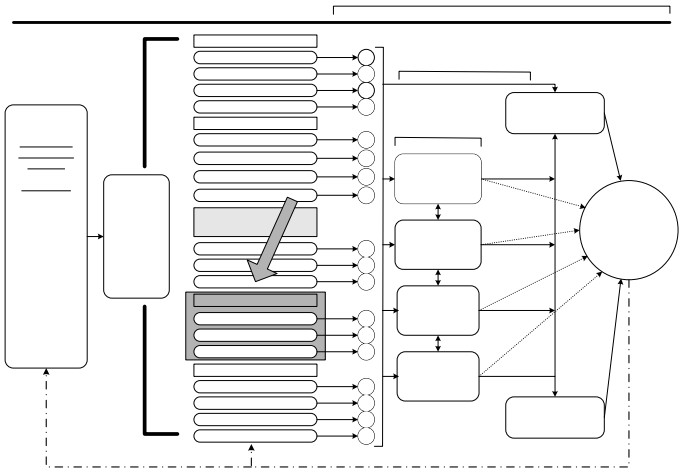
Health and Social Services

Introduction



It is important that all students come to school ready and able to learn because learning readiness is a prerequisite to school success and improvement. Unfortunately, some youth come to school who are not ready and able to learn. As described in the needs and resources assessment chapter, "non-academic barriers" often get in the way of creating the right conditions for students and families. Table 8.1 presents examples of these non-academic barriers to learning that must be taken into consideration within designing program and service strategies related to health and social services within the Ohio Community Collaboration Model for School Improvement (OCCMSI).

Table 8.1: Example non-academic barriers

Example child-related barriers	Example family-related barriers
• Schools are under-funded, in general • Mental health and/or physical health needs • Lack of coping and social skills • Insufficient sleep and nutrition • Learning challenges such as dyslexia • Repeated aggressiveness and violent behavior • Substance abuse problems • Juvenile delinquency • Others…	• Parent un- or under-employment challenges • Housing stressors • Family conflict • High family mobility rates • Parents' unmet mental health and/or physical health needs • Lack of social supports and a sense of isolation • Perceived racism and discrimination • Others…
Example peer-related barriers	Example community-related barriers
• Associations with gang involved peers • Associations with violent peers • Associations with others involved in criminal activities, substance use, etc. • Peer attitudes and beliefs related to antisocial behaviors • Others…	• Lack of recreational and/or social opportunities • Lack of community cohesiveness and collective efficacy • Lack of affordable quality child care • Air, water and environmental quality problems • Community antisocial norms • Availability of drugs and alcohol • Others…

Some of these barriers are health-related. Examples of health-related barriers include unmet dental and medical needs. Medical and dental services are two kinds of health services designed to meet these needs. Additionally, schools offer other health-related programs and services such as health education and promotion programs, including physical activity programs. They also offer nutrition programs because nutrition affects students' physical well-being, growth and development, readiness to learn and risk of disease (ODE School Climate Guidelines, 2004).

Other non-academic barriers to learning can be classified as social and developmental. These barriers include child abuse and neglect, domestic violence, substance abuse, mental health needs and family-related problems. Social services are designed to meet these needs.

Each school community confronts important issues regarding how to design, locate and operate its health and social services in order to address non-academic barriers to learning, academic achievement, healthy development and success in school. For example, important issues loom regarding the roles and functions social and health service providers can and should perform. For example, how much responsibility should schools assume for the provision of services? Which ones should be located at school? And, when social and health service providers are located at school, can they also assist with instructional planning for students under their care?

Important questions like these structure the discussion in this chapter. It is designed to help you and other school community leaders make good decisions about service design and delivery. It also is designed to ensure that social and health services become an integral component in school improvement. This starts with your understanding of the contributions these services can make to positive school climates, learning and academic achievement. It also requires that you and other school community leaders know why and how to connect service providers with classroom teachers.

What do we mean by health and social services?

Every student should come to school free of various kinds of barriers to their learning, academic achievement and healthy development. Unfortunately, many students are not free of these barriers. Health, mental health, social, cultural, economic and family barriers, individually and in various combinations limit some students' learning, academic achievement and success in school Further, they complicate the work of teachers, principals and student support professionals.

Health and social services are designed to address and prevent these non-academic barriers. They are often defined by who owns and operates them (Adelman & Taylor, 1998). School-owned and -operated services include student support professionals such as school counselors, psychologists, social workers and behavioral specialists. Community-owned and -operated services involve the providers and services that are located in the community. There also are government-based services, which include services provided by the government to provide financial and medical assistance.

Whether services are school- or community-owned, services offered at the school are called *school-based services*. They are available because the school's student supportive service staff (i.e., school counselors, social workers, etc.) provide them or because service providers have re-located these services to the school. In other words, these services are co-located at the school. With this arrangement, both educators and service providers may claim they are developing "full-service schools" or "multi-service schools." Your job is not necessarily to develop one of these schools.

Rather, your job is to ensure students have access to services, especially the services essential to learning and academic achievement. This requires an inventory; you and other leaders must determine which services students (and their families) need, including where they should be offered. This inventory also must address newly-developing needs and conditions, the gaps in existing services, and the opportunities to link schools with community agencies.

Services offered in the community, and in partnership with the school, are called *school-linked services.* Community-based service providers include juvenile justice officers, social workers, psychologists, pediatricians, dentists, child welfare workers and family support workers. These community-based and school-linked services necessitate referral mechanisms, communication networks, transportation assistance, and integrated service design strategies. They ensure that the school benefits, and at the same time kids and families are served effectively.

