CHAPTER THIRTY-TWO

SCHOOL CONSULTATION
AND INTERVENTION

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Children and teens spend much of their lifetime in school settings, and schools are the major providers of mental health services for children (Hoagwood & Erwin, 1997), providing more than 75% of the care. (Bums et al., 1995; Costello et al., 1996). However, this seems to be more by default than by design, as the majority of school-based interventions have not been empirically tested (Hoagwood & Erwin, 1997). School-based mental health services are a logical choice to reach certain pediatric populations, especially socioeconomically disadvantaged children and teens, because these youngsters often have limited access to medical care. Furthermore, they may be at highest risk for certain disorders, and may need to be served via an alternative to the traditional clinic model.

History of School Consultation

Direct service and consultation models have been in existence for over 100 years. In 1898, the Chicago School Board initiated one of the first "school-labs" with its Saturday psycho-physical laboratories located in the District's central office.

from Handbook of Mental Health Interventions in Children & Adolescents; Hans Steiner (ed.) 2004; Jossey Bass (SF)

Twenty such clinics were known to be running by 1914 (French, 1990). By 1930, the Pennsylvania Department of Education had developed a model for certifying school psychologists. Its primary purpose was to designate students who were candidates for special education. In general, psychological services at that time were focused on age-based cognitive assessments of the "abnormal" child (Fagan, 1992; Hoagwood & Erwin, 1997).

One of the first to outline a more consultation-oriented approach was Dr. Jules Coleman (1947). In his work on consulting to casework agencies (Coleman, 1947), he emphasized the importance of concentrating on the *why now* aspect of consultation. That is, rather than focusing on the student's problems as such, the consultant was to try and understand the reasons that a case worker would ask for consultation at a particular time. The task was to find out *how* one could be helpful, and *what feelings* need to be understood from the consultee (caseworker). Maddux expanded on this by concentrating on caseworkers' feelings of anxiety, anger, and hostility toward their supervisors, colleagues, and clients (Maddux, 1950). Gerald Caplan wrote extensively about the need to understand that consultee concerns stemmed from intrapsychic conflicts aroused by the problems that a particular client was asking about (Caplan, 1956, 1959, 1963). A consultant could best help the consultee by encouraging a focus on this self-understanding of their own issues, such that they could better help their clients. Irving Berlin expanded on this further, and recommended keeping in touch with consultees even after the initial consultation to emphasize a sense of continual support, validation, and interest on the part of the consultant (Berlin, 1956). Mattison (2000, 2001) has helped to reframe the Special Education setting as a sort of "Therapeutic Day School." His major recommendations will be outlined later in this chapter. Bostic and Rauch (1999) have outlined key aspects of getting started in school consultation psychiatry: gaining access to a school or district, building an alliance with both senior administration and teachers as well as more junior staff, protecting confidentiality, devising a framework to deal with consultee questions and concerns, and negotiating a payment structure. The psychiatrist's role is then to develop the three R's of school consultation: focus on *relationships* of the people allied around a particular pupil, foster the *recognition* of the dynamic forces (motivations and resistances) that may impede or advance a student's healthy progress in school or at home, and generate *responses* to problems (Bostic & Rauch, 1999).

This chapter will focus on some of the major models proposed by the above authors, and present specific case examples of how their specific principles may be applied. As this publication was going to press, the American Academy of Child and Adolescent Psychiatry was developing the *Practice Parameters for School Consultation*, scheduled for publication in early 2004, and readers are strongly encouraged to add this to the list of useful references at the end of this chapter.

Putative Mechanisms of Efficacy and Targets of Treatment

As others have noted, while some psychiatrists may think of themselves more as consultants than direct service providers, many blend their roles and function both as school psychiatrist, and as teacher or staff consultant (Bostic & Bagnell, 2004). The *school psychiatrist or school-based mental health practitioner* provides direct service to students (therapy and/or medication management) and to staff (direct treatment, support groups, professional development seminars). In this model, teachers and other staff focus more specifically on teaching, while leaving the mental health issues to the psychiatrist (Bostic & Bagnell, in press). However, as the psychiatrist usually has only a part-time school site presence (a few hours per week), he or she is often seen as having a "consultant role." The *school consultant* functions more as an advisor, nonjudgmental colleague, and professional with a sympathetic ear. Roles may include indirect services to pupils through direct contact (face-to-face, phone, or video) with teachers, school psychologists, guidance counselors, school aides, and more senior administrators (principals, directors of special education, or superintendents). Educational staff and school consultants report being most satisfied with their collaborative relationships when they view each other with mutual respect, and understand their respective roles and stressors well (Weist, Proescher, Prodente, Ambrose, & Waxman, 2001).

We will now outline some specific strategies that are used in working with schools. Six overall concepts are presented: Establishing a relationship with a school or district, identifying a framework for treatment and consultation, working specifically with students and educators in regular education settings (those with Section 504 plans), the approach to special education settings and personnel, suggested modifications and accommodations for youths with specific disorders, and a summary of our team's approach to consultation.

Establishing a Relationship with a School or District

One of the primary tasks for any consultant is to understand the needs of the consultee as well as possible. School personnel are often under great pressure to balance the tasks of teaching children how to think, how to socialize, how to learn appropriate academic, vocational, and life skills, and how to continuously meet expectations in the form of academic standards. Hence, it is important for the consultant to be familiar with general characteristics of a school: its population, priorities, strengths, and weaknesses. Months of relationship-building may need to occur before a school or district is ready to contract for services. General approaches include conducting needs assessments with teachers or school psychologists (where both quantitative and qualitative aspects are addressed). These

may be done with teachers at the beginning of the school year, at the end of the year (with time during the summer to develop appropriate services, based on what the needs are), or more informally with senior administrators.

On the other hand, though many poorer school districts may desire consultant services, they may not be as able to pay as their better-funded counterparts in higher socioeconomic status (SES) districts. Ideas for funding such services are covered later in this chapter.

Setting a framework: The consultant needs to decide how she will approach cases. Consultee-centered approaches require a familiarity with the roles of various school personnel. Useful summaries have been delineated elsewhere. (See Bostic & Bagnell, in press.) We present an adapted version in Table 32.1.

TABLE 32.1. SCHOOL PERSONNEL.

Specific Personnel	Hours/day with Students	Number of Students	Years/Type of Training
Teachers*	6	20–35	Bachelor's degree, plus teacher certification Some have Master's degree
Special Education teachers*	6	Depends on number of classes in school and state-specific guidelines 6–28 pupils per teacher	Bachelor's degree, plus credentialing to provide instruction to those with special learning, emotional, or behavioral needs
School psychologists*	3–6	Usually 0.5–1 FTE psychologist for entire school (may be responsible for several hundred students at different schools within the same district) Poorer districts may have less than 0.25 FTE psychologist time for entire school	Master's degree, sometimes Doctoral degree
Guidance counselors*	6	Usually 1–2 counselors per grade Poorer districts may have only 0.25–1 FTE counselor for entire school	Master's degree
Classroom 1:1 aides	2–6	May be assigned to supervise 1–4 students in any particular school during a school day Often knows the pupil in question very well	May be in process of obtaining teacher credential High school degree or GED is sometimes a minimum requirement
*Resource specialists (includes both staff and "RSP teachers" A.K.A. Special Education teachers)	2–6	Depends on number of classes in school 6–50 students per teacher These staff members may function as tutors, or may teach groups of students with similar learning difficulties in the special education setting	Bachelor's degree, plus credentialing to provide instruction to those with special learning, emotional, or behavioral needs May have earned Master's degree or certificate in Special Education

TABLE 32.1.   (CONTINUED).

