1-1-1989

The student support team program : reaching the at-risk urban adolescent at school.

Michael E. Rozas
University of Massachusetts Amherst

THE STUDENT SUPPORT TEAM PROGRAM:

REACHING THE AT-RISK URBAN ADOLESCENT AT SCHOOL

A Dissertation Presented

by

MICHAEL E. ROZAS

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

September 1989

School of Education

THE STUDENT SUPPORT TEAM PROGRAM:

REACHING THE AT-RISK URBAN ADOLESCENT AT SCHOOL

A Dissertation Presented

by

Michael E. Rozas

Approved as to style and content by:

Robert B. Wellman, Chairperson of Committee

Robert Maloy, Member

Harry Schumer, Member

Marilyn Haring-Hidore, Dean
School of Education

ACKNOWLEDGEMENTS

I have been able to write this dissertation as a result of the encouragement and efforts of the many individuals who consistently supported the concept of the Student Support Team Program. In particular, the faculty of the school that housed the Student Support Team Program enthusiastically supported the project. The school's headmaster was extremely tolerant of my impatience and met my challenge to try to change old ways with understanding and optimism. The Team itself defended me and the program to those who could not envision change. Without their commitment and assistance as well as the additional resources they made available to me, I would have had a much more difficult--and lonely--battle. To each of them I am very grateful.

This dissertation would not exist without the willingness of hundreds of students and their parents; they allowed me to intrude into their lives, and I appreciate their trust in the program. It is for them that I wrote this dissertation with the hopes that others will be encouraged to develop similar school-based support programs.

Whatever contributions this study will make to school-based support programs are largely due to my committee members, each of whom played a unique role in the develop-

ment of this dissertation. They were a remarkable group, both intellectually and personally. They continually reminded me of my primary goals over the past few years and taught me the meaning of the word team, both in the academic and the professional sense. Thank you, Robert Wellman, Robert Maloy, and Harry Schumer.

I owe the largest personal debt to my husband, Santiago, who has spent numerous hours, days, months, helping me with everything from computer glitches to editing to typos and wiping away my tears with encouragement when all seemed hopeless.

Lastly, my six children, who at times were themselves neglected while I was engrossed in this study. Thanks for putting up with me.

I would like to dedicate this dissertation to my mother, Frances Marie Tobin, whose encouragement and strength has always always driven me.

ABSTRACT

THE STUDENT SUPPORT TEAM PROGRAM:
REACHING THE AT-RISK URBAN ADOLESCENT AT SCHOOL

SEPTEMBER 1989

MICHAEL E. ROZAS, B.A., CURRY COLLEGE
M.A., UNIVERSITY OF MASSACHUSETTS
Ed.D., UNIVERSITY OF MASSACHUSETTS
Directed by: Professor Robert B. Wellman

This thesis analyzes a model Student Support Team Program designed to systematically identify at-risk adolescents in an urban high-school setting and refer them to the appropriate services both within the school system and within the community. The program sought to intervene at the earliest possible point, before the adolescents' became insurmountable and the patterns of their adult lives become fixed in unproductive and unhappy grooves. Schools, the program assumes, are an ideal anchoring point for intervention programs for at-risk students. Coordinating the resources and services of the community's health and social services network, the criminal justice system, and the school itself was a primary goal; this coordination resulted in an integrated and efficient approach to providing services to at-risk adolescents as well as their families.

The dissertation discusses how the Team worked and what it accomplished over an 18-month period in 1988 and 1989. A group of professionals, designated the Student Support Team, was the backbone of this program. This Team conferred regularly to discuss and advise on the problems of students who had been referred to their program. The Team's responsibilities were to provide, directly or indirectly, the services necessary to help a particular at-risk adolescent. The Team also followed up on all cases.

Statistics on the at-risk population served by the program, as well as six in-depth case studies of adolescents and families, are presented to demonstrate the benefits of the Team's coordinated efforts. The costs of services provided by the school and other sources are also included to evaluate the program's cost effectiveness.

The main assumptions confirmed by this study are that this type of intervention program can assist in decreasing truancy, grade retention (failure to be promoted), and dropout rates at the high-school level. The broader goal of such programs is to help students who are facing psychological, family, social, and educational problems to resolve their crises in such a way that they may develop and mature into fully functional adults who can be contributors to their society.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS iv

ABSTRACT vii

LIST OF FIGURES xii

CHAPTER

I. INTRODUCTION TO THE STUDY 1

A. Statement of the Problem 2
B. Purpose of the Study 4
C. Some Perspectives on the Problems 5
D. Assumptions 11
E. Statement of Propositions 12
F. Added Benefits of the Program 13

II. BACKGROUND. 14

III. DESIGN OF THE STUDY AND RESEARCH. 33

A. Design of the Study and the Model Program . 33
B. Description of the Model Program. 36
C. Student Support Team Process. 37
D. Student Support Team Members. 39

IV. PRESENTATION OF FINDINGS 45

A. Methodology 45
B. Presentation of Six Case Studies. 46
C. Group Characteristics 79
D. Analysis of the General Study 81
E. Conclusions and Statistics. 84

V. SUMMARY AND RECOMMENDATIONS 93

A. Summary 93
B. Recommendations and Implications for Further Study 96

ENDNOTES 101

APPENDICES

A EVALUATION OF STUDENT SUPPORT TEAM PROGRAM GIVEN TO TEACHERS 105

B EVALUATION OF STUDENT SUPPORT TEAM PROGRAM BY STUDENT PARTICIPANTS 108

C EVALUATION OF STUDENT SUPPORT TEAM PROGRAM BY EXTERNAL AGENCIES 110

D STUDENT SUPPORT TEAM BACKGROUND SHEET 113

E STUDENT SUPPORT TEAM REFERRAL CHECKLIST 115

F AT-RISK REFERRAL REPORT 121

G STUDENT SUPPORT COORDINATOR ASSESSMENT FORM 123

H STUDENT SUPPORT TEAM STUDENT SERVICE FORM 128

I STUDENT SUPPORT COORDINATOR'S RECORD OF MONTHLY SERVICES RECOMMENDED FOR AND RECEIVED BY STUDENT. . 130

J THE STUDENT SUPPORT TEAM COORDINATORS MONTHLY RECORD OF SERVICES RECEIVED 132

K ACKNOWLEDGEMENT OF REFERRAL 134

L LETTER TO PARENT AND ENCLOSURE (STUDENT SUPPORT TEAM) 136

M RELEASE OF INFORMATION 139

N STUDENT SUPPORT TEAM 766 PRE-REFERRAL REQUEST . . . 141

O TEACHER CONSENT 143

P INTERAGENCY AGREEMENT PILOT PROJECT - RELEASE OF INFORMATION 145

Q LIST OF ACRONYMS 147

R SCHOOL-BASED SERVICES TO YOUNG PARENTS 149

S SUBSTANCE ABUSE TREATMENT & PREVENTION PROGRAM . . 155

T SCHOOL-BASED PSYCHOTHERAPEUTIC PROGRAM 157

U FORM 51-A 160

BIBLIOGRAPHY 163

LIST OF FIGURES

4.1 PRE- AND POST INTERVENTION 89

4.2 GRADE RETENTION RATES 90

4.3 DROPOUT RATE 91

4.4 ABSENTEEISM RATES 92

CHAPTER I

INTRODUCTION TO THE STUDY

The "at-risk" adolescent has recently been the topic of many studies by educators and psychologists worldwide. Many writers have tried to analyze this contemporary crisis and how educational and social organizations can help solve the problem. Although numerous theories exist, there is no widespread consensus among educators and social theorists about what method of intervention works best for this group.

In Within Our Reach: Breaking the Cycle of the Disadvantaged, Lisbeth Schorr discusses the various disorganized approaches to helping adolescents at risk: "Part of this gap between knowledge and action springs from traditions which segregate bodies of information by professional, academic, political and bureaucratic boundaries. Complex, intertwined problems are sliced into manageable but trivial parts. Efforts to reduce juvenile delinquency operate in isolation from programs to prevent early childbearing or school failure. Academics burrow for what remains unknown but often fail to herald what is known. Evaluators assess the impact of narrowly defined services and miss the powerful effects of a broad combination of interventions. Successes achieved by health centers, schools, and family

services agencies have common characteristics which form patterns which are rarely perceived."[1] While they may differ in exactly how to solve the problem, researchers do, however, generally agree that school can be a focal point for family life and that it can respond flexibly to a wide variety of adolescent needs and can provide comprehensive services as well.

A. Statement of the Problem

Our school systems have become surrogate parents to the at-risk adolescent. Over the past two decades, achievement in school has declined as adolescent crime and illicit behavior, and family instability have grown. According to the National Commission on Excellence in Education, the sacred American ideal of progress in education is being seriously challenged: "Each generation of Americans has outstripped its parents in education, in literacy, and in educational attainment. For the first time in the history of our country, the educational skills of one generation will not surpass, will not equal, will not even approach, those of their parents."[2]

One of the more obvious and basic changes in the last twenty years has been the loss of support networks within

the family structure. The family has ceased to hold its central position, and the importance of the home has receded for the young. Day-care centers and extended-day school programs are now replacing parental care. Many of today's children are the victims of their parents' successes and/or failures. For the most part, parents lack the skills needed for good parenting, or they are not sensitive to--or do not understand--the social issues their children must face.

Two other sociological trends that contribute to the rising problem of adolescents-at-risk are the migration of families in search of work to urban areas and the diminished power of religion. (In a recent essay, Joy Dryfoos suggests that these trends stem from broad environmental factors, including poverty, crime, substance abuse, violence, and inadequate housing and food.[3]) One other popular theory focuses on the effects of substantial social change following World War II. At that time, new opportunities and incentives brought about industrial and educational changes. Concurrently the baby boom has had its own impact on our society.

Other observers point to the pernicious influence of television in the last two decades. A recent study indicated that when the average high-school students graduate, they have each spent over 5,000 more hours watching tele-

vision than sitting in the classroom. Television has exposed its audiences to glamorized perspectives on sex, violence, and drugs, and in so doing has led to an unexpected moral decay. As Dr. Deborah Prothrow-Stith, Commissioner of the Massachusetts Department of Public Health, recently stated in an interview, "We show that fighting is glamorous on TV; it is rewarded and chosen by the hero as the first solution to a problem. There's no sorrow, no lamenting, when the 'make my day' attitude is put into action."[4] Television can undermine the values and morality of children and in this way has contributed to the current crisis of at-risk adolescents.

The school is a non-threatening environment for many at-risk adolescents. Students gather for significant portions of their day and are in a sense a captive audience. The school is thus a very appropriate institution to use in intervening on behalf of at-risk adolescents.

B. Purpose of the Study

This study was conducted in order to better understand the crisis of at-risk adolescents in our society, and the contribution that urban schools can make in early intervention and prevention of adolescent crises. This dissertation

describes and analyzes an innovative approach to intervention, the Student Support Team Program. Although I was the coordinator of this program and worked very hard to make it succeed, I have tried to maintain my objectivity in evaluating it for the purposes of this disseration. The program provides full-service support to inner-city, at-risk adolescent students. Six detailed case studies illustrate how this program has made a difference by reaching at school at-risk adolescents who would otherwise have fallen through the cracks of the human and health services network. By providing and coordinating services right on the students' "home turf"--their schools--the program has been able to administer a variety of agencies to students-at-risk in an efficient and effective way. Finally, a set of recommendations at the end of this study attempts to answer the question, "Now that we know that a Student Support Team Program can be successful in one urban middle/high school, where do we go from here?"

C. Some Perspectives on the Problems

Over the past twenty years, the behavior of students in urban school systems has changed dramatically, and that change has in turn adversely affected the teaching and

learning processes. A recent report of the College Board Commission on Counseling Issues identified the numerous problems facing urban students, families, and schools, including the profound effects of low expectations on minority students and the need to deal with issues of low student motivation. They concluded that urban students' problems must be addressed by competent, well-trained support staff who are prepared to respond to the diverse and ever-changing needs of a community.

Until recently, very few links existed between schools and health- and human-service agencies. The special knowledge and skill, as well as time, required to secure services from this pot of alphabet-soup agencies, has always been a major constraint. For one thing, the urban school counselor has always carried an unmanageable case load. Dr. Ernest Boyer, president of the Carnegie Foundation for the Advancement of Teaching observes: "Today, school counselors are expected to do what communities and our homes and our churches have not been able to accomplish. If they fail anywhere along the line, we condemn them for failing to fulfill our high-minded expectations."[5]

Boyer recommends that the student-counselor ratio be cut in half: "I consider it a national disgrace that some school districts have only one counselor for two to three

hundred students." For 1987, school profiles showed a low ratio in Los Angeles of one counselor to every 298 students and a high ratio in New York City of one counselor to every 623 students; the mean ratio was 420 students to one counselor.[6]

A second important issue concerns outdated and inadequate training. Many school counselors have not received the training necessary to successfully meet the needs of the urban adolescent. The position of counselor has often been a parochial appointment by headmasters and principals. It was not until 1985 that any school system required a master's degree in counseling for state certification. When a problem, such as alcohol and drug abuse, teen pregnancy, unattended medical problems, depression, or suicide threats, arose, the method of intervention was unclear.

Fragmented attempts to help frequently resulted in a simple notification to parents; referrals for the family would often be made without considering the whole problem. In many cases, improper referrals only added stress to an already overburdened family. Many of these families, themselves dysfunctional and economically strained, found themselves unable to provide the support and guidance needed to sustain these youngsters.

School systems, taking the lead from innovative corporate intervention programs for employee assistance, began to institute multi-service centers within the schools themselves as a way to address the various problems of at-risk adolescents. Various government organizations, including the National Governors' Association, the Association of State Boards of Education, the Education Commission of the States, and a collaborative effort among nine regional educational laboratories that serve all 50 states, have begun to address the problems of at-risk students and to seek coordinated efforts to meet the students' needs.[7] Wisconsin, for example, enacted legislation in 1985 to identify children-at-risk at local district levels, to intervene at local school levels, and to monitor and evaluate such programs.

The New Holstein Student Assistance Program is one program created on the basis of this legislation in Wisconsin. Serving 1500 students in grades K-12, its specific program's goals include: increasing student awareness of alcohol and other drug abuse; lessening the incidence of problems associated with alcohol or drug use; developing expertise in assessing at-risk factors, making referrals and facilitating groups that deal with student alcohol, and

other drug problems; and increasing awareness of local resources available to those in need of assistance for alcohol and other drug abuse.[8] The program claims a 28 percent decrease in absenteeism and a 42 percent improvement in grades overall; suspensions for drug and alcohol use have decreased by 27 percent. The program also claims a very high rate of success in educating its students to understand the roots of their own addictions.

Like many of its corporate precursors, however, the Holstein Program has its limitations. As Dr. Ken Newbury, Director of the Toledo Public School Student Assistance Program notes: "The development of a successful student assistance program requires vision, philosophy, and a sense of history. Student Assistance Programs that respond only to the current interest in chemical dependence by creating an array of student programs will probably fail when the focus shifts to other social problems or when funding is reduced."[9]

In Massachusetts, both the Boston Public School System, which serves more than 58,000 students, and the Newton Public School System, have taken a more comprehensive approach. Their Student Support Team Programs address not only alcohol and drug abuse, which are the main emphases of

the corporate assistance programs; they go further and try to solve various other problems that characterize at-risk adolescents and their families.

Because the approach is new, there is a limited amount of literature on at-risk adolescents and school-based Student Support Team Programs. Nevertheless documentation is very important. In fact, many researchers have stressed the lack of good data about the at-risk adolescent population. They also stress the dearth of knowledge about working solutions and observe the confusion and disagreement about what schools can and should do for disadvantaged or troubled young people. Programs need to go beyond traditional fragmented methods and create a new model, a model that makes the school the integrator and primary referral agency.

Integration is a key issue in this program. Family outreach services, for example, have been incorporated into the Student Support Team Program. Traditionally schools have not tried to assist dysfunctional families as a way of solving educational problems. But, as David Bills points out in his book on at-risk students, "Children-at-risk are really families-at-risk."[10] In some of the cases

analyzed here, outreach to families of at-risk adolescents is really part of the whole process.

Finally, this study tests a number of theories related to this specific program's ability to influence the student-at-risk's behavior in the areas of absenteeism, grade retention, and dropout rates.

D. Assumptions

The school has the credibility, authority, resources, and funding potential to implement comprehensive social services. It already has resources, such as guidance counselors and nurses, on which to build a program. In addition, the school has the support of the city and state administrations, as well as that of the taxpayers, that can help make these programs work. Furthermore, schools have other built-in advantages, such as convenience, familiarity, trust, routine, and opportunity for follow-up. Finally, in comparison with programs such as welfare, jails, and shelters, intervention programs like the Student Support Team are low in cost and high in benefits to the individual and the society at large.

E. Statement of Propositions

This disseration employs the case-study methodology to evaluate the goals of the Student Support Team. These goals include:

One: The intervention of a model Student Support Team Program can put the urban at-risk adolescent into contact with the appropriate human-service agencies to try to better meet their specific needs.

Two: The intervention of a Student Support Team Program can be a factor in a decrease of grade retention (i.e. not promoting a child at the end of the year) among the population studied.

Three: The intervention of a Student Support Team Program, by means of early intervention and the creation of alternative programs, can help decrease the school dropout rate for at-risk adolescents.

Four: The intervention of a Student Support Team Program can be a factor in increasing school attendance in the population being studied.

F. Added Benefits of the Program

Questionnaires developed for students involved in the study, for the therapists who worked through the Student Support Team Program within the school, for the administration and faculty who were involved involvement with the program, and for the Student Support Team members, revealed some indirect benefits from the implementation of this program. First, students came to understand how the Program worked and grew more aware of the local resources available to them and their families.

Second, the program indirectly improved the staff's ability to do their jobs and their general attitude toward their jobs. Benefits for staff members included more open attitudes toward students with problems. Teachers' level of communication both with students and family also improved substantially. Finally, faculty members seemed to gain a better sense of personal fulfillment from their involvement in the Student Support Team Program.

CHAPTER II

BACKGROUND

Literature on the theory of Student Support Team Programs and their implications for the at-risk adolescent is not abundant. The theories of both Erikson and Ponsioen, however, are relevant to the general topic.

Erik Erikson, a leading theoretician of the school of psychology that sees human needs in a developmental perspective, identifies eight "identity crises" in the human life cycle.[11] The concept of human needs which vary at different stages of life helps to explain the organization of various human services along lines of very specific target population. One can see that various health and social services respond to the specific stages in Erikson's plan. Thus, the four stages of childhood, which Erikson says are influential in personality growth and later development, correspond to many specialized social services for children. Adolescence is normally divided into three phases: early adolescence, ranging from ages 12 to 14 years old; middle adolescence, which covers the years 15 to 17; and old to late adolescence, which ranges from 18 to 21 years.[12] A more recent theorist, L.S. Neinstein, has developed a helpful way to look at the intersection of these three stages with the

tasks of adolescence.[13] He pays attention to four issues: the independence-dependence struggle, body-image concerns, peer-group involvement, and identity development (including vocational identity). Neinstein then goes on to show how each of the tasks is handled in each of the three stages. This analysis help in understanding what is the norm for an adolescent at a given age.

