From the Center's Clearinghouse ...

A Technical Aid Packet on

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

This Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA.

Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563
(310) 825-3634 Fax: (310) 206-8716; E-mail: smhp@ucla.edu Website: http://smhp.psych.ucla.edu

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Both are agencies of the U.S. Department of Health and Human Services.
Please reference this document as follows: Center for Mental Health in Schools at UCLA. (2003). School-Based Client Consultation, Referral, and Management of Care. Los Angeles, CA: Author.


Copies may be downloaded from: http://smhp.psych.ucla.edu

If needed, copies may be ordered from:
Center for Mental Health in Schools
UCLA Dept. of Psychology
P.O. Box 951563
Los Angeles, CA 90095-1563

The Center encourages widespread sharing of all resources.
Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, 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 programs.

MISSION:  To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.

Through collaboration, the center will

# enhance practitioner roles, functions and competence
# interface with systemic reform movements to strengthen mental health in schools
# assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools

*Technical Assistance*  *Hard Copy & Quick Online Resources*  
*MMonthly Field Updates Via Internet*  *Policy Analyses*  
*Quarterly Topical Newsletter*  
*Clearinghouse & Consultation Cadre*  
*Guidebooks & Continuing Education Modules*  
*National & Regional Networking*

Co-directors: Howard Adelman and Linda Taylor  
Address:  UCLA, Dept. of Psychology, 405 Hilgard Ave., Los Angeles, CA 90095-1563.  
Phone:  (310) 825-3634  FAX:  (310) 206-8716  E-mail:  smhp@ucla.edu  
Website:  http://smhp.psych.ucla.edu/

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.
What is the Center’s Clearinghouse?

The scope of the Center’s Clearinghouse reflects the School Mental Health Project’s mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; and available for searching from our website.

What kinds of resources, materials, and information are available?

We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our Introductory Packets, Resource Aid Packets, special reports, guidebooks, and continuing education units. These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

Accessing the Clearinghouse

- E-mail us at smhp@ucla.edu
- FAX us at (310) 206-8716
- Phone (310) 825-3634
- Write School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, Los Angeles, CA 90095-1563

Check out recent additions to the Clearinghouse on our Web site http://smhp.psych.ucla.edu

All materials from the Center's Clearinghouse are available for order for a minimal fee to cover the cost of copying, handling, and postage. Most materials are available for free downloading from our website.

If you know of something we should have in the clearinghouse, let us know.
The Center for Mental Health in Schools operates under the auspices of the School Mental Health Project at UCLA.* It is one of two national centers concerned with mental health in schools that are funded in part by the U.S. Department of Health and Human Services, Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration -- with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (Project #U93 MC 00175).

The UCLA Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. In particular, it focuses on comprehensive, multifaceted models and practices to deal with the many external and internal barriers that interfere with development, learning, and teaching. Specific attention is given policies and strategies that can counter marginalization and fragmentation of essential interventions and enhance collaboration between school and community programs. In this respect, a major emphasis is on enhancing the interface between efforts to address barriers to learning and prevailing approaches to school and community reforms.

*Co-directors: Howard Adelman and Linda Taylor.
Address: Box 951563, UCLA, Dept. of Psychology, Los Angeles, CA 90095-1563.
Phone: (310) 825-3634 FAX: (310) 206-8716 E-mail: smhp@ucla.edu
Website: http://smhp.psych.ucla.edu
School-Based Client Consultation, Referral, and Management of Care

Overview

- Developing Systems at School for Problem Identification, Triage, Referral, and Management of Care
- Responding to Referrals in ways that can “Stem the Tide”

I. Student Clients as Consumers

A. Enhancing Understanding of the Motivational Bases for Problems
B. Talking with Kids About Problems
C. The Best Consumer Protection is a Good Professional
D. Referral: More than Giving a Name and Address
E. Help-Seeking in Behavior and Follow Through on Referrals
F. Managing Care, Not Cases

II. Referral as an Intervention

A. The Pre-referral Process
B. About Pre-referral Teams
C. The Referral Process: Some Guidelines and Steps
D. Providing Information About Services
E. Developing Ways to Facilitate Access to Service
F. Follow-up on Referrals (including consumer feedback)
G. Managing Care, Not Cases
H. Related Resources for Case Management

III. Related Resources and References

A. References
B. Agencies and Websites
C. Additional Resources from our Center
Appendices

Examples of Resource Materials and Procedures

In this appendix, you will find materials to aid in (1) the triage process, (2) establishing a system to provide clients with ready access to information about referral resources, (3) assisting client referrals, and (4) assuring quality of care.

A. Tools to Facilitate Triage
   1. Triage Review Request Form
   2. Student's View of the Problem -- Initial Interview Forms

B. Tools to Enhance Client Access to Information on Referral Resources
   1. Examples of Resource Information Handouts for Students/Families
   2. Description of Referral Resource Files
   3. Example of One District's Referral Policy

C. Tools to Assist Clients with Referrals
   1. Referral Decisions -- Summary Form
   2. Guidelines and Follow-up Forms to Aid Referral Follow-through

D. Tools to Aid in Assuring Quality of Care
   1. Follow-up Rating Forms -- Service Status
   2. Management of Care Review Form
   3. Survey of System Status
Overview

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

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

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

The first question should be

*What's making this person function like this?*

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

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

The focus of this *technical aid packet* is on decisions about what assistance is needed, how serious the need is, where a student/family should go to get it, and how to ensure it is provided in coordinated and integrated ways.
In responding to the mental health and psychosocial concerns of students, school staff make a variety of decisions. This figure and the outline on the following page highlight matters to be considered as a school develops its systems for problem identification, triage, referral, and management of care.

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.

Initial Management of Care

- Screening/Assessment (as appropriate)
- Client Consultation and Referral
- Triage (determining severity of need)

Initial Management of Care

- 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 Monitoring

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

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

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

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

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

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

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

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

**Staff Development Focus**

**Improving the Referral System**

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

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

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

Triage processing

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

Clients directed to resources or for further problem analysis and recommendations

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

a. In many instances, prereferral interventions should be recommended. Some of these will reflect an analysis that suggests that the student's problem is really a system problem – the problem is more a function of the teacher or other environment factors. Other will reflect specific strategies that can address the student's problem without referral for outside the class assistance. Such analyses indicate ways in which a site must be equipped to implement and monitor the impact of prereferral recommendations.

b. When students/families need referral for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Care management should be designed to determine follow-through, coordination, impact, and possible need for additional referrals.

c. Referrals to assess the need for special or compensatory education often are delayed because of a waiting list. Back logs should be monitored and arrangements made to catch-up (e.g., by organizing enough released time to do the assessments and reviews).

Management of care (case monitoring and management)

a. Some situations require only a limited form of monitoring (e.g., to ensure follow-through). A system must be developed for assigning care monitors as needed. Aides and paraprofessionals often can be trained to for this function.

b. Other situations require intensive management by specially trained professionals to (a) ensure interventions are coordinated/integrated and appropriate, (b) continue problem analysis and determine whether appropriate progress is made, (c) determine whether additional assistance is needed, and so forth. There are many models for intensive management of care. For example, one common approach is to assign the responsibility to the professional who has the greatest involvement (or best relationship) with the student/family.

c. One key and often neglected function of the care manager is to provide appropriate status updates to all parties who should be kept informed.
I. Student Clients as Consumers

A. Enhancing Understanding of the Motivational Bases

B. Talking with Kids about Problems

C. The Best Consumer Protection is a Good Protection

D. Referral: More than Giving a Name and Address

E. Help-Seeking Behavior and Follow Through on Referrals

F. Managing Care, Not Cases
I. Student Clients as Consumers

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

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

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

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

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

After adopting this principle, it is a short leap to adopting the stance that school-based assistance for students and families should be consumer-oriented.
In a real sense, school personnel and the families and students they serve are all consumers. This is especially true for all those concerned about addressing barriers to student learning. What are they consuming? Information about causes and correction of learning, behavioral, emotional, and health problems. And, they want and deserve the best information available -- information that clarifies rather than mystifies, information that empowers rather than increases dependency.

Appropriately cautious information can

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

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

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

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

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

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

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

- See Module II of the Continuing Education materials entitled: Enhancing Classroom Approaches for Addressing Barriers to Learning: Classroom Focused Enabling
- A Quick Training Aid on Re-engaging Students in Learning
- A Quick Training Aid on Behavior Problems at School
- An Intro Packet on Learning Problems and Learning Disabilities

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

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

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

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

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

I. Creating the Context for Dialogues

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

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

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

III. Facilitating Talk

- Avoid interruptions.
- Start slowly, avoid asking questions, and minimize pressure to talk (the emphasis should be more on conversation and less on questioning).
- Encourage the youngster to take the lead.
- Humor can open a dialogue; sarcasm usually has the opposite effect.
- Listen with interest.
- Convey the sense that you are providing an opportunity by extending an invitation to talk and avoiding the impression of another demanding situation (meeting them "where they are at" in terms of motivation and capability is critical in helping them develop positive attitudes and skills for oral communication).
• Build on a base of natural, informal inter-changes throughout the day.
• When questions are asked, the emphasis should be on open-ended rather than Yes/No questions.
• Appropriate self-disclosure by another can disinhibit a reluctant youngster.
• Pairing a reluctant youngster with a supportive peer or small group can help.
• Train and use others (aides, volunteers, peers) to (1) enter into productive (nonconfidential) dialogues that help clarify the youngster's perceptions and then (2) share the information with you in the best interests of helping.
• For youngsters who can't seem to convey their thoughts and feelings in words, their behavior often says a lot about their views; based on your observations and with the idea of opening a dialogue, you can share your perceptions and ask if you are right.
• Sometimes a list of items (e.g. things that they like/don't like to do at school/after school) can help elicit views and open up a dialogue.
• When youngsters have learning, behavior, and emotional problems, find as many ways as feasible to have positive interchanges with them and make positive contacts outweigh the negatives.
• **Remember:** Short periods of silence are part of the process and should be accommodated.

---

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

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

---

For more materials on these topics, go to the Center Website and use the Quick Find Search to explore the following (among others) topics:

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

1. Use a space that will allow privacy and let others know not to interrupt.
   < Clarify that you care by showing empathy, acceptance, and genuine regard.
   < Indicate clear guidelines about confidentiality so the student feels safe in confiding but understands that if danger to self or others is discussed, others must be involved.

