SCOPE OF SERVICES
FOR BUILDING-BASED I&RS TEAMS

PROGRAM FOCUS

The I&RS team is an *adult-centered* program. By design, the I&RS team invites *requests for assistance* from school staff or parents, rather than referrals to the team. Welcoming requests for assistance clearly communicates that the team exists to *assist* staff or parents with educational problems they are experiencing with students or their children, rather than assume *total* responsibility for identified problems.

The *learning, behavior and health* issues presented to the team must in some way be related to the educational process. These issues, however, need not have an individual student as the focus for the problem to be reviewed by the team. For example, a teacher might be experiencing general classroom management problems (e.g., difficulty getting students settled to begin instructional lessons, students regularly talking out of turn and making inappropriate comments, students repeatedly leaving their seats without permission, significant numbers of students being inattentive during class instruction), and could use the I&RS team as a forum for problem solving and remediating these educational problems.

The program is not limited to providing assistance to classroom teachers. For example, school counselors, school social workers or substance awareness coordinators might experience difficulty working with a student and/or the student's family, and could benefit from reviewing the problem through the collaborative team process. School support staff (e.g., clerical, custodial, food preparation, transportation) are in positions to observe and interact with students and can be valuable sources of information, as well as benefit from participating in the I&RS team process.

Per N.J.A.C. 6A:16-7.2(a)6, parents must be *actively* involved in the *development and implementation* of I&RS action plans. Parents may also initiate a request for assistance of the school team in addressing issues and concerns they have with their children.

A GENERAL EDUCATION PROGRAM

The responsibility for establishing, implementing and evaluating programs of I&RS is clearly centered in the *general education program*, rather than special education. I&RS programs are intended to be used as a *primary mechanism* in a school building for assisting *general education staff* and expanding their skills and abilities to successfully accommodate the needs of significant numbers of students in the general education program who are at risk for school failure.

I&RS programs are not intended to replace traditional methods or resources for helping students to function effectively in school. They exist primarily to bring particularly difficult or repeat cases into focus using available resources in a coordinated manner.

Early versions of multidisciplinary teams similar to I&RS teams were closely identified with the purpose of pre-referral interventions. Programs of I&RS, however, *are not limited* to the purpose or conceptual framework of pre-referral interventions to the Child Study Team (CST).

As *global problem solving mechanisms* for diverse learning, behavior and health problems, I&RS teams are *separate and distinct* in mission and practice from pre-referral intervention and special education functions. A program of I&RS provides schools with the opportunity to institutionalize a sophisticated process for helping school staff resolve the *full range* of learning, behavior and health problems in the general education program, including those posed by the inclusion of students with learning disabilities in general education classrooms.

Therefore, a building-based program of intervention and referral services is *not necessarily* a pre-referral intervention mechanism for CST evaluations. An I&RS team is one of many resources used by schools to intervene with student problems, prior to child study team evaluations.

It should be noted that programs of intervention and referral services may not be used to delay obvious and appropriate referrals to special education (N.J.A.C. 6A:14-3 et seq.). Schools are not permitted to create any barrier for the administration of appropriate evaluations to determine the existence or nature of students' educational disabilities. This means, for example, that schools *may not require* the review of *all* student cases by the I&RS program prior to child study team review, since this requirement would create a barrier to the administration of appropriate evaluations.

MODES OF OPERATION

To be effective, the team must remain flexible in its operations and able to function in any of the following three modes, as appropriate to the diversity of circumstances that the team must be prepared to address. In all three modes, the collaborative proceedings are recorded in an I&RS action plan which is designed to resolve the identified problem(s). The three modes, which can be viewed as a continuum of services, differ according to who assumes ownership for the problem and which resources provide the services to remediate the problem.

- ***Collaborative Mode*** – In this mode, team members and the person requesting assistance *jointly* identify problems and, through consensus, develop and implement an I&RS action plan. Through the collection and analysis of thorough information, all team members reflect and agree upon the nature of the problem(s), objectives for behavioral improvement, preferred solutions and follow-up plans. Team members, as well as the requesting staff member may be responsible for implementing portions of the I&RS action plan, and/or involve other school and/or community resources to aide in its implementation, as appropriate. The team and the requesting staff member engage in a pure form of collaboration for the resolution of educational problems.

- ***Direct Services Mode*** – There are some instances that require the team's immediate or specialized action, where the team takes over partial or total responsibility for implementing the I&RS action plan. For example, if an I&RS team has incorporated the functions of the drug/alcohol core team into its operations, it should be prepared to provide the direct formal or informal intervention functions of the core team, as appropriate to the circumstances of each case. Another example is the crisis intervention functions provided for incidents of sudden violent loss (e.g., suicide, homicide), which typically are provided by a crisis intervention team, but could include the supportive involvement of the I&RS team.

- ***Indirect Services Mode (Consultation)*** – Sometimes parents or staff, particularly those considered master teachers, will benefit from a forum where they can consider new ideas, process their experiences with a problem(s) of concern and/or think about a problem(s) in a new way. In these instances, the team should be prepared to provide *consultation* services to the school staff member who is requesting assistance. In the indirect services mode, the decision for action is left to the staff member or parent who is requesting assistance, since it is understood that in this mode the ownership for the problem and the implementation of the I&RS action plan continues to reside with the requesting staff member and/or parent.

LIFE SKILLS DEFICIENCY MODEL

The essence of the I&RS process is represented in the formula below, which has been adapted from the Pennsylvania Department of Education's Student Assistance Program and Instructional Support Team models:

LIFE SKILL DEFICIENCY

+

LIFE CRISIS or EVENT

=

SPECIFIC OBSERVABLE BEHAVIOR

I&RS teams can be reasonably expected to effectively deal with two of the components of the formula: *specific observable behaviors* and *life skill deficiencies*, but less so, if at all, with life crises or events.

Specific Observable Behavior(s)

The *observation of behaviors* of concern is the point of intervention; it is the reason someone requests assistance from the I&RS team. Specific, observable, objectively described and quantified behaviors are also the focus of I&RS team information collection and assessment.

The thorough identification, quantification and objective description of *observable behaviors* is *necessary* for effective problem solving to occur. It is important that teams focus on *observable behaviors*, rather than attempt to project subjective interpretations or motivations, which typically can not be confirmed and do not lead to constructive strategies that will produce change. In other words, the team should be able to prove that the behaviors that have been identified and targeted are based in *fact*, rather than supposition or inference.

The I&RS team must *first* address the *observed behaviors* that prompted or justified the original request for assistance. Significant relief can be provided to those requesting assistance by concentrating on strategies that are specifically designed to reduce the incidence and/or prevalence

of problem behaviors. Targeting *observed behaviors* also affords teams the benefit of quantifying baseline data for comparison purposes. These comparisons help teams determine the effectiveness of their consensus strategies and can suggest new directions for I&RS action plans.

There are a variety of general behavioral indicators that could prompt a request for assistance. Examples of behaviors which indicate a student's risk for school failure include the following:

Behaviors that Indicate Risk for School Failure

➢ Not focusing on tasks.	➢ Deteriorating personal appearance and hygiene.	➢ Alcohol, tobacco and other drug abuse.
➢ Not completing assignments.	➢ Not working within structure (e.g., not staying in seat).	➢ Eating disorders.
➢ Not achieving to demonstrated skill level or test results.	➢ Diminished expression of affect.	➢ Early sexual involvement.
➢ Declining or failing grades.	➢ Erratic behavior.	➢ Multiple sexual partners.
➢ Cheating.	➢ Acting out of character.	➢ Dating young or having relationships with older partners.
➢ Chronic absenteeism or tardiness.	➢ Fighting.	➢ Bullying or being victimized by bullies.
➢ Decreased participation.	➢ Defying authority.	➢ Suicide ideation or attempts.
➢ Falling asleep.	➢ Violating school rules.	➢ Violence and vandalism.

Life Skill Deficiency

It is reasonable to assume that all students have some sort of *life skill deficiency*. For most students, these deficiencies reflect human frailties, as well as the essence of childhood and adolescence, but do not result in patterns of academic, behavior or health problems.

The implementation of strategies to improve observable behaviors may not be sufficient in *some cases* to bring about *long-term* changes. The identification and in-depth assessment of these behaviors provides the team with opportunities to also determine underlying life skill deficiencies that may contribute to the observed behaviors, and develop additional strategies that will increase the chances of *lasting* change.

The I&RS team should strive to identify and correct both *observable behaviors and life skill deficiencies*, as appropriate, to be effective in helping students develop internal locus of control over the identified problem areas and move toward school achievement. The identification of life skill deficiencies maintains a focus on *behaviors,* rather than assigning subjective interpretations or motivations to them, but is based on the assessment of problems at a greater depth of understanding about the observed behaviors.

In many instances, problem behaviors will be corrected by the team's initial strategies. Either based on the original presenting data or the quantified data on students' performance in response to the I&RS action plan, the team's strategies should also address the identified life skill deficiencies. Sometimes students' behaviors will require further assessment by the team or outside agencies to determine whether the presenting behaviors can be improved or ameliorated in school through skill building; whether formal evaluation is required to determine the existence of learning disabilities that require special education services; whether a referral to outside resources is necessary; or whether the circumstances require a coordinated effort among a variety of school and community resources.

The examples of observable behaviors and possible accompanying life skill deficiencies on the following page are not intended as a thorough analysis of *all* students who exhibit these behaviors, but to suggest possible distinctions between observed behaviors and related life skill deficiencies.

Life Skill Deficiencies

OBSERVABLE BEHAVIOR	POSSIBLE LIFE SKILL DEFICIENCY
➢ Not completing assignments.	➢ Lack of study or organizational skills.
➢ Chronic absenteeism or tardiness.	➢ Lack of sound sleep habits.
➢ Not working within structure (e.g., not staying in seat).	➢ Lack of impulse control.
➢ Declining or failing grades.	➢ Lack of bonding to school and other pro-social institutions.
➢ Deteriorating personal appearance and hygiene.	➢ Lack of skill for dealing with depression and grief.
➢ Fighting.	➢ Poor socialization or anger management skills.
➢ Alcohol, tobacco or other drug (ATOD) experimentation.	➢ Poor assertiveness skills.
➢ Suicide attempt.	➢ Low self-regard and lack of skills for coping with loss.
➢ Early sexual involvement.	➢ Low self-regard and lack of assertiveness skills.
➢ Erratic behavior.	➢ Poor decision-making skills: choosing friends who use alcohol or other drugs.

Life Crisis or Other Life Event

Unlike the learning opportunities presented by observed behavior problems and deficient life skills, the I&RS team typically is either unaware of these crises or unable to effectively deal with most of the *life crises or other life events* that may contribute to students' problems in school. It is not within the purview of schools to directly ameliorate crises that occur or originate outside of the educational environment. I&RS teams, however, *can* have a role to play with these life crises or life events under the required function of coordinating the services of community-based social and health provider agencies or socializing institutions (e.g., home, faith community).

Since the I&RS team does not have control over the occurrence or correction of these crises, it is important that team members keep a perspective on the appropriate focus for their activities: *addressing observed behaviors and life skill deficiencies.* It also is important for team members to remain sensitive to the powerful life events that often influence students' behavior. Understanding these events does not relieve students of responsibility for their behavior, but it might influence the nature of teams' strategies for individual cases.

As indicated in the chart below, it is possible that the observed behavior for one student could be the life skill deficiency or life crisis for another. For example, alcohol or other drug *use* could be the observed behavior for one student. Since the *disease of alcoholism* is a primary problem, however, another student's loss of control over the use of alcohol could be the critical life skill deficiency underlying demonstrations of erratic behavior. For a third student, family alcohol or other drug use could be the life crisis influencing the student's life skill deficiency of lack of impulse control, which drives the observed behavior of not being able stay in one's seat or to work within structure.

There is no set rule of thumb for the nature of students' problems. Teams must be prepared to collect comprehensive information from a variety of sources in order to accurately assess and address identified behaviors of concern; keep a clear eye toward the nature of the problems before them; and understand and accept the ones they can and can not influence. In other words, the team should collect as much information as possible on observed behaviors, life skill deficiencies and life crises or events; determine which they can realistically influence in both the *short-term* and *long-term*; and let go what can not be changed, unless future opportunities are presented to positively effect these behaviors or circumstances.

Some examples of life crises or life events that can precipitate observable behaviors of concern are identified below:

Examples of Life Crisis or Life Events

➢ Poverty.	➢ Hunger.	➢ Loss of job.
➢ Homelessness.	➢ Mental illness.	➢ Geographic relocations.
➢ Separation or divorce.	➢ Illness.	➢ Substance abuse.
➢ Child abuse and neglect.	➢ Death and dying.	➢ Lack of education and/or support for education.
➢ Domestic violence.	➢ Suicide attempts or completed suicides.	➢ Sexual abuse.
➢ Excessive violence in the neighborhood.	➢ Legal proceedings.	➢ Loss of anything cherished.
➢ Lack of adult supervision.	➢ Adjudication and incarceration.	➢ Victimization by pro-social or anti-social bullies.