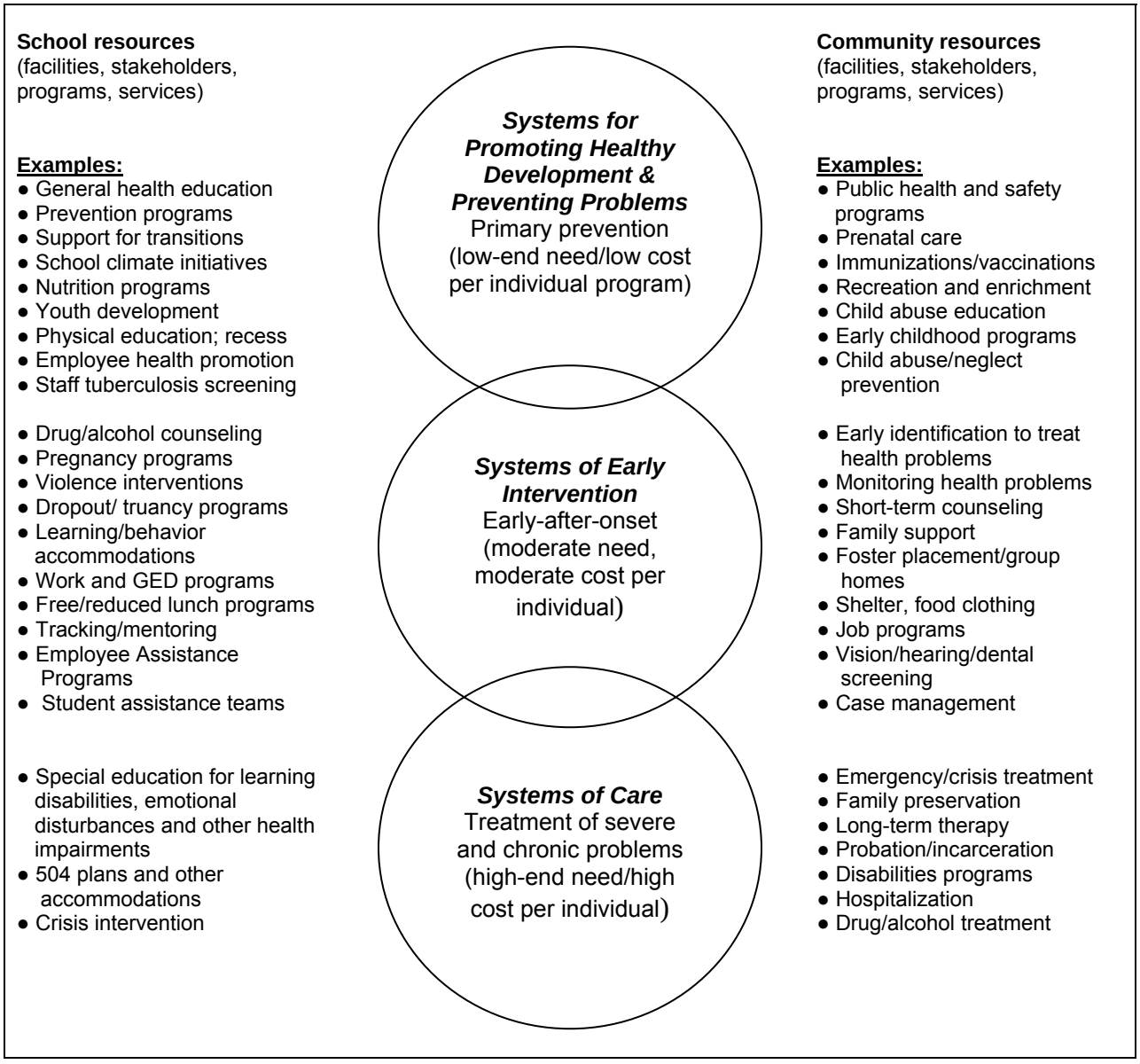
Figure 8.1 provides an overview of an expansive continuum of care related to the delivery of health and social services in schools (Adelman & Taylor, 1998; 2000a; 2000b; Browne, Gafni, Roberts, Byrne, & Majumdar, 2004). The continuum begins with primary prevention, health promotion, and youth development strategies targeted at the entire student population. It involves early intervention services directed toward targeted youth through the use of student assistance teams, school counselors, social workers, psychologists, and other support staff. It also includes more intensive interventions for youth with more critical problems and needs, and thus rely on important linkages to outside social and health service providers located in the community (particularly in relation to coordinated case management, accommodation plans, and individualized instruction).

Note that Figure 8.1 provides a dual inventory of school-owned and -operated and community-owned and -operated services; the aim is to maximize resources and avoid duplication. The key is to coordinate school-owned and -operated and community-owned and -operated services. It also is important to ensure the services offered at school are the ones students need in order to succeed in school. These services are the ones that target the various non-academic barriers to learning students bring with them to school.

Presently, too many teachers in too many of Ohio's schools confront daily students' non-academic learning barriers. Understandably, teachers are not prepared for the tasks at hand, and they do not want to be social workers, psychologists and nurses. However, they need help from these allied professionals and others. Teachers need this help to be "on call" – immediately available and responsive, much like the 911 system employed by police departments.

By necessity, educators and their community partners must develop a comprehensive, coherent, cohesive and feasible plan and system for getting services to teachers, students and families in need. Only then will they ensure that no child is left behind; and also that educators, especially classroom teachers, do not have to confront students' non-academic barriers alone – without sufficient services, supports, assistance and resources.

This continuum of services, while important, is simply an overview for your planning and development. The more important issue is whether services are effective, i.e., whether they improve outcomes by minimizing, removing and preventing non-academic barriers to learning, healthy development and academic achievement. The next section highlights the outcomes that are associated with school-based and/or -linked services health and social services.



Adapted from public domain documents written by H.S. Adelman & L. Taylor and circulated through the Center for Mental Health in Schools at the University of California at Los Angeles.

***Figure 8.1**: Comprehensive approach to addressing barriers to learning and promoting healthy development*

Outcomes associated with health and social services

A great deal of research has pointed to the importance of health and social services. Research has documented significant improvements in important outcomes as well as reductions in problem behaviors. Table 8.2 provides important examples of both.

Table 8.2: Key outcomes associated with health and social services

Improvements in:	**Reductions in:**
• Academic achievement • Positive school climate • Service accessibility • Behavioral and emotional functioning • Psychosocial functioning • Social and life skills • Self-control • Self-efficacy and -concept • Costs associated with mental health services • Service utilization (i.e., access to care) • Accuracy of diagnosis • Service integration	• Drug and alcohol use • Special education referrals • Discipline problems • Depression • Disruptive, aggressive and violent behaviors • Substance use • Anxiety • Withdrawn behaviors • Duplication of services • Worker isolation

From: Armbuster & Lichtman, 1999; Catron, Harris, & Weiss, 1998; Chalfant & Pysh, 1989; Eggert, Thompson, Herting, Nicholas, & Dickers, 1994; Hawkins, Catalano, Kosterman, Abbot, & Hill, 1999; Hoagwood, & Erwin,1997; Hunter, 2004; Knoff & Batshe, 1995; Marx, 2003; Meyers, Sampson, Weizman, Rogers, & Kayne, 1989; Murphy, Pagano, Nachmani, Sperling, Kane, & Kleinman, 1998; Nabors & Reynolds, 2000; Rones & Hoagwood, 2000 ; Sindelar, Griffin, Smith, & Watanabe, 1992; Sallis et al., 1999; Schoener, Guerrero, & Whitney, 1988; Weist, Paskewitz, Warner, & Flaherty, 1996; Weist , Myers, Hastings, Ghuman, & Han, 1999.

