Anaheim Union High School District

Intern Orientation
Social Work Intern

Orientation Outline

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SECTION ONE
Spread Your Wings and Help Change the World

S is for the Stand that each one of us has taken to help change the world.

O is for the Outstanding job completed by each and every one of us.

C is for the Children and families that deserve our help.

I is for the Inner beauty that will shine throughout our careers.

A is for the Altruism, which is a gift from God.

L is for each Life that should be valued.

W is for the Warmth that we will explicitly give to all.

O is for the Opportunity to see ourselves here today.

R is for no Regrets, we are Social Workers now.

K is for the Knowledge that each of us has diligently acquired.

E is for the Excellence that comes along with a college education.

R is having the Right attitude for this profession.

Dedicated to all Future, Current and Past Social Workers
Envisioned by Debra Jones, MSW student at CSULA
May 10, 2001
Tips for Placement Success

1. What are the three rules of social work practice?
2. Be able to complete the sentence: "This is just a small price to pay......"
3. Avoid the following words: why, blame, assume
4. Read and re-read the "Baker's Dozen" article.
5. Be prompt and punctual for all district meetings.
6. Understand the micro, mezzo, and macro approaches to school social work. Who are our constituents here?
7. Be able to present a case within five minutes using a logical format.
8. Know the three great lies and how to avoid them.
9. What does "P to the seventh" mean?
10. What is the "water" analogy for treatment?
11. Think in terms of a being a movie director during the session. Is this a panoramic or a close-in shot?
12. Give me a teamwork analogy. Are you having fun yet?
13. What does this mean: "It's a trial by mile; it's hard by the yard; but it's a cinch by the inch?"
14. What do you know about leadership in social work?
15. In communication, who controls what and how something is said? Who, then, is the most important person in this dynamic?
16. How is the commercial phrase: "Pay me now or pay me later" significant to social work practice?
17. Tell me about the elephant and blind men analogy. What significant does it have for us in this setting?
Change = Doing Things Differently

Whereas people have never understood change, they are even less prepared to understand more change. The only way to cope with change is to plan. But change usually effects a change in plans.

Therefore, planning should be flexible; it must take change into account. If plans are fully responsive to change, they change as change changes. Plans may seem to be identical with change. Hence, the solution to change is change itself.

We have nothing to fear but solutions.

Change and conflict are a lot alike. Both are based on perceptions or how different parties look at the same item and see different things. Conflicts emerge from everyday events and really reflect what is important to people. Thus, the elements of a peaceful resolution of a conflict is found in the conflict itself.

How we understand these elements and use them is what this placement teaches.
The Horse Story
(or Reasons to Avoid Change)

Common advice from knowledgeable horse trainers include the adage, "If the horse you are riding dies, then, get off the horse." Seems simple enough, yet in our situation, we tend to not follow that advice.

Instead, we choose from an array of other alternative that include:

* Buying a stronger whip
* Trying a new bit or bridle
* Switching riders
* Moving the horse to a new stable or corral
* Riding the horse for longer periods of time
* Saying things like this: "It's how we have always ridden them"
* Appointing a committee to study and report on dead horses
* Arranging to visit sites where they ride dead horses better
* Increasing the standards for riding dead horses
* Creating a new test for measuring riding ability
* Comparing how we rode dead horses ten or twenty years ago
* Complaining about the state of horses these days
* Developing new styles of riding
* Blaming the horse's parents, because it is often the breeding
* Tightening the cinch
The Handwriting on the Wall

1. **Change Happens.** They keep moving the cheese.

2. **Anticipate Change.** Get ready for the cheese to move.

3. **Monitor Change.** Smell the cheese often so you know when it is getting old.

4. **Adapt to Change Quickly.** The quicker you let go of old cheese, the sooner you can enjoy new cheese.

5. **Change.** Move with the cheese.

6. **Enjoy Change.** Savor the adventure and the taste of new cheese.

7. **Be Ready to Quickly Change Again and Again.** They keep moving the cheese.

**Citation:** Johnson, S. (1998). *Who moved my cheese?*

**Definition of Learning:** Change in participation over time. Procedural displays can resemble learning, but there not the same.
Growing Pains

It is not just children who go through growing pains. When children test the limits, adopt a new identity each week and try on attitudes for size, adults feel their pain—the pain of putting up with it all! While there are no strategies that have proved 100% effective in all situations, the following tips from the U. S. Department of Health and Human Services Family and Youth Services Bureau can help:

Educate yourself about adolescent development. Learn what to expect and how to help young people through their inevitable difficulties. Also, knowing that other children and adults are going through the same cycles can be comforting.

Remember your own adolescence. This is a good exercise to help you keep perspective. Most of us experienced similar behavioral patterns.

Listen more. Talk less. Adolescents have just come through more than a decade of being listeners in most situations. In their teens, children need a chance to share their feelings, hopes and fears.

Teach adolescents that life is not always fair. Tell them about the good times and the times that left you feeling frustrated or uncomfortable.

Teach adolescents that rights and responsibilities go hand in hand. Give them opportunities to contribute to classroom and household maintenance and decision-making.

Encourage adults other than teachers and parents to spend time with adolescents in your care. Young people will need additional support and guidance from a variety of people and resources.

Seek support and guidance for yourself. It can be a trying time for adults as adolescents move through their growing years. Be kind to yourself as well as to them.
STONE SOUP - ENOUGH FOR ALL

So goes the moral of my favorite childhood tale. As I remember it, there were these three good-natured fellows who ended up more than a bit lost and very, very hungry. As luck would have it, they stumbled upon a village (they always stumble in these fairy tales; it must have something to do with poor road conditions).

Well, as they looked around the village, it appeared to be deserted. Not a soul was walking about, and not a sound was to be heard. But the three fellows went about knocking upon the first cottage door, and calling out, "Greetings, we are but three hungry lost souls and ask if you have a bit of food you might be so kind as to share with us. We would be most grateful and in your debt (or general words to that effect)." Ever so slowly, a worn wooden shutter was cracked open just enough to see one suspicious eye peering back at them. A voice responded, "I am sorry dear sirs, but you see, we are but a poor family and have only enough to feed ourselves and nothing to spare (note that regardless of social-economic status, all fairy tale characters speak politely and with proper grammar). Being both hungry and of an optimistic nature, our three fellows continued on from door to door, repeating their request and receiving the same sad response.

Well, one might imagine that our lost and hungry gents would be on their way to search for a more affluent or, at least, a more generous village. But then what would be the point of the story? So, as you might have already guessed, they built a fire in the very center of the village, within easy view of each cottage, and placed on the fire a huge iron pot filled with water. Each one then placed a big gray stone on the bottom of the pot (What? that wasn't obvious!). They started stirring, sniffing, and exclaiming (rather loudly), "Hmmm, how tasty." One by one, each villager approached and asked the burning (no pun intended) question, "Excuse me dear fellows, but may I inquire as to what it is you are cooking?" (We just don't see these kinds of manners anymore. Alas!) "Why, Stone Soup of course! Oh yes, and simply wonderful stone soup it shall be - enough for all to share. Ah, but it would be so much more tasty if we had just a bit of potato to add. Oh, yes, chimed in the other two, just a bit of potato." One curious villager offered up that she indeed might have a bit of potato that she could add to the delicious stone soup. And so it goes until every member of the community has added its limited, but vital, resources to the pot - a bit of seasoning, some beef and a few carrots and the like, creating a wonderful concoction to be shared by all.
What Makes a Good School?

Lesson #1

AFTER SCHOOL
Good after-school programs, those that engage the interests of both students and staff, can bring dazzling results.

* It's all in the execution. Tired teachers who take on children at the end of a full day in the classroom are little more than baby-sitters. But when these programs are done right, they can do much more than safeguard at-risk children from the dangers of the streets and of the television. They can both extend and improve upon a regular school day's learning, making magic after the last bell rings.