For example, whereas a preoccupation with the body (size, shape, attractiveness) is to be expected in early adolescents, it would be unusual in late adolescence. Risk-taking behavior in early adolescence is generally due to poor impulse control, whereas in middle adolescence risk-taking often stems from feelings of omnipotence and immortality and thus leads to high rates of accidents, suicides, drug use, and pregnancies. By late adolescence, such behavior is no longer considered normal, and if it persists, it clearly indicates that the teenager has not developed normally or fully for a given age.

J.A. Ponsioen's approach focuses on people's more basic survival needs as distinguished from all other needs.[14] Ponsioen contends that every society's first duty is to take care of the basic survival needs of its citizens, which include biological, emotional, social, and spiritual requirements. According to this view, each society must

establish a level below which no person should fall. The established levels, of course, are not permanent; they change over time and can vary from society to society. The point is that when discrepancies exist in the availability of, and access to established levels of, goods and services among individual citizens or groups, it becomes the responsibility of the society to remedy the situation. And such is now the mission of our schools.

In 1960, the United Community Funds and Councils of America expounded this basic premise of social responsibility: "The principle of community responsibility is widely accepted in America today. It has two elements. First, there is the responsibility and accountability of the individual or organization to the community as a whole. Second, there is the responsibility of the community to foster the well-being of its individual members."[15] And government agencies are now picking up the ball. In January 1988, the Department of Labor noted the growing interdependency of education and the community. The department has awarded the Council of Chief State School Officers (CCSSO) a grant to help 10 states develop policies for at-risk students.

In a related development, about 30 superintendents of urban school districts joined forces with the Department of

Education in releasing a report on strategies for preventing adolescents from dropping out of school. As in the CCSSO report, the focus was once again on program intervention and the coordination of services through inter-agency arrangements in the communities.[16] Educators and human service providers do seem to be concurring that a comprehensive support system is essential in meeting the needs of the ever-increasing at-risk population.

But what is the price of all these supports? Brigitte Berger, who has written extensively on the role and responsibility of the family, believes that the American parent is relying too heavily on the schools to help fulfill the expectations they have for their children: "Our political society has by its powerful axis of educators, policy makers, and pundits of the media reduced the importance of the family's role."[17] She continues: "The affirmation of the family's role in the education of its children is more of an embarrassment than a serious recommendation."

Berger claims that the very basic functions of the family has now been questioned. In particular, patterns of behavior in ethnic and racial minorities and in poor families, with their distinct family arrangements and pronounced cultural milieus, have been declared defective and in need of intervention. But middle-class families, too, were

examined and found to be inadequate and, in some cases, even destructive to their children. This blanket criticism has opened the way for the influx of social workers, counselors, psychologists, and therapists that are an established part of our schools today.

Not only have the attempts to invest the school system with enormous tasks for which it seemed to be distinctly unsuited resulted in failure, but in the process of transformation of their functions, schools have been diverted from their essential tasks. At the same time, Berger points out, efforts to take away from the family what is the family's actual responsibility have, in large measure, contributed to a dangerous weakening of--and in some individual cases an actual breakdown of--the family.

Frankly, neither families nor educators would be altogether comfortable with Berger's opinion. Yet her analysis of the factors (such as the mobility of the family and economic independence) which have caused this educational dilemma, is sound. What's more, Berger does not hide behind the facade of curriculum reform and management techniques. On the other hand, she never directly states where she thinks the responsibility truly lies, although she does conclude that "a positive home environment that emphasizes parental understanding, parental control, and involvement is

still the best precondition for a child's successful performance in school and in life."

The problem is that many factors--general economic fluctuations like inflation and recession, unemployment (or underemployment), the rising divorce rate and the problems of the single-parent family, the surge of young mothers into the work place--all these factors affect the capacity of the family to provide care and protection for their children. In spite of families' strengths, these pressures make many of them far too vulnerable. As one government report recently pointed out: "One crisis, one mistake, one emergency can often plunge them into poverty or separate children from their parents."[18]

For the purpose of this study, at-risk adolescents are young persons, ranging from 12 to 18 years of age, who are, as defined by the Carnegie Council on Adolescent Development, "at-risk of reaching adulthood unable to adequately meet the requirements of the work place, the commitments of relationships in families and with peers, and the responsibilities of participation in a multicultural society and of citizenship in a democracy. These young people often suffer from undeveloped intellectual abilities, indifference to good health, and cynicism about the values that American society embodies."[19] They will fail either because of a

single, isolated problem, such as a learning disability, with which they cannot cope, or they will fail because of a combination of stresses. For these adolescents, relationships, both at home and at school, are nonexistent, weak, or sources of severe conflict. At-risk adolescents are easily influenced by peers.

Hard statistics are in general unavailable for this group. As the Carnegie Council goes on to point out: "No definitive statistics exist in the numbers of youth at-risk of unhealthy and unproductive lives. Recent first attempts at estimating these numbers indicate, however, that of the 28 million girls and boys ages 10 to 17 in the United States, about 7 million may be extremely vulnerable to the negative consequences of multiple high-risk behaviors such as school failure, substance abuse, and early unprotected intercourse. Thus it is estimated that the future of about 7 million youth--one in 4 adolescents--is in serious jeopardy. Another 7 million may be at moderate risk, because of occasional substance abuse and early but more often protected intercourse. About half of the nation's youth are at low risk of engaging in seriously damaging behaviors. They may, however, require strong and consistent support to avoid becoming involved in these problems.[20]

Today's at-risk adolescents face far more serious problems and in more areas than in past. These problems include:

Academic Difficulty: A recent Carnegie Report states that in Chicago only 10% of tenth graders can read effectively.[21] Data also indicates that one of every 20 youths has some form of functional limitations such as a handicapped condition, which can be physical, emotional, and/or educational, and almost 1 in every 100 has a severe limitation.[22]

Alcohol Abuse: A recent study cites that, for adolescents, alcohol remains the most frequently abused drug, and this abuse has not declined in the last three years. Ninety-two percent of high-school seniors have used alcohol, 66.4% are regular users, and about 5% are daily users. About 37%, in the survey, reported heavy drinking in the preceding 2 weeks.[23]

Adolescent Childbearing: More than 1 million teenage women became pregnant in 1984 and 480,000 gave birth. Almost 10,000 births involved girls less than 15 years of age, and there were more than 450,000 pregnancies and 167,000 births in the 15 to 17 age group. More than half of the total births to teenagers were out-of-wedlock births: 133,000 to white teenagers, 120,000 to black teenagers, and

8,087 to others.[24] Twenty-three per cent of all adolescent mothers will have a second baby within two years of their first, and 43% will have another within 3 years.[25]

Adolescent Abortion: The latest data indicates close to 1 million abortions annually among women in the 15- to 24-year range in the early 1980s. About 45% of all pregnancies of 15- to 19-year olds, and 31% of all pregnancies of 20- to 24-year olds end in abortions.[26]

Adolescent Arrest: In 1985, adolescents accounts for 38% of the arrests for burglary and motor vehicle theft, 41% of those for arson, and 33% of the arrests for larceny. Out of the nearly 2 million adolescent arrests in that year, 4.1% involved serious crime, 33% were serious property offenses, 34.1% involved less serious crimes such as vandalism and minor assault cases, and 28.1% involved noncriminal behavior (like truancy).[27]

Attendance Problems: Fourteen percent of all adolescents under the age of 16 are habitually truant from school. The Boston Juvenile Court system processed 12,140 Child in Need of Services petitions (CHINS) for truancy in 1986. Data compiled by that court indicates that 87 percent of all school truants become juvenile offenders.[28]

Child Abuse: The Massachusetts Department of Social Services statistics indicate that, for 1986, the total of

child abuse reports (Form 51A) filed was 19,781; 47 percent of these reports were substantiated, of which 52 percent were problems of neglect; 28 percent, of physical abuse; 11 percent, of abuse and neglect; and nine percent, of sexual abuse.[29]

Depression: Teenage suicide attempts, one index of depression among adolescents, account for 500,000 emergency room visits annually. For each 100 attempts, there is one death. Of course, those attempts that do not require medical attention remain uncounted.[30]

Diseases: Adolescents accounted for 62.5 percent of the gonorrhea cases and 40 percent of the syphilis cases in 1985. Nearly half the estimated 20 million sexually transmitted disease patients are under the age of 25.[31] The New England Journal of Medicine reports that a very small number nationwide (0.15 percent) of adolescent applicants to the U.S. Army test positive for the AIDS virus. But in some major urban centers, rates for adolescent AIDS cases exceed 10 per 1,000, or one percent. Rates approach 20 per 1,000, or two percent, in the New York City, San Francisco, and Washington, D.C.-Baltimore areas.

In a 1986 study, Lee Strunin and Ralph Hingson of the Boston University School of Public Health found that of 860 randomly selected adolescents, aged 16 to 19, 70 percent

were sexually active. More than half said they did not worry at all about contracting AIDS. Only 15 percent said they had changed their sexual behavior because of concern about AIDS, and of this group, only one in five used effective methods of protection.

Drug Abuse: Fifty percent of urban adolescents "sometimes" use drugs; the average age at first use is 14 years old. The Attitudinal Research Report/Boston Task Force on Drugs for 1986 states that the drugs most commonly used include cocaine, crack, PCP, Valium, marijuana, hashish, acid, mescaline, Percaset, codeine, heroin, Quaaludes, morphine, opium, glue, and alcohol. In a 1986 study, 1.1 percent of U.S. high-school seniors reported that they had used heroin.[32] In addition, there is a higher rate of intravenous drug use among adolescents who drop out of high school before graduation than those who graduate.

Homeless: There are approximately 1.2 million children and adolescents homeless nationwide; most are victims of dysfunctional families. It has been estimated that 40,000 teenagers lives on the streets of New York City with no family and no home.[33] Harvard University psychiatrist Dr. Ellen Bassuk discovered that school-aged children of homeless and chronically unstable families were significantly more depressed, on the whole, than children from similarly

poor but stable families. Jonathan Kozol has observed that families who end up in shelters usually face an uncommonly large number of problems, which together leave them unable to cope.[34]

Institutionalized Adolescents: The 1980 census reported that 360,000 youths (0.8% of the adolescent population as a whole) were confined to institutions.[35] About five-sixths of the institutionalized adolescents are male. The great majority of them were in prisons, jails, or juvenile detention/correction facilities.[36] Approximately 90,000 youths (0.2% of the population) were in mental hospitals or homes for the mentally handicapped.

Prostitution: An estimated 125,000 to 200,000 teenagers become involved in prostitution each year; approximately one-third of these are not runaways but live with their parents, with another guardian, or in foster care.[37]

Runaways: Approximately one million teenagers run away each year in the United States; more than half of them have run away at least three times. The National Network of Runaway and Youth Services states that 70 percent of the runaways who come to emergency shelters have been severely abused physically or sexually molested. A 1983 study of adolescents in youth shelters in New York City by David Shaffer and Carol L.M. Caton of the New York State Psychia-

tric Institute found that adolescent shelter users had psychiatric profiles similar to those that seek help in psychiatric clinics. Thirty percent were categorized as depressed, 18 percent as antisocial, and 41 percent as both depressed and antisocial. An estimated 187,500 runaways are involved in illegal activities, such as drug use, prostitution or solicitation, and drug trafficking.

School Dropouts: Nationwide, an estimated 27 percent of high-school students don't graduate; the national dropout rate has been over one million students annually.[38]

Sexual Activity: The Carnegie Council on Adolescent Development estimates that by the age of 16, 29% of all boys and 13% of all girls have become sexually active.[39] Each year, about 60,000 babies are born to adolescent girls under the age of 16.

Suicide: The National Center for Health Statistics indicates indicates the suicide rate for adolescents has leveled off.[40] However, during 1984, 5,026 adolescents took their lives. One prevalent stress factor in adolescent suicides is chaotic family situations; these situations increase the psychological states that can cause suicidal behavior: depression, guilt, anxiety, hopelessness, low self-esteem. Such conditions result in youngsters that are

emotionally deadened and psychologically immature in comparison with their peers.

Violence: According to the U.S. Department of Justice, more than 27,000 youths between the ages of 12 and 15 were handgun victims in 1985. By the age of fifteen, the average American teenager has seen 13,000 murders on television and has been exposed to an endless stream of war, famine, and holocaust in the daily news.41 In Boston authorities confiscated more than 90 weapons in the schools in one month.[42] In New York, Principal Edward Morris asked for a transfer from Park West High School, where he clearly lost control of violence-prone students, and where students in the cafeteria stomped a girl so brutally they broke her ribs. The National Institute of Education reported that almost one-third of the victims of physical attacks participating in a 1987 survey said they occasionally bring a weapon to school for protection. This fact reveals the even greater problem of the bully syndrome or victims of such aggressive behavior. What fosters aggressive behavior in a youngster is most often too little love and care and too much freedom in early childhood; this combination contributes strongly to the development of the aggressive personality. "What has been bred into a student has to be bred out, not beat out," says Norwegian psychologist Dan Olweus, who has done studies

on the school bully for 20 years and persuaded his country's Ministry of Education to start a nationwide campaign to address this issue.[43] For schools, his plan requires close supervision of children and rules against bullying that are clearly laid out and consistently enforced. The parents are involved in discussion groups on the subject. His plan also encourages both adults and classmates to support and protect victims. There has been a 59 percent improvement in the situation in two years with counseling.

Weapons/Homicide: A 1987-88 Boston report indicates that 55 students were expelled from the public school system for carrying guns (this is mandatory for second offenses); a total of 463 weapons were confiscated.[44] Another 2,500 must report to police probation officers for past offenses. The number of assault cases reported by urban schools for 1987 ranges from a low in Boston of 410 to a high in New York of 1,606. In a recent Baltimore high-school poll, 64 percent of the students knew someone who carried a handgun; 60 percent knew someone that had been shot, threatened, or robbed by a person with a handgun.[45] A 1985 U.S. Department of Justice report stated that more than 27,000 youths between the ages of 12 and 15 were victims of handguns.[46] The homicide rate in this country for young adults was 12 per 100,000 in a 1984 NCHS report.[47]

Welfare: The United States spent more than $19 billion in 1987 for income maintenance, health care, and nutrition payments to families that were started when the parents were still teenagers.[48] Of adolescents who gave birth, 46% will go on welfare within 4 years; of unmarried adolescents who gave birth, 43% will be on welfare within 4 years.[49]

Looking at these figures, one can see that our schools have changed significantly in the last decade, and these changes have caused the most extreme reforms in the history of educational institutions. We can no longer assume a coherent vision of the role schools play in society; instead, we must consider the many salient characteristics of the society in which they serve. "A decade ago, few programs existed for the teenage population, and two decades ago it would have been unthinkable to equip unmarried adolescents with contraceptives."[50] Yet now it is not unusual to find comprehensive health services being offered in the more progressive urban schools.

In 1987, eighty-five school-based clinics in 25 states were offering comprehensive health services, including family planning, and more programs were in the planning stages. The services provided by these clinics have markedly reduced school-age pregnancy, contributing to a higher school-completion rate.[51] The family, which is the earliest

socialization agent for children, has often become dysfunctional on account of divorce, single-parent families, unavailable grandparents, and increased parental absence. These changes have take a heavy toll on our young, and as a result schools have been asked to assume a far broader and more complex role than that of simply stimulating academic achievement. As Robert Cormandy observes: "The school must now be seriously concerned about such threats to student emotional and physical well-being as abduction, child abuse, suicide, substance abuse, and family crises."[52]

J. Kozol has recently addressed such serious threats to students. In his book Rachel and Her Children, Kozol writes about the new class of low-income families, about families who are becoming rootless and so creating a new subset of at-risk families and adolescents. When seen in the school context, they perhaps are the neediest of all. Support systems have not even begun to address this new class of student. Kozol points out many of the problems unique to this group, and he explores the implications for the future growth and development of these children. He cites Harvard psychiatrist Dr. Ellen Bassuk on homeless families: "The overall depression scores were higher for the homeless than for those who were comparably poor and those registered in a psychiatric clinic."[53] Bassuk also found that the school-

age children of the homeless were significantly more depressed than children from similarly poor but stable families. To describe these children, school teachers often resort to such drastic phrases as "deeply troubled," "emotionally disturbed," and "learning disabled."

Kozol also reports what is happening to the rapidly growing number of children who are living in shelters and hotels. The ominous findings reaffirm that early death and stunted cognitive development are not the only risks these children face. Kozol tells of children turning on themselves. In one case, a 10-year-old boy, ridden with anxiety, pulled out his permanent teeth and mutilated his body (it is this level of extreme anger that we more frequently see vented on society). Kozol concludes: "Such children, if they do not cause disruption in the streets and the hotels, may do so in the public schools." He wonders what will happen to these children when their behavior in school becomes so disruptive it simply becomes unmanageable and unacceptable. What will happen, he asks, to the youngster who never makes it to school and spends his day on the streets?

Kozol asks important questions that more urban public schools need to address. In this study's model program, the Student Support Team identified twelve cases where students

came to school for food and warmth. In one instance, a student returned to school after hours to clean up, do his laundry, and sleep in the Home Economics Room. Most are not so resourceful. Other researchers concur that the children who need intervention the most are those who are either homeless or who are growing up in neighborhoods characterized by intense poverty and social dislocation.

CHAPTER III

DESIGN OF THE STUDY AND RESEARCH

A. Design of the Study and the Model Program

This research consists of a study of a model Student Support Team Program in an urban middle/high school over an 18-month period. The program was experimental and funded by the urban school system through city and federal grants; additional services were obtained through third-party billing. A Student Support Coordinator headed the Team, which included seven other Team's members. Over the 18-month period, 355 students were referred. Six representative case studies from this group are included in detail for analysis in this thesis; the case studies present all the available evidence--social, psychological, environmental, and academic--that pertains to individual cases. These case studies were selected not only because they were representative of this specific group but because they were good examples of what exists in the general urban public-school student population. The students in the case studies were also selected on the basis of their own and their families' willingness to cooperate in the study.

This study was conducted using data from the entire group of 355 referred students. The intent was always to assess the pre- and post-intervention conditions of the referred students. No control group was used. The study used a variety of field methods, i.e. questionnaires, interviews both of the students and their families, report cards, teacher consultations, referral and assessment forms, attendance records, and other information that may be pertinent to the case.

The aim of the data gathering was to gain a full understanding of the students' complete backgrounds in order to better understand the stresses they contended with in their daily lives. For this purpose, the study used the Student Support Team Referral Checklist and the Assessment Form (see Appendix A), which requested data on a variety of general and specific subjects including: family structure (race, age, general physical condition of the student and their parents or guardian, residential situation, rules of the house, methods of discipline, chores, and responsibilities); mental health (personality, values, and self-awareness); social outlook (racial attitudes, leadership capabilities, and assertiveness levels); school behavior (educational background, achievements, standard test results, and occupational goals and aspirations). Other categories were also

included to help the Student Support Team formulate individual problems and recommend an approach to intervention.