In addition to these social and behavioral outcomes, research has emphasized important economic benefits. For example, for each dollar invested in comprehensive school health programs designed to prevent smoking, substance use, and other health behaviors will save upwards of 14 dollars in avoided health care costs for each dollar invested (Kolbe, Collins, & Cortese, 1997).

Key design principles and strategies in health and social services

Service providers, in partnership with families and educators, make choices about the design and implementation of their services and service system. Services simply must be tailored to the local context, and specific services may vary based on the non-academic barriers presented by a child or a family. The most important alternatives include:

- *Student-centered services* involve service planning aimed at one child. Here, the child is viewed as an expert and a partner, and service providers collaborate with this "client" to develop and implement service plans and improve results.

- Within *family-centered services*, the unit for service planning, delivery and evaluation is the family system. As with student-centered services, parents, students and other family members are viewed as experts and partners, and professionals collaborate with them in order to do good work that improves results.

- *Integrated services (i.e., service integration)* involve service planning where service providers, both school- and community-based, work together when two or more of them serve the same child and family. Providers mesh their respective service interventions into a coherent, comprehensive plan, which requires them to "wrap around" the child, parent or family. Service integration, with its wrap-around service planning, responds to several service system problems such as duplication, competition and conflict, and lack of communication and coordination. These and other problems make children and families feel as if they are "caught in the middle," and results suffer.

- *Interprofessional collaboration* refers to new working arrangements among service providers, educators and other professionals working with the same schools, community agencies and families. Professionals collaborate because they learn they can not achieve the results for which they are accountable and reap other benefits if they continue to work alone. Oftentimes, these professionals' agencies (e.g., a school and a boys and girls club) develop formal partnership agreements and establish interagency collaborations.

These alternatives are not competing or mutually exclusive. To the contrary, service providers, educators and families may rely on all of them at some time, and all are supported by research.

Other research-supported design principles should guide the development of school-based and school-linked health and social services. Initially these programs should be grounded in the overarching design principles and strategies for successful programs. In addition, there are key principles and strategies that are critical to health and social service delivery. Table 8.3 and 8.4 present design principles for successful health and social service programs.

Table 8.3: Check list of overarching design principles and/or strategies for successful programs

☐	Program is designed to create intended results
☐	The logic behind the program makes sense as the services link to outcomes
☐	Program uses multiple strategies to accomplish its goals (comprehensive)
☐	Program is evaluation-driven and continuously improved upon
☐	Program is research-supported and theoretically-sound
☐	A variety of teaching and learning strategies are used
☐	There is sufficient dosage
☐	The program is implemented the way it was originally designed
☐	Staff are well-trained in the program design
☐	Participants have a "say so" in how the program is structured and implemented
☐	Program is tailored to meet individual needs
☐	Program is appropriately timed and located
☐	Program is implemented in culturally competent ways
☐	Program is family-centered and -supportive
☐	Strategies foster self-determination and personal control
☐	Participants are empowered
☐	Participants' strengths are built upon in the program
☐	Positive relationships and bonding are created
☐	Program activities are enjoyable and meaningful to participants
☐	Staff are engaging

Table 8.4: Key design principles and/or strategies for health and social services

Principle and strategy	What this looks like
Critical structural components	
Service coordinator	• A single person receives special preparation and support to oversee the operation of school-based and -linked services (i.e., typically a social worker, special educator, counselor or psychologist) • This coordinator serves as the single point of contact for referrals and assistance • The coordinator serves as the principal's designated representative on school-based and community-based service planning teams • The coordinator develops effective working relationships with classroom teachers and has lead responsibility for developing the abilities to identify risks and problems, make referrals and work with other service providers • The coordinator facilitates partnerships, collaboration and interprofessional service teams (service integration) • The coordinator develops a service planning and delivery management team, which ensures that school and community resources are maximized and utilized
Comprehensive services	• Services are comprehensive enough to address the full range of student needs • Services conform to best practice guidelines (e.g., family-centered, culturally-responsive, strengths-based, solution focused and results-oriented) • Services address multiple domains and support systems (target families, communities, schools, peers, etc.) • Services decrease risk factors and build protective factors simultaneously • Services take into account the whole child and family system, including the impacts of economic and housing problems • Schools offer planned k-12 health and physical education curricula addressing comprehensive healthy youth development • Schools offer school health services to promote health for all students • Schools offer a variety of nutritious and appealing meals for students • Schools promote healthy school climates • Schools offer health promotion for staff
Continuum of services	• A well planned continuum of services exists, encompassing prevention, early intervention and crisis-responsive services • The continuum involves universal prevention/health promotion services to enhance protective factors • School and community health education and promotion programs are included in this continuum • There are key strategies in place to systematically identify and assess early problems and needs • Referral processes are in place to link students and families to need resources and supports • This continuum includes early detection-identification procedures and early intervention services • The continuum is tailored to increase long-term interventions for high risk youth and families • The continuum includes plans and protocols for classifying and reclassifying students and families as their conditions change