The following chart includes the same examples of observable behaviors and possible accompanying life skill deficiencies that are provided in the chart above titled Life Skill Deficiencies, along with a description of possible *life crises or events* that could be contributing factors to students' problems:

Life Skill Deficiencies & Life Crisis or Events

OBSERVABLE BEHAVIOR	POSSIBLE LIFE SKILL DEFICIENCY	POSSIBLE LIFE CRISIS OR EVENT
➢ Not completing assignments.	➢ Lack of study or organizational skills.	➢ Insufficient adult supervision.
➢ Chronic absenteeism or tardiness.	➢ Lack of sound sleep habits.	➢ Parents "party" at night.
➢ Not working within structure (e.g., not staying in seat).	➢ Lack of impulse control.	➢ Substance exposure in utero (fetal alcohol effects).
➢ Declining or failing grades.	➢ Lack of bonding to school and other pro-social institutions.	➢ Parents failed in school and do not value or support education.
➢ Deteriorating personal appearance and hygiene.	➢ Lack of skill for dealing with depression and grief.	➢ Chronically ill family member.
➢ Fighting.	➢ Poor socialization or anger management skills.	➢ Domestic violence.
➢ Alcohol, tobacco or other drug experimentation.	➢ Poor assertiveness skills.	➢ Pressure to use ATOD from siblings or peers.
➢ Suicide attempt.	➢ Low self-regard and lack of skills for coping with loss.	➢ Loss of something cherished.
➢ Early sexual involvement.	➢ Low self-regard and lack of assertiveness skills.	➢ Sexual abuse.
➢ Erratic behavior.	➢ Poor decision-making skills: choosing friends who use alcohol or other drugs.	➢ Addiction to alcohol or other drugs in the family.

THE STUDENT AT RISK FOR SCHOOL FAILURE

The book titled Developing the Resilient Child: A Prevention Manual for Parents, Schools, Communities, and Individuals, developed by The Northeast Regional Center for Drug-Free Schools and Communities, reports some significant findings about the needs of young people and the development of appropriate prevention strategies. First among these is the importance of designing interventions that are appropriate for the developmental stages of the targeted individuals, as well as the contexts in which they live.

The text explains that researchers, educators, and other individuals who work with children, have discovered that certain factors place children at risk for alcohol, tobacco and other drug abuse, violence, vandalism, truancy, early sexual involvement, school failure and other destructive behaviors. The following chart lists some of the *psychosocial* issues that place a child at risk:

Psychosocial At Risk Factors

ALIENATION
APATHY
BOREDOM
DARE
DEFIANCE
DEPRESSION
EMOTIONAL PAIN
ESCAPE
FAILURE
FAMILY PROBLEMS
FRUSTRATION
HOPELESSNESS
IGNORANCE
LONELINESS
LOW SELF ESTEEM
NEGATIVE PEER PRESSURE
NEGATIVE ROLE MODELS
NON-GOAL ORIENTED
POOR SELF IMAGE
POWERLESSNESS
REBELLION
REJECTION
TENSION
UNAWARE
UNCHALLENGED
UNEQUAL
UNLOVED
UNMOTIVATED

Cultural, Economic and Social At Risk Factors

In the cultural, economic and social contexts that make up a child's environment, certain risk factors have been identified (Kandal 1982, Cooper 1983, Polich 1984, Perry 1985, Hawkins 1985, Hawkins and Catalano 1985, 1987, 1988, 1992) that place children at risk for developing substance abuse or related destructive behavioral problems. The most prominent *risk factors* within key systems, as reported in Together We Can Reduce the Risks by Jeanne Gibbs and Sherrin Bennett, are identified below:

SCHOOL	**PEERS**
❑ Negative school climate. ❑ School policy not defined or enforced. ❑ Availability of alcohol, tobacco and other drugs (ATOD). ❑ Transitions between schools. ❑ Academic failure. ❑ Lack of student involvement. ❑ Labeling and identifying students as "high risk." ❑ Truancy and suspension.	❑ Early anti-social behavior. ❑ Alienation and rebelliousness. ❑ Favorable attitudes toward drug use. ❑ Early first use of ATOD. ❑ Greater influence by and reliance on peers than parents. ❑ Friends who use ATOD.
FAMILY	**COMMUNITY**
❑ Family management problems (i.e., - unclear expectations for behavior, - lack of monitoring, - inconsistent or harsh discipline, - lack of bonding or caring, - marital conflict). ❑ Condoning teen use of ATOD. ❑ Parental misuse of ATOD ❑ Low expectations of children's success. ❑ Family history of alcoholism.	❑ Economic and social deprivation. ❑ Low neighborhood attachment and community disorganization. ❑ Lack of employment opportunities and youth involvement. ❑ Easy availability of ATOD. ❑ Community norms and laws favorable to misuse.

Therefore, as indicated in the Life Skills Deficiency Model, explained earlier in this section, it is important for teams to consider the *broad range of possibilities* when examining individuals' behaviors and their interactions with peers, family, school and community. For example, when a student's classroom attendance begins to decline, it is necessary for school's to address the situation as a discipline problem.

Cultural, Economic and Social At Risk Factors, continued

This response, however, may not be sufficient to take into account possible contributing factors, such as student substance abuse or a family crisis.

Once risk factors have been identified, strategies can be chosen or designed to reduce specific factors. The I&RS team is in a position to collect complete information for designing a comprehensive strategy to address the surface, as well as the fundamental issues that affect students' school success. It is important to note that when teams develop plans to improve specific behaviors and life skills, it is common for the positive gains to spill over to other areas of student performance.

SCHOOL VIOLENCE

Most schools are safe environments. Less than one percent of all violent deaths of children occur on school grounds. The violence that occurs in communities, however, can find its way into schools. School violence reflects a far-reaching problem that can only be addressed in an effective manner when the home, community and school work together. For more information on comprehensive planning for school safety, you may obtain the publication titled A Guide for the Development of A Districtwide School Safety Plan, by the New Jersey Department of Education, at www.state.nj.us/education.

There is ample evidence that prevention and early intervention efforts, such as I&RS teams, can reduce violence and other troubling behaviors in schools. Applying *research-based practices* can help schools recognize the early warning signs of factors that lead to violence and provide appropriate types of support to prevent potential crises.

The publication titled Early Warning Timely Response: A Guide to Safe Schools, by the United States Department of Education, sets forth the following principles for identifying early warning signs and imminent warning signs for school violence.

Principles for Identifying Early Warning Signs of School Violence

Educators and families can increase their ability to recognize early warning signs for violence and other destructive behaviors by establishing close, caring and supportive relationships with children and youth, where adults get to know young persons' needs, feelings, attitudes and behavior patterns. The I&RS can be a key agent in the identification and remediation of patterns of behaviors or sudden changes in behavior at early stages of concern.

There is real danger, however, that early warning signs will be misinterpreted. Educators must ensure that the early warning signs are not misconstrued by applying the following principles:

- ***Do No Harm*** – There are certain risks associated with using early warning signs to identify students who are troubled. The primary intent should be to determine the nature of the observed behaviors and help children and youth as early as possible. The early warning signs should not be used as a rationale to exclude, isolate or punish students, or as a checklist for formally labeling or stereotyping them.

- ***Understand Violence and Aggression within a Context –*** Violent and aggressive behavior (*observed behavior*) as an expression of emotion may have a variety of antecedents (*life crises or event*s) that exist within the school, the home and the larger social environment.

  For example, certain environments or situations can set off violent behavior for some students. Some may act out with violence or aggression when they lack positive coping skills (*life skill deficiency*) to respond in socially acceptable ways to stress, and if they have learned to react with aggression.

- ***Avoid Stereotypes*** – Stereotypes can interfere with the school community's ability to identify and help students, and can ultimately harm them. The I&RS team should be sensitive to false cues, including race, socio-economic status, cognitive or academic ability or physical appearance and guard against judging student behavior based on these characteristics.

- ***View Warning Signs Within a Developmental Context*** – Children and youth have varying social and emotional capabilities at different levels of development (e.g., pre-school, elementary, middle and high school). It is important to keep perspective on what is developmentally appropriate behavior, so that observed behaviors are not misinterpreted.

- ***Understand that Young Persons Typically Exhibit Multiple Warning Signs*** – Research confirms that most youth who are troubled and at risk for aggression exhibit more than one warning sign, repeatedly, and with increasing intensity over time. Therefore, it is important not to overreact to single signs, words or actions.

Early Warning Signs of Violence

It is not always possible to predict behavior that will lead to violence or any number of other destructive acts. Educators and parents, however, can learn to recognize certain signs that suggest the existence of a problem or the potential for aggressive deeds.

Research studies indicate that most young persons whom become violent toward themselves or others feel rejected and psychologically victimized. In most cases, children who become violent as adolescents have exhibited aggressive or withdrawn behavior early in life. If not provided

Early Signs of Violence, continued

support, some of these children will continue a progressive developmental pattern toward severe aggression or violence. Research also shows, however, that when children have a positive, meaningful connection to an adult, whether at home, in school or in the community, the likelihood of violence is significantly reduced.

None of these signs alone is sufficient for predicting aggression and violence. More important, it is inappropriate, and potentially harmful, to use the warning signs as a checklist against which to match individual children. The I&RS team must ensure that the early warning signs are used exclusively for identification and referral purposes. Only appropriately trained and certified or licensed professionals should make diagnoses in consultation with the student's parents or guardians.

The following early warning signs from the United States Department of Education are presented with the qualifications that they are not equally significant and they are not presented in order of seriousness.

Social Withdrawal

In some situations, gradual and eventually complete withdrawal from social contacts can be an important indicator of a troubled child. The withdrawal often stems from feelings of depression, rejection, persecution, unworthiness and lack of confidence.

History of Discipline Problems

Chronic behavior and discipline problems both in school and at home may suggest that underlying emotional needs are not being met. These unmet needs may be manifested in violating norms and rules, defying authority, disengaging from school, acting out and aggressive behavior.

Excessive Feelings of Isolation and Being Alone

Research on these factors is mixed. The majority of children who are isolated and appear friendless are not violent. In fact, these feelings are sometimes characteristic of children and youth who may be troubled, withdrawn or have internal issues that hinder development of social affiliations. Research has also shown that in some cases, however, feelings of isolation and not having friends are associated with young persons who behave aggressively and violently.

Intolerance for Differences and Prejudicial Attitudes

All people have preferences. An intense prejudice, however, toward others based on racial, ethnic, religious, language, gender, sexual orientation, ability and physical appearance, when coupled with other factors, may lead to violent assaults against those who are perceived to be different. Membership in hate groups or the willingness to victimize individuals with disabilities or health problems should also be treated as early warning signs.

Early Signs of Violence, continued

Excessive Feelings of Rejection

Many young people experience emotionally painful rejection in the process of growing up. Children who are troubled often are isolated from their mentally healthy peers. Without support, they may be at risk of expressing their emotional distress in negative ways, including violence. Some aggressive children who are rejected by non-aggressive peers seek out aggressive friends who, in turn, reinforce their violent tendencies.

Affiliation with Gangs

Gangs that support anti-social values and behaviors, including extortion, intimidation and acts of violence toward other students, cause fear and stress among students. Youth who are influenced by these groups may adopt these values and act in violent or aggressive ways in certain situations. Gang-related violence and "turf" battles are common occurrences tied to perceived "threats," insults or differences or the use of drugs that often result in injury and/or death.

Feelings of Being Picked on and Persecuted

The youth who feels constantly picked on, teased, bullied, singled out for ridicule and humiliated at home or at school may initially withdraw socially. If not given adequate support in addressing these feelings, some children may vent them in inappropriate ways, including possible violence and aggression.

Patterns of Impulsive and Chronic Hitting, Intimidating and Bullying Behaviors

Children often engage in acts of shoving and mild aggression. Some mildly aggressive behaviors, however, such as constant hitting and bullying of others that occur early in children's lives, if left unattended, might escalate into more serious behaviors.

Low School Interest and Poor Academic Performance

It is important to assess the emotional, cognitive and social reasons for academic changes to determine the true nature of the problem. In some circumstances, such as when the low achiever feels frustrated, unworthy, chastised, and denigrated in the performance of schoolwork, acting out and aggressive behaviors may occur.

Inappropriate Access to, Possession of and Use of Firearms

Young persons who inappropriately possess or have access to firearms can have an increased risk for violence. Research shows that such youngsters also have a higher probability of becoming victims. Families can reduce inappropriate access and use of firearms and other weapons by restricting, monitoring and supervising children's access to them.

Early Signs of Violence, continued

Uncontrolled Anger

Anger is a naturally occurring response to hurt, frustration or fear. Anger that is expressed frequently and intensely in response to minor irritants might signal potential violent behavior toward self or others.

Drug and/or Alcohol Use

Apart from being unhealthy behaviors, drug and/or alcohol use reduces self-control and exposes children and youth to violence, either as perpetrators, as victims, or both.

Expression of Violence in Writings and Drawings

Young persons often express their thoughts, feelings, desires and intentions in their drawings and in stories, poetry and other written expressive forms. Many students produce work about violent themes that for the most part is harmless when taken in context. An overrepresentation of violence in writing, drawings or music that is directed at specific individuals (e.g., family members, peers, other adults) consistently over time may signal emotional problems and the potential for violence. The very real danger of misinterpreting such signs underscores the importance of seeking qualified professionals (e.g., psychologist, other mental health specialist) to determine their meanings.

Serious Threats of Violence

Idle threats are common responses to frustration. Alternately, one of the most reliable indicators that a youth is likely to commit a dangerous act toward self or others is a detailed and specific threat to use violence. Incidents across the country clearly indicate that threats to commit violence against oneself or others should be taken seriously. Steps must be taken to understand the nature of these threats and to prevent them from being carried out.