Lesson #2

TECHNOLOGY
All children, not just ones from families that can afford a home computer, should grow up with a mouse in their hand.

* As a learning tool, computers make children adventurers and avid learners, taking them beyond the traditional walls of the schoolhouse. The exorbitant price of wiring classrooms is only one hurdle, however. Teachers must be properly trained to integrate technology into the curriculum if the costly machines are to be more than fancy typewriters.

Lesson #3

CLASS SIZE
Smaller classes allow for more personal interaction between teachers and students, and they tend to reduce paperwork so teachers can spend more time planning lessons.

* While there is no ideal number of students per class, studies show that small classes work best especially for reading and math in the early primary grades. They are expensive however, requiring an expanded teaching staff and more classroom space per student.

Lesson #4

TEACHER PREPARATION
Nearly 2 million new teachers will be entering classrooms over the next decade. The system that prepares them for the job needs to improve.

* To raise the quality of teaching and increase respect for the profession, many colleges of education are instituting higher standards, creating extended internships and developing partnerships with public schools. Once on the job, teachers must have greater opportunities to continue their own education.

SECTION TWO
A Brief Description of the AUHSD

The mission of the Anaheim Union High School District is to promote student academic achievement and extra-curricular involvement. In working toward this goal, AUHSD is dedicated to 1) providing leadership, resources, and services to staff; 2) meeting the diverse needs of all students; 3) developing cooperation, communication, and coordination within our educational community; and 4) encouraging public support and involvement. To facilitate this mission, AUHSD is committed to the development of a positive climate that fosters the pursuit of excellence by students, staff, and community.

The AUHSD operates sixteen comprehensive schools including eight senior schools, eight junior high schools and one combination academy. Alternative Education options include continuation schools, opportunity programs, ROP, the Challenger Clinic, and Adult Education options.

The professions primarily represented in the district include education, counseling, medical, psychology and social work. There is a range of socioeconomic status students available at each campus with most being in the middle to low range where interns have been previously placed. The largest district "minority" is Hispanic with a recent significant increase in Asian and Pacific Islanders. Language barriers can exist for the monolingual staff or student. Primary language after English is Spanish.

The primary Caucasian district staff who had much in common with previous student populations now face cultural, language, and socioeconomic barriers. These obstacles are compounded by many stress factors that the parents and children face at home in their community. Low economic status often results in both parents working long hours and the family having fewer resources to contribute to their children's education. Many children live in single-parent households. Gang related activity with accompanying crime and delinquency has increased significantly in the in the community. High student mobility (40% at some schools) causes many students to attend several schools with accompanying lack of continuity in their education which often results in below grade performance. Teachers face significant challenges when developing effective intervention methods with these high-risk students.

Truancy and behavioral problems have been identified by the California Attorney General's Office (1991 SARB Manual) as leading to more serious delinquency behavior such as substance abuse and criminal activity. This connection is an increasing concern to parents, schools, law enforcement personnel, and community members. This problem is compounded by a lack of appropriate parenting skills and negative home and social environments.
ANAHEIM UNION HIGH SCHOOL DISTRICT  
"Spirit of Learning"

MISSION

THE ANAHEIM UNION HIGH SCHOOL DISTRICT, A PARTNERSHIP OF STUDENTS, PARENTS, STAFF, AND COMMUNITY, WILL PROVIDE EACH STUDENT WITH A HIGH QUALITY EDUCATIONAL PROGRAM IN A SAFE, MOTIVATING LEARNING ENVIRONMENT THAT PROMOTES:

- HIGH ACADEMIC ACHIEVEMENT BASED ON A STRONG FOUNDATION OF KNOWLEDGE AND SKILLS,

- DEVELOPMENT OF HABITS AND ATTITUDES FOR A LIFETIME OF LEARNING,

- EXPLORATION AND PREPARATION IN A BROAD RANGE OF CAREER AND INTEREST AREAS, AND

- COMMITMENT TO RESPONSIBLE CITIZENSHIP.
Focus Areas and Goals
2004-2005

* PRIMARY FOCUS AREA: STUDENT ACHIEVEMENT

GOAL: CONTINUE TO IMPROVE THE LEVEL OF STUDENT ACHIEVEMENT IN ALL CURRICULAR AREAS AND TO INITIATE A RENEWED FOCUS ON CAREER SKILLS SUCH AS INDUSTRIAL TECHNOLOGY.

Focus Area: Comprehensive Assessment and Accountability Program
Goal: Continue the implementation of a comprehensive student assessment program in grades 7-12 that measures the progress of improvement in identified areas of academic achievement.

Goal: Continue the comprehensive evaluation of district programs to monitor goals and determine effectiveness.

Focus Area: Safe, Positive Environment
Goal: Maintain a safe environment for students and employees while emphasizing respect and supporting traits such as trustworthiness, responsibility, fairness, caring and citizenship.

Focus Area: Parent/Family Involvement
Goal: Continue the development and enhancement of programs and activities for effective and meaningful parent/family involvement in their children's education.

Goal: Heighten student/family awareness of the benefits of good nutrition and exercise.

Focus Area: Human Resource Development
Goal: Maintain sound hiring practices; continue providing and enhancing necessary professional development programs, and continue to maintain an effective accountability system for all personnel.

Focus Area: Communication/Customer Service
Goal: To continue to expand our internal/external communications and service systems.

Focus Area: Technology
Goal: Provide an effective and efficient technology system for teaching, learning and management. Continue to explore new systems and
applications.

**Focus Area:** Facilities/Maintenance

**Goal:** Meet the facilities needs of present and future students and staff, assuring that buildings and grounds, district-wide, are kept clean and well maintained; new facilities are constructed and existing facilities are modernized.

**Focus Area:** Fiscal Accountability

**Goal:** Maintain internal controls over processing, systems and expenditures and exercise oversight of external consultants and entities to ensure that the fiscal resources of the district are used judiciously.

**Anaheim Union High School District**

**2006-2007**

**Student/Teacher Calendar**

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</tr>
<tr>
<td>30 31</td>
<td>26 27 28</td>
<td>25 26 27 28 29</td>
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</tbody>
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- **School Begins**
- **Non-Student/Non-Teacher Day**
- **Teacher Day: No Students**
- **End of the Quarter or Semester**
- **And Minimum Day for Students**

The Underlined Days (June 20-27) are subject to change to regular school days if it becomes necessary to bring the total days school is in session up to the State minimum.

http://anaheimway.a

**Progress Reports Due At**

8:30 a.m. At the Site On:

- **October 13**
- **December 15**
- **February 07**
- **March 19**
- **April 13**

**Grades Due At**

8:30 a.m. At the Site On:

- **November 15**
- **February 07**
- **April 13**

Page 2 of 2
## Demographic Change District Wide (by School) 1995-2005

### Enrollment*

<table>
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<tr>
<th></th>
<th>1995</th>
<th>2000</th>
<th>2005</th>
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<tr>
<td></td>
<td>25,134</td>
<td>30,117</td>
<td>33,112</td>
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### Ethnicity

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<th>1995</th>
<th>2000</th>
<th>2005</th>
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<tr>
<td>American Indian</td>
<td>0.6%</td>
<td>0.6%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>12.5%</td>
<td>11.4%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>0.8%</td>
<td>0.9%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Filipino</td>
<td>2.9%</td>
<td>3.6%</td>
<td>3.4%</td>
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<tr>
<td>Hispanic</td>
<td>45.2%</td>
<td>52.1%</td>
<td>59.3%</td>
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<tr>
<td>Black</td>
<td>3.7%</td>
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<td>3.6%</td>
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<tr>
<td>White</td>
<td>34.3%</td>
<td>27.5%</td>
<td>21.6%</td>
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### Language Minority Students