Specific Personnel	Hours/day with Students	Number of Students	Years/Type of Training
School adjustment specialists Social workers*	3–6	Depends on number of hours in school setting Often split time with other job setting Provide case management and/ or psychosocial treatments to students and families	Master's degree, or special training
Psychology Social work MFT interns*	2–6	Usually 10–20 clients per school Provide individual and group therapy Often interested in learning empirically proven medication approaches and psychotherapies from psychiatric consultant	Bachelor's degree, in process of earning Master's degree
School nurses*	3–8	1 FTE RN or LVN per school, but could be 1 FTE for entire district Address acute health care needs of students, including administration of medications	Bachelor's degree Advanced Practice Nurse may have Master's degree (MSN) Includes Public Health Nurses, Nurse Practitioners (NP), Clinical Nurse Specialists (CNS)
Occupational therapists	3–6	0.25–1 FTE per district Often consults on contractual basis May run groups for teaching activities of daily living May design ergonomic modifications for schoolwork Work 1:1 to help students who have difficulty coping with sensory integration May design and run social skills groups and behavior modification plans, along with psychologist or intern	Advanced degree usually includes Master's degree
Speech therapists	36	0.25–1 FTE per school Help students with communication disorders and social skills problems	Master's degree

*denotes staff who often initiate consultation.

**All paraprofessionals hired after January 8, 2002 must have (1) completed two years of study at an institution of higher education, (2) obtained an associate's (or higher) degree, or (3) met a rigorous standard of quality and be able to demonstrate, through a formal state or local academic assessment, knowledge of and the ability to assist in instructing reading, writing, and mathematics (or, as appropriate, reading readiness, writing readiness, and mathematics readiness).

Vice Principals (one to two per middle or high school) are usually responsible for all aspects of disciplinary procedures and enforcement, and report to the Principal. The *Principal* is in charge of all services and personnel at each particular school site. The *Director of Special Education* of a district is in charge of all of the school psychologists and special education staff, and reports to the superintendent, as does the Principal. The *Superintendent*, in turn, is responsible for guiding all educational activities for a specific school district. He reports to an elected school board (public schools), or to an appointed school board (charter, private, or parochial schools) (Bostic & Bagnell, in press).

Recent authors (Bostic, 2004; Mattison, 1999) have promoted models that have been partly adapted for modern school contexts from Caplan's earlier work. Bostic's approach includes five components germane to each consultation:

Bostic's Five Components

1. Decide who the actual consultee is, and what the confidentiality parameters are.
2. Focus on the consultee question, and pay attention to what the needs and wishes of the consultee are.
3. How does this problem affect the system? (How does the system experience the problem?)
4. What are the legal and ethical factors to be considered?
5. What is the consultant's biopsychosocial understanding of the problem?

Further, this model promotes the building of alliances and sharing of information that can help school staff recognize, resolve, and in time (hopefully) prevent problems. The three goals of this model are

(1) Allying with the consultee through validation of her perceptions of the problem. Respect is created for all who are involved, and the anxiety around a particular case is pooled. The latter results in an *overall decrease in anxiety of the system*, as the more people who can share and understand the problem, the less anxious each member of the team will be.

(2) Clarification of consultee objectives.

(3) Mobilization of resources.

This third component involves much in the way of empowerment of school staff. For example, autonomy and self-esteem of the consultee can be enhanced by praise at efforts currently being made, and by trying to expand the consultee's skills as much as possible. Our team has found it helpful to additionally offer to get resources for the consultee which may not be available to those outside of a university system (for example, selected reference material from a campus library, or materials obtained online or from a conference that may be helpful in the classroom).

Staff can be further empowered when the consultant uses the consultee's own words to frame specific interventions. With this empowerment, teachers will feel that they are part of the solution and more invested in suggestions and interventions. Finally, we try to help consultees anticipate potential problems before they occur and to practice role-plays of sample interventions to decrease anxiety. All of these interventions serve to increase the options available in a consultee's "toolbox."

Developmental Influences on Consultation

The following section will review important developmental considerations in school consultation.

Preschool

For many parents, this period will be the first time they are entrusting the care of their most cherished possession to a group of total strangers. Young children may experience much uncertainty in the world outside of their homes and their parents' watchful eyes. Personality development is in its infancy, as are the skills required to master self-care and interactions within a group setting (Nelson, 2001). School psychiatry consultants must help the daycare or preschool staffs understand as much as possible about the developmental and emotional life of three- to five-year-olds, as well as in assisting the parents of these youngsters. Consultants can model interactions with parents of preschoolers, as well as provide brief seminars or workshops in temperament, attachment, separation-individuation, and impulse control, adapted for the education level of the audience. (Education levels of parents and staff may be quite different.) Staff development seminars on adult and parental development should also be considered (Nelson, 2001).

Elementary School

Clinicians will be most successful if they remain cognizant of the developmentally typical conflicts, anxieties, and behaviors of this age group (Shaw & Feldman, 1997). As with preschoolers, efforts must be made to educate staff regarding the importance of their roles as major adult figures in each child's life. During this school stage, the importance of attaining a sense of competence, effectiveness, and mastery in the Eriksonian sense ("industry versus inferiority") must be communicated to teachers and parents. If this stage develops successfully, so too will self-esteem. Parental relationships are especially crucial in this regard. Those who enjoy their child, are responsive to her needs, and are involved and interested in their child's achievements are most likely to promote and enhance healthy self-esteem

development (Shaw & Feldman, 1997). Authoritative parenting (and teaching) styles, which feature frequent praise with warm and empathic (but consistent and firm) limit-setting, also foster self-worth and self-confidence. As these children grow into young adolescents, exciting cognitive, behavioral, and social-emotional changes take place. If major mood or behavior problems do occur, care must be taken to not attribute these simply to "raging hormones," as the majority of teens approach and enter puberty with relatively good functioning.

Middle School

Early (ages eleven to thirteen) and middle (fourteen to sixteen) adolescence are often identified as the periods of most intensive transition in cognitive, emotional, pubertal, and social domains. Although change, as a general theme, is the hallmark of the second decade of life, these six years in particular have generated a great deal of research interest within developmental psychology and psychopathology. (For an excellent discussion of the important themes of this age group for school consultants, see Feldman & Elliott, 1993 and Steiner & Feldman, 1996.) The young adolescent years are often filled with the greatest difficulty in adjustment for the *adults* involved in the early teen's life. Teachers and staff must resist becoming inadvertently "parentified." Developmental tasks for this age group include personality development, individuation from parents, and the establishment of peer groups and important relationships with members of the opposite sex (Conger, 1977).

High School

According to Kerr, within a high school setting the major goals of the consultant are to:

- Promote the students' well-being and safety in the context of their school setting and educational experience.
- Reduce problematic risk-taking behaviors so students can take full advantage of their school experiences (Kerr, 2001).

