Addressing Barriers to Learning

New ways to think . . .

Better ways to link

Volume 2, Number 3
Summer, 1997

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

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A BRIEF REPORT FROM THE SUMMIT ON

Addressing Barriers to Learning: Closing Gaps in Policy & Practice

As readers of this Newsletter know, our Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community resources.

In 1996, we held three regional meetings on the topic: *Policies and Practices for Addressing Barriers to Student Learning: Current Status and New Directions.* On July 28th of this year, we held a national summit on *Addressing Barriers to Student Learning: Closing Gaps in School/ Community Policy and Practice*. The various meetings brought together dedicated leaders representing an impressive mixture of national, state, and local agencies and organizations.

Contents

- *Need some help?* See pages 3 and 4.
- See page 10 for a discussion of *school-based case management teams* -- with emphasis on including teachers as key team members
- Page 11 offers one professional's *reflections on crisis counseling*

As we stressed in the report based on the 1996 meetings, *developing a comprehensive, integrated approach to addressing barriers to student learning continues to be a low priority* among policy makers. Also stressed was increasing concern about serious flaws in current policies and practices aimed at preventing and correcting learning, behavior, emotional, and health problems. This growing concern provides an opportunity for change.

Since last summer, we have continued to explore the current status of policy and practice around the country. We have zeroed in on state and local agencies and specific reform initiatives using structured surveys, reviews of formal documents they distribute and material they post on their webpages, and insights gleaned in discussions with those who are knowledgeable about prevailing policies and practices. The more we looked, the more we were struck by how few initiatives specifically approach barriers to learning as a primary and essential concern. Thus, our July summit was designed to begin a process to widely enhance realization of the importance of analyzing school reform and restructuring initiatives in terms of how well they address barriers to learning.

Participants at the summit had the opportunity to review a representative set of major initiatives aimed at improving student learning and development. Featured as a leaping off point for discussion were (a) models designed with support from the New American Schools Development Corporation, (b) changes in thinking at the California Department of Education resulting from its adoption of the concept of *Learning Support,* (c) an update on

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the *Community Schools* movement, (d) the upcoming effort to realign Missouri's *Caring Communities* initiative with the state's education reforms, (e) the Kauffman Foundation's work related to the *Successful Schools* initiative, (f) the movement for *Comprehensive School Health Programs* as stressed in the Institute of Medicine's recent report and as supported by the Centers for Disease Control and Prevention, and (g) the approach the Los Angeles Unified School District is taking to reform and restructure its student support programs and services. In addition, participants brought to the table an immense amount of experience with reforms around the country. The day's work yielded further appreciation of the potential contributions such initiatives can make and increasing awareness of how few models include a focus on addressing barriers to learning as a primary and essential component of reform and restructuring. Also evident was the likelihood of further confusion among policymakers and more fragmentation in practice at all levels as model advocates compete for adoption.

This brief report reflects our efforts to analyze and extrapolate from the various sources of data. In preparing the report, we have tried to capture and integrate the consensus of what was explored at the summit with our other sources. At the same time, we recognize that data are always filtered through a personal lens; we take full responsibility for any errors of omission or commission and for all interpretations

Fundamental Gaps in Policy/Practice

When the lens of addressing barriers to student learning is applied to current reform and restructuring initiatives, the major gaps in policy and practice can be grouped into five fundamental areas (see the Figure). What follows is our effort to highlight the major gaps in each of these areas as our analyses have identified them.

Although the litany of gaps are all too familiar to anyone who works in the field, there are a number of implications that arise from viewing them within the framework provided. These implications are explored in some detail after we comment on each area and list out some of the fundamental gaps in policy and practice.

