Mental Health and School-Based Health Centers

Module II

Working with Students Who Come to the Center

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

Robert Mnookin

When it comes to mental health and psychosocial problems, a SBHC's staff doesn't have to look very hard to find them. Because they are inundated with students who need assistance for mental health and psychosocial concerns, key services many centers find themselves providing are the identification and processing of such students. Major tasks in carrying out these services are initial problem identification, triage, screening/assessment, client consultation and referral and related follow-up.

Beyond identifying and processing students, SBHCs can foster preferral interventions, provide psychosocial guidance and support (related to classroom and individual needs), offer a small number of students psychosocial counseling, and when feasible, establish ongoing case monitoring/management. With an eye to primary prevention, some even are involved in mental health education. And all center staff need to be prepared to join others at a school site in responding to students' psychological crises.

Units:

Overview
A. Consent, Due Process, and Confidentiality
B. Problem Identification, Prereferral Intervention, and Consultation with School Staff
C. Screening/Assessment
D. Client Consultation and Referral
E. Responding to Student's Ongoing Psychosocial and Mental Health Needs
F. Responding to Crisis at a School
G. Management of Care and Follow-up Evaluation (Case Management)
Module II

*Working with Students Who Come to the Center*

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  ? The Referral Process: Some Guidelines and Steps
  ? Providing Information about Programs and Services
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IIF-3 A Few General Principles Related to Responding to Crises
Overview

Before discussing intervention, it is relevant to think about differentiating psychopathology from psychosocial problems.

The following is a way to think about the implications of a broad framework for understanding the causes of students' problems. This way of thinking offers a useful starting place for classifying behavioral, emotional, and learning problems and helps avoid overdiagnosing internal pathology.

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

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<th>Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause</th>
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<td>Problems caused by factors in the environment (E)</td>
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<tr>
<td>E (E&lt;---&gt;p)</td>
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<tr>
<td>Type I problems</td>
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- Type I problems: caused primarily by environments and systems that are deficient and/or hostile.
- Type II problems: caused primarily by a significant mismatch between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology).
- Type III problems: caused primarily by person factors of a pathological nature.

• Problems are mild to moderately severe and narrow to moderately pervasive

In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.
To highlight a few points about the illustration:

? Problems caused by the environment are placed at one end of the continuum and referred to as Type I problems.

? At the other end are problems caused primarily by pathology within the person; these are designated as Type III problems.

? In the middle are problems stemming from a relatively equal contribution of environmental and person sources, labelled Type II problems.

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

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

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

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

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as \( E \rightarrow P \)). Toward the other end, person variables account for more of the problem (thus \( e \rightarrow P \)).
Outlined below is an aid for thinking about causes of learning, behavior, and emotional problems.

**Factors Instigating Emotional, Behavioral, and Learning Problems**

<table>
<thead>
<tr>
<th>Environment (E)</th>
<th>Person (P)</th>
<th>Interactions and Transactions Between E and P*</th>
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<td><strong>(Type I problems)</strong></td>
<td><strong>(Type III problems)</strong></td>
<td><strong>(Type II problems)</strong></td>
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<td>1. Insufficient stimuli (e.g., prolonged periods in impoverished environments; deprivation of learning opportunities at home or school such as lack of play and practice situations and poor instruction; inadequate diet)</td>
<td>1. Physiological insult (e.g., cerebral trauma, such as accident or stroke, endocrine dysfunctions and chemical imbalances; illness affecting brain or sensory functioning)</td>
<td>1. Severe to moderate personal vulnerabilities and environmental defects and differences (e.g., person with extremely slow development in a highly demanding environment, all of which simultaneously and equally instigate the problem)</td>
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<tr>
<td>2. Excessive stimuli (e.g., overly demanding home, school, or work experiences, such as overwhelming pressure to achieve and contradictory expectations; overcrowding)</td>
<td>2. Genetic anomaly (e.g., genes which limit, slow down, or lead to any atypical development)</td>
<td>2. Minor personal vulnerabilities not accommodated by the situation (e.g., person with minimal CNS disorders resulting in auditory perceptual disability trying to do auditory-loaded tasks; very active person forced into situations at home, school, or work that do not tolerate this level of activity)</td>
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<td>3. Intrusive and hostile stimuli (e.g., medical practices, especially at birth, leading to physiological impairment; contaminated environments; conflict in home, school, workplace; faulty child-rearing practices, such as long-standing abuse and rejection; dysfunctional family; migratory family; language used is a second language; social prejudices related to race, sex, age, physical characteristics and behavior)</td>
<td>3. Cognitive activity and affective states experienced by self as deviant (e.g., lack of knowledge or skills such as basic cognitive strategies; lack of ability to cope effectively with emotions, such as low self-esteem)</td>
<td>3. Minor environmental defects and differences not accommodated by the individual (e.g., person is in the minority racially or culturally and is not participating in many social activities because he or she thinks others may be un receptive)</td>
</tr>
<tr>
<td></td>
<td>4. Physical characteristics shaping contact with environment and/or experienced by self as deviant (e.g., visual, auditory, or motoric deficits; excessive or reduced sensitivity to stimuli; easily fatigued; factors such as race, sex, age, or unusual appearance that produce stereotypical responses)</td>
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<tr>
<td></td>
<td>5. Deviant actions of the individual (e.g., performance problems, such as excessive errors in performing; high or low levels of activity)</td>
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*May involve only one (P) and one (E) variable or may involve multiple combinations.

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

On the following pages are several exhibits designed to provide an overview of matters discussed in this unit. They cover activities, processes, and other matters to be considered as a School Based Health Center and the school as a whole develop programs and systems for direct service and instruction related to mental health and psychosocial concerns. In reviewing these exhibits, note the many decision points that arise and the various stakeholders who are involved.

The identification process involves center and school staff, students, and parents. Educating all concerned about the nature of psychosocial and mental health problems and prevention and about available resources is a major task related to problem identification.

Once a problem is identified, the matter of consent to use the health center is decided -- in keeping with legal and district policies. Those without consent still need to be screened, but by school-district personnel. Hopefully, some district staff also are available to provide school-based or linked services for such students as necessary.

Initial case monitoring begins as soon as a student is identified as needing assistance. Monitoring continues to ensure proper assistance is provided directly at school or by a resource to which the student is referred. Ongoing case monitoring and follow-up evaluations are designed to check on the appropriateness and effectiveness of assistance provided. It must be anticipated that the first forms of assistance often do not work out and that case monitoring and evaluation are a natural and essential part of ensuring that students are properly helped.
Exhibit 10. Direct Interventions

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

- identifying and processing students
- crisis intervention

- ongoing case monitoring

Direct Services & Instruction

- primary prevention & treatment (inc. support for transitions)
- mental health education
- psychosocial guidance & support (classroom/individual)
- psychosocial counseling
Initial Problem Identification

Is there enough available information to understand the problem?

If not, you need to decide whether to gather additional data or make a referral for assessment.

Screening/Assessment (as appropriate)

Client Consultation and Referral

Triage (determining severity of need)

Direct Instruction

Psychosocial Guidance & Support

Psychosocial Counseling

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

Highly Specialized Interventions for Severe Problems (e.g., special educ.)

Initial triage & case monitoring

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

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

Ongoing case monitoring
Exhibit 12. Matters for a School to Consider in Developing its Systems for Problem Identification, Triage, Referral, and Case Management

**Problem identification**

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

**Triage processing**

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

**Clients directed to resources or for further problem analysis and recommendations**

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

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

(a) In many cases, prereferral interventions should be recommended. This means a site must be equipped to implement and monitor the impact of such recommendations.
(b) When students/families are referred for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Case management should be designed to determine follow-through, coordination, impact, and possible need for additional referrals.
(c) Referrals to assess the need for special or compensatory education often are delayed because of a waiting list. Back logs should be monitored and arrangements made to catch-up (e.g., by organizing enough released time to do the assessments and case reviews).

**Case monitoring/management**

(a) Some situations require only a limited form of case monitoring (e.g., to ensure follow-through). A system must be developed for assigning case monitors as needed. Aides and paraprofessionals often can be trained to for this function.
(b) Other situations require intensive management by specially trained professionals to (a) ensure interventions are coordinated/integrated and appropriate, (b) continue problem analysis and determine whether appropriate progress is made, (c) determine whether additional assistance is needed, and so forth. There are many models for intensive case management. For example, one common approach is to assign the responsibility to the professional who has the greatest involvement (or best relationship) with the student/family.
(c) One key and often neglected function of the case monitor/manager is to provide appropriate status updates to all parties who should be kept informed.
Exhibit 13. Steps in Meeting a Student's Needs

**Identifying that Sara Needs Help**

- Self or other identified
- Initial contact
- Decision made that assistance is needed

If Sara has consent to use SBHC, she is directed to the center's mental health screener. If Sara does not have consent to use SBHC, she is directed to appropriate school staff.

**Screening, Referral, & Initial Case Monitoring**

(with center M.H. screener)

- (a) clarify specific need
- (b) identify appropriate help
- (c) clarify procedures for enrollment in intervention

**Screening, Referral, & Initial Case Monitoring**

(with school personnel, e.g., psychologist, counselor, nurse)

- (a) clarify specific need
- (b) identify appropriate help
- (c) clarify procedures for enrollment in intervention
- (d) case management and support for follow-through

**Facilitating Corrective Intervention**

- on-campus
- off-campus district services
- off-campus community services

**Ongoing Case Management & Follow-up Evaluation**

(to check on appropriateness and effectiveness of intervention)

- immediate
- longer-term

If necessary, another screening is initiated to reassess need and possibly to change intervention. If problem is corrected, intervention is terminated.
"Clearly, confidentiality mandates are very important and they need to be upheld. They have been developed to protect basic rights to privacy which all service providers must closely guard and carefully respect. Also, it must be recognized that in addition to governmental legal requirements, most professional disciplines have legal obligations or strong ethical standards that prohibit release of information about a client, patient, or student without consent.

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

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

William Davis, 1994

Before moving into the specifics of mental health services and instruction, a few words are in order about some fundamental legal and ethical considerations.
Consent and Due Process

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

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

Due process protects people's rights; procedural safeguards are meant to help guarantee that everyone is treated fairly. They are meant to ensure that parents are involved in decisions regarding testing and placement of their child. That is, such interventions are not supposed to take place without parental consent. Exhibit 14 highlights some of the safeguards spelled out in law.

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

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

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

All three elements are of equal importance. These elements can be captured by three questions: Does the person have the ability to consent? adequate information to do so knowledgeably? the freedom to decline?
Exhibit 14: Some Due Process Safeguards

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

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

3. Parents have the right to

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

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

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

Where the laws allows, licensed professionals can offer some sensitive services without parent consent. School-based health centers allow for open access once parents have signed an initial consent form that allows the student to use designated services.

In many instances, however, students are not in a position or motivated to follow-through with a referral -- even though their problems may be severe. Thus, more often than not, parent involvement is needed to facilitate follow-through. For example, students may need parents to pay fees and for transportation. If a student is not an emancipate minor, the referral resource will probably require parental consent.
When parent involvement is indicated, the referral intervention includes efforts to help students understand the benefits of such involvement and encourage them to discuss the matter with their parents. School staff can play a major role in facilitating and perhaps mediating a student-parent discussion for students who see the need but are fearful of approaching their parents without support.

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

A Note About SBHC Consent Forms

In communicating appropriate information about the center to students and their families, it is essential to use a variety of strategies and often several languages. The information that must be communicated includes:

- why the SBHC has been established
- what services are offered (with special attention to explaining sensitive services such as mental health and birth control)
- who provides the services, where, and during what hours
- how the costs of services are underwritten
- who is eligible to use the center
- how to enroll (with special attention to the informed consent procedure and the right of parents to limit the type of services a student uses)
- confidentiality procedures and limits

Minimally, such information should be in a general flyer/brochure that is circulated to all parents and students and the basic information should also be included in the center's informed consent forms. An example of a SBHC Informed Consent Form is offered as Resource Aid IIIA-1.
Confidentiality and Privacy

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

Student to the Center Staff:

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

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

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

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

In this vein, but perhaps going a step further, the ethical guidelines for school counselors call for reporting instances when information provided by clients indicates circumstances likely to have a negative effect on others; that is, without revealing the identity of the client, the counselor is expected to report such circumstances "to the appropriate responsible authority." However, it is left to individual counselors to decide which circumstances are "likely" and what constitutes a "negative effect" that is serious enough to require reporting. One result of all this is to make the processes of ensuring privacy and building trust almost paradoxical.
Fortunately, most of what we talk over is private. If you want to talk about any of the three problems that must be shared with others, we’ll also talk about the best way for us to talk about the problem with others. I want to be sure I’m doing the best I can to help you.

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

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

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

States vary in the degree to which their laws specify limitations on privileged communication between counseling professionals and minor clients. Some protect only disclosures about problems related to alcohol and other drugs. Others give broad protection, specifying a few exceptions such as reporting child abuse and crime or potential criminal activity. The box on the next page highlights some basics related to understanding the root of confidentiality protections.
On Confidentiality

Soler and Peters (1993) stress:

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

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

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

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

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

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

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

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

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

Finally, it should be noted that the sharing of confidential information within and across agencies can be facilitated through developing a Consent to Exchange Confidential Information. See Resource Aid IIA-2 for examples of the type of forms being developed around the country to overcome the barriers to the type of sharing that is essential in coordinating services. (Note that the form is designed to meet the varying demands of federal and state laws and education codes.)
Privacy and Confidentiality

There are numerous reasons why it is important to maintain confidentiality in the delivery of health care services to adolescents. Possibly the most important is to encourage adolescents to seek necessary care, but additional reasons include supporting adolescents’ growing sense of privacy and autonomy and protecting them from the humiliation and discrimination that could result from disclosure of confidential information.

The confidentiality obligation has numerous sources in law and policy. They include: the federal and state constitutions; federal statues and regulations (such as those which pertain to Medicaid, Title X family planning programs, federal drug and alcohol programs, Title V maternal and child health programs, or community and migrant health centers); state statutes and regulations (such as medical confidentiality statutes, medical records statutes, privilege statutes, professional licensing statutes, or funding statutes); court decisions; and professional ethical standards.

Because these varied provisions sometimes conflict, or are less than clear in their application to minors, it is important that practitioners have some general guidelines to follow -- or questions to ask -- in developing their understanding how to handle confidential information. Confidentiality protections are rarely, if ever, absolute, so it is important for practitioners to understand what may be disclosed (based on their discretion and professional judgement), what must be disclosed, and what may not be disclosed. In reaching this understanding, a few of the most relevant questions include: What information is confidential (since it is confidential information that is protected against disclosure)? What information is not confidential (since such information is not protected)? What exceptions are there in the confidentiality requirements? What information can be released with consent? What other mechanisms allow for discretionary disclosure? What mandates exist for reporting or disclosing confidential information?

In general, even confidential information may be disclosed as long as authorization is obtained from the patient or another appropriate person. Often, when minors have the legal right to consent to their own care, they also have the right to control disclosure of confidential information about that care. This is not always the case, however, since there are a number of circumstances in which disclosure over the objection of the minor might be required: for example, if a specific legal provision requires disclosure to parents; a mandatory reporting obligation applies, as in the case of suspected physical or sexual abuse; or the minor poses a severe danger to himself or others.

When the minor does not have the legal right to consent to care, or to control disclosure, the release of confidential information must generally be authorized by the minor's parent or the person (or entity) with legal custody or guardianship. Even when this is necessary, however, it is still advisable -- from an ethical perspective -- for the practitioner to seek the agreement of the minor to disclose confidential information and certainly, at minimum, to advise the minor at the outset of treatment of any limits to confidentiality. Fortunately, in many circumstances, issues of confidentiality and disclosure can be resolved by discussion and information agreement between a physician, the adolescent patient, and the parents without reference to legal requirements.

Excerpted from "The Legal Framework for Minor Consent" by Abigail English written as the introduction to State Minor Consent Statutes: A Summary (April, 1995) prepared by the National Center for Youth Law (authored by M. Mathews, K. Extavour, C. Palamountain, & J. Yang).
Resource Aids

A. Resource Aid Included Here

Resource Aid IIA-1

SBHC Informed Consent Form

An example of the type of consent form SBHC’s have found effective.

Resource Aid IIA-2

Consent to Exchange Confidential Information

An example of a form used to overcome barriers to the sharing of confidential information across agencies when it is appropriate to do so (e.g., to coordinate services).

B. Related Resource Aid Packet Available from Our Center

Confidentiality and Informed Consent

Focuses on issues related to confidentiality and consent of minors in human services and interagency collaborations. Also includes sample consent forms.
(SBHC Informed Consent Form)

For Those Interested in Enrolling in the
School-Based Health Center
at _______________________School

WHO can use the Center?

All students enrolled at the school

HOW can a student use the Center?

Once a student has given us this CONSENT FORM signed by parent/guardian, the student can walk in and make an appointment or the parent/guardian or a school staff member can ask that the student be seen.

WHY should students use the Center?

Some students can't afford to go to a doctor or counselor. Others have difficulty getting to a doctor or counselor. Students may feel more at ease using a school’s Center.

WHEN is the Center open?

During school hours and at designated other times (call for specific times)

WHO staffs the Center?

A team of part time and full time professionals including:

- Physician
- Practitioner
- Psychologist
- Nurse
- Medical Assistant
- Health Educator

WHAT fees are charged for Center services?

Services are provided at no cost to students or parents. That is, no direct fees will be charged to you. Insurance companies or Medical Assistance will be billed when possible and agreeable to you.
WHAT services are provided?

We help students
* deal with barriers to learning
* adopt healthy behaviors
* get help early when they have problems
* talk to their parents about health and personal concerns

We offer three plans from which to choose.

Plan 1 = Provides both GENERAL and SPECIAL Health Services.

Plan 2 = Provides all Health Services except those parents designate below as services the student may not access (cross out any services you do not give consent for the student to use).

Plan 3 = No services may be provided the student at the Center.

**General services** include:

**Physical Care**
- Flu and colds
- Infections
- Headaches, earaches
- Sore throats
- Sprains, cuts, burns
- Skin problems
- Abdominal pain, back pain
- Chronic illness
- Physical disability

**Personal Counseling**
- Self-esteem
- Family counseling
- Relationship counseling
- Sexual abstinence counseling
- Stress and anxiety
- Depression
- Abuse and neglect
- Suicide prevention counseling

**Health and Wellness Education**
- Physical exams for sports or jobs
- Health screening for blood pressure and cancer
- Immunizations
- AIDS prevention
- Smoking prevention
- Safety promotion

**Nutritional Services**
- Sports nutrition
- Weight management
- Special Diets

**Laboratory Services**
- Pap smear
- Diabetes tests
- Urine tests
- Routine blood tests
- Sickle Cell tests
- Throat cultures

**Special Services** that are available:

- Alcohol and drug abuse assessment
- Sexually transmitted diseases -- education, diagnosis, treatment
- Pregnancy services -- tests, prenatal case management, WIC, option counseling referral
- Contraceptive counseling and prescriptions

THE CENTER
* DOES NOT
* PROVIDE abortion counseling or services or contraceptive supplies.
ANY QUESTIONS?

Please feel free to call to ask questions or arrange a visit.
Phone: ____________.

The following agreement must be signed before a student can use the Center.

We offer three plans from which to choose.

- **Plan 1** = Provides both **GENERAL** and **SPECIAL** Health Services.
- **Plan 2** = Provides only those Health Services which parents designate on the Consent Form as services the student may access.
- **Plan 3** = Parent wants no services for the student at the Center.

**PARENT CONSENT**

Please choose **ONLY ONE PLAN**. **Sign** and return form to the school’s Health Center.

Check one of the following. My choice is

- ____ **PLAN 1** -- **ALL** GENERAL Medical **AND** SPECIAL Health Services.
- ____ **PLAN 2** -- **ALL** Health Center Services **EXCEPT** for those I have crossed out on the preceding page.
- ____ **PLAN 3** -- **NO** GENERAL **OR** SPECIAL Health Services.

I have read and understand the services and different PLANS offered by the School’s Health Center. I give my permission for __________________________ to use the plan checked above.

(Student’s Name)

___________________________    ____________         ___________
Parent/Guardian Signature                       Date                 Daytime Phone

**STUDENT ASSENT**

___________________________    ____________         ___________
Student’s Signature                           Date                 Daytime Phone
CHILDREN'S INTERAGENCY

CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

PLEASE TYPE/PRINT ALL INFORMATION

Child's Name __________________________ Birth Date __________________________

Mother's Maiden Name ___________ Father's Name __________________________

Social Security No ______________ Record No. __________________________

I authorize ____________________________________________________________
to exchange information with ____________________________________________

Agency/Person/Organization

____________________________________ Address

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

______________________________________________________________.

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

______________________________________________________________.

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

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

______________________________________________________________.

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

________________________________________ Date, Event, or Condition

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

Date ___________________________ Witness ___________________________

Signed _________________________ Signed _____________________________

Parent, Guardian, Conservator Case Manager/County Representative

Agency ___________________________

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

The following records and/or information was released to:

- ____ Summary of Record
- ____ Psychiatric Evaluation
- ____ Results of Psychological/Vocational Testing
- ____ Diagnosis / Assessment
- ____ Medical Assessment, Lab, Test, etc.
- ____ Other (specify)
- ____ Social History
- ____ History of Drug / Alcohol Abuse
- ____ Treatment Plan
- ____ Other Evaluation / Assessment (specify)
- ____ Financial Information
- ____ Other (specify)

Released by:

SIGNATURE

TITLE ___________________________ DATE ___________________________
UNIT IIB: Problem Identification, prereferral intervention, And Consultation with school staff

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? Initial Problem Identification IIB-1
? Prereferral Interventions IIB-2
? Staff Consultation IIB-3
  >Mental Health Consultation in Schools IIB-3
  >Collaborative Consultation IIB-3
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**Unit IIB**

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**Resource Aids**

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Center staff identify many mental health problems each day. And, of course, some students come seeking help for themselves. Some are best served by helping to ensure that appropriate prereferral interventions are implemented; others can be assisted immediately and directly by center staff; others require referrals.

**Initial Problem Identification**

Early in a center's development, the emphasis simply is on letting school personnel, students, and parents know that help for psychosocial and mental health concerns is available. This involves educating teachers, peers, parents, and others to ensure they are informed.

To these ends,

- Be certain that mental health services and application procedures are described in all center flyers, brochures, and announcements sent to students, school personnel, and parents.

- Provide an information sheet on *Helping Students with Psychosocial Problems Seek Help* (see Resource Aid IIB-1) to clarify appropriate ways to identify students in need and guide them to help.

- Make available and readily accessible to all school staff and other potential referral sources a request-for-contact form (see Resource Aid IIB-2).

In keeping with the principle of using the least intervention needed, it is imperative to explore the effectiveness of prereferral interventions in assisting identified students before expending resources on screening/assessment and referral. In many instances, prereferral interventions may be a sufficient approach to the problem. At the very least, the assessment data generated by trying such interventions will be useful in making triage and referral decisions.

Over time, you will want to educate potential referrers appropriate indicators of problems (see Resource Aids IIB-3 and 4) and about prereferral interventions and how to help a student decide to seek help and about all resources available at school that provide help.
As discussed in other units of the guidebook, if the student is to be assisted at the center, you will want to *assess* the problem for purposes of triage and consulting with the student and concerned others. And if there are accessible referral resources at the school (e.g., a school psychologist, a counselor, a social worker) or in the community, the center will need to be certain there are well developed systems for connecting with such referrals.

**Prereferral Interventions**

Prereferral interventions require the involvement of classroom teachers and other school staff. Exhibit 15 is a guide center staff might use in helping teachers learn some basic steps to take prior to referring a student for special assistance.

---

**Exhibit 15: A Guide for Teachers and Other School Staff Regarding the Prereferral Process**

*When students have problems, the following steps may be helpful.*

**Step 1:** Based on your work with the student, *formulate a description* of the student's problem (see Resource Aid IIB-2).

**Step 2:** Have *a discussion* to get the student's view. You may want to include the family (see Resource Aid IIB-5).

**Step 3:** Try *new strategies* in the classroom based on your discussion (see Resource Aid IIB-6).

**Step 4:** If the new strategies don't work, *talk to others* at school to learn about additional approaches they have found 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 student motivation and capability, request additional staff development on working with students who have learning, behavior, and emotional problems).

**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.
Staff Consultation

Essentially, consultation is a collaborative problem solving intervention. Consultants enter into such a collaboration with the intent of improving the nature of intervention activity which others implement (Caplan, 1970; Cole & Siegel, 1990; Conoley & Conoley, 1990; Friend & Cook, 1996; Gutkin & Curtis, 1982; Meyers, Parsons, & Martin, 1979; Rosenfield & Gravois, 1996; Sarason, 1996; Zins, Curtis, Gradens, & Ponti, 1988; Zins, Kratochwill, & Elliott, 1994).

Mental Health Consultation in Schools

Mental health consultation focuses on the psychosocial aspects of human behavior and intervention processes and outcomes. In schools, mental health consultation is a critical facet of any comprehensive program to assist staff in addressing student’s problems. This need stems from the fact that psychosocial factors must be well understood and accounted for in solving students’ learning and behavior problems and reducing dropouts. This is the case in designing direct interventions and when referral for special services is necessary (assuming relevant services are available).

Although a considerable amount of school mental health consultation is focused on individual student problems, this need not and probably should not be the case. Such collaborative problem solving consultation can be used to help improve classroom, school, or district-wide programs with respect to both overcoming problems and enhancing positive psychosocial development.

Collaborative Consultation

Truly collaborative problem solving requires considerable skill (see Exhibit 16). Even when consultation is sought and those seeking the consultation are highly motivated to problem solve, consultants must be adept at

? initiating and maintaining a working relationship

and

? facilitating collaborative problem solving.

Moreover, consultants must be committed and able to avoid undermining collaboration by sharing their expertise in ways that are consistent with empowering (e.g., equipping) those seeking consultation to solve future problems on their own.
Exhibit 16: Building Rapport and Connection

To be effective in working with another person (student, parent, staff), you need to build a positive relationship around the tasks at hand.

Necessary ingredients in building a working relationship are

- minimizing negative prejudgments about those with whom you will be working
- taking time to make connections
- identifying what will be gained from the collaboration in terms of mutually desired outcomes -- to clarify the value of working together
- enhancing expectations that the working relationship will be productive -- important here is establishing credibility with each other
- establishing a structure that provides support and guidance to aid task focus
- periodic reminders of the positive outcomes that have resulted from working together

With specific respect to building relationships and effective communication, three things you can do are:

- convey empathy and warmth (e.g., the ability to understand and appreciate what the individual is thinking and feeling and to transmit a sense of liking)
- convey genuine regard and respect (e.g., the ability to transmit real interest and to interact in a way that enables the individual to maintain a feeling of integrity and personal control)
- talk with, not at, the individual -- active listening and dialogue (e.g., being a good listener, not being judgmental, not prying, sharing your experiences as appropriate and needed)

Ensuring confidentiality also is fundamental to building a positive working relationship.

Finally, watch out for ego-oriented behavior (yours and theirs) -- it tends to get in the way of accomplishing the task at hand.
With respect to collaborative consultation, Zins and his colleagues (1988) state that it involves

a nonhierarchical, egalitarian relationship in that both the consultant and the consultee engage in efforts to develop effective intervention techniques. In other words, they are considered equal contributors to the problem-solving process as each brings different perspectives and areas of expertise to the situation.

Although consultants should not unilaterally solve the problem and tell consultees which strategies to implement, both participants share responsibility for applying their expertise. Neither party should hold back ideas or interact predominantly in a nondirective manner. The purpose of collaboration is to establish an atmosphere that encourages all participants to contribute and share their expertise and resources (Tyler, Pargament, and Gatz, 1983; Zins, 1985) as collaboration can improve the flow of communication (Gutkin and Curtis, 1982) and facilitate creative problem solving (Sandoval, Lambert, and Davis, 1977). In fact, teachers have been found to prefer collaborative consultation to an expert approach; they perceive the collaborative consultant as being more attentive and the process as resulting in the development of more successful and relevant interventions (Wenger, 1979) (pp.29-30).

Recognizing the importance of consultant commitment to empowerment of those seeking consultation, Pugach and Johnson (1989) state that empowerment is

a tricky issue relative to collaborative consultation. . . . For collaborative working relationships to be realized, specialists will have to work hard to shed the "expert" image to which they have been socialized and which many classroom teachers have come to expect of them. . . . Currently, a realistic balance has not been achieved . . . . What remains to be seen is whether we can challenge ourselves to advance to the next level, that is, recognizing collaboration can occur only when all participants have a common understanding of their strengths and weaknesses and demonstrate a willingness to learn from each other (p. 235).

On consulting in the schools:

We do not know to what extent we can be of help ....
We do not present ourselves as experts who have answers.
We have much to learn about this helping process ...
together we may be able to be of help to children ....

Sarason, Levine, Goldenberg, Cherlin, & Bennett (1960)
Barriers to Collaboration

Consultation for those who are not motivated to problem solve raises additional concerns (again see Exhibit 15). Such persons will not only be passive participants in the problem solving process, they are unlikely to follow-through on potential solutions. In such cases, the consultant also needs skills related to

? understanding reactive and proactive barriers to problem solving and

? dealing with barriers to problem solving (especially affective interference).

As discussed in Unit IB, common barriers arise from differences in sociocultural and economic background and current lifestyle, skin color, sex, power, status, and professional training. In working relationships, differences can be complementary and helpful -- as when staff from different disciplines work with and learn from each other. However, differences become a barrier to establishing effective working relationships when negative attitudes are allowed to prevail. Interpersonally, the result generally is avoidance or conflict and poor communication.

When the problem is only one of lack of awareness and poor skills, it is relatively easy to overcome. Most motivated professionals can be directly taught ways to improve understanding and communication and avoid or resolve conflicts that interfere with working relationships. There are, however, no easy solutions for deeply embedded negative attitudes. Certainly, a first step is to understand that the nature of the problem is not differences per se but negative perceptions stemming from the politics and psychology of the situation.

It is these perceptions that lead to prejudgments that a person is bad because of an observed difference and the view that there is little to be gained from working with that person. Thus, minimally, overcoming negative attitudes interfering with a working relationship involves finding ways (1) to counter negative prejudgments (e.g., to establish the credibility of those who have been prejudged) and (2) to demonstrate there is something of value to be gained from working together.