Table 8.4: Key design principles and/or strategies for health and social services	
Principle and strategy	**What this looks like**
	• Classroom experiences are included in when service planning occurs
Expands current school service continuum	• The continuum builds from the current school continuum involving student assistance teams, individualized education plan and 504 processes, grade level meetings, school supportive service staff, health and nutrition programs, and others • The continuum also includes community resources and supports that further address unmet needs (school- and community-based mental health; interagency service delivery teams, school- and community-based youth development, etc.)
Interprofessional collaboration and service integration	• Assessments routinely seek to identify co-occurring needs in students and their families • When a student and/or the family has two or more co-occurring and interlocking needs, two or more service providers and student support professionals work together to serve the same child and family • Protocols are developed to facilitate information sharing and to protect the student's and the family's confidentiality • Service providers mesh their respective services into one coherent and comprehensive plan • Services are maximized and duplication is reduced • Teachers and principals participate, as needed in service integration planning • All professionals involved share responsibility for planning and accountability for results
School-agency partnerships	• Individuals and organizations plan and implement preventive and intervention strategies together in seamless, mutually beneficial ways • Middle managers and supervisors in social and health service agencies strike agreements with their workers and with school leaders, ensuring that "everyone is on the same page" • Policies, procedures and rules are changed, as needed, so organizations and people operate in harmony • Partnerships are mutually beneficial and supportive
Case management	• Systems and interventions are monitored on an ongoing basis • Follow up and accountability structures are in place • Systems and interventions are improved upon as necessary
Responsive to needs	
Strategic	• Assessment data are examined to determine what types of needs and issues are evident in the school community • Parents, families and youth are surveyed to determine where services should be located to facilitate use • Parents, families and youth are surveyed to identify other key barriers and facilitators for service use • Health and social services are provided that meet specific needs for youth and families in the school community • Services are well thought out systems of care and are in place to maximize resource usefulness and reduce duplication
Availability	• Human resources exist in the community and school to support the delivery of health and social services

Table 8.4: Key design principles and/or strategies for health and social services

Principle and strategy	What this looks like
Availability continued	• Fiscal resources exist in the community and school to support the delivery of health and social services • Services are located where people in need will actually use them (i.e., availability and accessibility)
Flexibility	• Services are individualized and adapted as conditions and aspirations change • Services are tailored to individual and family needs • Services are adapted to fit the local context • Services are modified and altered to meet ongoing progress needs
Least intrusive intervention	• Services are provided in the least intrusive manner as possible • Youth or families who need more services will receive more services • Youth or families who need fewer services will receive fewer services • Services will be provided to those that need them without being more intrusive than required • Service providers work closely with parents and families to ensure that their authority is preserved and strengthened
Access	• Service providers and educators routinely ask youth and families about the most convenient location(s) for service delivery • Barriers to access are eliminated by strategic location of services, whether they be community- or school-based • Assistance is provided to support access (i.e., child care, transportation, etc.) • Services are provided at times that are convenient for those that need them • Programs and services offered at the school are integrally linked with those offered in the community and vice versa (i.e., school-linked services) • Students and families are linked with outside services in the community when health and social services are not available on the school site • Programs and services are co-located to schools in order to enhance access to health and social services that are not usually accessible in particular areas (i.e., school-based services) • Stigma associated with health and social service settings is reduced via school-based services
Day-to-day operations	
Confidentiality	• Confidentiality of health and social service information is maintained. • Informed consent and assent, parent/guardian consent, and shared information agreements are used to protect individual's rights • Teachers and other individuals working in and with schools understand and respect confidentiality • Settings providing health and social services have private, confidential and comfortable physical space
Record keeping	• Records must be kept in locked cabinets where access is protected • Shared information forms are used that provide written consent for communicating across systems
Language	• Specialized, discipline specific language is avoided • Common languages that are understandable by various individuals,

Table 8.4: Key design principles and/or strategies for health and social services

Principle and strategy	What this looks like
Language continued	especially youth and parents, are developed and used • Translation services are provided for those who need them • Materials about health and social services are publicized in appropriate languages for the target population
Early identification, referral and coordination	
Early identification	• Strategies are in place to screen and identify early signs and symptoms, ensuring interventions occur shortly after the onset of the problems • Teachers and other essential individuals have the competencies to assess early signs and symptoms
Referral	• Referral networks linking youth and families to needed supports in schools and communities are in place • Teachers and school staff understand the referral process (i.e., they know where to go for help)
Single point of contact	• A single point of contact exists, allowing individuals to know what to do when they see an initial need or problem • A primary person is charged with coordinating and facilitating service delivery across the continuum
School-based coordinating teams	• Interagency representatives meet regularly to coordinate service delivery for students and families • Services internal and external to the school are linked in order to provide more streamlined supports • Representatives examine overall student, family and community data in order to assess needs for services • Representatives examine overall resources and explore ways to bring additional supports to the table • Representatives work on addressing gaps in services based on the needs and resource assessment
Assessment and triage	• Schools have a triage system that initially assesses needs and concerns, determining priorities for service delivery • Students and families are appropriately linked with services and supports • Channels exist so students and families are referred
Feeder systems and transitions	• Services are designed so they support elementary, middle and high school feeder systems to ensure youth and families are supported systemically across the service continuum • Schools facilitate transitions for individuals and families across systems • Efforts are in place to make transitions smooth for students and families (i.e., from elementary to middle school; fourth to fifth grade, school-to-work, school-to-college, etc.)
Qualities of service providers	
Understanding of schools	• Service providers in schools are trained in adolescent and child development and mental health • Service providers in communities understand schools and their educational focus

Table 8.4: Key design principles and/or strategies for health and social services

Principle and strategy	What this looks like
Staff competencies	• Workers have the appropriate knowledge and skills to do the work of which they are responsible • School based service professionals have interdisciplinary training allowing them to better work across multiple service domains
Well-defined roles and responsibilities	• Health and social service workers both internal and external to the school have well-defined roles and responsibilities • Roles and responsibilities are understood by those accessing services • Roles and responsibilities are understood by those referring others for services
Clear expectations	• Organizations and individuals involved in providing health and social services have a clear understanding about their responsibilities • Expectations are clear to others (i.e., individual roles and accountabilities) • Memorandums of understanding among schools and community-based organizations exist to support this process
Critical support	
Public relations	• A marketing strategy is created to allow individuals to be aware of available services • Proactive steps are taken in relation to public relations in order to inform stakeholders and alleviate potential opposition and controversy
Connections to classrooms	• General classroom curriculum for health education and promotion programs integrates program content, particularly that related to youth development and primary prevention • Teachers that implement curriculum are appropriately trained and supported • Teachers are informed about student and family progress • Teachers provide ongoing assessments in relation to student progress and needs
Teacher support	• Strategies to support youth and families begin with classroom teachers • Teachers receive support and training in how to identify, refer and address various needs and issues • Time is allotted to consult regularly with teachers and other school staff
Value	• Schools understand the need to address non-academic barriers and see their role in the service continuum • Health and social services providers value schools and understand their educational missions and mandates
Relationships	• Relationships and connections among youth and healthy adults, positive peers, practitioners, school, community, and/or culture are developed as services are delivered • Relationships among teachers, school staff, supportive service staff and community-based service providers are built
Non-traditional helpers	• Parents/guardians, teachers, peers, custodians, secretaries and others are engaged and provide non-traditional support in relation to meeting youth and family needs • Volunteers, aides, home visitors, peer mentors, etc. are recruited and