Further, she has described the essential features of the kind of caring high school community that can bring about the above results: The first component is developmental guidance, provided by all staff at the school. This is essentially how the school cares for all of its students, with the assistance of outside consultants. The second is how the school deals with those kids who might stumble along the way, or the "at-risk" population. The third component involves intervention. Examples include individual counseling and therapy, academic support for those in trouble, support groups, school mental health services, and staff support and professional development.

The final component involves crisis intervention for youths in acute need because of their own mental health issues, family problems, community events, threats of terrorism or other potential tragedy at the school. During these times, schools will likely seek help from the mental health community of psychiatrists, psychologists, family therapists, and social workers.

"Students receiving interventions are not merely at risk; they are in need . . ." (Kerr, 2001, p. 106)

Academic Modifications, Accommodations, and Service/Education Plans

When a child first presents with an academic or behavioral difficulty, the initial step is to gather the important school staff involved with the child and the parents, called a Student Support Team or Student Success Team (SST) meeting. It must be held within fifteen calendar days of the receipt of request by the school's SST site co-ordinator. It usually includes a teacher, counselor and/or psychologist, principal, parent, and outside professionals, such as a parent advocate or mental health consultant. If it is determined that the reason for difficulty is due to a *substantially limiting* mental or physical health disability, the student is eligible for services and/or special accommodations under Section 504 of the Rehabilitation Act of 1973. This federal statute stipulates that all schools that receive federal funding must provide an education to all children regardless of disability, in the *least restrictive setting*. A student with a disability is considered to be someone who has a physical or mental impairment that *substantially limits* one or more major life activities. The resultant intervention is an ISP, or Individualized Service Plan (A.K.A. 504 Plan), which specifies the types of accommodations that the school will provide. Because funding is not directly provided by the federal government, state and local districts vary widely on the degree to which they provide accommodations. Section 504 specifically excludes certain conditions from qualifying a student as disabled, including certain sexual disorders, gender identity disorders that do not result from a physical impairment, compulsive gambling, kleptomania, pyromania, and current psychoactive substance abuse disorders (Ravenswood City Unified School District Parent Handbook, 1996; Fullerton & Rollins, 1996). The Americans with Disabilities Act (ADA), 1990, applies the protections of Section 504 to public and private schools, but does not include parochial schools. If the ISP (504 plan) does not adequately address the student's educational needs, the next step is a referral to the local school district Committee on Special Education (CSE). Requests for an evaluation should be made in written form to the Director of the CSE for the specified district. Samples of letters can be found on the Parents Helping Parents Web site, www.php.com. The CSE has fifteen calendar days to respond in writing to the request, and to schedule an Individualized Education Plan (IEP) meeting. The parent must then sign an agreement to allow their child to be evaluated, and all assessments are to be completed within fifty calendar days of a signed assessment plan.

Bayer and Kaye (2002) have nicely summarized the major legal developments on special education that are relevant for school mental health practitioners. In the 1970s, several laws attempted to redress educational inequities for disabled children in the United States. Following the Rehabilitation Act of 1973, Congress passed the Education for All Handicapped Act, or PL 94-142, in 1975, which laid the groundwork for special education services. All persons aged six to twenty-one would be entitled to a *Free and Appropriate Education* (FAPE), regardless of handicapping condition. Furthermore, education must take place in the *Least Restrictive Environment*, whenever possible. This means that an otherwise qualified disabled student can be removed from the regular educational environment only if formalized classroom accommodations, supplementary aids, or other services fail to help educate the student satisfactorily (Fullerton & Rollins, 1996). A CSE is constituted in each school district to oversee an IEP for all students who qualify under this program because of a specific disability. (See Exhibit 32.1.) Later, the law was amended to apply to children as young as three (PL 99-457, 1986), and a Committee on Preschool Education would convene to develop an Individualized Family Service Plan (IFSP). Parents must participate with the components of the plan, must give informed consent, and have the right to due process whenever indicated. Re-evaluation of the IEP or IFSP must occur every year, and a full review (including retesting, if indicated) is required every three years ("triennial review"). In 1990, PL 94-142 was changed to emphasize the words "individual" over "education," and "disability" instead of "handicapped," and the IDEA ("Individuals with Disabilities Education Act"), PL 101-476, was born. Autism and traumatic brain injury were also added to the list of qualifying disabilities at that time, and ADHD and Tourette's disorder were added to the list in 1991. The latter two conditions may be classified under "Other Health Impaired," "Learning Disability," or "Emotional Disturbance," depending on the most debilitating symptoms. IDEA also required that IEP recommendations include "assistive technology" (alternative communication devices, occupational health assessments, and so on), "transition (to adulthood) services" (vocational training, rehabilitation, skills of daily living), and counseling where indicated. Finally, in 1997, IDEA was amended (PL 105-17, "IDEA 97") to include the following important additions: increased parent and student involvement in the IEP process, an emphasis on *inclusion* of special education students in the regular classroom setting, the need to plan for "transition services" beginning at age fourteen, focus on *positive behavioral strategies* in the classroom with a clear and consistent policy on discipline and consequences, and the option to wave retesting at the triennial review.

Note: An Individualized Program Plan (IPP) is similar to an IEP, applies to children and teens with developmental disabilities, and focuses on vocational and adaptive behavior strategies for those with cognitive limitations.

EXHIBIT 32.1. DETERMINING SPECIAL EDUCATION ELIGIBILITY.

(The categories listed below are general, and each state will have specific criteria to meet eligibility.)

1. DISABILITY CATEGORIES:

   Does the child have *one or more of the following types of disabilities* (documented by a psychiatric or medical evaluation/diagnosis, or educational/ psychological testing)?

   ➤ Autism (AUT)

   ➤ Deafness (D)

   ➤ Deaf-Blindness (DB)

   ➤ Emotional Disturbance (ED)

   ➤ Hearing Impairment (HI)

   ➤ Mental Retardation (MR)

   ➤ Multiple Handicapped (MH)

   ➤ Other Health Impairment (OHI)

   ➤ Orthopedic Impairment (OI)

   ➤ Speech or Language Impaired (SLI)

     ○ Articulation Disorder

     ○ Fluency Disorder

     ○ Language Disorder

     ○ Voice Disorder

   ➤ Specific Learning Disability (SLD)

   ➤ Traumatic Brain Injury (TBI)

   ➤ Visual Impairment (VI)

   Note: Students with ADHD may receive IDEA services under SLD, OHI, or ED categories, depending on the clinical presentation and degree of impairment.

2. If one or more of the above disabilities is present, is the child *making effective progress in school?* If the student is being *re-evaluated* to determine if a disability is still affecting the child, would he/she continue to make progress in school without the currently provided special education services?

3. Is any lack of progress a *result of the child's disability?*

4. Does the child *require specially designed instruction in order to make effective progress in school* or does the child require related services in order to access the general curriculum?

Source: Adapted from Bostic and Bagnell, in press.