Proactive steps toward building positive connections involve such fundamentals as conveying genuine empathy, warmth, regard, and respect and avoiding such dynamics as the "expert trap" and "rescue transactions." Self-criticism and self-disclosure can help create an atmosphere where defensiveness is minimized. Also, helpful is the expression of appreciation for efforts in the right direction. After a positive working relationship is established, it becomes feasible for the persons involved to help each other reduce inappropriate prejudgments and become increasingly sensitive to important differences related to status, power, culture, race, sex, age, professional training, and so forth.
Toward School-Based Consultation Teams

Where support in the form of consultation is available and readily accessible, it can be extremely beneficial to school staff and students and their families. Unfortunately, traditional models of mental health consultation designed to send in a mental health professional in response to each special request are too costly for most school districts to provide. Thus, the need for a model that uses and upgrades the talents of existing school staff to provide consultation to their colleagues with respect to student psychosocial problems.

That is, it is recognized that, at best, most districts can afford only a relatively few highly trained mental health professionals. Rather than exhausting this special resource with direct service (e.g., assessment and counseling) and direct consultation activity, a small cadre of mental health professionals can rotate from school to school helping relevant on-site staff create and evolve school-based psychosocial consultation teams. Once established, the members of such a team would be available and accessible to the rest of the school staff for mental health consultation regarding individual students and particular events. And, as a team, they would work together to identify, coordinate, and develop additional resources for meeting the psychosocial needs of students at the school (e.g., linking and publicizing existing programs, improving referral processes, upgrading crises responses, arranging for mental health inservice education, developing new psychosocial programs).

Teacher Assistance Teams

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

Rosenfield and Gravois (1996) use the concept of an Instructional Consultation Team as their approach for collaborative problem solving consultation.
**Offering Consultation and Responding to Requests**

Most school personnel need frequent reminders that mental health consultation is available. To this end, participating schools and personnel can be sent flyers and letters periodically and presentations at school staff meetings can be offered each year (see Resource Aid IIB-7 and 8).

Typically, mental health consultants are called upon to provide general support for teachers and to help analyze and determine ways to approach students with problems. From the perspective of the least-intervention needed continuum, the consultant’s first concern often is to help staff members understand school adjustment problems and how to deal with them in general. When a specific student is of concern, the consultant collaborates in efforts to clarify the nature of the problem and the degree of intervention that seems most appropriate (i.e., least disruptive and intrusive given the student's needs).

Follow-up information from the teacher clarifies when a chosen strategy has proven to be ineffective. In such cases, the focus of consultation shifts to an exploration of a more intensive, specialized intervention.

In addition to providing assistance and inservice education in the form of direct on-site consultation, a hotline has proven to be a useful way of encouraging and responding with prompt attention to concerns.

Consultants also are asked to provide formal presentations. A common need, for example, is to help staff improve skills for talking with and listening to students (see Resource Aid IIB-9).

**Concluding Comments**

Consultation is not an end in itself. The aim of consultation is to solve problems; the reason for consultation is to provide an additional form of assistance for those who carry out direct interventions in hopes that this aim will be achieved (see Resource Aid IIB-10 for an outline of the key steps and tasks in problem solving intervention.).

The prevailing approach to school mental health consultation involves bringing in specialists with expertise relevant to dealing with a particular problem. It is likely that there will always be instances where such an approach is needed. In the future, however, it seems worth exploring ways to mobilize the variety of individuals in every school who could be useful consultants for the psychosocial concerns that arise at that school.
SBHC staff consultation with school staff usually is thought of as a direct interchange focused on specific problems. And, indeed, initial consultation activity offered by a SBHC staff member usually follows this model. At the same time, as suggested in the introduction, it has been recognized that a model is needed that uses and upgrades the talents of existing school staff to provide consultation to their colleagues with respect to psychosocial concerns. Thus, as discussed in Unit IB, it is essential that SBHC staff think in terms of helping a school develop its own consultation team for dealing with psychosocial concerns.

Although a primary emphasis of SBHCs is to address the problems manifested by students with specific problems, the problem solving efforts of school-based consultation are seen as enhancing resources for all students at the school. This is accomplished because effective consultation improves a school's response to psychosocial problems by enhancing staff competence and stimulating programmatic changes.

Thus, consultation by SBHC staff is seen as potentially encompassing not only matters related to the causes and correction of individual students' problems, but also advocating for and helping to

? establish a Resource Coordinating Team focused on enhancing systems and addressing problems related to problem identification, prereferral intervention, collaborative consultation, screening, triage, referral, crisis response and prevention, counseling, mental health education, management of care, and concerns about consent, confidentiality, legal reporting requirements, and school district and SBHC policies

? identify programmatic resources available to the school and clarification of the needs of school staff with respect to psychosocially relevant concerns

? plan and implement staff inservice education and student mental health education.
A. Resource Aids Included Here

Resource Aid IIB-1

*Helping Students with Psychosocial Problems Seek Help*

This information sheet and request for contact form can be circulated to all school staff and other potential referral sources to raise consciousness regarding their role and clarify appropriate ways to (a) identify students with psychosocial problems and (b) guide them to help.

Resource Aid IIB-2

*Triage Review Request Form*

This form is used to request assistance in addressing concerns about a student/family. It encompasses a checklist for identifying the nature and scope of the apparent problem, current school functioning, and whether the student/family has asked for assistance.

Resource Aid IIB-3

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

This handout is designed to assist in educating staff about appropriate indicators of psychosocial and mental health problems.

Resource Aid IIB-4

*Being Specifically Alert to Substance Abuse Indicators*

This handout is designed to assist in educating staff about appropriate indicators of substance abuse.

Resource Aid IIB-5

*How to Explore Problems with Student/Family*  
*(Guidelines to Give Teachers)*

This handout is designed to provide teachers with a guide to exploring learning, behavior, and emotional problems with a student and/or family.
Resource Aid IIB-6

Prereferral Interventions: Some Things to Do (Guidelines to Give Teachers)

This handout is designed to provide teachers with a guide to some things to try before referring a student for special help.

Resource Aid IIB-7

Letter to Teachers Regarding Available Consultation

Sample letter inviting teachers to consult with SBHC mental health professional.

Resource Aid IIB-8

Reminder and Survey Related to Identifying Consultation Needs

This form suggests a way to provide school staff with another reminder about the availability of SBHC services and mental health consultation. It also may elicit information about school staff needs.

Resource Aid IIB-9

Example of Inservice Presentation to Enhance Staff Skills for Talking with and Listening to Students

This outline is provided as an example of the type of presentation SBHC staff may help present to school staff.

Resource Aid IIB-10

Outline of Key Steps and Tasks in Problem Solving Intervention

This figure and chart is designed to provide an outline of intervention (including consultation) conceived as problem solving.

B. Related Resource Aid Packet Available from Our Center

Screening/Assessing Students: Indicators and Tools

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.
HELPING STUDENTS WITH PSYCHOSOCIAL PROBLEMS SEEK HELP

Students with mental health needs are identified by

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

IF A STUDENT INDICATES S/HE HAS A PROBLEM AND YOU THINK IT SHOULD BE SCREENED BY A MENTAL HEALTH PROFESSIONAL, YOU CAN HELP BY DOING THE FOLLOWING:

**Inform and Reassure**

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

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

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

**Guide Students to Help**

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

OR

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

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

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

IF THE STUDENT IS NOT READY TO SELF-INITIATE CONTACT AND YOU FEEL S/HE SHOULD BE INTERVIEWED ANYWAY, INFORM THE MENTAL HEALTH PROFESSIONAL AT THE SBHC
**Triage Review Request Form**  
*(Request for Assistance in Addressing Concerns about a Student/Family)*

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

Student’s Name ________________________________ Date:_______

To: ________________________________ Title: ___________________

From: ________________________________ Title: ___________________

**Apparent problem** (check all that apply):

___ physical health problem (specify) ________________________________

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

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

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

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

Other specific concerns

**Current school functioning and desire for assistance**

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

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

Has the student/family asked for:
   information about service Y N
   an appointment to initiate help Y N
   someone to contact them to offer help Y N

If you have information about the cause of a problem or other important factors related to the situation, briefly note the specifics here (use the back of the sheet if necessary).
Being Alert to Indicators of Psychosocial and Mental Health Problems*

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

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

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

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

- very unhappy, sad, teary, depressed, indicates a sense of worthlessness, hopelessness, helplessness
- very anxious, shy
- very afraid, fearful
- can't seem to control emotions
- doesn't seem to have feelings

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

- very immature
- frequent outbursts/temper tantrums, violent
- often angry
- cruel to animals
- sleep problems and/or nightmares
- wetting/soiling at school
- easily distracted
- impulsive
- steals
- lies often
- cheats often
- destroys things
- accident prone
- unusual, strange, or immature speech patterns
- often doesn't seem to hear
- hurts self, self-abusive
- easily becomes overexcited
- truancy, school avoidance
- trouble learning and performing
- eating problems
- sets fires
- ritualistic behavior
- seizures
- isolates self from others
- complains often about physical aches and pains
- unaccounted for weight loss
- substance abuse
- runs away
Interactions with others
(Doesn't seem interested in others. Can't interact appropriately or effectively with others.)
- doesn't pay attention
- cruel and bullying
- highly manipulative
- alienates others
- has no friends
- refuses to talk
- promiscuous
- excessively reactive and resistant to authority
- highly aggressive to others -- physically, sexually

Indicators of Unusual Thinking
(Has difficulty concentrating. May express very strange thoughts and ideas.)
- worries a lot
- doesn't stay focused on matters
- can't seem to concentrate on much
- preoccupied with death
- seems to hear or see things, delusional

*Additional indicators for problems (such as depression in young people) are available through a variety of resources -- for example, see the organizations listed in the Resource Aid packet on Where to Get Resource Materials to Address Barriers to Learning -- available from the Center for Mental Health in Schools at UCLA.
Being Specifically Alert to Substance Abuse Indicators

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

The type of indicators usually identified are

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

School staff and those in the home need to watch for

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

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

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

**Amphetamines (stimulants)**

- excessive activity
- rapid speech
- irritability
- appetite loss
- anxiety
- extreme moods and shifts
- erratic eating and sleeping patterns
- fatigue
- disorientation and confusion
- increased blood pressure and body temp.
- increased respiration
- increased and irregular pulse
- tremors

**Cocaine (stimulant, anesthetic)**

- short-lived euphoria followed by depression
- nervousness and anxiety
- irritability
- shallow breathing
- fever
- tremors
- tightening muscles
### Inhalants

- euphoria
- intoxicated look
- odors
- nausea
- drowsiness
- stupor
- headaches
- fainting
- poor muscle control
- rapid heartbeat
- anemia
- choking

### Cannabinoids (e.g., marijuana, hash, THC)

- increased appetite initially
- decreased appetite with chronic use
- euphoria
- decreased motivation for many activities
- apathy, passivity
- decreased concentration
- altered sense of time and space
- inappropirate laughter
- rapid flow of ideas
- anxiety; panic
- irritability, restlessness
- decreased motor skill coordination
- characteristic odor on breath and clothes
- increased pulse rate
- droopy, bloodshot eyes
- irregular menses

### Narcotics (e.g., opium, heroin, morphine, codeine, methadone, and other pain killers)

- extreme mood swings
- poor concentration
- confusion
- insensitivity to pain
- drowsiness/decreased respiration
- slow, sallow breathing
- decreased motor coordination
- itchiness
- watery eyes/pinpoint pupils
- lethargy
- weight loss
- decreased blood pressure
- possible needle marks
- as drug wears off nausea & runny nose

### Barbiturates, sedatives, tranquilizers (CNS depressants)

- decreased alertness
- intoxicated look
- drowsy
- decreased motor coordination
- slurred speech
- confused
- extreme mood swings
- erratic eating and sleeping patterns
- dizzy
- cold, clammy skin
- decreased respiration and pulse
- dilated pupils
- depressed mood state
- disinhibition

### Hallucinogens (effecting perceptions; e.g., PCP, LSD, mescaline)

- extreme mood alteration and intensification
- altered perceptions of time, space, sights, sounds, colors
- loss of sense of time, place, person
- decreased communication
- panic and anxiety
- paranoia
- extreme, unstable behaviors
- restlessness
- tremors
- nausea
- flashbacks
- increased blood pressure
- impaired speech
- impaired motor coordination
- motor agitation
- decreased response to pain
- watery eyes
How to Explore 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 Unit IIC.
Prereferral Interventions 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.
Sample letter to teachers re. availability of consultation

Dear (Teacher),

We hope you are finding the (school-based health center) helpful. This letter is meant as a brief reminder that mental health consultation also is available to you as another way to explore possible solutions for the problems these students are manifesting.

Some of the ways such consultation might help are to

? work with you to further analyze the problem and what to do about it (including sharing observations and perspectives of the student)

? arranging for a formal case conference

? initiating outreach to parents

? joining you at a parent conference designed to explore the family's role

? initiating referral and supporting follow-through should this become necessary

If you feel some form of collaborative consultation assistance would help, please feel free to contact me at

Sincerely,
REMINDER AND SURVEY TO IDENTIFY CONSULTATION NEEDS

This is just a reminder about the services available through the (school-based health center). We also want to remind you that we are another resource for you when you need to consult about a student's problems.

Currently, we offer the following services:

(list all services)

1. 
2. 
3. 
4. 
5. 

We also may be able to help in the following ways if you are interested
(check off items to indicate your interest)

( ) 1. Mental health consultation about specific students and their families.

( ) 2. A workshop focused on ways to deal with students (and their families) mental health and psychosocial concerns.

( ) 3. Resource help identifying and obtaining special resources to aid your work with such students.

Are there any other ways you think we might be able to help?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
IMPROVING SKILLS FOR TALKING WITH AND LISTENING TO STUDENTS

Needs assessment indicated a high priority for techniques and strategies relevant to talking with and listening to students.

A good place to begin is with sharing experiences with each other regarding what works best.

GIVEN:

We all share a common vision of what we'd like to, but may have different ideas about how to get there.

We know a lot. Some of what we know works with some students, some of the time.

WHEN A TECHNIQUE DOESN'T WORK, HOW MIGHT WE UNDERSTAND THE PROBLEM?

Students often

? resent being identified by others as a problem
  (The resentment mobilizes emotions and defensive behaviors e.g., they may become angry/surly, scared/silent; they may deny, try to avoid, make promises they don't intend to keep);

? fear what may happen to information they provide
  (The dilemmas of confidentiality);

? don't want advice and reassurance from "authorities";
  (They have heard most of it before and don't value or trust what they're told);

? perceive all adults as "not like me" and thus think "you can't understand me"
  (They perceive differences in age, sex, language, culture, color).

GENERAL THOUGHTS ABOUT ADDRESSING THE ABOVE MATTERS:

Focus on understanding and changing student perceptions of you and your program.

? An invitation rather than a summons
  (Processes that lead students to want and even to seek help on their own);

? Respect for what students say
  >validating students concerns and feelings
  >offering real alternatives and choice in problem solving
  >ensuring appropriate confidentiality

? Building a helping relationship
  (Recognizing when a socialization agenda is in conflict with helping; use of techniques such as self-disclosure)

? Building trust
  (Recognizing that trust evolves and has its limits)

? Facilitating change
  (Understanding the match in terms of student motivation and capabilities; creating groups -- the benefits of sharing with others in comparable situations)
SPECIFIC IDEAS:

**INITIATING TALK** (Building Trust/Mutual Respect/Motivational Readiness)

In general,
- create a private space
- avoid interruptions
- start slowly to minimize sense of pressure
- encourage student to take the lead
- listen with interest
- if needed, guide student with structured interviews, surveys, sentence completion
- clarify the role and value of keeping things confidential

In addition, for groups,
- facilitate sharing through various activities (dyads, background)
- clarify that trust, respect, confidentiality, etc. are a function of commitment to the group -- not a matter of stating rules

**KEEPING TALK GOING** (Maintaining Trust/Respect/Motivation)

In general,
- focus on areas of interest, strength, self-esteem, as well as on analyzing problems
- build on previous contacts by referring to what has been shared
- continue to follow students leads in analyzing problems and avoid procedures they may perceive as efforts to control them
- continue to convey that the intent is to help not socialize

In addition, for groups,
- draw out similarities in experience and problems with a view to encouraging students to see the value of helping each other
- help students understand that giving advice usually is ineffective

**INITIATING CHANGE** (Problem Solving)

In general,
- help student identify a range of alternatives -- at first in a brainstorming way that helps to creatively break set
- explore pros and cons of alternative solutions in a way that validates student's perceptions
- help students choose an alternative -- hopefully a realistic and modest short-term objective
- identify ways that potential barriers will be overcome

In addition, for groups,
- clarify that some solutions are better for one person than another
- identify how students can support each other in reaching objectives
GROUP DISCUSSION AND SHARING:

Focus -- ideas that work and where you feel stuck

Process --
(1) Divide into 4 small groups based on the age of the students with whom you work (i.e., 1 hi school, 1 jr. high, and 2 elementary groups).
(2) Start with each group member relating strategies that have worked.
(3) After each has shared, move on to have each relate an experience when s/he has been frustrated by being unable to engage a student in dialogue. Choose one of these examples to discuss.
(4) Create a role-playing situation -- with the person who shared the problem acting as the student and another group member volunteering to be the outreach consultant. (As the situation evolves, others may want to enter in.)
(5) Have a debriefing discussion to see which techniques seem to help and what doesn't work well.

CLOSING:

Feeling you can really talk with students can help make your job feel less overwhelming and more satisfying.

"To help others you have to know what they need, and the only way to find out what they need is for them to tell you. And they won't tell you unless they think you will listen ... carefully. And the way to convince them you will listen carefully is to listen ... carefully."

David Nyberg
Tough and Tender Learning

A Few Reference

How to Talk So Kids Will Listen and Listen So Kids Will Talk
by A. Faber & E. Mazlish

Teacher and Child
by Haim Ginot

Systematic Training for Effective Parenting
by D. Dinkmeyer & G. McKay

Systematic Training for Effective Parenting of Teens
by D. Dinkmeyer & G. McKay
Outline of Key Steps and Tasks in Problem Solving Intervention

**Steps**

1. **Reorganize problem; initiate intervention**
   - (a) Be aware of the problem
   - (b) Decide intervention is needed
   - (c) Initiate intervention tentatively
   - (d) Build relationship (e.g., trust/respect)
   - (e) Deal with emotional charge (e.g., fears, anger)
   - (f) Become aware of mutual expectations related to intervention

2. **Analyze problems; establish working agreement**
   - (a) Mutually assess the problem
   - (b) Come to a shared understanding of the problems, including diagnostic classification if needed and cause-effect (functional) analyses if feasible
   - (c) Work through to shared understanding of expectations for working together
   - (d) Develop attitudes toward effective problem solving (e.g., openness to innovative solutions, deferring judgements)

3. **Generate possible solutions; evaluate alternatives**
   - (a) Come to a shared understanding of alternatives for solving the problem, deferring judgement as much as possible
   - (b) Use new information arising from process to further clarify the problem
   - (c) Develop criteria for evaluating pros and cons of alternatives
   - (d) Apply criteria

4. **Select initial solution and backups; clarify ways to carry out alternatives**
   - (a) Come to a shared understanding of proposed solution (e.g., implications and subtleties)
   - (b) Evaluate additional alternatives that arise
   - (c) Choose primary and backup solutions
   - (d) Develop plan for achieving selected alternatives (e.g., identify support/skill needs)
   - (e) Develop needed skills
   - (f) Develop criteria for deciding whether problem is resolved or whether to adopt backup

5. **Support implementation of alternatives; evaluate progress**
   - (a) Deal with emotional charge
   - (b) Continue development of needed skills
   - (c) Make formative evaluation
   - (d) Apply criteria to decide whether to shift to backup solution

6a. **Alternative not satisfactory**
   - (a) make formative and summative evaluations (outcomes provide data for decisions)
   - (b) Apply criteria regarding need for other alternatives
   - (c) If alternative has not been satisfactory, analyze feedback to determine whether information suggests additional alternatives (e.g., alternatives not previously realized or perspectives of the problem that were not previously understood and that may lead to new alternatives)

6b. **Problem solved (outcome)**
   - (a) make formative and summative evaluations (outcomes provide data for decisions)
   - (b) Apply criteria regarding need for other alternatives
   - (c) If alternative has not been satisfactory, analyze feedback to determine whether information suggests additional alternatives (e.g., alternatives not previously realized or perspectives of the problem that were not previously understood and that may lead to new alternatives)
A Few Related References


UNIT IIC: Screening/assessment

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? A Few Procedural Guidelines and Specific Topics to Explore  
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**Resource Aids**

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Unit IIC
Screening/Assessment

Screening is part of the registration process at most SBHCs (see Resource Aid IIC-1). Screening can be used not only to clarify and validate the nature, extent, and severity of a problem, but also to determine the student's motivation for working on the problem (see Resource Aid IIC-2). If the problem involves significant others, such as family members, the assessment also can help determine the need for and feasibility of parental or family counseling.

If a walk-in screening interview is not feasible, the Center should establish systems that let students make immediate appointments. For example, a confidential sign-in appointment system can be used for those times when staff are not available. From a student's perspective, screening should validate her or his concerns and feelings and lay the foundation for identifying resources for help.

More Than Identifying a Problem

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

In general, you will want to explore

What's going well?

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

What seems to be the causes of the problems?

What already has been tried to correct the problems?

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

On the following pages are some aids related to exploring the problem with the student (and family). Included are:

? some procedural guidelines and a basic interview format (see Exhibit 17)

? an outline of specific areas and topics to explore (see Exhibit 18)
Exhibit 17: Some Procedural Guidelines and a Basic Interview Format

Procedural Guidelines

(1) Use a private space.

(2) Start out positive and always convey a sense of respect. (Ask about the good things that may be going on in the student's life, and express an appreciation for these.)

(3) Start slowly, use plain language, and invite, don't demand or be too directive and controlling. In this regard, the initial emphasis is more on conversation and less on questioning.

(4) Indicate clear guidelines about confidentiality (Is it safe for the individual to say what's on his/her mind?)

(5) Convey that you care (empathy, warmth, nurturance, acceptance, validation of feelings, genuine regard).

(6) Be genuine in your demeanor and conversation.

(7) With students who are reluctant to talk, start with relatively nonverbal activity, such as drawing and then making up a story or responding to survey questions that involve choosing from two or more read responses. With younger students, you can also try some "projective questions," such as "If you had three wishes...", "If you could be any animal...", "If you could be any age...", "If you were to go on a trip, who would you want to go with you?" and so forth. There are also published games designed to elicit relevant concerns from children.

(8) In exploring concerns, start with nonsensitive topics.

(9) Listen actively (and with interest) and at first go where the individual is leading you.

(10) To encourage more information, use open-ended questions, such as "What was happening when she got angry at you?" and indirect leading statements, such as "Please tell me more about..." or direct leading statements such as "You said that you were angry at them?" (Minimize use of questions that begin with "Why;" they often sound confrontative or blaming?)

(cont.)
Exhibit 17 (cont.):  Some Procedural Guidelines and a Basic Interview Format

A Basic Interview Format

Start out on a positive note

? Ask about the good things that may be going on in the student's life (e.g., Anything going on at school that s/he likes? Interests and activities outside of school?)

Slowly transition to concerns

? Ask about any current concerns (e.g., troubles at school? at home? in the neighborhood? with friends? how long have these problems been evident?)

? Explore what the student/family think may be causing the problem(s).

? Explore what the student/family think should be done to make things better.

? Explore what the student/family might be willing to try in order to make things better.

Expand exploration to clarify current status, problems and their causes related to

? home situation and family relationships

? physical health status

? emotional health status

? school functioning, attitudes, and relationships

? activities and relationships away from school

If appropriate and feasible explore sensitive topics

? involvement with gangs and the law

? substance use

? sexuality

Add any favorite items you think are helpful.

Move on to explore

? What's already been tried to correct the problems

? What the student/family think should be done to make things better and are willing to try

Finally

? Clarify whether they truly think that things can be made better.
Exhibit 18. Outline of Specific Areas and Topics that Might be Explored to Better Understand the Nature and Scope of Problems

To explore what's going well and what's not, you will want to ask about current status related to various aspects of a student's daily life. To this end, Henry Berman, MD, proposes an approach to interviewing that he calls HEADS (Home, Education, Activities, Drugs, and Sexuality). This acronym is meant to guide the interviewer in exploring key facets of a young person's life, especially those that may be a source of trouble.

Borrowing and adding to this framework, the following areas and topics might be explored with respect to current status. Where problems are identified, past circumstances related to the area and topic can be further discussed to help clarify duration, possible causes, and past or current efforts to deal with them.

Home & Health?

**Place of residence?**
- Where does the student live and with whom?
- Physical conditions and arrangements in the residence?
- Family status, relationships, and problems? (separation, loss, conflict, abuse, lack of supervision and care, neglect, victimization, alienation)

**Physical health?**
- Developmental problems?
- Somatic complaints?
- Accident proneness?
- Indications of physical or sexual abuse?
- Indications of eating problems?
- Recent physical injury/trauma?

**Emotional health?**
- Anxieties?
- Fears?
- Frustration?
- Anger?
- Frequent and extreme mood swings?
- Self-image? (degree of: perceived sense of competence/efficacy; sense of worth; feelings of personal control over daily events; feelings of dependency on others; gender concern; self-acceptance; defensiveness)
- Isolation or recent loss?
- Hopes and expectations for the future?
- If unhappy, is s/he depressed?
- If depressed, is s/he suicidal?
- Psychic trauma?
- Symptoms of mental illness? (hallucinations, delusions)

(Cont.)
Outline of Specific Areas and Topics that Might be Explored to Better Understand the Nature and Scope of Problems

Education?

School functioning?
  School attended, grade, special placement?
  Learning? (level of skills)
  Performance? (daily effort and functioning, grades)
  Motivation? (interests, attendance)

Relationships at school?
  Behavior? (cooperation and responsiveness to demands and limits)
  Special relationships with any school staff? (anyone really liked or hated)
  Plans for future education and vocation?

Activities?

Types of interests? (music, art, sports, religion, culture, gang membership)

Responsibilities? (caring for siblings, chores, job)

Relationships with peers?
  Any close friends?
  Separation/loss?
  Conflict?
  Abuse?
  Neglect?
  Victimization?
  Alienation?

Relationships with other adults?

Involvement with the law?

How individual usually spends time?

Drugs?

Substance use? abuse?  (see Rersource Aid IIC-3)

Sexuality?

Active sexually? (informed about pregnancy and STD prevention?)

Considering becoming active sexually?

Is, has been, or currently wants to be pregnant?
You will also want to use the contact to **observe** aspects of the student/family that can shed additional light on these matters. These include

**Appearance**: dress, grooming, unusual physical characteristics

**Behavior**: activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity

**Expressive Speech**: fluency, pressure, impediment, volume

**Thought Content**: fears, worries preoccupations, obsessions, delusions, hallucinations

**Thought Process**: attention, concentration, distractibility, magical thinking, coherency of associations, flight of ideas, rumination, defenses (e.g., planning)

**Cognition**: orientation, vocabulary, abstraction, intelligence

**Mood/Affect**: depression, agitation, anxiety, hostility absent or unvarying; irritability

**Suicidality/Homicidality**: thoughts, behavior, stated intent, risks to self or others

**Attitude/Insight/Strengths**: adaptive capacity, strengths and assets, cooperation, insight, judgement, motivation for treatment

In assessing possibilities and motivation for addressing problems, you will want to explore

- desirable and desired, long-terms outcomes
- barriers that may interfere with reaching such outcomes
- immediate needs and objectives for intervention.

And you will want to clarify the student's, parents', and school's role in the process, and any other assistance that is needed, feasible, and desired.

Remember, if you are going to do a formal interview with a student about psychosocial/mental health concerns, you usually need a signed informed consent form from a parent or legal guardian. And, even if it is not required, it is good practice to get the student's assent as well.
A. Resource Aids Included Here

Resource Aid IIC-1

*Health Center Student Registration Form and Initial Questionnaire*

When a student comes to a SBHC for the first time, the matter of informed consent arises (see Unit IIA). Given there is informed consent, a registration form and screening questionnaire are usually filled out.

From a clinical perspective, such forms and questionnaires may be best filled out with the student over a session or two to avoid overwhelming and perhaps scaring the student to the point they will not return. This is especially important for those students who have come seeking specific help.

The forms illustrated here are slightly modified versions shared with us by various school-based health centers. Note that Centers are being encouraged to use standard, computer-linked student registration and encounter forms. The ( ) next to various items are for computer codes; they are left blank here to avoid confusion.

Resource Aid IIC-2

*Initial Counseling Interview Form*

An example of an interview designed to clarify student view of the problem and her/his need and motivation for help. Two versions are provided: one for use with all but very young students; the other is for use with very young students. In some instances, students are asked to respond prior to meeting with the intervener; in other instances, the interviewer uses the form as a guide while talking with the student.

Resource Aid IIC-3

*Substance Abuse Checklist*

A initial screening instrument to help focus on possible substance abuse.
B. Related Resource Aid Packets Available from Our Center

**Screening/Assessing Students: Indicators and Tools**

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.