2. Start out on a positive note and always convey a sense of respect.
   < Ask about things that are going well at school and outside of school
   < Use language that invites sharing and is more conversational than questioning.
   < If students are reluctant to talk you may need to start with nonverbal activity, such as drawing, or with semistructured surveys

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

4. As you follow the student’s lead, listen actively and encourage information through open ended questions that allow for exploration rather than closure.
   < This will lead to a broader range of concerns about school, home, relationships, self.
   < With other students you may find it helpful to explore more sensitive topics such as involvement substance use, gangs, sexuality.

5. It is very important to have a plan on how to end the interview. This includes
   < Clarifying it is time, not caring, that causes the need to stop at this point.
   < Summarize what has been shared with a sense of accomplishing at new ways to understand the problems and new plans to try in solving them
   < Plan the next step, such as the next appointment, a follow up time to check on progress, and open door if there is another need to talk, how to connect to others in the daily environment at school who may be of help.
C. The Best Consumer Protection Is a Good Professional

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

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

Referrals for service are commonplace at school sites.

And, for the most part,

referrals are relatively easy to make.

But,

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

Schools must develop effective referral intervention strategies.

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

- provide ready reference to information about appropriate referrals,

- maximize follow-through by using a client consultation process that involves students and families in all decisions and helping them deal with potential barriers.

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

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

- to provide consumers with ready access to information on relevant services

- to minimize abuses often found in professional referral practices.

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

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

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

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

The fact is that the woman never got the medication because she neither had the money nor access to an apothecary. Moreover, her village had no provision for hydrotherapy, and the prescribed diet included too many foods she either did not like or could not afford.

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

(Adapted from Berne, 1964)
To aid in reviewing client need and consideration of potential resources, information is presented in an organized and comprehensible manner. To facilitate decision making, guidance and support are provided in exploring the pros and cons of the most feasible alternatives. To encourage consumer self-protection, basic evaluative questions are outlined for consumers to ask of potential service providers before contracting for services.

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

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

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

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

An example of some specific steps used in an assessment and consultation process is provided on the next page.
Some Specific Steps in an Assessment and Consultation Process

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

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

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

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

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

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

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

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

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

Excerpt

**Seeking Help From the Internet During Adolescence**

Madelyn S. Gould, Jimmie Lou Harris Munfakh, Keri Lubell, Marjorie Kleinman, Sara Parker

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

Lack of help-seeking behavior from formal sources, such as mental health professionals, is one factor in the low rates of treatment among disturbed adolescents. Research suggests that when disturbed teenagers seek help, they prefer help from informal sources such as friends. In general, female adolescents have more positive attitudes about helpseeking and are more likely to seek both formal and informal support for emotional disturbances than are males. Ethnic minority adolescents are more likely to approach informal sources such as family members and relatives. Adolescents' preference for informal sources of help seems to increase with age, and may, in turn, contribute to their low rate of formal mental health treatment.

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

*Journal of the American Academy of Child & Adolescent Psychiatry* 2002; 41(10):1182-1189
Mental Health and Help-Seeking Among Ethnic Minority Adolescents

Lori A. Barker and Howard S. Adelman

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

Journal of Adolescence 1994, 17, 251-263
Psychological Correlate of Help-seeking Attitudes among Children and Adolescent.

Garland AF, Zigler EF.

A self-report measure of attitudes about seeking help from adults for psychosocial problems was administered to approximately 200 children and adolescents. More negative help-seeking attitudes were associated with male gender, adolescence, depressive symptomatology, and lower self-efficacy. Implications for effective delivery of mental health services to at-risk youth are discussed.


Adolescent Opinions About Reducing Help-seeking Barriers and Increasing Appropriate Help Engagement

Coralie J. Wilson and Frank P. Deane

Relationship and trust were key approach factors for current help seeking. Memories of successful prior helping episodes were also important. Education about appropriate help seeking, presented in ways consistent with those currently used by adolescents (e.g., through peer networks), might reduce help-seeking barriers. Should include key adults who act as gatekeepers within adolescent networks (e.g., parents and teachers). Assertive outreach and follow-up might be important factors for continued help-source engagement. Themes provide a basis for suggestion about ways to facilitate adolescent help seeking and maintain appropriate help-source engagement.

F. Managing Care, Not Cases

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

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

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

The focus in Section II of this technical resource aid is on principles and procedures to guide establishment of a comprehensive referral intervention. The perspective taken in developing such an intervention is that it should be consumer oriented and user friendly.
II. Referral as an Intervention

A. The Pre-referral Process

B. About Pre-referral Teams

C. The Referral Process: Some Guidelines and Steps

D. Providing Information About Services

E. Developing Ways to Facilitate Access to Service
   1. Highlighting the Most Accessible Referral Resources
   2. Referral Resource Files
   3. Support and Direction for Follow-through
   4. Personal Contact with Referral Resources
   5. Enhancing On-Campus Services

F. Follow-up on Referrals (including consumer feedback)

G. Managing Care, Not Cares
   1. Initial Monitoring of Care
   2. Ongoing Management of Care
   3. System of Care

H. Related Resources for Case Management
II. Referral as an Intervention

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

Referral: A Transition Intervention

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

On the following pages is a resource aid to guide school-based efforts to plan and implement a prereferral process.
A. The Pre-referral Process

When a student is seen as having problems, teachers and other school staff may find the following steps helpful.

Related guidelines and materials are attached.

Step 1: Based on your work with the student, formulate a description of the student's problem.

Step 2: Have a discussion to get the student's view. You may want to include the family.

Step 3: Try new strategies in the classroom based on your discussion.

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

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

<table>
<thead>
<tr>
<th>A Checklist to Aid in Describing the Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher's Name: __________________________ Rm. ______ Date__________</td>
</tr>
</tbody>
</table>

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

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

Social Problems
( ) Aggressive
( ) Shy
( ) Overactive
( ) _______________

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

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

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

Other specific concerns:

Comments: If you have information about what is causing the problem, briefly note the specifics here.
**Step 2:** Have a discussion to get the student's view. You may want to include the family. (See suggestions below).

---

**Exploring the Problem with the Student and Family**

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

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

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

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

1. Starting out on a positive note: Ask about what the student likes at school and in the class (if anything).
2. Ask about outside interests and "hobbies."
3. Ask about what the student doesn't like at school and in the class.
4. Explore with the student what it is that makes the things disliked (e.g., Are the assignments seen as too hard? Is the student embarrassed because others will think s/he does not have the ability to do assignments? Do others pick on the student? Are the assignments not seen as interesting?)
5. Explore what other factors the student and those in the home think may be causing the problem?
6. Explore what the student and those in the home think can be done to make things better (including extra support from a volunteer, a peer, etc.).
7. Discuss some new things the student and those in the home would be willing to try to make things better.

See student interview form in Appendix A.
**Step 3:** Try new strategies in the classroom based on your discussion.

---

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

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

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

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

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

Step 6: Work with referral resources to coordinate your efforts with theirs for classroom success.
II. Referral as an Intervention (cont.)

B. About Pre-referral Teams

A Meta-analysis of Pre-referral Intervention Teams: Student and Systemic Outcomes

Matthew K. Burns and Todd Symington

Although prereferral intervention teams (PIT) are common in public schools, there is little and conflicting research to support them. The current article conducted an empirical meta-analysis of research on PITs by reviewing 72 articles. Nine of the articles matched the inclusion criteria for the study and 57 effect size (ES) coefficients were computed, which resulted in a mean ES of 1.10. The studies were further broken down by category of dependent variable (DV), and resulted in a mean ES of 1.15 for student outcomes and 0.90 for systemic outcomes. PITs that were implemented by university faculty resulted in a mean ES of 1.32, but field based PITs resulted in a mean ES of only .54. Studies that used random assignment resulted in higher ES coefficients than those that used nonrandom assignment. Implications for research and cautious suggestions for practice are discussed.


Student Success Teams: A Blueprint for Building Student and School-wide Progress

California Dropout Prevention Network in 2000
CA Dept. of Education

The Student Success Team, is a positive school-wide early identification and early intervention process. Working as a team, the student, parent, teachers and school administrator identify the student’s strength and assets upon which an involvement plan can be designed. Concerns are seen as obstacles to student success and not descriptors of the student’s character. As a regular school process, the SST intervenes with school and community support and a practical improvement plan that all team members agree to follow. Follow-up meetings are planned to provide a continuous casework strategy to maximize the students’ achievement and school experience.
II. Referral as an Intervention (cont.)

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).

References
II. Referral as an Intervention (cont.)

C. The Referral Process: Some Guidelines and Steps

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

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

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

- to identify feasible resources
- and then
- to evaluate their appropriateness.

Effective referral intervention strategies involve procedures that

C provide ready reference to information about appropriate referrals

C 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

C the nature and scope of student problems as perceived by students and their family

C differences among clients in terms of background and resources

C the ethical and motivational importance of client participation and choice.

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

A referral intervention should minimally

C  provide readily accessible basic information about all relevant sources of help

C  help the student/family appreciate the need for and value of referral

C  account for problems of access (e.g., cost, location, language and cultural sensitivity)

C  aid students/families to review their options and make decisions in their own best interests

C  provide sufficient support and direction to enable the student/family to connect with an appropriate referral resource

C  follow-up with students (and with those to whom referrals are made) to determine whether referral decisions were appropriate.

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

Step 1

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

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

Step 2

*For those who contact you, establish whether referral is necessary*

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

Step 3

*Identify potential referral options with the client*

If the school cannot provide the service, the focus is on reviewing with the student/family the value and nature of referral options. Some form of a referral resource file is indispensable (see Appendix B for more on the idea of a Referral Resource File).

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 Appendix B).*
Referral Steps (cont.)

Step 6

*Work on strategies for overcoming barriers*

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

Step 7

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

That is, summarize

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

Step 8

*Provide client with follow-through status forms*

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 Appendix C for examples of tools to aid these steps.*
D. Providing Information about Services

Whether you are in a situation with few or many referral options, it is essential to compile and share basic information about all potential services (see Appendix B). 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 Appendix B).

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.
II. Referral as an Intervention (cont.)

E. Developing Ways to Facilitate Access to Service

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

- materials listing the most accessible referrals and ways to circulate such materials widely,
- a comprehensive referral resource file,
- an array of procedures to support and direct students in following-through on referrals.

And, it also may be useful to make personal contact with individuals at various agencies and programs as a way of opening doors for students referred from the school.

(1) Highlighting the Most Accessible Referral Resources

Once the most accessible referrals are identified, they can be listed and the lists can be widely circulated (see Appendix H 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.
(2) **Referral Resource Files**

A referral resource filing system is intended to contain a comprehensive compilation of basic information on available services (see Appendix B).

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

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

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

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

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

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

This involves finding out:

*Does the student agree that a referral is necessary?* (See student interview form in Appendix A.)

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 Appendix C 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).