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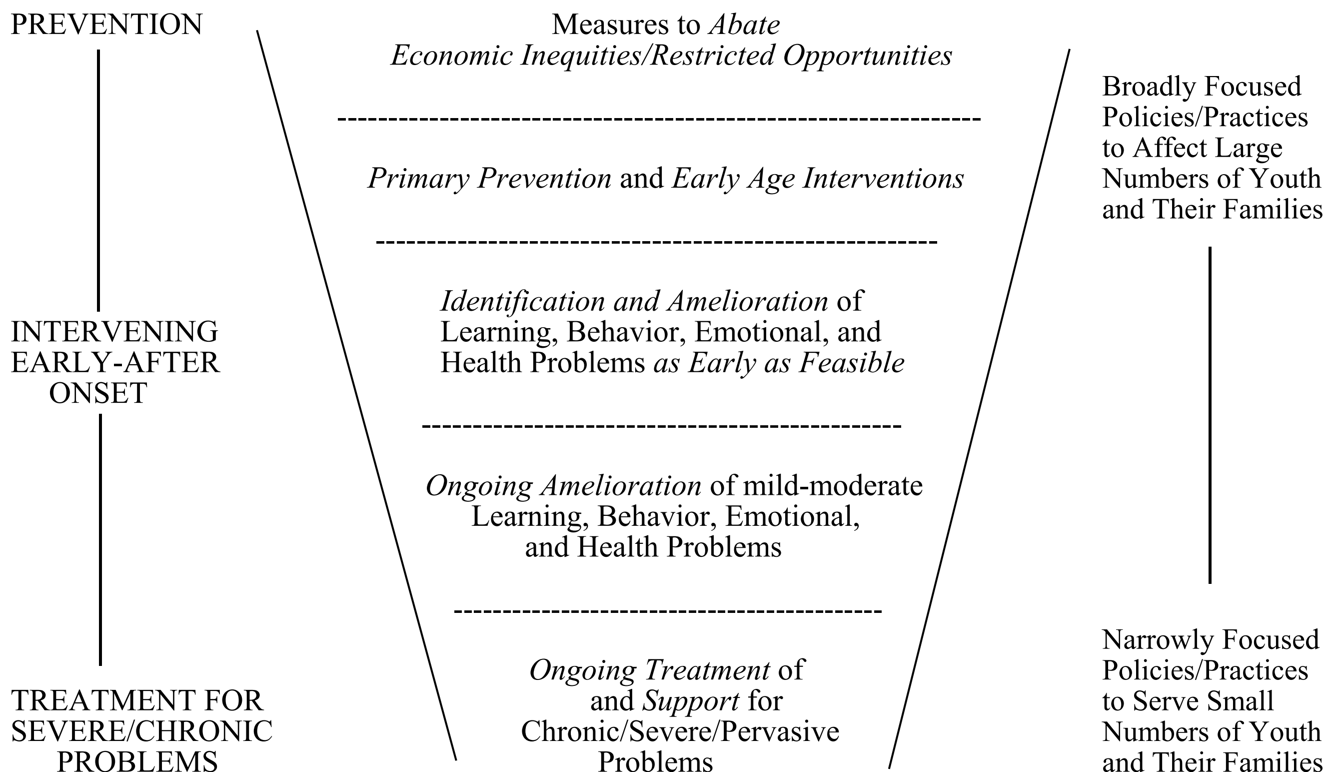
Figure: Addressing barriers to student learning: A continuum of five fundamental areas for analyzing policy and practice.



Center News

Over the next few months, we will introduce a self-study continuing education section on our Website. The first course is the module we have prepared entitled *Addressing Barriers to Learning: New Directions for Mental Health in Schools.* The first of this set of three units will be on-line sometime in September. Unit 2 will be added to the site in November and Unit 3 in December. For those who do not have access to the Internet, the entire module is available from the center for the cost of copying and mailing.

We also have begun the process of making our resource packets available over the Internet. Eventually, most of our materials will be in data bases that can be accessed through our Website. For now, we are simply adding them one at a time directly to the site. Currently on-line are two packets: (1) *Confidentiality and Informed Consent* and (2) *Students and Psychotropic Medication: The School's Role*.

Center For Mental Health In Schools at UCLA

For those of you who have not yet visited our website, please take a look:

http://www.lifesci.ucla.edu/psych/mh/

Also, if you aren't receiving our electronic newsletter (ENEWS), add yourself to the list -- send an email request to:
maiser@bulletin.psych.ucla.edu

leave subject line blank, and in the body of the message -- type: **subscribe mentalhealth**

To contribute to ENEWS or the website, you can send us an Email at: **smhp@ucla.edu**

or send us a FAX: (310) 206-8716
or phone: (310) 825-3634
or write c/o the return address on this newsletter.

Don't hesitate to request technical assistance.
And please tell others about us.