**Assessing to Address Barriers to Learning**

Discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on procedures and instruments to measure psychosocial, as well as environmental barriers to learning.
Resource Aid IIC-1

SCHOOL-BASED HEALTH CENTER
Registration Information Form

Student’s Center ID# ____________ Registration Date: ____/____/____ Consent Form: All Services

___ New ___ Revised

Designated Services ___

YOUR NAME: __________________________________________________________ SEX: ____ (M/F)
(Please print) Last First Middle

BIRTHDATE: ____/____/____ Grade: ______

RACE: ( )White ( )Black ( )Latino/Hispanic ( )Asian ( )Other ______________________

ADDRESS: __________________________________________________________

Street Apt. # State Zip Code

HOME PHONE: ____ / ________________

Where were you born? (check one answer)
( )USA ( )Mexico ( )Guatemala ( )China ( )Korea
( )Vietnam ( )Philippines ( )El Salvador ( )Other __________________________

If born out of the USA, when did you come to this country? Month/Year: ______/_____

PARENT(S) OR LEGAL GUARDIAN(S) NAME(S)
Mother___________________________________ Father_________________________________

Last First Last First

Other____________________________________ RELATIONSHIP:_________________________

Last First

Mother’s Maiden Name ____________________________

(____)__________________________ (____)__________________________

Work Phone Home Phone

Whose idea is it for you to come to this center? (Check one answer)
( )My own idea ( )School Nurse ( )Center Staff ( )Parent/Guardian
( )Friend/School Mate ( )Teacher ( )Other School Staff
( )Other Family Member ( )Someone else __________________________

What is your usual/regular source of medical care? (Check only one)
( )Private Doctor/Clinic ( )Emergency Room ( )None ( )Community Clinic
( )Health Department ( )HMO ( )Military Clinic ( )Other __________________________

Last Physical Exam: ___/___ Mo./Yr. Doctor/Clinic Last Seen: ___/___ Mo./Yr. Last Dental Exam: ___/___ Mo./Yr.
ABOUT YOUR PARENTS

Primary Language (indicate F for father and M for mother)
( ) English ___ ( ) Spanish ___ ( ) Cantonese ___ ( ) Korean ___ ( ) Vietnamese ___
Other ___________

Marital Status: _____ (N= Never married, M = Married, D = Divorced/separated)

Where were your parent's born? (indicate F for father and M for mother)
( ) USA____ ( ) Mexico____ ( ) Guatemala____ ( ) China____ ( ) Korea____
( ) Vietnam____ ( ) Philippines____ ( ) El Salvador____ ( ) Other ____________
If born out of the USA, when did they come to this country?
Father: Month/Year: ______/______   Mother: Month/Year: ______/______

Does your family get food stamps? ( ) Yes ___ ( ) No ___ ( ) Don't know ___

Are you in the special breakfast/lunch program? ( ) Yes ___ ( ) No ___ ( ) Don't know ___

INSURANCE STATUS: (CIRCLE ONE)
NONE    HMO    PRIVATE    MEDI-CAID

BILLABLE _____ Y _____ N

Insurance Company ______________________________ Policy # ______________________
Subscriber # ______________________________

Is student covered by Medi-Caid? Yes _____ No _____ Medi-Caid No. _____________

Name of Insured: ______________________________________________________________
Address: _____________________________________________________________________
    Street                       City                     State                       Zip Code
Phone: ______________________________

Parent SS No. ______ - ______ - ______ Student SS No. ______ - ______ - ______
Registration Questionnaire

The following questions will help us in serving you. Your responses will be treated confidentially -- except if you indicate that you plan to hurt yourself or hurt others or if you have been abused.

Your Name: _____________________   Today’s Date: ______________   Your Birthdate: _________

Place of Birth : _____________________________

1. Are you taking any medications?  
   Yes   No   Not Sure
   ____     ____        ____

2. Do you have any problems that are bothering you these days?  
   Yes   No   Not Sure
   ____     ____        ____

3. Do you have a hard time concentrating in school?  
   Yes   No   Not Sure
   ____     ____        ____

4. Do some teachers pick on you?  
   Yes   No   Not Sure
   ____     ____        ____

5. Are you doing worse than before in school?  
   Yes   No   Not Sure
   ____     ____        ____

6. Are you absent or tardy a lot?  
   Yes   No   Not Sure
   ____     ____        ____

7. Do you think you might not graduate?  
   Yes   No   Not Sure
   ____     ____        ____

8. Do you have relationship problems with friends?  
   Yes   No   Not Sure
   ____     ____        ____

9. Do you feel that you’re too sensitive?  
   Yes   No   Not Sure
   ____     ____        ____

10. Do you feel that you’re different from other people?  
    Yes   No   Not Sure
    ____     ____        ____

11. Do you get picked on by others?  
    Yes   No   Not Sure
    ____     ____        ____

12. Do you have frequent arguments with your parents?  
    Yes   No   Not Sure
    ____     ____        ____

13. Do people in your family fight, yell at you, or put you down too much?  
    Yes   No   Not Sure
    ____     ____        ____

14. Have you ever been physically punished (hit, slapped, etc.) so that it left bruises or other injuries?  
    Yes   No   Not Sure
    ____     ____        ____

15. Do people in your family expect too much of you?  
    Yes   No   Not Sure
    ____     ____        ____

16. Do you have enough privacy in your home?  
    Yes   No   Not Sure
    ____     ____        ____

17. Do you feel you don’t get enough positive attention in your family?  
    Yes   No   Not Sure
    ____     ____        ____

18. Do you feel that people in your family don’t understand you?  
    Yes   No   Not Sure
    ____     ____        ____

19. Are you living with someone other than your parents?  
    Yes   No   Not Sure
    ____     ____        ____

20. Does anyone in your family have problems with alcohol/drugs?  
    Yes   No   Not Sure
    ____     ____        ____

21. Has anyone you were close to either died or left you?  
    Yes   No   Not Sure
    ____     ____        ____

22. Do you get angry easily?  
    Yes   No   Not Sure
    ____     ____        ____

23. Do you feel nervous a lot?  
    Yes   No   Not Sure
    ____     ____        ____

24. Do you sleep a lot or have trouble sleeping?  
    Yes   No   Not Sure
    ____     ____        ____

25. Do you get depressed?  
    Yes   No   Not Sure
    ____     ____        ____

26. Do you get headaches, stomach-aches or other pains a lot?  
    Yes   No   Not Sure
    ____     ____        ____
27. Has anything sexual ever happened that you felt uncomfortable, confused or upset about?  

28. Do you ever seriously think about ending your life?  

29. Have you ever made plans to end your life?  

30. Have you ever tried to end your life?  

31. Would you be interested in learning about programs that serve gay, lesbian, and bisexual youth?  

32. Do you ever get into physical fights?  

33. Have you ever been involved in gang activity?  

34. Have you ever been in trouble with the law?  

35. Have you tried alcohol or other drugs?  

36. Do you use alcohol or other drugs?  

37. Do you ever get drunk or wasted?  

38. Are you having a hard time with the customs of this country?  

39. Have you ever had sex with another person?  

40. Have you had different sexual partners?  

**Answer the next questions only**

**if you have had sex with another person:**

41. Do you worry about “safe sex”/birth control?  

42. Would you like information about “safe sex”/birth control?  

43. Have you ever had a sexually transmitted disease?  

44. Have you or your partner been pregnant before?  

45. Do you have any children?  

46. Do you think you or your partner are pregnant now?  

47. Do you or your partner want to get pregnant?  

48. Do you or your partner use birth control?  

49. If yes, which of the following do you use?  
   a. birth control pill  
   b. foam, jelly, cream, or suppository  
   c. a diaphragm  
   d. the rhythm method (the right time of the month)  
   e. the withdrawal method (pulling out)  
   f. other (specify)_________________________
SAMHSA ISSUES NEW PRACTICE GUIDELINES ON
IDENTIFYING AND TREATING ADOLESCENT SUBSTANCE ABUSE

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) issued two new best practice guidelines to aid in improving the early identification and treatment of adolescent substance abuse. The guidelines are part of a series of Treatment Improvement Protocols (TIP) regularly produced by CSAT. The new TIPs respond in part to the growing number of adolescents receiving treatment. From 1991 to 1996, the number of adolescents under age 18 receiving substance abuse treatment in the United States on any given day almost doubled, from 44,000 to 77,000.

The first guideline, Screening and Assessing Adolescents for Substance Use Disorders (TIP #31), describes warning signs of substance use disorders for adolescents. It explains when to screen and when to move forward into a professional assessment of the adolescent, and how to involve the teen's family. For example, the guideline recommends screening for teens who come to emergency rooms with trauma injuries, or who suddenly are prone to accidents, injury, or gastrointestinal disturbances.

The other guideline, Treatment of Adolescents With Substance Use Disorders (TIP #32), stresses crucial differences between treating adults versus adolescents. It outlines available treatment options for adolescents including 12-step programs, residential community programs and family therapy. It notes that "the treatment process must address the nuances of each adolescent's experience, including cognitive, emotional, physical, social and moral development,...gender, ethnicity, disability status, stage of readiness to change, and cultural background."

The full series of Treatment Improvement Protocols are available through the National Clearinghouse for Alcohol and Drug Information on the Internet at http://www.health.org/catalog/ordersystem2.asp?Topic=103 or by phone at (800) 729-6686.
**Student's View of the Problem -- Initial Interview Form**
(For use with all but very young students)

Interviewer ______________________ Date______________

Note the identified problem:

Is the student seeking help?    Yes   No

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

__________________________________________________________

Questions for student to answer:

Student's Name _______________________________ Age _____   Birthdate ___________

Sex:  M  F   Grade ________       Current Placement ______________________

Ethnicity __________ Primary Language ____________________

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>very serious</th>
<th>serious</th>
<th>Not too serious</th>
<th>Not at all serious</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(3) How long have these been problems?

___ 0-3 months  ___4 months to a year  ____more than a year  

(cont.)
(4) What do you think originally caused these problems?

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

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

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

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

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

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

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

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

(12) What type of help do you want?

(13) What changes are you hoping for?

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

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

If you're not hopeful, why not?

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

Are there any other matters you want to discuss?
Student's View of the Problem -- Initial Interview Form
(For use with very young students)

Interviewer __________________ Date________________

Note the identified problem:

Is the student seeking help?   Yes   No
If not, what were the circumstances that brought the student to the interview?

____________________________________________________________________________

Questions for student to answer:

Student's Name _______________________________ Age _____   Birthdate ___________

Sex:  M  F Grade ________       Current Placement _______________

Ethnicity __________ Primary Language ____________________

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

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

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

1  2  3  4  5  6
not at all not much only a more than a Quite a bit Very
little bit little bit bit much

What about school don't you like?

What can we do to make it better for you?

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

What seems to be causing these problems?

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

1  2  3  4  5  6
not at all not much only a more than a Quite a bit Very
little bit little bit bit much

What about things at home don't you like?

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

What seems to be causing these problems?

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

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

What about other kids don't you like?

What can we do to make it better for you?

(7) What type of help do you want?

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

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

If you're not hopeful, why not?

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

Are there any other things you want to tell me or talk about?
SUBSTANCE ABUSE CHECKLIST*

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

Student’s Name __________________________   Age _____   Birthdate ___________
Date: ________ Interviewer _______________________

(Suggested points to cover with student, parent, other informed sources)

(1) Substance Use

Has the individual used substances in the past? Y   N

In the last year or so? Y   N

Does the individual currently use substances? Y   N

How often does the individual

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>Once in a while</th>
<th>About Once a Week</th>
<th>Several Times a Week</th>
<th>Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>drink beer, wine or hard liquor?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>smoke cigarettes?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>smoke marijuana (pot)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>use a drug by needle?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>use cocaine or crack?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>use heroin?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>take LSD (acid)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>use PCP (angel dust)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>sniff glue (huff)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>use speed?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>other? (specify)_______________</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Has the individual ever had treatment for a substance problem? Y   N

Has anyone observed the individual with drug equipment, needle marks, etc.? Y   N

*Use this checklist as an exploratory guide with students about whom you are concerned. Because of the informal nature of this type of assessment, it should not be filed as part of a student's regular school records.
(2) Recent Dramatic Changes in Behavior and Mood

Have there been major changes recently with respect to the individual’s

- relationship with family members? Y N
- relationship with friends? Y N
- performance at school? Y N
- attendance at school? Y N
- participation in favorite activities? Y N
- attitudes about things in general? Y N

(3) Prevailing Behavior and Mood Problems

Have any of the following been noted:

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

*Learning Problems and Learning Disabilities: Moving Forward.*

*Assessment.*

Behavioral assessment.
E.S. Shipiro. In: *Handbook of Behavior Therapy in Education*. J.C. Witt, S.N. Elliot, 


*ADHD in the Schools: Assessment and Intervention Strategies.*

Development of a questionnaire for assessing the school environment.

*Best Practices in Assessment for School and Clinical Settings.*


**Brief Research Syntheses Available from the ERIC Clearinghouses.**

The following are a few more of the many ERIC Digests (research syntheses) 
related to Assessment. They are available in libraries, over the Internet, or directly 
from the Educational Resources Information Center (ERIC) by phone, 1-800-LET-ERIC.

? 1995 -- ERIC Digest, number ED388 888 30. New Assessment Methods 
for School Counselors

? 1995 -- ERIC Digest, number EDO CG 95 3. Mental Health Counseling 
Assessment: Broadening One’s Understanding of the Client and the 
Client’s Presenting Concerns.

? 1995 -- ERIC Digest, number EDO CG 95 11. Emerging Student 
Assessment Systems for School Reform.
UNIT IID: Client consultation and referral

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# Exhibits and Resource Aids in Unit IID

## Exhibits

**Unit IID**

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## Resource Aids

**Unit IID**

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UNIT IID
Client Consultation and Referral

"They love our clinic and use it often, but they won't cross the street to go to a referral."

Referrals are a central activity of school-based centers.

And, for the most part,

Referrals are relatively easy to make.

BUT,

because most students are reluctant to follow-through on a referral, we usually need to do more than give a student a name and address.

More than Giving a Name and Address

The screening process should lead to (1) identifying appropriate resources for intervention, (2) clarifying procedures for enrollment in a service/program, (3) supporting follow-through.

1. Identifying Appropriate Resources for Intervention

A resource file and handouts (see Resource Aids IID-1 and 2) can be developed to aid in identifying appropriate services -- on and off campus -- for specific types of problems (e.g., drug and alcohol programs, suicide prevention, individual or family psychological counseling).

As discussed in Resource Aid IID-1, in identifying appropriate services, first consideration is given to on-campus resources, then to off-campus district services, and finally to services in community agencies. With regard to off-campus referrals, it is important to be aware of school district policies (see Resource Aid IID-3).

At this point, check to be certain the student truly feels the service is a good way to meet her or his needs.

2. Clarifying Procedures for Enrollment in a Service/Program

A referral decision form (see Resource Aid IID-4) can provide guidelines in working with students to clarify specific

(a) directions about enrolling in a recommended service and what to do if the service doesn't work out,
(b) problems that might interfere with successful enrollment and how to overcome them (e.g., problems related to parental consent, travel, fees).

A copy of a referral decision form can be given to the student as a reminder of decisions made; the original can be filed for purposes of case monitoring.

Before a student leaves, it is essential to evaluate the likelihood of follow-through on recommendations. Has a sound plan been worked out for doing so? If the matter is in serious doubt, the above tasks bear repeating.

3. Supporting Follow-through

In most cases, it will be necessary to take specific steps to help the student follow-through. For instance, students often need to be put in direct contact (e.g., by phone) with the person who will enroll them in a program.

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.

The Referral Process: Some Guidelines and Steps

Centers must develop referral intervention strategies that effectively

- 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.

Exhibit II-19 outlines referral intervention guidelines and steps.
Exhibit II-19. Referral Intervention Guidelines and Steps

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.

(cont.)
Exhibit II-19. (cont.) Referral Intervention Guidelines and Steps

Steps*

Step 1

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

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

Step 2

For those who contact you, establish whether referral is necessary

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

Step 3

Identify potential referral options with the client

If the school cannot provide the service, the focus is on reviewing with the student/family the value and nature of referral options. Some form of a referral resource file is indispensable (see Resource Aid IID-1).

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?

*Before pursuing such steps, be certain to review school district policies regarding referral (see Resource Aid IID-3).
Exhibit II-19. (cont.) Referral Intervention Guidelines and Steps

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*

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*

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.

*See Resource Aids IID-4, 5, 6, and 7 for examples of tools to aid these steps.
Providing Information about Programs and Services

Whether you are in a situation with few or many referral options, it is essential to compile and share basic information about all potential services (see Resource Aids IID-1 and 2). A prerequisite for establishing and updating a good referral information system is to identify a staff member who will accept ongoing responsibility for the system.

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

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

? at the school site,

? elsewhere by school district personnel,

? in the local community,

? outside the immediate community.

If the school does not have a list of on-campus resources, a first step is to survey school staff and prepare a list of on-campus services dealing with psychosocial and mental health concerns (see Resource Aid IID-2).

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.
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.

Highlighting the Most Accessible Referral Resources

Once the most accessible referrals are identified, they can be listed and the lists can be widely circulated (see Resource Aid II-11 for examples). Such listings might take the form of

? 1-2 page handouts,

? wallet-size handouts,

? program description flyers & posters.

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

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

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

A referral resource filing system is intended to contain a comprehensive compilation of basic information on available services (see Resource Aid IID-1).

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.
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 initial interview form in Unit IIC Resource Aid IIC-2.)

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

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

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

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

? careful exploration of such factors

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

? a written summary of referral recommendations and strategies for overcoming barriers

? two follow-up feedback forms -- one for the student to return to the school and one for the referral agency to send back.

See Resource Aids IID-4, 5, 6, and 7 for examples.

Other major supports that might be offered students include

? helping them make initial phone contacts and appointments (including having the student talk directly with the person to be seen)

? providing specific directions and even transportation to the first appointment

? parents or staff accompanying a student to the first appointment

? following-up (as described in a subsequent section).

**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.

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 Resource Aid IID-1) 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 Resource Aid IID-4.) 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.*

*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.
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 Resource Aid IID-7)
- 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.

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.)

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

A. Resource Aids Included Here

Appendix II-A

Connecting a Student With The Right Help

This appendix provides a bit more discussion of processes and problems related to client consultation and referral.

Resource Aid IID-1

Description of Referral Resource Files

Provides an overview of how to establish and maintain referral resource files and also provides an example of a form used to summarize basic information on agencies and services.

Resource Aid IID-2

Examples of Resource Information Handouts

The types of handouts that can be circulated to students, families, and staff are illustrated. Such full page and wallet-size listings are used to keep everyone aware of readily accessible resources on and off campus.

Resource Aid IID-3

Example of a School District Referral Policy

SBHCs need to be aware of district policy on referrals and release of student information.

Resource Aid IID-4

Referral Decisions -- Summary Form I

This form summarizes (a) specific information on the chosen referral, (b) planned strategies for overcoming barriers, and (c) back-up referral options. At the conclusion of the referral intervention, the student leaves with such a summary and a copy is retained in the student's file.
Resource Aid IID-5

*Guidelines for Acknowledging Status of Referral*

This information sheet is used to encourage referral resources to report back on student follow-through.

Resource Aid IID-6

*Response to Request for Assistance*

This form is used to indicate that a request for assistance was attended to and that the referrer was so informed.

Resource Aid IID-7

*Referral Follow-Through*

The following set of forms are used as aids in facilitating follow-through and for follow-up. One is given to the student at the end of the referral intervention, and the companion form is sent to the referral first choice. Another form is then used to guide and document the follow-through process.

B. Related Resource Aid Packet Available from Our Center

*Confidentiality and Informed Consent*

Focuses on issues related to confidentiality and consent of minors in human services and interagency collaborations. Also includes sample consent forms.

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

Discusses why it is important to approach student clients as consumers and to think in terms of managing care, not cases. Outlines processes related to problem identification, triage, assessment and client consultation, referral, and management of care. Provides discussion of prereferral intervention and referral as a multifaceted intervention. Clarifies the nature of ongoing management of care and the necessity of establishing mechanisms to enhance systems of care. Examples of tools to aid in all these processes are included.
Description of Referral Resource Files

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

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

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

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

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

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

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

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

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

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

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

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

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

How to contact the service

Name: ________________________ Phone: __________
Address: _______________________ City _______________

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

Clients served

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

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

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

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

Type of services Fees:
(please check services offered)

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

____ ________________      ________________
____ ________________      ________________
____ ________________      ________________

Sliding Scale? YES NO

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

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

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

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

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

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

Date this form was filled out: ________________________
Examples of Resource Information Handouts for Students/Families

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

ON-CAMPUS MENTAL HEALTH RESOURCES

GENERAL PSYCHOSOCIAL PROBLEMS

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

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

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

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

**School Counselors**
information, screening, and referral

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

SPECIAL PROBLEM FOCUS

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

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

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

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

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

RELATED CONCERNS

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

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

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

**Individual, Group, and Family Counseling**

Hathaway Childrens Serv.
11600 Eldridge Ave.
Lake View Terr., 91342
(818) 896-1161 Ext. 231
Manos Esperanza
14412 Hamlin
Van Nuys, 91405
(818) 376-0028
North Valley Family Counseling Center
661 S. Workman St.
San Fernando, 91340
(818) 365-5320

San Fernando Valley Child Guidance Clinic
9650 Zelzah
(818) 993-9311
Boys & Girls Club of San Fernando
11251 Glencoe Blvd
Pacoima, 91331
(818) 896-5261
Because I Love You General Information Line
(818) 882-4881

El Nido Services
12502 Van Nuys Blvd
Pacoima, 91331
(818) 896-7776
Families Anonymous
(818) 989-7841
Sons & Daughters United/ Parents United
Sexually Abused Children (13-18) Intake: M & T, 1-4:30
(213) 727-4080

**Drug Programs**

El Proyecto del Barrio
13643 Van Nuys Blvd.
Pacoima, 91331
(818) 896-1135
Vista Recovery Center
7136 Haskell Ave.
Van Nuys, 91406
(818) 376-1600
IADARP - Reseda
(818) 705-4175

Life-Plus
6421 Coldwater Canyon
North Hollywood, 91606
(818) 769-1000
ASAP - Panorama City Hosp.
14850 Roscoe Blvd.
Van Nuys, 91406
(818) 787-2222

**Phone Counseling**

Valley Hotline
(818) 989-5463
Helpline Youth Counseling
(213) 864-3722
Child Abuse Hotline Dial 0 -- Ask for Zenith 2-1234

Suicide Prevention
(213) 381-5111
Spanish Bilingual Helpline
(818) 780-9727
Rape Hotline (818) 708-1700

Alateen
(213) 387-3158
Info Line
(818) 501-4447
Runaway 1-800-843-5200

**Emergency Counseling**

Crisis Management Center
14445 Olive Drive
Sylmar 91342
(818) 364-4340 24 hours

Olive View Mid-Valley Hospital
(818) 901-0327 or 782-1985

FOR ADDITIONAL RESOURCES, SEE THE SCHOOL'S RESOURCE REFERENCE FILE.
Example of a Wallet-Card Developed at a School Site for Students to Carry with Them

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<td>Cocaine Anonymous</td>
<td>(818) 988-1777</td>
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<td>Narcotics Anonymous</td>
<td>(818) 750-3951</td>
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<tr>
<td>El Projecto del Barrio</td>
<td>(818) 896-1135</td>
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<tr>
<td>Suicide Prevention</td>
<td></td>
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<tr>
<td>Hotline for teens</td>
<td>1-800-621-4000</td>
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<tr>
<td>24-hour Crisis</td>
<td>(213) 381-5111</td>
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<td>Child Abuse</td>
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<td>Hotline</td>
<td>1-800-272-6699</td>
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<tr>
<td>Family 24-hour Crisis Center</td>
<td>(818) 989-3157</td>
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<td>Rape</td>
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<tr>
<td>Rape Hotline</td>
<td>(818) 793-3385</td>
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<tr>
<td>Victims Anonymous</td>
<td>(818) 993-1139</td>
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<td>Run Away</td>
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<tr>
<td>Run-away Hotline</td>
<td>1-800-621-4000</td>
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<tr>
<td>L.A. Youth Network</td>
<td>(213) 466-6200</td>
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<tr>
<td>Stepping Stone</td>
<td>(213) 450-7839</td>
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<td>Pregnancy/Family Planning</td>
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<td>Pregnancy Testing</td>
<td>(818) 365-8086</td>
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<td>El Nido Services</td>
<td>(818) 893-7776</td>
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<tr>
<td>L.A. County Health Department</td>
<td>(818) 896-1903</td>
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<td>Other Resources</td>
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<td>S.F.H.S. Teen</td>
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<td>Health Clinic</td>
<td>(818) 369-7517</td>
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<td>Teenline</td>
<td>1-800-TLC-TEEN</td>
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<td>Aids hotline</td>
<td>1-800-922-2437</td>
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<tr>
<td>Spanish Bilingual</td>
<td></td>
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<tr>
<td>Helpline</td>
<td>(818) 780-9727</td>
</tr>
<tr>
<td>Family Problems Group</td>
<td>(818) 882-4881</td>
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</tbody>
</table>

IID-22
Example of One School District's Referral Policy

INTRODUCTION

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

I. SCHOOL PERSONNEL RESPONSIBLE FOR REFERRALS

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

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

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

II. SELECTION OF AGENCIES

A. Referrals may be made to:

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

B. Referrals shall not be made to:

   1. A profit or non-profit proprietary agency. (proprietary: "held in private ownership")
   2. Private practitioners or groups of private practitioners.

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

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

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

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

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

IV. RELEASE OF PUPIL INFORMATION

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

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

Interviewed by___________________ Date___________

Referred to:

1. On-campus program/resource:  ________________________________________

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

3. Off-campus community agency _________________________________________

4. No referral _________(please indicate why)

_____________________________________________________________________________

PLANS FOR ENROLLMENT

Person to contact________________________ Phone__________
Location_____________________________________________

Appointment time____________________________

Plans for making initial contact (anticipate any problems):

Back up plans:

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

In a week or two, you will be contacted to see if everything worked out as planned.
Enter a note into your "tickler" system as a reminder to follow-up.
GUIDELINES FOR ACKNOWLEDGING STATUS OF REFERRAL

Rationale:

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

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

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

Procedures for Communicating Referral Status and Preserving Confidentiality:

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

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

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

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

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

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

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

Information Beyond Acknowledging Referral Status:

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

Student's Name: __________________________ Todays' Date:_____________

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

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

_____________________________________________________.

_________________________________________________________________

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

____ I would like another session to discuss my needs.
REFERRAL FOLLOW-THROUGH STATUS

TO:

FROM:

We recently referred __________________ to you.

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

_________________________________________________________________

Name of person responding: _______________________________

Todays’ Date:____________

_____ The above named student contacted us on __________ and was provided appropriate services.

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

_________________________________________________________________

Please return this form to:

Smith High School Health Center
1340 S. Highland Ave.
Johnston, Missouri 90005
School's Record of Response to Request for Assistance in Addressing Concerns about a Student/Family

Name of student _________________________________

Name of staff member who made contact with student ________________________________

Date of contact with student ________________________________.

The following are the results of the contact:

Follow-up needed? Yes ___  No ___

________________________________________________________________________

If follow-up:
Carried out by ________________________________ on ________________

(name of staff member)

Results of follow-up:

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

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

If no, note date that the referrer was informed that her/his request was attended to. ________________

IID-29
Form Used to Aid Follow-Up on Referral Follow-Through

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

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

DATES FOR FOLLOW-THROUGH MONITORING

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

_____________________________________________________________________________

I. Immediate Referral Follow up Information

Date of referral __________ Today's date_____
Immediate Follow up made by. __________________________ Date_____
                                   __________________________ Date_____
                                   __________________________ Date_____

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

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

Indicate any new referrals recommended

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

____________________________________________________________________________

II. Long Term Referral Follow-Up Information

Have identified needs been met?

Contact the student at appropriate intervals (beginning three months after referral) and administer "Follow-up Interview Form -- Service Status."
UNIT IIE: response to students' ongoing psychosocial and mental health needs

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# Exhibits and Resource Aids in Unit IIE

## Exhibits

### Unit IIE

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## Resource Aids

### Unit IIE

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UNIT IIE
Response to Students' Ongoing Psychosocial and Mental Health Needs

The focus here is on three topics:

? psychosocial guidance and support
? psychosocial counseling
? prevention/mental health education

Psychosocial Guidance and Support

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

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

For students registered with the SBHC (see Resource Aid IIC-1 for a sample Registration Form), center staff can play a role as another person for students to contact if something is amiss between what is happening in class and a student's therapeutic regimen. And they can be a good resource to act as a school-site case manager so that there is coordination between the school's efforts to teach and treatment practices.

Guidance and support involves a range of potential activity:

? advising
? advocacy and protection
providing support for transitions (e.g., orienting new students and connecting them with social support networks, facilitating students with special needs as they transition to and from programs and services)

mediation and conflict resolution

promoting and fostering opportunities for social and emotional development

being a liaison between school and home.

being a liaison between school and other professionals serving a student

Psychosocial Counseling

The nature and scope of counseling at a center depends on mental health staff time. Most counseling will be short-term; some work with families may be feasible. Informal counseling involves brief encounters with students who drop-in without an appointment or who are contacted, by intent or by chance, at various sites on the campus. Based on screening questionnaire and interview data (see Resource Aids IIC-1 and 2), it will be clear that some student's problems are more than you should try to handle, and you will make the best effort you can to connect them with the right help.

For those seen at the center, a Standard Visit Form (chart record) of psychosocial problems provides an aid to other center staff who need to be aware of a student's problems and mental health interventions (see Resource Aid IIE-1).

Good counseling builds on the type of caring which is fundamental to all helping interventions. It also encompasses the basics of any good working relationship -- and a bit more. Some basics are highlighted here; these and others are discussed at greater length in a variety of works -- a few of which are referenced at the end of this section.

In general, counseling requires the ability to carry on a productive dialogue, that is, to talk with, not at, others. This begins with the ability to be an active (good) listener and to avoid prying and being judgmental. It also involves knowing when to share information and relate one's own experiences as appropriate and needed. Some thoughts about engaging students in a productive dialogue are outlined on the following pages.
Counseling also requires the ability to create a working relationship that quickly conveys to the student

?  *positive value and expectation* (that something of value can and will be gained from the experience)

?  *personal credibility* (that the counselor is someone who can help and can be trusted to be keep his or her word, be fair, and be consistent, yet flexible)

?  *permission and protection to engage in exploration and change* (that the situation is one where there are clear guidelines saying it is okay and safe to say what's on one's mind).

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

Then, the process requires the ability to respond with

?  *empathy, warmth, and nurturance* (e.g., the ability to understand and appreciate what others are thinking and feeling, transmit a sense of liking, express appropriate reassurance and praise, minimize criticism and confrontation)

?  *genuine regard and respect* (e.g., the ability to transmit real interest, acceptance, and validation of the other's feelings and to interact in a way that enables others to maintain a feeling of integrity and personal control).