Past History of Violent and Aggressive Behavior

Unless provided with support and counseling, a youth who has a history of aggressive or violent behaviors is likely to repeat those behaviors. Youth who show early patterns of antisocial behavior frequently and across multiple settings are particularly at risk for future aggressive and antisocial behavior. Similarly, youth who engage in overt behavior, such as bullying, generalized aggression and defiance, and covert behaviors, such as stealing, vandalism, lying, cheating and fire setting also are at risk for more serious aggressive behavior.

Research suggests that age of onset may be a key factor in interpreting early warning signs. For example, children who engage in aggression and drug abuse before age 12 are more likely to show violence later on than are children who begin such behavior at an older age. In the presence of such signs it is important to review the child's history with behavioral experts and seek parents' observations and insights.

Imminent Warning Signs of Violence

Unlike early warning signs, *imminent warning signs* indicate that a student is very close to the *possibility* of behaving in a way that is potentially dangerous to self and/or others. Imminent warning signs require an immediate response. Therefore, the I&RS team should be vigilant in examining the data collected for team review to determine a student's risk for causing harm to self or others, or make requests for assistance based on their own observations of behaviors of concern.

No single warning sign can predict that a dangerous act will occur. Rather, imminent warning signs usually are presented as a sequence of overt, serious, hostile behaviors or threats directed at peers, staff or other individuals. Usually, imminent warning signs are evident to more than one staff member, as well as to the student's family, which underscores the importance of thorough information gathering by a coordinated system of I&RS.

Imminent warning signs may include:

➢ ***Serious physical fighting with peers or family members.***	➢ ***Severe rage for seemingly minor reasons.***	➢ ***Possession and/or use of firearms and other weapons.***
➢ ***Severe destruction of property.***	➢ ***Detailed threats of lethal violence.***	➢ ***Threats of suicides or other self-injurious behaviors.***

When warning signs indicate that danger is imminent, safety must ***always*** be the first and foremost consideration. Specific ameliorative interventions can be designed after the immediate threat of danger has been contained. The I&RS team and other school staff should *immediately* refer warning signs for urgent intervention by school authorities, consistent with school board policies and state and federal regulations, and consideration should always be given to calling upon law enforcement officers when a student:

- ***Has presented a detailed plan (i.e., time, place, method) to harm or kill self or others, especially if the student has a history of aggression or has attempted to carry out threats in the past.***
- ***Is carrying a weapon, particularly a firearm, and has threatened to use it.***

SUBSTANCE ABUSE

Of continuing alarm for educators are the unacceptably high rates of student substance abuse. Significant concerns involve the increased use of alcohol, tobacco and other drugs (ATOD) by *younger* students; the increased *intensity* of use by young people; the *frequency* of use by students; and the *variety* and *unpredictable contents or strengths* of substances that are used either individually or in combination.

Adult denial, or deciding not to recognize and appropriately respond to ATOD abuse as a *primary* problem, has been a foremost dynamic that has prevented student substance abusers from recovering and performing to their potential in school. Youth substance abuse often is perceived as either an individual or a social phase, which, like other "trends," will pass. All too often adults' thoughts and actions regarding ATOD use among youth are counterproductive (e.g., "We drank when we were kids and it didn't hurt us."). The I&RS team can be an important mechanism for breaking the pattern of denial described above by ensuring that substance abuse and related issues are given full consideration as educational problems to be solved. Since all districts are required to "establish a comprehensive substance abuse intervention…and treatment referral program" (N.J.S.A. 18A:40A-10), the provisions of the I&RS code can also help districts fulfill the substance abuse intervention and referral program requirement.

Effective strategies for dealing with student ATOD-related problems must be designed to address the complexity, scope and context in which they occur. ATOD problems are particularly insidious because, as is the case with most students who have difficulties with ATOD, we typically do not observe direct substance use until the later stages of students' ATOD problems. We are far more likely to witness changes in students' academic performance, behavior and health long before we have hard evidence of ATOD abuse.

ATOD and related problems that have taken weeks, months, years or more than a decade to develop will not be resolved by a single act. The first action, however, is necessary to begin the intervention process. As indicated in the Life Skills Deficiency Model, which is explained earlier in this section of the manual, I&RS teams will enable substance abuse problems to continue if they only consider presenting or obvious problems. The I&RS team should remain vigilant in considering all possible influences (e.g., ATOD abuse) on student behavior as it reviews the compiled academic, behavior and health information for each case.

Substance Abuse, continued

Since the I&RS team collects comprehensive information on identified problems, it is in an ideal position to recognize the signs of substance abuse and other high-risk behaviors and take action to address student ATOD abuse as a primary problem, at early stages of identification.

Described below is information that can provide perspectives and insights into connections between substance abuse and academic, behavior or health facts. It is important for teams to remember that their role is to identify possible substance abuse and related behaviors of concern, rather than make a diagnose of substance abuse or chemical dependence or treat these problems. Certified experts outside the school should be used to make a clinical diagnosis for students of concern to either determine the nature of the substance abuse problem; recommend an appropriate course of action; or establish that substance abuse is ruled out as a primary problem and does not warrant a diagnostic categorization or placement.

Continuum of Youth Substance Use

The nature of youth ATOD use has followed a fairly consistent pattern since the 1970s; in fact, their pattern closely follows the nature of adult involvement with psychoactive chemical substances. The information provided below is not intended to prepare team members to diagnose ATOD problems, but to provide perspective on potential target audiences and give strength to the importance of *early identification* of student's *risk for harmful involvement* with substances.

Category of Use	Percentage of Youth	Summary of Characteristics	Considerations
No Use	5-15%	▪ Not particularly peer-oriented. ▪ More adult-oriented (seeks out and takes direction from parents and teachers). ▪ More likely to live in strong, stable families with healthy traditions and rituals. ▪ Has clear goals and strategies for goal achievement.	▪ There probably is far less concrete information on these students, when compared to the preponderance of research literature on student substance users. ▪ It is important, however, for schools to provide sufficient support to student's choices not to use substances; reinforce the message that substance abuse is wrong, harmful and not "normal" behavior; and provide opportunities for them to be positive role models.

Continuum of Youth Substance Use, continued

Category of Use	Percentage of Youth	Summary of Characteristics	Considerations
Experimental/ Recreational Use	65-85%	▪ Very peer-oriented. ▪ Common age of first use: 11-13 years. ▪ Looks like an adult addict or alcoholic, if we only look at the fact that chemicals have been used, rather than considering the nature of the use and the role it plays in young persons' lives. ▪ Use tends to be tied to social activities.	▪ A significant portion of students, who are engaged in this illegal and inappropriate student behavior, typically would not be diagnosed with a dependency problem. They, however, get in trouble (e.g., DUI arrests, vandalism, school policy violations) as a result of their use. ▪ Since we can not know which categories students will eventually fit into (e.g., a recreational user could eventually become dependent), teams must take all incidences of substance abuse seriously. Teams should constantly look for opportunities to intervene at the earliest possible stages of identification for all problems they review, because any observed at risk behavior could have its roots in substance abuse or related problems.

Continuum of Youth Substance Use, continued

Category of Use	Percentage of Youth	Summary of Characteristics	Considerations
Circumstantial Use/ Harmful Involvement/ Dependence	5-20%	▪ Use becomes a part of students' style of coping with every day life events and stressors. ▪ Common age of first use: 9-10 years. ▪ Risk-taking dramatically increases. ▪ More high-risk variables are associated with their lives. ▪ Tend to look peer-oriented, but there is little intimacy and support in these students' lives.	▪ Since these students tend to be the most obvious cases, they are more likely to come to the attention of the team. Providing appropriate care to these students is important. Teams, however, should guard against only considering the more pronounced cases. ▪ In addition to being well prepared to appropriately identify students with apparent problems, school staff should be trained to identify indicators that place youth at risk for *developing* substance abuse and related problems.

Progression of Chemical Dependency

As explained in Intervention: How to Help Someone Who Doesn't Want Help, by Vernon E. Johnson, the progression of chemical dependency can be described in the following four sequential phases. In Johnson's model, social users remain in phases one or two. Phase three signals the loss of control over one's use of chemicals. We do not fully understand why some people progress and some do not. We, however, do know what happens to them when they do.

Phase One: ***Learning about the Mood Swing.***

Phase Two: ***Seeking the Mood Swing.***

Phase Three: ***Harmful Involvement.***

Phase Four: ***Harmful Dependency.***

Progression of Chemical Dependency, continued

Phase One		
LEARNING ABOUT THE MOOD SWING		
Characteristics	***Priorities***	***Consequences***
➢ Every person who has consumed a psychoactive chemical substance (e.g., alcohol, marijuana, nicotine) has engaged in this phase: *learning how to use*. ➢ First experience(s) of the chemically induced *mood swing*. ➢ *Learns* one's mood can be changed and that the chemically induced euphoria is *temporary*. ➢ Learns to *trust* the chemical and its effects. ➢ Learns to *control* the degree of the mood swing by regulating the quantity taken. ➢ The experience is predominantly positive, both socially and emotionally. There often is learning that, contrary to the cautionary messages from parents, teachers and the communications media, the use of the substance was not a bad or life-threatening experience. ➢ There are no *"price tags"* or negative consequences when the effects of the chemical wears off.	1) Family. 2) Friends. 3) School or Job. 4) Sports. 5) School Activities or Hobbies. 6) Getting *"high" or intoxicated* is added to the list for the first time.	➢ Social: Few, if any, other than the first episode of intoxication or "getting high." ➢ Personal: Few, if any, with the exception of toxic inhalants. ➢ Physical: Possibly, a first hangover, which is frequently offset by euphoric recall (i.e., remembering the positive aspects and the positive social experience surrounding the substance use).

Progression of Chemical Dependency, continued

Phase Two		
SEEKING THE MOOD SWING		
Characteristics	***Priorities***	***Consequences***
➢ First *negative* dimension (e.g., guilt, hangover) experienced, but always *returns to normal*. ➢ Increased *tolerance* to dosage levels or quantities. ➢ *New peer group* identities might form around substance use (i.e., friends not known to one's parents) while *maintaining old friendships* (i.e., friends known to one's parents). ➢ Continued ability to *control* the times, quantities and outcomes of use. ➢ *Pattern* of use might exist, but weeknight use is the exception. ➢ *Reasons devised* to use at times other than acceptable occasions (e.g., impress friends, get ready for a social event). ➢ *Self-imposed rules* (e.g., "I only drink at parties." "I only smoke on weekends." "I never use with younger kids.") are made to govern use. ➢ Activities might suffer. ➢ Sneaking out at night; secretive or anonymous phone calls. ➢ The attraction is as much the camaraderie, excitement, and belonging that come from the experience, as it is the effects of the chemical.	1) Family. 2) Friends (*old and new*). 3) School or Job. 4) Getting *"High" or Intoxicated*. 5) Sports. 6) School Activities or Hobbies.	➢ *Legal*: Increased risk of being caught. ➢ *School*: Possible truancy or suspension from extra-curricular activities. ➢ *Home*: Consequences for not doing chores or fulfilling responsibilities. ➢ *Physical*: Hangovers, bad psychoactive experiences e.g., "trips") trouble sleeping on weekends, oversleeping on Monday morning. ➢ *Mental*: Spends more time and energy planning the next "high;" minimizes extent of use; denies and makes excuses for substance use and behavior changes. ➢ *Emotional*: Severe and unexplainable mood swings; normal emotional tasks (e.g., grieving, relationship issues) are delayed. ➢ *Spiritual*: Family values and substance using values come into conflict.

Progression of Chemical Dependency, continued

Phase Three		
HARMFUL INVOLVEMENT		
Characteristics	***Priorities***	***Consequences***
➢ Periodic *loss of control* (i.e., can not predict the outcome of one's use once it has begun). ➢ *Violates value* system, which results in emotional pain. ➢ Spontaneous *rationalizations* (e.g., "Everyone else does it." "I don't use as much as other kids." "It only happened this once, and won't happen again." "I only use at parties.") occur to hide the emotional pain. ➢ The rationalizations contribute to a *loss of insight* that grows into a complex *delusional system*. As a result, negative feelings remain *unidentified* and are *unresolved*. ➢ *Projections* (e.g., "Mom's a nag." "The teachers don't like me." "The other kids are weird." "You…." "They….") of self-hatred onto others. ➢ Anticipation and *preoccupation* with use. ➢ Complete *lifestyle* changes (e.g., music, clothes, language, established rituals for use, solitary use begins, ingenious at hiding ATOD, expert "cons"). ➢ *Peer group change* becomes distinct and complete.	1) *Chemical-induced "High."* 2) Family. 3) *New Friends*. 4) School or Job. 5) Sports. 6) School Activities or Hobbies.	➢ *Legal*: Shoplifting, vandalism, selling drugs, arrests. ➢ *School*: Declining grades and/or truancy becomes more frequent; sleeping in class; marked changes in attitude; school suspensions; forged passes and excuses for absences. ➢ *Home*: Stealing from parents; spending increasing amounts of time in room with door closed, or outside of the house; staying out overnight; becoming verbally and physically abusive. ➢ *Friends*: Losing or dropping non-using friends; loss of intimacy and support. ➢ *Physical*: Personal hygiene suffers; injuries; respiratory or other medical problems; weight loss or gain; overdoses; brain damage. ➢ *Mental*: Blackouts begin; shorter attention span; decreased motivation and drive. ➢ *Emotional*: Depression or suicidal thoughts; feeling cut off from friends, ridiculed or ostracized. ➢ *Spiritual*: Severe shame and guilt result from the conflict between family values and substance using values.