(4) **Personal Contact with Referral Resources**

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

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

In addition to helping establish special relationships that can facilitate access for students referred by the school, these contacts also provide additional information for referral resource files.
When Can Students Seek Assistance without Parent Involvement?

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

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

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

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

(5) Enhancing On-Campus Services

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

Additional on-campus resources can be accomplished by

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

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

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

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

Let's look over what's available. (Referral Resource Files are used -- see Appendix B) 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)
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 Appendix A.) I'd also like you to let me know how our plans work out. Here's a form for you to return to me; all you have to do is put a check mark to let me know what happened and then drop the form in the school mail box sometime next week. (See Appendix C.)

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.
II. Referral as an Intervention (cont.)

F. 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 Appendix D)
- a feedback form sent directly to the referral of first choice
- a procedure for daily identification of students due for referral follow-up
- analysis of follow-through status based on feedback
- follow-up interviews with students/families for whom there is no feedback information (See Appendix D).

For example:

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

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

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

The feedback form sent directly to the chosen service simply calls for a confirmation of follow-through. (With on-campus referrals, it has been found useful to establish a reciprocal feedback system. (See Appendix D.)

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

Practice-Based Interventions

NIMH Affective Disorders Workgroup

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

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

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

*Mental Health Services Research, Vol. 4, No. 4, December 2002 (copyright 2002)*
Practice Notes:

G. Managing Care, Not Cases

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

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

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

Initial Monitoring of Care

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

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

Ongoing Management of Care

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

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

Such ongoing monitoring requires systems for:

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

Effective Care Management is based upon:

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

A few basic guidelines for primary managers of care are:

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

Systems of Care

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

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

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

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

< Case Management: Concepts and Skills

< Curriculum for Community-Based Child and Adolescent Case Management Training

< Building Scaffolds of Support: Case Management in Schools

< Case Management with At-Risk Youth

< Advanced Technology to Assist with Student Care

< Accounting for Cultural, Racial, and other Significant Individual and Group Differences
What is Case Management?
"Case management as a way of helping people has a long and rich history."
"While the focus of case management is linking a client to needed services, other elements involve advocacy and social action"
"If the goal is service access and coordination, the case manager's efforts are designed to alleviate or counter the fragmentation of services and the natural tendency of bureaucratic organizations toward disorganization. For the case manager to achieve this goal, the following elements or conditions must be present:

< An accurate assessment and ongoing evaluation of client needs;
< The ability to link clients to resources appropriate to their needs;
< The power to ensure that appropriate and needed services are actually delivered;
< The capacity to see that services are utilized"

Case Management Tasks

"Probably the most comprehensive listing of tasks required of and performed by case managers was developed by Bertsche and Horejsi in 1980. The thirteen basic tasks provide a clear and concise description of case management responsibilities:

1. Complete the initial interviews with the client and his or her family to assess the client's eligibility for services.

2. Gather relevant and useful data from the client, family, or other agencies, and so on to formulate a psychosocial assessment of the client and his or her family.

3. Assemble and guide group discussions and decision-making sessions among relevant professionals and program representatives, the client and his or her family, and significant others to formulate goals and design an integrated intervention plan.

4. Monitor adherence to the plan and manage the flow of accurate information within the action system to maintain a goal orientation and coordination momentum.

5. Provide 'follow-along' to the client and his or her family to speed identification of unexpected problems in service delivery and to serve as a general troubleshooter on behalf of the client.

6. Provide counseling and information to help the client and his or her family in situations of crisis and conflict with service providers.
7. Provide ongoing emotional support to the client and his or her family so they can cope better with problems and utilize professionals and complex services. (Continued…)

8. Complete the necessary paperwork to maintain documentation of client progress and adherence to the plan by all concerned.

9. Act as a liaison between the client and his or her family and all relevant professionals, programs, and informal resources involved in the overall intervention plan to help the client make his or her preferences known and secure the services needed.

10. Act as a liaison between programs, providing services to the client to ensure the smooth flow of information and minimize the conflict between the subsystems.

11. Establish and maintain credibility and good public relations with significant formal and informal resource systems to mobilize resources for current and future clients.

12. Perform effectively and as a 'good bureaucrat' within the organization to be in a position to develop and modify policies and procedures affecting clients and the effectiveness of the service delivery system.

13. Secure and maintain the respect and support of those in positions of authority so their influence can be enlisted on behalf of the client and used, when necessary, to encourage other individuals and agencies to participate in the coordination effort

**A Final Word**
"The potential of case management to help people solve their problems, make better use of the available community and governmental resources, and work together to advocate and develop new and better resources is tremendous…. Case management programs can give their clients fish, fishing poles, and guidance to the lakes where the fish are. "

II-28
Summary of
Curriculum for Community-Based Child and Adolescent
Case Management Training

Norma Radol Raiff (December, 1992). Developed under contract with the South Carolina Department of Mental Health for the Southern Human Resources Development Consortium for Mental Health, 2414 Bull Street, P.O. Box 485, Columbia, South Carolina 29202.

The curriculum was developed to help states and local programs to prepare specialized community-based case managers to work with seriously emotionally disturbed children and adolescents.

Includes Units on the following topics:

< Why is children's case management different from adult case management? Public, clinical, and parent perspectives. This unit introduces participants to the philosophy of "a system of care." Objectives include describing the state or program's eligibility criteria and identifying five differences between child and adult mental health case management.

< Families as allies: Empowerment perspectives. This unit helps participants identify and reinforce skills and attitudes associated with successful family collaboration. Sensitivity to the cultural diversity of families and techniques for a more responsive practice will be discussed. Objectives include describing why collaboration is essential, identifying barriers, and discussing family empowerment strategies.

< Consultative case management: Team building and beyond. In this unit participants learn the philosophy of case management as consultation with parents and other team members. Objectives include defining what consultation means, identifying the dynamics and process of team meetings, and describing how case managers can be consultants with others.

< Monitoring and quality assurance: Standards of documentation. This unit describes the process of setting goals for a service plan, and monitoring based on quality assurance and quality improvement standards. Objectives include describing an assessment process that recognizes both strengths and needs, developing a working service plan, defining standards of documentation, and suggesting steps for improving practice.

< Resource acquisition. In this unit, participants learn about collaborative structures which are vehicles for resource acquisition and the development of individualized services. Objectives include describing the local (State) "system of care," describing the resources and procedures for accessing these resources.

< Putting it together: A guided role play. This unit gives participants an opportunity to apply case management skills in three different practice situations: referral, strengths interviewing, and negotiation. Objectives include understanding and working with common issues in child team settings, proficiency in initiating contact with a parent/child, and proficiency in negotiating systems in partnership with a parent/child.

< Advocacy for children with serious emotional disturbance/behavioral disorders. This additional unit provides an overview of the role of advocacy in child case management.

< Appendices with optional assessments and masters for overheads.
Excerpts from:

**BUILDING SCAFFOLDS OF SUPPORT: **

**CASE MANAGEMENT IN SCHOOLS**


**KEY FEATURES OF INDIVIDUAL CASE MANAGEMENT:**

The key features of case management were identified initially as mainly welfare related and included:

- A trusting and enabling relationship between the young person and worker,
- A focus on understanding the young person in the context of the social and emotional environment in which the young person is located,
- Ensuring continuing care where there are complex and/or multiple problems, and
- Ameliorating the emotional problems accompanying issues the young person may face (family conflict, homelessness, loss of income or economic support, poverty).

Activities undertaken in case management are wide ranging and include assisting young people with study skills (sometimes this was done individually or at other times collectively). The most common activity through the schools was work placement. At times the worker would meet with the young people's families. Sometimes the worker would meet with the teachers the young person did not get on with, and also meet with those with whom the young person liked to mediate and discuss issues. Workers also connected the young people to youth groups and to counselling.

For some workers, casework embraced mediation between one young person and his/her peers. Some workers acted as advocates on behalf of the young person for housing. Mentoring was provided as an individual approach. Typically this took place in conjunction with outside agencies.
The implementation of an effective school model of case management should take into account a wide range of considerations, including the following strategies:

**Develop a clearly articulated philosophy and theoretical framework:**

Critical concepts include:

- recognizing that all young people are potentially at risk
- developing engagement (how to involve young people in learning)
- developing membership (developing all young people’s sense of being a part of the school)
- developing community (developing a culture of shared concern)
- building effective networks.

**Identify a designated person and join a network:**

As a first step in building scaffolds of support, there needs to be a designated person in conjunction with a team or network, who plans, coordinates and liaises within and outside the school.

**Develop a process to identify the needs of all young people in the school:**

This might include developing a formal relationship between each student and a staff member. It could involve developing a more formal assessment process.

**Establish a comprehensive work experience program:**

The value of strong work experience or vocational learning programs is emphasized in other sections of the report.

**Develop a process to identify and address systemic risk factors in the school:**

Identify ways of removing barriers which inhibit any young person’s opportunity to succeed educationally, socially and interpersonally within the school environment.

**Develop a process to identify and respond to risk in the community:**

Recognise the risk factors in the local community, for example unemployment, drug issues, violence, racism, family issues and lack of community networking. Establish means within the school of increasing awareness of and building proactive responses in young people to these issues. Establish strong collaborative community networks to provide effective support for young people.

**Establish strong school and community networks:**

Networks with parents, school and other education providers, and with other agencies and the broader community greatly enhance the education, training and employment opportunities available to all young people.

**Evaluation of practice**

Ongoing formative and summative evaluation is essential in determining the extent to which the support needs of young people are being met. The focus needs to be on addressing and improving the scaffolds of support for all young people in schools through identification and response to individual employment, education and training needs. The purpose of evaluation should be to refine and develop successful initiatives while recognising the lessons from unsuccessful initiatives.
Except

Case Management with At-Risk Youth

Available on-line: [http://graduateschool.heller.brandeis.edu/chr/case.htm]

Why is Case Management Needed?

At-risk youth have needs that are often complex and intertwined. They require help determining which among a variety of services they need, when, and in what order. They require assistance finding and accessing those services, and support to successfully complete those services.

Human service institutions, on the other hand, are often one-dimensional and specialized. They typically offer services that are funded and provided as separate entities: housing is the niche of one agency, education that of another, and job training that of a third.

The result is that there is often a mismatch between the behavior of the helping-professions and the needs of the youth whom those services intend to help. Without case management, interventions are often uncoordinated and scarce resources squandered. A young person can easily fall through the cracks or give up trying to navigate what is, in most locales, a disjointed multi-institutional "non-system." The function of case management is to overcome the mismatch between institutions and client needs and to provide the continuity of services that is critical for at-risk youth.