Exhibits II-20 and II-21 highlight matters related to (a) engaging students in a productive dialogue and (b) counseling and student motivation.
Exhibit II-20. A Few Thoughts About Engaging Students in a Productive Dialogue

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

*How to Facilitate "Talk"

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

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

Some specific things to do are

- Create a private space and a climate where the student can feel it is safe to talk
- Clarify the role and value of keeping things confidential
- Avoid interruptions
- Start slowly, avoid asking questions, and minimize pressure to talk (the emphasis should be more on conversation and less on questioning and on nonsensitive topics related to the student's main areas of personal interest)
- Encourage the student to take the lead
- Humor can open a dialogue; sarcasm usually has the opposite effect
- Listen with interest
- Respond with empathy, warmth, nurturance, and genuine regard and respect
- Use indirect leading statement such as "Please tell me more about ...." or direct leading statements such as "You said that you were angry at your parents?"
- If needed, use structured tools (surveys, sentence completion) to guide a student (Examples of tools that may be useful are included in the accompanying materials resource packet entitled Screening/Assessing Students: Indicators and Tools.)
- Sometimes a list of items (e.g., things that students generally like and dislike at school or after school) can help elicit a student's views and open-up a dialogue
- When questions are asked, use open-ended, rather than yes/no questions
- Appropriate self-disclosure by a counselor may disinhibit a reluctant student

(cont.)
In addition, for groups

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

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

**How to Keep Talk Going**

In general, the focus is on maintaining motivation.

Some specific things to do are

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

Build on previous discussions by referring to what has been shared

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

Continue to convey that the intent is to help not socialize

In addition, for groups

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

Help students understand that giving advice usually is ineffective

**Remember:**

Short periods of silence are part of the process and should be accommodated.
Exhibit 21. Some Points About Counseling and Student Motivation

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

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

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

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

(3) **Enhancing intrinsic motivation is a basic outcome concern.** A student may be motivated to work on a problem during counseling but not elsewhere. Responding to this concern requires strategies to enhance stable, positive attitudes that mobilize the student to act outside the intervention context and after the intervention is terminated.
Essentially, good counseling reflects the old maxim of "starting where the student is." But more is involved than matching the student's current capabilities. As suggested, attending to a student's motivational levels is also critical. Thus, it is the counselor's responsibility to create a process that will be a good fit with the student's capabilities and motivation.

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

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

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

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

And be sure to avoid the "Rescue Trap."
The Rescue Trap

So you want to help! That's a nice attitude, but it can sometimes lead to trouble -- especially if you aren't aware of the interpersonal dynamics that can arise in helping relationships. Several concerns have been discussed in the psychotherapy literature. One that almost everyone has experienced has been described as a "rescue."

A rescue is helping gone astray. Rescues encompass a cycle of negative interpersonal transactions that too commonly arise when one person sets out to intervene in another's life in order to help the person.

Think about a time when someone you know told you about a problem she or he was having. Because the person seemed not to know how to handle the problem, you offered some suggestions. For each idea you offered, the person had an excuse for why it wouldn't work. After a while, you started to feel frustrated and maybe even a bit angry at the person. You may have thought or said to the individual, "You don't really want to solve this problem; you just want to complain about it."

In rescue terms, you tried to help, but the person didn't work with you to solve the problem. The individual's failure to try may have frustrated you, and you felt angry and wanted to tell the person off. And that may only have been the beginning of a prolonged series of unpleasant interpersonal transactions related to the situation.

If you were ever in such a situation, you certainly experienced the price a person pays for assuming the role of rescuer. Of course, you know you didn't mean to become involved in a negative set of transactions. You wanted to help, but you didn't realize fast enough that the individual with the problem wasn't about to work with you in order to solve it. And you didn't know what to do when things started going wrong with the process.

If you can't remember a time you were the rescuer, you may recall a time when someone tried to rescue you. Perhaps your parents, a teacher, or a good friend made the mistake of trying to help you when or in ways you didn't want to be helped. The person probably thought she or he was acting in your best interests, but it only made you feel upset -- perhaps increased your anxiety, frustration, anger, and maybe even made you feel rather inadequate.

Rescue cycles occur frequently between teachers and students and parents and their children. Well-intentioned efforts to help usually begin to go astray because someone tries to help at a time, in a way, or toward an end the person to be helped doesn't experience as positive.

Let's take the example of a teacher, Ms. Benevolent, and one of her students, Jack. Ms. Benevolent is a new teacher who has just begun to work with a group of students with learning problems. She sees her students, Jack included, as handicapped individuals, and she wants so much to help them.
The Rescue Trap (cont.)

Unfortunately, Jack doesn't want to be helped at the moment. And when he doesn't want to be helped, Jack is not mobilized to work on solving his problems. Indeed, efforts to intervene often make him feel negative toward his teacher and even toward himself. For example, he may feel anger toward Ms. Benevolent and feel guilty and incompetent because of not working to solve his learning problem. Ironically, not only does he see the teacher as a helper, he also feels victimized by her. In response to these feelings, he behaves in a self-protective and defensive manner. Sometimes he even assumes the stance of being a helpless victim. ("How can you expect me to do that? Don't you know I have a learning handicap?")

Because Jack continues to respond passively or in ways the teacher views as inappropriate, eventually she becomes upset and starts to react to him in nonhelpful and sometimes provocative ways. She may even have a tendency to subtly persecute Jack for not being appreciative of all her efforts to help him. ("You're just lazy." "If your attitude doesn't improve, I'm going to have to call your parents.")

The more the teacher pushes Jack to act differently and attacks him for acting (and feeling) as he does, the more likely he is to feel victimized. However, sooner or later he is likely to become angry enough about being victimized that he reacts and counterattacks. That is, if he can, he shifts from the role of victim to the role of persecutor.

When interveners who see themselves as benevolent helpers are attacked, they may tend to feel victimized. Indeed, the experience of having been unsuccessful in helping may be sufficient to make some interveners feel this way. As Jack shifts to a persecuting role, Ms. Benevolent adopts a victim role. ("After all I've done for you, how can you treat me this way?" "All I'm trying to do is help you.")

Of course, interveners are unlikely to remain victims for very long if they can help it. If they do, "burn out" may well occur.

Sometimes, after the fighting stops, the parties make up, and the intervener starts to see the other person's behavior as part of the individual's problems and tries once more to help. However, if great care is not taken, this just begins the whole cycle again.

How can the cycle be avoided or broken? One of the essential ingredients in a good helping relationship is a person who wants to be helped. Thus, it is necessary to be sure that the person is ready and willing to pursue the type of help that is being offered.

If the person is not ready and willing, interveners are left with only a few options. For one, the intervener can choose to give up trying to help. Or if it is essential that the individual be forced to do something about the problem, the intervener can adopt a socialization strategy. Or effort can be made to explore with the individual whether he or she wants to think about accepting some help.
In effect, this last approach involves trying to establish motivational readiness.

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

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

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

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

Finally, a cautionary note about taking care of your own mental health as well as that of other staff in the center and throughout the school:

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

Some of the stress comes from working with troubled and troubling youngsters. Some is the result of the frustration that arises when everyone works so hard and the results are not good enough.

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

Over time, all the stress combines and can lead to demoralization, exhaustion, and burnout.
The cost of ignoring staff stress is that the programs and services they offer suffer because of less than optimal performance by staff who stay and frequent personnel turnover. As with family members, center and other school staff find it difficult to attend to the needs of students when their own needs are going unattended.

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

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

Mother to son: *Time to get up and go to school.*
Son: *I don't want to go. It's too hard and no one there likes me.*
Mother: *But You have to go -- you're the principal.*

**A Note on Diagnosis**

Formal differential diagnosis plays a major role in distinguishing true psychopathology from every day psychosocial concerns. Diagnostic classification also is demanded by third party payers. The most widely used system for diagnosing mental disorders throughout the U.S.A. is the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Appendix II-2 provides a brief summary of the categories commonly used with children and adolescents.
Prevention/Mental Health Education

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

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

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

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

This requires programs that

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

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

*identify, correct, or at least minimize physical and mental health and psychosocial problems as early after onset as is feasible*
Appreciation of the developmental demands at different age levels is helpful, and awareness of an individual's current levels of development is essential. Basic textbooks provide guides to understanding developmental tasks.

### Examples of Major Developmental Tasks

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

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

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

<table>
<thead>
<tr>
<th>Responsibility and integrity</th>
<th>Personal safety and safe behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g., understanding and valuing of societal expectations and moral courses of action)</td>
<td>(e.g., understanding and valuing of ways to maintain safety, avoid violence, resist drug abuse, and prevent sexual abuse)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self-esteem</th>
<th>Health maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g., feelings of competence, self-determination, and being connected to others)</td>
<td>(e.g., understanding and valuing of ways to maintain physical and mental health)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social and working relationships</th>
<th>Effective physical functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g., social awareness, empathy, respect, communication, interpersonal cooperation and problem solving, critical thinking, judgement, and decision making)</td>
<td>(e.g., understanding and valuing of how to develop and maintain physical fitness)</td>
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<thead>
<tr>
<th>Self-evaluation/self-direction/self-regulation</th>
<th>Careers and life roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g., understanding of self and impact on others, development of personal goals, initiative, and functional autonomy)</td>
<td>(e.g., awareness of vocational options, changing nature of sex roles, stress management)</td>
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<table>
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<tr>
<th>Temperament</th>
<th>Creativity</th>
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<tr>
<td>(e.g., emotional stability and responsiveness)</td>
<td>(e.g., breaking set)</td>
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</table>

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

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

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

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

A variety of materials are available to support your efforts to respond to students' mental health and psychosocial concerns (see Resource Aid IIE-2).

How Good are School-Based Programs?

An extensive literature reports positive outcomes for psychological interventions available to schools. Some benefits have been demonstrated not only for schools (e.g., better student functioning, increased attendance, less teacher frustration), but for society (e.g., reduced costs related to welfare, unemployment, and use of emergency and adult services).\(^1\)

At the same time, it is clear that school-based applications must be pursued cautiously. With respect to individual treatments, positive evidence generally comes from work done in tightly structured research situations; unfortunately, comparable results are not found when prototype treatments are institutionalized in school and clinic settings. Similarly, most findings on classroom and small group programs come from short-term experimental studies (usually without any follow-up phase). It remains an unanswered question as to whether the results of such projects will hold up when the prototypes are translated into wide-spread applications (see Adelman & Taylor, 1997; Durlak, 1995; Elias, 1997; Weisz, Donenberg, Han, & Weiss, 1995). Available evidence is insufficient to support any policy that restricts schools to use of empirically supported interventions, and the search for better practices remains a necessity.

---

Resource Aids

A. Resource Aids Included Here

Appendix II-2

About the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994)

This appendix provides a brief summary of the DSM-IV categories commonly used with children and adolescents.

Resource Aid IIE-1

Chart Record of Psychosocial Problems

Provides an example of a checklist chart record.

Resource Aid IIE-2

Where to Get Resource Materials to Address Barriers to Learning

Describes a Resource Aid Packet that contains a sampling of organizations and publishers that offer a variety of materials relevant to addressing students’ psychosocial and mental health concerns. Included is information about resources available upon request and/or purchase. A few example materials are included here as samples of what is available.

B. Related Resource Aid Packets Available from Our Center

Dropout Prevention

Highlights intervention recommendations and model programs, as well as discussing the motivational underpinnings of the problem.

Learning Problems and Learning Disabilities

Identifies learning disabilities as one highly circumscribed group of learning problems, and outlines approaches to address the full range of problems.
Teen Pregnancy Prevention and Support

Covers model programs and resources and offers an overview framework for devising policy and practice.

Cultural Concerns in Addressing Barriers to Learning

Highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. This packet also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.

Students and Psychotropic Medication: The School’s Role

Underscores the need to work with prescribers in ways that safeguard the student and the school. Contains aids related to safeguards and for providing the student, family, and staff with appropriate information on the effects and monitoring of various psychopharmacological drugs used to treat child and adolescent psycho-behavioral problems.

Substance Abuse

Offers some guides to provide schools with basic information on widely abused drugs and indicators of substance abuse. Includes some assessment tools and reference to prevention resources.

Where to Get Resource Materials to Address Barriers to Learning

Offers school staff and parents a listing of centers, organizations, groups, and publishers that provide resource materials such as publications, brochures, fact sheets, audiovisual & multimedia tools on different mental health problems and issues in school settings.

Clearinghouse Catalogue

Our Clearinghouse contains a variety of resources relevant to the topic of mental health in schools. This annotated catalogue classifies these materials, protocols, aids, program descriptions, reports, abstracts of articles, information on other centers, etc. under three main categories: policy and system concerns, program and process concerns, and specific psychosocial problems. (Updated regularly)
Consultation Cadre Catalogue

Provides information for accessing a large network of colleagues with relevant experiences related to addressing barriers to student learning and mental health in schools. These individuals have agreed to share their expertise without charging a fee. The catalogue includes professionals indicating expertise related to major system and policy concerns, a variety of program and process issues, and almost every type of psychosocial problem. (Updated regularly)

Catalogue of Internet Sites Relevant to Mental Health in Schools

Contains a compilation of internet resources and links related to addressing barriers to student learning and mental health in schools. (Updated regularly)

Least Intervention Needed: Toward Appropriate Inclusion of Students with Special Needs

Highlights the principle of least intervention needed and its relationship to the concept of least restrictive environment. From this perspective, approaches for including students with disabilities in regular programs are described.

Parent and Home Involvement in Schools

Provides an overview of how home involvement is conceptualized and outlines current models and basic resources. Issues of special interest to under-served families are addressed.

Understanding and Minimizing Staff Burnout

Addresses various sources and issues of burnout and compassion fatigue among school staff and mental health professionals. Also identifies ways to reduce environmental stressors, increase personal capability, and enhance social support to prevent burnout.
SCHOOL-BASED HEALTH CENTER  
Standard Visit Form (Chart Record) -- Mental Health & Psychosocial Concerns

Student’s Center ID# ____________ Visit Date ____/____/_____  Intervener ______________

Consent Form: Allows for this service _____ Registration Date: ____/____/____

Student Name: __________________________________________________________

SEX: ____ (M/F)

BIRTHDATE: ____/____/____   Age:____   Grade:____

Ethnicity:___________________ Primary Language:__________

**Presenting Problem for Mental Health services:**

Change in status since last visit: positive _____   negative _____   no change _____

Clinician's view of Problem:

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<thead>
<tr>
<th>Severity (of prob. or reaction)</th>
<th>Duration (onset or length)</th>
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<tr>
<td>Very Sev.</td>
<td>Sev.</td>
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### I. Emotional State

- A. Sad
- B. grief
- C. suicidal thinking
- D. fearful
- E. anxious
- F. low esteem
- G. aggression/anger
- H. other (specify)  

### II. Relationship Problems:

- A. family
- B. peers
- C. close friend
- D. teachers
- E. other (specify)
Clinician's view of Problem:

### III. School Functioning:

| A. trouble adjusting to new school | __ | __ | __ | __ | __ | __ | __ |
| B. learning problems | __ | __ | __ | __ | __ | __ | __ |
| C. unmotivated at school | __ | __ | __ | __ | __ | __ | __ |
| D. behavior problems | __ | __ | __ | __ | __ | __ | __ |
| E. considering dropping out | __ | __ | __ | __ | __ | __ | __ |
| F. other (specify) | __ | __ | __ | __ | __ | __ | __ |

### IV. Psychological support needed for other problems:

| A. diet (weight loss, anorexia, bulimia) | __ | __ | __ | __ | __ | __ | __ |
| B. sexual behavior | __ | __ | __ | __ | __ | __ | __ |
| C. pregnancy | __ | __ | __ | __ | __ | __ | __ |
| D. assertiveness | __ | __ | __ | __ | __ | __ | __ |
| E. somatic complaints | __ | __ | __ | __ | __ | __ | __ |
| F. sleep problems | __ | __ | __ | __ | __ | __ | __ |
| G. gender concerns | __ | __ | __ | __ | __ | __ | __ |
| H. other (specify) | __ | __ | __ | __ | __ | __ | __ |

### V. Abuse/Neglect by others:

| A. physical | __ | __ | __ | __ | __ | __ | __ |
| B. sexual | __ | __ | __ | __ | __ | __ | __ |
| C. victimization | __ | __ | __ | __ | __ | __ | __ |
| D. emotional | __ | __ | __ | __ | __ | __ | __ |
| E. neglect | __ | __ | __ | __ | __ | __ | __ |
| F. other (specify) | __ | __ | __ | __ | __ | __ | __ |

### VI. Substance Abuse:

| A. drugs | __ | __ | __ | __ | __ | __ | __ |
| B. alcohol | __ | __ | __ | __ | __ | __ | __ |
| C. other (specify) | __ | __ | __ | __ | __ | __ | __ |
Clinician's view of Problem:

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<tr>
<th>Severity (of prob. or reaction)</th>
<th>Duration (onset or length)</th>
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**VII. Transition Problems:**

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<tbody>
<tr>
<td>A. change in residence</td>
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<tr>
<td>B. family changes</td>
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<tr>
<td>(e.g., birth, death,</td>
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<td>separation)</td>
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<tr>
<td>C. changes at school</td>
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<td>(e.g., new school,</td>
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<td>new programs)</td>
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<tr>
<td>D. other (specify)</td>
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**VIII. Other:** (specify)

**Apparent Cause**

**Intervention Plan**

- Therapy/counseling with Center Mental Health staff  
  ___________ Individual ___________ Group ___________
- Work with Center Health Educator  
  ___________ Individual ___________ Group ___________
- Other (specify) _____________________________________________________

**Impact of the Session Just Conducted**

- very productive ____  unproductive ____  somewhat productive ____  uncertain ____

**Any changes in Intervention Plan (including referrals)?**
Where to Get Resource Materials to Address Barriers to Learning,

Among the various ways the Center for Mental Health in Schools at UCLA packages resources are our Resource Aid Packets. Resource Aid Packets are designed to complement our series of Introductory Packets. These resource aids are a form of tool kit. One such Resource Aid, entitled Where to Get Resource Materials to Address Barriers to Learning, is designed to provide a sampling of organizations and publishers that offer a variety of materials relevant to addressing students' psychosocial and mental health concerns. Included is information about resources available upon request and/or purchase. The packet is divided into three sections:

Section I identifies national centers and clearinghouses, professional organizations and foundations that provide printed documents such as fact sheets, brochures, pamphlets, posters, etc. that are useful for educational programs and campaigns. Most of the places listed in this section supply bulk materials for free or require a minimum recovery fee.

Section II lists publishers and distributors of books, curriculum modules/packages, posters, multimedia tool kits (e.g. audio/videotapes and educational software programs), educational games, and so forth that serve as supplementary aids and strategies for classroom learning, as well as counseling purposes. Some also offer in-service training materials for staff development in dealing with the students’ psychosocial problems. In general, the materials listed in this section are available for purchase.

Finally, Section III contains sample fact sheets provided by organizations listed in section I.
Cited References


UNIT IIF: responding to Crises at a school

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<th>Title</th>
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<td>IIF-4</td>
<td>&gt; Who Should Be Responsible?</td>
<td></td>
</tr>
<tr>
<td>IIF-5</td>
<td>&gt; Planning for Crises</td>
<td></td>
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<tr>
<td>IIF-10</td>
<td>&gt; A School-Based Crisis Team</td>
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<td>IIF-15</td>
<td>&gt; Crisis Aftermath Subteams</td>
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<td>&gt; Maintaining Crisis Response Capability and School Awareness</td>
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<td>IIF-18</td>
<td>Psychological First Aid</td>
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<tr>
<td>IIF-22</td>
<td>Addressing Specific Areas of Concern Related to Crises</td>
<td></td>
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<td>IIF-23</td>
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<td>IIF-48</td>
<td>A Few Related References</td>
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## Exhibits and Resource Aids in Unit IIF

### Exhibits

#### Unit IIF

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<th>Exhibit</th>
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<td>22. Scope of Crisis Events and Intervention Phases</td>
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<td>23. Major Facets of Crises Response</td>
<td>IIF-9</td>
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</table>

### Resource Aids

#### Unit IIF

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<td>IIF-2 Crisis Response Checklist</td>
<td>26</td>
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<tr>
<td>IIF-3 Some Key Considerations in Establishing a System for School-Based Crisis Response</td>
<td>30</td>
</tr>
<tr>
<td>IIF-4 Informing the Students and Staff</td>
<td>34</td>
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<tr>
<td>IIF-5 A Few Indicators of Reactions to Trauma</td>
<td>37</td>
</tr>
<tr>
<td>IIF-6 A Crisis Screening Interview</td>
<td>39</td>
</tr>
<tr>
<td>IIF-7 Aftermath Classroom Activities</td>
<td>42</td>
</tr>
</tbody>
</table>
David Schonfeld, Marsha Kline, and their colleagues at Yale note:

Schools are no longer the "islands of safety" that they once were believed to represent, as street crime, random violence, and large-scale accidents pervade schools in all parts of the country and affect children of all ages on a regular basis . . . . In a survey conducted in 1978 in two public high schools in Kansas City, Kansas, nearly 90% of the students reported having experienced the death of a grandparent, aunt, uncle, sibling, or someone else they cared about, 40% of the students reported the death of a close friend of their own age, and approximately 20% had witnessed a death. In a 1990 survey involving urban high school students, half the students reported that they knew someone who had been murdered, 37% had witnessed a shooting, and 31%, a stabbing (Pastore et al., 1991). In another survey of students attending 10 inner-city high schools, rates of direct gun-related victimization were alarmingly high; 20% of the students reported having been threatened with a gun and 12% had been the target of a shooting (Sheley et al., 1992). The exposure to community violence and violent deaths is not restricted to adolescents and adults . . . . In a 1992 study conducted in an urban pediatric continuity clinic in Boston, 7% of the children had witnessed a shooting or stabbing before the age of 6 years . . . . As schools face an escalating number of crises, the probability that any child or group of children will experience violence or sudden death of a friend and/or loved one is increasing.

These events often require a response from the school in order to address the children's developmental needs during times of crisis and uncertainty. These crisis periods can disrupt learning, at a minimum, and also have the potential to retard children's emotional and psychological adjustment to the event and impair their subsequent development.

Despite the overwhelming need for a crisis prevention and response plan, many schools remain unprepared. . . . School systems, therefore, need to develop and institute a coordinated and systematic response plan before another crisis occurs. School systems, however, may be reluctant to consider the potential for crises to occur and may deny the need for crisis intervention services . . . . This organizational denial of the need for crisis intervention services may also be reflected in an organizational push to resolve a crisis prematurely -- "to get things back to normal as soon as possible." . . . . Schools increasingly need an effective crisis prevention and response plan in order to avert disasters where possible and to ameliorate their impact on children when the disasters cannot be avoided . . . .
All center staff will find it wise to prepare to cope with common crisis events that may arise for students. Such crises usually involve outside threats to a client's health and safety and threats by a client to hurt self and/or others. Initially, the need is for training in how to respond to students who are overly aggressive toward staff or present with concerns about suicide or abuse. Eventually, steps can be taken to integrate center staff into school procedures for comprehensive crises intervention.

**School-Based Crisis Intervention: Overview**

In this section, you will find a brief, basic discussion of the need for a school to be able to plan and implement a response to crises. The material can be used to raise staff awareness of need and as shared reading prior to initiating staff training. The following topics are explored:

1. Who Should Be Responsible?
2. Planning for Crisis
3. A School-Based Crisis Team
4. Crisis Aftermath Subteams
5. Maintaining Crisis Response Capability and School Awareness
SCHOOL-BASED CRISIS INTERVENTION

Crises are dangerous opportunities.
Chinese saying

Crisis, emergency, disaster, catastrophe, tragedy, trauma -- all are words heard too frequently at schools today. Almost every school has had a major crisis; every school is likely to have one. Besides natural disasters such as earthquakes and fires, students experience violence and death related to the suicide of friends, gang activity, snipers, hostage-taking, and rape. Some students react with severe emotional responses -- fear, grief, post traumatic stress syndrome. Moreover, such experiences and other events that threaten their sense of worth and well-being can produce the type of intense personal turmoil that leads students to think about hurting themselves or others.

If no effort is made to intervene, emotional reactions may interfere with a student's school and home performance, can be imminently life threatening, or may be the start of long-term psychosocial problems. And, when a significant portion of the student body is affected, major facets of a school's functioning are likely to be jeopardized.

As used here, the term, school-based crisis intervention, refers to a range of responses schools can plan and implement in response to crisis events and reactions. All school-based and school-linked staff can play an important role in crisis intervention.
**Who Should Be Responsible?**

Given the complexity of crisis events and reactions, planning and implementing school-based crisis intervention require special expertise (e.g., how to deal with natural disasters as contrasted to dealing with gang violence or suicide, how to plan for crowd management, rumor control, aftermath counseling, prevention). Thus, individuals and subgroups with diverse expertise need to be involved, and all who are involved usually need additional specialized inservice training.

Whatever happens at the school level is shaped by district policy and procedural guidelines. In most instances, the district's administration will have provided the school with detailed guidelines for handling major disasters during the emergency itself and in the immediate aftermath (see Resource Aid IIF-1). Such guidelines also should clarify available district support resources (e.g., district crisis teams, medical and counseling services).

It is rarer for districts to have addressed, in the same detail, policies and procedures for what to do in the days and weeks that follow the event and what to do to improve future responses or to prevent future occurrences where feasible.

Regardless of what guidelines the district provides, it falls to the school to develop a specific operational plan and to identify and prepare personnel to carry it out. This might all be done by a school's administration. That is, they might assume the task of planning and then identifying and assigning specific duties to staff (e.g., school nurse, specific teachers, psychologist). However, as noted above, the diversity of expertise required suggests a broad-based approach to planning and implementation. Thus, schools probably will find the concept of a school-based crisis team useful. And SBHC staff can play a key role in making certain such a team is operational and well-trained.
The proper handling of school-wide crises is essential to minimizing negative impact on learning and mental health. A comprehensive crisis intervention approach provides ways for school personnel, students, and parents to return to normalcy as quickly as feasible, address residual (longer-term) psychosocial problems, and explore preventive measures for the future. To achieve these desirable outcomes, a school district must adopt, implement, and institutionalize a set of crisis intervention procedures.

Developing procedures for a school-based response to crises requires mechanisms for initial planning, implementation, and ongoing evaluation and change. Effective mechanisms to accomplish these tasks include:

- a school-based planning committee (whose efforts hopefully are augmented by district support staff)

- a school-based crisis team

Note: The planning and crisis team may be one and the same or may be two separate and coordinated groups.

Rather than asking one person to take responsibility for organizing for crises, the school administration is well-advised to form a small planning committee of school staff. The individuals asked to serve, by role and interest, should be ready to evolve a working plan and become the nucleus of a school-based crisis team. They also should be given appropriate released or compensated time, support, recognition, and appreciation.

In the best of circumstances, the district should provide not only policy and procedural guidelines, but support staff to help the school planning committee (including SBHC staff) formulate a specific plan, organize and train the crisis team, and coordinate with relevant district and community resources.

**Planning for Crises**

Every school needs a plan for school-based crisis intervention. It is important to anticipate the specifics of what may happen and how to react. Once the need for a plan is recognized, it underscores the need to identify who will be responsible for planning responses to crisis events.
Once identified, planners of school-based crisis intervention can work out criteria, procedures, and logistics regarding such general matters as

- who will assume what roles and functions in responding to a crisis
- what types of events the school defines as a crisis warranting a school-based response
- what defines a particular event as a crisis
- how will different facets of crisis response be handled (who, what, where)
- how to assess and triage medical and psychological trauma
- how to identify students and staff in need of aftermath intervention
- what types of responses will be made with respect to students, staff, parents, district, community, media
- what special provisions will be implemented to address language and cultural considerations
- which school personnel will make the responses
- how district and community resources will be used
- which personnel will review the adequacy of each response and make appropriate revisions in crises response plans
- what inservice staff development and training are needed.
- how will everyone be informed about emergency and crisis procedures

As part of the general plan, it is essential to address contingencies. What will be done if someone is not at school to carry out their crisis response duties? What if a location is not accessible for carrying on a planned activity?
It should be stressed that school crises often are community crises. Therefore, the school's plan should be coordinated with community crisis response personnel and, where feasible, plans and resources should be seamlessly woven together. The same is true with respect to neighboring schools. A blending of planning and implementation resources assures a wider range of expertise and can increase cost-efficacy.

As an aid for planning, Resource Aid IIF-2 provides samples of crisis response checklists.

Once a general plan is made, over time planners can work out further details related to specific concerns (see Appendix II-3). In doing so, they should give priority to those that seem to occur with the greatest frequency.

Exhibit 22 presents a matrix outlining the scope of crisis events and phases to be considered in intervention planning. Resource Aid IIF-3 outlines general ideas related to a school-based response to school-wide crises.

Several points should be highlighted related to Exhibit 22. Clearly, the scope of the event (major school-wide crises as contrasted to small group or individual crises) profoundly shapes how many staff members are needed during the various phases of the crisis.

Also, difficulties that must be dealt with during the crisis itself raise many problems that are quite distinct from those arising in the immediate aftermath and in the days and weeks following the event (e.g., hysteria and fear as contrasted with grief reactions and post traumatic stress).

Exhibit 23 outlines major facets of crisis response related to each of the four phases.
### Exhibit 22. Scope of Crisis Events and Intervention Phases

<table>
<thead>
<tr>
<th><strong>Scope of Event</strong></th>
<th><strong>During the Emergency</strong></th>
<th><strong>Immediate Aftermath</strong></th>
<th><strong>Days/Weeks Following</strong></th>
<th><strong>Prevention in the Future</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Major School-wide Crisis (e.g., major earthquake, fire in building, sniper on campus)</td>
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<tr>
<td>Small Group Crisis (e.g., minor tremor, fire in community, suicide)</td>
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<tr>
<td>Individual Crisis (e.g., student confides plan to hurt self/others)</td>
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</tbody>
</table>

**Scope of Event**

- **Major School-wide Crisis** (e.g., major earthquake, fire in building, sniper on campus)
- **Small Group Crisis** (e.g., minor tremor, fire in community, suicide)
- **Individual Crisis** (e.g., student confides plan to hurt self/others)
Exhibit 23. Major Facets of Crises Response

**During the emergency**

- Communication (e.g., sounding the alarm if necessary; clarifying additional steps and providing information about the event, location of first aid stations if needed, etc.; rumor control; dealing with the media; keeping track of students and staff; responding to parents; interfacing with rest of the district and community)

- Direction and coordination (e.g., running an emergency operations center; monitoring problems; problem solving)

- Health and safety (e.g., mitigating hazards to protect students and staff; providing them with medical and psychological first aid; providing for search and rescue, security, evacuation)

**Immediate aftermath**

- Communication (e.g., clarifying causes and impact and debunking rumors; providing information about available resources for medical and psychological help) See Resource Aid IIF-4.