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<tr>
<th></th>
<th>1995</th>
<th>2000</th>
<th>2005</th>
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<tbody>
<tr>
<td>LEP</td>
<td>32.1%</td>
<td>28.0%</td>
<td>29.0%</td>
</tr>
<tr>
<td>FEP</td>
<td>13.7%</td>
<td>25.0%</td>
<td>31.9%</td>
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<tr>
<td>Total</td>
<td>45.8%</td>
<td>53.0%</td>
<td>60.9%</td>
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*LEP = Limited English Proficiency  
FEP = Fluently Proficient

### 48 Languages Spoken

- Arabic
- Armenian
- Assyrian
- Bosnian
- Burmese
- Cantonese
- Cebuano
- Chaozhou
- Dutch
- English
- Farsi
- Filipino
- French
- German
- Greek
- Gujarati
- Hebrew
- Hindi
- Hmong
- Hungarian
- Ilocano
- Indonesian
- Italian
- Japanese
- Khmer
- Khmu
- Korean
- Lahu
- Lao
- Mandarin
- Pashto
- Polish
- Portuguese
- Punjabi
- Rumanian
- Russian
- Samoan
- Serbo-Croatian
- Spanish
- Taiwanese
- Thai
- Tigrinya
- Toishanese
- Tongan
- Turkish
- Ukranian
- Urdu
- Vietnamese

### Community Mobility Rates

Fact: Based on 2004/2005 data, 21% of all students enter, transfer or leave before completing the school year. The mobility rate for each school is listed below.

<table>
<thead>
<tr>
<th>Junior Highs</th>
<th>Senior Highs</th>
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<tbody>
<tr>
<td>Ball</td>
<td>Anaheim</td>
</tr>
<tr>
<td>Brookhurst</td>
<td>Cypress</td>
</tr>
<tr>
<td>Dale</td>
<td>Katella</td>
</tr>
<tr>
<td>Lexington</td>
<td>Kennedy</td>
</tr>
<tr>
<td>Orangeview</td>
<td>Loara</td>
</tr>
<tr>
<td>South</td>
<td>Magnolia</td>
</tr>
<tr>
<td>Sycamore</td>
<td>Savanna</td>
</tr>
<tr>
<td>Walker</td>
<td>Western</td>
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*(Excludes Alternative and Adult Education)*
Anaheim Union High School District

District Office
501 Crescent Way†
Anaheim, CA 92801-5499 999-3511

High Schools
Anaheim High (20)
811 West Lincoln Avenue
Anaheim, CA 92805-2499 999-3717

Cypress High (28)
9801 Valley View Street
Cypress, CA 90630-3994 220-4144

Gilbert-East High (26)*
501 Crescent Way
Anaheim, CA 92803-3520 999-3605

Extended Suspension/
Modified Expulsion 999-5623

Gilbert-South High (68)
1800 West Ball Road
Anaheim, CA 92804 999-3738

Gilbert-West High (41)
6855 La Palma Avenue
Buena Park, CA 90620-2499 220-4054

Hope Education Center (47)
7901 Knott Avenue
Buena Park, CA 90620-2469 220-4198

Kathala High (25)
2200 East Wagner Avenue
Anaheim, CA 92808-4999 999-3621

John F. Kennedy High (27)
8281 Walker Street
La Palma, CA 90623-2196 220-4101

Loara High (24)
1765 West Cerritos Avenue
Anaheim, CA 92804-6198 999-3677

Magnolia High (22)
2450 West Ball Road
Anaheim, CA 92804-5298 220-4221

Oxford Academy (42)
5172 Orange Avenue
Cypress, CA 90630 220-3055

Savanna High (23)
301 North Gilbert Street
Anaheim, CA 92801-5099 220-4262

Western High (21)
501 South Western Avenue
Anaheim, CA 92804-1699 220-4040

Junior High Schools
Ball Junior High (38)
1500 West Ball Road
Anaheim, CA 92802-1626 999-3663

Brookhurst Junior High (31)
601 North Brookhurst Street
Anaheim, CA 92801-3879 999-3813

Dale Junior High (35)
900 South Dale Street
Anaheim, CA 92804-4097 220-4210

Lexington Junior High (44)
4351 Orange Avenue
Cypress, CA 90630-2799 220-4201

Orangeview Junior High (32)
3715 West Orange Avenue
Anaheim, CA 92804-2699 220-4205

South Junior High (40)
2320 East South Street
Anaheim, CA 92806-4599 999-3667

Sycamore Junior High (37)
1801 East Sycamore Street
Anaheim, CA 92805-3486 999-3616

Walker Junior High (34)
8132 Walker Street
La Palma, CA 90623-2097 220-4051

Centers
Trident Education Center (65)
1800 West Ball Road
Anaheim, CA 92804 999-3738

Alternative Education Schools listed below are located at the Trident Education Center:

Anaheim Adult Education (61) 999-5616

Anaheim Home Education
Program (AHEP) (82) 999-3738

Gilbert South High School
& child care (68) 999-3738

Language Assessment
Center (LAC)† 999-3788

Outreach/Attendance Office 635-8816

Polaris High School/LS (61) 999-3738

Trident Continuation
High School (TCHS) (69) 999-5616

Polaris Education Center (62)
830 South Dale Street
Anaheim, CA 92804 220-4004

Alternative Education Schools listed below are located at the Polaris Education Center:

Polaris Opportunity-Day School (62)

Challenger Clinic (62)

Extended Suspension/
Modified Expulsion (61/62) 999-5623

† Mailing Address for District Office and
Gilbert-East – 501 Crescent Way,
P.O. Box 3520
Anaheim, CA 92803-3520

‡ Although the Assessment Center is not an
Alternative Education Program, it is also
located at the Trident Education Center
School Social Work Intern Job Description

Anaheim Union High School District

I. Requirements
A. Bachelor's Degree in Human Services, Psychology, or related fields.
B. Presently enrolled in 1st or 2nd year master's social work/counseling program.
C. Good clinical, interpersonal, and communication skills.
D. Ability to use and learn Apple or IBM computer programs.

II. General Functions
A. Clinical assessment, treatment, and documentation of children and their families in a school-based setting.
B. Assist in facilitating the school district's goals through collaboration.
C. Assist in program planning, outreach and community resources within the school and community systems.
D. Desire to work with elementary, junior and senior high school students, both males and females, regular and special education students, students from different social, economic, racial and ethnic backgrounds.
E. Desire to earn a Pupil Personnel Services Credential (PPSC).

III. Sample Specific Duties
A. Maintain a client and school caseload (according to university and state requirements, school needs, and supervisor's agenda).
B. Develop and update student assessment and treatment plans.
C. Maintain consistent individual sessions with assigned students.
D. Develop and maintain treatment groups as developed.
E. Collaborate with school system players and other involved agencies as needed.
F. Maintain documentation of students' treatment and progress by accurately and currently maintaining student records.
G. Include family members in all students' school adjustment issues and conduct collateral treatment including home visits as clinically indicated.
H. Develop detailed discharge plans and connect students with appropriate referrals.
I. Actively participate in SITs and SARB as available.
J. Develop and implement a personal evaluative component.
K. Actively participate in supervision with the school social worker intern supervisor at least weekly.