Effective Case Management

In order to locate and walk a young person through a sequence of services, the typical case management system has the following components:

- Finding and attracting appropriate clients;
- Intake and assessment;
- Designing a service plan;
- Intervening in the community: broke ring, advocating, and linking;
- Implementing and monitoring the service plan;
- Evaluating the effectiveness of case management.
What makes these activities effective, however, is the philosophy or approach that guides them. As we reviewed the literature and talked with practitioners, four major themes stood out as central to almost every aspect of the case management process:

**Case Management Requires Partnership.** Case management is, first and foremost, a system of partnerships: between case manager and client, and between organizations. In an effective case management system, the case manager works in partnership with the client, sharing responsibility, rather than working on the client. There is a division, rather than a substitution, of labor. Case management also involves partnerships among institutions. At some level, each must be willing to be flexible and to share access to services or resources. In that context, the case manager works for all the partners, helping institutions access clients, and linking clients with those institutions that offer the services young people need.

**Intervening in the Community: Brokering, Advocating, and Linking.** For a case manager to make effective referrals, institutions at the receiving end must have slots available on an needed basis. They must be willing to grant timely admission to their programs, rather than placing the client on a waiting list. Ideally, the case manager can say: "I need my client enrolled in your program this week," and have it happen. Persuading institutions to do this is not easy.

Agencies providing case management have taken a variety of approaches to the referral process. Some place primary responsibility for identifying and securing services with the case manager, who works to develop needed slots on a case by case basis. Other agencies have organized the referral process more formally by assigning the task to a "resource developer" who secures service slots from agencies in the same manner as job developers have traditionally obtained employment slots from businesses.

The basic principles of case management point to a multifaceted role for the case manager. In essence, case managers are "jacks of all trades." They stimulate, coordinate, and monitor service delivery so that youth do not fall through cracks. They do whatever is necessary to remove barriers hindering a client's advance towards self-sufficiency.
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
Accounting for Cultural, Racial, and Other Significant Individual and Group Differences

All interventions to address barriers to learning and promote healthy development must consider significant individual and group differences.

In this respect, discussions of diversity and cultural competence offer some useful concerns to consider and explore. For example, the Family and Youth Services Bureau of the U.S. Department of Health and Human Services, in a 1994 document entitled *A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs*, outlines some baseline assumptions which can be broadened to read as follows:

Those who work with youngsters and their families can better meet the needs of their target population by enhancing their competence with respect to the group and its intragroup differences.

Developing such competence is a dynamic, on-going process -- not a goal or outcome. That is, there is no single activity or event that will enhance such competence. In fact, use of a single activity reinforces a false sense of that the "problem is solved."

Diversity training is widely viewed as important, but is not effective in isolation. Programs should avoid the "quick fix" theory of providing training without follow-up or more concrete management and programmatic changes.

Hiring staff from the same background as the target population does not necessarily ensure the provision of appropriate services, especially if those staff are not in decision-making positions, or are not themselves appreciative of, or respectful to, group and intragroup differences.

Establishing a process for enhancing a program's competence with respect to group and intragroup differences is an opportunity for positive organizational and individual growth.
The Bureau document goes on to state that programs:

are moving from the individually-focused "medical model" to a clearer understanding of the many external causes of our social problems ... why young people growing up in intergenerational poverty amidst decaying buildings and failing inner-city infrastructures are likely to respond in rage or despair. It is no longer surprising that lesbian and gay youth growing up in communities that do not acknowledge their existence might surrender to suicide in greater numbers than their peers. We are beginning to accept that social problems are indeed more often the problems of society than the individual.

These changes, however, have not occurred without some resistance and backlash, nor are they universal. Racism, bigotry, sexism, religious discrimination, homophobia, and lack of sensitivity to the needs of special populations continue to affect the lives of each new generation. Powerful leaders and organizations throughout the country continue to promote the exclusion of people who are "different," resulting in the disabling by-products of hatred, fear, and unrealized potential.

... We will not move toward diversity until we promote inclusion ... Programs will not accomplish any of (their) central missions unless ... (their approach reflects) knowledge, sensitivity, and a willingness to learn.

In their discussion of "The Cultural Competence Model," Mason, Benjamin, and Lewis* (1996) outline five cultural competence values which they stress are more concerned with behavior than awareness and sensitivity and should be reflected in staff attitude and practice and the organization's policy and structure. In essence, these five values are

(1) Valuing Diversity -- which they suggest is a matter of framing cultural diversity as a strength in clients, line staff, administrative personnel, board membership, and volunteers.

(2) Conducting Cultural Self-Assessment -- to be aware of cultural blind spots and ways in which one's values and assumptions may differ from those held by clients.

(3) Understanding the Dynamics of Difference -- which they see as the ability to understand what happens when people of different cultural backgrounds interact.

(4) Incorporating Cultural Knowledge -- seen as an ongoing process.

(5) Adapting to Diversity -- described as modifying direct interventions and the way the organization is run so that they reflect the contextual realities of a given catchment area and the sociopolitical forces that may have shaped those who live in the area.

III. Related Resources and References

A. References

B. Agencies and Websites

C. Additional Resources from Our Center

< Consultation Cadre

< Materials: Quick Find
III. Related Resources and References

A. References


Children’s Services: Social Policy, Research, and Practice, Case Management Services at Ten Federally Funded Sites Targeting Homeless Children and Their Families, 5(2), 113-112, Lawrence Erlbaum Associates, Inc., Copyright 2002,


Kataoka SH, Zhang L, Wells KB., Unmet Need for Mental Health Care Among U.S. Children: Variation by Ethnicity and Insurance Status, Am J Psychiatry 2002 Sep; 159 (9):1548-55


Losen, D. & Orfield, G., Racial Inequity in Special Education. Harvard Education Press, Copyright 2002


Mamlin, N., & Harris, K.R. (1998). Elementary teachers’ referral to special education in light of inclusion and prereferral: “Every child is here to learn...but some of these children are in real trouble”. Journal of Educational Psychology, 90,385-396.


Ortega AN, Rosenheck R., Hispanic Client-Case Manager Matching: Differences in Outcomes and Services Use in A Program for Homeless Persons with Sever Mental Illness, J Nerv Ment Dis 2002 May; 190(5); 315-23


The Center for Human Resources at Brandeis University developed several guides on the topic of case management for at-risk youth. Contact: the Center's director, Susan Curnan at Brandeis University, P.O. Box 9110, 60 Turner St. Waltham, MA 02254-9110 -- (617) 736-3770.
III. Related Resources and References (Cont.)

B. Agencies and Websites

American Case Management Association, Inc.
Endeavors to provide a forum for interdisciplinary collaboration
American Case Management Association
10310 West Markham Street, Suite 209
Little Rock, Arkansas 72205
Phone: 501/907-ACMA (2262)
Fax: 501/227-4247
theacme@earthlink.net
http://www.acmaweb.org/main.html

Case Management Resource Guide
Searchable database of over 120,000 specialty healthcare services, facilities, businesses and organizations
1500 Walnut Street, Suite 1000
Philadelphia, PA 19102
Toll-free: 800/784-2332
Phone: 215/675-1212
Fax: 215/735-3966
info@cmrg.com
http://www.cmrg.com/

Case Management Society of America
An International not-for-profit membership society of case managers, nurses, and allied healthcare professionals
Case Management Society of America
8201 Cantrell Road, Suite 230
Little Rock, AR 72227
Phone: 501/225-2229
Fax: 501/221-9068
cmsa@cmsa.org
http://www.smsa.org/

The Center for Multicultural and Multilingual Mental Health Services
The Center provides support to mental health professionals who work cross-culturally and cross-linguistically. Created to assist mental health workers in meeting the needs of clients who have a culture and/or language barrier to treatment. The Center is dedicated to bridging the gap between diverse client populations and mainstream mental health provider organizations.
The Center for Multicultural and Multilingual Mental Health Services
4750 North Sheridan Road, Suite 300
Chicago, IL 60640
Phone: 773/751-4081
Fax: 773/271-7261
http://www.mc-mlmhs.org/

National Mental Health Association Resource Center
The NMHA Resource Center is a nationally recognized resource for information on mental illness and treatments, and referrals for local treatment services. To meet the need of hundreds of thousands of information-seeking individuals, the Resource Center provides the following services at no cost to the public:
< Tool-free line: 1-800-969-NMHA (800-969-6642)
< Network of more than 340 affiliates TTY line for the hearing impaired: 1-800-433-5959
< Referrals to more than 7,000 organizations nationwide
< 60 different brochures and fact sheets on a variety of mental health topics
< Staff of experience, professionally trained employees.
National Mental Health Association
2001 N. Beauregard Steet, 12th Floor
Alexandria, VA 22311
Phone: 703/684-7722
Fax: 703/684-5968
Mental Health Resource Center 800/969-NMHA
TTY Line 800/433-5959
http://www.nmha.org/infoctr/index.cfm
National Mental Health Consumers’ Self-Help Clearinghouse
A consumer-run national technical assistance center serving the mental health consumer movement. We help connect individuals to self-help and advocacy resources, and we offer expertise to self-help groups and other peer-run services for mental health consumers.
http://www.mhselfhelp.org/

SAMSHA’s National Mental Health Information Center
(Substance Abuse and Mental Health Services Administration)

Consumer/Survivor Mental Health Information
For information about resources available in your community contact your local affiliates of national self-help organizations.
http://www.mentalhealth.org/consumersurvivor/default.asp
C. Additional Resources from our Center

### School-Based Client Consultation Referral and Management Care
**Consultation Cadre List**

Professional across the country volunteer to network with others to share what they know. Some cadre members run programs, many work directly with youngsters in a variety of settings and focus on a wide range of psychosocial problems. Others are ready to share their expertise on policy, funding, and major system concerns. The group encompasses professionals working in schools, agencies, community organizations, resource centers, clinics and health centers, teaching hospitals, universities, and so forth.

People ask how we screen cadre members. We don’t! It’s not our role to endorse anyone. We think it’s wonderful that so many professionals want to help their colleagues, and our role is to facilitate the networking. If you are willing to offer informal consultation at no charge to colleagues trying to improve systems, programs, and services for addressing barriers to learning, let us know. Our list is growing each day; the following are those currently on file related to this topic. Note: the list is alphabetized by Region and State as an aid in finding a nearby resource.