- Direction and coordination (e.g., determining need to maintain emergency operations center; continuing to monitor problems and problem solve)

- Health and safety (e.g., continuing with activities initiated during the event)

**Days/weeks following**

- Communication (e.g., providing closure to students, staff, parents, district, community)

- Direction and coordination (e.g., continuing to monitor problems and problem solve)

- Health and safety (e.g., providing for those in need of longer-term treatment either through provision of direct services or referral; case management)

**Prevention**

- Communication (e.g., holding debriefing meetings to clarify deficiencies in response to the crisis)

- Direction and coordination (e.g., using debriefing analyses to plan ways to prevent, if feasible, similar events from occurring, to minimize the impact of unavoidable events, to improve crisis response procedures, to enhance resources)

- Health and safety (e.g., providing education for students, staff, parents)
**A School-Based Crisis Team**

Resources are always limited. Some schools will feel that they don't have the resources to devote to a crisis team. The fact is, however, that few schools can afford to risk not being able to respond effectively to crises. Any school that has some team meeting together to address students' problems can at the very least make the focus on crisis part of that team's work. Examples of such teams are a student assistance team, a student study team, or a resource coordinating team. Alternatively, neighboring schools might pool resources to develop a multi-school crisis team.

As with so many special committees and teams, school-based crisis teams often are initiated with great fanfare but over time simply become a title on a plan. Initial enthusiasm wanes; other activities become more pressing; members leave the school.

To be successful, a school-based crisis team must be highly valued by the school administration and composed of interested staff. The value and interest should be manifested in

1. bimonthly crisis team planning/staff development meetings that are scheduled during working hours
2. regular communications and staff development activities with the entire school staff
3. immediate replacement of departing team members and careful orientation of new members
4. formal recognition of team contribution to school's mission, and so forth.

Although some members of a school-based crisis team are dictated by role in the school (e.g., a school administrator, nurse, psychologist), there always are other staff who have special expertise or interest (e.g., SBHC staff with first aid and counseling training).
The following steps are guidelines for establishing, training, and maintaining crisis planning and intervention team(s). The outline in Appendix II-3 offers greater detail regarding these steps.

1. The school's decision makers can identify and empower two staff members who are interested in (motivated to) improve the school's crisis response capability. The SBHC's mental health professional could play an invaluable role as one of the two.

2. These two persons can then proceed to recruit a core of about 4-8 others, either by role or because of their special affinity for crisis intervention. This core will do the planning. (In large schools, the core team probably will want additional affiliated team members who can be mobilized when a response is necessary.)

3. Initial training of the team should focus on general crisis intervention policies and practices and on ways to keep the team functioning. It may be necessary to bring in district personnel (or even outside trainers) to provide some of the initial training.

4. After initial training, the team needs to meet regularly (e.g., every few weeks) to formulate and write up specific plans.

5. Plans in hand, a series of inservice meetings for school staff are indicated to increase their awareness of the importance of crisis intervention and the procedures they should follow.

6. After a crisis event, the team should have a special debriefing session to analyze how well procedures were followed and to discuss possible improvements -- including additional training needs and future preventive actions where feasible.
Each team needs to identify a team leader to

? organize planning and training sessions

? provide overall coordination during a crisis response

? liaison with district and school administrators and with community emergency response agencies (fire department, police).

Other team members will take on roles and functions related to

? mobilizing the team when needed (e.g., telephone trees, beepers)

? coordinating communications and controlling rumors

? first aid (medical, psychological)

? crowd management

? media

? evacuation and transportation

? individual and group supportive counseling

? aftermath interventions

and so forth.

Every team role and function needs to be backed-up by 1-2 team members in case someone is absent or incapacitated.

In addition to having a designated person and back-ups for mobilizing the team, it is wise to have essential contact information posted in several visible places (e.g., next to phones in office locations).

Obviously, for a team to be effective, it must function well as a group. Thus, it is essential to use planning and training time in ways that build a sense of mutual respect, trust, and support. An effective team communicates well, understands everyone's role, backs each other up, and gets the job done. A member must feel comfortable asking another for assistance during a crisis (especially when feeling overwhelmed). And at the appropriate time, each member indicates appreciation for all that each team member has done.
CRISIS TEAM ACTIVITY: AN EXAMPLE

During the Emergency and in Immediate Aftermath

I. MAJOR SCHOOL-WIDE CRISIS
   (e.g., major earthquake, fire in building, sniper on campus)

   A. Administration directs and coordinates emergency procedures.
      (e.g., emergency procedures such as evacuation, lock-down, contact with
      hospitals/police, contacts and interfaces with parents in need of direction)

   B. Crisis Team members without specific emergency assignments or students-in-hand
      converge at designated place.

   C. Crisis Team sets in motion procedures to
      1. gather and disperse accurate information to students, staff, parents, media
         (special focus on rumor control, support, and debriefing);
      2. assess immediate needs for psychological first-aid;
      3. ensure sufficient psychological first-aid is in place
         (e.g., establishes and maintains a special drop-in counseling resource for those
         affected; supplements resources by calling for district level help);
      4. direct students, staff, and parents in need to psychological first-aid resources
         (announces a central contact place, conducts outreach);
      5. keep administration informed.

II. SMALL GROUP CRISIS
   (e.g., a situation such as a classmate's death where most students are unaffected;
   the focus is on providing for specific classes, groups, and individuals who are upset)

   A. Any member of the Crisis Team who thinks there is a crisis situation can contact another
      member to decide whether a Team meeting should be called.

   B. If they agree, these two members should send a notice convening the meeting at the
      earliest, feasible time at a designated place.

   C. Preset procedures can be followed to cover classes for teachers on the team and to send
      students back to class who may be having individual appointments with team members.

   D. Crisis Team meets to assess who needs psychological support and counseling

   E. Crisis Team sets in motion procedures to
      1. gather and disperse accurate information to affected students, staff, parents, (special
         focus on rumor control, support, and debriefing);
      2. ensure sufficient support and counseling are in place
         (e.g., establishes and maintains a special drop-in counseling resource for those
         affected; supplements resources by calling for district level help);
      3. direct students, staff, and parents in need to appropriate resources (announces a
         central contact place, conducts outreach)
      4. coordinate resources and ensure they are maintained as long as needed (who, where)
      5. keep administration informed.

   (cont.)
III. INDIVIDUAL'S CRISIS  
(e.g., student confides threat to hurt self or others such as suicide, assault)

A. Staff, student, or parent may refer such an emergency to any member of the Crisis Team.

B. The Crisis Team member becomes the case manager for the problem until it is resolved or else arranges for someone else to case manage.

C. Preset procedures can be followed to cover classes for teachers on the team and to send students back to class who may be having individual appointments with team members.

D. The case manager is the primary intervener and arranges for appropriate action steps and for a back up crisis team member.

E. The case manager interviews the student and anyone else involved to assess needs  
(e.g., degree of danger, resource needs on and off campus, need to contact parents, need to contact legal authorities)

F. Case manager confers with back up team member to set in motion procedures to  
   1. provide immediate on campus help  
   2. call for additional support (e.g., from district, county)  
   3. contact parents

---

Days/Weeks Following

Following the emergency, the Crisis Team meets to identify appropriate steps for the ensuing days/weeks (e.g., information, support, counseling for classes, groups, individuals)

(1) Circulate accurate information to minimize destructive/disruptive rumors. An example of one procedure for doing this involves providing teachers with accurate information about the event and asking them to judiciously cover the matter with their students. They should be reminded to do this in a way that not only provides accurate information about the event, but clarifies that the feelings students are having are natural and reminds students of available resources should they have a particular concern. Provision should be made to back up teachers (e.g., those who feel their situation requires someone with specific skills). The same type of written notice for parents may also be indicated.

(2) Circulate a handout to all school personnel regarding what they should watch for in the aftermath and what they can do if students appear especially upset.

(3) Implement special support/counseling activities.

Debriefing and Planning for Prevention

At a later date, the Crisis Team meets for a debriefing session to evaluate how procedures worked, what revisions are needed, and to clarify preventive implications.
Crisis Aftermath Subteams

Although all crisis team members are involved in responding to emergencies, special expertise may be required in handling problems that arise in the days and weeks following an event. Thus, it may be worth establishing subteams or designating specific individuals to develop special expertise around the different types of aftermath problems. An aftermath subteam, then, is composed of one or more individuals who are prepared to focus on specific problems (e.g., suicide; violence and gang activity; earthquake, fire, and other natural disasters; rape).

Each subteam draws on the talents of such people as the nurse, school psychologist, counselors, peer counseling coordinators, dropout coordinators, administrators, and any others who have interest and talent related to such problems. To ensure that each subteam and the total team meet regularly for training and other preparedness activity, subteam leaders and a crisis aftermath team coordinator are needed.

It is important to keep in mind that the problems in dealing with the crisis itself are quite distinct from those arising immediately after the circumstances of the event itself are handled. At least, four different types of aftermath problems can be distinguished:

- Disaster reactions
- Grief reactions
- Fear of Violence reactions
- Suicide prevention

Subteams can prepare, implement, and monitor procedures for dealing with the psychosocial aftermath of crisis events that are likely to spread to a significant segment of students. Of particular concern are procedures for rumor control, dealing with contagion effects, and providing support for any students who have strong psychological reactions.

(Some persons on the aftermath team also will be on teams designed to deal with the prevention and actual occurrence of crisis events; nevertheless, it is important to distinguish the problems of dealing with the crisis itself from those that arise in the immediate aftermath.)
DEALING WITH THE MEDIA

Media reports can make responding to crises more difficult. Thus, it is essential to have a media coordinator/liaison and to meet with media in a designated area. (Usually, the media should not be given access to students without parent consent.) Everyone should keep the following in mind when dealing with the media.

Prepare

Write down what you want to communicate. In doing so,

? state appropriate concern for victims and their families

? provide appropriate factual information (e.g., students involved, ages), including information about the steps taken to deal with the crisis (as well as any preventive measures previously taken); at the same time, safeguard privacy and confidentiality and details that police should handle related to criminal acts and suicide

? ask media to communicate resources for assistance available at the school and in the community.

You will find it useful to have prepared and kept on file the outline of a formal news release so that you can simply fill in the details prior to meeting with the media.

Give Straightforward Information

No matter what you are told, assume that everything you say will be quoted (and perhaps misquoted). Thus, respond to questions by reiterating points from your prepared statement. However, when you don't have information on a matter, simply state this in a straightforward manner. Keep a positive demeanor.

Avoid Common Mistakes

? Don't restate any question you are asked (especially negatively phrased questions) because through editing and selective quoting it can be made to appear part of your statement.

? Don't interpret events or motives or predict what will happen.

? Don't speculate, ad lib, blame anyone, or try to be deceptive.

? Don't let anyone bait you into an argument because you are almost certain to look like you are defensive (perhaps trying to hide something), and you probably will say something in a way that reflects badly on you and the school.

Correct the Record

As you become aware of errors in media coverage, take the opportunity of future media inquiries to include corrective information in your statement.
**Maintaining Crisis Response Capability and School Awareness**

Because of changes in staffing and in staff interests, crisis response procedures must be reviewed at the beginning of each school year and may need revitalization. It probably requires 2-3 dedicated staff to keep the process functioning well.

In this regard, a school nurse can play an important catalytic role. For example, at the beginning of a school year, s/he can help arrange an early meeting of crisis response personnel to

- review and improve crisis response procedures
- plan information dissemination to staff and students
- plan additional inservice training for crisis response.

Another aspect of maintaining crisis response capability arises from efforts to maintain staff and student awareness of crisis procedures. That is, if regular steps are taken to keep staff and students informed, this can result in continuous review and improvement procedures.

For multiple reasons, then, it is essential for someone to take responsibility for planning how to keep staff and students aware and updated on the school's crisis response procedures. This task might fall to a school administrator or to a crisis team member.

Examples of steps that might be taken are

1. Each class could be provided with an outline of "Emergency Procedures" and "Crisis Team information" to be posted on the wall.

2. At the beginning of each semester, updated information could be circulated to all school personnel explaining who can be contacted and the function of the Crisis Team.

3. At the beginning of the year and at midyear a presentation could be made at a faculty meeting.

4. As another reminder and update, monthly reports based on the minutes from crisis planning and debriefing meetings also might be reproduced and circulated to all school personnel.
Psychological First Aid

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

Psychological first aid for students/staff/parents can be as important as medical aid (See Resource Aid IIF-5 for indicators of reactions to trauma.) The immediate objective is to help individuals deal with the troubling psychological reactions.

(1) Managing the situation. A student who is upset can produce a form of emotional contagion.

To counter this, staff must

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

(2) Mobilizing support. The student needs support and guidance.

Ways in which staff can help are to

? try to engage the student in a problem-solving dialogue
  >normalize the reaction as much as feasible
  >facilitate emotional expression (e.g., through use of empathy, warmth, and genuineness)
  >facilitate cognitive understanding by providing information
  >facilitate personal action by the student
  (e.g., help the individual do something to reduce the emotional upset and minimize threats to competence, self-determination, and relatedness)

? encourage the student's buddies to provide social support
? contact the student's home to discuss what's wrong and what to do
? refer the student to a specific counseling resource (see Resource Aid IIF-6 for a sample crisis screening interview).

Exhibit 24 provides a few general principles related to responding to crises.
Exhibit 24. A Few General Principles Related to Responding to Crises

Immediate Response -- Focused on Restoring Equilibrium

In responding:

? Be calm, direct, informative, authoritative, nurturing, and problem-solving oriented.

? Counter denial, by encouraging students to deal with facts of the event; give accurate information and explanations of what happened and what to expect -- never give unrealistic or false assurances.

? Talk with students about their emotional reactions and encourage them to deal with such reactions as another facet of countering denial and other defenses that interfere with restoring equilibrium.

? Convey a sense hope and positive expectation -- that while crises change things, there are ways to deal with the impact.

Move the Student from Victim to Actor

? Plan with the student promising, realistic, and appropriate actions they will pursue when they leave you.

? Build on coping strategies the student has displayed.

? If feasible, involve the student in assisting with efforts to restore equilibrium.

Connect the Student with Immediate Social Support

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

Take Care of the Caretakers

? Be certain that support systems are in place for staff in general

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

Provide for Aftermath Interventions

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

(see Resource Aid IIF-7 for examples of classroom activities)
REFLECTIONS ON CRISIS COUNSELING

When I first joined the crisis team, I thought we’d usually be dealing with emergencies that disrupted the whole school. But, most of the emergencies have involved individual students who seem suicidal or have taken a drug overdose, and most of the aftermath counseling has involved small groups of students and staff who are affected by the death of a student or staff member.

In times of crisis, I often have felt overwhelmed by the depth of despair and grief experienced by so many. In reaching out, I have had to learn how to draw in those among the quiet ones who will let some of it out only if I encourage turn-taking during an aftermath group session.

I also have learned how to avoid overwhelming those who are not ready, psychologically, to deal with what happened and those for whom the event itself is not important except as a trigger setting off strong emotions (e.g., pent up grief related to the death of others who were close to them and/or fears about their own mortality). At the same time, I’ve learned to avoid playing into the dynamics of those who just seem to get caught up in and want to maintain the supercharged atmosphere created by a crisis.

Early in my crisis team experience, I was surprised when one administrator seemed reluctant to have the team offer aftermath support. He wanted things to return to ‘normal’ as fast as possible and was convinced the team’s activity would keep things stirred up. He also expressed concern that many students would be overwhelmed by the added pressures of reflecting on what had happened, listening to others' reactions, and expressing their own. He had concluded that the best strategy was to encourage everyone to put the event behind them and get on with things. We agreed that he was probably right with respect to most students. And, we finally convinced him that we could proceed in ways that would help to normalize the situation for the majority and still provide for those with special needs.

I have since learned that many people share a concern that crisis interveners don’t appreciate how many individuals are ready to get on with things. So, I always try to assure everyone that I understand this, and then I clarify that helping those with special needs is an important part of getting things back to normal.

(cont.)
A specific aspect of normalization after the death of a student or staff member seems to be a wide-spread desire to gather funds to help the family if there is a need and/or to arrange a tribute. When this is the case, the concerned energy of most of the school population can be channeled in this direction after initial expressions of emotion are validated. Extended aftermath groups are necessary only for those seen as profoundly affected.

One of the hardest things about crisis counseling is establishing a relationship with students who don't know me at a time when they desperately need someone familiar whom they can trust. Therefore, I try, whenever possible, to enlist someone to work beside me whom the students look up to. At the very least, I quickly identify someone in the group with whom I can ally myself.

Responding to crisis is exhausting. Thus, we have found it essential to have enough team members to spell each other whenever extended counseling is required on a given day. In responding to the needs of others, it is easy to ignore the impact on ourselves.

As a health professional, what drew me to crisis intervention is that I knew it was an essential element of any comprehensive approach to maintaining psychological well-being. What I didn't realize was what a powerful contribution an active school-based crisis team could make to a school's sense of community. At first, team meetings focused on improving crisis response plans and communicating them to the rest of the school. We found our efforts to take care of these matters were reassuring to others. Once these tasks were accomplished, we found ourselves addressing other school safety concerns and ways for students and staff to be more supportive of each other. In many ways, the crisis team has become a special forum for sharing concerns and a symbol of the school community's commitment to taking care of each other. And, I think that is pretty basic to maintaining our mental health!
Addressing Specific Areas of Concern Related to Crises

Given the range of crises that SBHC staff are called upon to deal with, it is not feasible to cover all the specifics here. As a further resource Appendix II-4 provides some resource aids on the following topics:

- Community and Gang Violence
- Suicidal Crisis
- Family Violence
- Sexual Assault
- Grief and Loss
- Hostage Situations
- Post Traumatic Stress Disorder

While it takes a while for all members of a crisis team to learn about such specific areas of concern, each member might elect to focus on a particular topic and then over time share what has been learned with others on the team and with the rest of the staff.
A. Resource Aids Included Here

Resource Aid IIF-1

District Policy Considerations

Outlines forms of support that districts may provide.

Resource Aid IIF-2

Crisis Response Checklist

This is a checklist of major things to be done related to immediate response and follow-up activity. Also included here is an example of a checklist developed by one large school district.

Resource Aid IIF-3

Some Key Considerations in Establishing a System for School-Based Crisis Response

Outlines nine points answering some basic concerns that arise during discussions of planning school-based crisis response.

Resource Aid IIF-4

Informing the Students and Staff

Provides a few guidelines and an example of how to announce crisis-related information. A sample letter for informing the family is also included here.

Resource Aid IIF-5

A Few Indicators of Reactions to Trauma

A handout for staff to raise their awareness.
Resource Aid IIF-6

A Crisis Screening Interview

A brief instrument to aid in clarifying whether a student needs special assistance in dealing with reactions to a crisis.

Resource Aid IIF-7

Aftermath Classroom Activities

Handouts for pre-school and kindergarten, elementary, and junior and senior high.

B. Related Resource Aid Packets Available from Our Center

Responding to Crisis at a School

Provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. Contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training and as information handouts for staff, students, and parents.

Violence Prevention and Safe Schools

Outlines selected violence prevention curricula and school programs and school-community partnerships for safe schools. Emphasizes both policy and practice.
DISTRICT POLICY CONSIDERATIONS

Check to see if the district has made a policy statement about crisis intervention or any specific form of crisis-related event, such as a natural disaster, an act of violence in the schools, or the death of a student or staff member. Such statements should help clarify how the district defines a crisis, how it has designed its overall response to crises, and what type of responses it expects at each school. The statement also may suggest specific organization and strategies for crisis response. It also may indicate the district's position on seeking help from individuals and agencies not affiliated with the district (other than public sector emergency services).

The following is a brief indication of the type of specific guidelines you may find in district policy statements.

From a district's perspective, crises usually are events that have the potential to

C cause a major disruption in normal functioning
C produce major physical and/or psychological harm to those at the school (e.g., students, staff, parents).

The definition may be limited to events that affect the entire population at a school, or it may be extended to events that affect subgroups or even an individual (e.g., in the case of a potential suicide). Regardless of the breadth of definition, the first concern of policy makers is for ensuring physical safety; hopefully, this is followed immediately by attention to psychological considerations.

Ideally, district policy specifies guidelines for district and school-by-school planning, organizing, and training for crises, and debriefing after a crisis (with a view to improving future crises responses and preventive actions). In particular, guidelines can help answer such questions as

C How do we decide that a situation should be treated as a crisis?
C How do we decide what responses are needed to deal with the crisis?
C How do we ensure that planned responses are implemented?
C How do we enlist additional help?

Districts will differ in the specificity with which they spell out procedures for a school to follow during a crisis. Optimally, the district not only will detail such procedures, but also will provide for district level support. District level support is useful in establishing and maintaining crisis response mechanisms and in training and consulting with on-site staff, as well as providing for supplemental staffing to respond to specified crises. In large districts, such support may be organized regionally (e.g., regional support crisis teams consisting of representatives of medical and psychological/counseling support services, district administration, media relations).

In some districts, a school-based crisis intervention team is delineated as the prototype mechanism to provide for the physical safety and psychological needs of students, staff, and parents in responding to a crisis. Such a team also might be assigned responsibility for on-site planning for crises response, or else some of the members might participate on a crisis planning team. Because situations vary, district policy probably will not specify team membership or size other than to cite the need for participation by role (e.g., administrator, nurse, psychologist, counselor, teachers). Obviously, ultimate responsibility for the team belongs to the principal; however, the principal probably will be expected to delegate such responsibility -- perhaps to the team as a whole.
Crisis Response Checklist

In the midst of a crisis, it is hard to remember all the specific steps and preparatory plans that have been discussed. Each site and each person responsible for crisis response needs to have a checklist that provides a ready and visible reference guide for use during a crisis. Such a checklist is also an important training tool. The following is an outline of what such a checklist might cover.

I. Immediate Response

Check to be certain that

- appropriate "alarms" have been sounded
- all persons with a crisis role are mobilized and informed as to who is coordinating the response and where the coordination/emergency operation center and medical and psychological first aid centers are located

This may include coordinators for

- overall crisis response
- first aid (medical, psychological)
- media
- communications
- crowd management
- transportation

- phone trees are activated
- team leader and others clarify whether additional resources should be called in (from the District or community -- such as additional medical and psychological assistance, police, fire)
- all assignments are being carried out (including provisions for classroom coverage for crisis response team members and for any instances of a staff death)
- corrective steps are being taken when the response is inadequate
- all communication needs are addressed by implementing planned means for information sharing and rumor control (e.g. Public Address announcements, circulation of written statements, presentations to staff/students/parents in classes or in special assemblies);

This includes communications with

- staff
- students
- crisis team
- media
- home
- district offices and other schools
- community
- fire, police

- plans for locating individuals are implemented (e.g., message center, sign-in and sign-out lists for staff and students)

- specific intervention and referral activity are implemented (e.g., triage, first-aid, search, rescue, security, evacuation, counseling, distribution of information about resources and referral processes -- including teentalk and suicide prevention lines and interviews to assess need for individual counseling)

- support and time out breaks for crisis workers are implemented

- informal debriefings of crisis workers are done to assess how things are going and what will be required in the way of follow-up activity.
II. Follow-up Activity

In the **aftermath**, check to be certain that

___ continuing communication needs are addressed (clarifying causes and impact; debunking rumors, updating facts, providing closure; updating information on available resources)

___ if relevant, family contacts are made to learn funeral and memorial service arrangements, and to determine if there is additional assistance the school can provide (School-related memorial services for gang members, suicides, etc. are controversial; clear policies should be established in discussing crisis response plans.)

___ crisis-related problems continue to be monitored and dealt with (including case management of referrals and extended treatment)

___ facets of crisis response that are no longer needed are brought to an appropriate conclusion

___ debriefing meetings are held (to appreciate all who helped, clarify deficiencies in crisis response, and make revisions for the next time)

___ crisis response plans are revised and resources enhanced for dealing with the next crisis

___ additional training is planned and implemented

___ appropriate prevention planning is incorporated (e.g., at least to minimize the impact of such events)
Example of One District's Crisis Checklist

I. ASSESSMENT

___A. Identify problem and determine degree of impact on school.

___B. Take steps to secure the safety and security of the site as needed.

___C. Make incident report to district administrator.

___D. Determine if additional support is needed.
   ___1. Call school police and/or city police
   ___2. Call Cluster Crisis Team
   ___3. Call other district crisis personnel

___E. Alter daily/weekly schedule as needed.

II. INTERVENTION: COMMUNICATION

___A. Set up a Command Center

___B. Establish Sign-In Procedures at ALL campus entry sites*

___C. Administrator/designee/crisis manager should:
   ___1. Review facts/determine what information should be shared
   ___2. Consider police investigation parameters
   ___3. Notify family with sensitivity and dispatch. (Consider a personal contact with family.)

___D. Develop and disseminate bilingual FACT SHEET (written bulletin)
   ___1. Faculty
   ___2. Students
   ___3. Parents/Community

___E. Begin media interactions.
   ___1. Identify a media spokesperson (Office of Communications may be utilized)
   ___2. Designate a location for media representatives.*

___F. Contact neighboring schools

___G. Contact schools of affected students siblings.

___H. Other communication activities
   ___1. Classroom presentations/discussions
   ___2. Parent/community meetings
   ___3. School staff meeting

___I. Provide for RUMOR CONTROL
   ___1. Keep a TV set or radio tuned to a news station
   ___2. Verify ALL facts heard
   ___3. Update Fact Sheet as needed
   ___4. Utilize student leaders:
      a) As sources knowledgeable of rumors among students
      b) As peer leaders to convey factual information
      c) As runners (written bulletins should be sealed when necessary)
III. INTERVENTION: FIRST AID AND EMERGENCY RELEASE PLAN

___A. Initiate First Aid Team procedures

___B. Designate Emergency Health Office location*

___C. Initiate Emergency Release Plan procedures

___D. Designate student check-out location*

IV. INTERVENTION: PSYCHOLOGICAL FIRST AID/COUNSELING

___A. Logistics: Designate rooms/locations/areas**
   ___1. Individual counseling -- Location:___________________________ **
   ___2. Group counseling -- Location: _____________________________ **
   ___3. Parents -- Location: _____________________________________ **
   ___4. Staff (certificated and classified) -- Location:__________________ **
   ___5. Sign-In for Support Services -- Location: _________________

___B. Initiate the referral process, including procedures for self-referral.
   ___1. Identify a crisis team member to staff all locations.**
   ___2. Provide bilingual services as needed.
   ___3. Distribute appropriate forms for student counseling referrals to staff.
   ___4. Disseminate student referral information to teachers and other staff.

___C. Identify and contact high risk students.

___D. Identify and contact other affected students, staff, and personnel.

___E. Initiate appropriate interventions:
   ？ Individual counseling
   ？ Group counseling
   ？ Parent/community meetings
   ？ Staff meetings (ALL staff)
   ？ Classroom activities, presentations
   ？ Referrals to community agencies

IV. INTERVENTION: DISSEMINATE APPROPRIATE HANDOUTS TO STAFF/PARENTS

V. INTERVENTION: DEBRIEFING

___A. Daily and mandatory

___B. Crisis intervention activities
   ___1. Review the actions of the day
   ___2. Identify weaknesses and strengths of crisis interventions
   ___3. Review status of referred students
   ___4. Prioritize needs/personnel needed the next day
   ___5. Plan follow-up actions

___C. Allow time for emotional debriefing

* Logistics/room designations/space allocations
** Support personnel needed for these locations

Developed by the Los Angeles Unified School District
Some Key Considerations in Establishing a System
for School-Based Crisis Response

The following nine points provide answers to some basic concerns that arise during discussions of school-based crisis response.

(1) Scope of events

All schools require a clear set of emergency procedures for dealing with major, school-wide crises (e.g., earthquake, fire, snipers) when they occur and in the immediate aftermath.

Decisions have to be made about whether the scope of crisis response will include specified procedures for any of the following:

? crises that affect smaller segments of the student body

? crises experienced by individual students (e.g., drug overdose, suicide attempt)

? community events that produce strong reactions among students at school (e.g., earthquakes that occur during nonschool hours, a neighborhood shooting of a gang member who is student)

? planning responses (e.g., psychological support) for helping (treating/referring) traumatized students (staff?) in the days and weeks following an event

? preventive procedures

(2) Crisis criteria

When should an event be seen as requiring a crisis response?

With the exception of most major, school wide crises, crises tend to be in the eye of the beholder. Thus, some school personnel are quite liberal and others are quite conservative in labeling events as crises.

After deciding on the scope of events to be treated as crisis, the dilemma of the planners and ultimately of the decision makers is that of establishing a set of checks and balances to ensure potential crises are not ignored and that there is not an overreaction to events that should not be treated as crises. Given the inevitability of differences regarding how an event is perceived, efforts to formulate crisis criteria probably should focus on delineating an expedient process for deciding rather than the more difficult task of detailing what is and isn't a crisis.

For example, one school developed a process whereby each member of its crisis team was encouraged to take the initiative of contacting another team member whenever s/he felt an event might warrant a crisis response. If the contacted team member agreed that the event should be seen as a crisis, the rest of the crisis team were contacted immediately for a quick meeting and vote. If the majority concurred, the event was defined as a crisis and appropriate crisis responses were implemented.
(3) **Who needs aftermath help?**

Again, there will be inevitable differences in perception. It is clear, however, that plans must be in place to provide help and/or referral whenever staff, parents, or students themselves indicate that a student is experiencing significant emotional reactions to a crisis. Usually, all that is needed is a procedure for alerting everyone to the possibility of emotional reactions and who on the staff will be providing support and counseling and/or referrals.

Planners also may want to consider what types of general responses may be appropriate with regard to specific types of events. Should there be a "debriefing" meeting for the entire school? for specific subgroups?

And decisions will have to be made about whether there will be support/counseling/referrals for emotional reactions of school staff.