Requests from Colleagues

Barbara Olson (from Arizona) is concerned that schools usually do not have proactive programs to address problems that can arise for students with frequent/lengthy absences. Such absences, of course, can contribute to increasingly negative attitudes toward school, grade retention, dropouts, and other problems.

Send us information about any sound programs (hopefully that aren't too costly) for dealing with the problems that arise in relation to absenteeism. We'll report back on what we receive.

And don't hesitate to contact us with your requests.

As the Center Approaches Year 3 . . .

We are continuing to gather information on state and local policies that have relevance to development of *comprehensive, integrated approaches to addressing barriers to student learning and enhancing healthy development.* Please help if you can. Send materials or information on who we should contact.

We want to expand our range of collaborative activity. In addition to working with our sister center at the University of Maryland at Baltimore, we value the involvements that have emerged with (a) national organizations such as the National Association of School Nurses, National Association of School Psychologist, the National Association of Social Workers, and the Center for Effective Collaboration and Practice, (b) regional centers such as the Mountain Plains Regional Resource Center, and (c) reform initiatives in such diverse locales as California, Iowa, Maine, New Mexico, Minnesota, North Dakota, and Ohio.

One of our goals is to help bolster regional and local efforts. If you have ideas for roles we might play in your area, let us know.

There's always an easy solution to every human problem -- neat, plausible, and wrong.
H.L. Mencken

Center Staff:
Howard Adelman, Co-Director
Linda Taylor, Co-Director
Perry Nelson, Coordinator
Judy Onghai, Asst. Coordinator
. . . and a host of graduate and undergraduate students

Do You Know About?

^^^Institute of Medicine (IoM) of the National Academy of Sciences report on:

SCHOOLS AND HEALTH: OUR NATION'S INVESTMENT

The report examines four topics related to school health: education, services, infrastructure, and research/evaluation and offers recommendations in each arena. This major report concludes that, although school health programs have promise, most are "poorly coordinated, inadequately funded and under evaluated." A brief excerpt from the Executive Summary:

"Schooling is the only universal entitlement for children in the United States. The committee believes that students, as a part of this entitlement, should receive the health-related programs and services necessary for them to derive maximum benefit from their education and to enable them to become healthy, productive adults. This view appears to be broadly accepted, since the committee has found that many of the components of a Comprehensive School Health Program (CSHP) already exist in many schools across the country -- health education, physical education, nutrition and food service programs, basic school health services, counseling and psychological services, and policies addressing the quality of the school environment. The question then arises: What would it take to transform existing programs in typical communities into the vision of a comprehensive school health program?

First, although many components of a CSHP already exist widely, their implementation and quality require attention. New standards and recommendations have been released in many fields that have yet to reach the local level. Another serious deficiency is the apparent lack of involvement of critical community stakeholders in designing and supporting current programs. Perhaps the most difficult issue to resolve before existing programs can be considered 'comprehensive' involves the role of the school in providing access to services typically considered the responsibility or the private sector, such as certain preventive and primary health care services. 'Providing access' does not necessarily mean that services will be delivered at the school site; rather, it implies ensuring that all students are able to obtain and make use of needed services. Each community must devise appropriate strategies to ensure that all of its students have access to these basic preventive and primary care services..."

For copies of the report call National Academy Press at (800) 624-6242 or (202) 334-3313.

^^^Children's Mental Health: Creating Systems of Care in a Changing Society.
B.A. Stroul (Ed.). Baltimore:
Paul H. Brookes Publishing

This book is described as a "road map" for affordable and comprehensive MH services to children and youth from diverse backgrounds. Topics include: a new paradigm for comprehensive, individualized, family-focused, and culturally competent MH services; system development at all levels; management issues; family involvement; and service delivery.

The Center for Effective Collaboration and Practice has an "Author Online Site"and an "Online Expert Forum."

http://www.air-dc.org/cecp/cecp.html

Their first expert online is Dr. Alan Kazdin who is the director of the Child Conduct Clinic at Yale Child Study Center.

^^^Model Mental Health Programs and Educational Reform
Special Section: *American Journal of Orthopsychiatry, 67,* 1997.