Table 8.4: Key design principles and/or strategies for health and social services

Principle and strategy	What this looks like
Non-traditional helpers continued	utilized to meet youth and family needs
Accountability	
Outcomes focused	• Health and social services are delivered with the end goal of improving healthy youth development, enhancing learning and increasing academic achievement
Quality	• Health and social services providers use programs and strategies that are research-supported and evidence-based • Health and social services providers implement programs and services with fidelity • Programs and services are delivered with sufficient dosage to create outcomes
Shared accountability and ownership	• Partners involved in the continuum of services feel mutually responsible for students and family outcomes • Students and families feel empowered and supported through the process

From: Adelman & Taylor, 1998; 2000a; Anderson-Butcher, 2005; Briar-Lawson & Drews, 1998; Browne, Gafni, Roberts, Byrne, & Majumdar, 2004; Elias, 2002; Payton, Wardlaw, Graczyk, Bloodworth, Tompsett, & Weissberg, 2000; Weist, Sander, Walrath, Link, Nabors, Adelsheim, et al., 2005.

Other considerations in health and social services

It is important to understand there are other considerations that influence the types of health and social services that are provided. Various phases related to the implementation of the health and social service continuum are explored. New roles and responsibilities are identified in relation to new priorities for schools; expectations and role clarity; single points of contact and streamlined referral processes; coordinating teams, case management, and lead responsibility; and overall legal considerations. Each one will be discussed as to their influence on the school community system.

Phases of implementation

In the OCCMSI, the integration of health and social services with school improvement requires five key developmental and operational phases. These phases derive from the research and successful practice involving school-based and school-linked health and social service programs.

- First, a team of school and community service providers inventory school-owned and -operated and community-owned and -operated services and programs. In many of Ohio's counties, this inventory will reveal an undiscovered and untapped treasure – namely, service provider partnerships, which already are in place. Three notable examples are Partnerships for Success, Families and Children First Councils and Communities that Care, and there are others.

- Second, the health and social services team, in close consultation with students, families, classroom teachers and the principal, makes decisions about service location. They decide which services will be school-based – namely, those that teachers, students and student support professionals must have nearby for students' learning, academic achievement and sense of connection to school.

- Third, teachers and service providers develop the "on call", 911-like system that will operate at the school. Typically, teachers learn how to identify risk factors requiring services, and also how to refer students. Teachers also learn how to use service providers and students' service experiences as instructional resources. When it is feasible, service providers integrate instruction and services. This integrated approach is in stark contrast to the usual "fix, then teach" approach that divides service providers and teachers – and sometimes catches students and their families in the middle.

- Fourth, the team and the key persons they consult determine which services will be based and offered in the community, but with clear, effective linkages to school. They also determine how these school-linked services will stay connected to school, especially how they can support teachers and students in classrooms. Service planning also includes the school climate, aiming to establish, maintain and strengthen a dynamic, safe, health-enhancing and supportive learning environment.

- Fifth, the team and their key school and community consultants develop an integrated implementation-evaluation plan designed to ensure that services are effective and successful. This requires service designs that focus on improved access, more quality and higher accountability – as evidenced in an unrelenting focus on improved results. It also requires designs that recognize, eliminate and prevent fragmentation, duplication and undesirable competition.

New roles and responsibilities

Given these five phases, the health and social services continuum requires new roles and responsibilities for those working in and with schools. New ways for connecting schools and health and social services systems are needed, and they require new ways of defining various roles and responsibilities. Schools and their community partners also must consider various legal issues evident when working across systems. Each of these areas is discussed in the following.

New priorities for schools

With the advent of NCLB, schools have focused their reform efforts inwardly, concentrating on instructional strategies, curriculum alignment and standard-based accountabilities. Education indeed is the mission of schools; and many educators problem solve by teaching "harder" and "longer", as opposed to reaching outwardly and differently via expanded health and social service linkages.

The research identifies many conditions and needs that impact student success. The truth is schools cannot do their jobs of educating unless students come to school ready, able and motivated to learn. As such, perceptions about the school's role in addressing these non-academic barriers must change if the growing needs of youth today are met. Educators will have to expand their roles to work in partnership with others to address conditions, build strengths,

and support whole-child development; that is, if they truly want to get their arms around overall student achievement, in general.

Rethinking expectations and roles

Many student supportive services staff (i.e., school social workers, counselors and psychologists) have been relegated to monitoring truancy and other behavioral issues, providing career and vocational training/advising, assessing for disabilities, and coordinating proficiency testing. In the model, these individuals' jobs are modified, allowing them to focus more of their time on providing direct services, collaborating with other service providers and working on service teams.

Similarly, health and social service providers in the community also must rethink their roles and responsibilities. They no longer provide services in isolation. They may deliver services at schools where youth and families are more likely to access them. They may sit on service teams, coordinating and linking both school and community supports for youth and families. They also may bring additional resources to the schools, providing case management and student advocacy in relation to unmet school needs.

Teachers also become active within the health and social service continuum. Traditionally, teachers and other school staff are often left out of service planning. Consistent with the traditional image of schooling, teachers teach and providers provide service. Specifically, teachers often want supportive service providers to "fix" students and return them when they are finished. In this model, teachers become agents of early identification, assessment and referral. These individuals see youth each day, have connections with parents/guardians, and are able to pick up on various needs and stressors. As such, early identification and referral often times begins in classrooms, and start with teachers. In response, teachers get the help they and the youth want and need.

In addition, new roles and responsibilities for "informal helpers" are created. For instance, parents/guardians have volunteered and/or been hired, trained and supported to provide classroom assistance, mentoring, hall monitoring, parent/guardian support and after-school programs (e.g., Briar-Lawson & Drews, 1999; Lawson & Briar-Lawson, 1997). Likewise, youth can take on new roles and responsibilities as they serve as peer leaders, bully-prevention specialists, playground monitors and mentors for younger children.

