analyses of the problem can point to corrective steps for implementation by teachers, student support staff, other professionals, parents, or students themselves. (For more resources on this, see the Center's Quick Find entitled: *Behavior Problems and Conduct Disorders* at http://smhp.psych.ucla.edu/qf/p3022_01.htm.)



A Cautionary Note about Special Assistance

Too many schools tend to redefine and constrict the curriculum for individuals identified as needing special assistance. For example, remedial programs often focus primarily on students deficits. Always working on one's problems and trying to catch up can be grueling. It takes tremendous motivation to spend day in and day out mostly working on one's problems. Moreover, restricting opportunities can delay development in areas not included and risks making the whole school experience rather deadening.

CONCLUDING COMMENTS FOR SECTION III

Transforming how schools provide special assistance to students and families is critical for improving student and learning supports and thus is an essential facet of enhancing equity of opportunity. From the school's perspective, the aim is to provide special assistance in ways that increase the likelihood that a student will be more successful at school, while also reducing the need for teachers to seek special programs and services.

Without a systematic approach to special assistance, referral processes become flooded, and the capability of providing effective help for many students with learning, behavior, and emotional problems is undermined. By developing a systematic approach to special assistance, schools can play a greater role in social and emotional development and embrace a holistic and family-centered orientation.

And in a real sense, special assistance as a facet of a unified and comprehensive system of student and learning supports is fundamental to enhancing classroom and school climate and developing a community school.

For more specific examples of ways to enhance *Student and Family Special Assistance*, see the self-study survey at
http://smhp.psych.ucla.edu/pdfdocs/toolsforpractice/studentfamilysurvey.pdf

For Free and Easily Accessed Online Resources Related to *Student and Family Special Assistance*

In the Classroom

See *Enhancing Classroom Approaches for Addressing Barriers to Learning: Classroom-Focused Enabling*
>http://smhp.psych.ucla.edu/pdfdocs/contedu/cfe.pdf

Out of the Classroom

See our Center's *Practitioner's Tool Box*
>http://smhp.psych.ucla.edu/summit2002/toolbox.htm

See our Center's Quick Find on *Case/Care Management*
>http://smhp.psych.ucla.edu/qf/casemanagment.htm

Also see related topics listed on the Quick Find menu
>http://smhp.psych.ucla.edu/quicksearch.htm

IV. Understanding Referral as an Intervention

A. The *Referral* Process: Some Guidelines and Steps

B. Providing Information About Services

C. Developing Ways to Facilitate Access to Service

1. **Highlighting the Most Accessible Referral Resources**
2. **Referral Resource Files**
3. **Support and Direction for Follow-through**
4. **Personal Contact with Referral Resources**
5. **Enhancing On-Campus Services**

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

E. Managing Care, Not Cares

1. **Initial Monitoring of Care**
2. **Ongoing Management of Care**
3. **System of Care**
4. **More About Case Management**

III. Understanding Referral as an Intervention

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

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

III. Understanding Referral as an Intervention

A. The Referral Process: Some Guidelines and Steps

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

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

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

- to identify feasible resources

and then

- to evaluate their appropriateness.

Effective referral *intervention* strategies involve procedures that

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

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

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

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

Referral Intervention Guidelines

A referral intervention should minimally

- provide readily accessible basic information about all relevant sources of help
- help the student/family appreciate the need for and value of referral
- account for problems of access (e.g., cost, location, language and cultural sensitivity)
- aid students/families to review their options and make decisions in their own best interests
- provide sufficient support and direction to enable the student/family to connect with an appropriate referral resource
- follow-up with students (and with those to whom referrals are made) to determine whether referral decisions were appropriate.

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

*Referral Steps**

Step 1

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

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

Step 2

For those who contact you, establish whether referral is necessary

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

Step 3

Identify potential referral options with the client

If the school cannot provide the service, the focus is on reviewing with the student/family the value and nature of referral options. Some form of a referral resource file is indispensable (for more on the idea of a Referral Resource File, see **http://smhp.psych.ucla.edu/pdfdocs/clientinfo.pdf**).

Step 4

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

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

Step 5

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

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

(cont.)

Referral Steps (cont.)

Step 6

Work on strategies for overcoming barriers

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

Step 7

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

That is, summarize

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

Step 8

Provide client with follow-through status forms

For examples of tools to aid these steps, see http://smhp.psych.ucla.edu/pdfdocs/referral.pdf)

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

Step 9

Follow-up with students/families (and referrers) to determine status and whether referral decisions were appropriate

For examples of tools to aid these steps, see http://smhp.psych.ucla.edu/pdfdocs/referral.pdf)

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

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

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

*Before pursuing such steps, be certain to review school district policies regarding referral.