(4) **Types of responses**

Planning focuses on delineating, establishing, and maintaining procedures and equipment and assigning responsibilities for (1) communication, (2) direction and coordination, and (3) health and safety during each of the four phases specified in the accompanying Figure. It encompasses every major detail related to who, what, where, when, and how.

Other materials in this unit provide examples of the types of activities to be considered in such planning.

A special need arises with respect to handling the media. It has become increasingly evident that each school should identify and train a specific person to act as a spokesperson in order to minimize the ways media reports can exacerbate difficult situations.

(5) **Providing for Language and Cultural Differences**

The influx of immigrants has increased the necessity of identifying individuals who speak the language and are aware of relevant cultural considerations that may arise during a crisis response. If one is fortunate enough to have such individuals on the school staff (in professional or nonprofessional positions), then planning involves delineating their roles during the crisis, clarifying how they can be freed from other responsibilities, and how they can be trained to carry out their special roles. If such persons are not readily available, then planning also must address how to recruit such help. Possible sources include mature students, parents, staff from nearby community agencies, other community volunteers.
Scope of Crisis Events and Intervention Phases

<table>
<thead>
<tr>
<th>Scope of Event</th>
<th>During the Emergency</th>
<th>Immediate Aftermath</th>
<th>Days/ Weeks Following</th>
<th>Prevention in the Future</th>
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</thead>
<tbody>
<tr>
<td>Major School-wide Crisis</td>
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<tr>
<td>(e.g., major earthquake,</td>
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<tr>
<td>fire in building,</td>
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<tr>
<td>sniper on campus)</td>
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<tr>
<td>Small Group Crisis</td>
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<tr>
<td>(e.g., minor tremor, fire</td>
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<tr>
<td>in community,</td>
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<td>suicide)</td>
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<td>Individual Crisis</td>
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<td>(e.g., student confides plan</td>
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<tr>
<td>to hurt self/others)</td>
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</tbody>
</table>
(6) Which School Staff Respond to Crises

Obviously, there are some staff who because of their role are critical to the success of crisis response (e.g., school nurses, psychologists, specific administrators, office staff, plant manager). In addition, there are others who have relevant interests and special abilities (e.g., first aid and counseling skills). To provide a comprehensive and coordinated response, plans should focus on ways to establish, train, and maintain a Crisis Intervention Team consisting of a combination of both types of staff (i.e., role-relevant and interested individuals). In all likelihood, there will be considerable overlap between the Crisis Planning Committee and the Crisis Intervention Team. Plans also must be made to identify, train, and maintain a number of individuals who will play supplementary roles when there are major disasters such as fires, earthquakes, and large-scale violence on campus (e.g., all school personnel, designated students, parent liaisons).

(7) Other District and Community Resources

Some crises require mobilization of off-campus resources. Planning involves identifying available resources and clarifying steps by which they will be mobilized when needed.

(8) Crisis Debriefing

At an appropriate time after a crisis response, an analysis of the quality of the response should be made to identify the need for improved procedures and additional training. For this to occur, a planning committee must designate who will organize the debriefing and who will be responsible for following through with developing improved procedures and organizing training sessions.

(9) Inservice Training

In addition to training needs that emerge from debriefing analyses, plans should be made for ongoing staff development based on requests from staff involved in crisis planning and intervention.
Informing the Students and Staff

Many administrators prefer not to make a P.A. announcement when there has been a crisis event that affects the school. There is no hard and fast rule here. In part, it depends on the situation (such as how much there is a need for immediate communication), and in part it depends on the ability of the administrator to use the P.A. in an effective manner.

Thus, the most common means of communication is a note to teachers and school staff members. Such communications should be made as quickly as feasible and should be done in a clear and open manner (providing all known information). In turn, teachers and staff are directed to inform students, doing so with concern and caring so as to calm and clarify. If feasible, students should be informed in small-group settings where questions can be answered, rumors clarified, and concerns addressed.

The following is a sample of a statement used to provide staff and students with relevant information about the death of a student.

We regret to inform you of the death of (name). S/he died on (date) as a result of

At times such as these, it is important for everyone to be informed and to have some time to express thoughts and feelings. Part of first period will be used for such sharing.

In addition, we encourage anyone who is very upset to come to room ( ) where staff members will be available throughout today to help. Staff members will also be available upon request over the next two days should anyone want further assistance. Such assistance can be obtained by (explain process).

As soon as the information is available, we will circulate a notice about funeral arrangements and provisions for attending if the funeral is during school hours.
Facilitating Class Discussion

In general, informing and discussing a traumatic event with students is best done in small-groups where questions can be answered, rumors clarified, and concerns addressed. Some students may choose not to enter into discussion, and some may even express a desire to be excused. Don't force the situation; honor the student's wishes.

Students often start off by saying such things as

\[ I \text{ feel terrible.} \]
\[ S/he \text{ was my friend.} \]
\[ Why \text{ did it have to happen?} \]
\[ I'm \text{ really mad that it happened.} \]
\[ We knew he was upset; we should have done something. \]
\[ Things \text{ like this don't make sense.} \]
\[ It \text{ could happen to me.} \]
\[ It's just one of those things. \]
\[ I can't believe it. \]
\[ If it weren't for (name of someone), it wouldn't have happened. \]

You can often help keep students more fully express their thoughts and feelings by paraphrasing what they have just said. Try not to make intrusive comments. At the same time, move the discussion away from any attempts to glamorize or romanticize the event.

After they have been able to express themselves, you need to let them know that what they are thinking and feeling is very natural under the circumstances and that, for some of them, it may take a while before such thoughts and feelings are worked through.

Be sure to tell them that who is available to students if they or a friend are very upset. Watch for any student who appears very upset and follow predetermined procedures for connecting that student with someone who is ready to provide psychological first aid.
Sample Letter to Send Home

November 20, 1996

Dear Family Members:

We regret to inform about an unfortunate event affecting our school. Yesterday, (brief factual statement about event). An investigation is underway, and until it is complete we will not have all the details about this tragedy.

The school's crisis team has begun meeting with students and staff. We anticipate some may need continuing support for a while to help them deal with the emotional upset that such an event produces. In this regard, enclosed are some materials that you may find helpful in talking about the matter at home.

If you have any questions or concerns you think we can help address, please feel free to call the school (number) and ask for any of the following staff: ____________________________.

The following community agencies also are ready to help anyone who is feeling overwhelmed by their emotions.

   (local) Community Mental Health Center (phone)
   Family Services (phone)
   etc.

We know that events such as this are stressful. We are taking every step we can to be responsive to the needs of our students and their families.

Sincerely,

Principal
A Few Indicators of Reactions to Trauma

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

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

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

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

- very unhappy, sad, teary, depressed, indicates a sense of worthlessness, hopelessness, helplessness
- very afraid, fearful
- can't seem to control emotions
- excessive anger or self-blame (especially if it is expressed as threats to harm self or others)
- doesn't seem to have feelings

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

- frequent outbursts, violent hurts self, self-abusive
- cruel to others truancy, school avoidance
- sleep problems and/or nightmares trouble learning and performing
- wetting/soiling at school eating problems
- agitated and easily distracted ritualistic behavior
- destroys things isolates self from others
- accident prone unaccounted for weight loss
- excessive/uncontrolled talking substance abuse
- often doesn't seem to hear runs away
**Interactions with others**
(Doesn't seem interested in others. Can't interact appropriately or effectively with others.)

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

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

- worries a lot
- doesn't stay focused on matters
- can't seem to concentrate on much
- seems disoriented, has trouble knowing what day it is or relating recent events
- may indicate fear s/he is losing her/his mind
- is preoccupied with some idea (often bizarre) or with death
- seems to hear or see things, delusional, may experience flashbacks
- denies apparent problems
A Crisis Screening Interview

Interviewer________________________ Date__________

Note identified problem:

Is the student seeking help?   Yes   No

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

__________________________________________________________

Student’s Name _______________________________ Age _____ Birthdate ___________

Sex:  M  F          Grade ________       Current class ______________________

Ethnicity __________________Primary Language ____________________

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

In answering, please provide as much details as you can. At times, I will ask you to tell
me a bit more about your thoughts and feelings.

1. Where were you when the event occurred?
   (Directly at the site? nearby? out of the area?)

2. What did you see or hear about what happened?

3. How are you feeling now?
4. How well do you know those who were involved?

5. Has anything like this happened to you or any of your family before?

6. How do you think this will affect you in the days to come?  
   (How will your life be different now?)

7. How do you think this will affect your family in the days to come?

8. What bothers you the most about what happened?

9. Do you think anyone could have done something to prevent it?  
   Yes  No
   Who?

10. Thinking back on what happened,  
    how angry do you feel about it?  
        not at all  a little  more than a little  very
        1       2       3       4
    how sad do you feel about it?  
        1       2       3       4
    how guilty do you feel about it?  
        1       2       3       4
    how scared do you feel?  
        1       2       3       4
11. What changes have there been in your life or routine because of what happened?

12. What new problems have you experienced since the event?

13. What is your most pressing problem currently?

14. Do you think someone should be punished for what happened?  
   Yes  No  
   Who?

15. Is this a matter of getting even or seeking revenge?  
   Yes  No  
   Who should do the punishing?

16. What other information do you want regarding what happened?

17. Do you think it would help you to talk to someone about how you feel about what happened?  
   Yes  No  
   Who?  
   How soon?

   Is this something we should talk about now?  
   Yes  No  
   What is it?

18. What do you usually do when you need help with a personal problem?

19. Which friends and who at home can you talk to about this?

20. What are you going to do when you leave school today?  
   If you are uncertain, let's talk about what you should do?
Aftermath Classroom Activities

In addition to discussion, teachers can help students deal with their reactions to a crisis through a variety of classroom activities.

The work done on this by the Los Angeles Unified School District has been found useful by schools around the country. For example, Genesee County in Michigan has included the following adaptation in their crisis handbook.

Classroom activities enable students to express and discuss feelings about crises. The following are simply examples to stimulate teachers' planning.
PRE-SCHOOL AND KINDERGARTEN ACTIVITIES

Play Reenactment

Toys that encourage play reenactment of students' experiences and observations during a traumatic experience can help integrate the experiences. Useful toys include fire trucks, rescue trucks, dump trucks, ambulances, building blocks and dolls.

Physical Contact

Children need lots of physical contact during times of stress to regain a sense of security. Games involving structured physical touching help meet this need.

Nourishment

Extra amounts of finger foods and fluids help provide the emotional and physical nourishment children need in times of stress. Oral satisfaction is especially necessary, because children tend to revert to more regressive or primitive behavior in response to feelings that their survival or security is threatened.

Puppets

Playing with puppets can be effective in reducing inhibitions and encouraging children to discuss their feelings.

Art

Have the children do a mural on butcher paper with topics such as what happened when the traumatic event occurred. This is recommended for small groups with discussion afterward, directed by an adult. Have the children draw individual pictures about the event and then discuss or act out elements of their pictures. This activity allows for discussing experiences, and helps children discover that others share their fears.

Stories

Read stories to the children that tell about other children's (or animals') experiences in a disastrous event. This can be a nonthreatening way to convey common reactions to frightening experiences, and to stimulate discussion. It helps to emphasize how people resolve feelings of fear.

Large Muscle Activity

When children are restless or anxious, any activities that involve large muscle movements are helpful. You might try your own simple version of doing exercises to music, like skipping and jumping.
ELEMENTARY SCHOOL ACTIVITIES

Play Reenactment

For younger children, using toys that encourage play reenactment of their experience and observations during the traumatic event can help integrate the traumatic experience. Toys might include ambulances, dump trucks, fire trucks, building blocks and dolls.

Puppets

Play with puppets can be effective in reducing inhibitions and encouraging children to talk about their feelings and thoughts. Children often will respond more freely to a puppet asking about what happened than to an adult asking the questions directly. Help or encourage students to develop skits or puppet shows about what happened in the event. Encourage them to include anything positive about the experience as well as those aspects that were frightening or disconcerting.

Art and Discussion Groups

Do a group mural on butcher paper with topics such as "What happened in your neighborhood (school name or home) when the traumatic event occurred?" This is recommended for small groups with discussion afterward, facilitated by an adult. This type of activity can help students feel less isolated with their fears and provide the opportunity to vent feelings. Have the children draw individual pictures and then talk about them in small groups. It is important in the group discussion to end on a positive note (such as a feeling of mastery or preparedness, noting that the community or family pulled together to deal with the crisis); in addition to providing the opportunity to talk about their feelings about what took place.

Share Your Own Experience

Stimulate group discussion about disaster experiences by sharing your own feelings, fears or experiences. It is important to legitimize feelings to help students feel less isolated.

Disaster Plans

Have the children brainstorm their own classroom or family disaster plan. What would they do if they had to evacuate? How would they contact parents? How should the family be prepared? How could they help the family?

Reading

Read aloud, or have the children read, stories or books that talk about children or families dealing with stressful situations, pulling together during times of hardship, and similar themes.
Creative Writing or Discussion Topics

In a discussion or writing assignment, have the children describe in detail a very scary intense moment in time and a very happy moment. Create a group story, recorded by the teacher, about a dog or cat that was in an earthquake, flood or other disaster. What happened to him? What did he do? How did he feel? You can help the students by providing connective elements. Emphasize creative problem-solving and positive resolution.

Playacting

In small groups, play the game, "If you were an animal, what would you be?" You might adapt discussion questions such as "If you were that animal, what would you do when some traumatic event occurred?" Have the children take turns acting out an emotion in front of the class, without talking, and have the rest of the class guess what the feeling is and why the student might have that feeling. Do this for good as well as bad feelings.

Other Disasters

Have the children bring in newspaper clippings on disasters that have happened in other parts of the world. Ask the students how they imagine the survivors might have felt or what they might have experienced.

Tension Breakers

A good tension breaker when students are restless is the co-listening exercise. Have the children quickly pair up with a partner. Child #1 takes a turn at talking about anything he or she wants to, while Child #2 simply listens. After three minutes, they switch roles and Child #2 talks while Child #1 listens.

Also, when the children are anxious and restless, any activities that involve large muscle movements are helpful. You might try doing your own version of exercises to music, like skipping or jumping.
Activities

Classroom activities that relate the traumatic event to course study can be a good way to help students integrate their experiences and observations, while providing specific learning experiences. In implementing the following suggestions, or ideas of your own, it is important to allow time for the students to discuss feelings stimulated by the projects or issues being covered.

Home Room Class

Group discussion of their experiences of the event is particularly important among adolescents. They need the opportunity to express feelings, as well as to normalize the extreme emotions they may have experienced. A good way to stimulate such a discussion is for the teacher to share his or her own reactions to the event. The students may need considerable reassurance that even extreme emotions and crazy thoughts are normal in a traumatic event. It is important to end such discussions on a positive note, such as talking about what heroic acts were observed.

Break the class into small groups and have them develop a disaster plan for their home, school or community. This can help students regain a sense of mastery and security, as well as having practical merit. The small groups can then share their plans in a discussion with the entire class.

Conduct a class discussion and/or support a class project on how the students might help the community recovery effort. It's important to help them develop concrete and realistic ways they might be of assistance. Community involvement can help overcome feelings of helplessness and frustration, and deal with survivors' guilt and other common reactions in disaster situations.

Have a home safety or preparedness quiz. What would you do under certain circumstances (such as finding a hurt child, being without water or electricity, or having an earthquake hit the area). Talk about what is necessary to survive in the wilderness. How does this knowledge apply to a community following a disaster? Encourage students who have had first aid training to demonstrate basic techniques to the class.

Science

Conduct projects on stress, physiological response to stress, and how to deal with it.

Creative Writing

Ask the students to write about an intense moment they remember very clearly not a day or an hour, but a short period of time lasting no more than three minutes. Make up a funny disaster. Write a story about a person who is in a disaster and give it a happy ending.
Literature or Reading

Have the students read a story or novel about young people or families who have experienced hardship or disaster. Have a follow-up discussion on how they might react if they were the character in the story.

Psychology Class

Initiate a discussion on how course content might apply to the stress reactions students observed during and following a traumatic event. Discuss post-traumatic stress syndrome. Have a guest speaker from Mental Health Services or a therapist involved in counseling victims speak to the class.

Peer Listening

Provide information on common responses to traumatic events. Use structured exercises using skills students are learning in class to help them integrate their experiences. Point out that victims need to repeat their stories many times. Students can help family and friends affected by the event by using good listening skills.

Health Class

Discuss emotional reactions to the event and the importance of taking care of one's own emotional well being. Discuss health hazards in a disaster, such as water contamination or food that may have gone bad due to lack of refrigeration. Discuss health precautions and safety measure. Guest speakers from public health and/or mental health and from the fire department might talk to the class.

Art Class

Have the students portray their experiences or observations of the event in various art media. Have the students do a group project, such as a mural, showing the community recovery efforts following a disaster.

Speech/Drama

Have the students portray the catastrophic emotions that come up in response to a traumatic event. Have the students develop a skit about some aspect of the event.

Math Class

Have the class solve mathematical problems related to the impact of the event.

Social Studies/Government

Study governmental agencies responsible for aid to victims. How do they work? How effective are they? Write letters or petitions to agencies responsible for handling disasters. Discuss the political implications of the event within a community.

History Class

Discuss historical events and disasters. Discuss how the victims and survivors of those events might have felt. Have the students bring in newspaper clippings on current events in other parts of the world. What kinds of experiences might the victims have had? Have you experienced anything similar?
A Few Related References


### Module II: Working with Students Who Come to the Center

#### UNIT IIG: Management of Care & Follow-Up Evaluation
(Case Management)

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UNIT IIG  
Management of Care & Follow-Up Evaluation

Early in a center's development, the emphasis is on regular monitoring and formative evaluation to ensure students' needs are met. In subsequent phases of center development, longer-term case follow-up and efficacy evaluation.

Specific tasks involved here include

- Immediate monitoring through feedback from interveners, students, and records
- Continued monitoring and formative evaluation through feedback from interveners, students, and records

As already suggested, case management begins from the time a student is referred. Monitoring forms sent to students and interveners provide an easy way to check on the appropriateness of a current service.

**Immediate Monitoring.** As already noted, a student follow-through interview can be done within the first few weeks after projected enrollment in a service (see referral follow-up forms included as Resource Aids in Unit IID and Resource Aids IIG-1 and 2). This is a good time for identifying students who did not follow-through (perhaps because of a practical problem not identified and worked on during screening).

**Continued Monitoring/Management and Formative Evaluation.** Follow-up checks are indicated periodically. At the very least, a student follow-up interview seems indicated after 2 months and/or at the date a service originally was scheduled to end. 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 reassess the student's needs and to determine whether another referral should be made determine or other next steps. If the intervention is completed, the focus shifts to an evaluation of status at end of intervention (see Resource Aid IIG-1 and 2).
Managing Care, Not Cases

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

Nicholas Hobbs

Embedded within the meaning of care that emphasizes help also is caring. Many professionals have suggested that a sense of caring is crucial if programs and services are to be successful in helping youngsters. Thus, in discussing management of care, they assume the intent is to help and the method should convey a sense of caring. To avoid undermining the emphasis on care, the word "case" (as in case management) can be replaced with the term care.

Whatever term is used, the process 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.

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.

As already indicated, 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 (see Resource Aids in Unit IID and at the end of this unit).
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.

**Ongoing Monitoring/Management of Care**

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

Monitoring involves follow-ups with interveners and students/families. This can take a variety of formats (e.g., written communications, phone conversations, electronic communications). More specifically, 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
All monitoring and management of care require a system of record keeping designed to maintain an up-to-date record on the status of the student as of the last contact and that reminds you when a contact should be made. (Again, see the various Resource Aids designed to facilitate follow-up on referrals and ongoing monitoring/managing of care.)

Management of care, of course, involves more than monitoring processes and outcomes. Management also calls for the ability to produce changes as necessary.

Sometimes steps must be taken to improve the quality of processes, including at times enhancing coordination among several interveners. Sometimes intervention plans need to be revised to increase their efficacy and minimize their "costs" -- including addressing negative "side effects." Thus, management of care involves using the findings from ongoing monitoring to clarify if interventions need to be altered and then implements strategies to identify appropriate changes and ensure they are implemented with continued monitoring. Along the way, those involved in managing the client's care may have to advocate for and broker essential help and provide the linkage among services that ensures they are coordinated. They also must enhance coordinated intervener communication with the student's caregivers at home.

Who does all this monitoring and management of care? Ideally, all involved parties -- interveners and clients -- assume these functions and become the management team. One member of such a team needs to take primary responsibility for management of care (a primary manager). Sites with sufficient resources often opt to employ one staff member to fill this role for all clients. However, given the limited resources available to schools, a more practical model is train many staff to share such a role. Ultimately, with proper instruction, one or more family members might be able to assume this role.

All who assume the role or primary care manager must approach it in a way that respects the client and conveys a sense of caring. The process should be oriented to problem-solving but should not be limited to problem treatments (e.g., in working on their problems, young people should not be cut off from developmental and enrichment opportunities). In most instances, a youngsters's family will be integrally involved and empowered as partners, as well as recipients of care.
Unfortunately, there are times when a client is forced to enroll and/or remain in a program (e.g., mandated counseling, diversion programming). By definition, such intervention eliminates client choice and self-determination and is likely to be experienced as disempowering. Clients in such situations can be expected to manifest various forms of reactive behavior. The challenge for all interveners in these instances is one of overcoming negative motivation by finding ways the client can regain their sense of self-determination. The primary care manager can assist in meeting this need by inviting the client’s participation in all subsequent team reviews and decision making.

Well-implemented management of care can help ensure that clients are helped in a comprehensive, integrated manner that addresses her/him as a whole person. A positive side effect of all this can be enhancement of systems of care.

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

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 (see Resource Aids);

- 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.
Advanced Technology to Assist with Student Care

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

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

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

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

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

References
Resource Aids

A. Resource Aids Included Here

Resource Aid IIG-1

Follow-up Rating Form -- Service Status

Examples of rating forms (one for client self-report; another for the intervener) to provide an indication of how well the intervention is proceeding.

Resource Aid IIG-2

Management of Care Review Form

This form is designed to both guide and provide a record of client care -- including all team activity and decisions.

B. Related Resource Aid Packets Available from Our Center

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

Discusses why it is important to approach student clients as consumers and to think in terms of managing care, not cases. Outlines processes related to problem identification, triage, assessment and client consultation, referral, and management of care. Provides discussion of prereferral intervention and referral as a multifaceted intervention. Clarifies the nature of ongoing management of care and the necessity of establishing mechanisms to enhance systems of care. Examples of tools to aid in all these processes are included.

Confidentiality and Informed Consent

Focuses on issues related to confidentiality and consent of minors in human services and interagency collaborations. Also includes sample consent forms.

Cultural Concerns in Addressing Barriers to Learning

Highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. This packet also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.
Follow-up Rating Form -- Service Status  (Intervener Form)
(To be filled out periodically by interveners)

To:  (Intervener's name)

From: _____________________, Primary Care Manager

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

Student's Name or ID # ________________________ Birthdate _______ Date___________

Number of sessions seen:   Ind.___  Group _____

What problems were worked on?

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

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

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

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

Recommendations made for further action:

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

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

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

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

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

Prognosis

1 2 3 4
very positive  positive  negative  very negative
Follow-up Rating Form -- Service Status (Client Form)
(To be filled out periodically by the clients)

Student’s Name or ID # ________________________ Birthdate _______ Date___________

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

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

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

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

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

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

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

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

5. How hopeful are you about solving your problems?

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

If not hopeful, why not?

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

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

Student’s Name or ID # ________________________ Birthdate _______

Primary Manager of Care ________________________________________

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

___________________       _____________________ _____________________
___________________       _____________________ _____________________
____________________________________________________________________________

Initial Plan

Date management of care file opened: __________

Student Lives with: __________________________ Relationship _________________
Address__________________________________________ Phone _________________

Home language ____________________________________________

Type of concern initially presented
(briefly describe for each applicable area) How serious are the problems?
not too very serious
serious

Learning:          1       2      3      4      5      6
Behavior:          1       2      3      4      5      6
Emotional:          1       2      3      4      5      6
Other:          1       2      3      4      5      6

Problem Identified and Referred by: __________________________ date________
Initial client consultation done with: __________________________ date _________
 Conducted by:_________________________________

Indicate diagnosis (if any): __________________________
Recommendations/Decisions/consents:

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

Appropriate client follow-through?

Yes       No

If no, why not?

Is the original plan still appropriate?

Yes       No

If no, why not?

What changes are needed?

Any problems with coordination of interventions?

Yes       No

If yes:

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

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

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

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

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

Date: ____________________

Team members present:
________________________
________________________
________________________
________________________

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

With respect to concerns initially presented, at this time --

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

Appropriate client follow-through? Yes No

If no, why not?

IIG-12
Is the current plan still appropriate?  Yes  No

If no, why not?

What changes are needed?

Any problems with coordination of interventions?  Yes  No

If yes:

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

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

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

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

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.
Note: This sheet may be used several times over the course of intervention (e.g., every 2 mths).

Ongoing Team Review

Date:______________

Team members present:

______________________         ____________________ _____________________
______________________         ____________________ _____________________
______________________         ____________________ _____________________

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

With respect to concerns initially presented, at this time --

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

Appropriate client follow-through? Yes  No

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

If no, why not?

What changes are needed?

Any problems with coordination of interventions?  Yes  No

If yes:

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

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

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

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

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

Date: ______________

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

With respect to concerns initially presented, at this time --

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

Why is the intervention ending?

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

What plans are there for meeting these needs?

If there are no plans, why not?
SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

With intervention ending, the primary manager must be certain that (1) everyone who should be informed is provided relevant information and (2) evaluation data are entered into the appropriate systems.
A Few References on the Basics of Helping and Counseling


Appendix II-1

Connecting a Student with the Right Help
Connecting a Student with the Right Help

As highlighted in throughout Unit II, the process of connecting the student with appropriate help can be viewed as encompassing four facets: (1) screening/assessment, (2) client consultation and referral, (3) triage, and (4) monitoring/managing care. This appendix provides a bit more information about such matters.

Screening to Clarify Need

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

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

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, sometimes peers, etc. If feasible and appropriate, a classroom observation and a home visit also may be of use. You will find some helpful tools in the accompanying materials.

? And you can do a screening interview. The nature of this interview will vary depending on the age of the student and whether concerns raised are general ones about misbehavior and poor school performance or specific concerns about lack of attention, overactivity, major learning problems, significant emotional problems such as appearing depressed and possibly suicidal, or about physical, sexual, or substance abuse. To balance the picture, it is important to look for assets as well as weaknesses. (In this regard, because some students are reluctant to talk about their problems, it is useful to think about the matter of talking with and listening to students -- see Exhibit 20).

? 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 that are symptoms of problems also are common characteristics of young people, especially in adolescence. Cultural differences also can be misinterpreted as symptoms. To avoid misidentification that can inappropriately stigmatize a youngster, all screeners must take care not to overestimate the significance of a few indicators and must be sensitive to developmental, cultural, and other common individual differences.
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 the diagnosis of mental health and psychosocial problems. The following are a few examples to underscore these points.

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

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

? At this stage, assessment is really a screening process such as you do when you use an eye chart to screen for potential vision problems. If the screening suggests the need, the next step is referral to someone who can do 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.
Client Consultation and Referral

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

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

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

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

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

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

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

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

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.

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

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

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

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

(Adapted from Berne, 1964)

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**

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:

1. 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;

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

3. 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.

At school sites, one mechanism for focusing on enhancing systems of care is a Resource Coordinating 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 Coordinating 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 Coordinating 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 Coordinating 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 Coordinating 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 Coordinating Council brings together representatives from each school's Resource Coordinating Team to facilitate coordination and equity among schools in using school and community resources.
Appendix II-2

About the Diagnostic and Statistical Manual of Mental Disorders
(DSM-IV, 1994)

Because the DSM is so widely used throughout the U.S., school professionals need to have some level of awareness of its focus and the categories that are used with respect to children and adolescents. If you are unfamiliar with this classification scheme, you will find a summary description on the following pages.
About the Diagnostic and Statistical Manual of Mental Disorders
(DSM-IV, 1994)

Among the purposes of diagnostic systems such as the DSM are to (1) facilitate communication among professionals and (2) standardize criteria for diagnosis.

Multiaxial Assessment

With the intent of capturing a good deal of the complexity of psychological problems, the DSM focuses simultaneously on several dimensions. This effort is referred to as multiaxial assessment. Simply stated, an axis is a dimension to be considered in assessment. Recent versions of the Diagnostic and Statistical Manual of Mental Disorders developed by the American Psychiatric Association (see DSM-IV, 1994) include a focus on five dimensions -- thus the term multiaxial. The five are:

Axis I  *Clinical Disorders* -- the focus is on assessing symptoms to identify whether criteria are met for assigning one of the psychiatric disorders (or other conditions that may be the focus of clinical attention) identified in the DSM-IV classification scheme.

Axis II  Personality Disorders/Mental Retardation -- the focus is on facets of an individual's persona or intellectual ability that are likely to be resistant to change.

Axis III  *General Medical Conditions* -- the focus is on any medical conditions that may be contributing to psychological problems or may be a factor in intervention.

Axis IV  *Psychosocial and Environmental Problems* -- the focus is on specific contextual factors that have relevance for conclusions about differential diagnosis, treatment, and prognosis.

Axis V  *Global Assessment of Functioning* -- the focus is on how well the individual is presently functioning.