*Updated 12/26/02*

#### Central States

<table>
<thead>
<tr>
<th>State</th>
<th>Contact Name</th>
<th>Title/Position</th>
<th>Organization/Location</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kansas</strong></td>
<td>Joyce Markendorf</td>
<td>School Health Consultant</td>
<td>Kansas State Dept of Health &amp; Environment</td>
<td>913/296-1308</td>
<td>913/296-4166</td>
<td><a href="mailto:JoyMarx@aol.com">JoyMarx@aol.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3422 SW Arrowhead Rd.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Topeka, KS 66614</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Phone: 913/296-1308</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fax: 913/296-4166</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Email: <a href="mailto:JoyMarx@aol.com">JoyMarx@aol.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Minnesota</strong></td>
<td>Jose Gonzalez</td>
<td>Interpreter / Supervisor</td>
<td>Minneapolis Dept. of Health &amp; Family Support</td>
<td>612/673-3815</td>
<td>612/673-2891</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>250 4th St. So., Rm 401</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Minneapolis, MN 55415</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Phone: 612/673-3815</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fax: 612/673-2891</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Email:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Missouri</strong></td>
<td>Beverly McNabb</td>
<td>Director of Child &amp; Adolescent Education</td>
<td>St. John's Behavioral Health Care</td>
<td>417/885-2954</td>
<td>417/888-8615</td>
<td><a href="mailto:BAM6749@sprg.smhs.com">BAM6749@sprg.smhs.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>St. John's Marian Center</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1235 E. Cherokee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Springfield, MO 65804</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Phone: 417/885-2954</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fax: 417/888-8615</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Email: <a href="mailto:BAM6749@sprg.smhs.com">BAM6749@sprg.smhs.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Missouri</strong></td>
<td>Andrea Woodward</td>
<td>Clinical Director</td>
<td>Counseling Association Network</td>
<td>816/523-7071</td>
<td>816/523-6990</td>
<td><a href="mailto:clgcastwk@hotmail.com">clgcastwk@hotmail.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1734 East 63rd Street, Suite 446</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Kansas City, MO 64110</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Phone: 816/523-6990</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fax: 816/523-7071</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Email: <a href="mailto:clgcastwk@hotmail.com">clgcastwk@hotmail.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Name</td>
<td>Title</td>
<td>Organization</td>
<td>Address</td>
<td>Phone</td>
<td>Fax</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>Ohio</td>
<td>Joseph E. Zins</td>
<td>Professor</td>
<td>University of Cincinnati</td>
<td>339 Teachers College</td>
<td>513/556-3341</td>
<td>513/556-1581</td>
</tr>
<tr>
<td>Washington DC</td>
<td>Meredith Branson</td>
<td>Psychologist</td>
<td>Department of Pediatrics, Georgetown University Hospital</td>
<td>2 PHC Georgetown U Hospital</td>
<td>202/687-5437</td>
<td>202/687-7161</td>
</tr>
<tr>
<td>Delaware</td>
<td>Deanna Mears Pandya</td>
<td>Mental Health Counselor</td>
<td>VNA Wellness Center</td>
<td>1901 S. College Avenue</td>
<td>302/369-1501</td>
<td>302/369-1503</td>
</tr>
<tr>
<td>Delaware</td>
<td>Kathy Spencer</td>
<td>Social Worker</td>
<td>Dover High School Wellness Center -VNA</td>
<td>1 Patrick Lynn Drive</td>
<td>302/672-1586</td>
<td>302/674-2065</td>
</tr>
<tr>
<td>Delaware</td>
<td>Lawrence Dolan</td>
<td>Principal Research Scientist</td>
<td>Center for Res. on the Education of Students Placed at Risk</td>
<td>Johns Hopkins University</td>
<td>410/516-8809</td>
<td>410/516-8890</td>
</tr>
<tr>
<td>Delaware</td>
<td>Gregory Durrette</td>
<td>Project Cood.</td>
<td>Christiana Care Health Services, The Wellness Center</td>
<td>DelCastle Technical High School</td>
<td>302/892-4460</td>
<td>302/892-4463</td>
</tr>
<tr>
<td>Delaware</td>
<td>Deanna Mears Pandya</td>
<td>Mental Health Counselor</td>
<td>VNA Wellness Center</td>
<td>1901 S. College Avenue</td>
<td>302/369-1501</td>
<td>302/369-1503</td>
</tr>
<tr>
<td>Delaware</td>
<td>Kathy Spencer</td>
<td>Social Worker</td>
<td>Dover High School Wellness Center -VNA</td>
<td>1 Patrick Lynn Drive</td>
<td>302/672-1586</td>
<td>302/674-2065</td>
</tr>
<tr>
<td>Delaware</td>
<td>Deanna Mears Pandya</td>
<td>Mental Health Counselor</td>
<td>VNA Wellness Center</td>
<td>1901 S. College Avenue</td>
<td>302/369-1501</td>
<td>302/369-1503</td>
</tr>
<tr>
<td>Delaware</td>
<td>Kathy Spencer</td>
<td>Social Worker</td>
<td>Dover High School Wellness Center -VNA</td>
<td>1 Patrick Lynn Drive</td>
<td>302/672-1586</td>
<td>302/674-2065</td>
</tr>
<tr>
<td>Delaware</td>
<td>Lawrence Dolan</td>
<td>Principal Research Scientist</td>
<td>Center for Res. on the Education of Students Placed at Risk</td>
<td>Johns Hopkins University</td>
<td>410/516-8809</td>
<td>410/516-8890</td>
</tr>
<tr>
<td>Delaware</td>
<td>Gregory Durrette</td>
<td>Project Cood.</td>
<td>Christiana Care Health Services, The Wellness Center</td>
<td>DelCastle Technical High School</td>
<td>302/892-4460</td>
<td>302/892-4463</td>
</tr>
</tbody>
</table>
New Hampshire
Charles Kalinski
Learning Resource Specialist
Merrimack High School
38 McElwain St.
Merrimack, NH 03054
Phone: 603/424-6204
Fax: 
Email: currenttides@mediaonc.net

Pennsylvania
Ann O'Sullivan
Associate Professor of Primary Care Nursing
University of Pennsylvania School of Nursing
420 Guardian Drive
Philadelphia, PA 19104-6096
Phone: 215/898-4272
Fax: 215/573-7381
Email: osull@pobox.upenn.edu

Northwest
Alaska
Michele Schindler
School Counselor
Harborview Elementary School
10014 Crazy Horse Dr.
Juneau, AK 99801
Phone: 907/463-1875
Fax: 907/463-1861
Email: schindlm@jsd.k12.ak.us

Arkansas
Maureen Bradshaw
State Coordinator, for Behavioral Interventions
Arch Ford Education Service Cooperative
101 Bulldog Drive
Plumerville, AR 72117
Phone: 501/354-2269
Fax: 501/354-0167
Email: mbradshaw@conwaycorp.net

Florida
Howard M. Knoff
Professor
School Psychology Program/Institute for School Reform
University of South Florida
4202 East Fowler Avenue, EDU 162
Tampa, FL 33620-7750
Phone: 813/974-9498
Fax: 813/974-5814
Email: knoff@tempest.coedu.usf.edu

Rode Island
Robert Wooler
Executive Director
RI Youth Guidance Center, Inc.
82 Pond Street
Pawtucket, RI 02860
Phone: 401/725-0450
Fax: 401/725-0452
Email:

Southeast
Florida
Howard M. Knoff
Professor
School Psychology Program/Institute for School Reform
University of South Florida
4202 East Fowler Avenue, EDU 162
Tampa, FL 33620-7750
Phone: 813/974-9498
Fax: 813/974-5814
Email: knoff@tempest.coedu.usf.edu
Florida
Christy Monaghan
Psychologist
Florida School for the Deaf and Blind
207 N San Marco Ave.
St. Augustine, FL 32084
Phone:
Fax: 904/823-4039
Email: monaghanem@mail.fsdb.k12.fl.us

Georgia
Ronda Talley
Executive Director and Professor
Rosalynn Carter Institute for Human Development
Georgia Southwestern State University
800 Wheatley St.
Americus, GA 31709
Phone: 912/928-1234
Fax: 912/931-2663
Email: rtalley@canes.gsw.edu

Kentucky
Daniel Clemons
Coordinator
Fairdale Youth Service Center
1001 Fairdale Road
Fairdale, KY 40118
Phone: 502/485-8866
Fax: 502/485-8761
Email:

Kentucky
William Pfohl
Professor of Psychology
Western Kentucky University
Psychology Department
1 Big Red Way
Bowling Green, KY 42101
Phone: 270/745-4419
Fax: 270/745-6474
Email: william.pfohl@wku.edu

Louisiana
Dean Frost
Director, Bureau of Student Services
Louisiana State Department of Education
P.O. Box 94064
Baton Rouge, LA 70804
Phone: 504/342-3480
Fax: 504/342-6887

North Carolina
Bill Hussey
Section Chief
Dept. of Public Instruction
301 N. Wilmington St.
Raleigh, NC 27601-2825
Phone: 919/715-1576
Fax: 919/715-1569
Email: bhussy@dpi.state.nc.us

North Carolina
Regina C. Parker
Community Relations Coordinator
Roanoke-Chowan Human Service Center
Rt. 2 Box 22A
Ahoskie, NC 27910
Phone: 252/332-4137
Fax: 252/332-8457
Email:

North Carolina
William Trant
Director Exceptional Programs
New Hanover County Schools
1802 South 15th Street
Wilmington, NC 28401
Phone: 910/254-4445
Fax: 910/254/4446
Email: wtrant@wilmington.net

Tennessee
Mary Simmons
Director
School Counseling Services
Tennessee Department of Education
710 James Robertson Pkwy., 5th Floor
Nashville, TN 37243-0379
Phone: 615/532-6270
Fax: 615/532-8536
Email: msimmons@mail.state.tn.us
Virginia
Richard Abidin
Director of Clinical Training
Curry Programs in Clinical and School Psychology
University of Virginia
405 Emmet Street, 147 Ruffner Hall
Charlottesville, VA 22903-2495
Phone: 804/982-2358
Fax: 804/924-1433
Email: rra@virginia.edu

West Virginia
Lenore Zedosky
Executive Director
Office of Healthy Schools
West Virginia Department of Education
1900 Kanawha Blvd., Building 6, Room 309
Charleston, WV 25305
Phone: 304/558-8830
Fax: 304/558-3787
Email: lzedosky@access.k12.wv.us

Southwest

California
Marcia London Albert
7900 Loyola Blvd.
Los Angeles, CA 90045-8208
Phone: 310/338-2847
Fax: 310/338-7657
Email: malbert@lmu.edu

California
Jackie Allen
Professor
Allen Consulting Associates
705 Montana Vista Ct.
Fremont, CA 94539
Phone: 510/656-6857
Fax: 510/656-6880
Email: jallen20@ix.netcom.com

California
Bonny Beach
Lead Counselor
Fallbrook Union Elementary School District
Student Assistant Program
P.O. Box 698; 321 Iowa Street
Fallbrook, CA 92028
Phone: 619/723-7062
Fax: 619/723-3083
Email: 