B. Providing Information about Services

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

(See **http://smhp.psych.ucla.edu/pdfdocs/clientinfo.pdf**)

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

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

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

If the school does not have a list of on-campus resources, a first step is to survey school staff and prepare a list of on-campus services dealing with psychosocial and mental health concerns (see **http://smhp.psych.ucla.edu/pdfdocs/clientinfo.pdf**).

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

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

C. Developing Ways to Facilitate Access to Service

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

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

1. *Highlighting the Most Accessible Referral Resources*

Once the most accessible referrals are identified, they can be listed and the lists can be widely circulated. (For examples, see http://smhp.psych.ucla.edu/pdfdocs/clientinfo.pdf).

Such listings might take the form of

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

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

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

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

2. *Referral Resource Files*

A referral resource filing system is intended to contain a comprehensive compilation of basic information on available services -- see

http://smhp.psych.ucla.edu/pdfdocs/clientinfo.pdf .

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

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

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

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

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

3. *Support and Direction for Follow-through*

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

This involves finding out:

Does the student agree that a referral is necessary? (See student interview form in **http://smhp.psych.ucla.edu/pdfdocs/triaging.pdf** .)

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

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

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

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

- careful exploration of such factors
- specification of strategies to deal with them.

At the conclusion of the referral session(s), a potential enabling device is to provide the student with

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

  For examples, see **http://smhp.psych.ucla.edu/pdfdocs/referral.pdf**

  .

Other major supports that might be offered students include

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

4. Personal Contact with Referral Resources

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

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

In addition to helping establish special relationships that can facilitate access for students referred by the school, these contacts also provide additional information for referral resource files.

When Can Students Seek Assistance without Parent Involvement?

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

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

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

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

5. Enhancing On-Campus Services

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

Additional on-campus resources can be accomplished by

- recruiting and training interested school personnel and students to offer appropriate services (e.g., mediating, mentoring, counseling)
- outreaching to convince appropriate agencies and professionals to offer certain services on-campus (e.g., arranging for on-campus substance abuse counseling by personnel from county mental health or a local community mental health clinic)
- outreaching to recruit professionals-in-training and professional and lay volunteers
- helping create new programs (e.g., stimulating interest in starting a suicide prevention program and helping train school staff to run it).

Case Example

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

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

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

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

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

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

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

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

(cont. on next page)

Case Example (cont.)

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

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

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

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

I've written all this down; here's your copy. (See example in toolbox. **http://smhp.psych.ucla.edu/pdfdocs/triaging.pdf** .) *I'd also like you to let me know how our plans work out. Here's a form for you to return to me; all you have to do is put a check mark to let me know what happened and then drop the form in the school mail box sometime next week.*
(See example in toolbox, **http://smhp.psych.ucla.edu/pdfdocs/referral.pdf .**)

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

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

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

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

If she has made contact, does it now seem like the right choice was made? If not, the reasons why need to be clarified and additional options explored.

III. Understanding Referral as an Intervention

D. Following-Up on Referrals (including consumer feedback)

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

The elements of such a system might include

- feedback forms given to clients for themselves and the referral agency (see example in toolbox, **http://smhp.psych.ucla.edu/pdfdocs/quality.pdf**)
- a feedback form sent directly to the referral of first choice
- a procedure for daily identification of students due for referral follow-up
- analysis of follow-through status based on feedback
- follow-up interviews with students/families for whom there is no feedback information (See example, **http://smhp.psych.ucla.edu/pdfdocs/quality.pdf**).

For example:

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

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

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

The feedback form sent directly to the chosen service simply calls for a confirmation of follow-through. (With on-campus referrals, it has been found useful to establish a reciprocal feedback system. (See example in toolbox, **http://smhp.psych.ucla.edu/pdfdocs/quality.pdf** .)

If no feedback forms are returned, the student can be invited to explore what happened and whether additional support and direction might help.

Excerpt

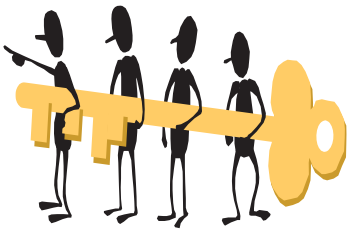
*Evidence-based Treatments Must Have a Referral and Case Management Context**

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

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

**NIMH Affective Disorders Workgroup (2002). Mental Health Services Research, 4, No. 4.*

E. Managing Care, Not Cases



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

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

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

1. Initial Monitoring of Care

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

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

2. Ongoing Management of Care

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

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

Such ongoing monitoring requires systems for:

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

(cont.)