This issue features seven articles including:

"Implementing Prevention Programs in High-Risk Environments: Application of the Resiliency Paradigm" (by Gager & Elias)

"Addressing Barriers to Learning: Beyond School-Linked Services and Full-Service Schools" (by Adelman & Taylor)

"Teacher Consultation: Impact on Teachers' Effectiveness and Students' Cognitive Competence and Achievement" (by Goldman, Botkin, Tokunaga & Kuklinski)

^^^Children's Defense Fund Publications, 1997

Among the many resources in CDF's biannual publication brochure:

"Who Cares? State Commitment to Child Care and Early Education" [Examines state funding for child care and early education services]

"Working with State and Local Elected Officials: A Guide for Early Care and Education Advocates" [A detailed guide for child care advocates and others interested in influencing state and local policies for children.]

Contact: CDF, PO Box 90500, Washington, D.C. 20090-0500 (202) 662-3652

(continued from p. 2)

(1) Measures to Abate Economic Inequities/Restrictive Opportunities

Everyone is aware that restricted opportunities affect learning and development. Restricted opportunities stem from a variety of documented factors and play a role in causing learning, behavior, emotional, and health problems. The root of many of these variables can be traced to conditions related to poverty. Thus, measures to abate poverty remain one of the most fundamental areas where major gaps in policy and practice undermine efforts to improve educational outcomes for *all* youth. As long as so many young people live in poverty, many will confront an enormous range of restricted opportunities that lead to poor school performance, and interveners trying to address such problems increasingly will be overwhelmed. And, of course, not only do youngsters with problems suffer, *all* public school students are negatively affected as larger proportions of school/community resources are diverted to cope with problems. What makes all this so ironic and poignant is that it exacerbates economic and social inequities by severely limiting who in the society reaps the benefits of formal education and who suffers the consequences of schools where high rates of failure and disaffection are the norm.

Major Gaps in this Area. There is consensus that current reforms represent woefully inadequate measures to abate the scope of restrictive opportunities that exist in the country. Relevant analyses, reflecting fundamental differences in social and educational philosophy, are readily available and need not be repeated here.[1]

(2) Primary Prevention and Early Age Interventions

The next line of defense in addressing barriers to learning involves primary prevention and early age interventions (e.g., fostering healthy development, promoting public health and safety, developing programs for community recreation and enrichment in poverty impacted areas).

Major Gaps in this Area. Current policies and practices do not ensure

- quality day care and pre-kindergarten education;
- home involvement in fostering healthy development and in solving youngster's problems;
- health care for young children;
- personalized instruction in the primary grades;
- recreation and enrichment programs for all youth;
- open enrollment options to provide a range of qualitatively good school program opportunities from which students and their families can choose a good fit.

(3) Identification and Amelioration of Learning, Behavior, Emotional and Health Problems as Early as Feasible

Given that primary prevention and early age interventions are not yet a high priority in policy and practice, *early identification* and *amelioration* have gained some prominence as the next line of defense. The intent is to combine both facets. With respect to health, the federal government's Early Periodic Screening, Diagnosis, and Treatment initiative has demonstrated both the potential and the inadequacies of current policy and practice related to early identification and amelioration. In an era of reduced public expenditures, insufficient underwriting of this program has curtailed aggressive outreach and tailoring of strategies to reach various population groups. Even more basic is the lack of resources for ensuring that medical, dental, and mental health treatments are available and accessible. Consequently, in many cases, significant treatable problems are found, but families cannot be connected with appropriate treatment. In schools, comparable gaps are seen in the dearth of programs that (a) provide immediate support to students when they begin to perform poorly academically and (b) anticipate and provide immediate support for those experiencing difficulty adjusting to school, making other transitions, or responding to crises -- all of which are strongly associated with poor academic performance.

Major Gaps in this Area. The need is to strengthen policy and practice to ensure

- aggressive outreach to find the problems ***and*** ameliorate them -- including home involvement in solving youngsters' problems and in fostering ongoing healthy development.

(4) Ongoing Amelioration of Mild-Moderate Problems

Activity that helps ameliorate mild to moderate problems has been significantly reduced by prolonged curtailment of funding for education and public services (including recreational and enrichment opportunities that foster healthy development). Relatedly, the number of students with learning, behavior, emotional, and health problems is increasing. Thus, it is not surprising that referrals for special help are escalating. Less services, more referrals equals not enough special help to go around. What should be a relatively small

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pool of youth in need of adjunctive services has become an overwhelming onslaught that drains dwindling resources to the point where the majority cannot be served. And, for a large proportion of students this guarantees below grade level performance at the end of middle school, non enrollment in college prep courses, and a high likelihood of dropping out. (Because so many of these students are seen as a product of failing social and educational systems, some analysts refer to them as *pushouts*.)