Progression of Chemical Dependency, continued

Phase Four		
HARMFUL DEPENDENCY		
Characteristics	***Priorities***	***Consequences***
➢ Spends increasing amounts of time getting or preparing to get "high," because he can not stand the way he feels in his normal state. ➢ Uses for *survival*, rather than euphoria. Uses to feel normal, rather than less bad. ➢ More *rigid* about how and when substances are used (e.g., must use first thing out of bed, or before lunch, or on the way to school, or as soon as the school day ends or before attending family functions). ➢ *Blackouts (i.e., periods of amnesia)* become more frequent. ➢ *Arrested development* (i.e., social, emotional, cognitive, behavioral, physical, spiritual). ➢ *Physical addiction* can occur. ➢ *Paranoid* thinking. ➢ Total *conflict with values*. ➢ *Geographic* escapes and change of drugs. ➢ Loss of desire to live; lows are really low.	1) *Chemical-induced "High."* 2) *New Friends*. 3) Family. 4) School or Job. 5) Sports. 6) School Activities or Hobbies. ***NOTE***: Priorities 3-6 are either nonexistent or are in complete conflict with the new lifestyle.	➢ *Legal*: Commits crimes (e.g., breaking and entering, robbery, assault, battery, prostitution); might deal more drugs, more frequently; engages in physical violence; spends more time in the legal system. ➢ *School*: Might sell drugs at school; substance use during school hours is common; might be suspended or expelled; might vandalize school. ➢ *Home*: Family fights become more physical or severe; stays away from home for longer periods of time; might leave or be told to leave. ➢ *Friends*: Responds to peers who express concern by avoiding them or using violence against them. ➢ *Physical*: More injuries; rapid deterioration of health (e.g., chronic cough, severe weight loss); withdrawal. ➢ *Mental*: Impaired recall and functioning; flashbacks. ➢ *Emotional*: Deep remorse and despair; suicidal. ➢ *Spiritual*: The conflict between values and behavior no longer restrains or inhibits substance use.

Substance Abuse, continued

The Disease Concept Chemical dependency (e.g., alcoholism, drug addiction) meets all of the criteria for a disease set forth by the American Medical Association. The criteria for determining whether a condition is a disease are described below:

A DISEASE:

Can Be Described:	It has its own symptoms, which can be observed and explained. There are identifiable patterns; we know what we are looking at when we see it. Just as a physician diagnoses diabetes, addiction can be identified by its characteristics and manifestations.
Is Predictable:	It follows a consistent pattern.
Is Progressive:	It becomes progressively worse. The affected person becomes physically, spiritually, emotionally and psychologically ill.
Is Chronic and Permanent:	There is no cure for the disease; it only gets worse. Recovery from the disease must be based on abstinence from mood-altering chemical substances.
Is a Primary Problem:	It is not a secondary symptom of some other problem (e.g., poverty, domestic violence, poor academic performance, truancy, broken home).
Is Terminal/ Fatal:	If left untreated or if the pattern continues, the result is premature death. The disease can only be arrested. As is the case with individuals who have diabetes or cancer, the person will die if the disease is not checked.

Substance Abuse, continued

Intervention As discussed earlier in this section of this manual (i.e., Scope of Services for Building-based I&RS Teams) one of the modes of operation for I&RS teams is a *direct services mode*, in which the team takes over *partial or total* responsibility for a case. It is likely that the direct services mode will apply to cases where a student's harmful involvement with substance abuse is an area of concern. In substance abuse cases, the direct services mode includes the planning and execution of formal or informal *interventions*.

Intervention Definitions

Some common definitions of intervention are provided below:

1) *A process or event that prevents, alters or interferes with the progression of a condition.*

2) *Any actions or decisions made that get between the individual and his behavior.*

3) *All of the critical steps undertaken to increase one's motivation for change.*

4) *A process of change over a period of time.*

It is important for teams to remember that intervention is a *process*, rather than a single event. Intervention is a *series* of actions, conditions or stages that are designed to ameliorate a condition. Understanding intervention as a process is particularly important for teams as they deal with the denial, projections and delusional thinking exhibited by most individuals who are harmfully involved with psychoactive chemical substances. The very nature of their harmful involvement with substances prevents these individuals from responding with rational thought or to one intervention event.

Therefore, teams should be prepared for significant resistance from students and their families, and design I&RS action plans as a process or a series of interventions designed to achieve the *ultimate* goal*: to help the person become motivated to accept the team's offer for professional help or change*. Once the goal has been achieved, the intervention process becomes one of support, referral and health maintenance.

Intervention, continued

An intervention *event* is always one of the actions, conditions or stages undertaken in the intervention *process*. Each event is designed to provide a student and/or his family with the opportunity to make a choice to accept the team's offer of help. An intervention event is a supportive action, service or confrontation that is based on the findings of specific information about a student's behavior. When the decision is made to present the student with data on his behavior, the firm recitation of facts is *alway*s balanced with expressions of *caring and concern* and is presented in a *supportive* manner, with *warmth and respect*.

Intervention Assumptions and Considerations

- ***"Raising the Bottom"*** – As explained above, there is a predictable and progressive pattern to chemical dependence that is chronic and terminal. We do not have to wait for the disease to run its course and watch students "bottom-out" before help is offered. We can "raise the bottom" to arrest the condition and initiate recovery.

- ***Precipitating a Crisis*** – The bottom can be raised through crises. Crisis situations will either come about "naturally" (e.g., through the student's behavior) or the team can create crises for students through the intervention process. The key for interventions is to effectively *combine consequences and concern* to stimulate the student to respond to offers of help.

  The fact that *consequences are not synonymous with punishments* is important for teams to remember. If the goal is to influence a student's choice to accept help, crisis opportunities should be fully used to attach *meaningful consequences* (e.g., intervention-education groups, community service in drug/alcohol treatment centers, in-school suspension programs that include class work, assessments and counseling, drug/alcohol policies and procedures that are gradated and that balance consequences with care and supportive services) that will increase the chances that the goal will be achieved.

- ***School Assessment vs. Clinical Diagnosis*** – Teams must not diagnose substance abuse problems; not all student substance use indicates addiction or requires community treatment services. Appropriately certified school staff may conduct *assessments* for the purpose of making preliminary determinations regarding students who exhibit behavioral patterns that suggest involvement with alcohol or other drugs. On the other hand, *clinical diagnoses* are conducted by appropriately certified professionals from *outside the school*.

  Recommendations from clinical diagnoses determine the appropriate interventions or level of care. Teams can significantly facilitate the diagnostic process by providing information on cases to diagnosticians.

Substance Abuse, continued

Substance Abuse Treatment

The I&RS team should be cognizant of the dynamics, vocabulary and stages of substance abuse treatment. All school staff should be aware of some key assumptions about treatment:

1) Treatment is not a cure.

2) Treatment is a brief period or event in the extended process of recovery.

3) The process of recovery is initiated in treatment, but often takes two to three years or longer to take hold.

4) Sobriety is a lifelong challenge.

Phases of Recovery

As explained in When Chemicals Come to School: The Student Assistance Program Model, by Gary L. Anderson, and adapted below, there are four basic phases of the recovery process, regardless of treatment modality:

TREATMENT PHASE	CHARACTERISTICS AND GOALS
Phase 1: ***Admission***	➢ The emphasis is on *cognitive* changes. ➢ The individual is helped to learn the signs of chemical dependence and recognize them in himself; helped to identify with others who have experienced similar symptoms; and helped to see the extent of his denial. ➢ At the cognitive level, at least, he identifies himself as being chemically dependent.

Phases of Recovery, continued

TREATMENT PHASE	CHARACTERISTICS AND GOALS
Phase 2: ***Compliance***	➢ The emphasis is on *behavioral* changes. ➢ Superficial changes in lifestyle or situational habits are made to accommodate the needs of the outside world, rather than because the individual believes he needs them. ➢ The individual's primary mission centers on the question: "What do I have to do to get out of here?" ➢ Believes he can stay "straight" on his own, that "this can be beaten" by the exertion of one's will. ➢ It is not uncommon for the individual to leave treatment in this phase, with little buy-in to the requirements for a lifetime of recovery.
Phase 3: ***Acceptance***	➢ The emphasis is on *emotional* changes. ➢ Begins to accept the disease and its past, present and future implications at some emotional depth. ➢ Learns the seductive and genuine power of his denial, which leads to acceptance of the idea that support from others is an essential ingredient for ongoing recovery. ➢ More open to assessment, more trusting of others and more favorably inclined to change.
Phase 4: ***Surrender***	➢ The emphasis is on *spiritual* changes. ➢ There is complete openness to change and help on a spiritual level and from other people. ➢ There is a complete identification with the chronic nature of the disease and its future implications. ➢ There is a major transformation from a focus on the negative to the integration of a positive pattern of thinking, feeling and behaving. ➢ There frequently is a profound sense of gratitude, and forgiveness for self and others.

Substance Abuse Treatment, continued

Treatment for young people is different in many respects from treatment for adults. One of the most significant differences is an emphasis on *habilitation*, rather than rehabilitation. Rehabilitation, by definition, is the restoration of something to a former capacity, state of being, condition of health or useful or constructive activity. Young people in treatment, however, often have missed or retarded significant stages of social, emotional, spiritual and even physical development as a result of their substance abuse. The task in adolescent treatment is not to restore young people to a previous state, but *to make them capable* of functioning in a healthy, useful and constructive way.

Due to the onset of major changes in the health care delivery system, many students do not have the opportunity to receive services of sufficient duration or intensity for fully bringing about these dramatic developmental changes. Therefore, I&RS teams must be cognizant of the treatment stages described above to help understand each student's behavior, develop appropriate interventions and provide adequate support for students' recovery when they return to school.

Issues in Recovery

As indicated above, recovery is a lifelong process. A magic wand is not waved in treatment programs that makes individuals perfect. Individuals in recovery struggle to maintain their commitment to a life of sobriety. This dynamic is exacerbated by the oppositional and testing behavior that characterizes adolescence. Additionally, young people in treatment are instructed to avoid *"people, places and things"* that contribute to a drug-using lifestyle, but are placed back in school, which often represents the "people, places and things" to be avoided in order to stay sober.

Described below are some principles and issues for teams to understand and address with students who are returning from treatment:

Relapse Principles

- Relapse is a reactivation of old behavior patterns, which begins *before* the use of a substance.
- Relapse is a *symptom of the disease*, rather than a failure of treatment.
- Relapse is a *normal* occurrence in the recovery process and should be planned for and proactively addressed.

Issues in Recovery, continued

Relapse Issues

Students will typically demonstrate signs of relapse *before* they use a substance. The I&RS team and other school staff should be trained to identify and intervene when they observe these indicators. In so doing, they can increase the chances that students will not use again and will maintain their recovery program.

The I&RS process does not end when a student enters treatment. It makes little sense for teams to spend time and energy on getting students into treatment and doing little or nothing to ensure that treatment takes hold. I&RS teams should think of themselves as partners in the treatment and recovery process. The distinction is that I&RS teams' responsibilities come *before* and *after* students' participation in a program outside of the school.

Since intervention is a continuing process of change over a period of time, rather than a one-time event, teams should devise systematic plans for identifying early warning signs of relapse and providing students with support, as extensions of or amendments to the teams' original intervention plans.

Students in recovery are accustomed to being confronted on their behavior and in being open and honest with themselves and others. When a behavior of concern is identified, an intervention does not have to be a sophisticated plan of action. An intervention can be a one-on-one conversation that includes the following:

Relapse Interventions

- A sincere expression of caring and concern.
- A description of the behavior or issue of concern.
- An invitation to talk and/or a referral to an appropriate school resource.
- Encouragement to get back to "working the program" of recovery.

Relapse Issues, continued

Student Relapse Indicators

Some of the more prominent issues that can affect students' recovery and the feelings and behaviors that might indicate relapse are described below:

- ***Workaholism*** – Replacing substances with work. Undue emphasis on what one "should be," rather than what one is. Can reflect unrealistic expectations and avoidance of intimacies.
- ***Self-Pity*** – Feeling victimized, rather than taking responsibility for oneself.
- ***Frustrations*** – Can reflect lack of feeling or appropriate expression of anger; feeling blocked from achieving goals; unrealistic expectations or poor coping skills. Seeing the "cup" as half empty, rather than half full.
- ***Forgetting Gratitude*** – Not remembering that one needs and must appreciate others to stay sober.
- ***Relaxing*** – Letting up on the continuous discipline of recovery (e.g., "I'm okay now."). Not integrating daily meditations, affirmations, meetings, support groups into their lives, but using them as "pills" from time to time when "needed." Forgetting that the mainstay of recovery is a changed lifestyle.
- ***Setting Unachievable Goals*** – This is a set-up for disappointment, frustration and self-pity. Recovering students should only set out to be sober today, rather than for the next day or the next 25 years.
- ***Fatigue*** – Becoming abnormally tired and careless about one's health.
- ***Dishonesty*** – Various forms of excuse-making (e.g., exaggerations, cover-ups, under-estimations) that often start small and innocent, but typically grow into more elaborate "cons," deceptions, denials and delusions.
- ***Righteousness*** – As things get better, a feeling of arrogance and superiority toward those who continue to struggle with recovery.
- ***Impatience*** – Suggests the illusion of control and dissatisfaction with the rate and direction of recovery.

Relapse Issues, continued

Issues for School Staff

In addition to the relapse indicators described above, there a number of issues that school staff should take into consideration when working with recovering students.