Effective Care Management is based upon:

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

A few basic guidelines for primary managers of care are:

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

3. Systems of Care

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

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

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

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

(cont.)

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

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

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

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

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

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

> For more on this, see **http://smhp.psych.ucla.edu/pdfdocs/quality.pdf** and other Center documents on the topic.

4. More About Case Management

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

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

What is a Case Manager?

http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx

Definition of Case Management

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual s and family s comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Philosophy of Case Management

The underlying premise of case management is based in the fact that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems and the various reimbursement sources.

Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The case manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the client and the reimbursement source. Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimi e the outcome for all concerned.

Certification determines that the case manager possesses the education, skills and experience required to render appropriate services based on sound principles of practice.

Excerpt

Advanced Technology to Assist with Student Care

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

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

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

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

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

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REPORT

Case Management for Students at Risk of Dropping Out

Implementation and Interim Impact Findings from the Communities In Schools Evaluation

04/2015 | William Corrin, Leigh Parise, Oscar Cerna, Zeest Haider, Marie-Andrée Somers

http://www.mdrc.org/publication/case-management-students-risk-dropping-out

mdrc
BUILDING KNOWLEDGE TO IMPROVE SOCIAL POLICY

Too many students drop out and never earn their high school diploma. For students at risk of dropping out, academic, social, and other supports may help. Communities In Schools seeks to organi e and provide these supports to at-risk students in the nation s poorest-performing schools, including through case-managed services. School-based Communities In Schools site coordinators identify at-risk students, work with them individually to assess their needs, develop a case plan to meet those needs, connect them with supports in the school and community based on that plan, and monitor their progress to ensure that their needs are met.

This report, the first of two from a random assignment evaluation of Communities In Schools case management, focuses primarily on the implementation of case management in 28 secondary schools during the 2012-2013 school year. The implementation research yielded several key findings:

- The services provided by Communities In Schools were an important component of the participating schools' support systems for students, but there were also many services provided by school staff members and other external partners.
- Over about 30 weeks, case-managed students received an average of 19 service contacts totaling 16 hours. More than 75 percent of case-managed students received academic services, about 60 percent received social or life skills support, and half received behavior support.
- "Higher-risk" case-managed students — those who failed a course or were chronically absent or suspended in the previous year — did not receive more case-managed services than others.
- Compared with those randomly assigned to the non-case-managed group, case-managed students reported participating in more in-school support activities in several categories, including academically and behaviorally focused meetings with adults and mentoring.

The report also includes interim one-year findings about case management s impact on student outcomes.

- Case management had a positive impact on students' reports of having caring, supportive relationships with adults outside of home and school, the quality of their friendships, and their belief that education matters for their future. But for most outcomes concerning students' interpersonal relationships and educational perspectives — relationships with caring, supportive adults at home or school and educational attitudes, engagement, goals, and expectations — there were no notable differences between case-managed and non-case-managed students.
- After one year, Communities In Schools case management has not yet demonstrated improvement in students' attendance or course performance, or reduced behaviors that lead to disciplinary action — outcomes associated with increasing their chances of graduation. It is possible that case management could take more than a year to show an effect.

This report concludes with suggestions for improvement for Communities In Schools based mainly on the implementation findings. The next report will present two-year impact findings and more about the implementation of case management in the 2013-2014 school year.

High-Impact Opportunity #3

Provide or Expand Services That Support At-Risk Students, Including Through Medicaid-funded Case Management

ADMINISTRATORS (/ADMINS/LANDING.JHTML?SRC=LN) / LEAD & MANAGE MY SCHOOL

Healthy Students, Promising Futures

State and Local Action Steps and Practices to Improve School-Based Health

http://www2.ed.gov/admins/lead/safety/healthy-students/toolkit_pg4.html

What

Schools and health organizations should work together to provide wraparound services (services that address the full spectrum of health, education, safety, and welfare needs) to students, in order to remove barriers to learning that may be created by health conditions, exposure to violence or trauma, or instability or stress in the community or at home.

Research Shows

Wraparound services have been shown to benefit children, including those who are low-income, chronically absent, homeless, or otherwise at risk of falling behind in school. Childhood trauma or maltreatment, such as neglect and abuse, can negatively affect brain development. Coordinated services that protect young children from the effects of trauma are likely to promote brain development and learning ability.