Mattison described the characteristics of 169 consultations performed during consultation to special education classrooms (Mattison, 2001). The vast majority of referred students were performing poorly academically. Questions from teachers included establishing a psychiatric diagnosis (56%); helping with classroom management strategies, especially for externalizing behaviors (51%); clarifying medication doses and need for medication (32%); recommending placement (31%); helping in understanding family issues (6%); and whether or not a child had a learning or language disorder (2%). Among diagnoses made, ADHD was the most common (79%), and 56% of the entire sample was classified as Learning Disabled. He recommends that the school consultant conceptualize the ED/SED (Emotionally Disturbed/Severe Emotional Disturbance) Classroom as a sort of "therapeutic day school," as these students tend to be the most psychiatrically ill among their peers in any community. Also, the graduation rate for SED students at about 40% provides further evidence for the need to have child psychiatrists in the milieu.

Tables 32.2 through 32.8 itemize some classroom-specific therapeutic techniques, based on recommendations from teachers and mental health experts.

Let us now turn to the work by various investigators that has shown empirical effectiveness. In a ten-year research review, Hoagwood and Erwin (1997) identified sixteen studies of school-based mental health services that met criteria for rigorously designed outcome studies (defined as use of random assignment to the intervention, inclusion of a control group, and use of standardized outcome measures). The three types of interventions that had the most empiric support were teacher consultation (TC), cognitive behavioral therapy (CBT), and social skills training. Positive outcomes were also associated with art therapy and relaxation training. TC intervention studies examined the effects of behavioral consultation on pre-referral (to special education placement) practices and reductions in problematic behaviors, and demonstrated positive results (Fuchs & Fuchs, 1989). Effective CBT approaches included those that focused on the prevention of affective disorders, the tertiary treatment of depression in the schools, and the prevention of drop-outs.

Clarke and associates (1995) examined 150 teens at risk for developing depressive disorders, who were randomly assigned to either a fifteen-session cognitive group prevention intervention or a control condition. Results strongly favored the prevention group, with affective disorder incidence rates of 14.5%, compared to 25.7% for the control group (Clarke et al., 1995).

Reynolds and Coats (1986) demonstrated statistically significant reductions in depressive symptoms on both self-report and clinical interviews during their intervention with thirty depressed high school teenagers. Random assignment was made to one of three interventions: CBT, relaxation training, or wait-list control.

TABLE 32.2. CLASS INTERVENTIONS FOR ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD).

Elementary/Middle School

Inattention/Organizational difficulties
—Encourage firm policies such as, "Class participation is not optional."
—Be ready to closely monitor ADHD students for several months.
—Recommend a full line of organizational materials, and be prepared to teach students how to use them; encourage them to be creative with the art/design on its covers to make it uniquely "theirs."
—Systematically teach students to enter assignment information on calendars and memory joggers.
—Put list of materials needed for class on student's book.
—Have student keep separate set of classroom materials (such as pencil, paper, even texts whenever possible) in desk, with another set at home.
—Affix/Tape pen/pencil to desk.
—Place seat in location that limits distractions.
—Give signal for instructions (for example, "Sammy, when I squeeze your shoulder, you need to pay attention to the directions.").
—Have student repeat directions back to teacher.
—Provide check-in points during lesson (for example, every third problem).
—Use a timer to clarify time for task.
—Provide untimed tests or assignments.
—Provide information in small chunks.
—Pair preferred, easier tasks with more difficult ones.
—Provide visual cues to signal return to on-task behavior.
—Diminish external distractions. (Provide headphones, tennis balls on chair legs.)
—Provide temporary stopgap measures when necessary.
—Purchase a small supply of emergency materials.

(". . . consider the purchase of extra pencils and a stack of notebook paper as an investment in stress management," Guyer, 2000, pg. 72)

—E-mail assignments to home.
—Consider home-school notebooks as a form of daily sign-offs/communication for parents and teachers.
—Encourage a class lesson that is not contingent on successful completion of last night's homework.
—Reward any efforts in positive direction, and provide continued encouragement and immediate feedback whenever possible.
—Examples include public praise, such as, "I like the way Joey is sitting up and looking at the board."

Middle/High School

Inattention
—Place the student close to the teacher's desk.
—Present the material in several different media (chalkboard, overhead, pictures, video, small group discussions, and so on).
—Do not be critical of the student in front of his/her peers.
—Use a "buddy" system for peer-to-peer help, when appropriate.
—Give the student only one assignment at a time.

(Continued)

TABLE 32.2.   CLASS INTERVENTIONS FOR ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) (CONTINUED).

—Consider formal attention training, using cassette tapes with tones at regular intervals to remind the student to pay attention.
—Try shortening assignments, or giving extra time to complete assignments.
—Partial (predictable and time-dependent depreciable) credit should be given for late assignments.
—Build as much structure into the class as possible.
—Have one location for completed assignments to be placed, and established routines/schedules for the class day.
—Post expected assignments for the day/week in the same place.
—Allow student to audit class or attend previously before taking for credit.
—Call on student often.

Distractibility
—Suggest the use of earplugs if noises are distracting.
—Seat the student where it will be easy to get her back on task, and next to students who are relatively quiet.
—Give regular, positive feedback.
—Reward the student for attending. (Allow for tic-tac-toe, doodling, a quiet computer game.)
—Assign work that can be done independently.
—Encourage and provide opportunities for leadership when possible (handling out papers, going to main office for errands).
—Use nonverbal means to help the student focus.

Disorganization
—Encourage discussion of the lack of organization that you've observed.
—Get the student to admit that lack of organization is a problem.
—Send home a week's/month's worth of assignments at a time.
—A planner is key; encourage artwork/stickers/political statements to make the planner uniquely "theirs," and not merely a suggestion of adults.
—Partner with parents in helping the teen get organized at home as well.
  —Put a schedule on the disorganized student's door.
  —Select clothes for the next day before going to bed.
  —Put everything going to school at the front door before going to bed.
  —Be as specific as possible, and help to create the "action plan." (For example, "Clean out your desk" is less helpful than "Take out all the candy wrappers and crumpled papers from your desk.")
—Strategically plan study hall period to derive greatest benefit (such as at end of day, just after lunch, or first period).
—Schedule A.M. check-in and P.M. check-out to organize for school day and for homework.
—Allow extra time between classes for transition, or to organize backpack or locker.
—Increase frequency of feedback to both student and pupil in selected classes.
—Establish a regular parent conference frequency.
—Allow for parent input on selection of following year's teachers.
—Use praise as a reward as much as possible.

TABLE 32.2. (CONTINUED).

—Acknowledge your own disorganization (we all have some), and find ways for the teen to give you helpful hints.

Specific Test-Taking Modifications
—Allow for extra time.
—Arrange for short breaks during tests.
—Permit student to retake tests.
—Allow for alternate test room or day.
—Let student show competence through an alternate modality, such as an oral report or exam.
—Use short, frequent quizzes instead of long tests.
—Provide computer access during essay exams.
—Consider open book or take-home exams.
—Consider approved notes as prompts for recall during test.