Several of the forms used were developed specifically for this program, but a substantial amount of information has been obtained from the general records. For instance, the evaluation questionnaire (see Appendix A) especially designed for the program consists of three separate forms: one for the student, one for the school faculty, and one for the external support agencies. The questionnaire focuses on four areas of concern: identification, assessment, referral, and follow-up and support. The identification process focused on determining as early as possible which students were at risk. The assessment process involved using all the appropriate techniques for gathering information about the students. The referral procedures involved making sure that the teachers, students, and external support agencies were in contact and aware of the process. Finally, during the follow-up period, a monitoring system was used to ensure that students had the incentive and confidence to remain in the program and to make sure the system was flexible enough to accommodate students making permanent changes.

Interviews, on the other hand, were always somewhat structured and standardized. The interviewer always asked a number of the questions to establish the general background.

However, the interviewer also remained ready to switch gears and focus on individual circumstances. The line of questioning was meant to be flexible and sympathetic.

B. Description of the Model Program

The model program was designed to give the schools the chance to develop a coordinated counseling and support plan for the at-risk student. It was unique in bringing to the school system a method already successfully used in corporations and community multi-service centers. The program used the expertise of various specialists, who together form the Student Support Team. Headed by a Student Support coordinator, the Team also includes a school administrator, a psychologist, a school adjustment counselor, a social worker linked to a local mental health clinic, a school nurse and medical doctor linked to the City Hospital, a school guidance counselor, and a special needs coordinator.

The program's goals were prevention and referral for the at-risk adolescent with emotional, social, and/or educational problems. In addition to the identification, assessment, referral, and follow-up procedures described above, several other guidelines were established to coordinate the delivery of support services. The Team met

regularly to discuss students' problems and exchange other information. It was important to be aware of the general school's climate in order to intervene as early as possible. The Team established ways to identify and use both internal and external student support services. Last, the program established bridges for the students with the social-service network, the court system, and other agencies.

The program organized and directed the Student Support Team in several ways. It required evaluations and training of the personnel for their specialized roles as members of the Team of advisors. Team members were updated on current counseling theory and introduced efficient and standard methods for delivering services. In addition, an important part of the program was to provide central coordination for the Team as well as ongoing evaluation of its efforts.

C. Student Support Team Process

The Student Support Team met regularly once a week, for not more than 90 minutes, for case review and presentation. The meeting typically resulted in a written plan that would address four issues. First, the Team might recommend modifying a student's academic program within the school building or within the school system. Second, the Team

might decide to introduce new supports for a specific student. Third, it could recommend new supports for staff and/or students aimed at prevention. Four, the Team would establish times for follow-up, evaluation, and review.

In general, the referral process begins when a school staff member, for example a teacher or nurse, identifies an exceptional or unmanageable problem. After trying his or her own method of solution, the referring agent obtains a form from the Student Support Team Coordinator or other designated personnel. Together the referring agent and the coordinator complete the forms and add all pertinent material. With five days notice, the case can then be included on the Student Support Team meeting agenda and the referring agent is informed of this action. The Coordinator distributes relevant material (e.g., a copy of original referral, educational history, results of available psychological and/or educational testing, anecdotal data) to each Team member at least three days prior to the Team meeting.

The Team meeting itself is convened by the Headmaster/Principal or her designee. Each case on the agenda is presented to the Team. After a case is presented, each Team member involved gives any relevant information, any Team member is then free to suggest specific recommendation, and then the chairperson (usually the Headmaster) gives specific

directions/plan of action and designates person(s) responsible for the actions and follow-up report.

The Team usually reaches a decision to modify the academic program and/or introduce new supports for the student, or to recommend interventions that the Team itself address broader areas such as alternative placement, family intervention, etc. Other types of recommendations may also be appropriate at this time (for example, the case may remain open for a certain period of time to gather additional information and/or to implement further strategies such as specific testing, academic tutoring, or counseling). The Team always records its own discussions and recommendations. At subsequent meetings, the Team reviews on-going cases.

D. Student Support Team Members

The Student Support Team consists of: (a) Support Team School-Community liaison (Student Support Coordinator); (b) Headmaster or Principal; (c) Guidance Counselor or Advisor; (d) Psychologist; (e) Pupil Adjustment Counselor; (f) School Nurse and/or Medical Doctor; (g) Special Needs Coordinator); (h) Human Service Collaborative Member and; (i) other staff, as required, to address the specific case at hand.

For the program to be successful, all members of the Team should have specific qualifications and meet certain responsibilities. Over and above those factors, the Team members must be committed to both the students and the program itself.

The Student Support Team Coordinator should have urban teaching experience, state certification in Guidance as well as a graduate sub-specialty in social work or a closely related field. The Coordinator should be acquainted with state laws and with local agencies and programs concerned with child welfare. This Team leader serves as liaison between the school and external agencies. The Coordinator assists in referrals of at-risk adolescents and their families to external agencies, obtaining parental consent when necessary. Coordinators obtain information for parents and students on developmental issues.

Within the framework of Team organization, the Coordinator organizes outreach activities of the Team's joint and individual efforts on behalf of students, setting times, dates, and places for meetings and distributing necessary materials. The Coordinator is responsible for intake interviews and casework functions of the at-risk adolescents referred to the program. The Coordinator is generally responsible for developing funding sources for individual

therapy programs. The Team leader also aids in specifying and implementing building-based programs and student orientation to the program. Finally the Coordinator oversees all Team reports and, in some cases, serves as the designated Student Support Team Chairperson.

The School Administrator is the Headmaster/Principal and is accountable for the overall function of the Student Support Team. Administrators are responsible for funding the program and hence must be particularly committed to its concept. They also act as the chairs of the Student Support Teams. Administrators advise on how to implement internal programs, advise the Teams on policy recommendations for at-risk adolescents, and ensure the implementation of Team recommendations. Administrators promote in-service programs, and provide places for the program office and areas suitable for group and individual therapy.

The Team Psychologist should be state-certified for, and have experience in, psychological-educational assessment. The Psychologists on Program Teams complete psychological-educational evaluations for students upon the request of the support Team. They identify factors contributing to academic deficiencies and give the Team diagnoses and recommendations for treatment of any cognitive disorders. The Psychologists also treat at-risk adolescents,

both in individual and group sessions. Finally the Psychologists make themselves available to the at-risk adolescents and to teachers and administrators for consultation.

It is worth noting that, in the model program, the Student Support Team recommended in its annual review a change from using the school psychologist on the Team itself. The Team observed that the school psychologist is not just responsible to the Team but to the school as well and may be overburdened to begin with in his ordinary case load. National urban trends do show that individual psychologists are theoretically assigned responsibility for 1,500 students of which 10 percent will need psychological services. Thus a single school psychologist could be providing service to 150 students at any given time. In addition, school psychologists spend 70 percent of their time as psychometricians and only 30 percent on referral and treatment. What's more, most practicing school psychologists are not trained psychotherapists. For these reasons, it does seem more desirable to use a clinical psychologist as a Team member, and this is what the model Team recommended in its annual review.

The fourth Team member, the school Guidance Counselor is certified by the State Board of Education. The Guidance Counselors' role is to counsel every student in the acade-

mic, personal, social, and vocational areas. As Team members, they closely monitor students who are having academic, social, or personal problems, and try to detect early those students who may be at risk. They communicate often with classroom teachers in effort to identify at an early stage adolescents who are at risk and to refer them to the Team Coordinator. They counsel referred students on a regular basis and give the Team progress report on those students. Guidance Counselors also review and assess the educational history of each new student. In addition, they are responsible for educational and vocational counseling for those students deemed at risk.

The Special Needs Coordinator, or Special Education Liaison, is the fifth member of the Team. These Special Needs Coordinators help assess educational deficiencies and needs of the at-risk adolescents. They provide the students with information on remedial services and are responsible for overseeing the state regulations on services and benefits for special needs students.

The sixth member of each Team, the School Pupil Adjustment Counselor, is licensed by the state and has experience in case management, family therapy, and community outreach. As Team members, these Adjustment Counselors facilitate family therapy and other services, such as parent-support

groups; they also provide a liaison with other social and human-service agencies, acting as a source of information and contact for agencies such as day-care and after-school programs. They are responsible for the sociological evaluations of referred students. They also are responsible for teacher consultations about the individual families.

The Social Worker (preferably a Psychiatric Social Worker) is licensed by the state and works not for the school but for a state, a city, or a private foundation. As Team members, the social workers are advisors and are also responsible for treating students, in group or individual therapy, when their case loads permit it. They help in problems such as child neglect, and financial and welfare needs, and are on call for crisis intervention. They are also responsible for keeping the Student Support Coordinators informed of the welfare of the at-risk adolescents via biweekly case reviews.

The seventh member of the Team is a Medical Doctor, who is generally an intern from a local hospital. The Doctor advises the Team and gives routine medical exams, when necessary, to referred at-risk adolescents. The Doctor is also on call for medical emergencies.

CHAPTER IV

PRESENTATION OF FINDINGS

A. Methodology

This project primarily uses the case-study method to evaluate the Student Support Team Program. Referred students were followed in-depth to test the theory that a synthesized coordinated approach to providing student services to at-risk adolescents in a school setting works better for the at-risk adolescent than the more traditional fragmented approach of referring a student to various agencies with no or little coordination of services.

The six cases studies test the efficacy of the Student Support Team Program in various ways. Three cases involve at-risk adolescents who had been referred to various agencies, which failed, for one reason or another to help them, prior to the students' being involved with the Student Support Team Program. When the Team had an opportunity to coordinate these three students' cases, it brought agencies together and devised a plan of intervention. The three other cases describe situations in which the families had not made contact with any agency at all before the Team took over. The Team, and the agencies and services it coordi-

nated, got the family the financial help it needed in order that the at-risk adolescent might remain in school through graduation.

Three of the cases began initially as referrals to the Team; the others began as problems in the Guidance Counselor's office. It was not until each of these latter three students had ceased to come to school altogether that they were brought to the attention of the Student Support Team. The interesting point here is that all three students were academically sound, with no apparent behavior problems, just attendance problems. Only later did the Team uncover some deeper behavior problems.

B. Presentation of Six Case Studies

Identifying information in the following case studies such as the names, locations, and dates, have been disguised in order to protect the individuals involved in the case studies.

Case Study #1

Profile: Kim Lim was a 13-year old Vietnamese national, who had been in the United States for four years and was then living in a predominantly white public-housing project with both parents. She was the youngest of five children and the only one living at home. Her history included

physical and emotional abuse by her parents, running away from home, truancy, and verbal and physical confrontations with her peers that had led to many school suspensions.

An eighth-grade substitute teacher referred Kim Lim to the Student Support Coordinator because the student expressed suicide ideations in an essay: "I hate myself, I am so ugly, why was I ever born, I want to die!!!!!!!" she had written. The Coordinator immediately got in touch with the student and asked her about her essay. After an extensive assessment the Coordinator concluded that the student was not in any immediate danger of harming herself; however the suicidal expressions required that the school system notify the parents. When the Coordinator told Kim of this requirement, the girl became hysterical, getting down on her hand and knees, crying in the lap of the Coordinator, begging her not to tell her parents because they would get very angry and punish her.

The Coordinator was every concerned about the emotional state of this young adolescent: Kim was intensively angry at everyone in her world; not only was her home life unhappy but she also couldn't get along with others at school. All these issues surfaced during the intervention and assessment session. The Team decided to wave the parental report and to seek immediate intervention. A Psychiatric Social Worker

saw the student, and, after a second assessment, the youngster was allowed to go home. The next day the Guidance Counselor compiled as much of the girl's school history as possible; the School Nurse gathered information about Kim's medical complaints at previous schools. Several incidents of unexplained bruises and body markings had led earlier teachers to file suspected child-abuse complaints and these reports had been substantiated.

In search of more information about the family, the Coordinator contacted the Asian Community Center. This contact proved fruitful. There was a history of drug abuse, delinquency, running away from home, and dropping out of school by older siblings. The Coordinator then checked on the disposition of the case at the Department of Social Services; a case worker had been assigned to the family because of abuse charges.

Within a week of the first encounter, Kim Lim came to the Coordinator's office for help. She claimed she had been picked up the night before for shoplifting, and she needed to find out if she would have to appear in court and if she would have a police record because of this incident. The Coordinator contacted the store security and acted as an advocate for the youngster, thus relieving some of immediate stress. The Student Support Team was also able to assist

the Department of Social Services in providing testing and on-site counseling for this at-risk adolescent (the department had previously arranged counseling for the student and her family but had provided no follow-up).

At the next scheduled Student Support Team meeting, the Team decided that Kim should be moved out of her present class, where she was the only Asian and somewhat of a scapegoat because of that. The Team suggested she be placed in a class that included some other Asians. It also recommended that she see a therapist on-site for individual counseling.

The Psychiatric Social Worker started seeing the student on a weekly basis during school time. They worked on various issues; some of these issues revolved around her stay in a refugee camp as a Vietnamese immigrant and were related to cultural differences and other issues of transition; other issues revolved around family conflicts and sexual misuse by family and friends. Kim confided to the Social Worker that her father had beaten her (bruises were evident on the body). When the Social Worker filed child-abuse charges (Form 51a) however, the action only alienated the student. When the Department of Social Services investigated, the girl denied that her father had caused the bruises; the case thus remained unsubstantiated.

Because she felt angry and betrayed, Kim missed the next two counseling sessions with the Social Worker. During that time, several incidents occurred, including racial slurs and death threats toward her, which once again led the Team to intervene. This time the Team referred her to peer mediation to solve her problems and convinced her to resume therapy.

Through this kind of intervention by the Student Support Team, this at-risk adolescent remained in school, passed all subjects with honor grades, and gained some insight into family issues and problems and how they affected her school performance and social conduct. This adolescent also learned how to make decisions that would lead to positive outcomes.

Case Study #2

Profile: Beth West was a 14-year-old black girl who had been raped. She was homeless, and had been without a permanent home for eight years. Her mother was suspected of being an addict. A 22-year-old brother, suspected of incest with a sister, was in prison for crimes against children. Beth had a reported history of depression, histrionic suicide ideations, possible pregnancies, drug/alcohol abuse, poor hygiene, repeated school failures, a severe attendance

problem, a tendency to act out her feelings, and several verbal and physically threatening assaults on teachers.

The Coordinator first encountered this at-risk adolescence in a crisis situation: the student inflicted wounds upon herself in an attempt to commit suicide. The Coordinator stayed with Beth until she was able to hand over her weapon and compose herself so that she no longer had to be restrained. The Coordinator remained with the child in the hospital for seven hours until a maternal aunt arrived, followed soon thereafter by the mother. During this time in the hospital, Beth received both a psychiatric and a medical evaluation. The hospital physician decided to file neglect charges against the mother and to admit the student to the hospital.

When the Coordinator tried to follow up at the hospital the next day, she learned that the at-risk adolescent had been released into the custody of her mother; the release had taken place in part because there had been no adolescent beds available and in part because the student had no medical insurance. The Department of Social Services was supposed to follow this case up within 48 hours. No follow-up occurred, however, because the address that the mother gave the hospital and the Department of Social Services was an empty city lot.

The student did not return to school for ten days after that. The Team called an emergency meeting and decided that the Coordinator should get in touch with the Department of Mental Health, the Department of Youth Services, and the Department of Social Services in order to locate the girl. But all the Coordinator found out from these phone calls was that the status of the neglect charges, which remained unsubstantiated.

The Coordinator maintained constant contact with the case worker from the Department of Social Services. The case worker was able to reach the mother on several occasions, and he reported that the mother wanted no involvement with any public services for herself or for her daughter. The mother and daughter did go to a therapy session set up by the Department of Mental Health, but the daughter refused to speak during session and no more appointments were scheduled. The records note that the mother was offered public housing several years before, but she had refused it.

During the months that followed, the relationship between Beth and several members of the Team became stressful. The closer the Team came to helping the student, the more hostility the student exhibited. At the point when the Coordinator was able to involve the Department of Mental Health and the Department of Social Services, Beth

threatened the Coordinator's life. The Department of Social Services eventually closed the case; noting "three home visits to nonexisting homes" and "the obvious resistance from the mother," they said they could do nothing further. Although the aunt was not involved in taking care of Beth nor was she particularly helpful in obtaining services for her niece, the Coordinator kept in touch with her because the Team decided she appeared to be the only constant in the student's life.

Beth failed the eighth grade for the second time, but, on the recommendation of the Student Support Team, she was promoted into grade nine and referred to the Special Education Department for monitoring and an educational evaluation. The Team Guidance Counselor wrote to Beth during the summer vacation to try to re-engage her and to encourage her to make contact with the Student Support Team Program Office and to formulate a plan for continuing her education in a high-school setting that would meet her specific needs.

In the fall, the at-risk adolescent did return to the same school; she was now living with a friend of her mother's, a reported drug addict, and taking care of that woman's young child. The situation between the Student Support Team and the student did not improve. The student

was intentionally assigned to a homeroom that required that she walk by the Student Support Office every day. The Coordinator arranged for a therapist to see Beth at school, but Beth refused. The Coordinator then arranged for her to be part of an adolescent support group. Again the student refused, this time by rolling up the appointment pass and tossing it in the Counselor's face. The adolescent did, however, attend the group and participated. Later, she again came to the attention of the Student Support Team, first because of referrals based on her attendance record, and then because the registrar discovered she had no valid address.

Upon contacting the Department of Social Services, the Student Support Coordinator was told the case was closed and that it was her responsibility to refile charges of neglect if there were reasonable doubt. Knowing the adolescent's allegiance to her mother and wishing to maintain its connection with the student, the Team decided it would be best to file a Child in Need of Services petition with the court system instead. (That type of petition tends to put the onus on the child for not coming to school, and at the same time mandates that the parent appear in court with the child.)

During this period, Beth went to the nurse's office and the Guidance Counselor's office complaining of physical and social problems; these visits resulted in referrals to the Student Support Team. One major problem was that she said she was pregnant by her 26-year-old boyfriend and that she was uncertain about having an abortion. But the school nurse checked with the health clinic and found that the student had never been there as she claimed. Beth soon thereafter implied that she had a miscarriage and became very depressed about her present living situation. The Student Support Team noted a definite pattern and recommended that the aunt be contacted. The Counselor contacted the aunt, who had no idea where the child was. When asked about the mother's friend, with whom it was believed Beth was living, the aunt said that she knew this woman, and she was very good to Beth. At one time there was talk of the aunt's trying to gain custody of the at-risk adolescent.

The aunt asked the Counselor to help her restore communication with her niece. She claimed she was ill and could not take custody of Beth or even provide housing for her, because she lived in an elderly housing complex which did not allow for children.

Several days later, the at-risk adolescent came to the Student Support Team Office and apologized for her past

behavior. She broke down and said she needed help; she said she could not continue on with the way things were for her now. When she was able to compose herself, the Coordinator escorted her to class and told her she would get back to her within the hour. Arrangements were made for an emergency Student Support Team meeting, but before the meeting took place, the Coordinator was called to the girls' lavatory because the at-risk adolescent had told a classmate she was going to do something to herself. In assessing the situation, it was concluded that Beth could no longer guarantee that she was not going to hurt herself. The aunt was called and she agreed to be seen but said that, due to illness, she could not help.