IV. Indirect Service
A. Participate in staff and in-service trainings as available.
B. Be available for special projects: such as grant writing, teacher/staff collaborative training, and teaching parent education classes.
C. Become increasingly familiar with district programs, other business, mental health, criminal justice and social service agencies in the community.
D. Continually be aware of opportunities to coordinate, collaborate, to combine and refine district and community resource.
DATE: 14 Sept 2001

TO: All District Staff Working with Social Work Interns

FROM: Don Baumeister
Supervising Clinical Social Worker

RE: Suggested Checklist for Social Work Intern Site Orientation

The majority of this year's social work interns (SWIs) have begun in the district. They will spend several days training and be placed at your site as quickly as possible. Here are several suggestions that may assist your new intern in becoming more quickly acclimatized to your school. If you have any questions, please let me or Lorraine Riley, MSW know at your earliest convenience (999-3791). As additional specifics become available especially with the inclusion of the Straight Talk counselors, I will keep you informed.

* Location and procedure of call slips and tardy slips
* Location of child abuse report forms
* Phone accessibility and instructions for use
* Knowledge about special services offered at your school: tutoring, peer assistance, sports, work experience, and the like
* When and where staff meetings are held
* Location and availability of student cum files, how they are read and updated
* Introduction to office staff, academic counselors, registrar, and health clerk
* Tour of the campus
* Lunch: time, location, and cost
* Copy of the bell schedule
* Copy of teachers' conference times
* How to obtain a student's attendance, disciplinary, and academic record
* Availability of student's current class schedule
* Location and availability of a computer that can be used by the intern
* Name and schedule of the assigned school psychologist
* Location of teachers, administrators, staff, and intern's mailboxes
* Where the intern referral forms are kept and sent
* Location and availability of the photocopy machine (We can supply paper)
* Given relevant material on the site-specific policies and regulations
* As available, speak with the previous intern
* Spend sufficient time with the Assistant Principal or school counselor
* Introduce at the next general faculty meeting
* Any additional information that may assist the intern in properly servicing your students and their families

Thanks again for all your assistance.
Preceptor Job Description

A preceptor is an on-site professional who has agreed to "supervise" the social work intern in a day-to-day environment or when the assigned clinical social work supervisor is unavailable. The preceptor is an invaluable resource to the student about the complexities and idiosyncrasies of each school or agency.

Appropriate Task Assignments include the following:

1. Create the necessary social support networks for the interns and their role in host sites.
2. Daily briefing with interns regarding possible referrals, concerns, campus atmosphere, possible SAR Bs, and caseload review.
3. Familiarize intern with local referral sources and referral directories at school site.
4. Orient intern to school, including but not limited to, introductions to Counselors, Staff, Teachers, etc. and provide tour of school, including location of school files.
5. Be available to assist intern in processing difficult clients and for consultation on an "as needed" basis.
6. As much as possible include the intern in meetings especially SIT team meetings, staff meetings, and other meetings/inservices, as available.

Theoretical Orientation

The basic clinical orientations include school integration, services, crisis intervention, short-term/focused treatment, longer-term treatment, family treatment and support, and community resource referrals.
FOUR DISTINCT BUT INTERRELATED EDUCATIONAL PATHWAYS

**Special Education**

Parent Request → Psych Testing → IEP Meeting → Services Provided → Appeal

**Discipline**

Detention → Suspension → Due Process → Expulsion → Board → Decision Hearing → Hearing → Hearing

**Child Welfare and Attendance**

Call Home → Send a Letter → Outreach Worker HV → SST → SARB → District Attorney

**504 Regulations**

Parent Request → Medical Diagnosis → Committee Meeting → Accommodations Developed → Progress Review
ANAHEIM UNION HIGH SCHOOL DISTRICT

Student Success Teams

- Student Identified for SST Intervention through attendance, behavior, GPA, or family request.

SST Convened

- Student complying with SST Recommendations but not "doing average work," consider 504 eval
- Monitor student progress with follow up
- Student complying with SST Recommendations continue to monitor

Student non-compliant with SST Recommendations

SARB

- Transfer to Horizon
- File WIC 601 with Probation
- Alternative Education Opportunities/Options
- District Attorney Parent Filing
The School Attendance Review Board (SARB) is a community-school program meeting the needs of children and youth with attendance and behavior problems.

WHAT IS SARB?

SARB was established by the California legislature in 1975 for the purpose of:

1. making a better effort to more effectively meet the needs of students.
2. reducing duplication of services provided by public agencies.

To achieve these purposes, the law provides for a representative board made up of the following:

- Public Social Services Department
- Probation Department
- Parents and/or other Community Representatives
- Schools
- Law Enforcement
- Private Agencies

Representatives of these agencies make up the SARB and are specifically charged with finding solutions for students having school attendance and behavior problems.

SARB also surveys available community resources, determines the appropriateness of their services to meet the needs of the students referred, and makes recommendations for the establishment of needed resources.

WHO IS REFERRED TO SARB?

- Students whose irregular school attendance has not improved by school intervention or home contact.
- Students whose behavior problems have not been resolved by school efforts.

WHAT DOES SARB DO FOR STUDENTS?

Some of the more frequent actions of SARBs include:

- Recommending changes in the student's program that may be unusual but necessary.
- Advising students on where to seek help in securing employment.
- Advising the student and/or family on available counseling.
- Arranging parenting classes.
- Facilitating transfer to a different school when necessary.
- Requesting assistance from other county agencies and programs when needed.
- Advising on available student tutoring when needed.
- Coordinating assistance from volunteers to help students get to school.
- Recommending the establishment of needed resources.
- Extend time when student may apply for or receive a California Driver's License.

FACTS RELATED TO TRUANCY

- Absenteeism causes major losses in educational achievement.
- Absenteeism results in poor performance on tests.
- Absenteeism contributes to a higher dropout rate, delinquency, and vandalism.
- Absent pupils commit most daylight burglaries.
- Absenteeism raises the cost per student for education.
- Older children in a family frequently set attendance patterns for younger brothers and sisters.
- Absence patterns are established as early as kindergarten.

Students are required to attend school fulltime between the ages of six and 16 years and at least part-time until the age of 18.

CALIFORNIA EDUCATION CODE SECTIONS 48200 AND 48400

HOW DO YOU GET HELP FROM SARB?

Teachers, school administrators, parents, or students may seek SARB help when attendance and behavior problems have not been resolved through existing school resources.

Referrals to SARB may be made by contacting your principal, Safe Schools administrator, or local SIT chairperson. Phone (714) 999-3791 for general information, or (714) 999-5654 for director's office.

SS 96-97
ANAHEIM UNION HIGH SCHOOL DISTRICT
CHARACTER COUNTS! PROGRAM

A person of character lives according to the Six Pillars of Character: TRUSTWORTHINESS, RESPECT, RESPONSIBILITY, FAIRNESS, CARING, and CITIZENSHIP.

TRUSTWORTHINESS

Integrity — DO: Stand up for your beliefs • Follow your conscience • Be honorable and upright • Live by your principles no matter what others say • Have the courage to do what is right and to try new things even when it is hard, costly • Build and guard your reputation 
DON'T: Do anything wrong • Lose heart if you fail or don’t get what you want

Honesty — DO: Tell the truth and nothing but the truth • Be sincere • Be forthright and candid 
DON'T: Lie • Cheat • Steal • Be sneaky, tricky, or deceptive

Reliability — DO: Keep your promises • Honor your word and commitments • Be dependable • Do what you are supposed to do • Return what you borrow • Pay your debts • Be on time

Loyalty — DO: Stand by and protect your family, friends, school and country • Be a good friend • Look out for those who care about you • Keep secrets of those who trust you 
DON'T: Betray a trust • Let your friends hurt themselves • Do anything just so others will like you • Ask a friend to do anything wrong or spread gossip that could hurt others

RESPECT

Golden Rule — DO: Treat others the way you want to be treated • Respect the dignity, privacy and freedom of all individuals • Value and honor all people, no matter what they can do for you or to you • Respect others’ property — take good care of property you are allowed to use and don’t take or use property without permission • Respect the autonomy of others — tell them what they should know to make good choices about their own lives 
DON'T: Use or manipulate others • Abuse, demean, or mistreat anyone