- ***Re-entry*** – The recovering student is not a "new" person, but is in the process of learning a new way of being. He is not cured, but is recovering "one day at a time."
- ***"Rehab High"*** – The recovering student may have false expectations that the "real world" will mimic the support, safety and intimacy of the treatment environment. There is a feeling that "Never again will I have problems."
- ***Trust is Shaky*** – People often have not changed their feelings about the student, and the student has not completely changed, only stopped using substances.
- ***Peers (Old and New)*** – The recovering student is faced with the challenge of making new friends, while having a negative reputation. At the same time, he must contend with those with whom he previously got "high."
- ***Too Much or Too Little Expected*** – It is unrealistic to expect a "D" student to suddenly become an "A" student. It is unfair to dismiss the student because he is only a "junkie."
- ***Delayed Social and Emotional Development*** – The recovering student frequently has the emotional make-up of a child, but the body of an adolescent. It takes time for the recovering student to catch up with each year of missed development.
- ***Grades/Career Goals*** – The recovering student becomes concerned with his school performance and his future. Panic often ensues (e.g., "How can I possibly catch up?").
- ***People, Places and Things*** - The recovering student must learn to avoid that which supported the substance abuse. Some students, particularly drug-using friends, are threatened by the new behavior and will take it as a personal challenge to get the recovering person to use again.

DEPRESSION AND SUICIDE

An ever-present concern for schools is the possibility that a member of the school community will attempt or be successful at taking his own life. Suicide among children is a rare event; however, the increased suicide rates among young persons underscores the need for intensified prevention efforts.

Significant numbers of students attempt suicide every year. Obviously, a child who attempts suicide needs attention, but many who make attempts go unknown or unnoticed by systems unequipped to provide them with services. Experts in the field of suicidology contend that an unknown number of deaths among all youth that are listed as accidents (e.g., being struck by a car, being in a single car accident) are actually suicides. Provided below are some facts on youth suicide:

YOUTH SUICIDE FACTS

- A suicide attempt is made every 2.5 minutes.
- A completed suicide occurs every 90 minutes.
- The suicide rate has risen 300% in the last 30 years.
- Drugs and alcohol are involved in up to 80% of all suicides.
- For the total population, 7-21% of alcoholics commit suicide, compared to 1% of the general population.
- Females attempt suicides four to eight times more frequently than males.
- Males complete suicides four times more frequently than females.

Methods for Attempting and Completing Suicides:

BOYS		***GIRLS***	
Firearms	65%	Firearms	58%
Hanging	20%	Hanging	5%
Overdose	10%	Overdose	20%

Depression and Suicide, continued

Warning Signs of Suicide

- *Actual* suicide attempts or gestures.
- *Previous* suicide attempt(s).
- Expressing suicidal *thoughts* or *threats*.
- Making *final arrangements* (e.g., giving away valued items, completing all unfinished class work and chores), as though for a final departure or putting affairs in order.
- Recent *loss* of a close relationship through death or suicide; *loss* of self-esteem (e.g., as a result of rejection, humiliation), or any *loss* of significance to an individual.
- Pre-occupation with *themes of death* expressed in talking, writing, music or art work.
- Prolonged depression (i.e., inability to find pleasure in otherwise pleasurable experiences), with manifestations of hopelessness, guilt, persistent sadness, despair, helplessness and worthlessness.
- Physical signs of *depression* (e.g., changed sleeping patterns, changed eating habits, loss of appetite, weight loss, frequent stomach aches, headaches, fatigue, loss of energy).
- Major *personality* or *behavior changes* (e.g., excessive anxiety, anger, apathy, lack of interest in personal appearance, decreased sexual activity).
- Sudden unexplained *"switch"* in mood (e.g., euphoria or heightened activity after a long period of "gloom and doom;" an outgoing person becoming withdrawn, aloof and isolated).
- *Self-destructive* or persistent risk-taking behavior (e.g., self-inflicted cigarette burns, cuts, stabbings, jumping from high places, excessive speeding, reckless driving).
- *Persistent* abuse of alcohol and other drugs.
- Loss of *interest* or pleasure in usual activities.
- *Speaking* and/or *moving* with unusual speed or slowness.
- Diminished ability to *think* or *concentrate*; slowed thinking or indecisiveness; preoccupation with personal thoughts; excessive daydreaming.
- Failing grades or marked *decline* in school performance (e.g., failing grades, truancy, falling asleep in class).

Depression and Suicide, continued

There are few events in the life of a school that are more painful than the suicide of a student. Fortunately, most student suicides do not initiate cluster responses, although apprehensiveness about copycat suicides is not misplaced, and the development of proactive strategies to minimize "contagion" is warranted.

The sudden violent loss of a member of a school community resulting from suicide creates a crisis for all the remaining members. As explained in Managing Sudden Traumatic Loss in the Schools, by Maureen M. Underwood and Karen Dunne-Maxim, that was co-sponsored by the New Jersey Department of Education, "The most helpful approach to resolution of the situation makes use of the principles of crisis intervention theory, which suggest that *1) Support, 2) Control, and 3) Structure* stabilizes a situation until it can return to its pre-crises state. In addition, the fear of contagion or imitation after a suicide also provides some guiding principles that add to this intervention framework:

1) Nothing should be done to glamorize or dramatize the event.

2) Doing nothing can be as dangerous as doing too much.

3) The students cannot be helped until the faculty is helped."

Schools can approach these principles by establishing clear policies and procedures that address implementation details and which are centered on the following points:

1) ***Maintain the structure and order of the school routine*** (e.g., following class schedules, not dismissing the student body early) to provide some predictability and to help faculty and students feel in control; and

2) ***Facilitate the expression of grief in a controlled and organized way*** (e.g., using small classroom discussions, rather than general school assemblies, as vehicles for discussion of the death; limiting funeral attendance to students with parental permission) to also introduce order into an event that may otherwise be chaotic.

Although the I&RS team is not designed to be the school's emergency and crisis response team, it typically includes members of the crisis team and can be a valuable supportive resource in the event of a suicide or other sudden traumatic loss event. It can also assist in the development of strategic plans for managing these crises.

Depression and Suicide, continued

In Grief Counseling and Grief Therapy, William Worden describes the various stages or "tasks" that need to be accomplished before mourning is completed. As suggested in Managing Sudden Traumatic Loss in the Schools, his framework provides structure for schools to plan for grief and healing. His model, which is summarized below, can be used as an outline for planning the school's response to loss.

TASKS OF GRIEVING

Task One: ***To Accept the Reality of the Loss***

- Acknowledge the loss.
- Stick to the facts.

Task Two: ***To Work through the Pain of Grief***

- Provide a time and place for people to grieve.
- Assess the needs of high-risk students and use community resources to provide them with assistance.

Task Three: ***To Adjust to an Environment in which the Deceased is Missing***

- Assist people in managing without the deceased.

Task Four: ***To Emotionally Relocate the Deceased and Move on with Life***

- Allow people time to come to terms with the loss.

HEALTH ISSUES AND STUDENT PERFORMANCE

The I&RS team is designed to address student *health* issues, as well as academic and behavior concerns. School staff commonly understands that children must be healthy to learn, but they may not readily associate their concerns regarding students' behavior and academic performance with health problems.

It is incumbent upon teams to be observant of health issues that are either obvious or which may underlie identified academic or behavior concerns. Therefore, the I&RS team should include the collection and analysis of student health information, along with school performance data.

Without the coordination of information and effort of the I&RS team, concerns about a student's health can either go unnoticed or can be dealt with in an inappropriate or a fragmented and ineffective manner. The example below, which has been adapted from Health is Academic: A Guide to Coordinated School Health Programs, by Eva Marx, Susan Fredlick Wooley and Daphne Northrup, describes how a student health issue might go unnoticed or be inappropriately treated:

> *It is Monday morning in physical education class. Syreeta is complaining again to her teacher that she has a stomach ache. The teacher recalls that Syreeta sat out last week's class because her stomach was bothering her. The teacher wonders whether she should send the student to the school nurse this time.*
>
> *In second period history class, Syreeta's teacher catches her dozing and, when the homework assignments have been collected, Syreeta's is not among them, once again. The teacher wonders whether it is time for a parent-teacher conference.*
>
> *During lunch, Syreeta is quiet and withdrawn, poking at her food with a fork, but not eating it. The teacher who is monitoring the cafeteria is Concerned Syreeta is usually an outgoing, good-Humored person, but she has been like this for the last several days. The monitor wonders whether he should ask the school counselor to set up an appointment to talk with Syreeta.*

Health Issues and Student Performance, continued

In the example, each teacher has observed a fragment of potentially worrisome behavior. Each has a doubt about the student's health or academic performance. More than likely, if the student's problems appear to be serious enough to eventually warrant each teacher's intervention, the interventions are likely to be fragmented: a visit to the school nurse, a conversation with the student's parents and a referral to a counselor. Even when emergency concerns require immediate action, the case can be reviewed by the I&RS team to ensure coordination, comprehensive planning and support for Syreeta, her family and her teachers.

In situations such as Syreeta's, the piecemeal, potentially competitive or uncoordinated efforts to address the intertwined social, educational, psychological and health needs of students are counterproductive and a poor use of school resources. Ultimately, uncoordinated strategies do not work for students and do not work for the students' teachers.

There is an inextricable link between students' health and their ability to learn (World Health Organization, 1996). If the team does not address students' health issues in concert with academic and behavior concerns, the school will more than likely have to deal with them, in one way or another, by default. Only when students are healthy will schools be able to fully meet their goals (Smith, 1996).

Some common health problems at the elementary level (e.g., asthma, allergies, eyesight, hearing) and at the secondary level (e.g., eating disorders, substance abuse, pregnancies, injuries) have an immediate impact upon students' ability to perform in school. Six preventable behaviors, which may be less readily apparent, are established in childhood and account for most of the serious and preventable illnesses and premature deaths in the United States (Kolbe, 1990):

- Tobacco Use.
- Poor Eating Habits.
- Abuse of Alcohol or Other Drugs.
- Behaviors that Result in Unintentional Injury.
- Physical Inactivity.
- Sexual Behaviors that Result in HIV Infection, Other Sexually Transmitted Diseases or Unintended Pregnancy.

Health Issues and Student Performance, continued

As explained in Health is Academic: A Guide to Coordinated School Health Programs, in some schools these problems are widespread and obvious. In others they exist just beneath the surface of school life. Whenever they emerge, however, they can disrupt students' lives, classrooms and the overall school environment. When students are sick, distracted, impaired in their ability to perform to their potential or unable to attend school, the efficiency and effectiveness of educational institutions become constrained. Underlying many academic problems are poor health or psychological or social problems that must also be addressed for schools to support the achievement of high academic standards.

Described below are examples of health problems that can interfere with students' performance in school, possible observable indicators and educational implications.

Health Issue	***Observable Indicators***	***Educational Ramifications***
Diabetes	Frequently asks to use lavatory and water fountain. Diminished attention to class activity and responsiveness when called upon.	Fluctuations in blood glucose affect attention and mood. The student's need for frequent meals, regular exercise and blood glucose monitoring may conflict with the school schedule.
Eating Disorders (i.e., anorexia, bulimia)	Multiple requests to be excused from class, and changes in appearance or demeanor upon return. Class tardiness. Sudden increases or decreases in weight. Extreme mood swings. Deterioration of healthy appearance of skin, hair and nails. Adoption of regular smoking of tobacco.	If the problem becomes chronic, the metabolic and emotional effects will affect alertness and clarity of thought, healthy physical and emotional development and the expression of affect.
Ulcerative Colitis	Multiple absences from class to use toilet.	Student viewed by the teacher as a "nuisance" or "problem student."

Health Issues and Student Performance, continued

Asthma	Coughing, wheezing or difficulty breathing. Repeated requests to be excused from class to see the school nurse. Repeated absences from school.	Absences from school may interfere with students' academic progress. Asthma attacks could cause classroom distractions. Episodes may be triggered by airborne matter (e.g., dust, powders, mold, aerosol products) in the school building, as well as students' in-school physical activity.
Pregnancy	Change in physical appearance (e.g., thickening of the waistline, dark circles under the eyes, nausea, especially during the morning, extreme fatigue) and dress (e.g., loose-fitting clothes). Unexplained absences from school. Numerous absences from school for 'health care' reasons.	Potential dropout and failure to graduate. Students' behavior may have placed them at risk for additional pregnancies, sexually transmitted diseases (STDs) or human immuno-deficiency virus (HIV). Particularly for girls, sexual involvement at an early age can be an indicator of inadequate engagement with school and other pro-social institutions or activities.

The Relationship of Health Issues to I&RS

Since the health professional has general knowledge of common health issues affecting classroom performance, it is important for the team to include their input in the I&RS process. The educational interests of school health professionals can be represented by having them serve as members of the I&RS team or by collecting information from them as part of the comprehensive set of data that is gathered and assessed for all requests for assistance. A few examples and issues regarding the interaction of the I&RS team and school health resources or issues are provided below:

Education and Health Example #1

A student whose classroom work has been declining, but not his homework, may need corrective lenses or a hearing aid. The nurse can share information relevant to her concerns regarding the observed behaviors' in response to the request for assistance or upon review of team data collection. As part of the I&RS action plan, she might recommend the administration of a vision and/or hearing test.

Health Issues and Student Performance, continued

Education and Health Example #2

A teacher has requested assistance for a student who for the past two weeks has been requesting to use the lavatory or to get drinks of water an average of one time per class. The teacher reports that in the same time period the student has begun to have trouble focusing on tasks (i.e., not responding when called upon) and staying attentive in class (i.e., nodding off, daydreaming). His test scores have gone down, and he has not completed four homework assignments, because he has been in the lavatory when instructions are given.