Major Gaps in this Area. Policy/practice is needed that goes beyond such current emphases as increasing standards and fostering collaborations; a primary focus also must be on ensuring

- high quality, integrated school-community programs designed to provide ongoing academic support and other related services needed to help students who are performing poorly at school; this includes assisting families so they can play a stronger role in helping their youngsters learn and perform more effectively;

  (As noted in last year's report, achieving high quality programs involves transforming the education support resources schools own and operate so that the efforts (a) function in an integrated, programmatic way and (b) are woven together as much as feasible with community owned resources. The idea is both to use combined resources more effectively in addressing barriers to learning and to evolve a comprehensive approach for doing so.)

- quality programs for students not taking college preparation courses in high school -- because they are uncertain about higher education or have decided not to go on.

  (Examples of program options include courses in computers and information technology; programs related to graphic, performing, and culinary arts; high school academies focused on business and health careers.)

(5) Ongoing Treatment of and Support for Chronic/Severe/Pervasive Problems

The increasing volume of students with mild-moderate problems is overwhelming the relatively few corrective strategies society has established. This means that a significant number of youngsters receive little or no special assistance, and their problems worsen. Because of this state of affairs, there is a tendency for teachers and parents to want more and more youngsters with mild-moderate problems referred for special education and related remedial and therapeutic services. Referrals have increased markedly for special education and other specialized treatments intended for those with the most chronic/ severe/pervasive problems. Because of inadequate gatekeeping, this swells the ranks diagnosed and misdiagnosed students and misuses and overloads specialized systems of care. And, whether or not they end up in special education, students whose problems continue unabated over several years are prime candidates for dropping out of school.

Major Gaps in this Area. Policy/practice are needed to ensure

- more effective gatekeeping and detection of false positive diagnoses related to special education and related remedial and therapeutic services;

- enhancement of intervention effectiveness.

  (The focus on enhancing intervention effectiveness should include further clarification of the respective contributions of special instruction, psychotherapy/ counseling, dropout recovery, family respite/ support/ preservation, juvenile justice transition programs, and truly comprehensive systems of care.)

(cont. on page 7)

A Point About *Accountability*

Everyone is aware that policymakers want accountability. When it comes to any expenditure for schooling, policymakers tend simply to call for achievement test scores as *the criteria* for effective practice. From the perspective of interventions to address barriers to student learning, this raises the problem of *disconnected* accountability. That is, although achievement scores are the ultimate proof, these measures are too far removed from the immediate outcomes of interventions designed to ameliorate learning, behavior, emotional, and health problems. Appropriate assessment of the impact of interventions to *enable* students to learn and teachers to teach requires benchmarks that have a direct relationship to immediate objectives. For example, because they are essential prerequisites to enhanced academic achievement, policymakers should adopt variables such as more home involvement, less absences/ tardies, effective transitions, fewer dropouts, less violence, and less mobility as reasonable benchmarks in holding nonacademic interventions accountable.

Some Implications

In addition to gaps in policy and practice that are evident when looked at from the perspective of addressing barriers to learning, other implications arise from analyses using a framework that recognizes the interrelationship of the continuum of fundamental school and community interventions that are needed.

No integrated set of policies for addressing barriers to learning

From a "Big Picture" perspective, probably the largest gap is the virtual absence of an *integrated set of policies* for addressing barriers to learning. The widespread prevalence of piecemeal programs and fragmented practices are widely attributed to funding and guidelines tied to problems that have been narrowly categorized (e.g., safe and drug free schools, pregnancy prevention, child abuse protective services, juvenile crime reduction) or are separated from each other more for political than sound intervention reasons (compensatory and special education). In the absence of an integrated "big picture" framework for policymaking, it seems inevitable that the argument of advocates for narrow and often competing initiatives will push policymakers into enacting fragmented programs with no plan for how the pieces eventually come together to resolve major psychosocial, educational, and health concerns.