Tolerance and Acceptance — DO: Judge others on their character, abilities, and conduct without regard to race, religion, gender, where they live, how they dress, or the amount of money they have • Be tolerant, respectful, and accepting of those who are different from you • Listen to others and try to understand their points of view

Nonviolence — DO: Resolve disagreements, respond to insults, and deal with anger peacefully and without violence 
DON'T: Use threats or physical force to get what you want or to express anger

Courtesy — DO: Use good manners • Be courteous, polite and civil to everyone 
DON'T: Use put-downs, insults, yelling, or ridicule to embarrass or hurt another

UNDERLINED words are vocabulary words to be learned at the appropriate developmental level

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RESPONSIBILITY

Duty ————
DO: Know and do your duty • Acknowledge and meet your legal and moral obligations

Accountability —
DO: Accept responsibility for the consequences of your choices, not only for what you do but what you don’t do • Think about consequences on yourself and others before you act • Think long-term • Do what you can do to make things better • Set a good example
DON’T: Look the other way when you can make a difference • Make excuses or blame others

Pursue Excellence ————
DO: Your best • Persevere • Don’t quit • Be prepared • Be diligent • Work hard
• Make all you do worthy of pride

Self-Control ———
DO: Take charge of your own life • Set realistic goals • Keep a positive outlook • Be prudent and self-disciplined with your health, emotions, time and money • Be rational — act out of reason not anger, revenge or fear • Know the difference between what you have a right to do and what is right to do • Be self-reliant — manage your life so you are not dependent on others; pay your own way whenever you can

FAIRNESS

Justice ————
DO: Be fair and just • Treat people equally • Make decisions without favoritism or prejudice • In imposing punishment be sure the consequences for wrongdoing are consistent, certain, and proportional (not too harsh or lenient)
DON’T: Take more than your fair share • Take advantage of or blame others unfairly

Openness ————
DO: Be open-minded and impartial — consider what people have to say before you decide • Be careful — get the facts, including opposing viewpoints, before making decisions (especially blaming or accusing another)

CARING

Concern for Others ————
DO: Be compassionate and empathetic • Be kind, loving, and considerate • Be thankful and express gratitude for what people do for you • Forgive others for their shortcomings
DON’T: Be mean, cruel or insensitive

Charity ————
DO: Be charitable and altruistic — give money, time, support, comfort without strings for the sake of making someone else’s life better, not for praise or gratitude • Help people in need

CITIZENSHIP

Do Your Share ————
DO: Be a good citizen and a good neighbor • Care about and pursue the common good • Be a volunteer — help your school and community be better, cleaner, and safer • Protect the environment by conserving resources, reducing pollution, and cleaning up after yourself • Participate in making things better by voicing your opinion, voting, serving on committees, reporting wrongdoing and paying taxes

Respect Authority and the Law ————
DO: Play by the rules • Obey parents, teachers, coaches, and others who have been given authority • Observe just laws • Honor and respect principles of democracy
ANAEHEIM UNION HIGH SCHOOL DISTRICT

SEXUAL HARASSMENT INFORMATION SHEET

Sexual harassment is a form of discrimination, which is prohibited by both federal and state law. District Policy 6106 prohibits sexual harassment of employees and District Policy 8700 prohibits sexual harassment of students. Sexual harassment includes gender-based harassment of a person the same sex as the harasser. Both state and federal law and District Policy prohibit retaliation against any complainant or participant in the sexual harassment complaint process.

Definition: Prohibited sexual harassment includes, but is not limited to, unwelcome sexual advances, requests for sexual favors and other verbal, visual or physical conduct of a sexual nature when:

- Submission to the conduct is explicitly or implicitly made a term or condition of an individual’s employment.
- Submission to or rejection of such conduct by an individual is used as the basis for an employment decision, including, but not limited to, promotion, demotion, transfer, reassigned or termination.
- The conduct has the purpose or effect of unreasonable interfering with an individual’s work performance or creating an intimidating, hostile or offensive work environment.

Examples of Sexual Harassment: Sexual harassment includes, but is not limited to:

- Unwelcome sexual advances, flirtations or propositions.
- Offering employment benefits in exchange for sexual favors.
- Suggestive or obscene letters, notes or invitations.
- Making sexual gestures, displaying sexually suggestive objects, pictures cartoons or posters.
- Sexual slurs, epithets, threats, graphic verbal comments, and verbal abuse of a sexual nature, derogatory comments, leering or sexually degrading descriptions.
- Spreading sexual rumors, sexual jokes, stories, cartoons, drawings or pictures.
- Touching an individual’s body or clothes in a sexual way, assault, impeding or blocking movements.
- Any act of retaliation against an individual who reports a violation of the District’s sexual harassment policy or who participates in the investigation of a sexual harassment complaint.

Prohibition: The District prohibits sexual harassment in the working environment of employees or applicants by any person in any form. Employees who permit or engage in such harassment may be subject to disciplinary action up to, and including, dismissal.

Complaint Procedure: Any employee who believes he or she has been sexually harassed should report the incident through either the informal or formal complaint process. An informal complaint may be made with the Assistant Superintendent, Human Resources, or their designee. A formal complaint must be in writing and made to the Assistant Superintendent, Human Resources. Any employee having knowledge of conduct by another employee, student, volunteer or individual in the employment or academic community which may constitute sexual harassment of employees or students is required to immediately report such conduct to any of the individuals specified in the District’s policies.

Employees needing additional information regarding the District’s sexual harassment policies should contact the Assistant Superintendent, Human Resources at (714) 999-3552. A copy of the District’s Policies & Procedures prohibiting sexual harassment of employees and sexual harassment of students can be obtained from the office of the Assistant Superintendent, Human Resources.

Legal Remedies: The District encourages employees to file their complaints of sexual harassment with the District so that the complaint can be resolved at the earliest possible date. However, employees are not prohibited from submitting their complaint directly to the Department of Fair Employment and Housing (DFEH). The address and telephone number of the local office of the DFEH is as follows:

Santa Ana DFEH
28 Civic Center Plaza, Room 538
Santa Ana, CA 92701
(714) 558-4159

Employees who file a complaint may be entitled to civil law remedies, including, but not limited to, injunctions, restraining orders, hiring, reinstatement, back pay, promotion or monetary damages.

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| School Crime Reporting | | | | | | | | | | | | | | | | | | | | | |
| Problem-Solving Model | | | | | | | | | | | | | | | | | | | | | |
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| Positive Recognition of Students | | | | | | | | | | | | | | | | | | | | | |
| Positive Education | | | | | | | | | | | | | | | | | | | | | |
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| Men-Entice Programs | | | | | | | | | | | | | | | | | | | | | |
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Rev. 10/02
SECTION THREE
NASW Code of Ethics

SOCIAL WORKERS’ ETHICAL RESPONSIBILITIES IN PRACTICE SETTINGS

Supervision and Consultation

Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.

Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation or potential harm to the supervisee.

Social workers who provide supervision should evaluate supervisees’ performance in a manner that is fair and respectful.

Education and Training

Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.

Social workers who function as educators or field instructors for students should evaluate students’ performance in a manner that is fair and respectful.

Social workers who function as educators or field instructors for students should take reasonable steps to ensure that clients are routinely informed when services are being provided by students.

Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.

Performance Evaluation

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.
Clinical Supervision Guidelines

The purpose of clinical supervision is to provide structured opportunities to learn about self, clients, and systems.

The primary vehicle for individual supervision is the process (not progress) recording. Second Year students are responsible for two process recording per week while First Year students are responsible for three recordings per week. This requirement is a university mandate but may be adjusted to meet individual student's learning needs.