Whereas the student has never been a behavior problem, he recently has demonstrated uncooperative behavior (e.g., not following directions) or attention-seeking behavior (e.g., making faces, non-task-specific comments at inappropriate times) that is interfering with instruction. When questioned by the teacher, the student has not been able to account for the behavior changes, and the student's mother has not noticed any changes at home.

Team data collection shows that two other teachers report similar observations. The physical education teacher indicates that lately the student has been lethargic and tired (i.e., just stands around with arms folded, does not participate), and has not volunteered for activities, which is a real change for this previously active student.

Based on the data, the team develops an action plan that could include the following: 1) As advised by the school nurse, suggest the parents arrange a medical evaluation to determine whether or not there is diabetes or a related medical disorder. 2) Arrange contact with the guidance counselor or substance awareness coordinator (SAC) to determine whether other issues are affecting the student's performance. 3) Consult with the teacher to permit the student to go to the bathroom as needed and to maintain a water bottle in class for a period of one week, pending the results of the medical examination. For the identified time period, suggest the teacher provide the student with written copies of all homework assignments. In addition, the teacher is asked to chart and report back to the team the student's behavior and performance for the designated time period.

After the assigned time period, the team collects and reviews the new data, which shows that the student's attentiveness has increased; all homework assignments have been submitted; classroom disruptions related to his requests to go to the lavatory have diminished; and the uncooperative and attention-seeking behavior has decreased somewhat. The counselor or SAC reports that the student indicated he was aware of the changes but could not account for them, saying: "I just don't feel right." The results of the medical evaluation have come back positive for diabetes.

The team updates the action plan to include the following activities: 1) The school nurse, in consultation with the family and health care provider, will develop an *individualized health-care plan* to address the student's health care needs within the school setting (e.g., blood glucose testing in the nurse's office, administration of insulin or carbohydrates, adjustments to the student's schedule, particularly for physical education class and meals). The plan will be shared with appropriate school personnel, and appropriate support, follow-through and monitoring will take place. 2) The guidance counselor will initiate sessions to provide support and build motivational factors for the student.

Health Issues and Student Performance, continued

Education and Health Example #3

Sometimes the school health professional will have specific knowledge of a student's health status, but may not share details with the team due to confidentiality regulations. The school health professional, however, *can* provide appropriate suggestions for I&RS action planning that is *based* on their privileged information. The I&RS team should respect the limitations of the health professional and accept the information that will help the team develop an appropriate action plan as it continues its work in support of the student.

For example, a student who has regularly received "C" and "B" grades has a failing grade in three subjects for the first marking period, and has been found sleeping in class on three occasions. The student has indicated little concern about his performance; has not accepted offers for instructional assistance; and has chosen not to talk with his teacher about his situation.

The school social worker, who has some knowledge of family matters related to this behavior, may suggest during team action planning that the teacher send the student to the nurse's office for a nap whenever he seems tired over the next two weeks, after which time the strategy will be reconsidered. He also indicates that the student might benefit from an after-school adult mentoring program that provides positive encouragement, adult engagement and academic assistance.

The social worker *does not* reveal that the student's mother has been hospitalized for infections related to HIV/AIDS, and that the student has been experiencing nightmares that keep him awake for long periods of time. Instead, the social worker urges the team to establish a plan to help the student handle stress and promote academic progress.

TEEN SEXUALITY

Students mature in their development as sexual beings at the same time that they develop other facets of their personal skills, aspirations and identities. A number of issues and problems can arise in this development, some of which bear directly upon academic performance (e.g., pregnancy leading to parenthood; preoccupation with boy/girlfriend at the expense of school work) and others of which may be more distantly related (e.g., the student whose physical development is delayed relative to peers; the student who develops early and engages in premature sex).

There is an enormous body of theory and research about the causes and antecedents of adolescent health behaviors in general, and sexual behaviors in particular. Kirby (1997) and Brindis (1991) have identified multiple factors related to sexual behavior, contraceptive use, pregnancy and childbearing.

Teen Sexuality, continued

High Risk Factors for Unprotected Intercourse or Pregnancy, Premature Sexuality and Childbearing

Personal or Peer Factors

- Early development of puberty.
- Nonconforming and impulsive behavior.
- Lack of concern about risks.
- Early delinquency or truancy.
- Substance abuse and other unhealthy behaviors.
- Low religious participation.
- Easily influenced by peers.
- Low levels of income.
- Low levels of education.
- Have friends whom they believe are sexually active.
- More aggressive and not well liked by peers.
- Experience sexual pressure or abuse.
- Begin dating young, and if female, more likely to have relationship with an older male.
- More permissive attitudes toward premarital sex.
- If sexually-involved:
  - have sex with multiple partners,
  - more negative attitudes toward contraception,
  - lower self-efficacy in getting and correctly using contraception,
  - more likely to want to have a child or to feel ambivalent about having a child during adolescence.

School/Academic Factors

- Low expectation for success in school.
- Low school grades.
- Few perceptions of positive life outcomes.

Family Factors

- Single parent.
- Low income.
- Parent(s) with low level of education.
- Permissive parents.
- Mother or sisters who were teen mothers.
- Inadequate parent-child support or supervision.
- Parents divorced, separated or never married.

Community Factors

- High levels of poverty.
- Significant degree of segregation.
- High unemployment.
- High residential turnover.
- Low levels of education.
- High divorce rates.
- High rates of non-marital births.

Teen Sexuality, continued

Blum and Rinehart (1998) report findings from the National Longitudinal Study of Adolescent Health which indicate that a student's sense that they are treated fairly at school, are close to people at school and get along with teachers and other students at school provides protection against early first sexual intercourse, as well as participation in violence and substance use. Dryfoos (1990) has also reported that students' level of engagement with school activities and students' academic performance are related to a variety of at risk behaviors, including at risk sexual behaviors. Therefore, by increasing academic and social success, the I&RS team can contribute to the reduction of risks for premature sex and the promotion of students' healthy sexual development.

I&RS teams should guard against discomfort or denial concerning the sexuality of children. Adult uneasiness can particularly pose an obstacle to addressing issues of student sexual development when clear signs of puberty (e.g., changes in facial hair, muscular or fat development, breast development) have not been displayed. For example, findings from the Youth Risk Behavior Survey report that among New Jersey high school students: 32% of students age 15 or younger indicated they ever engaged in sexual intercourse, with 19% as recently as the month prior to survey. Additionally, in Sex on Campus: The Naked Truth About the Real Sex Lives of College Students, by Elliott and Brantley, the findings of a survey of college students indicate that 17% of self-identified gay and bisexual men, and 11% of self-identified gay and bisexual women report knowing that they were gay or bisexual during grade school.

I&RS team members should remain sensitive to the tasks of adolescent sexual development and their effects on school performance. In instances where requests for assistance indicate risks for premature sexual activity or where teenage pregnancy or child rearing are issues, the I&RS team can be instrumental in arranging for appropriate instruction, supportive school services (e.g., clubs or service organizations, counseling) and community services (e.g., social services, health care, vocational guidance, recreational services, child care, adult mentors), as well as provide oversight of the students' educational progress.

Described below are some key tasks for adolescent sexual development that have been adapted from Sex is a Gamble, Kissing is a Game, by Brooks-Gunn and Paikoff, in Promoting the Health of Adolescents: New Directions for the Twenty-first Century, Millstein, Petersen and Nightingale, editors.

Teen Sexuality, continued

Tasks for Adolescent Sexual Development

Where appropriate, the I&RS team should strive to devise I&RS action plans that will help students:

- Develop appreciation of their own gender and the other gender.
- Develop positive feelings about newly acquired secondary sexual characteristics.
- Learn to manage sexual arousal.
- Learn to manage menstruation and other changes in physical function.
- Develop new forms of intimacy with peers.
- Establish a sense of autonomy.
- Develop skills to limit adverse consequences of sexual behavior.
- Develop positive values and goals related to sexuality and sexual behavior.

Sexual Harassment

A survey conducted by the American Association of University Women found that four out of five students have experienced some form of sexual harassment at school. More than one third considered this harassment as a normal part of school life. In a survey of school teachers reported by Telljohann, more than 20% said that students in their classes often use abusive language when describing homosexuals. Therefore, I&RS teams should remain cognizant of the possibility of harassment as a contributing factor to the concerns identified in requests for assistance.

CHILD ABUSE AND NEGLECT

By law (N.J.S.A. 9:6-8.10) and New Jersey Department of Education regulations (N.J.A.C. 6A:16-10), ***any person*** having a reasonable cause to believe that a child has been abused or neglected in any environment (e.g., home, school, other institution) is required to notify the Division of Youth and Family Services (DYFS), New Jersey Department of Human Services. School staff play an important role as reporters since they closely observe and interact with children on a consistent and extended basis.

As is the case with other student at risk conditions or issues, the I&RS team can play a pivotal role in identifying children who are victims of abuse and neglect. Whenever student information before the team suggests abuse or neglect, the team should immediately report the incident or concern to DYFS.

Each school district is required to have a liaison to DYFS to assist in resolving communication and procedural issues and coordinate staff training (N.J.A.C. 6A:16-10.2(a)5). The team should establish or ensure that a working relationship is established with the liaison.

Where appropriate, the team can also provide support and assistance to educators who work with abused children. The team can impart current information and appropriate strategies for helping staff to nurture and develop the potential of these students, while maintaining privacy rights.

CHILDREN FROM HEALTHY AND VULNERABLE FAMILIES

"All happy families are alike,
but each unhappy family is unhappy in its own way."
Leo Tolstoy

Countless students are living with a family situation that is marked by a pattern of pain and distress. For example, research studies indicate that one in five (20%) students in a typical classroom are children of alcoholics. Unhealthy family conditions or family crises increase a child's vulnerability, or risk, for school failure and the development of self-defeating behavior patterns and lifestyles.

The I&RS team should remain sensitive and responsive to family influences on student behavior. Family problems do not excuse inappropriate student behavior either within or outside the school setting. Understanding a student's family circumstances, however, can provide valuable insights for I&RS team planning, and provide opportunities for support and constructive interventions.

It is important to remember that the "Norman Rockwell" picture of a family: a working father, a housewife mother and two children of school age, constitutes only six percent of households in the United States today. At least two million school-age children have no adult supervision at all after school; two million more are being reared by neither parent. On any given night, between 50,000 and 200,000 children in the United States have no home.

Team members should guard against stereotyping students, thereby limiting them, according to their family conditions. While it is true that students often act out family problems in school, teams should not assume that all acting out behavior is based in impoverished, illicit or socially unacceptable activities or family lifestyles. For example, students who face chronic illness in the family or experience the death of a loved one may be as susceptible to exhibiting high risk behaviors as are students who are victims of other types of family problems. The team should collect as much information as possible to substantiate the exact nature of a family's pain, as appropriate, in order to provide suitable support.

Regardless of the nature of a family's distress, the team's role is *not to fix* or save the family or the student. Rather, the team's role is to offer, provide and coordinate as much *help* in the school and community as possible; always maintaining focus on the student's *behavior*.

Healthy Family Characteristics

A goal of all systems, including families, is to maintain a sense of balance in power, relationships, communication and roles. In healthy families, these four elements are fluid, open and consistent; there is a balance in the nurturing and governance functions of parents.

Power is fluid. Discipline is fair, consistent, age-appropriate and allows for negotiation, as suitable to developmental levels and situations.

Roles are predictable and consistent. Children know what to expect (e.g., in the morning, after school, at bedtime, during holidays).

Communication is open and two-way. There is talking and sharing.

Relationships are marked by nurturing behavior, such as quality time, warmth, caring, reaching out, giving, respecting, sharing, laughing and crying.

All families fall out of balance at various times, but tend to respond to circumstances in a manner that returns them to health. Characteristics of healthy families, which have been identified, in part, by Dolores Curran in Traits of a Healthy Family, are described below.

❑ ***Communicates*** and ***listens***. This involves quality interactions, which includes clarifying what is heard to test understanding. This communication occurs separate from parents' executive functions (e.g., giving directions, making requests, disciplining).	❑ Has a ***balance of interaction*** among ***all*** family members.
❑ ***Affirms*** and ***supports*** one another.	❑ Has a shared ***religious/spiritual*** core.
❑ Develops a sense of ***trust*** among family members.	❑ Values ***service*** to others.

Healthy Family Characteristics, continued

❑ Actively ***teaches respect*** for self and others (e.g., clearly communicating expectations for behavior, teaching skills to carry out expectations and specifying how and when to use the skills), rather than just correcting disrespectful behavior.	❑ ***Respects*** the ***privacy*** of one another.
❑ Exhibits a sense of ***shared*** individual and family ***responsibility***.	❑ Fosters ***family time*** and ***conversation***.
❑ Teaches a sense of ***right*** and ***wrong***.	❑ Shares ***leisure time***.
❑ Has a real ***sense of family*** as a unit, in which ***traditions and rituals*** abound.	❑ ***Admits*** and ***seeks help*** for problems.

Vulnerable Family Characteristics

Maintaining their system of balance is just as important to vulnerable and unhealthy families as it is to healthy ones. The key difference is that balance points for vulnerable families will be marked by different characteristics from the ones that have been identified for healthy families. In vulnerable families, the four elements of power, communication, relationships and roles are rigid, closed, inconsistent and have stigma attached to them; there are inappropriate degrees and types of nurturing and governance functions.

Power is rigid. Authority is absolute and can not be challenged. Rules are inflexible. Discipline is arbitrary, inconsistent, harsh or nonexistent.