Hyperactivity/Impulsivity (all ages)
—Devise behavioral contracts clarifying classroom expectations/alternatives.
—Arrange for/encourage exercise before class.
—Reinforce quiet behaviors with verbal praise.
—Provide a competing response for motoric activity (squeezeball, fabric to rub, finger exercises).
—Identify times and places student can move about within the class, and outside class (for example, take attendance sheets to office).
—Use movement as a reward.
  —If the student is quiet for a certain period of time, he will be rewarded by being able to use the computer, move around the room, or perform an errand that involves leaving the classroom.
—Provide cues to signal stop talking, and identify later opportunity to talk.
—Encourage cognitive behavior strategies, such as asking, "And what are you supposed to be doing right now?" to encourage self-monitoring.
—Clarify volume and activity level expectations before attempting games or less structured activities.
—Assign a specific place for student to stand, or a specific student to stand next to in line.
—Rotate active periods with inactive periods.
—Have student write down an answer before she raises her hand to answer aloud.
—Allow for non-disruptive calming techniques, such as listening to classical music with headphones on.
—Have student identify other students who are "ready."
—Establish waiting routine. (Count to five, then raise other hand.)
—For teens, consider allowing gum chewing in class. Guyer (2000) reports that when she allows it, the mouths moving with gum tend to talk less, and there is less body movement. Use guidelines about no popping, sticking under desk, and so on.
—Brainstorm, especially with teens, about innovative ways to quietly expend energy (repeated leg lifts, stretches in the back of the classroom).

Source: Adapted from Rief, 1993; Robin, 1998; Guyer, 2000; and Bostic and Bagnell, in press.

TABLE 32.3.   MOOD DISORDERS.

—Educate teachers and staff about mood disorders and CBT principles for addressing symptoms.
—Establish check-in plan to clarify mood status during school day.
—Connect academics and interests to increase motivation (such as reading an alternative novel, summarizing a current news event for the class).
—Base grade on work completed/attempted rather than expected, and allow for partial credit when work is turned in late.
—Break assignments into small, easily completed segments.
—Attempt opportunities for student to "fix mistakes" when work doesn't meet expectations.
—Start student's school day later or earlier consistent with student's circadian rhythm.
—Encourage snacks and exercise to minimize weight changes and improve energy.
—Provide a time and place beforehand to regroup if weepy, fatigued.
—Attend extracurricular clubs and activities to increase peer connections.
—Tape-record lectures.
—Identify activities student does more/less when mood is improving/worsening.
—Narrow choices to two when student becomes indecisive.
—Establish hierarchy of people to contact if student reports suicide ideation.
—Devise safety plan for crisis situations.
—Acknowledge student's feelings rather than dispute or argue feelings.
—Identify "evidence" surrounding negative perceptions of self or events.
—Reinforce efforts in the correct direction (such as "Wow, you did get half these problems done.").
—Focus on successive approximations toward goals (such as being able to stay in class twenty minutes today without crying).

Source: Adapted from Bostic and Bagnell, in press.

TABLE 32.4.   ANXIETY DISORDERS.

Devise protocol to diminish anxiety in classroom/school

—Educate teachers and staff about anxiety disorders and CBT principles for addressing symptoms, such as encouraging positive self-talk and problem solving.
—Provide steps student may take to relax (deep breathing, counting to ten, visualization).
—Provide alternative foci to distract from somatic symptoms (such as "mantras," calming activities).
—Identify safe place in school to de-escalate anxiety symptoms and guidelines for appropriate use.
—Model appropriate behavior in anxiety-provoking situation.
—If avoiding school, address cause and initiate immediate plan for return; may require gradual reintroduction.

Specific Phobias
—Identify desensitization approach agreeable to student.
—Identify alternatives to unnecessary exposure to phobic stimulus.

Social Phobia
—Identify staff person or peer to meet student on arrival.
—Modify stressful social situations (such as, eat lunch in small group, practice speaking one on one).

TABLE 32.4. (CONTINUED).

—Encourage small group interaction, areas of competency.
—Avoid singling student out in classroom setting.

Separation Fears
—Identify staff person to meet student on arrival.
—Provide times for student to convey messages to family.
—Identify hierarchy of safe persons for student to access if parent unavailable.
—Have parent send notes to student to read as reward for staying in school.

Panic Attacks
—Identify relaxation ritual (breathing exercises, positive visualization).
—Establish parameters for meeting/measurements by school nurse.

Obsessive-Compulsive Symptoms
—Educate teachers and staff about DRO (Directed Reinforcement of Other Behaviors), and other CBT principles for OCD.
—Establish acceptable teacher comments to "unstick" student when obsessing.
—Personify obsessions and provide steps for student to resist uncomfortable thoughts.
—Allow student to dictate/tape record if cannot touch pencil or paper.
—Allow alternative activities if student cannot initiate particular task.
—Allow student to alter sequence of work (start on even-numbered problems, from end).
—Identify less school-intrusive compulsive behaviors (such as touching surface under desk to "short-circuit OCD").

Post-Traumatic Stress Disorder
—Avoid unnecessary exposures to evocative stimuli.
—Provide alternative schoolwork (such as a different story, film) to avoid eliciting past trauma.
—Identify cues (nonverbal, simple phrases) to signal student when shutting down.
—Follow general hints under Anxiety Disorders (above).

Source: Adapted from Bostic and Bagnell, 2004, and March and Mulle, 1999.

TABLE 32.5. EATING DISORDERS.

—Help teachers and school staff be knowledgeable about the particular eating disorder, and encourage flexibility in both scheduling and types of food allowed in class/school.
—Identify student-acceptable comments that classroom personnel (teachers, aides, pupils) can employ during eating periods.
—Allow student to eat in more comfortable setting (for example, with a teacher or counselor, in a particular classroom away from peers if necessary, leaving campus to eat with a parent).
—Allow for eating or snacking while doing other activity (while reading, during P.E.).
—Allow student to go to bathroom before eating, and remain in classroom/activity for a specified time (for example sixty minutes) after eating.
—Identify alternative foods or snacks available for student if certain foods are unattractive.

Source: Adapted from Bostic and Bagnell, in press.

TABLE 32.6.   CONDUCT DISORDER/OPPOSITIONAL DEFIANT DISORDER.

—Make each student feel welcome in the classroom.
—Start each lesson with enthusiasm.
—Take time to connect with each student.
—Take a disability perspective, and remember where these kids have trouble:
  —Processing information when frustrated.
  —Recognizing and communicating their frustrations appropriately.
  —Using effective problem solving and conflict negotiation skills.
—Focus on developing "thinking skills" for handling frustration more adaptively.
—Provide student opportunities to describe her perception of events (for example, write out incident).
—Avoid use of "standards" writing as punishment ("I must not curse at teachers" fifty times).
—Provide choices in completing tasks (such as, doing problems in different order).
—Identify alternative acceptable behavior.
—Be on the lookout for neutral or good behavior, and praise appropriately.
—Devise consistent cues or language (such as "reading time") to redirect student.
—Fix the problem rather than affix blame.
—Use incentives before punishments.
—Anticipate and *plan* for misbehavior.
—Reward appropriate behaviors at multiple intervals during the school day.
—Project alternatives and consequences with student.
—Effective praise is

  Immediate, contingent on desired behavior, specific (describe behavior of student), and *credible* (personal, sincere, and focused on improvement).

  "Praise will only be effective if the student believes that it is true."
  (Applebaum, 2001, p. 63)

—Identify good efforts even if ultimately behavior is unsuccessful.
—Remove the audience or the student if escalations emerge.
—Role-play alternative responses and plan for what to do "next time."
—Allow student to fix mistake (for example, following property destruction).
—Enlist friends and family to help student get to school.
—Identify where school may contact student if not in school.