California
Howard Blonsky
School Social Worker
Program Integration & Compliance, Special
Education Services
1500 Howard Ave #206
Burlingame, CA 94010
Phone: 415/355-6904
Fax: 415/355-6910
Email: hblonsk@muse.sfusd.edu

California
Claire Brindis
Director
Ctr for Reproductive Health Research and Policy,
Univ. of Calif.
Institute for Health Policy Studies/ Professor,
Department of Pediatrics,
Division of Adolescent Med
Box 0936, Laurel Heights Campus
San Francisco, CA 94143-0936
Phone: 415/476-5255
Fax: 415/476-0705
Email: brindis@itsa.ucsf.edu

California
Kelly Corey
Regional Director of Business Dev.
Provo Canyon School
P.O. Box 89292
Temecula, CA 92589-2292
Phone: 909/694-9462
Fax: 909/694-9472
Email:
California
Christine Davis
Counselor
LAUSD
Manual Arts Cluster
5972 W. 76th Street
Los Angeles, CA 90045
Phone: 213/731-0811
Fax:
Email: davis5972@sprynet.com

California
Sylvia Dean
Coordinator of Psychological Service
Los Angeles School District
11380 W. Graham Place - Bldg. Y
Los Angeles, CA 90064
Phone: 310/444-9913
Fax: 310/497-5722
Email:

California
Todd Franke
Assistant Professor
School of Public Policy and Social Research
University of California, Los Angeles
3250 Public Policy Building, Box 951656
Los Angeles, CA 90095-1452
Phone: 310/206-6102
Fax:
Email: tfranke@ucla.edu

California
Randall Hansen
Licensed Educational Psychologist
Family Medical Care
110 North Spring Street
Blythe, CA 92225
Phone: 760/921-3167
Fax: 760/921-3167
Email: rhansen@telis.org

California
John Hatakeyama
Deputy Director
Children and Youth Services Bureau
L.A. County Dept. of Mental Health, C&FSB
550 S. Vermont Ave.
Los Angeles, CA 90020
Phone: 213/738-2147
Fax: 213/386-5282
Email: jhatakeyama@dmh.co.la.ca.us

California
Janice Jetton
Pediatric/Adolescent Nurse Practitioner
Kaiser Permanente, Orange County
Coordinator/Huntington Beach Union High SD
1982 Port Locksleigh Place
Newport Beach, CA 92660
Phone: 949/640-1977
Fax: 949/640-0848
Email: JanJetton@aol.com

California
Christy Reinold
School Counselor
Lodi Unified School District/Oakwood Elementary
1315 Woodcreek Way
Stockton, CA 95209
Phone: 209/953-8018
Fax: 209/953-8004
Email:

California
Marian Schiff
School Psychologist
LAUSD Montague St. School
13000 Montague St.
Pacoima, CA 91331
Phone: 818/899-0215
Fax:
Email:
California
Susan Sheldon
School Psychologist
Los Angeles Unified School District
5423 Monte Vista St.
Los Angeles, CA 90042
Phone: 213/254-7262
Fax: 213/259-9757
Email: 

Robert Spiro
School Psychologist
6336 Beeman Ave.
North Hollywood, CA 91606
Phone: 818/760-2577
Fax:
Email:

Howard Taras
District Physician
San Diego City Schools
2351 Cardinal Lane, Annex B
San Diego, CA 92123
Phone: 858/627-7595
Fax: 858/627-7444
Email: htaras@ucsd.edu

Lois Weinberg
Education Specialist
Mental Health Advocacy Service
1336 Wilshire Blvd., Suite 102
Los Angeles, CA 90017
Phone: 213/484-1628
Fax: 213/484-2907
Email: weinberg@gse.ucla.edu

Andrea Zetlin
Professor of Education
California State University, Los Angeles
School of Education
5151 State University Drive
Los Angeles, CA 90032
Phone: 310/459-2894
Fax: 310/459-2894
Email: azetlin@calstatela.edu

Colorado
Anastasia Kalamaros-Skalski
Assistant Research Professor
School of Education
University of Colorado at Denver
P.O. Box 173364, Campus Box 106
Denver, CO 80217-3364
Phone: 303/620-4091
Fax: 303/556-4479
Email: stacy_kalamaros-skalski@together.cudenver.edu

Hawaii
Harvey Lee
Program Specialist
Pacific Resources for Education and Learning
1099 Alkea Street
Honolulu, HI 96813-4500
Phone: 808/441-1300
Fax: 808/441-1385
Email: leeh@prel.hawaii.edu

Don Leton
Psychologist
Honolulu Schools
Special Services
4967 Kilauea Av.
Honolulu, HI 96816
Phone: 808/733-4940
Fax: 808/733-4944
Email: leton@hula.net

Nevada
Rita McGary
Social Worker
Miguel Rivera Family Resource Center
1539 Foster Rd.
Reno, NV 89509
Phone: 702/689-2573
Fax: 702/689-2574
Email: sunwindy@aol.com
The following reflects our most recent response for technical assistance related to CASE/CARE MANAGEMENT. This list represents a sample of information to get you started and is not meant to be an exhaustive list.

(Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one).

Materials produced by Our Center

- **NEW! Quick Training Aid**
  A brief set of resources to guide those providing an inservice session on Case Management in the School Context. Also useful as a quick self-tutorial. (note: opens up in a new window)
- **A Technical Aid Packet on School-Based Client Consultation, Referral, and Management of Care**
- **Addressing Barriers to Learning: New Directions for Mental Health in Schools**

Selected Materials from our Clearinghouse

- **A Guide to Case Management for At-Risk Youth**
- **Case Management in Service Integration: An Annotated Bibliography**
- **Children and Adolescent Case Management: An Annotated Bibliography**
- **Curriculum for Community Based Child and Adolescent Case Management Training**
- **Packet of Case Management Models**
- **School-Based Case Management: An Integrated Service Model for Early Intervention with Potential Dropouts**
- **What It Takes: Structuring Interagency Partnerships to Connect Children and Families with Comprehensive Services**

Relevant Publications on the Internet

- **A School-Based Care Management Service for Children with Special Needs**
- **NASW Standards for Social Work Case Management**
- **CARAS: A School-Based, Case Management System for At-Risk Students**
- **Integrated Services: A Summary for Rural Educators**
- **What It Takes: Structuring Interagency Partnerships to Connect Children and Families with Comprehensive Services**

Related Agencies and Websites

- **Case Management Society**
- **American Case Management Association**
- **National Center for Case Management and Automation Children's Hospital of Los Angeles**
- **Case Management Resource Guide**
- **State of California Child Welfare Services/Case Management System**

Relevant Publications That Can Be Obtained at Your Local Library

We hope these resources met your needs. If not, feel free to contact us for further assistance. For additional resources related to this topic, use our search page to find people, organizations, websites and documents. You may also go to our technical assistance page for more specific technical assistance requests.

If you haven't done so, you may want to contact our sister center, the Center for School Mental Health Assistance, at the University of Maryland at Baltimore. If our website has been helpful, we are pleased and encourage you to use our site or contact our Center in the future. At the same time, you can do your own technical assistance with "The Fine Art of Fishing" which we have developed as an aid for do-it-yourself technical assistance.
<table>
<thead>
<tr>
<th>Shortcut Text</th>
<th>Internet Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quick Training Aid</td>
<td><a href="http://smhp.psych.ucla.edu/qf/case_mgmt_qt/">http://smhp.psych.ucla.edu/qf/case_mgmt_qt/</a></td>
</tr>
<tr>
<td>A Technical Aid Packet on School-Based Client Consultation, Referral, and Management of Care</td>
<td><a href="http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=2305DOC9998">http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=2305DOC9998</a></td>
</tr>
<tr>
<td>Addressing Barriers to Learning: New Directions for Mental Health in Schools</td>
<td><a href="http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=2312DOC9998">http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=2312DOC9998</a></td>
</tr>
<tr>
<td>Children and Adolescent Case Management: An Annotated Bibliography</td>
<td><a href="http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=2305DOC2">http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=2305DOC2</a></td>
</tr>
<tr>
<td>Curriculum for Community Based Child and Adolescent Case Management Training</td>
<td><a href="http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=2305DOC3">http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=2305DOC3</a></td>
</tr>
<tr>
<td>School-Based Case Management: An Integrated Service Model for Early Intervention with Potential Dropouts</td>
<td><a href="http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=2305DOC8">http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=2305DOC8</a></td>
</tr>
<tr>
<td>What It Takes: Structuring Interagency Partnerships to Connect Children and Families with Comprehensive Services</td>
<td><a href="http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=1202DOC40">http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=1202DOC40</a></td>
</tr>
<tr>
<td>A School-Based Care Management Service for Children with Special Needs</td>
<td><a href="http://www.findarticles.com/cf_dls/m0FSP/2_23/63536761/print.jhtml">http://www.findarticles.com/cf_dls/m0FSP/2_23/63536761/print.jhtml</a></td>
</tr>
<tr>
<td>CARAS: A School-Based, Case Management System for At-Risk Students</td>
<td><a href="http://www.thejournal.com/magazine/vault/A1326.cfm">http://www.thejournal.com/magazine/vault/A1326.cfm</a></td>
</tr>
<tr>
<td>A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research</td>
<td><a href="http://aspe.hhs.gov/progsys/homeless/symposium/7-Casemgmt.htm">http://aspe.hhs.gov/progsys/homeless/symposium/7-Casemgmt.htm</a></td>
</tr>
<tr>
<td>Case Management Society</td>
<td><a href="http://www.cmsa.org/">http://www.cmsa.org/</a></td>
</tr>
<tr>
<td>American Case Management Association</td>
<td><a href="http://www.acmaweb.org/">http://www.acmaweb.org/</a></td>
</tr>
<tr>
<td>National Center for Case Management and Automation Children's Hospital of Los Angeles</td>
<td><a href="http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=02496">http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&amp;ITEM=02496</a></td>
</tr>
<tr>
<td>search</td>
<td><a href="http://smhp.psych.ucla.edu/search.htm">http://smhp.psych.ucla.edu/search.htm</a></td>
</tr>
<tr>
<td>technical assistance page</td>
<td><a href="http://smhp.psych.ucla.edu/techreq.htm">http://smhp.psych.ucla.edu/techreq.htm</a></td>
</tr>
<tr>
<td>Center for School Mental Health Assistance</td>
<td><a href="http://csmha.umaryland.edu/">http://csmha.umaryland.edu/</a></td>
</tr>
<tr>
<td>“The fine Art of Fishing”</td>
<td><a href="http://smhp.psych.ucla.edu/selfhelp.htm">http://smhp.psych.ucla.edu/selfhelp.htm</a></td>
</tr>
</tbody>
</table>
Appendices

Examples of Resource Materials and Procedures

In this appendix, you will find materials to aid in (1) the triage process, (2) establishing a system to provide clients with ready access to information about referral resources, (3) assisting client referrals, and (4) assuring quality of care.