For the four axes (I-IV) that focus on specific areas, the DSM-IV classification scheme provides a range of possible categories and delineates relevant criteria. The categories are:

Axis I
- Disorders usually first diagnosed in infancy, childhood, or adolescence (excluding Mental Retardation, which is diagnosed on Axis II)
- Delirium, dementia, and amnestic and other cognitive disorders
- Mental disorders due to a general medical condition
- Substance-related disorders
- Schizophrenia and other psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Sexual and gender identity disorders
- Eating disorders
- Sleep disorders
- Impulse-control disorders not elsewhere classified
- Adjustment disorders
- Other conditions that may be a focus of clinical attention
Axis II

- Paranoid personality disorders
- Schizoid personality disorders
- Schizotypal personality disorders
- Antisocial personality disorders
- Borderline personality disorders
- Histrionic personality disorders
- Narcissistic personality disorders
- Avoidant personality disorders
- Dependent personality disorders
- Obsessive-compulsive personality disorders
- Personality disorder not otherwise specified
- Mental retardation

Axis III

- Infectious and parasitic diseases
- Neoplasms
- Endocrine, nutritional, and metabolic diseases and immunity disorders
- Diseases of the blood and blood-forming organs
- Diseases of the nervous system and sense organs
- Diseases of the circulatory system
- Diseases of the respiratory system
- Diseases of the digestive system
- Diseases of the genitourinary system
- Complications of pregnancy, childbirth, and the puerperium
- Diseases of the skin and subcutaneous tissue
- Diseases of the musculoskeletal system and connective tissue
- Congenital anomalies
- Certain conditions originating in the perinatal period
- Symptoms, signs, and ill-defined conditions
- Injury and poisoning

Axis IV

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system/crime
- Other psychosocial and environmental problems

With respect to Axis V (Global Assessment of Functioning), the point is to clarify the level of coping ability/adaptive functioning. The assessor rates the individual on a scale of 1 to 100.

91-100 = superior functioning, no symptoms
81-90 = good functioning, minimal symptoms
71-80 = a few transient and commonplace symptoms
61-70 = mild symptoms but functioning pretty well
51-60 = moderate symptoms and functional problems
41-50 = serious symptoms and impairment in functioning
31-40 = some impairment in reality testing or major impairment in several functional areas
21-30 = delusions or hallucinations or serious impairment in judgment or inability to function
11-20 = some danger of hurting self or others or occasional failure to maintain hygiene
1-10 = persistent danger of severely hurting self or others or inability to maintain hygiene
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

The following group of categories is of particular interest to those working with young people:

? Mental Retardation (coded on Axis II)¹
  mild mental retardation
  moderate mental retardation
  severe mental retardation
  profound mental retardation
  mental retardation, severity unspecified

? Learning Disorders¹
  reading disorder
  mathematics disorder
  disorder of written expression
  learning disorder NOS²

? Motor Skills Disorder
  development coordination disorder

? Communication Disorders
  expressive language disorder
  mixed receptive-expressive language disorder
  phonological disorder
  stuttering
  communication disorder NOS

? Pervasive Developmental Disorders
  autistic disorder
  Rett's disorder
  childhood disintegrative disorder
  Asperger's disorder
  pervasive developmental disorder NOS

? Attention-Deficit and Disruptive Behavior Disorders
  attention-deficit/hyperactivity disorder
    combined type
    predominantly inattentive type
    hyperactive-impulsive type
  attention-deficit hyperactivity disorder NOS
  conduct disorder
    (childhood or adolescent-onset)
  oppositional defiant disorder
  disruptive behavior disorder

? Feeding and Eating Disorders of Infancy or Early Childhood
  pica
  rumination disorder
  feeding disorder of infancy or early childhood

? Tic Disorders
  Tourette's disorder
  chronic motor or vocal tic disorder
  transient tic disorder
  tic disorder NOS

? Elimination Disorders
  encopresis
    with constipation and overflow incontinence
    without constipation and overflow incontinence
  enuresis (not due to a general medical condition) -- nocturnal, diurnal, or both

? Other Disorders of Infancy, Childhood, or Adolescence
  separation anxiety disorder
  selective mutism
  reactive attachment disorder of infancy or early childhood (inhibited or disinhibited)
  stereotypic movement disorder
  disorder of infancy, childhood, or adolescence NOS

¹Diagnoses of mental retardation and learning disorders must be based on use of one or more of the standardized, individually administered intelligence tests. In addition, diagnosis of learning disorders requires use of standardized, individually administered achievement tests in determining the degree of discrepancy between intellectual functioning and achievement.

²NOS = Not Otherwise Specified -- As indicated in the DSM: "Because of the diversity of clinical presentations, it is impossible for the diagnostic nomenclature to cover every possible situation. For this reason, each diagnostic class has at least one Not Otherwise Specified (NOS) category and some classes have several...."
Other Categories Used in Diagnosing Child and Adolescent Problems

The following are additional categories often used in diagnosing young people:

? Adjustment Disorder *
  with depressed mood
  with anxiety
  with mixed anxiety and depressed mood
  with disturbance of conduct
  with mixed disturbance of emotions and conduct
  unspecified
  Specify if: acute/chronic

*The essential feature of such a disorder is described as "the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors."

? Anxiety Disorders
  panic disorder without agoraphobia
  panic disorder with agoraphobia
  agoraphobia without history of panic disorder
  specific phobia (specified)
  social phobia
  obsessive-compulsive disorder
  posttraumatic stress disorder
  acute stress disorder
  generalized anxiety disorder
  anxiety disorder due to ...
  (indicated general medical condition)
  substance-induced anxiety disorder
  anxiety disorder NOS

? Mood Disorders
  Depressive Disorders
    major depressive disorder
    (single episode/recurrent)
    dysthmic disorder
    depressive disorder
  Bipolar Disorders
    bipolar I disorder
    bipolar II disorder
    cyclothymic disorder
    bipolar disorder NOS
    mood disorder due to ...
    (indicated general medical condition)
    substance-induced mood disorder
    mood disorder NOS

? Other Conditions That May Be A Focus of Clinical Attention

  Relational Problems
    relational problem related to a mental disorder or general medical condition
    parent-child relational problem
    sibling relational problem
    relational problem NOS

  Problems Related to Abuse or Neglect
    physical abuse of child
    sexual abuse of child
    neglect of child

  Additional Conditions that May Be a Focus of Clinical Attention
    child or adolescent antisocial behavior
    academic problem
For statistical (and payment) reporting purposes, assessments made using the DSM are assigned codes. For example, each of the categories listed above has a specific code assigned to it. Thus, if a youngster is diagnosed as attention-deficit hyperactivity disorder, combined type, the problem is assigned the code 314.01; if the diagnosis is conduct disorder, the code is 312.8. A special set of codes, called V codes, are used to identify individuals who have problems that require treatment but do not meet the criteria set for one of the disorders.

A summary diagnosis and coding might look like this:

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Conduct disorder -- adolescent onset (severe)</th>
<th>312.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis II</td>
<td>No evident disorder</td>
<td>V71.09</td>
</tr>
<tr>
<td>Axis III</td>
<td>No apparent contribution</td>
<td></td>
</tr>
<tr>
<td>Axis IV</td>
<td>Problems with educational setting</td>
<td>3</td>
</tr>
<tr>
<td>Axis V</td>
<td>Current functioning</td>
<td>GAF = 50</td>
</tr>
</tbody>
</table>

W. Paul Jones has written a useful little book for school staff interested in the DSM. He entitles the work: *Deciphering the Diagnostic Codes: A Guide for School Counselors* (1997, Corwin Press). In the work, he states that using the DSM really begins with the General Assessment of Functioning. That is, if the GAF is high, even if there are symptoms there is no disorder to diagnose. Axis IV is used to assess psychosocial facet, Axis III considers medical conditions, Axis II looks at persistent, cross-situational patterns of behavior or conditions that are related to symptoms. Finally, the primary focus of treatment is identified on Axis I.

**Some Cautions**

1. *Diagnoses must be based on formal criteria and professional assessment.*

   Because so many terms used in formal classification schemes such as the DSM have found their way into everyday language, the words often are used without reference to formal criteria and without use of related professional assessment. For example, it is easy to fall into the trap of referring to common learning problems as learning disabilities, very active children as hyperactive or ADHD, commonplace anxieties as anxiety disorders, and sadness as depression or a mood disorder. *Use of formal diagnostic categories requires careful application of designated criteria as operationalized in formal assessments.* Such criteria have an inclusionary and exclusionary focus to facilitate differential diagnosis and are concerned with severity, pervasiveness, onset, and duration in determining whether there is a clinically significant impairment. They also stress ways of determining whether symptoms are substance-induced (through use of alcohol and others drugs/medications or as a result of toxin exposure) and what should be considered in determining whether symptoms are the result of a general medical condition.

2. *Diagnoses should not be based on ensuring reimbursement from third-party payers.*

   In his book, W. Paul Jones (cited above) recognizes the role that third-party payment for mental health services plays in the overdiagnosis of psychopathology by requiring identification of a disorder for reimbursement. He cautions "when, for example, a parent-child relation problem is identified on Axis I as the primary focus of treatment, there is a high probability that no third-party reimbursement will be available. If the provider can
find sufficient evidence to identify another disorder on Axis I, for example, anxiety, and then list the parent-child problem on Axis IV, the probability of eligibility for reimbursement by an insurer increases dramatically. ... until or unless third-party reimbursement becomes available before problems become severe, V codes will probably be reported on Axis I at a lower rate than codes that are eligible for reimbursement."

Two cautions discussed in the DSM-IV also should be noted:

(3) DSM diagnostic criteria are only guidelines and not all conditions needing treatment are included.

"The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses ... to enhance agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training .... [The work reflects] a consensus of current formulations of evolving knowledge .... They do not encompass, however, all the conditions for which people may be treated...."

(4) Watch out for cultural diversity.

"Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture."

**DSM and the International Classification of Diseases (ICD)**

The *official* diagnostic classification and coding system in use in the U.S. is the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM). Under development is the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10) -- developed by the World Health Organization (WHO). The U.S. Department of Health and Human Services plans to require use of ICD-10 codes for reporting purposes throughout the U.S. (probably around the turn of this century). The DSM notes that to facilitate the transition, "preparation of DSM-IV has been closely coordinated with the preparation of Chapter V, 'Mental and Behavioral Disorders,' of ICD-10 . . . ." so that the respective codes and terms are fully compatible. Appendix H in the DSM-IV provides a cross-translation.
In this appendix, you will find some material on

(1) **Building a School-Based Crisis Team**

Organizational steps are outlined. Also includes
- an example of a Meeting Invitation
- an outline of the meeting's topic: *Focus on Planning*
- an example of a worksheet for the session

(2) **Crisis Team Training**

Highlights the need for both general and specialized training over time.

(3) **Two Initial Training Sessions**

Highlights the focus of the initial training by outlining the two session topics

*Focus on Action*
*Focus on Prevention*
Building a School-Based Crisis Team

The process of organizing a school-based crisis team begins with the site's leadership. Once there is agreement on the value of establishing such a team, someone must be designated the responsibility of building the team. That person begins by identifying those who have formal roles they must play during a crisis, those with specific skills that are needed, and any others who may be especially motivated to be part of such a team.

The next step is to set a meeting time and invite the potential members.

To increase the likelihood that the meeting is focused and productive, it helps to do some presession structuring. This includes:

- asking others to play a role during the meeting (e.g., meeting facilitator, time keeper, note taker -- see accompanying sample form)

- providing them with copies of the site's existing crisis response plans and some general material to read on the subject of school-based crisis response (such as the overview presented in Section I of this resource aid).

During the meeting, it helps to use worksheets that focus the discussion on key topics and decisions about tasks assignments and timelines.

The meeting, of course, will review the site's existing crisis response plans and discuss a variety of related matters.

By the end of the meeting, agreements should have been made about team membership, roles, and decide on initial training dates and who will conduct the training.
Example of Meeting Invitation

Meeting to Organize
the School's Crisis Response Team

Date

To:

From:

As you know the school has decided to (re)organize a school-based crisis team. You have been identified as a key person to talk with about the team.

At the meeting, we will review the site's existing crisis response plans and discuss a variety of related matters. By the end of the meeting, we will clarify crisis team membership, roles, and initial training dates.

In preparation for our meeting, please review the attached material.

The meeting is scheduled for (date, day, time)

To help make the meeting run smoothly and productively, the following staff have agreed to guide the process.

Meeting facilitator will be_______________________________

Meeting time keeper will be_____________________________

Meeting scribe will be_______________________________

Finally, since a crisis demands that we work quickly, teamwork under pressure will be good practice. This means starting and ending the meeting on time and setting time limits for each task.
Session Topic:

FOCUS ON PLANNING

What are our roles and functions as team members?

(1) Meeting facilitator reviews the key team roles and functions

(2) Decide who will take each role. (Fill in Worksheet -- see accompanying example).
    If there are enough people, designate a back up for each position.
    Discuss chain of command. Who will be in charge, who will be next, if these two are not available or busy who would be third.
    Enter all necessary contact information (e.g., home numbers, beepers).

(3) Discuss the last crisis at the school.
    If one doesn't come to mind, use the possibility of a car accident outside school involving a student and observed by most students and parents. Each team member should assume her/his role in talking through the specifics of what to do. Treat this as brainstorming with no discussion until the exercise is finished. Then take five minutes to highlight the good ideas and additional suggestions for action.

(4) Plan on a way each team member will inform others at the school about the crisis team membership and roles. For examples who will talk to faculty, parent center coordinator, office staff, TA's, Playground staff, support staff?

(5) Prepare for the next meeting which will FOCUS ON ACTION
    Date for next meeting
    Meeting facilitator
    Meeting time keeper
    Meeting scribe
    Someone should volunteer to copy and distribute the preparation material for the next meeting.
## Worksheet

### Team Membership, Roles, and Functions

<table>
<thead>
<tr>
<th>Roles/Functions</th>
<th>Name</th>
<th>Chain of Command</th>
<th>Contact Information</th>
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<tr>
<td>(One person may serve more than one role/function)</td>
<td>(Who's in charge? Back-ups?)</td>
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<td>Team Leader</td>
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<td>Media Liaison</td>
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<td>First Aid Coordinator(s)</td>
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<td>Communications Coordinator</td>
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<tr>
<td>Crowd Management Coordinator</td>
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<tr>
<td>Evacuation/Transportation Coord.</td>
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AppII-3d
Crisis Team Training

The team as a whole should receive general training with respect to crisis intervention and team building. In addition, each subteam or designated "specialist" needs specialized training.

The team leader should bring all members together once a month so that each can learn from the experiences and training of the others. The minutes of this meeting can be reproduced as a monthly report to the school, and this report can act as a reminder of the importance of dealing with the aftermath of crises, of who should be contacted at such times, and as an indication of the team's impact.

Besides mastering the school's crisis response plan and emergency steps, general training involves learning

- how to minimize student contagion in the aftermath of such a problem
- how to reassure the majority of students about the problem
- how to identify and provide psychological first aid to students who have especially strong reactions (including assisting with someone in acute shock or trauma)
- counseling skills appropriate to the event (including active listening skills, small-group techniques for both students and adults, conflict resolution, critical incident stress debriefing, support group facilitation)

Each subteam should receive specialized training with respect to the specific type of crisis with which the subteam is concerned (e.g., fire, earthquake, suicidal youth). Specialized training involves learning

- the types of reactions students, staff, and parents are likely to have to a particular type of crisis;
- how to respond to specific types of reactions.

Note: A special training opportunity for interested team members is to participate in a disaster drill held by local hospitals, police, fire departments, offices of emergency services, etc.
Two Initial Training Sessions

The first sessions after the organizational meeting stress specific preparation for action and prevention.

Session 1: **FOCUS ON ACTION**

*What steps should we plan for?*

Session 2: **FOCUS ON PREVENTION**

*How can we enhance resources to prevent some crises and minimize others?*

(1) Focus on Action

Prior to the session, team members are to review the material on Planning for Crisis in Section I of this resource aid, as well as the material on key considerations and the Crisis Checklists contained in Section II.

At the session(s):

1) The meeting facilitator talks through a crisis intervention flow chart. For each step, team members write in the name(s) of who on the team will be responsible for the function.

2) The meeting facilitator asks each member to talk through one section of the checklist. Briefly personalize this for the school (who, what, when, where). If this takes too long for one meeting, carry it over to a second FOCUS ON ACTION Meeting.

3) If there has been a crisis at the school or one has been averted or minimized, discuss it briefly. Assess what worked well and what didn't. Make any changes in the plans and decide how to inform others.

Preparation for the next meeting **FOCUS ON PREVENTION.**

Date of the meeting: 

Meeting time keeper:

Meeting facilitator: 

Meeting scribe:
Crisis Event

Administrator(s) contact superintendent and other appropriate district administrators and go to scene: assess situation

- Contact police/ambulance and administer first aid as necessary
- Public information office advised
- Remove uninvolved students from area
- Contact parents
- Meetings with staff, parents, etc.
- Establish counseling support network
- School assemblies/Staff inservices

Crisis Intervention Flow Chart

Personal/Life Threatening Event
(2) Focus on Prevention

At this session(s), the discussion and training explores the following matters.

If a crisis situation has occurred at the school, part of the time is used for debriefing (What happened? How was it handled? What went well? What didn't? Is a change in plans needed?).

To begin to plan ways to minimize and perhaps avert crises, the team needs to understand how existing programs might be enhanced and new ones developed. The discussion begins with the questions:

What are ways the school can avert or minimize crisis situations?

Can we do so by enhancing certain programs and developing preventive approaches?

This leads to discussion of:

What does the school have? Need?

What else might strengthen the safety net?

In this context, team members can learn to map what's in place and analyze whether it needs to be improved (e.g., Is the school's emergency plan effective? Is there a safe school plan? a Parent Center? a District Crisis Team? Is there a conflict mediation program? a human relations program? Could linkage with some community resources result in better recreation and enrichment opportunities and reduce gang violence?)

With a view to enhancing resources for all facets of crisis response and prevention, team members need to connect with community resources. As a first step, they can begin by mapping resources that can assist during and in the aftermath of a crisis (see attached worksheet).

Future training sessions should try to achieve a balance between capacity building for crisis response and pursuing ideas for crisis prevention. In terms of timing, everyone tends to be most motivated to learn in the wake of a debriefing done after a crisis. For purposes of simulated practice, the team might use any disaster drills the school carries out (e.g., fire, earthquake). As new members join, it is a good opportunity for experienced members to orient and teach them and, in the process, to review and consolidate what they have learned to date.
Starting to Map Community Resources

What resources are available in the school district and community to assist during and after a crisis? List all the community resources you know about. (Consult any resource books and look in the local phone book.)

Divide up the list and contact each to get updated information about services.*

<table>
<thead>
<tr>
<th>Resource/Agency</th>
<th>Contact Name</th>
<th>Phone Number</th>
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*Add the page of Community Resources to the site's Crisis Handbook.
INFORMATION ON RESOURCES

All crisis response plans should include material on resources that can be used for (1) training purposes, (2) preventing and minimizing crises and their impact, and (3) responding during and after a crisis. Such resources include

- local agencies and professionals with relevant expertise and services
- other individuals who might supplement efforts to prevent or minimize
- video and film resources for training and as a stimulus for student discussions
- reading materials for training, student discussions, and "bibliotherapy"

The following organizations are resources for information and in some cases materials.

U.S. Dept. of Education: Safe and Drug-free School Office
555 New Jersey Ave., NW, Rm. 214b
Washington, DC 20208-5725
I (202) 219-1547
FAX I (202) 219-1817

National School Safety Center
4165 Thousand Oaks Blvd., Suite 290
Westlake Village, CA 91362
I (805) 373-9277
FAX I (805) 373-9277

National Alliance for Safe Schools
9344 Lanham-Severn Rd, Suite 102
Lanham, MD 20706
I (301) 306-0200
FAX I (301) 306-0711

Prevention Intervention Program in Trauma, Violence and Sudden Bereavement in Childhood
UCLA Department of Psychiatry and Biobehavioral Sciences
750 Westwood Plaza
Los Angeles, CA 90024
I (213) 206-8973
Robert S. Pynoos, MD, Director

National Crime Prevention Council
1700 K Street NW
Washington, DC 20006
I (202) 466-6272
FAX I (202) 296-1356
email: shields@mail.ncpc.org

Office of Juvenile Justice & Delinquency Prevention
U.S. Dept. of Justice
633 Indiana Ave., NW
Washington, DC 20531
I (202) 307-5911
FAX I (202) 514-6382

Department of Health and Human Services
Public Health Service
Centers for Disease Control
Atlanta, GA 30333

The National Committee on Youth Suicide Prevention
666 Fifth Avenue, 13th Floor
New York, NY 10103
I-212-247-6910

Youth Suicide National Center
1825 Eye Street, NW, Suite 400
Washington, D.C. 20006
I-202-429-2016

American Association of Suicidology
2459 South Ash Street
Denver, CO 80222
I-303-692-0985

The Center for Suicide Research and Prevention
Rush-Presbyterian-St. Luke's Medical Center
1720 West Polk St.
Chicago, IL 60612
I-312-942-7208
David C. Clark, Executive Director

*Additional resources are listed in Our Center's Introductory Packet on Violence Prevention and Safe Schools
Addressing Specific Areas of Concern

In this appendix, you will find information on

1. **Community and Gang Violence**
   Presents a brief overview on anticipating violence, dealing with it when it occurs, intervening in its aftermath, violence prevention, and creating safe campuses.

2. **Suicidal Crisis**
   ? A handout presenting some do's and don'ts related to students who appear suicidal and when a suicide is in progress.
   ? A Suicidal Assessment -- Checklist (with an accompanying checklist of steps to follow when a student is thought to be a suicidal risk).

3. **Family Violence**
   A handout emphasizing child abuse and neglect as a major form of family violence and a personal crisis. Briefly highlights how child abuse and neglect are defined and lists common symptoms.

4. **Sexual Assault**
   A handout describing sexual assault as encompassing sexual abuse, rape, incest, and exposure. Indicators of this form of crisis are highlighted and the need for crisis response is underscored.

5. **Grief and Loss**
   ? A handout outlining stages of grieving, ways to help students deal with loss, and ways to help bereaved students return to school.
   ? A related series of handouts from Genesee County Mental Health
     > Finding Hope Beyond Grief  > Helping Kids to Cope with Grief
     > Helping to Survive Loss  > Families Facing Loss
     > Grief: Sharing the Burden  > Helping Children Recover From Loss

6. **Hostage Situations**
   A handout on things to do in immediate response to this type of crisis and how to assist the police in resolving the situation.

7. **Post Traumatic Stress Disorder**
   A handout highlighting the importance of understanding that school-age children who experience trauma directly or indirectly may experience major post traumatic symptoms and require psychological first-aid and treatment.
COMMUNITY AND GANG VIOLENCE*

Increasing concern about violence on campus has led to multifaceted intervention activity:

(1) to anticipate violence
(2) to deal with violence when it occurs and with its aftermath
(3) to prevent violence and create safe campuses

Anticipating Violence

In some instances, violence is anticipated. Schools need to have planned and rehearsed their response to such events. Take, for example, a situation where there is potential conflict between two gangs on campus. Obviously, steps should be taken to warn off perpetrators. In addition, there is a need to

C put appropriate school staff on alert

C enlist and enable those who can play a special role (e.g., cover the classes of teachers who can relate positively with gang members; recruit students who may be able to play a constructive role; solicit help from others in community who have a special relationship with gang members)

C increase the visibility of authority (e.g., staff, police)

C begin an open interchange with gang leaders and mediate between the factions

C move unresponsive student elements from the campus to another locale

C implement rumor control processes

C immediately take steps to remedy all justified grievances

C keep working with conflicting parties until a workable agreement is achieved.

Dealing with Violence and its Aftermath

Should violence occur, the first steps to be implemented are emergency mobilization and crisis response procedures (e.g., activation of security procedures). For example, a coded emergency P.A. announcement often is used to

C alert teachers to lock their doors and ask students to stay put during the emergency
C alert classified staff to assume assigned stations (e.g., at outside doors allowing only authorized persons in and helping with other specific responses)
C seek aid from community agencies.

*Also available from the Center is an Introductory Packet on Violence Prevention and Safe Schools.
Other tactics during the event involve

- encouraging students to verbalize their feelings
- providing a place for students to talk out their concerns
- being honest -- promise only what can be delivered.
- buying time in other ways that can help cool the situation, without violating due process

If the situation cannot be controlled, the police will have to take over.

At all times, maintain effective communications with the staff and security personnel.

In the rare case of a hostage situation, there is the additional problem of dealing with the hostage taker. Again, it is important to alert and mobilize staff. Then, the person best equipped to do so can try to make contact with the perpetrator. In communicating with the captor, however, there are some things to do and not to do:

1. try to calm everyone, including the captor down and buy time until a trained negotiator can get there (e.g., ask captor what is wanted and restate requests; indicate you want to help the person get what s/he wants; if you can, find out who s/he is)

2. don't confront or threaten with ultimatums

3. personalize references to the captor and captives (i.e., try to use names and emphasize everyone involved is a person not an object -- not a hostage-taker, a hostage, or a negotiator); if s/he won't tell you, try to find out names from staff and students

4. if it is safe to do so, quietly evacuate everyone who is not needed and close off area; otherwise direct everyone to avoid complicating the situation (e.g., to keep a low profile)

5. get information about the physical plant ready for the police (e.g., maps, information about phones, accessways)

In providing help in the aftermath, special attention should be given to exploring with an individual (a) the degree of trauma s/he may have experienced (e.g., Were they directly victimized or a close friend of a victim?), (b) what specifically is bothering her/him (e.g., Are they feeling frightened, angry, guilty, vengeful?), and (c) what s/he feels might help currently (e.g., Is there someone with whom s/he would like to talk?).

After the immediate needs of those affected are addressed, the following procedures can help prevent a recurrence:

- debrief to review what happened and revise response and prevention plans as needed
- especially review channels for student grievances (Are students aware of such procedures? Are students' voices of concern really being heard and responded to?)
- maintain involvement of parents and agencies that came to school in the time of crisis
- expand involvement of school and community stakeholders in planning.
A few guidelines to highlight related to responding to crises that involve criminal acts on school grounds (including knife and gun wounds) include:

? taking care of the victim (if someone can do so, apply first-aid; do not remove a knife -- it may be preventing excessive bleeding; try to keep the individual from making the wound worse)
? quickly alerting administrators who will call 911 for appropriate assistance
? isolate the area
? being certain staff are responding to other students in ways that minimizes rumors and unrest
? preparing for the media
? informing parents/guardians -- in doing so, try to be calm. State "Your child has been hurt (not shot) and we would like for you to meet your child at the hospital (not the school)." Because you will not usually know how bad the wound is, tell them you are unsure of the extent of injury. If it is unclear where the student will be taken, tell the parent you will call back in a few minutes with the information. Keep the conversation brief. Focus on minimizing panic and avoiding stirring up a situation where someone might come running to seek revenge.

Whether a result of violence or other causes, should a death occur, the school should consider making provisions to

(1) announce
? the occurrence
? facts about any special circumstances surrounding the death with a view to countering rumors
? times and places for the funeral and related services
? times and places for grief groups and counseling

(2) provide concerned classroom teachers with guidelines for
? sharing the experience with their classes
? teaching about death and bereavement

(3) send representatives to
? visit the family at home
? the funeral and related services

(4) work with students who want to
? express their sense of loss to each other and to the family
? arrange a tribute or memorial
? help the family if they are financially unable to pay death-related costs

**Preventing Violence**

Curriculum approaches to violence prevention provide a framework for schools to adapt for their specific needs. One such curriculum and an accompanying 1 hour training video have been developed by Dr. Deborah Prothrow-Stith. The focus is on teaching students the risks of physical violence and positive methods for dealing with anger. There are 10 lessons
covered in the manual, along with related student handouts, background information, and a resource list. The lessons are entitled:

(1) There is a lot of violence in society
(2) Homicide: statistics and characteristics
(3) Exploring risk factors
(4) Anger is normal
(5) There are healthy and unhealthy ways to express anger
(6) There's more to lose than to gain from fighting
(7) What happens before, during, and after a fight?
(8) Preventing violence
(9) Fighting--what else is there?
(10) Practice throwing a curve

The manual can be purchased from Teenage Health Teaching Modules, Education Development Center, Inc., 55 Chapel Street, Newton, MA 02160.

Another approach specifically focuses on gangs with the intention of creating a safe and neutral campus environment. As a basis for such work, it is essential to establish a group of school staff members who are or will become educated about gangs in general and those in the immediate community.

Increasingly, schools are developing gang-oriented, safe-school programs. Such programs tend to have three major elements.

(1) Reduction of stimuli that can precipitate conflict

For example:

? dress code and conduct rules focused on minimizing blatant symbols of gang affiliation

? patrols to deter graffiti or to remove it as soon after it appears as is feasible

(2) Prevention

For example:

• educating students, families, staff about factors leading to violence at school, indicators of a student's possible gang involvement, factors that make a student a target of gang recruitment or attack, what can be done to contribute to a safe and neutral campus

• development of positive alternative opportunities for involvement to counter anti-social activity such as establishment of a wider range of course options, a peer counseling program, and so forth

(3) Corrective intervention

For example:

? establishment of support groups and after school tutoring for use on a voluntary basis and as a one time option to punishment for gang activity and major rule infractions

• referral for other forms of help such as treatment for alcohol and other drug abuse

AppII-4d
SUICIDAL CRISIS

Students may make a statement about suicide (in writing assignments, drawing or indirect verbal expression). Another may make an actual attempt. And, some do end their lives.

Suicidal Thoughts -- What to do

Assess the situation and reduce the crisis state (see accompanying Suicidal Assessment Checklist).

The following are some specific do and don'ts if you are worried that the act is imminent.

Some do's:

C Send someone for help.
C Remain calm; remember the student is overwhelmed and confused as well as ambivalent.
C Get vital statistics, including the student's name, address, home phone number and parent's work number.
C Encourage the student to talk. Listen! Listen! Listen! And when you respond, reflect back what you hear the student saying. Clarify, and help him or her to define the problem, if you can.

Consider that the student is planning suicide. How does the student plan to do it, and how long has s/he been planning and thinking about it? What events motivated the student to take this step?

C Clarify some options (e.g., school and/or community people who can help, e.g., a school mental health professional, a community mental health clinic or a hospital.
C If feasible, get an agreement to no-suicide ("No matter what happens, I will not kill myself." If the student refuses or the promise is vague, contact the principal or the school district.)

Some don'ts:

C Don't leave the student alone and don't send the student away
C Don't minimize the student's concerns or make light of the threat
C Don't worry about silences; both you and the student need time to think
C Don't fall into the trap of thinking that all the student needs is reassurance
C Don't lose patience
C Don't promise confidentiality -- promise help and privacy
C Don't argue whether suicide is right or wrong
Suicide in Progress -- Acting Promptly

The individual may use a gun, rope, knife, medications and other drugs, or a place from which to jump. You must act promptly and decisively.