Important *do nots*
—Return the anger.
—Avoid the student.
—Think the student is "spoiled."   n!,
—Walk on "eggshells."
—Be logical with an out-of-control student.
—Attempt to reason with an out-of-control student.
—Repeat your requests or commands more than once or twice.
—Use negatives when upset. ("How could you do something so stupid? How could you be so sneaky?")
—Be inconsistent.

  "Grant freedom within limits. Stay in charge. You're the teacher." (Applebaum, 2001, p. 42)

Source: Adapted from Applebaum, 2001; Bostic and Bagnell, in press.

TABLE 32.7.   PSYCHOTIC DISORDERS.

—Identify and avoid distressing stimuli.
—Allow alternative activities or content to avoid provoking delusions.
—Provide grounding activities (such as working with hands, non-emotional reading
   content).
—Devise steps to employ when delusional (for example, when paranoid, check in
   with teacher who provides safe/code words agreed to beforehand).
—Provide hierarchy of safe places to de-escalate if overstimulated.
—Identify safe subjects to discuss when delusional or hallucinating.
—Establish non-frightening protocol to respond to delusions or hallucinations.
   For example, (1) Change topic, (2) Change activity, (3) Change setting or room,
   (4) Involve additional, safe, familiar staff, (5) Access other stabilizing adult
   (counselor, parent), (6) PRN medication.

Source: Adapted from Bostic and Bagnell, in press.

TABLE 32.8.   PERVASIVE DEVELOPMENTAL DISORDERS.

Communication
—Use one- or two-word command prompts (such as "laces" and then "shoes"
   instead of "Now tie your laces on top of the shoes.")
—Facilitate language use: model appropriate phrases with visual cues, match words
   to gestures.
—Structure situations to encourage language use.
—Provide pictures that allow communication for students to point to.
—Build social and emotional awareness: facilitate two-way communication by
   teaching awareness of others' thoughts or feelings, clarification of literal
   interpretations, and understanding of humor and jokes.

Social Interaction
—Identify situations in which the student can work with another student(s).
—Practice social acts in role-play with clearly outlined steps.
—Use a peer or adult to help student interact with others.
—Provide explicit teaching about how to start conversations, respond to other's
   comments, and end conversations.

Restrictive Routines/Interests
—Provide alternative tasks, particularly when sensory overloaded.
—Prioritize target behaviors (such as safety first).
—Identify more appropriate "one step up" routines (for example, pilot video game
   to replace violent combat video game).

Source: Adapted from Bostic and Bagnell, in press.

TABLE 32.9. NONVERBAL AND SOCIAL COGNITION DISORDERS.

—Provide written material that is visually clear and simple.
—Allow more space and time for physical activities.
—Consider allowing the use of favorite restricted interest (Fantasy games, Pokemon cards, Anime, and the like) as incentives for adherence to a behavior plan.
—Recognize literal interpretations and explain multiple meanings of words/phrases.
—Point out generalizations that can be drawn from assignments.
—Verbally emphasize similarities, differences, and connections between past and current assignments.
—Provide a verbal map of the school the student can use to find rooms.
—Assist, simplify, or break down motor tasks such as using scissors.
—Rehearse transitions between classes.
—Specify daily routine, and use social stories when deviating.
—Allow the student to ask the two most important questions to begin work, and then check in after the student begins the assignment.
—Provide index cards to cover up written material unnecessary to immediate task.
—For those with very poor writing skills, focus on (and consider grading) readability rather than neatness.
—When necessary, limit handwriting and provide alternatives, such as computer typing and tape recording.
—Provide enlarged print tests, and extra space for handwritten answers.
—Provide directions in writing as well as verbally to connect modalities.
—Provide direct social skills instruction, and role-play appropriate social interactions.
—Provide direct instruction about what is communicated through facial expressions, intonation, gestures, and other mannerisms.

Source: Adapted from Bostic and Bagnell, in press.

Prominent symptom reductions were seen in both treatment groups, but not in the controls (Reynolds & Coates, 1986).

Rosal and colleagues (1993) examined thirty-six students in grades four through six with moderate to severe behavioral problems, and demonstrated significant functional improvement for those children who received either CBT or art therapy, compared to a group that received no therapy. Improved adaptive behaviors were demonstrated by use of the Connors Teacher Rating Scale, though none of the three groups showed any changes on measures of locus of control, pre- and post-intervention (Rosal, 1993).

Social skills training programs that have empiric support were those that focused on school adjustment and substance use problems. Bierman and colleagues (1987) were interested in developing a program to help socially rejected and negative boys become more socially and functionally adaptable. Boys in grades one through three who showed highly negative social behaviors were randomly assigned to one of four conditions: instructions and coaching in positive behaviors, prohibitions and response cost for negative behaviors, a combination of instructions and prohibitions, or no treatment. The interventions took place

over ten sessions, which were thirty-minute, supervised, small group play sessions. Treatment effects were assessed using behavioral observations and teacher/peer ratings. The most robust effects were for boys receiving the combined program, who showed immediate post-treatment decreases in negative initiations, later decreases in negative peer responses, and stable positive peer interactions. This project showed both functional improvement and symptom reduction (Bierman, Miller, & Stabb, 1987).

Thorkildssen (1985) randomly assigned children in six elementary school special education settings to participate in an interactive videodisc social skills training program, or to continue in their resource room programs. Results showed significantly greater improvements for the experimental group on measures of peer acceptance.

Dupper and Krishef (1993) examined the effects of a social skills cognitive training program on locus of control for sixth and seventh graders with behavior problems. Significant differences were observed, favoring experimental over control groups on locus of control measures (functioning) and on teacher ratings of self-control (symptom reduction).

Henderson and colleagues (1992) examined locus-of-control orientation, self-concept, and appropriate coping skills development among sixty-five children from an inner-city school. The students were randomly assigned to a stress management group or control group, with the stress management group showing higher scores on measures of self-concept, and a more internal locus of control.

Lochman and colleagues (1993) examined the effect of social skills training program with aggressive, non-aggressive rejected, and rejected African-American children. Random assignment was used for selection to experimental or control group. Post-treatment and one-year follow-up studies showed the most improvements on non-impulsive problem solving for the aggressive and the rejected children, but not for the non-aggressive rejected group.

Most recent studies have looked at CBT interventions (with and without medication) specifically for anxiety and depression. Ginsburg and Drake (2002) evaluated the effectiveness of a manualized ten-session CBT group intervention for African-American teenagers. Twelve adolescents were randomly assigned to either CBT (n = 6) or a group attention-support control condition (n = 6). Post-treatment results showed that self- and clinician ratings of anxiety were significantly less in the CBT-treated group than in the control group. Teens in both groups reported lower rates of social anxiety at the end of the intervention (Ginsburg & Drake, 2002).

Bernstein and colleagues (2000) found that imipramine plus CBT was substantially more effective than placebo plus CBT for school refusal in an

eight-week prospective randomized double-blind trial with sixty-three subjects participating (and forty-seven subjects completing). Subjects' mean age was 13.9 +/−3.9 years, and ethnic composition was 90% white, 8% African-American, and 2% Hispanic. Readers are encouraged to consult a recent comprehensive review of research on school refusal by King and Bernstein (2001), for further discussion of this topic.