Single points of contact and streamlined referral processes

Some needs and problems simply cannot be handled in the classroom. School communities who have successfully implemented comprehensive health and social service continuums often times designate single points of contacts, or one common referral place, that help streamline referral processes and service planning. This infrastructure typically starts with a point person in the school who is responsible for doing a preliminary assessment and triaging the referral to the appropriate channel in the school.

Where schools are concerned, and when more than one school is the planning unit, this point person often is someone from the district office. When it is just one school, it is often a school social worker. In other cases, schools can not do this work and an intermediary person from a local community-based organization does it.

Essentially, teachers identify needs and make strategic referrals. Strategic referral forms are helpful within this process. Specifically, teachers and other school staff may notice certain conditions that are impeding student success. In turn, they complete a referral form that describes the underlying issues, and directs youth and their family to the single point of contact who is then charged with triaging the supportive service response. Individuals and groups are then "on call" at the school and in the community in response to teachers' referrals.

Coordinating teams, case management and lead responsibility

It also is helpful to have case-oriented teams such as triage, referral, case management, case progress review, teacher assistance or student support teams, and/or IEP teams. These specific teams focus on ensuring that everyone is working toward either the same or complementary goals for the youth and their families. These teams also may explore how people gain access to services, how resources are coordinated, determine what resources the school needs, and explore how to get the resources.

Ideally these teams are comprised of both school-based and community-based professionals. Using these teams, school supportive service staff (i.e., school social workers, counselors, nurses, etc) and local service providers (i.e., mental health providers, eligibility workers, advocates/mentors, child welfare workers, etc.) work together to streamline supports and services.

Someone involved in these case-oriented teams typically assumes lead responsibility; and is accountable for ensuring programs and services are offered in relation to identified youth and family needs. This lead person is charged with providing targeted interventions and supports, coordinating services and providing overall case management. Table 8.5 presents examples of case management roles.

Table 8.5: Case management roles

1. Link students and their families to needed health and social services that cannot be provided by case management team
2. Ensure through monitoring and evaluation that services are integrated and there is appropriate communication between providers, students and families
3. Advocate on behalf of the students to secure needed services and entitlements
4. Anticipate student crises
5. Assist in the facilitation of team meetings to plan, monitor and adjust coordinated services
6. Develop and maintain cooperative working relationships within the school among case management team members, teachers, counselors, administrators and outside the school with family members and health and social service providers
7. Assist professionals in determining the composition of each student needs
8. Provide the legwork needed to support true coordination and service integration
9. Foster collaboration among service providers and minimize turf and trust issues
10. Develop coordinated service plans
11. Linking multiple services provided for youth and families together in strategic ways
12. Evaluating and adjusting service plans based on changing needs and progress

From: Smith, et al., 1997; Rothman, 1992.

Legal considerations

Individuals working within the health and social service continuum must be especially mindful of a multitude of legal considerations. These include:

- *Family Educational Rights And Privacy Act (FERPA)* protects the privacy of parents and students by requiring school districts to: (1) Provide a parent access to their child's educational records; (2) Provide a parent an opportunity to seek correction of records he/she believes to be inaccurate or misleading; (3) With some exceptions, obtain the written permission of a parent before disclosing information contained in the student's educational record; and (4) Annually inform parents of these rights under this act. (From: www.deltabravo.net/custody/ferpa.html)

- The *Protection of Pupil Rights section of the General Education Provisions Act* establishes standards related to the assessment or evaluation. Specifically, the act indicates that no student shall be required to submit to a survey, analysis or evaluation that reveals information about personal issues such as mental and psychological problems and/or anti-social or self-incriminating behaviors without the prior consent of the student (if the student is an adult or emancipated minor), or without the prior written consent of the parent. (From: www.ed.gov/legislation/GOALS2000/TheAct/sec1017.html)

- The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) regulates national standards and requirements that enable the electronic exchange of certain health information. Specifically, it realizes the trend toward the computerization of health information and how this trend may increase access to information, but also needs to protect the security and privacy of the information. Schools, organizations and others must be in compliance with several requirements related to this area.

- The *Child Abuse Prevention and Treatment Act and the related Ohio Statute* mandates known or suspected child abuse and neglect reporting by law by certain professionals, including individuals working in health care, mental health, social work, education, law, religion and child care fields. (From: http://nccanch.acf.hhs.gov/general/legal /statutes/manda.pdf)

In the end, these laws and others are designed to safeguard youth and family's rights and privacy, as well as ensure confidentiality. More specifically, they call for the use of parent and youth consent forms, shared information agreements, memorandums of understanding and creative insurance/liability policies. Stakeholders also must realize they are mandated reporters of suspected or known abuse and/or neglect. In the end, the ultimate goal of these policies is to protect youth and families. These regulations must be taken into account as schools and communities partner together to provide health and social services.

Common barriers in health and social services

Several barriers exist when schools and communities strive to integrate and coordinate health and social services. The following section highlights specific barriers and provides strategies for minimizing the impact of each challenge.

Remember, the primary mission of schools is to develop and promote academic learning; health and social services are designed to achieve this mission. This relationship does not diminish the importance of these services. In fact, research and experience tell us that schools must gain control over non-academic barriers to learning if they are to be successful with their primary mission.

Barrier: Perceptions of schools not as health and social service agencies

Nonetheless, public perceptions of school's roles and functions – and the family's primary roles and functions – often prove to be challenging. Simply stated, in this perception, the schools educate and the families are responsible for meeting students' needs. Social and health services, if they are needed at all, belong in the community, not in schools. These public perceptions comprise a major barrier to the development of a comprehensive, coherent and effective service system, one that is both school-based and school-linked; and one that focuses on the removal of non-academic barriers to improve learning and academic achievement. Table 8.6 presents common perceptions of schools not as health and social service agencies barriers and makes suggestions about how to address them.