Deemphasis of the prevention end of the continuum causes problem-oriented interventions to be overwhelmed and problems become intractable

The sequence of interventions outlined as a continuum in the accompanying figure highlights how intertwined the areas are. Inadequate attention at the broadest level (prevention) leads to increasing numbers who need help at other points in the continuum. Thus, in the absence of an increased emphasis on measures to abate economic inequities/ restricted opportunities, primary prevention, and early age interventions, excessive numbers of youth continue to overwhelm existing programs and services. As indicated in the figure, these fundamental areas require policies and practices that are broadly focused (designed to affect large numbers of youth and their families). Failure to close gaps in these areas ensures that many more youngsters than should be the case will continue to develop problems and be a needless drain on existing resources. Indeed, the concern here is not just about having more people to treat because we don't do enough prevention, the concern is that by not pursuing prevention aggressively we contribute to the growing numbers seeking assistance for problems. In some communities, the numbers are so large that the resources available to deal with them are woefully inadequate, and the problems run rampant and seem intractable.

Collaboration for what?

. . . to evolve comprehensive, integrated approaches to address the full continuum of intervention needs

The push for collaboration has stimulated discussions about potentially valuable system changes. One unfortunate side effect is that many groups are brought together to "collaborate" without taking time to build a sense of vision, commitment, and readiness for change. Thus, it is not surprising that the "not another meeting" phenomenon has surfaced. Policy simply calling for interagency collaboration to reduce fragmentation and redundancy with a view to greater efficiency is insufficient. And in the long run, it well may be counterproductive to improving intervention effectiveness. The example of school-linked services initiatives illustrates the point. Such initiatives tend simply to focus on co-locating a limited amount of community agency resources on a few school campuses. On the positive side, such cooperative ventures provide some clients easier access and attract some who otherwise would not have received services. It also allows some areas of intervention such as child welfare and juvenile justice programs to work more closely with other community and school resources. The work also demonstrates the feasibility of community agencies coming to school sites. On the negative side, such services are woefully inadequate to meet the needs of students and without fully integrating with school operated programs and services, school-linked services are producing a new form of fragmentation. Moreover,

some policymakers are pointing to the demonstrations as evidence that community services can replace school-owned and operated support services (e.g., as reflected in increasing talk of contracting out work done by some pupil services personnel). Such a policy would have a number of serious repercussions, including reducing the overall pool of resources for addressing barriers to learning and preventing efforts to reform and restructure existing resources to evolve a comprehensive approach.

Effective collaboration requires policy and practices that ensure:

"big picture" mapping, analysis, redeployment and blending of resources

Currently, there is no overall analysis of the amount of resources used to address barriers to learning or of how they are expended. Without such a "big picture" analysis, policymakers and practitioners are deprived of information that is essential to enhancing system effectiveness. Until there is comprehensive mapping and analysis of resources, major redeployment and blending of resources are unlikely to occur and the token efforts made will have little effect. At the same time, there should be no illusions about current allocations; even when public school and community agency resources are redeployed and blended, there is no reason to believe that existing resources are sufficient to evolve a comprehensive approach for addressing barriers to learning. This has obvious budgetary implications, but it also underscores the need to pay greater attention to integrating with all neighborhood resources (families, youth and faith organizations, local businesses).

creation of linked mechanisms for system change

Collaboration designed to produce the type of major changes implied above requires linked policy that

- delineates high level leadership assignments and underwrites essential leadership training related to *both* the vision for change *and* how to effect such changes
- provides adequate funds for capacity building to accomplish desired system changes
- creates change teams and change agents to do the day-by-day activities that build essential stakeholder support and redesign institutionalized structures and processes so system changes are established and maintained
- guarantees roles and training for the effective involvement of line staff, families, students, and other community members in shared decision making.

inservice training is upgraded and is provided to all involved parties

An essential element of successful capacity building is inservice training that significantly upgrades the competence of all who are involved in intervention efforts, including a focus on attitudes, knowledge, and skills related to system changes. Current policies and practices pay scant attention to inservice to improve approaches to addressing barriers to learning -- nevermind differentiating inservice to ensure different personnel are able to perform their functions effectively.