For depressive disorders, work by Lewinson and associates (1990) and Gilham and associates (1995) have shown the effectiveness of CBT, and Freres and colleagues (2002) have demonstrated that a manualized CBT intervention can be useful for *prevention* of depressive symptoms in an at-risk population. The Penn Resiliency Project (PRP) utilizes a twelve-session twenty-four-hour manualized protocol, and it has recently added a parent component, the PRP for Parents Freres et al. (2002). The latter is a six-session, nine-hour manualized treatment in which parents are taught the core skills that their children are learning, but at an adult level. This manualized treatment is well-suited for school settings. Currently, a large scale NIMH-funded study is examining this treatment (parent plus child) versus the child-only version and a usual care control.

Mattison (2000) reviewed literature pertaining to four specific issues that consultants often get asked about: absenteeism, disciplinary referrals, retention, and dropping out. The summary of recommendations that consultants should consider is as follows:

Be attentive to excessive absences, frequent disciplinary referrals, signs that a retention recommendation is imminent, and focus on the underlying reasons.

Encourage early identification, specific diagnosis (preferred to the term "labeling"), and tailored treatment planning with sustained involvement of school staff.

Establish objective "at-risk" parameters and evaluate high risk students for which interventions are most appropriate for them.

Help the district choose an efficient screening instrument (or help them design one). It should include academic, behavioral, and family components. One suggestion by Mattison is the Critical Events Index and the Adaptive and Maladaptive Rating Scales of the Systematic Screening for Behavioral Disorders (Walker and Severson, 1992). A Child Behavior Checklist may be sufficient (Achenbach, 1991), as it also includes family and teacher components.

Help with implementation, ideally through the auspices of the SST or IEP.

Help the school staff intervene with the child, and be as specific as possible with what it can provide (versus simply referring to community resources).

"Ideally, a mental health team will emerge with whom the mental consultant can then collaborate." (Mattison, 2000, p. 412)

Recent work by Kataoka and colleagues (2003), Stein et al. (2002, 2003), and Jaycox (2003) have nicely demonstrated how CBT-oriented mental health programs may be developed specifically for certain populations (traumatized Latino immigrant children, for example), and then developed into a manual for broader use, also with empiric support (Jaycox, 2003; Kataoka et al., 2003; Stein, Jaycox et al., 2003; Stein, Kataoka et al., 2003; Stein et al., 2002).

Violent Students and Threat Assessments

Though the above scenarios represent the most frequent reasons for consultation, more and more, assistance is being sought from consultants regarding students' capacity to do harm to others. Rappaport (2000) presents a list of important considerations when making a threat assessment:

- Sharing responsibility is key. Psychiatrists acting alone deprive themselves and their consultee of crucial collaboration.
- Consultants must be aware of those adolescents who may be marginalized and have low frustration tolerance, yet not be the "Teenage Werewolf" (overtly externalizing, not subtle about their agitation). Though the marginalized may be more subtle in their presentation, they may still be capable of lethal violence.
- Help staff navigate the tasks of correctly estimating a student's harm potential, while being able to appropriately assess their own biases. One example is the troubled school athlete whose violence potential is overlooked, and about whom staff are overly optimistic due to their own investment in the student's potential school contributions. The opposite reaction can occur in response to overt verbal expressions of anger by a teen. Staff must be helped to differentiate normal frustration from potentially dangerous remarks. To not do so impairs useful student-staff relationship building.
- Students must be given an opportunity to give their perspective on events. Rappoport recommends an approach that overtly seeks a better understanding of the teen by the interviewer, in order to minimize perceptions of interrogation. Also, information to be shared with school personnel should be done with adolescent permission whenever possible.
- Key to the role of consultant is the aspect of providing an understanding, non-judgmental sanctuary for school staff. They should feel at ease enough to

be thoughtful and reflective, while the consultant supports their thinking and working through difficult situations (preferably aloud). As these situations are often very complex and the stakes high, clarity is critical. Rappoport concludes by referring the reader to James Garbarino's *Lost Boys* (1999), and by encouraging consultants to use their roles to advocate for systemic interventions that can make children and teens more resourceful. Some of these include the encouragement of parent education, of bully-proofing schools, and of making certain that structured extracurricular activities and mentoring exists (Rappaport, 2000).

"As collaborative consultants, we can assist in creating a safe learning space for students and staff, and share responsibility and contain affect so that educators can make good decisions."
(Rappoport, 2000, p. 165)

Twemlow warns of a covert power dynamic (PD) that pervades all schools that experience violence (Twemlow, Fonagy, & Sacco, 2001). This PD is in reference to an overt or covert pattern in which an individual or group controls the thoughts or actions of others. The environment in school reveals this PD through high levels of disciplinary referrals and poor academic achievement. He advises that consultants ought to thoughtfully and carefully help school staff become aware of this PD in a way that does not demean or bully them. Examples include non-coercive discipline plans, creation of an awareness and zero-tolerance of the bully-victim-bystander cycle, using peer mentors and adult volunteers on school grounds for conflict resolution outside of the classroom, and utilizing physical education time to practice appropriate role-plays in conflict resolution. Goals of this sort of teaching include the softening of the power dynamic, while restoring a more peaceful and less humiliating climate to the school (Twemlow et al., 2001).

Diverse Roles for Consultants

Other authors have promoted the use of school consultants as direct implementers of psycho-education programs targeted toward prevention of violence, substance abuse, suicide, teen pregnancy, and sexually transmitted diseases (Walter, 2001), as consultants during crises (Arroyo, 2001), and as consultants to boarding schools (Gottlieb, 2001), as consultants to schools in rural communities (Adelsheim, Carrillo, & Coletta, 2001) and as consultants to facilities on remote islands (Campo, 2001). Others have examined consultation in large urban districts (Wang, 2001), to school administrators (Blader & Gallagher, 2001) and to schools of education (Berkovitz, 2001). These and other outstanding contributions to the school consultation literature appear together in a volume edited by Berkovitz (2001), and include a comprehensive review of current models of consultation and of successful school mental health centers (Rappaport, 2001).

The Stanford School Mental Health Team

Within the Stanford University School-based Mental Health Service, we have brought together the disciplines of child psychiatry, psychology, education, and pediatrics to try and best address the needs of several different school settings. As a consultation service, we are contracted with an organization that specializes in serving children and teens with developmental disabilities. We also serve as mental health consultants to an entire school district, with two high schools, three middle schools, and ten elementary schools. And through grant support, we work with a relatively poorer school district in targeting interventions that focus on youth development through life skills, group process, substance abuse education and violence prevention, and on prevention of "teacher dropout/burnout" through teacher and staff consultation. We shall describe our work with the school districts in more detail in the following sections.