Some do's:

? Be directive. Tell the student, "Don't do that; stand there and talk with me." "Put that down." "Now talk with me." "Hand me that." "I'm listening."
? Mobilize someone to inform an administrator and call 911 and get others to help you.
? Clear the scene.
? The administrator or a designee should contact parents to advise them their child is hurt and that you will call back immediately to direct the parent to the hospital to meet the child.
? Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings "You are really angry." "You must be feeling really hurt." "You must be feeling humiliated."
? Secure any weapon or pills; record the time any drugs were taken so you can provide this information to the emergency medical staff or police.
? Get the student's name, address and phone number.
? Stay with the pupil; provide comfort.
? Secure any suicidal note and factually note when the incident occurred and what the pupil said and did.
? Ask for a debriefing session as part of taking care of yourself after the event.

Some don'ts

? Don't moralize ("You're young, you have everything to live for.")
? Don't leave the student alone (even if the student has to go to the bathroom).
? Don't move the student.

In all cases, show concern and ask questions in a straightforward and calm manner. Show you are willing to discuss suicide and that you aren't appalled or disgusted by it. Open lines of communication. Get care for the student.
SUICIDAL ASSESSMENT -- CHECKLIST*

Student's Name: _________________________  Date: ________  Interviewer: ________________

(Suggested points to cover with student/parent)

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

Does the individual have frequent suicidal thoughts?  Y  N

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

Does the student have a detailed, feasible plan?  Y  N

Has s/he made special arrangements as giving away prized possessions?  Y  N

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

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress?  Y  N

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

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

(3) PSYCHOSOCIAL SUPPORT

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

Does the student feel alienated?  Y  N

(4) HISTORY OF RISK-TAKING BEHAVIOR

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

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.
FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK -- CHECKLIST

___(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.

___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.

___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.

___(4) Try to contact parents by phone to

   a) inform about concern
   b) gather additional information to assess risk
   c) provide information about problem and available resources
   d) offer help in connecting with appropriate resources

Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

___(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:

   *student's name/address/birthdate/social security number
   *data indicating student is a danger to self (see Suicide Risk -- Checklist)
   *stage of parent notification
   *language spoken by parent/student
   *health coverage plan if there is one
   *where student is to be found

___(6) Follow-up with student and parents to determine what steps have been taken to minimize risk.

___(7) Document all steps taken and outcomes. Plan for aftermath intervention and support.

___(8) Report child endangerment if necessary.
DEPRESSION/SUICIDE

“I am sad all the time.”
“I do everything wrong.”
“Nothing is fun at all.”

-- items from the
“Children’s Depression Inventory”
(Kovacs & Beck, 1977)

Mental health professionals are very sensitive to symptoms of depression -- probably because of the possibility of suicide. In determining whether students are depressed, it is important to differentiate commonplace periods of unhappiness from clinical depression. It is also important to recognize that not all students who commit suicide are clinically depressed and that most persons who are unhappy or depressed do not commit suicide.

As a first step toward differentiating among the large number of teens who will report dissatisfaction with their life, it is useful to develop a clear understanding of the normative concerns of students in a specific school and community. Many students living in ghettos where daily living and school situations often are horrendous can be expected to be quite unhappy with such conditions and certainly deserve to be helped. The help needed, however, is not primarily psychotherapeutic; the need is for major changes in socioeconomic and educational conditions. Mental health professionals have a role to play here. But it is primarily one of working with others to improve such conditions -especially ways the school might improve its programs to counter frustration, unhappiness, apathy, and hopelessness and expand opportunities for students to increase expectations about a positive future.

Help for students enrolled in school-based health centers -- counseling or referral for counseling -- must be reserved for those whose problems, regardless of cause, go beyond the norm. (See Weiner, 1989, for a broad perspective on understanding the causes of depression and implications for treatment.)

School-based health center personnel can contribute to school-wide preventive programs through mental health education for students and parents and consultation and in-service for school staff. Such activity (1) encourages greater awareness of students' emotional states, especially reactions to stress, and (2) teaches individuals how to be supportive of each other through active listening, not minimizing others' feelings, and helping others problem solve rather than offering them glib advice.

With specific regard to suicide, there are school prevention programs, curricula, and audiovisual aids to draw on as resources. (If you need references, see Selected Resources from our Center.) A unit focused on suicide prevention might be included in a variety of courses. School staff, students, and parents can be taught to watch for danger signs. Teachers, other school support staff, and peer counselors can be taught how to hold discussions with upset students in the aftermath of a suicidal event. If community-based suicide prevention services -- such as hotlines and counseling -- are available, they can be advertised periodically; otherwise, efforts might be directed at helping the school or district establish such services.

On a more individual level, students who can't cope adequately because of the way they are thinking and feeling or who have made suicide attempts or who report concrete plans to do so require immediate intervention. Students who are extremely upset, but not seen as at risk for suicide, may require a few individual or group sessions with a trained professional -- from the school staff (e.g., psychologist, counselor, specially trained teacher), from the school-based health center staff, or from outside the school setting.
To evaluate suicidal risks in need of immediate attention (possibly hospitalization), the following areas have been consistently stressed (e.g., see Davis, 1985, Spirito et al., 1989; also see the preceding checklists):

(1) **Past attempts, current plans, and view of death**
(e.g., Does the individual have frequent suicidal thoughts? Have there been suicide attempts by the student or significant others in his or her life? Does the student have a detailed, sophisticated plan? Does s/he have the means? Has s/he made special arrangements to leave this world, such as giving away prized possessions? Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife?)

(2) **Reactions to precipitating events**
(e.g., Is the student experiencing severe psychological distress? Have there been major changes in recent behavior along with negative feelings and thoughts? Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) **Psychosocial support**
(e.g., Is there a lack of a "significant other" to help the student survive? Does the student feel alienated?)

(4) **History of risk-taking behavior**
(e.g., Does the student take life-threatening risks or display poor impulse control?)

In approaching individuals seen as potentially suicidal, there is considerable agreement about steps to be taken. To begin with, Sandoval, Davis, & Wilson (1987) stress (in an article entitled "An overview of the school-based prevention of adolescent suicide"):

“...it is important to make some kind of immediate contact with the student. Remaining silent and ignoring these behaviors are the worst thing one can do. An open discussion will rarely make a situation worse. The first step in suicide prevention at this level is to begin an open and frank discussion about how the individual is feeling. It is particularly important to avoid 'trying to talk someone out of suicide.' For example, it is a mistake to tell a student, 'Everything will be all right,' 'You will feel better in the morning,' or 'You really have a great deal to live for and are fortunate compared to others in the world.' Giving messages of this kind make the individual feel even more worthless and hopeless than before.”

Students at risk for suicide usually require relatively long-term individual or group counseling. Thus, referral to outside resources usually is required. The health center staff can play a useful role in meeting this need by developing an effective referral system and establishing appropriate support procedures to ensure follow-through. In addition, center staff may be able to help establish ongoing life support groups to supplement and continue support when counseling ends.
For more help with these problems, send for the Consultation Cadre list, and contact center staff who have offered to share their expertise in this area. Among the material found by the Clearinghouse staff are a suicide program bulletin and a prevention curriculum (and related teacher’s guide and training videotape) developed by the Los Angeles Unified School District (LAUSD, 1987a; 1987b). The curriculum is designed to (1) help students understand suicidal feelings and ideation and how to cope better and (2) teach them to help others who seem depressed/suicidal by responding appropriately and using available resources at school and in the community. The curriculum includes two 50 minute class lessons which can be integrated, for example, into a 10th grade health education course.

References cited above related to Depression/Suicide:


Selected Resources from our Center

Resource Aid Packet on Screening/Assessing Students: Indicators and Tools

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems such as depression/suicide.

Resource Aid Packet on Responding to Crisis at a School

Provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. Contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training and as information handouts for staff, students, and parents.

Introductory Packet on Assessing to Address Barriers to Learning

Discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on procedures and instruments to measure psychosocial, as well as environmental barriers to learning.
FAMILY VIOLENCE

Family violence takes many forms and includes child abuse and neglect.

Family Violence

Any intentional mistreatment of one family member by another constitutes family violence. It may include neglect, sexual abuse, and verbal and psychological abuse. It may range from mild to lethal.

Child Abuse and Neglect

Legally, most school professionals are mandated to report child abuse, but because family violence is so widespread, it is often not seen as crisis. Yet, when family violence occurs, it can be experienced as a major trauma by a child.

*Abuse* occurs when a child's caretaker through willful neglect or intention causes the child to be injured or places the child in danger.

Abuse includes

- causing internal and external physical injury (watch for students who, more often than their classmates, have large bruises, serious lacerations, burns, fractures)
- causing neonatal addiction to drugs
- deprivations that cause failure to thrive (growth and developmental delays)
- sexual abuse.

Causing serious emotional trauma also constitutes abuse.

Chronic problems or abrupt changes in behavior may be indicators of child abuse. Watch for children who, more often than their classmates, are

- restless
- negativisti, unresponsive, and anti-social
- dejected and self-deprecatory
- fearful/withdrawn
- compulsive
- apathetic
- apt to provoke others to attack

Any form of family violence may be experienced as a major trauma by a child. Sometimes such children act out what they have observed -- physically and sexually abusing others.
Neglect is chronically not attending to a child's basic health or welfare needs (failure to provide nurturance and safety; adequate food, clothing, and shelter; appropriate medicine and education). Caretakers are seen as neglectful if their attention to a child is improper or inadequate or if they fail to provide appropriate care, supervision, education, and emotional support.

In addition to symptoms of emotional, learning, and behavioral problems, neglected children often show significant indications of

- malnutrition
- fatigue/listlessness
- poor hygiene
- not having adequate clothing for the weather conditions

Report and Help

In meeting reporting obligations, professionals often are creating another crisis for the child. Thus, it is essential to institute an individually oriented crisis response.

Over the long run, schools need to play a greater role in developing programs that contribute to the prevention of all forms family violence.
SEXUAL ASSAULT

Sexual assault includes not only rape or incest, but also any forced physical contact with genitals and even being forced to look at genitals, undress or expose oneself. Incest is sexual assault and abuse by a family member (sibling, parent, step-parent, grandparent, uncle, aunt or other relative).

Force includes not only physical force, but use of bribes, trickery, or emotional pressure to engage someone in sexual contact or inappropriate touching. Examples of bribes are offering money, special privilege and treats.

A Few Myths Regarding Sexual Assault

Myth: Few children are sexually assaulted.
Fact: Recent findings suggest that at least one out of eight boys and one of four girls will be sexually assaulted by the age of eighteen. A rape is reported in the U.S.A. approximately once every six minutes.

Myth: Victims provoke their sexual abuse.
Fact: No one has a right to hurt another. The attitude that victims are partly responsible makes them feel at fault and makes others treat sexual assault as a lesser crime.

Myth: Discussing sexual assault is bad for children.
Fact: Inaccurate or false information is bad for anyone. Informing children about sexual abuse can be seen as basic safety information and a facet of prevention.
Indicators of Sexual Abuse

Any common symptoms of learning, behavior, and emotional problems may be an indicator of sexual abuse. Professionals often are told to watch for children who indicate they don't want to go home or want to stay with you or who make unusual statements about their contact with specific adults.

"S/he wears funny underwear." "S/he told me everyone does it and showed me pictures." "S/he said I mustn't tell anyone -- or else."

A few other possible but obviously fallible indicators are:

- Young children with unusual knowledge of sexual topics
- Unusual interest in the genitals of people or animals
- Public masturbation/promiscuity with peer
- Difficulty in walking or sitting
- Pain or itching in genital area or other stress-related somatic complaints
- Regression to infantile behavior (thumb sucking, baby talk)
- Sleep disturbances (nightmares, bedwetting, fear of sleeping alone)
- Eating problems

Students who are raped report feeling powerless and fear being killed or seriously injured. Afterward, the feeling of vulnerability continues and may be accompanied with shock and disbelief, sleep disturbances, flashbacks, mood swings, difficulty concentrating, guilt, shame, and self-blame. These symptoms may not occur immediately but may arise days or weeks after the rape.

Crisis Response

If a student has just been raped, the first crisis responses are to ensure safety, arrange for medical treatment, and report the matter to the proper authorities.

Subsequent crisis response for all sexual assaults must include intervention to ensure victimization does not recur. Crisis counseling and aftermath therapy can assist victims in understanding what they are going through and will likely experience; this can prevent exacerbation of the problem and help speed up recovery. One paradox of discussing assault with a victim is that some experience a crisis of disclosure. It helps to ensure privacy and as much confidentiality as is appropriate (remembering that a few key professionals will need to know if they are to help).
GRIEF AND LOSS

Students experience a variety of losses -- some of which are so significant as to lead to grief reactions. Students manifesting major grief reactions are experiencing a personal crisis.

Stages of Grieving

Grieving disrupts a student’s normal functioning. But it need not be a long lasting problem and "working" through grief can help restore emotional health. Although the stages of grief may not occur in order, they have been described as follows:

- **Shock** -- usually the first reaction -- often experienced as numbness or physical pain and associated with withdrawal.

- **Denial** -- acting as if no loss has occurred.

- **Depression** -- feeling pain, despair, emptiness -- may not be accompanied by some emotional release such as crying (if the person can cry, it helps release stress).

- **Guilt** -- self-blame for not having expressed more caring or belief the loss was his/her fault.

- **Anxiety** -- panic reactions as reality sets in.

- **Aggression** -- toward those who might have prevented the loss and sometimes toward the lost object (may have trouble acknowledging anger toward the object of loss, but if such anger can be expressed it can help with recovery).

- **Reintegration** -- loss is accepted (although there may be periods of relapse).

Helping Students Deal with Loss

One of the most difficult losses is the death of someone who was loved. As in all loss situations, grieving students need to experience school as a safe place to think about and express their loss. To this end, crisis counselors and other school staff need to be prepared to

1. Recognize the loss and encourage students to talk about what happened and how they are feeling. ("Tell me what happened." "I’m so sorry”)

2. Tell them as a group what happened and respond emotionally. Directly relate the facts and let them know how you feel. ("It hurts to know your mother died.")
(3) Allow students to express their reactions and be prepared to validate the variety of emotions that will emerge in relation to each stage of grieving. Offer time for students to share their feelings and facilitate the exploration. When working with groups, validate the feelings expressed -- even if they seem harsh. (Students will express anger, fear, guilt, and so forth. Sometimes, they will even indicate relief that what happened to someone else didn't happen to them. Others may find it hard to express anything.) Responses should be warm and understanding. Students need to told it is O.K. to cry.

(4) Be prepared to answer questions directly and sensitively. Relate the facts of an event to the degree that you can. In discussing death, recognize its finality -- don't compare it with sleeping (that can lead to sleep problems for students).

(5) In the situation where a student is returning to school after experiencing the death of a cherished other, be sure that classmates have been prepared with respect to what to say and how to act. It is critical that they welcome the student and not shy away ("Glad you're back, sorry about your brother." "When you feel like it, let's talk about it." ).

(6) Don't forget to take care of yourself -- especially if the loss is one for you too.

Helping Bereaved Students Return to School

Students experiencing loss sometimes don't want to go to school anymore. There are many reasons for this. Crisis response plans should address what to do to maximize a student's return after a loss.

(1) Outreach. A home visit can help assess needs and how to address them. A step-by-step plan can be made with the student's family.

(2) Special support and accommodations at school. Teachers and other staff need to be informed as to the plan and of ways to help the student readjust. Connecting the student to special friends and counselors who will be especially supportive. Ensuring that everyone understands grief reactions and is ready to be appropriately responsive. Added support around classroom learning activities can help if the student is having trouble focusing.

(3) Counseling to help the student through the stages of grief. In general, the student needs to have prompt and accurate information about what happened, honest answers to questions, an opportunity to work through the grief, and lots of good support.
Handouts on Grief and Loss

Included here are some well-designed handouts for students and staff developed by the Genesee County Community Mental Health agency.
Finding Hope Beyond Grief

You have experienced a loss whether it be a loss of a relative or a friend: Or as a rape, assault, violence victim; or in moving or changing jobs. There are many situations which can lead to loss and it is important to note there are many kinds of loss. A loss of a friendship, loss of dignity, loss of independence. or a loss of trust are just a few examples.

Understanding loss is a healing process which you need to work toward. The time it takes for an emotional wound to heal varies from person to person. The healing process is best done openly and honestly. The following suggestions may help ease recovery for adults and teens.

1. Let your friends and family help you. Take advantage of their offers to help you. It makes them feel good, they are doing something for you.

2. Share your feelings. If you are feeling overwhelmed, talk it over with a trained counselor or another bereaved person. Objectivity is often helpful.

3. Do not use alcohol and drugs. The work of mourning does not proceed while you are numb. It resumes when sedation wears off.

4. Work on acknowledging reality. Tell yourself, "it happened. I have to deal with it".

5. Anger is natural. Try to keep it in focus.

6. Try to replace "why" with "what"? Stop looking for causes and begin to think about next steps. Ask, "What do I do now?" The answer may be :1 nothing" and that's normal. One day at a time is all you can manage.

7. Begin your what with small questions. "What should I wear?", for example.

8. Pain is part of the process, accept it. It will be bad, but pain is a by-product of the healing process - like the pain you feel when a broken bone is mending.

9. Give yourself quiet time. You will need time alone to let your mind run free, let it roam. Don't fight. This will help you heal.

10. Adjust to your own time frame. You cannot rush the grieving process. Listen to your inner self and your feelings.

11. Remind yourself of your worth. Take good care of yourself emotionally physically, socially and mentally.

12. Be ready for relapses. You will wake up one day feeling good and think it is over. It is not. Later that day you may feel a vivid reminder. Do not despair. Healing takes time. Be patient with yourself.

For the person experiencing loss, life has changed significantly and there are many adjustments to be made. It takes time and patience to deal with a significant loss. Following the suggestions above should take away some of the pain and stress associated with these types of experiences.
HELPING TO
SURVIVE A LOSS

Death is never easy to deal with but it is a part of life. The loss of a loved one is one of life's most stressful events. Because of the pain associated with someone dying, it is important that you know how to confront and acknowledge the intense emotions of those times.

All people go through a process of grief when someone close dies. Grief is a natural, healthy response to a significant loss in our lives. Although the grief process is never the same in everyone, certain feelings are common. These feelings include shock, denial, anger, guilt, depression, loneliness, and hopefully, acceptance. Usually people can get through the grieving process alone, but sometimes there is a need for professional help to understand the "facts of death".

The period of bereavement is not an easy one for anybody. Family members need to be consoled and helped through the traumatic ordeal. Here are some things you can do to help the grieving process go smoother for those closest to the deceased.

1. Listen. Allow the grieving person to talk openly about the person who has died, the death, etc. if that is what they want to do. There is no right or wrong way to grieve. While some people are very talkative, others are quiet and introspective. Remember, it's more important for you to be a help than a hinderance during this time.

2. Be present. Your mere presence can sometimes be of more comfort than you realize. Giving a hug or holding hands can be a tremendous source of support. If you can't be with the grieving person, call, write or send flowers or a sympathy card. These and similar gestures will be appreciated.

3. Be patient. The grieving process takes time. Each phase must be addressed. Don't try to rush the person through it or try to protect them from their loss. As hard as it may be to watch, the pain and the waiting are necessary to their recovery from their loss.

4. Offer sincere support. Be certain you are of comfort to the grieving person. Supportive remarks would include "It takes time", "I know you'll miss your loved one and your life together, I will too" and "She was such a good person". Comments like "it was his time to go" or "You'll get over it with time" probably won't comfort the grieving person.

5. Be useful. You can take some of the pressure off of the grieving person by taking care of household chores, assisting with thank-you notes, helping with meals and answering the telephone. Someone who is experiencing the death of a loved one may not feel like attending to these tedious activities.

If you would like more information on helping someone deal with their grief, or you need help in getting through your own grief process, call (313) 257-3740. A professional counselor is there to listen and help.

GENESEE COUNTY COMMUNITY MENTAL HEALTH PREVENTION INFORMATION SERVICES
420 W. Fifth Avenue * Flint Michigan *(313) 257-3707
GRIEF
Sharing the Burden

Grief is a healthy, natural and necessary reaction to a significant change or loss in life. Many situations can result in grief: death of a family member or friend, divorce, injury, loss of a job, or giving up a dream.

There is a great deal that you and your family can do to help those close to you cope with grief. Try to place yourself in the grieving person's situation. Decide what type of support would be most helpful.

Grief is a painful experience. The time it takes for an emotional wound to heal varies from person to person.

Many experts like to list stages of grief. There is no real order to the grieving process. It is better to think of grief as a cluster of reactions.

You can help by understanding what grieving people commonly experience

An immediate response is probably shock and numbness. Often it is difficult to believe the loss has happened.

Feelings of anger toward themselves and others for preventing the loss are typical.

It is common for those grieving to blame themselves 'c something they did or didn't do prior to the loss.

Feelings of depression are often prevalent. Many times grieving people are unwilling to perform even routine task because of a lack of motivation.

Increased responsibility leaves the grieving person wondering where to begin or turn.

Eventually the grieving person will begin to accept the loss. remember with less pain and focus on a future filled wit- hope.

Helping partnerships are essential to easing and sharing the burden of grief. Immediately following a change or loss the grieving person needs to accept support from family members, friends or a minister.

Gradually family members and friends return to their lives. For the grieving person, life has been changed permanently and there are many adjustments to be made. As numbness wears off, often comforting friends and family members may no longer be close by.

Ways You Can Help Someone With Grief

Show you care by giving the person a hug. Empathize. Be a good listener. Be patient.

Talk about similar experiences you have had. Provide practical assistance with everyday chores. If you feel your loved one may need additional advice, a counselor can listen and help with setting new goals and adjusting to the loss. Call (313) 257-3740, a counselor is always available.

Recovery takes time. People often need the most help after the initial shock of a loss. Continue to provide support for as long as it's needed.
HELPING KIDS TO COPE WITH GRIEF

A lot of people have very wrong ideas when it comes to helping children to deal with grief. Sometimes these misconceptions can prove to be more damaging than helpful. Listed here are several myths commonly associated with grief. We have offered some alternatives to help you if you are helping a child or young person who is grieving or if you have lost a loved one.

Myth #1: Tears are a sign of weakness.
Tears are a very normal way to release the intense emotions a grieving person is feeling inside. Encouraging a child to withhold his or her feelings is encouraging potential emotional problems.

Myth #2: It is best to avoid talking about the death with or around a child who is grieving.
People who are grieving the loss of a loved one usually are grateful to those who keep memories alive, and who are not afraid to talk about the death. Depending on the age of a child, he or she may want to know more about the deceased person or details about the death.

Myth #3: Once you’re over the grief process, you have stopped caring about a loved one.
Recovering from a significant loss is healthy. The love a youngster has developed for someone close who has died will last long after they have gotten over the shock of the death.

Myth #4: Children should be sheltered from grief.
Kids need to vent their feelings about the loss of a loved one just like adults. According to their age, adults need to explain the loss and the grieving process to children. This will help them to better understand the feelings they are experiencing that they are not accustomed to.

Myth #5: The grieving process is the same for everyone and you can identify each phase in order.
The grieving process is a very complicated one and differs from person to person. You will not see a grieving child changing neatly from one defined stage to another. In fact, it is common for people to drift back and forth between the stages of anger, denial and acceptance.

The loss of a loved one, whether it is a parent, grandparent, sibling or other relative, can be especially difficult for children. Death is one of life's most stressful events and is a period which needs to be handled with extreme sensitivity. If you know a young person who is grieving or you need some help getting through this tough time yourself, call (313) 257-3740. A professional counselor is always there to help.

GENESEE COUNTY COMMUNITY MENTAL HEALTH
PREVENTION & INFORMATION SERVICES
420 W. Fifth Avenue * Flint Michigan * (313) 257-3707
Imagine that your family has just experienced a loss of some kind. Will you know how to handle the intense emotions that accompany a crisis? Different family members may have different reactions to a loss. These responses may range from anger and denial to shock and depression. It is natural to have many reactions to a loss.

Losing someone or something close is different for a youngster than for an adult. A crisis to a young person might seem trivial to a parent or older sibling. Moving to a new neighborhood, changing schools, losing close friends, losing a pet or a favorite teacher or the loss of a meaningful object are examples of traumatic events in a young person's eyes. Because they view crises differently, children may react in ways that adults may not understand.

In response to a crisis, your 3-10 year old child may:

1) become more active and restless or easily upset;
2) become quiet or withdrawn - not wanting to talk about their experience;
3) be afraid of loud noises, rain, thunderstorms, etc.;
4) be angry and act out by hitting, screaming and throwing;
5) feel guilt that he may have caused the loss because of a previous wish or past behavior;
6) worry about what will happen to them;
7) be afraid to be left alone or to sleep alone;
8) revert to infant behaviors - thumb sucking, bed wetting, wanting a bottle, wanting to be held;
9) experience symptoms of illness - nausea, headache or fever.

Children can experience the same heightened emotions as you do following a significant loss or change. If the loss occurred suddenly, emotions tend to be intensified because the child was not prepared for it. This is a time for increased sensitivity to your child's feelings. You may want to leave a night light on for your child, rock him or her to sleep and be a little lenient with household rules.

Most reactions to a crisis or loss are normal and need to be handled with sensitivity and tolerance. No matter what the crisis or loss is, it is hard for children to understand what has happened. Some youngsters, depending on their age, will need your continued guidance and understanding to help them through the experience. How you help your child may have a lasting effect.

If your child has experienced a loss at home, be sure to share that information with your child's school teacher. No matter what the situation is, it is always helpful to have someone to talk problems out with. You may need to seek professional assistance. Call (313) 257-3740 to talk to a trained counselor who will listen to your concerns.

GENESEE COUNTY COMMUNITY MENTAL HEALTH PREVENTION & INFORMATION SERVICES
420 W. Fifth Avenue * Flint Michigan * (313) 257-3701
Helping Children Recover From Loss

Sometimes during a family crisis, children may get lost in the shuffle and confusion. Unfortunately, they are left to deal with a significant loss alone which can be damaging to the child. Adults and children need help coping with a loss whether it's a death, a move to a new neighborhood or school, divorce, etc., but children are especially vulnerable to the effects of such a loss. A child may have experienced a loss at school like a friend who has moved away or a favorite teacher who has been replaced.

While most parents would like to shield their child from the details of a crisis of any kind, it is much better to be open and honest with him or her. It is important that the loss is explained in terms the child can understand.

You can help your child through a crisis by:
1) Talking with him or her. Give correct and simple information. Allow him or her to tell their stories of what has happened.
2) Listening with a neutral perspective to what he or she is saying and how he or she says it. This helps you and your child clarify feelings. You may say, "How does (the loss) make you feel?" to elicit feedback from your child.
3) Reassuring him or her. Help him or her feel safe and secure. You may need to repeat this reassurance many times: "We are together and we will take care of YOU."
4) Providing physical comfort. Touching, hugging and contact is important during this time.
5) Observing your child at play. Listen to what is said and how the child plays. Frequently, children express feelings of fear or anger while playing with toys or friends.
6) Providing play which relieves tension. Allow the child to play with playdough, paint, pillows, balloons or balls.
7) Allowing your child to grieve and mourn. Giving a child the opportunity to express feelings is important to good emotional growth. Telling a child to "grow up" or "be a big boy/girl" can be detrimental to a child's emotional recovery.

You can help your child the most through a crisis situation by including him or her in the grief and recovery process. Children are very perceptive and may feel that they are being left out because the crisis was their fault. If you sense your child feels guilty or responsible for the loss, you may need to relieve them of their burden. You may have to say, 'Maybe what you said or did wasn't nice, but you are not responsible for this.' A loss is more difficult to deal with when there is regret or guilt.

This is a time for increased sensitivity to your child's feelings. You may want to leave a night light on for your child or rock him or her to sleep. It may also help to be a little lenient with household rules.

If your family has recently experienced a crisis or a significant loss and you need help dealing with your feelings and those of your children, call (313) 257-3740. A professional counselor is there to help in any way possible.
HOSTAGE SITUATIONS

Fortunately, hostage situations are rare. Nevertheless, crisis response plans need to specify what to do until the police arrive and what to do to assist the police.

Immediate Response

(1) Call 911.

(2) Activate crisis response -- being very careful not to sound alarms that might cause others to move into dangerous areas. The first priority is safety and care of students and staff.

(3) Seal off the area.

(4) Avoid confronting or in any way further agitating the hostage taker.

(5) In talking with the hostage taker:

- keep your voice calm and try to keep the conversation from being in any way threatening;
- express concern ("I'm concerned about you and those with you." "What is it you would like us to do?");
- refer to captives only in people terms (children, boys, girls, women, men). This may help the hostage taker to keep thinking of them as human beings -- not objects);
- acknowledge and restate the captor's requests;
- avoid making promises or commitments (but if pushed to respond, do so agreeably and diplomatically).

Above all else try to buy time and keep the situation from getting worse while waiting for the hostage negotiators to arrive.

(6) Evacuate the area/school only if absolutely safe and secure routes are available. If evacuation is not feasible, direct everyone to stay put, stay down, and stay out of sight.

To Assist the Police

If there are witnesses, the police will appreciate having them readily accessible. Such individuals can help clarify the current situation and what happened. (In this regard, they will need to be sequestered in a safe place, with a supervision who can both provide emotional support and can keep them from talking with each other in ways that will lead to distorted recall.) If the hostage taker is known to the school, the police will also want to talk to anyone who knows the person and may want any school records on the individual and on the hostages.

The police also will want maps and the person who knows the most about the physical school plant so that they can clarify the location of doors, windows, hallways, closets, roof access, basements, control panels, fire extinguishers, communication links, and so forth.

Finally, the police will problem want to handle the media but may want someone from the school to be available.
POST-TRAUMATIC STRESS DISORDER

There is increasing concern that post-traumatic stress is not just an adult problem.

School-age children who experience trauma directly or indirectly may

? re-experience the trauma (intrusive imagery or sound or a full re-experiencing of a violent incident).

? experience a numbing of responsiveness physically and emotionally (becoming less involved and interested in activities and people -- even close friends and parents).

? report and manifest a variety of symptoms (grief reactions, avoidance of things that remind them of the event, poor school performance, jumpiness and nervousness, sleep disturbances, separation anxiety related to a person about whom they are worried).

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

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