There are as many variations on how to write process recordings as there are clinical supervisors. Please feel free to experiment with this format. However, in the beginning use a format that incorporates the following headings:

1. Identifying Information (age, race, sex, marital status, etc.)
2. Purpose(s) of the Interview, Group, or Meeting (assessment, continuing treatment, termination, etc.)
3. Session Content (more detailed and significant at the beginning of supervision than in later sessions)
4. Social Work Roles (What hats did you wear during this session?)
5. DSM-IV Diagnosis (all five axes - this information must be mastered to compete in the open job market)
6. Treatment Plan (use the initial problem definition and the DSM symptoms to specifically formulate a detailed plan for interventions)
7. Feelings (trust me - let it all hang out here including transference and countertransference issues)
8. Questions for Supervision (list all areas needed for discussion)

Clinical Supervision is not therapy but the parallel processes that occur between the intern and supervisor are often the same that transpire among the intern and clients.

Group Supervision may also be scheduled for every other week with an intern assigned to develop a significant topic for each discussion meeting.
TOP TEN

THE TOP TEN QUALITIES . . .

. . . OF A GOOD SUPERVISOR

Knowledgeable - willing and able to teach
Approachable - people oriented
Supportive - offers guidance and feedback
Good communication skills
Appreciative and encouraging
Sense of humor
Empathy and sincerity
Assigns meaningful work
Flexibility - scheduling hours and tasks
Team leader - helps us feel part of the organization

. . . OF A GOOD INTERN

Burning desire to learn
Professionalism:
Authentic - honest, open
Good communication skills
Genuine interest in agency population
Flexibility
Open to share struggles
Open to feedback
Initiative - risk, self-motivated, creative
Be willing to offer solutions . . . not just problems
CASE PROGRESS RECORDINGS

Progress Recordings differ from Process Recordings in that the former is limited to a brief summary in a structured fashion describing what happened during a particular client-therapist encounter. The later are primarily used in training environments and are a more detailed, in-depth discussion of a session with particular emphasis on what the clinician learned or could have learned from this meeting.

There are many different ways to record therapeutic progress. Oftentimes, a particular organization will require the meetings memorialized in a fashion which meets its unique requirements. However, two common example are outlined more fully below: SOAP and SDIR(H).

SOAP is an acronym for the topic headings which the therapist discussed with the client. The letters stand for Subjective, Objective, Application, and Plan. The clinician records the client's subjective view of the problem or focus of treatment. The clinician next writes his/her own objective statement regarding the problem or treatment intervention(s). Next, the therapist discusses the client's "progress" toward meeting the treatment goals or objectives. Lastly, the therapist outlines any modifications or additions to the agreed upon intervention plan.

Another typical model for chart documentation takes a medical-model emphasis. The letters stand for Symptoms, Dysfunctions, Interventions, Response, and Homework (as needed). The therapist focuses on the identified psychiatric symptoms (depression, anxiety, etc.), then articulates how these symptoms interfere or limit or affect the client's ability to function in everyday life. This functional analysis includes the entire client's ecosystem (e.g., work, play, family, and religious life). Next, the clinician records what interventions were attempted during this session. Sometimes different intervention would be linked to different theoretical orientations. Regardless, each intervention needs to be recorded in order to develop a plan to increase the probabilities of success of later interventions based on past unsuccessful ones. Lastly, the success or failure of each intervention is recorded and based upon whether or not the client's symptomatology was reduced. If homework is given, then it is recorded next. This provides the clinician with a memory aid to monitor progress while providing a transition opportunity in the next meeting or to the next intervention strategy.
Date:  

To: All Social Work Intern Preceptors  

From: Don Baumeister  
TLC 999-3791  

Re: Request for Mid-Year Evaluations  

I am interested in how the Social Work Interns are doing so far this year. Please use the following format if it is helpful. Please be candid and make whatever recommendations you think would be beneficial for your school and students.

1) The Social Work Intern on my campus (______________) is seeing these types of students:

2) The Social Work Intern on my campus is using these types of interventions with our students:

3) Our Social Work Intern has made a difference in the following ways on our campus:

4) What I like least about the Social Work Intern program is the following:

5) My expectations for the program [have, have not] been met so far this year.

6) My recommendations for improvement of the Social Work Intern program include the following suggestions on the back of this document:
SUSPECTED CHILD ABUSE REPORT
(Required under Penal Code sections 11166 and 11168)

I. INSTRUCTIONS
A. Please use 'FAX' Report Monday through Friday, 8:00 a.m. to 5:00 p.m. only. After hours, weekends, and holidays call the Child Abuse Registry Hotline (714) 940-1000 or 1-800-207-5564. Do not send the suspected Child Abuse Report form, S58572, if you have faxed this form.

B. Do not use 'FAX' Report if you have already telephoned the report to CAR. Submit the standard "Suspected Child Abuse Report," Form S58572.

C. The 'FAX' Report is intended to save you and CAR time. If you feel it is essential to talk to a social worker, please call the Child Abuse Registry instead of using the 'FAX' Report.

D. Please complete every space on the 'FAX' Report. If you do not know certain requested information, write unknown.

E. Please type or print legibly in black ink to avoid a time consuming callback.

F. "Narrative" (Items #7, #8, #9). Complete information in this area is essential. Please comment as fully and specifically as you can regarding the physical abuse, sexual abuse, emotional abuse, neglect or other abuse you are reporting. State how and when the information in this report was received by you or your facility. Who has observed the abuse? Describe any physical injuries, including marks and bruises. How often or how long has the abuse occurred (give dates, if available). Does the alleged perpetrator continue to have access to the child? Is the child presently in danger? Include medical impressions and/or diagnosis, if available, and name of the examining physician. Do behaviors or circumstances suggest any danger to an investigating social worker?

If additional space is needed, please continue in the appropriate item # on another 'FAX' Report form, again identifying the victim in Item #2 to ensure the pages can be properly matched.

II. REPORTING RESPONSIBILITIES

- No child care custodian or health practitioner reporting a suspected instance of child abuse shall be civilly or criminally liable for any report required or authorized by this article (California Penal Code Article 2.5). Any other person reporting a suspected instance of child abuse shall not incur civil or criminal liability as a result of any report authorized by this section unless it can be proved that a false report was made and the person knew or should have known that the report was false.

- Any child care custodian, health practitioner, or employee of a child protective agency (CPA) who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she reasonably suspects has been the victim of child abuse shall report such suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. The "FAX" Report will meet this requirement.

- Any child care custodian, health practitioner, or employee of a child protective agency who has knowledge of or who reasonably suspects that mental suffering has been inflicted on a child or its emotional well-being is endangered in any other way, may report such suspected instance of child abuse to a child protective agency. Infliction of willful and unjustifiable mental suffering must be reported.

III. DEFINITIONS

- "Child care custodian" means a teacher, administrative officer, supervisor of child welfare and attendance, or certificated pupil personnel employee of any public or private school; an administrator of a public or private day camp; a licensees, an administrator, or an employee of a community care facility licensed to care for children; headstart teacher, a licensing worker or licensing evaluator, public assistance worker; an employee of a child care institution including, but not limited to foster parents, group home personnel and personnel or residential care facilities; a social worker or a probation officer or any person who is an administrator or present or, or a counselor in a child abuse prevention program in any public or private school.

- "Health practitioner" means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, a paramedic, a person certified pursuant to Section 2913 of the Business and Professions Code, a marriage, family and child counselor trainee, as defined in subdivision (c) of Section 4903 of the Business and Professions Code, an unlicensed marriage, family and child counselor intern registered under Section 4980.44 of the Business and Professions code, a state or county public-health employee who treats a minor for venereal disease or any other condition, a coroner, or a religious practitioner who diagnoses, examines, or treats children.