What took place then was very disappointing, if not alarming: the Support Services Department of the School Committee was called and the student's situation was explained, including the facts that the student had no legal address, no immediate legal guardian, no welfare benefits (Medicaid or other), and no insurance coverage. That department recommended that the Student Support Coordinator call the Director of the Department of Mental Health for guidance on how to proceed with this case. The Director was not available, but the call was directed to her assistant, who referred it to someone else in the department. This

employee was handling another crisis, however, and said she would get back to the Coordinator when she could. The Student Support Coordinator then called the city's Mental Health Crisis Team, who could not help the at-risk adolescent because she had no legal residence. The Crisis Team did, however, supply a phone number for the Department of Mental Retardation, which they thought might be of help.

The Department of Mental Health recommended contacting the city's adolescent mental health clinic, which was the right place, but in order for this clinic to admit and hold an adolescent for an upcoming available bed, Beth had to be legally recommended for commitment by a psychiatrist.

The Coordinator next called a neighborhood Mental Health Clinic, but no psychiatrist was available on that particular day. She then called City Hospital's Adolescent unit, but could only leave a recorded message there. She then tried to reach the unit's administrator, who did not respond to her beeper. The Coordinator then left a message with the Pediatric Psychologist. She contacted the former case worker at the Department of Social Services, but the worker was not at her desk. That department's supervisor was out to lunch. The assistant supervisor was on vacation. The supervisor on duty finally checked the files, noted that the case was closed. The supervisor paged the former case

worker, who described the mother as "volatile, hostile, and threatening." The mother wanted no involvement, he said, with the Department of Social Services, the Department of Youth Services, with housing agencies, or with welfare; in fact, she wanted no services at all. The case worker said the problem was no longer the responsibility of his department. His advise was to get Beth certified as committable and then send her to a private psychiatric hospital.

The Student Support Team then requested emergency Medicaid (health services) for the at-risk adolescent, but Medicaid could not provide services because of the mother's past rejection of such benefits.

Beth was brought to her aunt's house for the evening. She returned to the Student Support Office the next morning. The Team Nurse took her to the local health center where she was evaluated by the psychiatrist who was then on duty; twelve hours later an ambulance picked the student up and took her to a State Mental Hospital. The Department of Mental Health said the delay of twelve hours was due to the need for the Department of Social Services to take legal custody of the child and award her emergency medical assistance.

The student stayed at the hospital for thirty days; the Student Support Team participated in her treatment and

discharge plan. Beth was discharged to her aunt, who now has temporary custody of her. The Student Support Team monitors Beth daily. Her prognosis is poor. She does not keep her outside mental health appointments. Her attendance has improved; however she is still hostile, and had three school suspensions in the first two weeks after she returned to school. She continually lies to her aunt and has thus put her temporary custody placement at risk.

The Student Support Team maintains contact with the four human service providers assigned to this case by means of case conferences held at the Student Support Office. The Student Support Coordinator and the Department of Mental Health are arranging for on-site therapy for Beth by the Department of Mental's Health's Psychologist.

In the event that the aunt gives up custody, the Student Support Team, in conjunction with the Departments of Social Services and Mental Health, has developed a contingency plan, whose major goals are intervention and prevention.

The complexity of this case and factors such as abandonment, homeless, neglect, and abuse, made it extremely difficult for this at-risk adolescent to get help through the traditional system of fragmented services. The Student Support Team's intervention facilitated the start of a

treatment program to address the multifaceted problems of this adolescent. Had the Team not intervened, this student would more than likely have dropped out of school and perhaps have become another--and a much worse--statistic.

Case Study #3

Profile: Richard Kane was a 16-year-old black male whose mother died when he was three. He lived alternately with his grandmother, his father, and his aunt. Richard was the youngest of two male children. He had a history of headaches and violent behavior; he had also been involved with gangs.

The fact that Richard could do well in school was supported by former teachers as well as by the school psychologist. He had a turbulent upbringing, and he had had an alarming and increasing number of discipline problems at school. His parents had never cooperated with the school; in fact, at one point, the school felt compelled to file neglect charges. Richard's discipline problems had escalated to the level where he had become aggressive and dangerous to others. One incident involved his stealing rocks from the science labs and throwing them at other students; he seriously injured one student in the eye. Richard could finally no longer function academically; he repeated the seventh grade twice.

Richard had been involved in two weapons charges. As a seventh-grade student he had brought a loaded gun and a knife to school. At that time, he was suspended and sent to a six-week awareness program designed for students caught with weapons. The second charge was similar to the first, and Richard was expelled from the school system, but because of his age and his chaotic upbringing, the school system opted to re-admit him after a one-year expulsion term. He returned to school as an eighth grader (a social promotion) and was assigned to an alternative school program for problematic students. Richard attended this program uneventfully for four months and was then transferred as a ninth grader to the school where the Student Support Team Program was in place. The Guidance Counselor referred him to the Team on the first day of his enrolment.

The Guidance Counselor was concerned about Richard because his older brother, then 20 years of age, had been a student at the high school and had been charged with two counts of murders. The Student Support Counselor reviewed the detailed reports that accompanied the student's transfer records and found some recommendations.

After his first weapons offense in June of 1987, Richard was tested psychologically and, because of medical, academic, and legal problems, it was suggested that his case

might require Department of Social Services intervention. In October of 1987, a more extensive evaluation yielded the following conclusions:

--The student's increasingly reckless behavior may ultimately result in an untimely death if not effectively remedied.

--The student is very capable in a cognitive sense, but adequate educational achievement is presently precluded by a host of unaddressed physical, emotional, and social factors.

--The student has been deprived of adequate, consistent parenting, and/or substitute nurturing.

--The student's unconscious perception that he has been devalued and rejected appears to have a basis in reality.

--The student is clearly a danger to himself and others; this will continue if his present course toward self-destruction is not abruptly and effectively interrupted.

--The student lacks even the most fundamental "street smarts" (as defined by the WISC-R Comprehension subtest). This type of knowledge is taught by family and exposure to environment; his condition makes him even

more vulnerable to the attractions of the street in his milieu.

--The student has many strengths which he is unable to implement effectively because of his affective distress.

--The student has been referred to the Neurological Unit at Children's Medical Center for evaluation and treatment of his persistent, excruciating headaches.

The report included the following recommendations:

--Refer to alternative education program, temporarily, pending involvement with Department of Social Services for possible cost-sharing for psychotherapeutic, residential, educational facility, or perhaps an adolescent group home.

--Upon receipt of neurological report, consider referral of student to psychopharmacist/psychiatrist for assessment of need for medication and/or evaluation.

--Family counseling should be considered to support the student and to acquaint his father with the responsibilities of parenting.

--The student should be consistently and meaningfully encouraged to prepare himself for entrance to a competitive high school. He most assuredly has the cognitive abilities to compete for academic (athletic?)

scholarships if he can gain sufficient mastery of his life.

--Weekly psychotherapy is essential.

--All those engaged in meeting his needs are commended for their diligence and efficiency.

--Monitor this student closely. He has some fine potential and is clearly at a definitive crossroad in his life.

From these lists of conclusions and recommendations, a summary was prepared for the school service plan: Richard needs extra help in mathematics. The reports suggest a more nurturing home and school environment with more focus on his personal and educational needs. He does need support meetings with his Guidance Counselor at least twice a month.

In October of 1988, after the second weapons infraction, the following clinical impressions and recommendations were recorded:

Richard did complain of headaches last year and spoke about medication he was to take. These headaches sometimes upset him and change his attitude. Richard learns new information quickly and is easy to manage. He does, however, like to tell stories which border on the unrealistic. Richard gave this worker the impression he is a quiet individual, but has a history of fights and suspensions from

school. When asked his reason for having a firearm in school, he responded that he was "showing off." Richard needs to participate in ongoing counseling during school hours.

When the Student Support Coordinator met Richard, she encountered an attractive black male who was neatly attired and looked his stated age. He was articulate and related well throughout the one-hour session, although the Coordinator noted that his mood was somber, and that he never made eye contact when he spoke. He appeared surprised to find out his older brother had once attended the school and that the Coordinator had known him personally. Richard said he was pleased with his new school placement because he knew "most of the guys."

The session was informative. Richard confirmed that he did have a probation officer; however, he only he only saw him when he has to appear in court. He did talk about the incidents that recently sent him to court. One was for armed robbery six months before; the charge was dismissed. Another had been for murder, and he was found not guilty. Two months earlier he had been charged with assault and battery, and those charges had yet to come to trial. He has been locked up twice in the Department of Youth Services,

once when he was arrested on the murder charge, and the other time for failing to appear in court.

Richard reported to the Coordinator that he still had headaches, but they were less frequent and shorter in duration. He claimed he saw a physician at a local health clinic regularly for his headaches and that he took a prescription of Fiorinal daily that makes him sleepy. Richard was then living with his aunt in a public project in one of the worst neighborhoods in the city. His aunt, Mrs. Long, a recovering drug addict, was raising 10 of her own children plus two grandchildren of whom she had custody because their mothers were addicts. Her sons were well-known to the local courts.

Although both Richard and his father had received strong encouragement to attend individual or family counseling, neither had chosen to do so. No follow-up on the original recommendations had occurred, nor was there any follow-up after a request was made for Department of Social Services' involvement in this case; there was also no active referral placed for "a psychotherapeutic, residential, educational facility." In summary, the system left the responsibilities of obtaining critically needed services for this at-risk adolescent to the parent, the same parent that

it had concluded "deprived the student of adequate, consistent parenting and/or substitute nurturing."

This case is related to several of this study's general assumptions: It tests the effectiveness of the Student Support Team's intervention as coordinator for various services that would otherwise have gone unused. Many urgent recommendations had been made by several agencies as early as three years before, but because of a lack of coordination, none of these recommendations were acted upon, so that the adolescent continued to face trouble, most recently that of involvement in a murder charge. As early as two years before, a psychiatrist had made the uncanny observation that Richard's responses provide "an alarming vivid indication of the pervasiveness of this youngster's feelings of abandonment and isolation. Such feelings frequently engender murderous behavior."

When the Student Support Team intervened, it recommended several actions. First of all it called for a full battery of psychological tests to obtain up-to-date information about the student; it further suggested contacting his health clinic for the status of his neurological problems. A complete Special Education Evaluation, including a complete medical exam, a sociological assessment (home visit), and an educational evaluation, was indicated. In addition,

the Team recommended that someone should meet with his Probation Officer, who had been responsible for Richard's case for three years, to review the conditions that continued to bring Richard to the courts' attention and to ascertain why the Department of Youth Services has not intervened. A meeting with the father was also suggested to try to convince the parent of the seriousness and urgency of his son's situation.

The Team recommended that immediate steps be taken to ensure that the father sign a request for the Department of Social Service to become involved with the youngster. This request would not deprive the parent of custody or any other right, but, as a voluntary action, it is considered a parental assistance program. Once the Department of Social Services was involved, the Team recommended using a tracker, i.e., a trained social worker who carried a very limited number of cases; this limitation allowed trackers to become involved in their cases on a daily basis and to coordinate all recommendations and appointments.

Richard needed this type of coordinated and monitored support years before he came to the attention of the Student Support Team. At last, he had come in contact with an organization who could arrange for all the services to meet

his needs. One only hopes that for this at-risk adolescent the effort did not come too late.

Case Study #4

Profile: Luis Centeio was an 18-year-old Portuguese male. He was the oldest of four children and the only male in a household; his mother spoke no English. Luis was academically talented and had received an award in mathematics, but he had a history of poor attendance.

The Student Support Team's referral concerning Luis Centeio stated simply: "quit school, needs to work, would like information on a Graduate Equivalency Diploma Program." The Guidance Counselor stated that he knew very little about this boy, although he had had several sessions with him to discuss the importance of good attendance. The Guidance Counselor had been unable to speak to the parent because of the language barrier. The Team suggested that the parent come to school for a meeting where the student would translate. The Team also recommended, if necessary, the creation of a trial work study program for Luis.

The Student Support Coordinator telephoned the at-risk adolescent's home and made an appointment for both him and his mother to come to the Student Support Office. The mother seemed to be a very concerned parent; she greatly regretted that her son had to leave school. She explained

that her husband had abandoned them three years before and that she had been working two jobs as a commercial cleaning woman. (Luis, it turned out had worked with her at night cleaning office buildings--one of the reasons he missed so much school.) The mother said she had recently injured her back and was unable to work at all, which was why Luis had to leave school to work full-time and support the family. The at-risk adolescent stated that he wanted to finish high school, but the welfare of his family came first.

Neither the mother nor any of the children had any health benefits or received any public assistance. The counselor suggested to the mother that some public aid might be an alternative to her son's dropping out of school, but the mother considered sending her children back to the Azores a more desirable option than public assistance. In fact, she said that, given the problems they were having in school, she believed she would have to send them back home as soon as she could save up enough money. The mother was very upset about her children's school problems and asked the counselor if she could call the various schools to see what could be done. She also told the Coordinator that they had many bills and probably did not have enough heating oil to make it through the month. Mrs. Centeio did not want her son to have to leave school, but if he didn't start working

full time, she said, they would lose their apartment. She thanked the Coordinator for her concern and her help, and then she left.

The Coordinator contacted the local Portuguese Social Service Center, but they had no knowledge of the family. She spoke to a community worker about the case and was assured that the worker would be in touch with the family with aid. Next she went to the local Fuel Assistance Office, which administered a low-income cooperative program. The program's director believed he would be able to convince Mrs. Centeio to participate. They would also be able to extend her a limited amount of credit so that the family could get services immediately.

The Coordinator then contacted both the junior high school and the elementary school where the younger children attended classes to find out the nature of the school problems; they ranged from academic to social. The Coordinator found out what tutorial and counseling programs were offered at a community center near the Centeio home. She then contacted Luis and gave him the information she had gathered. Three days later the at-risk adolescent returned to school full time. Two months later his mother had surgery on her back. The younger children started attending the Community

Center daily, and Mrs. Centeio began taking English classes at the center as well.

This case illustrates well how the Student Support Team Program can perform networking tasks and secure services the right services to meet the needs of an at-risk adolescent and his family. The Centeio case was not a life-or-death situation like so many of the other referrals, but it does show some typical quality-of-life needs and how programs can work to prevent a student from dropping out of school.

Case Study #5

Profile: Carol Chan was a 17-year old Chinese national. She was the youngest of three children, but her two siblings were living in San Francisco. She was living in a three-bedroom apartment in the city's Chinatown section with her parents and both her paternal and maternal grandparents. Both her parents were factory workers. No English was spoken in the home. Carol's school records indicated an above-average intelligence. She was in the eleventh grade and had a poor attendance record due to illness.

The school attendance monitor referred Carol Chan to the Student Support Team. During the spring of her sophomore year (prior to the establishment of the Student Support Team Program), she had been ill most of the time. Typically she would be absent for a long stretch and then reappear

with a doctor's letter which would verify her illness and entitle her to an attendance waiver (an attendance waiver was required for any absence of more than seven days; otherwise a student automatically failed for the term).

The attendance monitor reported that Carol had not returned to school at all in the fall of her junior year. When reached at home, the father would simply tell the monitor that his daughter was "sick, very sick." The attendance monitor suggested that a home tutor might help Carol.

The Student Support Team decided to send a registered letter, written in Chinese, to the student's home requesting a specific diagnosis from a medical doctor. This diagnosis was necessary to initiate a home schooling program. The Team also contacted a community outreach worker in Chinatown and requested a visit to the family. The Team Nurse volunteered to contact the student's doctor directly in order to verify the situation. In the process of pursuing this, the Nurse discovered that Carol was seeing not a doctor but a Chinese curer.

The Student Support Coordinator contacted the Community Social Center and spoke to a social worker who knew of the family and who had known Carol personally when she was younger. The social worker visited the home and within a few days both the social worker and the student came to

Student Support Office. Carol, it seemed, was still ill; later it was discovered that she was suffering from bulimia, an eating disorder that can cause dangerous chemical imbalances in the body.[54] It was also discovered at this time that Carol had dropped out of school not because of illness but because she was working full-time to pay for a good defense lawyer for her boyfriend, who had been arrested for robbery.

In this case, the Student Support Team Program reached out into the community for support for the at-risk adolescent. The community social worker regularly kept in touch with her and helped bridge the cultural gaps she faced between herself and her parents, her school, and the medical community. Carol returned to school after hospitalization and continued to see a psychiatrist as an outpatient at a local medical facility. Because Carol was habitually quite late (about thirty minutes) for these appointments, the Student Support Team also recommended that she see a therapist at school.

Case Study #6

Profile: Nat Shillings was a black male and the oldest of five children; he lived with his father, stepmother, and four half-brothers. Both parents were college-educated. Nat had a history of acting out his feelings at home, of

running away from home, and breaking the law, including breaking and entering, assault and battery, and auto theft. He was enrolled in the honors program at school, but he had a poor attendance record. Nat was described as a loner who was subject to angry outbursts that resulted in physical fights with other students.

Nat was a transfer student from a private day academy. The Guidance Counselor had worked with him for over two years on the issues of attendance and fighting but had seen very little progress. "Talking with Nat was like talking to the wall," the Guidance Coordinator noted. The student always politely agreed but nothing really ever changed.

Two referrals brought Nat to the attention of the Student Support Team Program. His Probation Officer requested that his attendance, grades, and behavior be monitored for the benefit of the court. The Probation Officer said she found Nat to be arrogant and uncooperative. He did not keep his court clinic appointments; also, she planned to ask for an extension of his probation because she believed he was still using drugs. In regard to this referral, the Student Support Team recommended monitoring the adolescent, requested a conference with the parents, and arranged for on-site therapy for the drug problem.

The second referral followed soon after the first and came from Nat's English teacher. She attached an essay to the back of the referral form with a note that said: "Read this assignment. I think it will be helpful in understanding Nat." The essay was an autobiographical piece telling about how Nat had lived in Barbados with his mother. They had been very poor, but he remembered being happy. When he was seven-years old, his father, whom he had never met, arrived. Nat was handed over to him and was on his way to the United States with his father that very same evening. The boy went on to tell of his new life: his family, his home, clothes, food, and language. Although Nat did not articulate his feelings of loss toward his mother, the general tone of the story was a sad one.

The Student Support Coordinator met with Nat to review the two referrals; the session was encouraging because the student told the Coordinator he was aware of the issues he faced both internally and externally at that time. But this at-risk adolescent rejected the idea of his parents coming for a meeting with the Student Support Team nor did he welcome any therapeutic intervention. Nat claimed he had no drug problem and that he had been straight for a year. He was, however, willing to work with the Team to salvage his

academic record and to learn how to better control his temper.

In consideration of Nat's cognitive abilities, the Student Support Team decided to place him in an advanced studies program. He did excellent work the first semester; he was then allowed to attend classes at the local university. Nat not only did his regular high-school work but took two college-level classes, one in English and one in math.