A. Tools to Facilitate Triage

1. Triage Review Request Form
2. Student's View of the Problem -- Initial Interview Forms

B. Tools to Enhance Client Access to Information on Referral Resources

1. Examples of Resource Information Handouts for Students/Families
2. Description of Referral Resource Files
3. Example of One District's Referral Policy

C. Tools to Assist Clients with Referrals

1. Referral Decisions -- Summary Form
2. Guidelines and Follow-up Forms to Aid Referral Follow-through

D. Tools to Aid in Assuring Quality of Care

1. Follow-up Rating Forms -- Service Status
2. Management of Care Review Form
3. Survey of System Status
Appendix A

Tools to Facilitate Triage

Two aids are provided here:

1. *Triage Review Request Form*

2. *Student's View of the Problem -- Initial Interview Forms*
   - form for use with all but very young children
   - form for use with very young children

Note: The Center's Resource Aid Packet on *Screening/Assessment: Indicators and Tools* contains related materials such as aids for initial problem identification and guides to understanding the screening process.
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/alcoh. abuse ( ) pregnancy prevention/support ( ) self esteem
   ( ) depression/suicide ( ) eating problems (anorexia, bulim.) ( ) relationship problems
   ( ) grief ( ) physical/sexual abuse ( ) anxiety/phobia
   ( ) dropout prevention ( ) neglect ( ) disabilities
   ( ) gang involvement ( ) reactions to chronic illness

Other specific concerns

Current school functioning and desire for assistance

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

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

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

If you have information about the cause of a problem or other important factors related to the situation, briefly note the specifics here (use the back of the sheet if necessary).
(For use with all but very young students)

**Student's View of the Problem -- Initial Interview Form**

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

not at all      not much            only a      more than      quite a bit       very much
little bit      a little bit

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?

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

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?
(For use with very young students)

Student's View of the Problem -- Initial Interview Form

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 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 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 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 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  2  3  4  5  6
not at all  not much  only a little bit  more than a little bit  Quite a bit  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  2  3  4
very hopeful  somewhat  not too hopeful  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?
Appendix B

Tools to Enhance
Client Access to Information on Referral Resources

Three aids are provided here:

1. Examples of Resource Information Handouts for Students/Families

2. Description of Referral Resource Files

3. Example of One District's Referral Policy
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

<table>
<thead>
<tr>
<th>Service</th>
<th>Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hathaway Childrens Serv.</td>
<td>11600 Eldridge Ave.</td>
<td>(818) 896-1161</td>
</tr>
<tr>
<td>Lake View Terr., 91342</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manos Esperanza</td>
<td>14412 Hamlin Avenue, Van Nuys, 91405</td>
<td>(818) 376-0028</td>
</tr>
<tr>
<td>North Valley Family Counseling</td>
<td>661 S. Workman St., San Fernando, 91340</td>
<td>(818) 365-5320</td>
</tr>
<tr>
<td>San Fernando Valley Child Guidance Clinic</td>
<td>9650 Zelzah, Pacoima, 91331</td>
<td>(818) 993-9311</td>
</tr>
<tr>
<td>Boys &amp; Girls Club of San Fernando</td>
<td>11251 Glenoaks Blvd, Pacoima, 91331</td>
<td>(818) 896-5261</td>
</tr>
<tr>
<td>Because I Love You General Information Line</td>
<td>(818) 882-4881</td>
<td></td>
</tr>
<tr>
<td>El Nido Services Families Anonymous</td>
<td>12502 Van Nuys Blvd, Pacoima, 91331</td>
<td>(818) 989-7841</td>
</tr>
<tr>
<td>Sons &amp; Daughters United/Parents United</td>
<td>Sexually Abused Children (13-18)</td>
<td>Intake: M &amp; T, 1-4:30</td>
</tr>
<tr>
<td>Drug Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>El Proyecto del Barrio Vista Recovery Center</td>
<td>13643 Van Nuys Blvd, Pacoima, 91331</td>
<td>(818) 896-1135</td>
</tr>
<tr>
<td>IADARP - Reseda</td>
<td>7136 Haskell Ave., Van Nuys, 91406</td>
<td>(818) 705-4175</td>
</tr>
<tr>
<td>Life-Plus ASAP - Panorama City Hosp.</td>
<td>14850 Roscoe Blvd, Van Nuys, 91406</td>
<td>(818) 787-2222</td>
</tr>
<tr>
<td>Phone Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valley Hotline</td>
<td>(818) 989-5463</td>
<td></td>
</tr>
<tr>
<td>Helpline Youth Counseling</td>
<td>(213) 864-3722</td>
<td>Child Abuse Hotline Dial 0 -- Ask for Zenith 2-1234</td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td>(213) 381-5111</td>
<td></td>
</tr>
<tr>
<td>Spanish Bilingual Helpline</td>
<td>(818) 780-9727</td>
<td></td>
</tr>
<tr>
<td>Alateen</td>
<td>(213) 387-3158</td>
<td></td>
</tr>
<tr>
<td>Info Line</td>
<td>(818) 501-4447</td>
<td>Runaway 1-800-843-5200</td>
</tr>
<tr>
<td>Emergency Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Management Center</td>
<td>Olive View Mid-Valley Hospital</td>
<td>14445 Olive Drive</td>
</tr>
<tr>
<td>Same day appointments</td>
<td>8101 Sepulveda Blvd., Van Nuys, 91402</td>
<td>(818) 364-4340 24 hours</td>
</tr>
<tr>
<td>Olive View Mid-Valley Hospital</td>
<td>14445 Olive Drive, Sylmar 91342</td>
<td></td>
</tr>
<tr>
<td>FOR ADDITIONAL RESOURCES, SEE THE SCHOOL’S RESOURCE REFERENCE FILE.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**San Fernando High School**

**Community Resources**

| Alcohol & Other Drugs | | |
|-----------------------|-------------------|
| Alcoholics Anonymous | 1-800-252-6645    |
| Be Sober              | 1-800-BE-SOBER    |
| Cocaine Anonymous     | (818) 988-1777    |
| Narconics Anonymous   | (818) 730-3951    |
| El Pueblo del Barrio  | (818) 896-1135    |

**Suicide Prevention**

- **Hotline for teens**: 1-800-621-4000
- **24-hour Crisis**: (213) 381-5111

**Child Abuse**

- **Hotline**: 1-800-272-6099
- **Family 24-hour Crisis Center**: (818) 949-3157
- **Rape Hotline**: (818) 793-3385
- **Victims Anonymous**: (818) 993-1139

---

**Run Away**

- **Run-away Hotline**: 1-800-621-4000
- **L.A. Youth Network**: (213) 446-6200
- **Stepping Stone**: (213) 450-7839

**Pregnancy/Family Planning**

- **Pregnancy Testing**: (818) 365-8086
- **El Nido Services**: (818) 896-7776
- **L.A. County Health Services**: (818) 896-1903

**Other Resources**

- **S.F.H.S. Team**
- **Health Center**: (818) 365-7517
- **Teenline**: 1-800-TEEN-TEEN
- **Aids Hotline**: 1-800-922-2437
- **Spanish Bilingual Hotline**: (818) 780-9727
- **Family Problems Group**: (818) 882-4881
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.
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: ________________________
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

(please check services offered)

Fees:

_____ 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).
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.
Status of Referral Follow-Through

Student's Name: _________________ Today's 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.
Status of Referral Follow-Through

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: ____________________________

Today's Date: ____________

____ The above named student/family contacted us on ____________ and was provided appropriate services.

____ We have no record of this student/family making contact with us.

__________________________________________

Please return this form to:

Mrs. Benson
Smith High School
1340 S. Highland Ave.
Johnston, Missouri  90005
Record of Contact with Referrer

Date: _________

To: _______________________

From: _______________________

Thank you for your request for assistance for _______________________.

(name)

A contact was made on ____________.

Comments: _______________________

Appendix C

Tools to Assist Clients with Referrals

Two aids are presented here:

1. *Referral Decisions -- Summary Form*

2. *Guidelines and Follow-up Forms to Aid Referral Follow-through*
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.
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.
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.  ____________
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."
Appendix D

Tools to Aid in Assuring Quality of Care

Two tools are provided here:

1. Follow-up Rating Forms - Service Status

2. Management of Care Review Form

3. Survey of System Status
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)

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

If the problems worked on differ from the "presenting" problems (e.g., referral problem), also indicate the current status of the presenting problems.

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

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?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<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>

How much did the intervention help the student to deal with her/his problems in a better way?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<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>

Prognosis

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>very positive</td>
<td>positive</td>
<td>negative</td>
<td>very negative</td>
</tr>
</tbody>
</table>
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?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<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>

2. How much did the counseling help you better understand your problems?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<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>

3. How much did the counseling help you deal with your problems in a better way?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<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>

4. At this time, how serious are the problems for you?

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

5. How hopeful are you about solving your problems?

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

If not hopeful, why not?

6. If you need help in the future, how likely are you to contact the counselor?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td>not too likely</td>
<td>likely to</td>
<td>definitely will</td>
</tr>
</tbody>
</table>
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?
[b]not too serious[/b] 1 2 3 4 5 6
[b]very serious[/b] 1 2 3 4 5 6

Learning:

Behavior:

Emotional:

Other:

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

Date: __________________

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

Team members present:

Date:_________________

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>Learning:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Emotional:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Other:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Amount of Improvement Seen
not too much | very much

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.
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>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>

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>not too severe</th>
<th>How Severe?</th>
<th>very severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning:</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Behavior:</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Emotional:</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other:</td>
<td>1</td>
<td>2</td>
<td>3</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.
The following resource aides were designed as a set of self-study surveys to aid school staff as they try to map and analyze their current programs, services, and systems with a view to developing a comprehensive, multifaceted approach to addressing barriers to learning.

In addition to an overview Survey of Learning Supports System Status, there are self-study surveys to help think about ways to address barriers to student learning by enhancing:

- Classroom-based Approaches to Enable and Re-engage Students in Classroom Learning
- Crisis Assistance and Prevention
- Support for Transitions
- Home Involvement in Schooling
- Community Outreach for Involvement and Support
- Student and Family Assistance Programs and Services
- School-Community Collaboration
About the Self-Study Process to Enhance the Component for Addressing Barriers to Student Learning

This type of self-study is best done by teams.