- "Child protective agency" (CPA) means a police or sheriff's department, a county probation department, or a county welfare department.
**REPORTING PARTY**

1. Name/Title: ___________________________ Phones: (____) _______ Callback Hours: (____) _______
   Agency: ___________________________ Address: ___________________________

**VICTIM**

2. Name: ___________________________ Sex: ____ Birthdate/Age: _______ Ethnicity (Eth): _______ Language (Lang): ___________________________
   Address: __________________________________________ Phone: (____)
   Present Location of Child: ___________________________ Phone: (____)
   Name of Child's School/Day Care Provider: ___________________________ Hours of Attendance: _______

**SIBLINGS**

3. Names | Sex | Birthdate/Age | Eth | Lang | Names | Sex | Birthdate/Age | Eth | Lang
   Address of Siblings: __________________________________________ Phone: (____)

**PARENTS/STEPPARENTS/AND OTHERS IN THE HOME**

4. Names | Sex | Birthdate/Age | Eth | Lang | Names | Sex | Birthdate/Age | Eth | Lang
   Address: __________________________________________ Phone: (____) Relationship: ___________________________
   Phone: (____) Relationship: ___________________________

**ALLEGED PERPETRATOR**

5. Name: ___________________________ Sex: ____ Birthdate/Age: _______ Ethnicity: _______ Language: ___________________________
   Address: __________________________________________ Phone: (____) Relationship to Victim: __________

**INCIDENT INFORMATION**

6. Date/Time of Incident: ___________________________ City where incident occurred: ___________________________
   Type of Abuse: [ ] Sexual [ ] Physical [ ] Neglect [ ] Emotional [ ] Other
   If Child was in Out-of-Home care at Time of Incident, Check Type of Care: [ ] Family Day Care [ ] Child Care Center
   [ ] Foster Family Home [ ] Small Family Home [ ] Group Home, Institution or Residential Facility

**NARRATIVE**

7. Fully Describe the Nature and Extent of the Abuse: (Be behaviorally specific and avoid general or vague terms)

8. Are there any current injuries? If yes, describe injuries (size, location, color):

9. Does the alleged perpetrator have current access to the minor(s):

10. For Police Use Only. DR #
    Do you want Children and Family Services to investigate further? _____ Yes _____ No (report is for information only)

_________________________ Date of Report
_________________________ Signature of Reporting Party

FOR SSA USE ONLY

CAR SSW ______ Dispo Level ______ Reason ______ Source ______ Program Dispo’d to: ______

Assigned to _______ Info Copy to _______ Reason Refused _______ Date & Time Assigned _______
SUSPECTED CHILD ABUSE REPORT

To Be Completed by Reporting Party
Pursuant to Penal Code Section 11160

A. CASE IDENTIFICATION

VITAL NAME:

REPORT NO./CASE NAME:

DATE OF REPORT:

B. REPORTING PARTY

NAME/TITLE

ADDRESS

PHONE

DATE OF REPORT

SIGNATURE OF REPORTING PARTY

1. POLICE DEPARTMENT 2. SHERIFF'S OFFICE 3. COUNTY WELFARE 4. COUNTY PROBATION

AGENCY

ADDRESS

OFFICIAL CONTACTED

PHONE

DATE/TIME

C. REPORT SENT TO

NAME (LAST, FIRST, MIDDLE)

ADDRESS

BIRTHDATE

SEX

RACE

PRESENT LOCATION OF CHILD

1. NAME

2. BIRTHDATE

3. SEX

4. RACE

D. INVOLVED PARTY/SIBLING/VICTIM

NAME (LAST, FIRST, MIDDLE)

ADDRESS

HOME PHONE

BUSINESS PHONE

1. NAME

2. BIRTHDATE

3. SEX

4. RACE

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET OR OTHER FORM AND CHECK THIS BOX: 

DATE/TIME OF INCIDENT

PLACE OF INCIDENT

1. OCCURRED

2. OBSERVED

IF CHILD WAS IN ORN HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:

1. FAMILYDAY CARE

2. CHILD CARE CENTER

3. FOSTER FAMILY HOME

4. SMALL FAMILY HOME

5. GROUP HOME OR INSTITUTION

2. TYPE OF ABUSE (CHECK ONE OR MORE):

1. PHYSICAL

2. MENTAL

3. SEXUAL ASSAULT

4. NEGLECT

5. OTHER

3. NARRATIVE DESCRIPTION:

4. SUMMARIZE WHAT THE ABUSED CHILD OR PERSON ACCOMPANYING THE CHILD SAID HAPPENED:

5. EXPLAIN KNOWN HISTORY OF SIMILAR INCIDENT(S) FOR THIS CHILD:

INSTRUCTIONS AND DISTRIBUTION ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). A CPA is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS-8583 II (1) an active investigation been conducted and (2) the incident is not unfounded.

Blue or Black WHITE Copy: County Welfare or Probation BLUE Copy: District Attorney GREEN Copy: Reporting Party YELLOW Copy
### Table 1. **Contrasts Between School and Mental Health Law**

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<td>Past behavior</td>
<td>Future behavior</td>
</tr>
<tr>
<td>7. Basis for decision</td>
<td>Moral culpability</td>
<td>Professional diagnosis</td>
</tr>
<tr>
<td>8. Philosophical assumptions</td>
<td>Free will</td>
<td>Determinism</td>
</tr>
<tr>
<td>9. Attribution of responsibility</td>
<td>Personal</td>
<td>Heredity/environment</td>
</tr>
<tr>
<td>10. Justifications</td>
<td>(a) Retribution</td>
<td>(a) Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>(b) Deterrence</td>
<td>(b) Deterrence</td>
</tr>
<tr>
<td></td>
<td>(c) Rehabilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(d) Incapacitation</td>
<td></td>
</tr>
</tbody>
</table>
SECTION FOUR
Student Evaluation/Contact Sheet

Name: ___________________ Age: ___ Grade: ___ Sex: ___
Student #: __________ School: __________ Ethnicity: __________
Address: ___________________________________________________________________________
Living Arrangements: __________________________________________________________________
Date: ______ Siblings: __________________________________________________________________
Presenting Problem: _____________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Academic Problems: ____________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Case Evaluation: ______________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Academic Testing: _____________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
DSM-IV DX: __________________________________________________________________________
Strengths/Weaknesses: __________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Planned Intervention: __________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Comments: __________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Case Outcome: _________________________________________________________________________
_____________________________________________________________________________________
TLC Orientation Date: __________________________________________________________________
The Clinical Process

1. Develop the therapeutic relationship

2. Gather the relevant data

3. Filter the data using your developing clinical template
   a. Bio/Psychosocial Information
   b. Mental status examination
   c. Diagnosis
   d. Treatment plan
   e. Prognosis

4. Analyze and re-evaluate the data as a whole

5. Implement the plan

6. Evaluate the plan
1. IDENTIFYING INFORMATION

Client's First Name: ___________________  Grade: _____  Age: _____

Special Ed (Type): ______________________  Sex: _____

Birth Order: ______________  Race: __________  Other: __________

2. REFERRAL SOURCE

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

3. PRESENTING PROBLEM (verbatim as explained by client):

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

4. PSYCHO SOCIAL HISTORY/SESSION CONTENT  Session Date(s): __________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

42
4. PSYCHO SOCIAL HISTORY (cont.)