True home involvement requires outreach and support designed to mobilize families

Policies and practices stressing parent involvement do not go far enough. They do not account for the fact that in many homes grandparents and other relatives have become the primary child caretakers. In addition, they completely ignore the influence of older siblings. And they overrely on parent education as the key intervention strategy and are widely ineffective in involving the majority of homes. An integrated set of policies to address barriers to student learning in a comprehensive manner must broaden the focus from parent to home involvement and underwrite strategies for outreach and for providing a range of supportive interventions designed to mobilize families.

New thinking about higher education and school/community relationships

Those involved in school and community reforms recognize that institutions of higher education currently are part of the problem (e.g., because of what they don't teach undergraduates, what they don't focus on in pursuing research, the inadequacy of professional preparation programs and professional continuing education programs). Can such institutions become a greater part of the solution? Most colleges and universities have long histories of informal and formal relationships with public schools and community agencies. These include special projects designed to improve school and agency performance, placements for training, programs to encourage college students to volunteer as aides, tutors, and mentors, outreach to increase college enrollments, and much more. Some of the activity is designed to advance knowledge, some enriches college instruction, and some is done in the interest of service and public relations. For the most part, the activity is ad hoc and fragmented rather than programmatic and integrated. Clearly, the connections between higher education and public schools and agencies are not part of an overarching policy vision for the many ways the institutions should benefit from each other. Involvement of higher education in more substantive collaborations will not occur because of good intentions. To achieve more than a marginal involvement of these mega-resource institutions requires policy, models, and structural changes that ensure the type of truly reciprocal relationships necessary to produce progress in addressing the pressing educational, social, and health concerns confronting our society.

Participants at the summit recognized that the thinking of key policymakers is shifting. Among the positive trends, the federal government wants more intra and interagency collaboration, the U.S. Dept. of Education is calling for school-wide planning to counter fragmentation, the U.S. Dept. of Health and Human Services is under-writing initiatives for comprehensive school health programs, and foundations are moving away from supporting initiatives that fold when project funding ends. And, as the presentations at the summit demonstrated, there is no lack of ideas for how to make things better. At the same time, it is clear that policy continues to be developed in a piecemeal manner, with the focus often on marginal responses to complex problems. Policy makers can and must do better. The full report from the summit will discuss an agenda for moving forward.

We keep getting stuck because we find it so easy to state the outcomes we want -- and then sit back without ever taking on the many problems that must be dealt with to get from here to there.

NEW From The Center's Clearinghouse

School-Based Mutual Support Groups
(For Parents, Staff, and Older Students)

A technical aid packet for establishing mutual support groups in a school setting. Outlines a sequence of steps and tasks for

- working within the school to get started,
- recruiting members,
- training them to run their own meetings,
- follow-up support.

The specific focus is on parents; however, the procedures are readily adaptable for use with others, such as older students and staff.

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[1]Below are a few references dealing with concerns about economic inequities/restricted opportunities.

For an intervention-oriented discussion of environment and reciprocal deterministic perspectives of learning, behavior, emotional, and health problems, see

H.S. Adelman & L. Taylor (1993). *Learning problems and learning disabilities*. Pacific Grove, CA: Brooks/Cole.
H. S. Adelman & L. Taylor (1994). *On understanding intervention in psychology and education.* Westport, CT: Praeger.

For an urban schooling view of the problem, see

L.F. Miron (1996). *The social construction of urban schooling: Situating the crisis.* Cresskill, NJ: Hampton.

For an up-to-date social policy/practice perspective relevant to economic inequities, see the discussion and references cited in

"Focus on Welfare Reform" in *The Community Agenda* -- published jointly by The Center for the Study of Public Policy and The *Together We Can* Initiative phone: 202/822-8405, ext. 45.

Ideas into Practice

School-Based Case Management

In the last issue, we highlighted the importance of developing systems at a school for *problem identification, triage, referral,* and *management of care.* Below we provide more detail on school-based teams for *case* management, or as we prefer, management of *care.* A strong emphasis is given to the value of teachers as key team members.

When a student/family is involved with more than one intervener, management of care is a concern (e.g., to ensure coordination, improve quality, and enhance cost-efficacy). As additional services are implemented, the role of teachers as primary interveners often is not capitalized upon. This is especially likely when teachers are not collaborative members of teams to manage care. Teachers are part of many committees and teams at a school. And, there is a role for teachers on school-based teams for management of care. This is not to say that all teachers can or should be included. Some teachers, however, want to participate, and their collaborative efforts are invaluable.