However, it is NOT about having another meeting and/or getting through a task!

It is about moving on to better outcomes for students through

- working together to understand what is and what might be
- clarifying gaps, priorities, and next steps

Done right it can

- counter fragmentation and redundancy
- mobilize support and direction
- enhance linkages with other resources
- facilitate effective systemic change
- integrate all facets of systemic change and counter marginalization of the component to address barriers to student learning

A group of school staff (teachers, support staff, administrators) could use the items to discuss how the school currently addresses any or all of the areas of the component to address barriers (the enabling component). Members of a team initially might work separately in responding to survey items, but the real payoff comes from group discussions.

The items on a survey help to clarify

- what is currently being done and whether it is being done well and
- what else is desired.

This provides a basis for a discussion that

- analyzes whether certain activities should no longer be pursued (because they are not effective or not as high a priority as some others that are needed).
- decides about what resources can be redeployed to enhance current efforts that need embellishment
- identifies gaps with respect to important areas of need.
- establishes priorities, strategies, and timelines for filling gaps.

The discussion and subsequent analyses also provide a form of quality review.
A tool for mapping and planning

**Survey of Learning Supports System Status**

As a school sets out to enhance the usefulness of learning supports designed to address barriers to learning, it helps to clarify what you have in place as a basis for determining what needs to be done. You will want to pay special attention to

- clarifying what resources already are available
- how the resources are organized to work in a coordinated way
- what procedures are in place for enhancing resource usefulness

This survey provides a starting point.

The first form provides a template which you can fill in to clarify the people and their positions at your school who provide services and programs related to addressing barriers to learning. This also is a logical group of people to bring together in establishing a resource-oriented team for learning supports at the school.

Following this is a survey designed to help you review how well systems for Learning Supports have been developed and are functioning.
Learning Supports Staff at the School

In a sense, each staff member is a special resource for each other. A few individuals are highlighted here to underscore some special functions.

**Administrative Leader for Learning Supports**

<table>
<thead>
<tr>
<th>Administrative Leader for Learning Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School Psychologist</strong></td>
</tr>
<tr>
<td>times at the school ______________________</td>
</tr>
<tr>
<td>C Provides assessment and testing of students for special services. Counseling for students and parents. Support services for teachers. Prevention, crisis, conflict resolution, program modification for special learning and/or behavioral needs.</td>
</tr>
</tbody>
</table>

**School Nurse**

<table>
<thead>
<tr>
<th>School Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>times at the school ______________________</td>
</tr>
<tr>
<td>C Provides immunizations, follow-up, communicable disease control, vision and hearing screening and follow-up, health assessments and referrals, health counseling and information for students and families.</td>
</tr>
</tbody>
</table>

**Pupil Services & Attendance Counselor**

<table>
<thead>
<tr>
<th>Pupil Services &amp; Attendance Counselor</th>
</tr>
</thead>
<tbody>
<tr>
<td>times at the school ______________________</td>
</tr>
<tr>
<td>C Provides a liaison between school and home to maximize school attendance, transition counseling for returnees, enhancing attendance improvement activities.</td>
</tr>
</tbody>
</table>

**Social Worker**

<table>
<thead>
<tr>
<th>Social Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>times at the school ______________________</td>
</tr>
<tr>
<td>C Assists in identifying at-risk students and provides follow-up counseling for students and parents. Refers families for additional services if needed.</td>
</tr>
</tbody>
</table>

**Counselors**

<table>
<thead>
<tr>
<th>Counselors</th>
<th>times at the school</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>C General and special counseling/guidance services. Consultation with parents and school staff.</td>
<td></td>
</tr>
</tbody>
</table>

**Dropout Prevention Program Coordination**

<table>
<thead>
<tr>
<th>Dropout Prevention Program Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>times at the school ______________________</td>
</tr>
<tr>
<td>C Coordinates activity designed to promote dropout prevention.</td>
</tr>
</tbody>
</table>

**Title I and Bilingual Coordinators**

<table>
<thead>
<tr>
<th>Title I and Bilingual Coordinators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinates categorical programs, provides services to identified Title I students, implements Bilingual Master Plan (supervising the curriculum, testing, and so forth)</td>
</tr>
</tbody>
</table>

**Resource and Special Education Teachers**

<table>
<thead>
<tr>
<th>Resource and Special Education Teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>times at the school ____________________</td>
</tr>
<tr>
<td>C Provides information on program modifications for students in regular classrooms as well as providing services for special education.</td>
</tr>
</tbody>
</table>

**Other important resources:**

**School-based Crisis Team (list by name/title)**

<table>
<thead>
<tr>
<th>School-based Crisis Team (list by name/title)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**School Improvement Program Planners**

<table>
<thead>
<tr>
<th>School Improvement Program Planners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Community Resources**

<table>
<thead>
<tr>
<th>Community Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>C Providing school-linked or school-based interventions and resources</td>
</tr>
</tbody>
</table>

**Who** | **What they do** | **When**
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who</th>
<th>What they do</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Survey of Learning Supports System Status

Items 1-9 ask about what processes are in place.

Use the following ratings in responding to these items.

DK = don't know
1 = not yet
2 = planned
3 = just recently initiated
4 = has been functional for a while
5 = well institutionalized (well established with a commitment to maintenance)

1. Is someone at the school designated as the administrative leader for activity designed to address barriers to learning (e.g., learning supports, health and social services, the Enabling Component)?

2. Is there a time and place when personnel involved in activity designed to address barriers to learning meet together?

3. Is there a resource-oriented team (e.g., a Learning Supports Resource Team) – as contrasted to a case-oriented team?

(a) Does the team analyze data trends at the school with respect to
> attendance
> drop outs
> achievement

(b) Does the team map learning supports programs to determine whether
> identified priorities are being addressed adequately
> program quality is up to standards
> gaps have been identified and priorities for the future are set

(c) Which of the following areas of learning support are reviewed regularly?
> Classroom-based Approaches to Enable and Re-engage Students in Classroom Learning
> Crisis Assistance and Prevention
> Support for Transitions
> Home Involvement in Schooling
> Community Outreach for Involvement and Support
> Student and Family Assistance
4. Are there written descriptions of learning supports programs available to give
   >staff  DK  1  2  3  4  5
   >families  DK  1  2  3  4  5
   >students  DK  1  2  3  4  5
   >community stakeholders  DK  1  2  3  4  5

5. Are there a case-oriented systems in place for
   (a) concerned parties to use in making referrals?  DK  1  2  3  4  5
   (b) triage (to decide how to respond when a referral is made)?  DK  1  2  3  4  5
   (c) case monitoring and management?  DK  1  2  3  4  5
   (d) a student review team?  DK  1  2  3  4  5
   (e) a crisis team?  DK  1  2  3  4  5

6. Are there written descriptions available to give to staff and others about
   >how to make referrals  DK  1  2  3  4  5
   >the triage process  DK  1  2  3  4  5
   >the process for case monitoring and management  DK  1  2  3  4  5
   >the process for student review  DK  1  2  3  4  5

7. Are there systems in place to support staff wellness?  DK  1  2  3  4  5

8. Are there processes by which staff and families learn
   (a) What is available in the way of programs/services at school?  DK  1  2  3  4  5
   (b) What is available in the way of programs/services at school?  DK  1  2  3  4  5
   (c) How to access programs/services they need?  DK  1  2  3  4  5

9. Has someone at the school been designated as a representative to meet with the other schools in the feeder pattern to enhance coordination and integration of learning supports among the schools and with community resources?  DK  1  2  3  4  5
Survey of Learning Supports System Status (cont.)

The following items ask about effectiveness of existing processes.

Use the following ratings in responding to these items.

DK = don’t know
1 = hardly ever effective
2 = effective about 25% of the time
3 = effective about half the time
4 = effective about 75% of the time
5 = almost always effective

10. How effective are the processes for
   (a) planning, implementing, and evaluating learning supports system improvements?
   (b) enhancing learning supports resources (e.g., through budget decisions, staff development; developing or bringing new programs/services to the site; making formal linkages with programs/services in the community)?

11. How effective are the processes for ensuring that
   (a) resources are properly allocated and coordinated?
   (b) community resources linked with the school are effectively coordinated/integrated with related school activities?

12. How effective are the processes for ensuring that resources available to the whole feeder pattern of schools are properly allocated and shared/coordinated?

13. How effective is the
   (a) referral system?
   (b) triage system?
   (c) case monitoring and management system?
   (d) student review team?
   (e) crisis team?

14. List community resources with which you have formal relationships.
   (a) Those that bring program(s) to the school site
   (b) Those not at the school site but which have made a special commitment to respond to the school's referrals and needs.
We hope you found this to be a useful resource.
There's more where this came from!

This packet has been specially prepared by our Clearinghouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories.

**Systemic Concerns**

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards

**Programs and Process Concerns**

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prerereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
    - Enhancing triage & ref. processes
    - Least Intervention Needed
  - Short-term student counseling
    - Family counseling and support
    - Case monitoring/management
    - Confidentiality
    - Record keeping and reporting
    - School-based Clinics

**Psychosocial Problems**

- Drug/alcohol abuse
- Depression/suicide
- Grief
- Dropout prevention
- Gangs
- School adjustment (including newcomer acculturation)
- Pregnancy prevention/support
- Eating problems (anorexia, bulimia)
- Physical/Sexual Abuse
- Neglect
- Gender and sexuality
- Learning, attention & behavior problems
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Reactions to chronic illness
- Learning, attention & behavior problems
From the Center’s Clearinghouse...

Thank you for your interest and support of the Center for Mental Health in Schools. You have just downloaded one of the packets from our clearinghouse. Packets not yet available on-line can be obtained by calling the Center (310)825-3634.

We want your feedback! Please rate the material you downloaded:

How well did the material meet your needs?  Not at all  Somewhat  Very much

Should we keep sending out this material?  No  Not sure  Yes

Please indicate which if any parts were more helpful than others.

In general, how helpful are you finding the Website?  Not at all  Somewhat  Very Much

If you are receiving our monthly ENEWS, how helpful are you finding it?  Not at all  Somewhat  Very Much

Given the purposes for which the material was designed, are there parts that you think should be changed? (Please feel free to share any thoughts you have about improving the material or substituting better material.)

We look forward to interacting with you and contributing to your efforts over the coming years. Should you want to discuss the center further, please feel free to call (310)825-3634 or e-mail us at smhp@ucla.edu

Send your response to:
School Mental Health Project,
UCLA Dept of Psychology
405 Hilgard Ave.
Los Angeles, CA 90095-1563

The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- Phone: (310) 825-3634.

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.