The Student Support Coordinator kept in close contact with Nat, the Probation Officer, and the university. The Student Support Office was able to coordinate with the university's job-development officer to help Nat find a summer job tutoring inner-city youths. When Nat returned to school as a senior, he did academically sound work, and, although he was still on probation, the future looked bright for him. Because his summer teaching experience was so successful, and also because he had also received an A in calculus at the university, the Student Support Team recommended that it acknowledge his accomplishments by asking the school to let him co-teach an eighth-grade math class. The Team encouraged Nat to participate in the newly formed School Conflict Resolution Program, which operated under the Student Support Team Program. Nat agreed and went through a

30-hour training course, and thus became a certified mediator (the judge who had put him on probation swore him in). With the help of the Student Support Team, this at-risk teenager was able to convert some very destructive tendencies into positive actions that benefitted both himself and his community.

When the Student Support Team approached Nat about using his case for study, it asked him what he thought made working with the Team different from working with his guidance counselor. He replied: "You knew all about me. You knew what I had been into on the outside, and you were always in contact with the people that could have put me away. It was like you really were not part of the school."

Conclusion

The six adolescents-at-risk who were followed for 18 months were chosen because they are representative of how a Student Support Team can work to bring a number of intervention actions together in a synthesizing approach to providing human and medical services to at-risk adolescents, who have traditionally fallen through the cracks of the human services network. Clearly, the students followed in these case studies benefitted from their involvement with the Student Support Team Program and the follow-up support

it established. In fact, it's possible that the program saved some of these students' lives.

C. Group Characteristics

The Student Support Team handled referrals concerning 355 at-risk adolescents during an 18-month period. An analysis revealed the following composition according to major characteristics:

1. Racial composition:

54% black

26% white

10% Hispanic

6% Asian

1% East Indian.

These numbers happened to be in close correlation with the school composition, which was:

53% black

23% white

24% Other (including Asians, etc.).

2. Gender:

57% male

43% female.

3. Residence Situation:

64% lived with one parent

28% lived in a two parent home (including step-parents)

6% lived in foster care, or with other relatives

2% lived on their own.

4. The available reading levels, based on the Metropolitan Reading Test, an exam used by most urban school systems in the country. The group broke down as follows:

8% read within the 90 percentile

7% read within the 80 percentile

5% read within the 70 percentile

6% read within the 60 percentile

9% read within the 50 percentile

12% read within the 40 percentile

18% read within the 30 percentile

11% read within the 20 percentile

13% read within the 10 percentile

11% read under 10 percentile.

5. Grade retention (failure to be promoted) :

68% of all referrals had repeated one or more grades.

6. Dropouts:

3% dropped out during the study.

D. Analysis of the General Study

Over the time period studied, referrals from teachers and other school personnel increased, indicating the staff's trust in the program. Students involved with the team had a lower dropout rate than those not involved. Furthermore, the increase in resources (such as personnel and physical space) allocated to the program attest to the impact that this program made at the particular urban school where the study was conducted.

The problems of the 355 students referred to the program break down as follows. Many of these referrals are listed under more than one problem heading:

84 family-related problems (such as recent divorce, sibling rivalry, family chaos, depressed mothers, financial problems)

75 court-involved/within probation (referred by Probation Officers)

55 suspected drug use

38 severe attendance problems

38 pregnancy (serviced out of approximately 50 annually)

35 parenting

32 acting-out school behavior

32 two or three years behind grade level

23 gang involvement

18 weapons in school

18 suspected alcohol use

13 suicidal ideation

12 parent(s) addicted to drugs

12 in need of shelter

12 grieving loss of family member

12 health-related problems

11 wrong school placement

10 school (returned to the school by Team intervention)

10 homicide involved

9 runaways

8 suicide attempt (or gesture) by a parent

8 incest

8 day-care problems

8 suspected drug dealers

7 abortions (arranged by the Team)

6 promiscuity

5 child neglect (charges filed)

5 rape

5 prostitution

4 eating disorders

4 homosexual issues (3 male and 1 female)

3 exploitation

3 physical abuse.

In essence data examined by the researcher suggests that the panoply of problems encountered by these at-risk adolescents cannot possibly be addressed effectively by traditional, and fragmented, means of support. The Student Support Team Program proved to be a very essential way for coordinating, searching, selecting, and following up on the myriad services which are already available, but which are underutilized in general, and in particular by this largely disenfranchised population.

By actively pursuing the available services, the school population benefitted from referral to thirteen social service agencies, which together provided $320,670 worth of services to a total of 218 students serviced on-site, plus another 18 students treated off-site. The cost of the benefits were as follows:

Mental Health--$67,200 for 80 students

Community Counseling--$ 8,800 for eight students

Adolescent Clinic--$35,200 for 32 students

Drug and Alcohol Counseling--$32,400 for 60 students

Special Mental Health--$660 for one student

Family Counseling--$ 6,000 for 11 families

Psychological testing--$3,250 for 10 students

Case Consultation--$2,800 on call/as needed

Mediation training--$4,200 for 22 students

Alcohol Seminar--$500 for open house

Family Mediation--$360 for four families

Social Service Center--$800 for two students

Alternative School Placements--$103,400 for 15 students

Rehabilitation Program--$53,500 for three students.

E. Conclusions and Statistics

Although the current findings appear to be encouraging, more research, and over a longer period of time, is needed to make any final determinations. In some cases, the lack of official data may not allow us to reach definitive conclusions; however, it is believed that the initial results will stand in spite of the potential magnitude for error.

To return to the propositions stated at the end of Chapter I, this study has shown that:

1. The 18-month intervention of the model Student Support Team Program is a viable program for meeting the needs of the urban at-risk adolescent.

The definition of needs required versus needs met is an extremely difficult task. The questionnaires returned from

the servicing agencies, the school personnel, and the at-risk adolescents themselves, were decidedly favorable. Of the 32 questions posed in the Report Card (see the Appendix A), the respondents criticized only two areas of Student Support Team activity: one area concerned the at-risk adolescent's family and the other concerned the Team's preliminary assessment; these were the only two areas where any more than 25 percent of the respondents singled out a particular Team activity for negative comment. In fact, of the 14 questions that required judgmental evaluation, 12 were given "Excellent" marks by more than 96 percent of the respondents. Eighty-seven percent answered six of the seven Yes/No questions in the affirmative. Since the questions did not all carry equal weight, the evaluation singled out the most telling of them: "Would you refer or recommend the Student Support Team Program to a friend in need of help?" While a favorable answer to this question may not mean that a particular at-risk adolescent's needs had actually been met, a favorable answer does indicate that those adolescents at least believed that their needs were being met, and great strides toward the ultimate goals have been made if the adolescent does believe this. The answer to that question was 88 percent favorable.

2. The intervention of the Student Support Team can result in a decrease of grade retention (the failure to be promoted).

Of the 258 students referred to the Student Support Team during the first year of operation, only six percent, or 15 students, were retained in their grades. The national grade-retention rate is 25 percent of all students. The rate in the State of Massachusetts is 24 percent. While reaching conclusions on a single year's sampling is risky, the numbers noted here suggest program effectiveness. (The results of the longer running, similar program in New Holstein, Wisconsin, show an overall grade increase of 42 percent, which should have a direct effect on the grade retention in the system in the long run.)

3. The intervention of the Student Support Program can, by means of early intervention and the creation of alternative programs, decrease the school dropout rate.

It has been estimated that 27 percent of the students entering high school nationwide, will not graduate. In Massachusetts, the figure generally accepted is that over 50 percent of the ninth graders will not graduate. The high school that housed the Student Support Team Program had a dropout rate of approximately eight percent per year (thirty-two percent for the four high-school years). During

the 18-month study, only eight of the 355 at-risk adolescents dropped out of school, a yearly rate of about two percent for one and one-half years. Further, because of the direct effects of the Student Support Team intervention, 10 students who had previously left the school returned voluntarily with intentions to graduate.

4. The intervention of the Student Support Team Program can result in an increase of school attendance.

The data available shows that, within the high-school system where this study was conducted, 14 percent of the students were habitually truant. In the year prior to the implementation of the Program, the numbers for the specific high school in this study totalled 19 percent. The last set of numbers, prepared in February of 1989, showed a truancy rate of 16 percent in the school. That represents a substantial improvement in a short period of time--although certainly not a dramatic improvement nor one beyond the margin for error. However, the attendance records of the at-risk adolescents involved in the Student Support Team Program, increased remarkably and show a 38 percent improvement in the attendance record of the at-risk group overall.

Finally, of the several Student Support Teams organized in the school system of this study, some were substantially more successful than other due to a number of factors, which

were primarily related to how the Team was originally formed within the school. It has become clear that the successful programs each had a common factor: the program was coordinated in each case by a former guidance chairperson or counselor. In these schools, the Team Coordinator was already seen as a credible individual with genuine concerns and expertise about adolescents and their development and not as an outside intruder coming in to usurp the role of the existing support staff. However an exceptionally strong coordinator presents a danger as well, since a program can develop around a single individual, destroying the team concept. It is hoped that a more mature program will exhibit the work of a team rather than the effort of a single individual.