Consider

LEAs and schools can, in accordance with an approved state Medicaid plan and applicable federal privacy laws, use Medicaid funding to support district and school-based case managers, who can work to connect Medicaid-enrolled students in schools to necessary health care and related support services (e.g., housing, transportation). (Please refer to page XX for additional information on key federal laws protecting student data and privacy.)

LEAs and schools should explore, in compliance with applicable privacy laws, data sharing agreements with health organizations to address the academic and physical, mental, and behavioral needs of students at risk of falling behind and/or dropping out of school.

Example

At Park Elementary, in the Hayward Promise Neighborhood in Hayward, California, intervention specialists and case managers work together to support health and wellness, parent education, academics, social services, and mental health services as part of a cradle-to-career continuum. These coordinators manage referrals for students, which enable Park staff to better support students' and families' needs. For example, one such referral resulted in a public health nurse conducting biweekly home visits to a family to help them complete an action plan and enroll in Medi-Cal health benefits.

Links/Resources:

- To learn about the important role school counselors play in ensuring student success and the Federal Programs designed to support school counselors, visit http://www2.ed.gov/policy/elsec/guid/secletter/140630.html (/policy/elsec/guid/secletter/140630.html).
- To access a one-page HHS services locator document that lists available services such as assistance programs and social services for children, adolescents and young adults, visit: http://www.hhs.gov/ash/oah/resources-and-publications/assets/health_service_locator.pdf (http://www.hhs.gov/ash/oah/resources-and-publications/assets/health_service_locator.pdf).
- To understand the legal requirements for supporting homeless students with disabilities under the Individuals with Disabilities Education Act, visit http://center.serve.org/nche/downloads/briefs/idea.pdf (http://center.serve.org/nche/downloads/briefs/idea.pdf) and http://www2.ed.gov/about/offices/list/osers/osep/policy.html (/about/offices/list/osers/osep/policy.html).
- For guidance on how to support homeless children and youth using Elementary and Secondary Education Act Title I, Part A Funds, visit http://center.serve.org/nche/downloads/briefs/titlei.pdf (http://center.serve.org/nche/downloads/briefs/titlei.pdf).
- For information on the impact of teen pregnancy on student outcomes and for strategies to support pregnant and parent students, visit http://www2.ed.gov/about/offices/list/ocr/docs/pregnancy.pdf (/about/offices/list/ocr/docs/pregnancy.pdf).
- To learn what wellness informed care is and how to integrate it into your community/workplace, visit http://www.integration.samhsa.gov/health-wellness/wellness-strategies#wellness informed care. (http://www.integration.samhsa.gov/health-wellness/wellness-strategies#wellness informed care)
- For information on the prevention and early identification of mental health and substance use conditions and for further resources regarding these concerns, visit http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf (http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf).
- To ensure effective delivery of wraparound services, check out resources from the National Wraparound Initiative at http://nwi.pdx.edu/ (http://nwi.pdx.edu/).
- For background information on and resources related to wraparound services and their role in Positive Behavioral Support, visit http://www.pbis.org/school/tertiary-level/wraparound (http://www.pbis.org/school/tertiary-level/wraparound).
- To read about the National Education Association's information regarding wraparound services and its recommendations for actors at the local, state and federal level, visit https://www.nea.org/assets/docs/Wraparound-Services-05142013.pdf (https://www.nea.org/assets/docs/Wraparound-Services-05142013.pdf).

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Examining Implementation of Risk Assessment in Case Management for Youth in the Justice System. M. Peterson-Badali, T. Skilling, & Z. Haqanee (2015). *Criminal Justice and Behavior, 42,* 304-320.
http://cjb.sagepub.com/content/early/2014/10/01/0093854814549595.full.pdf+html

Abstract. Research on implementation of a case management plan informed by valid risk assessment in justice services is important in contributing to evidence-based practice but has been neglected in youth justice. We examined the connections between risk assessment, treatment, and recidivism by focusing on the individual criminogenic needs domain level. Controlling for static risk, dynamic criminogenic needs significantly predicted reoffense. Meeting individual needs in treatment was associated with decreased offending. However, there is "slippage" in the system that reduces practitioners' ability to effectively address needs. Even in domains where interventions are available, many youth are not receiving services matched to their needs. Implications and limitations of findings are discussed.