Relationship Building

The initial part of our work in all districts begins with several months of relationship building. Through regular meetings with front line teachers and senior administrative officials, we first try to get a sense for what the strengths and limitations are of the school environment as a whole, and of the current mental health services specifically. In each of the communities that we serve, we believe that the school-based approach affords a unique opportunity to work with youths in the context and setting of their daily lives. Our team uses a culturally informed resiliency approach that focuses on the inherent strengths of consultee, student, and system. According to the resiliency model, schools can offer children experiences that enhance their self-esteem and competence, thereby reinforcing resilience (Brooks, 1991, 1992; Curwin, 1992; Rutter, 1985, 1987; Zunz, Turner, & Norman, 1993). Although the work of the School Mental Health Team is school-based, all of us work as clinicians in a university-based clinic as well, and many of us work with trainees (psychology interns, adult psychiatry residents, or child psychiatry fellows). We try to emphasize the importance of school in a child's life for and with our trainees by taking a thorough school history for clinic-based patients as well, and to assist parents, teachers, and staff to remember the resiliency and strengths of each child for whom consultation is being sought. Clearly, consultants are not sought out because things are going well, and this must be acknowledged from the start. However, a paradigm shift from looking at all referred behaviors as strictly maladaptive can be refreshing, and can also provide the team with new ways of looking at old problems. Examples include asking questions in ways to find out about strengths. When taking the school

history from a referred client, for example, rather than asking, "How do you do in school?" we prefer to ask "What do you like in school?" or "What are you *good at* in school?" A response such as "recess" or "lunch" or "P.E." is answered back with, "Oh really? What is it about *fill in favorite non-academic period here* that makes it your favorite?" opens doors and builds a rapport in ways that parentified questions do not ("What kind of grades do you get?" "What's your teacher's name?"—both of which are important questions, but are not necessarily alliance-building).

Many of the schools we consult with have a large population of immigrant and refugee children. Guarnaccia and Lopez (1998) have highlighted some of the crucial issues regarding school services and the mental health needs of these youths and their families. Their recommendations are summarized as follows:

1. Pay special attention to the assessment of second language acquisition, not only for immigrant children, but also for children growing up in bicultural households.
2. Recommend culturally informed family interventions that will address the intergenerational tensions that often exist within immigrant families.
3. Promote teacher training to best understand and work with linguistically and culturally diverse children. Schools are uniquely poised to promote the value of cultural diversity and to counter prejudice against newly arrived students.
4. Help staff understand the special needs of immigrant parents in negotiating the complex systems of special education assessment.
5. Help staff to recognize the high levels of academic motivation among some immigrant parents as a valuable resource for their children and for the school.

Our Approach

We have found that a five-step process has worked well for us, and is similar to Mattison's seven-step model (Mattison, 1999). It works best with school districts that have the infrastructure to support a mental health team at the school.

1. A consultee initiates a question through the school psychologist, who then contacts the attending psychiatrist by e-mail. An intake packet is then sent to the parent's home, which contains information about our service, consent for evaluation and treatment, and several questionnaires and measures of childhood functioning. These include a qualitative target symptom questionnaire for parents and children, Child Behavior Checklist (CBCL), Parent Stress Inventory (PSI), Columbia Scale of Functioning (CSF), and Family Assessment

Device (FAD). We believe the relationship starts with the packet—it must be easy to read, appropriate for the education of the parent (we modify the measures based on parent literacy level), and sent out in a timely fashion.

2. Next (after the packet has been filled out and returned, with a signed consent form to evaluate and treat), a call is placed to the parents and an e-mail message sent to the school psychologist and teacher to clarify the consultee questions in more detail. An initial school visit is scheduled. The goal is to meet with the teacher and other important staff in the classroom, and to observe the child in class (elementary school), or schedule an interview (middle or high school) with the student.

3. After this meeting, initial feedback is given to parents by phone, and to staff by e-mail, and a second child interview is scheduled, preferably within the next one to two weeks. Further history is obtained from the parent, and both teachers and parents are given (short) supplementary forms to fill out, which may be more specific for suspected conditions, such as a Connor's questionnaire for ADHD, Multidimensional Anxiety Scale for Children (MASC) for anxiety disorders, or a Children's Depression Inventory (CDI).

4. The second and third sessions are conducted with the youth, and impressions are shared with the consultee. Differential diagnoses are considered, and a formulation is constructed with the consultee based on the information known. At times, an evaluation known as a functional behavioral assessment (FBA) may be warranted. This can be an important tool in understanding the reasons for a particular problem behavior. FBAs are typically done by a clinician with specialized training in such assessments. For useful resources on this tool, see O'Neill, et al. (1997), and McComas, Hoch, and Mace (2000).

5. The data are presented orally to the parents, either in person (preferred), or over the phone. In our experience, the feedback often takes place in front of an IEP or SST team, as the initial consultation may be urgently requested in order to plan appropriately. In this case, it is especially crucial to give parents some clinical impressions prior to the meeting, in order to minimize surprises at the time of the actual meeting. Written summaries are provided if requested. Our recommendations always include timelines to closely follow up our treatment plan, especially when recommendations are made for community resources. Often, families prefer to have us become the providers of treatment, given that we have begun a relationship with them and their child/teen. Though medication management is what we are asked to do most frequently, we also provide individual treatment with various psychotherapies, employing manualized therapies such as those by Kendall, Jaycox, or Mufson whenever available (Jaycox, 2003; Kendall, 1992; Kendall, Choudhury, Hudson, & Webb, 2002; Mufson, Moreau, Weissman, & Klerman, 1993).

Funding Sources

Our team has a fee-for-service contract with the school district, and services are paid for through a combination of funding sources, one of which includes the federally funded "Safe and Drug-Free Schools Program." This program includes moneys given to schools and local providers to provide science-based prevention and early intervention programs to prevent violence and substance abuse in schools.

Adelsheim (2000) has proposed exploring the availability of other funds at respective local districts. These include the Federal "Medicaid in the Schools" program, which allows for schools to bill directly for services provided to special education students through their IEPs. City and County governments may have set money aside for "dropout prevention," and this money has been used to fund both consultative and direct services from child psychiatrists and other mental health professionals. Other sources of funding highlighted by Adelsheim include Title XI, a federal program that allows districts to use up to 5% of their federal education funds to coordinate services for schools. Some districts have combined these with county physical and mental health funds to create school-based health centers, which can also serve as training sites for adult psychiatry residents, child and adolescent psychiatry fellows, pre- and post-doctoral education and psychology students, and other mental health trainees.

Private foundations and federal grant agencies continue to be very interested in supporting innovative school intervention programs. Because the funding streams usually require outcome measurement, it encourages evidence-based practice while also promoting the development of new models. For a useful reference on granting agencies, see Stovell (1998).

Summary and Future Directions

Children and teens spend a good deal of their waking hours in school. Consultation about, and direct service to, students within the context and setting of their daily lives allows for greater staff and client empowerment, resiliency building, and both prevention and treatment of problematic behaviors and symptoms than similar services in an outside clinic. Many excellent models of school consultation and school-based health clinics exist, and recent papers have summarized these. We hope to continue to help train the next generation of psychiatric school consultants through involving mental health and education trainees from year one, and to promote continued research into the major issues of importance to school staff, students, and parents.

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Resources

http://www.schwablearning.org

A valuable online resource for families affected by learning disorders.

http://www.parentshelpingparents.com

User-friendly site for parents who want to know more about special education laws.

http://smph.psych.ucla.edu

Center for Mental Health in Schools is an outstanding online resource for school mental health specialists.

http://www.ericae.net/nav-lib.htm

Educational Resources Information Center Clearinghouse on Assessment and Evaluation (ERIC)—a useful source of information for all areas of educational, assessment, theory, and practice.

http://www.fape.org

Family and Advocates Partnership for Education (FAPE): Another useful resource for families and other advocates on the special education system.