Roles are unpredictable. Children are unclear about what to expect each day (e.g., in the morning, after school, at bedtime, during holidays).

Communication is closed. Members of unhealthy families tend not to talk, trust or feel.

Relationships are marked by a lack of support and intimate involvement in family members' lives.

Characteristics of vulnerable families are provided below:

- The family structure is rigid. Everything must be done one way, all of the time, and only the adult has a say in what is right and wrong. Debate or discussion is not permitted.
- Family members develop patterns of behavior that enables the family to remain unhealthy (e.g., a family covers up for a student who is in trouble; a wife, whose husband has a hangover, calls her husband out "sick" from work; a family denies allegations that a problem exists).
- Family rules and boundaries are diffuse. Rules are set and broken to meet current needs. Rules established today often will not exist tomorrow, and the adult does not inform family members of changes until after the fact.
- The family is enmeshed in their difficulties. Everyone knows something is wrong, but nothing is done to change the behavior "for the sake of the family." No one can break away from the modes of unhealthy thinking, behaving and feeling.
- There are coalitions and collusion among family members. These alliances tend to place parents in conflict with each other, children in conflict with one another or children in conflict with parents. Secrets are kept, and the message sometimes is, "You caused a problem, but I will protect you." Adult information is inappropriately shared with children.
- There is a general lack of appropriate communication. Family members are often so consumed with their own concerns or their concerns about family problems that there is little energy or regard for interacting and empathizing with others.
- There is mistrust among family members. Parents, in particular, tend not to follow through on promises.
- The family is unable to solve or cope with problems. Even the smallest obstacle is treated as a major crisis.
- The family is unable or unwilling to acknowledge the existence of problems and seek help.

Adaptive Roles of Students from Vulnerable Families

The types of behaviors and roles children adopt in response to family distress are remarkably similar regardless of the source of the family distress. A student whose parent is chronically ill has as much of a chance for developing one of the four adaptive roles as does a child who lives with an active alcoholic or a young person coping with a divorce. The determinants of the role(s) a student takes on seem to be influenced by family position and the nature and intensity of the family's pain.

General Guidelines

The following general guidelines for action apply for children who exhibit adaptive roles in the school.

DO	***DO NOT***
❑ ***Set limits or rules*** for behavior and consistently follow through with *consequences* when violated.	❑ Make ***special exceptions*** for the student, such as permitting the breaking of rules or making deals out of sympathy.
❑ ***Collect data*** on unusual patterns of behavior, school performance, attitudes, thinking, hygiene or appearance.	❑ ***Accept irresponsibility*** from the student (e.g., Do not accept excuses for unsubmitted or late work. Do not accept unfinished work.).
❑ ***Get support*** from other teachers and pupil support services staff. ***Discuss and compare concerns*** with others who have the student in class or who come in contact with the student.	❑ ***Argue with the student***, ***justify***, ***defend or accept blame*** from the student for your actions when they are consistent and fair.
❑ Establish ***written contracts*** with the student. If contracts are broken, use this as data for planning interventions.	❑ ***Feel sorry*** for the student or accept responsibility for his/her behavior.

Guidelines for Adaptive Roles in Vulnerable Families

Listed below are descriptions and general guidelines for each of the adaptive roles students demonstrate in school, which have been adapted from the Here's Looking At You 2000 curriculum, by Roberts, Fitzmahan and Associates.

ROLE	DESCRIPTION	DO	DO NOT
HERO STUDENTS	❖ Very responsible. ❖ Strong need to control. ❖ Self-esteem is derived from accomplishments. ❖ Strong need to "look good" and do "what is right." ❖ Never can do enough, because the value is in doing, rather than feeling good about the effort. ❖ Manifest a drive or compulsion to be on top. ❖ Insatiable need for attention and approval. ❖ Feel the weight of the world on their shoulders. ❖ Feel responsible for others. ❖ Often class leaders who are parental and bossy in relationships with other students. ❖ Tend to be disappointed when losing at anything. ❖ Tend to be superior or snobbish when winning. ❖ Frequently labeled teacher's pets by other students. ❖ Focuses on tangibles. ❖ Tend to be serious. ❖ Tend to leave home quickly. ❖ Tend to be workaholics.	❖ Help HERO students learn how to: - relax and have fun; - be spontaneous; - follow; - negotiate; and - ask for help. ❖ Give attention to them at times they are not achieving or vying for attention. ❖ Validate their intrinsic worth and try to separate their feelings of self-worth from their achievements. ❖ Let them know that it is okay to make a mistake or to fail. ❖ Give them permission to express their full range of feelings. ❖ Help them learn it is okay to say no.	❖ Let them monopolize conversations. ❖ Let them always be the first to answer a question or to volunteer. ❖ Validate their worth only in terms of their achievements.

Guidelines for Adaptive Roles in Vulnerable Families, continued

ROLE	DESCRIPTION	DO	DO NOT
SCAPEGOAT STUDENTS	❖ Tend to blame others and make strong peer alliances. ❖ Self-esteem is derived from rebelliousness. ❖ Often disciplined by school staff for breaking rules. ❖ Tend to defy by talking back and neglecting work. ❖ Can be very frustrating to work with. ❖ Early involvement with self-destructive behaviors (e.g., substance abuse, unwanted pregnancy, legal problems). ❖ Tend to run away. ❖ Confront other's, including the family's, problems. ❖ Seldom respond to positive role models. ❖ Identify with other troubled/problem youth. ❖ Determine they can not measure up to the HERO, so choose not to compete. ❖ Provide target for blame, particularly for family troubles. ❖ The typical response is, "I don't know what to do with that student! I've tried everything!"	❖ Help SCAPEGOAT students learn how to: - express anger construct-ively; - separate their mistakes from those unfairly placed and take responsibility for the former; - pursue activities that will bring them positive attention; - express their hurt feelings; and - forgive themselves. ❖ Let them know when their behavior is appropriate. ❖ Give them positive "strokes" whenever they take responsibility for something. ❖ Attempt to develop empathy for them and their behavior.	❖ Feel sorry for them. ❖ Treat them as special, thereby giving them more power. ❖ Take their behavior personally or as a sign of one's own incom-petence as a professional.

Guidelines for Adaptive Roles in Vulnerable Families, continued

ROLE	DESCRIPTION	DO	DO NOT
LOST or ADJUSTER STUDENTS	❖ No sense of power or control; "shrugs" a lot. ❖ Aloof. ❖ Material attachments. ❖ Often gets lost in the shuffle. ❖ Tend to be unaware of feelings. ❖ Adults sometimes can not remember these student's names, because they are so quiet and are seldom behavior problems. ❖ Have few friends, if any, and like to work alone in school. ❖ Often very creative, but nonverbal. ❖ Other students either leave them alone or else tease them about not getting involved. ❖ Often live in a "fantasy" world. ❖ Spontaneous. ❖ Often overweight. ❖ High risk for eating disorders and suicide.	❖ Help LOST/ADJUS-TER students learn how to: - recognize their importance, feelings, wants and needs; - brainstorm alternatives to make choices for themselves; and - initiate and ask questions. ❖ Take an inventory of your students and attend to those consistently overlooked. ❖ Contact these children one-to-one. ❖ Point out and encourage their strengths, talents, creativity and personal interests. ❖ Use touch slowly. ❖ Help them build a relationship, perhaps with a classmate. ❖ Encourage work in small groups to build trust and confidence.	❖ Let them off the hook by allowing them to remain silent or never calling on them; wait for them until they answer. ❖ Let their classmates take care of them by talking and answering for them.

Guidelines for Adaptive Roles in Vulnerable Families, continued

ROLE	DESCRIPTION	DO	DO NOT
CAREGIVER **or** **MASCOT STUDENTS**	**CAREGIVERS:** ❖ Tend to focus on helping other people feel better. ❖ Tend to be nurturing or "motherly" in relationships with other students; the "social worker." ❖ Typically are unaware of their own needs. ❖ Usually are liked by friends and adults. ❖ Their sensitivity is noticeable. ❖ Tend to be fragile. ❖ Avoid conflict. ❖ Fear anger. ❖ Most aware of their families' pain.	❖ Help CAREGIVER students learn how to: - receive attention, praise, help and support from others; - give to and focus on themselves first; - recognize and accept their anger and fear; - deal with conflict; and - let others be responsible for their own feelings. ❖ Ask them to identify their own desires. ❖ Help them play. ❖ Ask them how it feels when they are assisting a classmate. ❖ Validate their intrinsic worth, separating it from their care-taking behaviors.	❖ Call on them to focus on another's emotional pain.

Guidelines for Adaptive Roles in Vulnerable Families, continued

ROLE	DESCRIPTION	DO	DO NOT
CAREGIVER or *MASCOT* STUDENTS, continued	**MASCOTS:** ❖ Typically are humorous. ❖ Frequently distract proceedings to get attention. ❖ Usually are charming. ❖ Tend to be hyperactive. ❖ Have short attention spans. ❖ Tend to hide, make faces and pull pranks.	❖ Get appropriately angry at "class clown's'" behavior. ❖ Give them a "job" or task with some importance and responsibility. ❖ Hold them accountable. ❖ Encourage responsible behavior. ❖ Encourage an appropriate sense of humor ❖ Insist on eye contact.	❖ Laugh with them at inappropriate times. (If you do, they won't take you seriously.) ❖ Laugh at silly behavior.

Indicators of Children with Chemical Dependence in Their Families

Children from substance abusing families have a tendency not to *talk, trust or feel*. These young people, however, often exhibit observable behaviors that *suggest* the existence of alcohol, tobacco or other drug (ATOD) dependencies in the home. Students might act out their families' substance abuse problems either during the general school day or during lessons on ATOD in the following ways, which are adapted from the book, Broken Bottles, Broken Dreams, by Deutsch.

Indicators of Children with Chemical Dependence in Their Families, continued

GENERAL INDICATORS	***INDICATORS DURING ATOD EDUCATION***
❑ Morning tardiness, particularly on Mondays. ❑ Consistent concern with getting home promptly at the end of a day or after an activity period. ❑ Strong body odor or unkempt appearance. ❑ Inappropriate clothing for the weather. ❑ Regression (e.g., thumb sucking, enuresis, infantile behavior, name calling, hyperactivity). ❑ Scrupulous avoidance of arguments and conflicts. ❑ Friendlessness and isolation. ❑ Poor attendance or constant presence. ❑ Frequent illness and need to visit the nurse, especially for stomach complaints. ❑ Fatigue and bitterness. ❑ Hyperactivity and inability to concentrate. ❑ Sudden temper and other emotional outbursts. ❑ Exaggerated concern with achievement and with satisfying authority by children who are already at the head of the class. ❑ Extreme fear about situations involving contact with parents.	❑ Extreme negativity about chemicals and all substance use. ❑ Equation of substance use with getting "high" or intoxicated. ❑ Greater familiarity with different kinds of alcohol drinks, chemical substances and slang terms than their peers. ❑ Inordinate attention to ATOD in situations in which its evidence is marginal. ❑ Student's typical passivity or distraction gives way to activity or focus during discussions on ATOD. ❑ Changes in attendance patterns during ATOD education activities. ❑ Frequent requests to leave the room, particularly during ATOD education activities. ❑ Lingering after an activity to ask innocent questions or simply to gather belongings. ❑ Mention of parents' occasional excessive drinking/drugging. ❑ Strong negative feelings about alcoholics and others with chemical dependence problems. ❑ Evident concern with whether alcoholism and other chemical dependence can be inherited.

THE RESILIENT CHILD

Giving consideration to risk factors, early warning signs, life skill deficiencies and family influences can help identify students at risk and reduce the chances of school failure or other life problems among students. The ultimate goal of I&RS team interventions, as well as for comprehensive school health programs, however, is to develop *resilient* young persons; those who are capable of responding to and managing the many factors that may place them at risk for school failure.

The profile of a resilient young person is one who "works well, plays well, loves well, and expects well." (Werner 1988). A resilient child possesses problem-solving skills, social skills, autonomy and a sense of purpose and future. Most youth become resilient through a complex interaction of protective factors within their world. These factors can be identified within young persons and their peers, their families, their schools and their communities.

The resiliency approach centers around the following question: "What enables some youth, not only to survive in the midst of adversity, but to do well in life?" There is a growing body of research that attempts to discern the factors and individual characteristics that make some children less vulnerable than others, though they grow up with serious family problems, poverty, violence and other stressful situations.

Researchers (Rutter 1979, Garmezy 1983, and Werner 1988) have discovered that some young persons develop specific skills, social competencies and attitudes that help them to handle stress and avoid self-destructive behavior. The researchers also learned that the greater the number of protective factors present in the key settings affecting student's lives, the more likely they are to develop resiliency. The charts below summarize the distinguishing characteristics of *resilient* youth.

Characteristics of Resilient Youth

The resilient youth is effective in work, play and relationships:

- **Establishes healthy friendships.**
- **Is goal-oriented and enjoys making satisfactory progress.**

The resilient youth is self-disciplined:

- **Has the ability to delay gratification and control impulsive drives.**
- **Maintains a future-orientation.**

Characteristics of Resilient Youth, continued

The resilient youth has healthy expectancies and a positive outlook:

- **Believes that effort and initiative will pay.**
- **Is oriented to success, rather than failure.**
- **Sets goals realistically.**

The resilient youth has critical-thinking and problem-solving skills:

- **Is able to think abstractly, to reflect and learn from experience and to be flexible.**
- **Considers alternative solutions, both to cognitive and social problems.**

The resilient youth has self-esteem and internal locus of control:

- **Feels competent and has a sense of power.**
- **Believes that he or she can influence events in his or her environment, rather than being controlled by what occurs.**

The resilient youth enjoys a sense of humor:

- **Has the ability to generate comic relief and alternative ways of looking at things.**
- **Can laugh at self and ridiculous situations.**

I&RS teams should strive to develop strategies that will build students' resilience to stress and self-defeating behaviors. I&RS teams should also look for patterns of deficiencies and strengths in the resiliency factors among the student population to inform decisions for school-wide planning.