Table 8.6: Perceptions of schools not as health and social service agencies – Specific barriers and minimizing strategies

Barrier: Perceptions of schools as not health and social service agencies	**Minimizing strategies**
• There is a common belief that schools should only focus on students' learning and academic achievement • Many have perceptions that academic achievement is enough, and non-academic barriers will go away simply as students get educated • School staff feeling threatened by community service providers • Teachers are already overburdened with classroom and teaching expectations; little time or energy to focus on the non-academic barriers to learning • Teachers and other school staff are often resistant to addressing comprehensive youth development and family and/or community issues • Teachers and other school staff do not value the role of supportive service staff • There are challenges with pulling students out of regular class time for services • There is an internal belief that community health and social service agencies duplicate and undermine the efforts of student support professionals at schools • School-based services duplicate, and	• Emphasize that services at school are connected to learning and teaching support systems • Increase public awareness, starting with the school board, of how many non-academic barriers students have that prevent learning and help to create an achievement gap • Increase public awareness of how school staff effectively and efficiently remove and minimize barriers; and help teachers enable students' learning • Educate community service providers about the role and missions of school; its policies and procedures, etc. • Educate teachers and school staff on how to effectively and efficiently link students and families to programs and services and also to use service providers as instructional consultants • Create streamlined referral systems and single points of contact that support teachers without overburdening them • Blend and integrate community and school resources so they support and build from each other • Develop a continuum of care that starts in the school and feeds to resources in the community • Create effective communication channels between supportive service staff/community service providers and teachers and classrooms • Supportive service staff and community service providers build relationships with teachers, showing them the value of what they are doing and how

Table 8.6: Perceptions of schools not as health and social service agencies – Specific barriers and minimizing strategies	
compete with, community-based services and vice versa • Others…	community is there to help them • Supportive service staff and community service providers should make every effort possible to avoid pulling student out of class time (use lunch, recess, before/after school, homeroom, planning periods for intervention); if it impossible to not use class time, rotate the time each week as to avoid students missing the same subject every week • Others…

Barrier: Communication, referrals and integration

You may expect more challenges as educators, service providers and other key leaders such as parents initiate planning and begin developing partnerships. For example, oftentimes communication links between educators and service providers are missing, and strategic referrals to school-based and – linked services are non-existent or ineffective. Or, the concepts of interprofessional collaboration and service integration are new to both educators and service providers. One wonders how providers can work together if they are not even aware of the possibilities. Table 8.7 presents common communication, referral, and integration barriers and makes suggestions about how to address them.

Table 8.7: Communication, referrals and integration - Specific barriers and minimizing strategies	
Barrier: Communication, referrals and integration • Referral systems are not in place • Teachers and service providers are unaware of what each needs and offers • Service providers at the school aren't aware of each others' roles and functions • School service providers and community-based service providers do not communicate; and therefore, services are fragmented, duplicative and competing • There is a lack of time, supports and resources needed to enable good communication and relationships between school-based and community-based service providers • Confusion exists about the roles of supportive service staff and community service providers • There are delays in referrals for student and family issues because teachers and school staff do not know what to do • Teachers and school staff wait until problems are really nested/deep end (do	**Minimizing strategies** • Foster communication and collaboration through coordinating teams • Increase awareness about the health and social services available in schools and communities • Assign lead responsibility to one person/agency to serve as single point of contact for communication about non-academic barriers • Make sure teachers and school staff know where to go for help and support in addressing non-academic barriers to learning • Supportive service staff and community service providers give feedback and updates to teachers about student progress • Build relationships between the school, the community and its stakeholders • Establish early identification, assessment and referral strategies • Provide youth development and health promotion services to prevent and deter onset of problem behaviors • Build teams of teachers, supportive service staff, community service providers, and others to map school and community resources

not get students and families referred until it is way too late) • Teachers are not included in decisions about service planning • Teachers do not know how to reintegrate students in their classroom after they have received services • Others…	• Plan collaboratively and strategically to meet gaps and reduce duplication • Provide joint professional development programs for teachers, principals and service providers, enabling them to talk to each other and work together better • Others…

Barrier: Funding for learning and support services

Funding is another major barrier related to the delivery of health and social services in connection with schools. Simply stated, schools and the services they provide – and community-based health and social service agencies and the services they provide – are both under-funded and strapped for resources. Maximizing resources, blending funding streams and reducing service duplication are essential if student and family needs are going to be systematically addressed. Table 8.8 presents funding for learning and support services barriers and makes suggestions about how to address them.

Table 8.8: Funding for learning and support services - Specific barriers and minimizing strategies

Barrier: Funding for learning and support services	**Minimizing strategies**
• Schools are under-funded, in general • There are not enough service providers to meet students' and teachers' needs. • Funding to address non-academic barriers to learning is limited in schools • Health and social services in communities are under-funded • Health and social service agencies often compete for the same funding and resources • Funding is tied to earmarked funds for special populations or subgroups (i.e., homeless, exceptional children, etc.) • There are common beliefs that having service providers takes away from educational dollars • School funding is often compartmentalized and rarely integrated (e.g., funding tied to family supports exist in Title 1, Title IV, etc., but rarely are these integrated) • Others…	• Co-locate community service providers at schools to reduce personnel and facility costs, transportation costs and support access to services • Train and deploy parents as paraprofessional service providers, assigning them low risk cases and having them assist service providers with follow-ups and paperwork • Schools reduce outreach costs when community service providers are working in tandem • Use Medicaid, TANF and other funding streams to support service provision • Blend and braid funding streams (both school and community) to maximize resources • Coordinate and integrate services to reduce duplication and maximize services • Realize that schools can get certain types of money and communities get others; and explore how to maximize resources from different sources • Collaborate on grants and special opportunities for funding • Others…

Remember to examine the sustainability chapter for more highlights related to funding.

Conclusion

The strategic integration of health and social services with school improvement involves the entire school community. Although this innovation expands the boundaries of school improvement, it proceeds with a clear plan regarding the proper roles, functions and missions of Ohio's schools; and with due recognition that some health and social service programs are best provided in community settings in close consultation with parents and families.

The Carnegie Task Force on Education's recent policy statement sums up the situation regarding schools' responsibilities for non-academic barriers. *School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.*

In other words, schools, in order to achieve their primary missions, must develop a comprehensive, coherent and responsive learning support system. Starting with student support professionals already located at schools (e.g., counselors, school social workers, psychologists), this learning support system also requires the involvement of community-based service providers.

By necessity, educators and their community partners must develop a comprehensive, coherent, cohesive and feasible plan for getting services to teachers, students and families in need. Only then will they ensure that no child is left behind, and also that educators, especially classroom teachers, do not have to confront students' non-academic barriers alone – without sufficient services, supports, assistance and resources.

This chapter has been structured with these needs and priorities in mind. Far from the last word on the subjects at hand, you now should have a good idea about how to get started.