Effectiveness of Wraparound Versus Case Management for Children and Adolescents: Results of a Randomized Study. E.J. Bruns, M.D. Pullmann, A. Sather, R. Denby Brinson, & M. Ramey (2015). *Administration and Policy in Mental Health and Mental Health Services Research, 42,* 309-322.
http://link.springer.com/article/10.1007/s10488-014-0571-3

Abstract. In this study, we compared service experiences and outcomes for youths with serious emotional disorder (SED) randomly assigned to care coordination via a defined wraparound process (n = 47) versus more traditional intensive case management (ICM; n = 46) The wraparound group received more mean hours of care management and services; however, there ultimately were no group differences in restrictiveness of residential placement, emotional and behavioral symptoms, or functioning. Wraparound implementation fidelity was found to be poor. Organizational culture and climate, and worker morale, were poorer for the wraparound providers than the ICM group. Results suggest that, for less-impaired youths with SED, less intensive options such as ICM may be equally effective to poor-quality wraparound delivered in the absence of wraparound implementation supports and favorable system conditions.

V. Other Related Resources and References

A. Additional References

B. Related Quick Find Resource and Toolkit

C. Self-study Surveys for Improving Student and Family Special Assistance

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B. Our Center's Quick Find and Toolbox

Quick Find On-line Clearinghouse

TOPIC: Case/Care Management

http://smhp.psych.ucla.edu/qf/casemanagement.htm

The Center's Online Clearinghouse Quick Finds provide direct links to additional documents, resources, and references.

Toolbox for Mental Health in Schools

This online free resource compiles a set of brief aids for school practitioners and those involved in pre-and inservice professional development programs.
http://smhp.psych.ucla.edu/summit2002/toolbox.htm

The toolbox complements the online system rebuilding toolkit.

As with all resources developed by our Center at UCLA, 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.

Currently, the resource is divided into the following 10 sections, each of which is under continuous development. Note that Section X contains tools cited in this document.

I. Framing Mental Health in Schools
II. Concerns and Controversies
III. Challenges and Opportunities in the Classroom
IV. About Behavior Problems and Social and Emotional Learning
V. Mental Health Assistance for Students at School
VI. Focusing on the Well-being of School Staff
VII. On-line Clearinghouse Quick Finds and Fact & Information Resources
VIII. Online Continuing Education Modules & Guidebooks
IX. Quick Training Aids & Tutorials
X. Tools for Facilitating Triage, Referral, and Quality of Care

Each section of the toolbox is under continuous development. All feedback and suggestions will be appreciated. Send comments to Ltaylor@ucla.edu

Self-study Surveys

General Overview of Student & Learning Supports Activity, Processes, and Mechanisms at a School

This two-step survey provides a starting point for clarifying

- what student and learning supports staff are at the school and what they do
- how student and learning supports resources are used
- how student and learning supports are organized and coordinated
- what procedures are in place for enhancing the impact of student & learning supports

Access at: **http://smhp.psych.ucla.edu/pdfdocs/toolsforpractice/general.pdf**

(1) The first form provides a template for quickly clarifying people and positions providing student and learning supports at a school, along with some of what they do. Once this form is completed it can be circulated as basic information for all school stakeholders and can be useful in the social marketing of learning supports. The people listed also are a logical group to bring together in establishing a system development leadership team for learning supports at the school.

(2) Following this form is a self-study survey designed to review and help improve processes and mechanisms relevant to the Learning Supports Component.

Student and Family Special Assistance Survey

Access at **http://smhp.psych.ucla.edu/pdfdocs/toolsforpractice/studentfamilysurvey.pdf**

Before providing special assistance to a student, the logical first step is to address general environmental factors that may be causing problems. In schools, this first step involves developing the other five arenas of the learning supports component. This can be sufficient for addressing conditions affecting a large proportion of students, and this reduces the need for further special attention. A few students, however, will continue to manifest learning, behavior, and emotional problems, and they and their families require extra assistance, perhaps including referral for specialized services and even a special education program.

Student and family special assistance includes a focus on such matters as

- Using responses to intervention (RtI) to initially identify and triage those who need such assistance
- Conducting additional assessment to the degree necessary – including diagnosis and planning of an Individual education program (IEP) when appropriate
- Providing consultation, triage, and referrals
- Conducting ongoing management of care
- Enhancing special assistance availability and quality

With specific respect to severe and chronic problems and students mandated for special education programs, special assistance includes connecting what the school offers with whatever is available in the community and facilitating access. In implementing the activity, the emphasis is on enhancing a "system of care" and ensuring the special assistance is integrated with the other facets of the comprehensive system of learning supports.