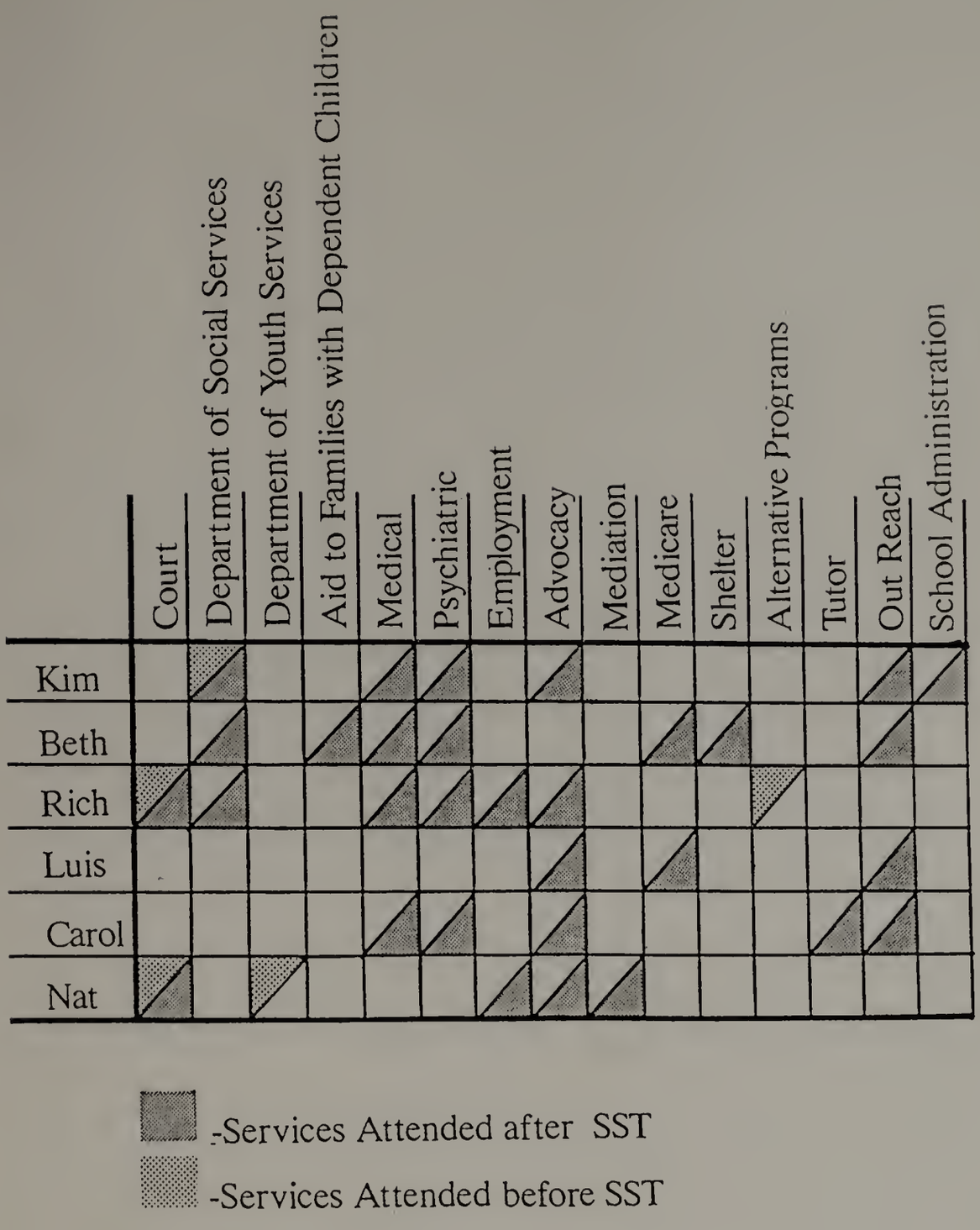


FIGURE 4.1: PRE- AND POST-INTERVENTION

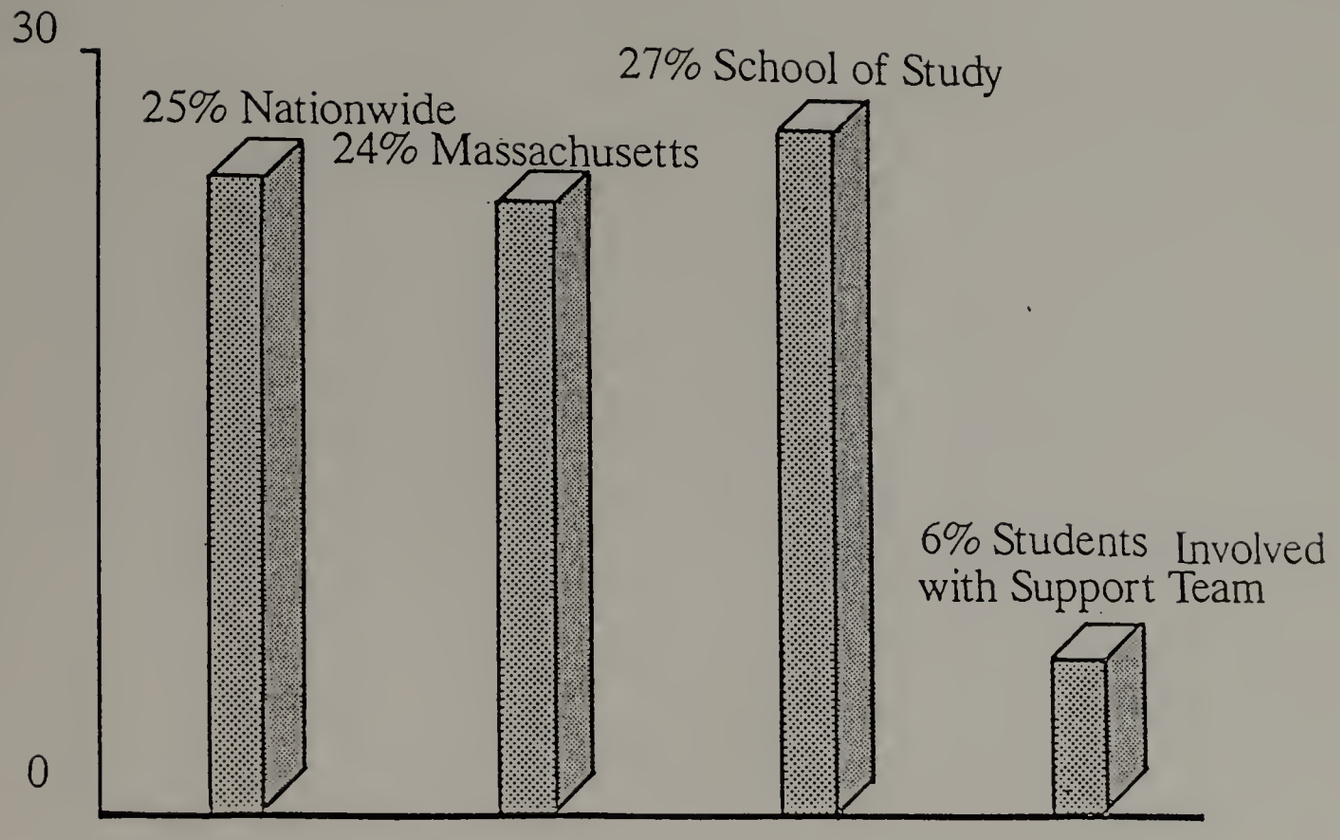


FIGURE 4.2: GRADE RETENTION RATES

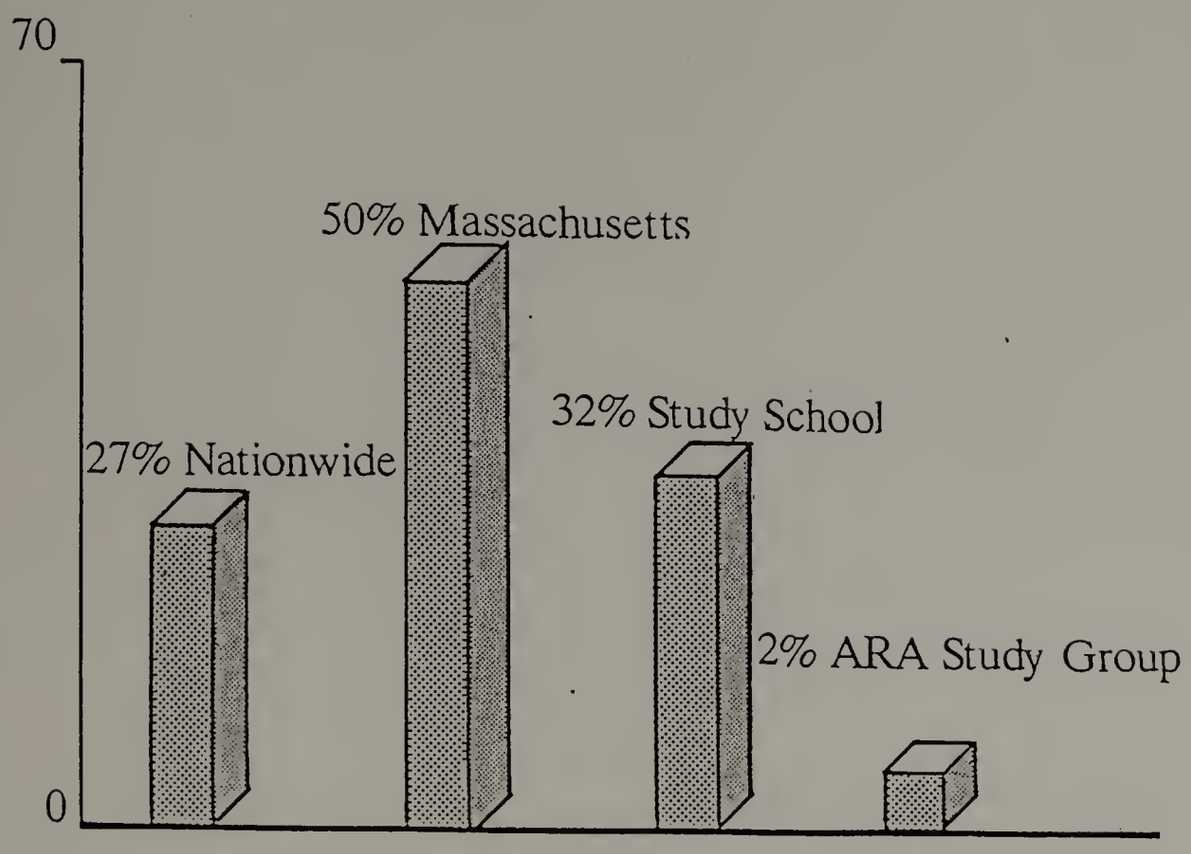
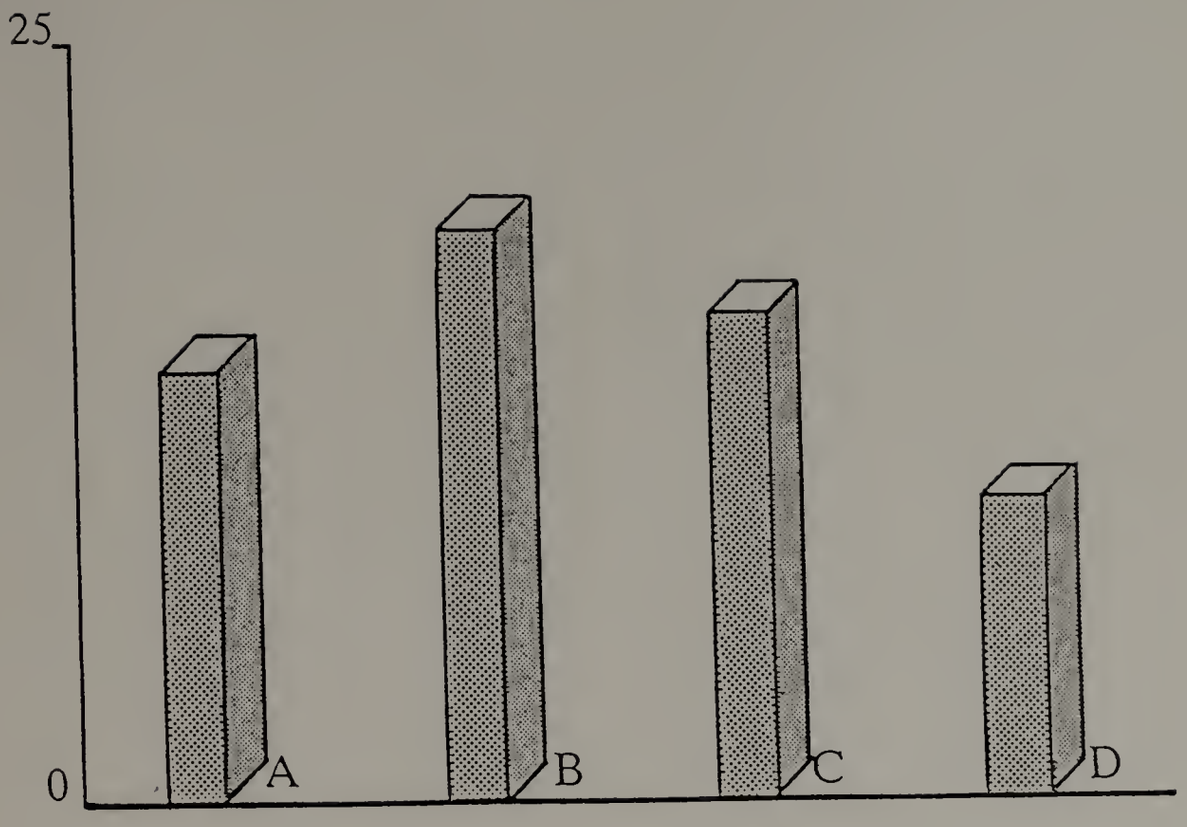


FIGURE 4.3: DROPOUT RATE



A-14% School System Wide
B-19% Study School before SST Program
C-16% Study School after SST Program
D-10% Absenteeism among ARA Group

FIGURE 4.4: ABSENTEEISM RATES

CHAPTER V

SUMMARY AND RECOMMENDATIONS

A. Summary

This study has examined a program that tries to deal with the problems a school system can encounter after students of the age of 13 and older enter the seventh grade; it did not attempt to define the causes of the dysfunctional behavior of at-risk adolescents. Student assistance programs are not, of course, a panacea, and it's important that they not be considered as a cure-all for the at-risk student population. The Student Support Program cannot alter the environmental conditions of the at-risk adolescent, but this limitation does not minimize its importance to the at-risk adolescent population. As Joy Dryfoos has written: "Programs alone cannot change the social environment in which children live. This society is being tested in a way that is different from all that has gone before. It has to face up to the potential loss of fully one-fourth of its youth who will never become productive citizens unless they receive immediate attention, attention that does in fact attempt to deal with the social environment of these youngsters."[55]

A decisive factor in my choice of subject for my dissertation was a course that I took with Dr. Robert Wellman at the University of Massachusetts at Amherst. The required readings were: High School by Ernest Boyer; A Place Called School by John Goodlad; Horace's Compromise by Theodore Sizer; Beyond Public Education by Myron Lieberman; Academic Strategy by George Keller; Paradigms and Promise by William Foster; and the report A Nation at Risk.

These books convinced me that I had been out of touch with some important educational issues. I asked myself: Have my priorities been out of sync with the rest of the educational circle? Should I really be so concerned that the 16-year-old sitting in my office has had 4 years of a foreign language before she attempts to commit suicide, or that the ninth grader's 18-year-old brother wouldn't have shot his father to death if he had physics? Did I believe for one moment that the 17-year-old cocaine dealer would attend an extended school year when he already is on the verge of dropping out because "it's more profitable out on the street"? Did I believe that if the seventh grader had been doing her homework, her father wouldn't have raped her? The litany of educational-reform programs for the eighties has blatantly omitted the problems that every urban educator

confronts on a regular basis, and what is omitted is the real educational dilemma of our time.

In summary, the data on uniform school support systems is limited because the concept and the implementation of these programs are new. One of the purposes of this study has been to make a contribution to this field. There are many theories concerning what is wrong with the schools, the American family, and the social fabric of our nation. This study has discussed some of these and has noted that there is no simple consensus. In practice, the school system sees the results of the breakdown in the family and society every day. School Support Team Programs are a direct response to that practical necessity.

It is through widely implemented intervention programs like the one discussed in this study that real educational reform will come about in the urban schools. Lisbeth Schorr, Lecturer in Social Medicine at Harvard Medical School, described the essence of such successful programs: "Model Programs, no matter how special their circumstances, bring home the fact that even in an imperfect world, something can be done to address certain, seemingly intractable social problems. They provide a vision of what can be achieved, a bench mark for judging other efforts, and, at

a minimum, a takeoff point in the search for a better understanding of the elements of intervention worthy of widespread intervention."[56]

B. Recommendations and Implications for Further Study

The data from this study clearly reinforces the idea that the urban youths of the eighties are facing different and more complex problems than those of previous generations. In a study conducted by the Fullerton, California, Police Department and the California Department of Education, today's leading school problems were compared to those of forty years ago:[57]

1940s	1980s
talking	drug abuse
chewing gum	alcohol abuse
making noise	pregnancy
running in the halls	suicide
getting out of place in line	rape
wearing improper clothing	burglary
not putting paper in the wastebaskets	arson
	bombings

With life expectancies of all other age groups in this country on the increase, it is a shocking fact that life expectancy for the adolescent is on the decline. Automobile accidents (mostly due to alcohol and drug uses), suicide, and homicide have become the top three killers of the American adolescent. Homicide is the number one killer of the black male adolescents in this country. For this population group it is now fashionable to join a street gang, both for status and for the protection that gangs purportedly guarantee their members. But the gangs themselves have become a major cause of death for minority adolescent males.

The proportion of children growing up in poverty has increased steadily from a 1970 low of 15 percent to 20 percent in 1985. The facts speak for themselves. Twelve million American youths, over 25 percent, live below the national poverty level. Of the households that have adolescents as members, over one-half are headed by single parents.

Adolescents, on the whole, lead troubled lives. One recent national poll of adolescents, conducted by Guideline Research for the American Home Economic Association, found that 58 percent of the adolescents interviewed had a friend who contemplated or committed suicide. One-third of them had friends who were sexually abused. Nearly half reported

alcohol problems among their friends. Almost one-third reported that they had friends with eating disorders, such as bulimia and anorexia. Drug abuse was named by 56 percent of the adolescents as the nation's greatest problem.

In the course of the present study, we have observed who is at risk, and the size and characteristics of this population. We have also discovered some approaches to helping these students through what is perhaps the most trying time of their lives. This study recommends the following actions:

Attendance: Student Support Programs can only help those students who attend. The Student Support Team found that some students only come to school on the days that they have counseling or a workshop. Schools must re-examine the philosophy of attending school for attendance sake and start to address the "wants" of the population they are supposed to serve. When the school environment becomes too structured and authoritarian, many students, unable to cope, are truant as often as possible.

In 1987, four years after the Commission on Excellence Report, many educators questioned how deep their impact had been. "The 1983 Reforms did not change the System at all; it just tightened the screws," said David R. Mandel of the Carnegie Forum on Education and the Economy. The fact is,

the school systems remain very unattractive to numbers of students, including most of our urban youth.

Alternative Programs: Alternative programs should be a part of Student Support Team Programs. These programs can offer reconstructed courses for the at-risk adolescent. They are a necessary aid for student who is trying to catch up from years lost to grade retention, the number one reason for dropping out of high school.

Early intervention: Student Support Team Programs must be developed for, and implemented in, elementary schools, where at-risk factors are already obvious but where the damage is much easier to repair.

At this point much research remains to be done in order to increase our knowledge of the schools' responsibilities and the roles schools can play to helping the at-risk adolescent. Long-term statistical studies should be able to discern what types of intervention work best. Research is also necessary in the area of family dynamics to better understand how the family encourages or deters the adolescent at-risk in his or her progress. Researchers should also study risk-factor patterns in order to find out how one set of problems and its solutions can affect another. Solid empirical evidence is needed to document how Student Support Programs impact the at-risk-adolescent population. To

determine the Program's effect on achievement and attendance will require large, long-term studies. And researchers should also investigate the disadvantages of Student Support Team Programs. For instance, does the student learn how to use support systems effectively, or does the Student Support Team Program, and similar programs, once again introduce a Band-Aid that covers the more serious problems?

Finally, the need to provide support services, especially innovative counseling strategies, must be the highest priority for national education plans. This goal will only be achieved when school systems, communities, and higher educational institutions work together in a unified and collaborative effort to teach their staffs the skills needed to identify both students' problems and the strategies to deal with them. On the whole, this study has proven that such interleaved coordination between education and human-service and state agencies is an essential step in providing some much needed services for at-risk adolescents.

ENDNOTES

1. Lisbeth B. Schorr, Within Our Reach: Breaking the Cycle of the Disadvantaged, (New York: Anchor Press, 1988), 18.

2. National Commission on Excellence in Education, 1981, A Nation at Risk: The Imperative for Educational Reform, Washington, D.C., U.S. Department of Education, 1983.

3. Joy Dryfoos, "Adolescents at Risk," Carnegie Quarterly 33 (Spring 1988): 6.

4. George Hackett, "Kids: Deadly Force," Newsweek, Jan. 11, 1988: 19.

5. Ernest Boyer, (Paper delivered at the National Association of College Admission Counselors, Annual Conference, Seattle, 1987).

6. Ezra Bowen, "Getting Tough," Time Magazine, 1 Feb. 1988, 55.

7. Harriet Doss Willis, Students At Risk: A Review of Conditions, Circumstances, Indicators, and Educational Implications, (Elmhurst, IL: North Central Regional Educational Laboratory, 1988), 2.

8. Joseph Wieser, "The New Holstein Student Assistance Program," Student Assistance Journal, May--June 1988, 23.

9. Ken Newbury, "A Student Assistance Philosophy," Student Assistance Journal, May--June 1988, 36.

10. David Bills, Students Who Are Educationally at Risk, (Duluth, MN: University of Minnesota Press, 1987), 112.

11. Erik H. Erikson, Vital Involvement in Old Age (New York: Norton, 1986), 35-38.

12. Henry Berman, "Talking Heads: Interviewing Adolescents," The InterStudy Edge, 1 (Jan, 1988): 4.

13. L.S. Neinstein, Adolescent Health Care: A Practical Guide (Baltimore: Urban & Schwarzenberg, 1984), 35-40.

14. J.A Ponsoien, Social Welfare Policy: Contributions to Theory, Institute of Social Studies, 3 (1962): 152.

15. United Community Fund and Council of America, "Priorities in Community Services," Community Services Bulletin, (Dec. 1960): 2-3.

16. Ann C. Lewis, "Strategies for Increasing the Numbers of Students Who Graduate," Educational Digest (Jan. 1988): 59-60.

17. Brigitte Berger, "The fourth R: The Repatriation of the School," in Challenge to American Schools (New York: Oxford, 1985).

18. United States Commission on the International Year of the Child, Report to the President (Washington, D.C.: U.S. Government Printing Office, 1979), 66-67.

19. Turning Points: Preparing American Youth for the 21st Century, (New York: Carnegie Corporation, 1989): 21.

20. Turning Points, 27.

21. Edward Fiske, "Carnegie Report Urges Crusade for 'Bypassed' Urban Schools," New York Times, Jan. 12, 1989, A1, B5.

22. Bureau of Statistics, Disability, Functional Limitation, and Health Insurance Coverage: 1984--85 (Washington, D.C.: Government Printing Office, 1986): 70, 8, 13.

23. "Student Drug Use: The Class of 1987," Student Assistance Journal, May/June, 1988, 9.

24. National Center for Health Statistics, Advanced Natality Statistics, 1984, Vol. 35, Supp. 4 (July, 1986): 14, 31--2.

25. Tamar Lewin, "More Teenagers Take Their Babies to School," New York Times, March 15, 1988, A1, A18.

26. Bureau of Census, Statistical Abstract of the United States: 1986 (Washington, D.C.: Government Printing Office, 1985), 66.

27. National Council on Crime and Delinquency, Facts About Juvenile Crime, (San Francisco, 1988): 3.

28. Joseph O'Reilly, Chief Probation Officer, Boston Juvenile Court, Conference on Student Support Services and the Courts, Jan., 1988, Boston.

29. Massachusetts Department of Social Services, "Characteristics of Abusive Families," 1--4.

30. Charles Vorkoper, "Teen Suicide: A Terrible Waste," in Our Troubled Teens (Pittsburgh: public Television Outreach Alliance, 1987): 24.

31. The figures in this paragraph and the next one can be found in: Patricia Hersch, "Coming of Age on City Streets," Psychology Today, (Jan. 1988), 28--37.

32. Hersch, "Aids and Adolescents," box in "Coming of Age on City Streets," 34.

33. Patricia Hersch, Study of Homeless Children, New York: NY: Public Health Report, 1988.

34. Jonathan Kozol, Rachel and Her Children (New York: Crown, 1988), 201.

*35. Bureau of the Census, Persons in Institutions and Other Group Quarters (Washington, D.C.: Government Printing Office), 2--3.

36. James R. Wetzel, American Youth; A Statistical Snapshot, (Washington, D.C.: William T. Grant Commission, 1987), 3.

37. The figures in this and the following paragraphs can be found in Hersch, "Coming of Age on City Streets," 28--37.

38. Samuel McMillan and Carolyn Behrman, "Dropping Out: Quiet Killer of the American Dream," in Our Troubled Teens, 39.

39. Carnegie Council on Adolescent Development, Turning Points, 64.

40. National Center for Health Statistics, Department of Health and Human Services, Advanced Report on Final Mortality Statistics, 1984, Vol. 35, No. 6, Supp. 2: 22--46.

41. Fergus M. Bordewich, "Mortal Fears," The Atlantic Monthly, (Feb. 1988), 34.

42. Melissa Ludtke, "Classroom Disarmament," Time, 1 Feb. 1988, 56.

43. Marjorie Roberts, "Schoolyard Menace," Psychology Today, Feb. 1988: 52--56.

44. Ludtke, Time, 56.

45. Bowen, Time, 55.

46. George Hackett, "Kids: Deadly Force," Newsweek, Jan. 11, 1988: 18.

47. National Center for Health Statistics, Advance Report on Final Mortality Statistics: 15.

48. Center for Population Options, Estimates of Public Costs for Teenage Childbearing in 1987, (Washington, D.C.: 1988).

49. Children's Defense Fund, Teenage Pregnancy: An Advocate's Guide to Numbers, (Washington, D.C.: Adolescent Pregnancy Prevention Clearinghouse): 29.

50. R. Parke, in Heatherington, Contemporary Readings in Child Psychology (New York: McGraw-Hill, 1988), 465.

51. Schorr, Within Our Reach, 56.

52. Robert B Cormandy, "Project Care: A Response to Students At Risk," NASSP Bulletin, 71:499 (May 1988): 35.

53. Jonathan Kozol, Rachel and Her Children (New York: Crown Publishers, 1988), 26.

54. Diagnostic and Statistical Manual of Mental Disorders, 3rd ed. rev. (Washington, D.C.: American Psychiatric Press, 1988).

55. Dryfoos, "Adolescents At Risk," 8.

56. Schorr, Within Our Reach, 262.

57. Bowen, "Getting Tough," 54.

APPENDIX A

EVALUATION OF STUDENT SUPPORT TEAM PROGRAM GIVEN TO TEACHERS

EVALUATION OF STUDENT SUPPORT TEAM PROGRAM GIVEN TO TEACHERS

REPORT CARD FOR THE STUDENT SUPPORT PROGRAM

Code: A...excellent, meeting all objectives

B...Good, meeting most objectives

C...Fair, needs improvement

D...Unsatisfactory, danger area

Y (yes) N (no)

In an effort to evaluate the Student Support Program the Team would like you to give a grade to the following categories:

Identification: How well do you think we are doing in the identifying of Students at risk? A B C D (please circle one)

Are you clear on what behavior is to be referred to the SST? A B C D

Do you inform parents of an impending referral to SST? Y N

Does it help your level of communication with the student and/or parent after you have made a referral? Y N

What do you suggest be done to improve identification? _____

_____

Process: Is the procedure clear in making a referral? A B C D

Do you understand the process of how the SST works?

A B C D

Do you have any suggestions on how to make this clearer to the faculty? _____

Assessment: Have your referrals been addressed? A B C D

Do you feel that you get adequate feedback from the SST on your referral? A B C D

three months Y N six months Y N

Do you feel that at any time the SST/C should confide in you about your referral? Y N

Have you made <u>more</u> or <u>less</u> referrals during the second year of the program?

Outcome Evaluation: (in your opinion)

Is the program achieving its objectives? A B C D

Are the students who are currently being identified the students in real need? Y N

Do you think the SST is serving all the students it can given the resources available to the program? Y N

Is the level of service acceptable? A B C D

Thank you for your cooperation in evaluating this program, it is out of your concern and input that we will be able to improve and continue to help meet the needs of so many of our students.

APPENDIX B

EVALUATION OF STUDENT SUPPORT TEAM PROGRAM

BY STUDENT PARTICIPANTS

EVALUATION OF STUDENT SUPPORT TEAM PROGRAM

BY STUDENT PARTICIPANTS

How long have you been involved with the SST program? _____

How did it make you feel when you were referred? _____

_____

How did you feel then, and how do you feel now towards the person that referred you? _____

_____

Are you comfortable coming to the SST office for services and help? _____

Do you talk with your family about the services you are getting or what is available to them through the SST office?