Remember, you do not have to do this work alone. No doubt you will find service provider collaboratives of some kind already operating in your local community. Start with your county department of child and family services, also called social services. In fact, you may find that your community is a Partnerships for Success site, an Ohio Family and Children's First site, or a Communities that Care site. Join these initiatives and gain access to the resources they provide.

The advantages of this approach to social and health services have been identified in this chapter. In brief, social and health services provide an effective way to expand the boundaries of school improvement without losing sight of, and distorting the school's primary missions and functions. As non-academic barriers are removed and prevented, students' learning, academic achievement and healthy development will improve. At the same time, both school-based and school-linked services fortify parents' authority and strengthen entire families. Major benefits like these justify investments in social and health services by educators, service providers, parents and other community partners.

References

American Academy of Pediatrics. School-Based Interventions. Pediatrics. 2004; 113: 1839-1845.

Adelman, H.S., & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. *Educational Psychologist, 33*(4), 135-152.

Adelman, H. S., & Taylor, L. (2000a). Promoting mental health in schools in the midst of school reform. *Journal of School Health, 70,* 171-178.

Adelman, H. S., & Taylor, L. (2000b). Shaping the future of mental health in schools. *Psychology in the Schools, 37,* 49-60.

Anderson-Butcher, D. (2006). The role of the educator in early identification, referral and linkage. In R. J. Waller (Ed.), *Child and Adolescent Mental Health Issues in the Classroom*. Sage Publications.

Armbuster, P., & Lichtman, J. (1999). Are school based mental health services effective? Evidence from 36 inner city schools. *Community Mental Health Journal, 35*(6), 493-504.

Brener, N.D., Martindale, J., & Weist, M.D. (2001). Mental health and social services: Results form the School Health Policies and Programs Study 2000. *Journal of School Health, 71*(7), 305-312.

Briar-Lawson, K., & Drews, J. (1998). School-based service integration: Lessons learned and future challenges. In D. van Veen, C. Day, & G. Walraven (Eds.). Multi-service schools: Integrated services for children and youth at risk (pp. 49-64). Leuven/Appeldorn, The Netherlands: Garant Publishers.

Browne, G., Gafni, A., Roberts, J., Byrne, C., Majumdar, B. (2004). Effective/efficient mental health programs for school-aged children: A synthesis of review. *Social Science & Medicine, 58,* 1367-1384.

Catron, T., Harris, V.S., & Weiss, B. (1998). Posttreatment results after 2 years of services in the Vanderbilt school-based counseling project. In M.H. Epstein, K. Kutash, & A. Duchnowski (Eds.). *Outcomes for children and youth with behavioral and emotional disorders and their families: Programs and evaluation best practices* (pp. 633-656). Austin, TX: Pro-Ed.

Chalfant, J. C., & Pysh, M. V. (1989). Teacher assistance teams: Five descriptive studies on 96 teams. *Remedial and Special Education, 10*(6), 49-58.

Elias, M.J. (2002). *Academic and social-emotional learning*. Educational Practice Series, 11. International academy of Education. Geneva, Switzerland. International Bureau of Education.

Guernsey, B.P., & Pastore, D.R. (1996). Comprehensive school-based health centers: Implementing the model. *Adolescent Medicine, 7*(2), 181-196.

Hoagwood, K., & Erwin, H. (1997). Effectiveness of school-based mental health services for children: A 10 year research review. *Journal of Child and Family Studies, 6*(4), 435-451.

Hunter, L. (2004). The value of school-based mental health services. In K.E. Robinson (Ed.). *Advances in school-based mental health interventions: Best practices and program models*. (pp. 1.1-1.10) Kingston, NJ: Civic Research Institute.

Kolbe, L.J., Collins, J., & Cortese, P. (1997). Building the capacity of schools to improve the health of the nation. *American Psychologist, 52*(3) 256-265.

Knoff, H.M., Batsche, G. M. (1995). Project ACHIEVE: Analyzing a school reform process for at-risk and underachieving students. *School Psychology Review, 24*(4), 579-603.

Larson, R. (2000). Toward a psychology of positive youth development. *American Psychologist, 55*(1) 170-183.

Lawson, H., & Briar-Lawson, K. (1997). *Connecting the dots: Progress toward the integration of school reform, school-linked services, parent involvement, and community schools*. Oxford, OH: Institute for Educational Renewal, Miami University.

Nabors, L.A., & Reynolds, M.W. (2000). Program evaluation activities: Outcomes related to treatment for adolescents receiving school-based mental health services. *Children's Services: Social Policy, Research, and Practices, 3*(3), 175-189.

Payton, J.W., Wardlaw, D.M., Graczyk, P.A., Bloodworth, M.R., Tompsett, C.J., & Weissberg, R.P. (2000). Social and emotional learning: A framework for promoting mental health and reducing risk behaviors in children and youth. *Journal of School Health, 70*(5), 179-185.

Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review, 3*(4), 223-241.

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

Sindelar, P. T., Griffin, C. C., Smith, S. W., & Watanabe, A. K. (1992). Prereferral intervention: Encouraging notes on preliminary findings. *The Elementary School Journal, 92*(3), 245-259.

Small, M.L., Jones, S.E., Barrios, L.C., Crosssett, L.S., Dahlberg, L.L., Albuquerque, M.S., Sleet, D.A., Greene, B.Z., & Schmidt, E.R. (2001). School policy and environment: Results from the school health policies and programs study 2000. *Journal of School Health, 7*(1), 325-333.

Smith, A.J., Armijo, E.J., & Stowitschek, J.J. (1997). Current applications of case management in schools to improve children's readiness to learn. *Journal of Case Management, 6*(3), 107-115.

Weist, M.D., Paskewitz, D.A., Warner, B.S., & Flaherty, L.T. (1996). Treatment outcomes of school-based mental health services for urban teenagers. *Community Mental Health Journal, 32*(2), 149-157.

Weist, M.D., Myers, C.P., Hastings, E., Ghuman, H., & Han, Y.L. (1999). Psychosocial functioning of youth receiving mental health services in schools versus community mental health centers. *Community Mental Health Journal, 35*(10), 69-81.

Weist, M., Sander, M., Walrath, C., Link, B., Nabors, L., Adelsheim, S. *et al*. (2005). Developing principles for best practice in expanded school mental health. *Journal of Youth and Adolescence, 34*(1), 7–13.