Management of care involves a variety of activity all of which is designed to ensure that student/family interests are well-served (Ballew & Mink, 1986; Rothman, 1992; Weil, Karls, & Associates, 1985). At the core is enhanced monitoring focused on the appropriateness of interventions (e.g., adequacy of client involvement, intervention planning and implementation, and progress). Such ongoing monitoring requires systems for

- tracking student/family involvement
- amassing and analyzing data on intervention planning and implementation
- amassing and analyzing progress data
- recommending changes.

Effective monitoring depends on systems that enable those involved with students/families to regularly gather, store, and retrieve data. In coming years, more and more of this information will be entered into computers to facilitate retrieval and assist in other ways with client care.

Besides monitoring processes and outcomes, management of care also involves changing interventions as necessary. Steps must be taken to improve the quality of processes, including coordination among interveners. Intervention plans must be revised to increase efficacy and minimize "costs" -- including addressing negative "side effects." Along the way, those managing care may have to advocate for and broker more help and provide the linkage among services to ensure communication and coordination -- including contact with care givers at home.

Who does all this monitoring and management? Ideally, all involved parties are part of a *management team.* Given that teachers are critical partners at almost every step, their collaborative participation as team members seems essential and can yield substantial "added value" to the process

One member of the team takes *primary* responsibility in each case (a *primary manager*). Sites with sufficient resources often opt to employ one staff member to fill this role for all clients. However, with limited resources, a more practical model is to train many staff, including willing and able teachers, to share such a role. Ultimately, with proper instruction, one or more family members also may assume this role.

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

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

A few basic tasks for primary managers of care are:

- Before a team meeting, write up analyses of monitoring data and any recommendations to share with management team.

- Immediately after a team meeting, write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks and when.

- Set-up a "tickler" system to remind you when to check on whether tasks have been accomplished.

- Follow-up with team members who have not accomplished agreed upon tasks to see what assistance they need.

Clearly, a case management team is essential in ensuring care is provided in a coordinated and effective manner.

References

Ballew, J., & Mink, G. (1986). *Case management in the human services.* Springfield, IL: Charles C. Thomas.

Rothman, J.R. (1992). *Guidelines for case management: Putting research to professional use*. Itasca, IL: Peacock.

Weil, M., Karls, J.M. & Associates (1985). *Case management in human service practice.* San Francisco: Jossey-Bass.

Lessons Learned

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.

One 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 who 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 find it essential to have enough team members to spell each other whenever extended counseling is required on a given day. In responding to other's needs, it's 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!

NEW!! From the Center

Guidebook: Mental Health AND SCHOOL-BASED HEALTH CENTERS

This resource is a considerably expanded version of a guidebook developed several years ago by the School Mental Health Project at UCLA (with support from the Robert Wood Johnson Foundation). When the project created the Center for Mental Health in Schools,* we began to upgrade the guidebook and have done so in ways that reflect our broad focus on *addressing barriers to student learning.* The guidebook now consists of

(a) an introductory overview of where the mental health facets of school-based health centers (SBHC) fit into the mission of schools,
(b) three modules, each containing a set of units and resources to aid with day-by-day SBHC operational considerations and concerns related to
- approaching the problem of limited resources not only as a one of fund raising, but as a major reason to integrate center activity with school and community efforts,
- specific facets of working with students who come to the center,
- approaching evaluation as a process of getting credit for all you do,

(c) a coda that highlights ways to and benefits of weaving together all resources for addressing barriers to learning into a comprehensive, integrated approach.

Each module and unit are designed to stand alone. Thus, the material can be read from beginning to end or used as reference to explore topics of immediate interest. The units are packaged in a sequence that reflects the developers' preference for starting with a big picture framework for understanding the context and emerging directions for mental health in schools.

If you have an old guidebook and would like a new one, we'll send it to you at half-price.

Please use the enclosed form to ask for what you need and to give us feedback. Also, send us information, ideas, and materials for the Clearinghouse.

PLEASE FILL OUT THE INSERTED FORM AND SEND IT TO US.

School Mental Health Project/
Center for Mental Health in Schools
Department of Psychology, UCLA
Los Angeles, CA 90095-1563
PX-22

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