_____

Has the intervention of the SST helped you? _____

_____

Would you refer/or recommend the SST Program to a friend in need of help? _____

APPENDIX C

EVALUATION OF STUDENT SUPPORT TEAM PROGRAM BY EXTERNAL AGENCIES

EVALUATION OF STUDENT SUPPORT TEAM PROGRAM

BY EXTERNAL AGENCIES

CODE A...Excellent, meeting the objectives

B...Good, meeting most objectives

C...Fair, needs improvement

D...Unsatisfactory, danger area

Please circle the one most appropriate:

Do you feel that the students that have been referred to you by the SST were appropriate referrals? A B C D

Do you feel that the initial intervention steps taken by the SST were appropriate? A B C D

Do you feel that the preliminary assessments made by the SSC are accurate? A B C D

Do you feel that the integration of services provided by the SST Program helps to meet the needs of the at-risk adolescent? A B C D

Do you feel the SST program gives the ARA the support needed for permanent change? A B C D

Do you feel that the SST program makes a good attempt at involving the family of the referred students in services and decisions? A B C D

Do you feel that the students that are being serviced by your agency through the SST Program would have sought out help on their own? Yes/No

Do you feel that the deliverance of services in a school setting is appropriate? Yes/No

Thank you for your cooperation in helping the program evaluate what we are doing and how we can continue to best meet the needs of the students we serve.

APPENDIX D

STUDENT SUPPORT TEAM BACKGROUND SHEET

STUDENT SUPPORT TEAM BACKGROUND SHEET

Name _____ Parent/Guardian _____ Phone # _____

Address _____ Student ID # _____ Case # _____

School _____ Grade ____ Home Room ____ Gender: M F DOB: _____ Case # _____

Race: Asian Black Hispanic White Nat/Amer. LEP: No YES, step __ Reporter: Yes No

Most recent test scores: MET 198_ Reading ___%tile, Math ____%tile; DPR: Score _____

Grade Level ____

Referred by: _____ Title _____ Date _____

Others who have worked with student: _____

DIRECTIONS: Please circle the appropriate responses for each item.

Reason(s) for Referral			Services Currently Receiving		
1. Academic difficulty	Yes	No	1. Chapter I	Yes	No
2. Dental/Medical	Yes	No	2. Bilingual Ed.	Yes	No
3. Family issues	Yes	No	3. Special Needs:	Yes	No
4. Pregnancy/parenting	Yes	No	Prototype 502. ___		
5. Social/emotional	Yes	No	4. BPS counseling		
6. Substance abuse	Yes	No	Other BPS services/programs:		
7. Attendance problems	Yes	No	5. _____		
# absences this year.....			6. _____		

Parent explanation on file Yes No

External Agency Services:

Other, specify:	Agency	Contact	Phone #
8. weapons	1.		
9. _____	2.		

Comments:

APPENDIX E

STUDENT SUPPORT TEAM REFERRAL CHECKLIST

STUDENT SUPPORT TEAM REFERRAL CHECKLIST

IDENTIFYING DATA:

Student's Name: _____

Age: _____ Date of Birth: _____

Sex: _____

Race: _____

Place of Birth: _____ Native Language _____

Student's Address: _____

_____ Apt. No. _____

Phone Number _____

Student Resides With: _____ Relationship _____

Parents:

Mother _____ Father _____

Address: _____

_____

Phone: (H) _____

(W) _____

Employer _____

Contact in Case of Emergency: Name _____

Address _____

Phone No. _____ Relationship _____

SCHOOL INFORMATION:

Student ID # _____ Grade: _____

Previous School: _____

Special Program: Metco Edco Compass Other _____

Grades Repeated: _____ Spec.Ed._____

Advanced classes: _____ Sport Team Member _____

Metro tests: English _____ga Math _____ga DRP _____

REPORTED SCHOOL BEHAVIOR:

___ Short attention span

___ Easily distracted

___ Daydreaming

___ Sleeps in class

___ Failure to do class work

___ Slow to do work

___ Lacks pride in work

___ Poor handwriting

___ Misinterprets directions

___ Needs reassurance

___ Unable to follow oral dir

___ Frequent schedule change

___ lacks study skills

___ Inconsistent performance

___ Failing grades

___ Rarely works to potential

___ Poor test performance

___ Reluctant to speak

___ Disrupts class

___ Walks around classroom

___ Physically active

___ Frequently tardy to class

___ Frequently absent

___ Cuts class

___ Frequent suspensions

Other comments _____

GENERAL BEHAVIOR:

___ Defies authority
___ Feigns illness
___ Destructive
___ Hyperactive
___ Suicide ideation
___ Self-abusive
___ Makes inappropriate remarks or gestures
___ Easily fatigues
___ Compulsive
___ Uses vulgarities
___ Lies
___ Shifts responsibility
___ Loud

Other _____

SOCIAL:

___ Disrespectful of others
___ Anti-social behavior
___ Responsive to others
___ Outgoing
___ Articulate
___ Scapegoated by peers
___ Leader
___ Manipulates authority
___ Influenced by peers
___ Involved in church group

Other _____

LEGAL: (to your knowledge)

___ CHINS filed, by whom _____

___ Court involved ___ On probation

Until (date) _____ _____ Involved in court clinic Name

of probation officer _____

District Court _____ Phone no. _____

Other: _____

_____

PERSONAL:

___ Pregnant ___ Parenting

Do you suspect this student might be involved with alcohol or drugs? _____

Behavior clues: Physical clues:

___ Unexplainable money ___ Weight loss/gain

___ New possessions/clothes ___ Appearance change

___ Associates with known users ___ Poor hygiene

___ Talks about use ___ Eyes read, puffy

___ Previous use ___ Pupils dilated

___ Abuse within family ___ Marks on arms/legs

___ Change in activities ___ Unsteady gait

___ Reported concern by peers ___ Slurred speech

___ Possession of paraphernalia ___ Fatigued, sleepy

___ Possession of alcohol ___ Odor of alcohol

___ Possession of Drug ___ Vomiting

___ Concern by other faculty ___ Loss of Inhibitions

Do you have any reason to suspect that this student is

___ Neglected ___ Abused

Other

Concerns: _____

_____

INTERVENTION HISTORY: (to your knowledge)

Has student ever been hospitalized for mental health?

When? _____ Where? _____

Has the student ever been involved in counseling?

____ Individual _____ Group _____ Family

Where? _____

When? _____

Name of counselor _____

Has student ever had a psychological evaluation? _____

Where? _____ When? _____

Name of psychologist _____

_____

If you have other concerns about this student please note:

_____

_____

_____

_____

_____

Referring teachers name: _____

Please list times and location of your Plan & Developing and administrative duties in case further information in needed.

_____

_____

Date presented to the SST _____

APPENDIX F

AT-RISK REFERRAL REPORT

AT-RISK REFERRAL REPORT

School _____ Referral Date _____

Student Name _____ DP# _____ Grade ____

Home Address _____ Telephone _____

Name of Parent/Guardian _____

Description of student action/behavior: (Include specific action/statement, data and time, names of witnesses, etc. Attach relevant documentation

_____

_____

_____

_____

_____

_____

Initial school responses: (Indicate steps taken, agency,referrals, names staff involved, etc. Attach relevant documentation.)

_____

_____

_____

_____

_____

Date to be referred to school's Student Support Team (SST)

_____ _____

_____

Signature of Headmaster

Attachment
cc: Student Support Services Department
Student File

APPENDIX G

STUDENT SUPPORT COORDINATOR ASSESSMENT FORM

STUDENT SUPPORT COORDINATOR
ASSESSMENT FORM

STUDENT'S NAME: _____ DATE _____

SITE: _____

I. RESIDING WITH: _____ Relationship _____

_____ HOME PHONE _____

_____ WORK PHONE _____

II. FAMILY MEMBERS:

	Name	Residence	DOB	School Attending
1.				
2.				
3.				
4.				
5.				
6.				
7.				

III. REFERRAL SOURCE

NAME: _____ TITLE: _____

REASON FOR REFERRAL: _____ PHONE: _____

IV. OTHER AGENCY CONTACTS

	Agency	Worker	Phone
1.			
2.			
3.			
4.			

V. PRESENTING PROBLEM

VI. HISTORY OF PROBLEM

VII. GENOGRAM

VIII. HISTORY

FAMILY

SCHOOL

SOCIAL

WORK

SEXUAL

MEDICAL

IX. SOURCES OF STRESS AND SUPPORT (environmental)

X. FORMULATION

XI. PLANS FOR SERVICE

SIGNATURE _____ DATE: _____

SIGNATURE _____ DATE: _____

SIGNATURE _____ DATE: _____

APPENDIX H

STUDENT SUPPORT TEAM STUDENT SERVICE FORM

SCHOOL _____ DATE _____

STUDENT SUPPORT TEAM
STUDENT SERVICE FORM

NAME_____ GRADE___ HOMEROOM___ TELEPHONE_____

STUDENT NUMBER_____ CHAPTER I_____ SPECIAL NEEDS _____

REASON FOR REFERRAL: ATTENDANCE ____ ACADEMIC ____ BEHAVIOR ___

REFERRED BY_____

OTHER SIGNIFICANT DATA

RECAP_____ OUTREACH WORKER_____ PROBATION OFFICER_____

EXTERNAL AGENCY INVOLVEMENT_____ SOCIAL WORKER_____

_____

SUPPORTING DATA

_____

DATE SERVICE OUTCOME

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX I

STUDENT SUPPORT COORDINATOR'S RECORD OF MONTHLY SERVICES RECOMMENDED FOR AND RECEIVED BY STUDENT

STUDENT SUPPORT COORDINATOR'S RECORD OF MONTHLY SERVICES RECOMMENDED FOR AND RECEIVED BY STUDENT

Student Name _____

ID _____

DIRECTIONS: After indicating the date a service is recommended, place a check for each month that service is received. When service is terminated, write data of termination under the appropriate month.

SERVICES/ACTIONS	Date Recommended	1987 Months Student Participated Jan	Feb	Mar	Apr	May	Jun
BPS REFERRALS							
1. Group Counseling							
2. Individual Counseling							
3. Special ed: referral							
services							
4. Nurse							
Others, specify:							
5.							
6.							
7.							
OUTSIDE AGENCY REFERRALS							
1. Alternative Program							
2. DSS							
3. Filing 51A							
4. Juvenile Court							
5. Medical							
6. Dental							
Others: Specify:							
7.							
8.							
9.							

CASE REVIEW DATES.....

APPENDIX J

THE STUDENT SUPPORT TEAM COORDINATORS MONTHLY RECORD OF SERVICES RECEIVED

Month _____

Student Support Team
Coordinator's Record of Monthly Services Received

I.	NEW REFERRALS	CONTINUATIONS	TOTALS	TERMINATIONS
Coordinator	_____	_____	_____	_____
SS TEAM	_____	_____	_____	_____

II. Service Provider Case Load:

Directions: Please fill in name of the agencies/programs in which you currently have SST students placed along with the number of SST students currently scheduled to be at that agency/program. *A student may receive services from more than agency, give each credit.

AGENCY/PROGRAM	# STUDENTS	KIND OF SERVICES
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

APPENDIX K

ACKNOWLEDGEMENT OF REFERRAL

ACKNOWLEDGEMENT OF REFERRAL

STUDENT SUPPORT SERVICES

Date: _____

Dear _____,

Your referral of _____, to the Student Support Team has been addressed.

We as a team are actively seeking a solution to your concerns.

The Student Support Team appreciates your support.

Sincerely yours,

Student Support Coordinator

APPENDIX L

LETTER TO PARENT AND ENCLOSURE (STUDENT SUPPORT TEAM)

LETTER TO PARENT

STUDENT SERVICES

Date: _____

Dear Parent:

The purpose of this letter is to inform you that your child, _____, has been referred to me for what we consider a serious matter.

My responsibility here at the is to coordinate support services and act as a liaison between the school, the home, the medical community and social agencies.

This office was established in response to the expanding number of new and complex problems facing our young people and the need to activate more freely all of the community's support systems in an effort to make your child's school experience both successful and enjoyable.

In response to his/her referral I would appreciate hearing from you as soon as possible. I can be reached at during school hours. However, this number is monitored, and you may leave a message at any time. I will return your call as soon as possible.

Sincerely yours,

Student Services Coordinator

STUDENT SUPPORT TEAM

The Student Support Team (SST) provides the School with an opportunity to develop a coordinated counseling and student support system.

WHO IS THE SST?

The SST is a group of in-school personnel including a school administrator,k the guidance counselors, educational team leaders, the school nurse, the SST Coordinator and others needed.

WHAT DOES THE SST DO?

The team meets weekly to review student referrals received from school staff or those received by student or family requests. The goal is to work as a team to recognize students' problems and intervene at the earliest possible point. Recommendations are made at the team meeting as to how students' needs can best be met. The SST Coordinator is responsible for follow-up on the recommendations, obtaining necessary consent forms and keeping the SST informed about students' progress.

HOW ARE STUDENT NEEDS ADDRESSED?

Students' needs are first addressed by resources within the school. Several community agencies have also agreed to provide services for Boston students and/or families. These services include: individual and family counseling group counseling, after school tutoring and community mediation. Issues addressed in counseling are focussed on the specific problem(s) as identified by the student, family and/or school. The following are a list of problems which could be addressed:

INTERNAL PROBLEMS:
PROBLEMS:
. Hyperactivity
. Withdrawn/shy
. Depression
. Self-abusive/suicidal behav.
. Low Self-esteem
. Identity crisis
. Issues of trust

LEARNING PROBLEMS:

Issues/Sexuality
. Truancy/school phobia
. Significant learning problems/ learning disabilities
. School placement evaluation/766

INTERPERSONAL/EXTERNAL

. Poor peer relations
. Impulsive/aggressive behavior
. Defiant/Stubborn
. Running Away
. Stealing
. Rebelliousness
. Firesetting
. Disruptive behavior
. Fighting with peers/siblings
. Developmental

APPENDIX M

RELEASE OF INFORMATION

RELEASE OF INFORMATION

To Whom It May Concern:

I _____ give my permission to
(client or guardian)

_____ of the Student Support Office
(counselor)

to receive/release information regarding _____
(client)

from/to

_____
(agency or individual)

_____
(agency or individual

_____
(agency or individual)

_____
(agency or individual

_____ _____
(client) (date)

_____
Name of client

_____
Date of birth

_____
Street address

_____
City State Date

APPENDIX N

STUDENT SUPPORT TEAM 766 PRE-REFERRAL REQUEST

STUDENT SUPPORT TEAM 766

PRE-REFERRAL REQUEST

Date: _____

Name: _____

Grade: _____

The above-named student was referred to the Student Support Team.

As a result of this intervention, one of the recommendations made was to initiate a core evaluation.

As this student's guidance counselor, you are requested to secure the pre-referral documentation.

This should be available to the Student Support Team on _____.

Thank you for your cooperation,

Student Support Coordinator

APPENDIX O

TEACHER CONSENT

TEACHER CONSENT

Dear: _____

_____ is interested in participating in _____ of _____ during _____ period on _____. He/she will miss your class once a week, but is willing to make up the work. If you are willing to allow this student to miss the class once a week and are willing to give them the make-up work, please sign below. The student cannot participate in the services without your permission and cooperation.

_____ has my permission to miss _____ once a week within the understanding he/she will make up work missed.

APPENDIX P

INTERAGENCY AGREEMENT PILOT PROJECT - RELEASE OF INFORMATION

INTERAGENCY AGREEMENT PILOT PROJECT - RELEASE OF INFORMATION

TO WHOM IT MAY CONCERN:

I authorize representatives of the agencies, school districts, or other representatives indicated below to have access to all student's records, including medical records and information pertaining to _____, Date of Birth _____ for the purposes of evaluating educational service NEEDS, preparing educational and/or service PLAN(S), and CO-MEDICATION, if necessary.

This release of information shall expire six months from the date it is signed.

(Indicate by placing your initials next to the agencies you are authorizing to have access records.)

_____ Department of Mental Health

_____ Department of Youth Services

_____ Department of Social Services

_____ Office for Children

_____ Department of Public Health

_____ Massachusetts Rehabilitation

_____ Massachusetts Commission for the Blind

_____ _____ Public Schools

_____ _____ Public Schools

_____ Other (Specify:) _____

Specific records/materials not to be released: _____

_____

_____

_____ _____

(Date) (Signature of Parent, if Student is Under 18)

_____

(Signature of Student Over Eighteen)

_____

(Signature of Court Appointed Legal Guardian, if Applicable)

APPENDIX Q

LIST OF ACRONYMS

LIST OF ACRONYMS

Explanation of Acronyms used in the Study:

AFDC ... Aid to Families with Dependent Children

AMA .... American Medical Association

ARA .... At Risk Adolescent

CCSSO .. Council of Chief State School Officers

CHINS .. Child in Need of Service

DMH .... Department of Mental Health

DSS .... Department of Social Services

DYS .... Department of Youth Services

ETL .... Special Education Liaison

GED .... Graduate Equivalency Diploma

P.O. ... Probation Officer

SAR .... Student at Risk

SSC .... Student Support Coordinator

SSO .... Student Support Office

SSS .... Student Support Service

SST .... Student Support Team

51A .... Report on alleged abuse or neglect of a minor

APPENDIX R

SCHOOL BASED SERVICES TO YOUNG PARENTS

SCHOOL-BASED SERVICES TO YOUNG PARENTS

I. Type: Service - THERAPEUTIC SERVICES
Program - School-Based Services to Young Parents

II. Goal: Preservation and strengthening of Family Life/Family Life/Family Substitute Care

III. Narrative:

A. Definition: A program located within the junior or senior high school that provides comprehensive and coordinated support, counseling, advocacy and training activities regarding adolescent pregnancy and parenting.

B. Policy: (See the general section, Item III-B.)

C. Objectives: In addition to meeting the objectives for Therapeutic Services generally the objectives of School-Based Services to Young Parents (Program THS-8) are:

1. To establish linkages with the schools, including school-based service delivery, in order to encourage and advocate for young parents to continue their education.

2. To provide support groups for young parents and their families to avoid isolation promote greater self-awareness and independence, and improve parenting skills.

3. To provide health and life skills education, with an emphasis on strengthening parenting skills.

4. To arrange for provision of health care, including family planning services, to young parents and their children.

5. To advocate for adolescent parents with existing community resources in order to obtain health care, counseling, legal support, alternative living arrangements, day care, educational and vocational planning, transportation and/or whatever other services might be necessary.