Strengthening or creating *protective factors*, which are described below, in key systems and fully utilizing or developing internal and external *assets*, are two of the primary approaches I&RS teams and school communities can use for building resilience in young persons.

Protective Factors

An I&RS team is well positioned to help strengthen known protective factors that can reduce high-risk behavior. As indicated in the chart below, many of the protective factors are simply the translation of the negative risk factors into positive action strategies. The work of Hawkins and Catalano has provided one of the clearest ways to define protective strategies, known as a social development model, which recommends that systems:

Protective Factors, continued

- Promote *bonding* to school, non-drug using peers, family and community.
- Define a clear set of *norms* about destructive behaviors.
- Teach the *skills* needed to create healthy relationships and take an active part in the community.
- Provide *recognition, rewards and reinforcement* for newly learned skills and behaviors.

The most prominent *protective factors* within key systems, as reported in Together We Can Reduce the Risks, are identified below.

SCHOOL	**PEERS**
❑ Expresses high expectations. ❑ Encourages goal setting and mastery. ❑ Staff members view themselves as nurturing caretakers. ❑ Encourages pro-social development (e.g., altruism, cooperation). ❑ Provides leadership and decision-making opportunities. ❑ Fosters active involvement of students. ❑ Trains teachers in social development and cooperative learning. ❑ Involves parents. ❑ Provides alcohol/drug-free alternative activities.	❑ Become involved in drug-free activities. ❑ Respect authority. ❑ Bond to conventional groups. ❑ Appreciate the unique talent that each person brings to the group.
FAMILY	**COMMUNITY**
❑ Seeks prenatal care. ❑ Develops close bonding with children. ❑ Values and encourages education. ❑ Manages stress well. ❑ Spends quality time with children. ❑ Uses a warmth/low criticism parenting style (rather than authoritative or permissive). ❑ Is nurturing and protective. ❑ Has clear expectations. ❑ Encourages supportive relationships with caring adults. ❑ Shares family responsibilities.	❑ Norms and public policies support non-use among youth. ❑ Provides access to resources (e.g., housing, healthcare, childcare, job training, employment, recreation). ❑ Provides supportive networks and social bonds. ❑ Involves youth in community service.

Protective Factors, continued

The stronger the bond to conventional systems and people, the greater the chances that youth will not engage self-defeating behavior. Hawkins points out that a bond of attachment and commitment develops:

- *When youth have opportunities for active participation.*
- *When they can develop the social, academic and interpersonal skills to perform with pride.*
- *When they receive consistent rewards.*

The I&RS team may not be in a position to enact all of the suggested school-wide and community changes under the risk and protective factors models, but their underlying principles, can be applied to I&RS cases. Since it can be frustrating and counterproductive for the I&RS team to experience the same types of problems reoccur or not improve, teams should make recommendations for school-wide changes and suggest strategies for improving the coordination and utilization of community resources based on the constructs described above, which are supported by I&RS team data on local school needs.

Assets-based Approach

Equal in importance to the identification and reduction of risk factors and the strengthening of protective factors to foster youth resilience, is the full assessment and development of external and internal *assets* among students, and those that exist among the various socializing institutions, such as schools, community organizations, parents/families and faith-based organizations. The distinguishing feature of assets-based approaches is the focus on the identification and development of the positive characteristics of a community and the coordination of resources to systematically build upon its assets.

In What Kids Need to Succeed: Proven, Practical Ways to Raise Good Kids, by Benson, Galbraith and Espeland, it is explained that the assets-based approach focuses on the development of existing strengths. It provides a schematic for bringing all facets of a community into alignment on the development of a common theme. The Search Institute, in The Asset Approach: Giving Kids What They Need to Succeed, has identified the following building blocks of development that help young people grow to be healthy, caring and responsible. Percentages of young people who experience each asset represent almost 100,000 sixth to twelfth grade youth surveyed in 213 towns and cities in the United States.

Assets-based Approach, continued

40 DEVELOPMENTAL ASSETS

EXTERNAL ASSETS

Asset Type	*Asset Name and Definition*	*Percent*
Support	1. ***Family Support*** – Family life provides high levels of love and support.	64%
	2. ***Positive Family Communication*** – Young person and/or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s).	26%
	3. ***Other Adult Relationships*** – Young person receives support from three or more non-parent adults.	41%
	4. ***Caring Neighborhood*** – Young person experiences caring neighbors.	40%
	5. ***Caring School Climate*** – School provides a caring, encouraging environment.	24%
	6. ***Parent Involvement in Schooling*** – Parent(s) is actively involved in helping the young person succeed in school.	29%
	7. ***Community Values Youth*** – Young person perceives that adults in the community value youth.	20%
Empowerment	8. ***Youth as Resources*** – Young people are given useful roles in the community.	24%
	9. ***Service to Others*** – Young person serves in the community one hour or more per week.	50%
	10. ***Safety*** – Young person feels safe at home, school and in the neighborhood.	55%
	11. ***Family Boundaries*** – Family has clear rules and consequences and monitors the young person's whereabouts.	43%
Boundaries and Expectations	12. ***School Boundaries*** – School provides clear rules and consequences.	46%
	13. ***Neighborhood Boundaries*** – Neighbors take responsibility for monitoring young people's behavior.	46%
	14. ***Adult Role Models*** – Parent(s) and other adults model positive, responsible behavior.	27%
	15. ***Positive Peer Influence*** – Young person's best friends model responsible behavior.	60%
	16. ***High Expectations*** – Both parent(s) and teachers encourage the young person to do well.	41%
Constructive Use of Time	17. ***Creative Activities*** – Young person spends three or more hours per week in lessons or practice in music, theater or other arts.	19%
	18. ***Youth Programs*** – Young person spends three or more hours per week in sports, clubs or organizations at school and/or in the community.	59%
	19. ***Religious Community*** – Young person spends one or more hours per week in activities in a religious institution.	64%
	20. ***Time at Home*** – Young person is out with friends "with nothing special to do" two or fewer nights per week.	50%

Assets-based Approach, continued

40 DEVELOPMENTAL ASSETS, continued		
	INTERNAL ASSETS	
Asset Type	***Asset Name and Definition***	***Percent***
Commitment to Learning	21. ***Achievement Motivation*** – Young person is motivated to do well in school.	63%
	22. ***School Engagement*** – Young person is actively engaged in learning.	64%
	23. ***Homework*** – Young person reports doing at least one hour of homework every school day.	45%
	24. ***Bonding to School*** – Young person cares about his school.	51%
	25. ***Reading for Pleasure*** – Young person reads for pleasure three or more hours per week.	24%
Positive Values	26. ***Caring*** – Young person places high value on helping other people.	43%
	27. ***Equality and Social Justice*** – Young person places high value on promoting equality and reducing hunger and poverty.	45%
	28. ***Integrity*** – Young person acts on convictions and stands up for his beliefs.	63%
	29. ***Honesty*** – Young person "tells the truth even when it is not easy."	63%
	30. ***Responsibility*** – Young person accepts and takes personal responsibility.	60%
	31. ***Restraint*** – Young person believes it is important not to be sexually active or to use alcohol or other drugs.	42%
Social Competencies	32. ***Planning and Decision Making*** – Young person knows how to plan ahead and make choices.	29%
	33. ***Interpersonal Competence*** – Young person has empathy, sensitivity and friendship skills.	43%
	34. ***Cultural Competence*** – Young person has knowledge of and comfort with people of different, cultural, ethnic and racial backgrounds.	35%
	35. ***Resistance Skills*** – Young person can resist negative peer pressure and dangerous situations.	37%
	36. ***Peaceful Conflict Resolution*** – Young person seeks nonviolent resolutions to conflict.	44%
Positive Identity	37. ***Personal Power*** – Young person feels he has control over "things that happen to me."	45%
	38. ***Self-esteem*** – Young person reports having high, positive self-esteem.	47%
	39. ***Sense of Purpose*** – Young person reports that "my life has a purpose."	55%
	40. ***Positive View of Personal Future*** – Young person is optimistic about his personal future.	70%

Assets-based Approach, continued

A few examples of applications for the Search Institute's assets model are supplied below:

Internal Assets: Educational Commitment

External and Internal Assets	*Schools*	*Parents and Families*	*Community Organizations*	*Faith Organizations*
School Performance (Youth do well in school.)	- Expect students to do well and encourage parents to expect the same. - Do not assume that youth know how to study; periodically review basic study skills.	- Affirm school success through family celebrations. - Stay in contact with teachers about progress; rather than waiting for a report card.	- Affirm and recognize success in school. - Teach basic study skills to youth who may not have developed them.	- Recognize good school performance. - Provide opportunities for youth to be tutors for younger children.
Achievement Motivation (Youth are motivated to achieve in school.)	- Focus attention on the relevancy of classroom content to life situations and issues. - Affirm and encourage achievement in diverse areas as students discover their own interests.	- Model an ongoing interest in learning and new discoveries. - Seek to understand and address the fears and motivations that may lie behind any apathy or resistance toward school.	- Intellectually challenge youth throughout all programming. - Encourage youth to use what they are learning in school to address issues in the organization's program.	- Affirm, rather than undermine, the value of education in all youth programming. - Make school a regular topic of conversation in youth groups.
Homework (Students regularly spend time doing homework.)	- Regularly assign homework and hold students accountable for completing it. - Make homework relevant to other parts of students' lives (e.g., family, work, play).	- Provide a comfortable place for children to study without distractions. - Turn off the television. - Limit hours on after-school jobs.	- Arrange after-school study programs. - Expect youth to complete school homework as part of program participation.	- Set up a homework hotline for youth to call on school evenings with questions. - Reduce conflicts between time commitments for faith activities and homework.

Assets-based Approach, continued

Internal Assets: Social Competencies

External and Internal Assets	*Schools*	*Parents and Families*	*Community Organizations*	*Faith Organizations*
Decision-making Skills (Youth are good at making decisions.)	- Challenge students to articulate the reasons behind their decisions. - Include student leaders on decision- making committees and boards.	- Include children in family decisions. - Explain the decision-making process. - Do not blow up at a poor decision; help children to learn from it.	- Let young people make decisions in programs and special projects. - Use experiential activities and simulations that challenge youth to make difficult decisions.	- Let teens make decisions in the direction of the youth program. - Show young people how their faith informs their decisions.

External Assets: Support

External and Internal Assets	*Schools*	*Parents and Families*	*Community Organizations*	*Faith Organizations*
Positive School Climate (School provides a caring, encouraging environment.)	- Nurture a sense of school ownership in students by involving them in decision making about relevant issues. - Create an environment where all feel supported and included.	- Report any concerns you have about children feeling uncomfortable or unsafe in school. - Volunteer in the school to tutor and support students.	- Teach youth how to cooperate and show care in all of their activities. - Break down school cliques by mixing teens into unfamiliar groups in community activities.	- Have the youth group volunteer to paint or do other projects in the school. - Encourage congregation members to volunteer in local schools.
Parent Involvement in School (Parents are involved in helping youth succeed in school.)	- Have teachers personally contact each family at least once during the school year. - Form a parent advisory committee to give input into policy decisions.	- Make it a point to talk with all of your children's teachers during the school year. - Regularly ask your children what they are learning in school. - Offer to help with homework in appropriate ways.	- Coordinate activities with the school so parents do not have to choose between school events and community events. - Provide activities for children to free parents to participate in parent meetings.	- Do not schedule congregation activities that conflict with important school activities for parents. - Encourage parents to take any concerns they have to the school.

Assets-based Approach, continued

External Assets: Boundaries

External and Internal Assets	*Schools*	*Parents and Families*	*Community Organizations*	*Faith Organizations*
Positive Peer Influence (Youths' best friends model responsible behavior.)	- Offer peer helping training in the school. - Use cooperative learning techniques in the classroom so students can learn from each other.	- Invite teenagers' friends to spend time in your home; get to know them. - Talk with your teens about their friends. Ask probing questions. - Affirm positive friendships.	- Provide opportunities for youth to be with their peers in settings where they are modeling healthy behavior. - Reaffirm and honor the healthy choices youth make.	- Launch a peer ministry program. - Have youth think about ways they can positively influence their friends in school.

The assets-based approach is consistent with the problem-solving processes used by I&RS teams. As part of the intervention and referral services process, I&RS teams develop comprehensive and proactive I&RS action plans for students after a thorough examination of their *assets* and *strengths,* and build upon these positive characteristics in a systematic way to help students grow and achieve.

SUMMARY

The diverse learning, behavior and health concerns students present to educators can be overwhelming. Although not a panacea, the I&RS team is positioned to assist and support educators, parents and community members in helping young people to achieve their potential.

Care should be given to pay equal attention to presenting problems, identified risk factors, family influences, protective factors and assets. Teams should guard against believing that all academic problems can be addressed with academically oriented solutions. Since it is common for problems that present themselves in the academic arena to be grounded in life skill deficiencies or life crises, the I&RS team should stand ready to view problems holistically in order to make short-term gains that lead to long-term change.