6. To provide community education and training on topics related to teenage pregnancy and parenting.

SCHOOL-BASED SERVICES TO YOUNG PARENTS

IV. Client/Target Population:

A. Primary Components: In addition to the primary components for Therapeutic Services generally School-Based Services to Young Parents has the following primary components:

1. School-Based Services to Young Parents (Program THS-8) is a program of counseling regarding pregnancy and Instructional/Educational methods and is located within the Junior or Senior High School.

a. Service provision should occur on the school premises but may at times occur in the community.

b. Provider staff encourage adolescent parents and their families to participate regularly in counseling sessions to prevent a sense of isolation from either peers or family and deal with current or potential problems related to early pregnancy or childrearing.

c. The Provider offers brief counseling and information and referral services to adolescents within the school while ensuring the provision of comprehensive services to pregnant and parenting adolescents.

d. The Provider offers health education targeted to pregnant and parenting adolescents and encompassing topics such as: human reproduction, sexuality, childbirth, parenting skills and infant health care needs.

e. A Health and Family Life Skills Education curriculum is provided which includes, at a minimum, the following topics:

(1) Prenatal and post-natal health care
(2) Child birth preparation
(3) Infant care/parenting
(4) Family planning
(5) Early childhood development
(6) Sexuality
(7) Nutrition
(8) Financial planning
(9) Employment
(10) Community resources.

2. The Provider provides Information and Referral services for pregnant and parenting adolescents, their partners and their families.

   (See the Standards for the Provision of Information and Referral services.)

3. The Provider assists young parents in obtaining day care services.

   a. The Provider builds linkages with local day care providers to help young parents access day care services.

4. The provider assists young parents with educational planning.

   a. Provider staff inform pregnant and parenting teens of options available to them to enable them to complete their high school education.

   b. Provider staff provide the advocacy and supports necessary to achieve an educational plan which will enable the young parent to remain in school.

   c. Provider staff offer information and assistance to young parents concerning post-secondary educational opportunities.

5. The Provider ensures that young parents receive vocational counseling services.

   a. The Provider provides information and support concerning workstudy opportunities for young parents.

   b. The Provider establishes linkages with vocational training programs, youth employment agencies and other career development resources to assist young parents in pursuing vocations and/or employment opportunities.

6. The provider provides training conferences for school personnel.

   a. Training conferences are scheduled at times mutually agreed upon by the provider and the school system, when school personnel will be able to attend without neglecting their usual duties.

b. The school system encourages its personnel to attend training conferences in order to foster sensitivity to the needs of young parents; to facilitate integration of the pregnant adolescent into the regular classroom; and to encourage pregnant and parenting adolescents to remain in school

7. The school-based Provider makes provisions for the following services during the summer months:

a. Ongoing counseling and support groups;
b. Job opportunities for the summer months;
c. Provision for day care services;
d. Accessing health care services for the adolescent mother and her infant; and
e. Home visits to the adolescent mother and her infant.

8. The Provider conducts long-term follow-up of young parents and their children.

a. The Provider staff conducts periodic follow-up interviews with young parents and their children.

B. Secondary Components: (See the general section Items V-3-1 through 10 for service options.)

(See the general section for Items VI-A through E.)

VII. Operational Specifications:

E. Affiliation/Linkage Policy:

The Provider maintains linkages through participation in coalitions, task, forces, community-based committees and regular contacts with providers of the following services needed by pregnant and parenting teens:

1. Health Care
2. Day Care
3. Education
4. Job Training and GED Programs
5. Financial Assistance
6. Housing
7. Legal Services

SCHOOL-BASED SERVICES TO YOUNG PARENTS

VIII. Administrative Specifications:

A. Reimbursable Services/Absenteeism Policy: School Based services to Young Parents is provided on a negotiated hourly unit rate basis except that a cost-reimbursement basis may be mutually agreed to for a limited and specified period of time under special circumstances. Reimbursement shall be made only for actual services delivered.

(See the general section for Items VIII-B through E and Items IX-A and B.)

B. In addition to the requirement specified in for Therapeutic Services generally, the Provider of School-Based Services to Young Parents shall meet the following requirements:

1. Periodic summaries to evaluate the effectiveness of service provision on an ongoing basis are submitted to the Department of Social Services.

2. The Provider supports the efforts of the Department of Social Services to monitor and evaluate the provision of services to young parents and their children.

APPENDIX S

SUBSTANCE ABUSE TREATMENT & PREVENTION PROGRAM

SUBSTANCE ABUSE TREATMENT & PREVENTION PROGRAM

October 17, 1988

YOUTH INTERVENTION PROGRAM

The Youth Intervention Program began in 1980 as a component of _____ a non-profit substance abuse counseling agency. At that time, the program was based in several inner-city schools. It was designed to prevent substance abuse among young people and/or redirect their activities toward a constructive and wholesome behavior. This program was short term in nature and educational in orientation.

Today the young people of our community are faced with more obstacles than ever. These obstacles can lead our youth to become very stressed; to become depressed; to have feelings of isolation and to have suicidal ideation. To meet these needs, we at the _____ Youth Intervention expand our services. Thus we have added a counseling program that provides treatment for all types of transitional problems. We support the healthy development of our youth and the family to which they are a part of.

Therefore, the _____ Youth Intervention Program continues to maintain a highly competent staff of clinicians that can work in the areas of both our first goal of "substance-abuse free youth," and our additional goal of a "stronger youth for tomorrow." Emphasis will be placed on youth and their families.

Services that we provide to the schools and other agencies are:

* Intake
* Assessments
* Treatment Planning
* Short-term Therapy
* Family Consultation
* Family Therapy
* Teacher Consultation
* Case Management Referrals
* Follow-up and After-care

All services are provided free of charge based on State funding through the Department of Public Health.

APPENDIX T

SCHOOL-BASED PSYCHOTHERAPEUTIC PROGRAM

Counseling
Center

SCHOOL-BASED PSYCHOTHERAPEUTIC PROGRAM

COUNSELING CENTER'S School-Based Psychotherapeutic Program is designed to provide comprehensive psychiatric assessment and intervention to students and families with emotional or psychiatric conditions severe enough to impact school performance and/or behavior are made available in the school to promote accessibility to the student, family and school personnel. The Program has provided services to area schools for fourteen years and has been recognized as a model program by the Department of Education.

TARGET POPULATION

The Program is designed to work with students experiencing moderate to severe difficulty in school including inappropriate classroom behavior, non-organic learning failure, multiple-absences not related to organic illness and/or other signs of emotional/family/ psychiatric difficulties.

TREATMENT COMPONENTS AND GOALS

An initial evaluation will include a diagnostic assessment and consultation with school personnel, family, physician and other commun-ity agencies. Treatment can include individual therapy, family therapy, group therapy, psychological testing, as well as consultation with appropriate school personnel. In-service training for teacher groups is also available. The goal of the therapist is to correct or improve the condition of the student and to prevent the necessity of placement outside the school or family. Clinical goals are to resolve underlying causative issues by dealing in an active way with problems both in school and at home.

TREATMENT TEAM

Fully qualified and credentialed program staff of psychiatrists, psychologists and social workers utilize a multi-disciplinary team approach that addresses the psychological and medical components of client problems. Our staff has particular strengths and sensitivity in child and adolescent treatment.

ABOUT COUNSELING CENTER

COUNSELING CENTER is a private, licensed, mental health clinic that provides a wide range of treatment to adults, children, couples and families. Personalized treatment is offered in a caring and supportive setting by our qualified and experienced staff of psychia-trists, clinical psychologists and licensed social workers. Counseling Center provides both the long standing relationships of a private professional practice and the comprehensive community based network of a private agency.

COUNSELING CENTER is part of Community Care Systems, a leader in mental health care management. This network of out-patient and inpatient facilities throughout New England enables us to provide a continuum of care of the highest quality. We can draw upon the resources of other qualified professionals in the system or if necessary, refer patients to medical or psychiatric hospitals within the Program.

PAYMENT FOR SERVICES

COUNSELING CENTER prides itself on its innovative and cost effective approaches to service delivery. Our services are provided either by third party reimbursement or contractual agreement. We accept nearly all insurance payments including Blue Cross and Medicaid.

APPENDIX U

FORM 51-A

FORM 51-A

COMMONWEALTH OF MASSACHUSETTS - DEPARTMENT OF SOCIAL SERVICES

REPORT OF CHILD(REN) ALLEGED TO BE SUFFERING FROM SERIOUS PHYSICAL OR EMOTIONAL INJURY BY ABUSE OR NEGLECT

Massachusetts law requires an individual who is a mandated reporter to immediately report any allegation of serious physical or emotional injury resulting from abuse or neglect to the Department of Social Services by oral communication. This written report must then be completed within 48 hours of making the oral report and should be sent to the appropriate Department office.

Please complete all sections of this form. If some data is unknown, please signify. If some data is uncertain, place a question mark after the entry.

DATA ON CHILDREN REPORTED:

NAME	CURRENT LOCATION/ADDRESS	SEX	AGE OR DATE OF BIRTH
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	

DATA ON MALE GUARDIAN OR PARENT:

Name: _____
First Last Middle

Address: _____
Street and Number City/Town State

Telephone Number: _____ Age: _____

DATA ON FEMALE GUARDIAN OR PARENT:

Name: _____
First Last Middle

Address: _____
Street and Number City/Town State

Telephone Number: _____ Age: _____

DATA ON REPORTER/REPORT:

_____ ☐ Mandatory Report ☐ Voluntary Report
Date of Report

Reporter's Name: _____
First Last

Reporter's Address: (If the reporter represents an institution, school, or facility please indicate.)

_____
Street City/Town

_____ _____ _____
State Zip Code Telephone Number

Has reporter informed caretaker of report? ☐ YES ☐ NO

ABUSE/NEGLECT REPORT - 3 (Revised April, 1983)

What is the nature and extent of the injury, abuse, maltreatment or neglect, including prior evidence of same? (Please cite the source of this information if not observed first hand.)

What are the circumstances under which the reporter became aware of the injuries, abuse, maltreatment or neglect?

What action has been taken thus far to treat, shelter or otherwise assist the child to deal with this situation?

Please give other information which you think might be helpful in establishing the cause of the injury and/or the person responsible for it. If known, please provide the name(s) of the alleged perpetrator(s).

Signature of Reporter

ABUSE/NEGLECT REPORT - 3 (Revised April, 1983)

BIBLIOGRAPHY

Auletta, K. The Underclass. New York: Vintage Books, 1982.

Bassuk, E.L., L. Rubin, and A.S Lauriate. "Characteristics of Sheltered Homeless Families." American Journal of Public Health 76:9 (Sept 1986): 1097-1101.

Berger, Brigitte. "The Fourth R: The Repatriation of the School." In Challenge to American Schools. New York, NY: Oxford, 1985.

Berman, Henry. "Talking Heads: Interviewing Adolescents." The InterStudy Edge, 1 (Jan, 1988): 4.

Bills, D. Students Who Are Educationally At Risk. Duluth: University of Minnesota Press, 1987.

Bordewich, F. "Mortal Fears." Atlantic Monthly Magazine. Feb. 1988, 30-34.

Boston Task Force on Drugs. Attitudinal Research Report. Boston, 1986.

Boston University Task Force. Baseline School Survey, Summary and Results. Boston, 1988.

Bowen, Ezra. "Getting Tough." Time Magazine. 2 Feb. 1988, 53-58.

Boyer, E. High School: A Report on Secondary Education in America. Princeton: Princeton University Press, 1983.

_____. Paper delivered at the National Association of College Admission Counselors, Annual Conference, Seattle, 1987.

Bunzel, J.H. Challenge to American School. New York: Oxford Press, 1985.

Bureau of Census. Statistical Abstract of the United States: 1986. Washington, D.C.: Government Printing Office, 1985.

Bureau of Statistics. Disability, Functional Limitation, and Health Insurance Coverage: 1984--85. Washington, D.C.: Government Printing Office, 1986.

Center for Population Options. Estimates of Public Costs for Teenage Childbearing in 1987. Washington, D.C.: 1988.

Children Defense Fund. An Anatomy of a Social Problem: In Search of Comprehensive Solutions. Washington, D.C.: Adolescent Pregnancy Prevention Clearinghouse, 1987.

_____. Teenage Pregnancy: An Advocate's Guide to Numbers. Washington, D.C.: Adolescent Pregnancy Prevention Clearinghouse.

_____. A Children's Defense Budget. Washington D.C., 1987.

_____. Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services. Washington D.C., 1988.

Commager, H.S. The Commonwealth of Learning. New York: Harper & Row, 1968.

Cordor, B.F., R.F. Cordor, and L. Schorr. "Massachusetts Study of Social and Psychological Characteristics of Adolescent Suicide Attempters in an Urban Disadvantaged Area." Adolescence 9:33 (1974): 1-6.

Davis, C. "Reading School Discipline Problems." New York Times Magazine. 5 Feb. 1988.

Department of Education. Condition of Education. Washington, D.C.: Government Printing Office, 1983.

_____. Digest of Education Statistics: 1983-84. Washington, D.C.: Government Printing Office, 1984.

_____. What Works: Schools That Work. Washington, D.C.: Government Printing Office, 1987.

Diagnostic and Statistical Manual of Mental Disorders. Washington D.C.: American Psychiatric Press, 1988.

Doyle, D.P. Debating National Educational Policy: The Question of Standards. Washington, D.C.: American Enterprise Institute, 1981.

Dryfoos, J. Adolescents At Risk. New York, NY: Oxford University Press, 1988.

_____. "Adolescents At Risk." Carnegie Quarterly 22:2 (Spring 1988): 6.

Edelman, M.W. Families at Peril. Cambridge, MA: Harvard University Press, 1987.

Edwards, L.E., M.E. Steinman, and E.Y. Hakanson. "An Experimental Comprehensive High School Clinic." American Journal of Public Health. 8 (1977): 765-76.

Erikson, Erik. Vital Involvement in Old Age. New York, NY: Norton, 1986.

Fiske, Edward. "Carnegie Report Urges Crusade for 'Bypassed' Urban Schools." New York Times, Jan. 12, 1989, A1, B5.

Garbarine, J. and D. Sherman. "High-Risk Neighborhoods and High-Risk Families: The Human Ecology of Children Maltreatment." Child Development 51 (1980): 188-98.

Garmezy, N. "Stressors of Childhood." In Stress, Coping, and Development in Children, edited by N. Garmezy and L. Rutters, 43-84. New York: McGraw-Hill, 1983.

Goodlad, J.I. Place Called School: Prospects for the Future. New York: McGraw-Hill, 1983, 310-13.

Griesemer, L.J. and Butler, C. Education Under Study: An Analysis Recent Major Reports on Education. Washington, D.C.: National Institute of Education, 1987.

Heise, D. Understanding Events: Affect and the Construction of Social Action. Cambridge, England: Cambridge University Press, 1979.

Hersch, Patricia. "Coming of Age on City Streets." Psychology Today, (Jan. 1988), 28--37.

_____. Study of Homeless Children. New York, NY: Public Health Reports, 1988.

Hetherington, P.R. Contemporary Readings in Child Psychology. New York: McGraw-Hill, 1988, 465.

Johnson, S.M. "Teacher Union In Schools: Authority and Accommodation." Harvard Educational Review 53 (Aug. 1983): 87. Knitzer, J. "Mental Health Services to Children and Adolescents: A National View of Public Policies." American Psychologist 39 (Aug. 1984): 905-11.

Kozol, J. Rachel and Her Children. New York, NY: Crown Publishing, 1988.

Leichter, H. The Family as an Educator. New York, NY: Teachers' College Press, 1974.

Levine, M.D. "A Study of Risk FActor Complexes in Early Adolescent Delinquency." American Journal of the Diseases of Childhood 139 (Jan. 1985): 50-56.

Lewin, Tamar. "More Teenagers Take Their Babies to School." New York Times, March 15, 1988, A1, A18.

Lewis, Ann C. "Strategies for Increasing the Numbers of Students Who Graduate." Educational Digest (Jan. 1988): 59-60.

Lewis, D.O. and D.A. Balla. Delinquency and Psychopathology. New York: Grune and Stratton, 1976.

Ludtke, Melissa. "Classroom Disarmament." Time Magazine. 2 Feb. 1988, 56.

Massachusetts Commission on Public Health. Prothow-Stith, D. Report on Teenage Violence. Boston, MA, 1988.

Massachusetts Department of Social Services. "Characteristics of Abusive Families," Fact sheet.

National Center for Health Statistics. Advanced Natality Statistics, 1984, Vol. 35, Supp. 4 (July, 1986).

National Commission on Excellence in Education. A Nation At Risk: The Imperative for Educational Reform. Washington, D.C.: Department of Education, 1983.

National Council on Crime and Delinquency. Facts About Juvenile Crime. San Francisco, 1988.

Neinstein, L.S. Adolescent Health Care: A Practical Guide. Baltimore: Urban and Schwarzenberg, 1984. 35-40.

Newbury, Ken. "A Student Assistance Philosophy." Student Assistance Journal. May-June, 1988: 36.

O'Reilly, Joseph. Chief Probation Officer, Boston Juvenile Court. Conference on Student Support Services and the Courts. Jan., 1988, Boston.

Ponsioen, J.A. "Social Welfare Policy: Contributions to Theory." Institute of Social Studies, 13 (1962): 152.

Provence, S., and A. Naylor. Working With Disadvantaged Parents and Their Children. New Haven: Yale University Press, 1983.

Ravitch, D. The Troubled Crusade: American Education 1945-1986. New York: Anchor Press, 1988.

Roberts, Marjorie. "Schoolyard Menace." Psychology Today, Feb. 1988: 52--56.

Rush, F.L. Psychology and Life. New York: Scott, Furman & Co, 1976.

Rutter, M., B. Maughan, P. Mortimore, and J. Duston. Fifteen Thousand Hours: Secondary Schools and Their Effects on Children. Cambridge, MA: Harvard University Press, 1979.

Schorr, L.B. "Bringing CHildren Out of the Shadows." Carnegie Quarterly 22:2 (Spring 1988), 76-89.

_____. Within Our Reach: Breaking the Cycle of Disadvantage. New York: Anchor Press, 1988.

Shannon, W. "Education's Failure is Our, Too." Boston Globe, 19 June 1983: 57.

Solnit, A.J. "Foreword." In S. Provence and A. Naylor. Working With Disadvantaged Parents and Their Children. New Haven: Yale, 1983.

Strunin, L. and R. Hingson. Sexual Behavior of the Adolescent. Boston, Ma: Boston University School of Public Health, 1986.

Taylor, R.A. "Why Fewer Blacks Are Graduating." U.S. News & World Report 22 (May 1988): 75-6.

Turning Points: Preparing American Youth for the 21st Century. New York: Carnegie Corporation, 1989.

United Community Fund and Council of America. "Priorities in Community Services." Community Service Bulletin, Dec. 1960: 2-3.

United States Commission on the International Year of the Child. Report to the President. Washington, D.C., Government Printing Office, 1979.

Vorkoper, Charles. "Teen Suicide: A Terrible Waste." In Our Troubled Teens. Pittsburgh: Public Television Outreach Alliance, 1987.

Weiser, Joseph. "The New Holstein Student Assistance Program." Student Assistance Journal, May-June: 36.

Wetzel, James R. American Youth; A Statistical Snapshot. Washington, D.C.: William T. Grant Commission, 1987.

Willis, Harriet Doss. Students at Risk: A Review of Conditions, Circumstances, Indicators, and Educational Implications. Elmhurst, IL: North Central Regional Educational Laboratory, 1988.

Zabin, L.S., M.B. Hirsch, E.A. Smith,, R. Streett, and J.B. Hardy. "Evaluation of a Pregnancy Prevention Program for Urban Teenagers." Family Planning Perspectives 18:3 (May-June 1986), 119-26.