5. MENTAL STATUS EXAM

General Description of the client:

Sensorium & Intellectual Functioning:

Mood & Affect:

Thought Content & Process:

Behavioral Disturbances & Physical Manifestations:

Other:

6. SOCIAL WORK ROLES

Direct Provision:

System Linkage:

System Maintenance & Enhancement:

Researcher:
System Development: ____________________________________________

Comments: __________________________________________________

______________________________________________________________

7. DSM IV DIAGNOSIS

Axis I: ________________________________________________________

______________________________________________________________

Axis II: ________________________________________________________

______________________________________________________________

Axis III: ________________________________________________________

______________________________________________________________

Axis IV: ________________________________________________________

______________________________________________________________

Axis V (GAF): _________________________________________________

______________________________________________________________

8. TREATMENT PLAN

Primary Client: _______________________________________________

______________________________________________________________

Family: _______________________________________________________

______________________________________________________________

School: _______________________________________________________

______________________________________________________________

Other: _________________________________________________________

______________________________________________________________

9. OVERALL PERSONAL FEELINGS

______________________________________________________________
10. QUESTIONS
Mental Status Evaluation Checklist

Directions: Rate current observed performance, not reported, historical, or projected. Circle the most appropriate descriptive terms in part C, and feel free to write in others. If an aspect of mental status was not assessed, cross out the heading. Write additional observations, clarifications, and quotations in part D.

Client: ___________________ Date: ________ Evaluator: ___________________

A. Informed consent was obtained about:

☐ The recipient(s) of this report ☐ Confidentiality ☐ Competency ☐ Other: _______________________

B. Evaluation methods

1. The information and assessments below are based on my observation of this client during:

☐ Intake interview ☐ Psychotherapy ☐ Formal mental status testing ☐ Group therapy

☐ Other: ___________________________________________

2. We interacted for a total of ____ minutes.

3. Setting of the contact: ☐ Professional office ☐ Hospital room ☐ Clinic ☐ School ☐ Home ☐ Work

☐ Jail/prison ☐ Other: _______________________

C. Mental status descriptors (Circle all appropriate items)

1. Appearance and self-care

   Stature: Average Small Tall (For age, if a child)

   Weight: Average weight Overweight Obese Underweight Thin Cachectic

   Clothing: Neat/clean Careless/inappropriate Meticulous Disheveled Dirty

   Appropriate for age, occasion, weather Seductive Inappropriate Bizarre

   Grooming: Normal Well-groomed Neglected Bizarre

   Cosmetic use: Age appropriate inappropriate for age Excessive None

   Posture/gait: Normal Tense Rigid Stopped Slumped Bizarre Other: ________

   Motor activity: Not remarkable Slowed Repetitive Restless Agitated Tense

   Other notable aspects: ____________________________

2. Sensorium

   Attention: Normal Unaware Inattentive Distractible Confused Persistent Vigilant

   Concentration: Normal Scattered Variable Preoccupied Anxiety interferes

   Focusses on irrelevancies

   Orientation: ☐ Time ☐ Person ☐ Place ☐ Situation ☐ Object

   Recall/memory: Normal Defective in: Immediate/short-term Recent Remote

   (cont.)
3. Relating

<table>
<thead>
<tr>
<th>Eye contact</th>
<th>Normal</th>
<th>Fleeting</th>
<th>Avoided</th>
<th>None</th>
<th>Staring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial expression</td>
<td>Responsive</td>
<td>Constricted</td>
<td>Tense</td>
<td>Anxious</td>
<td>Sad</td>
</tr>
<tr>
<td>Attitude toward examiner</td>
<td>Cooperative</td>
<td>Dependent</td>
<td>Dramatic</td>
<td>Passive</td>
<td>Uninterested</td>
</tr>
</tbody>
</table>

4. Affect and mood

<table>
<thead>
<tr>
<th>Affect</th>
<th>Appropriate</th>
<th>Labile</th>
<th>Restricted</th>
<th>Blunted</th>
<th>Flat</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood</td>
<td>Euthymic</td>
<td>Pessimistic</td>
<td>Depressed</td>
<td>Hypomanic</td>
<td>Euphoric</td>
<td></td>
</tr>
</tbody>
</table>

5. Thought and language

<table>
<thead>
<tr>
<th>Speech flow</th>
<th>Normal</th>
<th>Mute</th>
<th>Loud</th>
<th>Blocked</th>
<th>Faucity</th>
<th>Pressured</th>
<th>Flight of ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thought content</td>
<td>Appropriate</td>
<td>to mood and circumstances</td>
<td>Personalizations</td>
<td>Persecutions</td>
<td>Suspensions</td>
<td>Delusions</td>
<td>Ideas of reference</td>
</tr>
<tr>
<td>Preoccupations</td>
<td>Phobias</td>
<td>Somatic</td>
<td>Suicide</td>
<td>Homicidal</td>
<td>Guilt</td>
<td>Religion</td>
<td>Other:</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>Auditory</td>
<td>Visual</td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Logical</td>
<td>Goal-directed</td>
<td>Circumstantial</td>
<td>Loose</td>
<td>Perseverations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Executive functions

<table>
<thead>
<tr>
<th>Fund of knowledge</th>
<th>Average</th>
<th>Impoverished by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligence</td>
<td>Average</td>
<td>Below average</td>
</tr>
<tr>
<td>Abstraction</td>
<td>Normal</td>
<td>Concrete</td>
</tr>
<tr>
<td>Judgment</td>
<td>Normal</td>
<td>Common-sensical</td>
</tr>
<tr>
<td>Reality testing</td>
<td>Realistic</td>
<td>Adequate</td>
</tr>
<tr>
<td>Insight</td>
<td>Uses connections</td>
<td>Gaps</td>
</tr>
<tr>
<td>Decision making</td>
<td>Normal</td>
<td>Only simple</td>
</tr>
</tbody>
</table>

7. Stress

<table>
<thead>
<tr>
<th>Stressors</th>
<th>Money</th>
<th>Housing</th>
<th>Family conflict</th>
<th>Work</th>
<th>Grief</th>
<th>Losses</th>
<th>Illness</th>
<th>Transitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping ability</td>
<td>Normal</td>
<td>Resilient</td>
<td>Exhausted</td>
<td>Overwhelmed</td>
<td>Deficient supports</td>
<td>Deficient skills</td>
<td>Growing</td>
<td></td>
</tr>
<tr>
<td>Skill deficits</td>
<td>None</td>
<td>Intellectual</td>
<td>Communication</td>
<td>Interpersonal</td>
<td>Decision making</td>
<td>Self-control</td>
<td>Responsibility</td>
<td>Self-care</td>
</tr>
<tr>
<td>Supports</td>
<td>Usual</td>
<td>Family</td>
<td>Friends</td>
<td>Church</td>
<td>Service system</td>
<td>Needed:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Social functioning

<table>
<thead>
<tr>
<th>Social maturity</th>
<th>Responsible</th>
<th>Irresponsible</th>
<th>Self-centered</th>
<th>Impulsive</th>
<th>Isolates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social judgment</td>
<td>Normal</td>
<td>&quot;Street-smart&quot;</td>
<td>Naive</td>
<td>Needless</td>
<td>Victimized</td>
</tr>
</tbody>
</table>

D. Other aspects of mental status

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.
This report reflects the patient's condition at the time of consultation or evaluation. It does not necessarily reflect the patient's diagnosis or condition at any subsequent time.
REPORTING PERIOD: SEPTEMBER 2000 - MAY 2001
REPORTING AGENCIES:
___ Straight Talk
___ Social Work Interns

NUMBER OF COUNSELORS:
NAME OF SCHOOLS SERVED:

TOTAL # OF STUDENTS REFERRED FOR SERVICES:
TOTAL # OF STUDENTS RECEIVING ONGOING SERVICES:
TOTAL # OF STUDENTS COMPLETING SERVICES:
TOTAL # OF STUDENTS RECEIVING INDIVIDUAL COUNSELING:
TOTAL # OF STUDENTS IN A COUNSELING GROUP:

NEW # OF STUDENTS RECEIVING SERVICES IN THE FOLLOWING GRADE LEVELS:

<table>
<thead>
<tr>
<th>Grade Level</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>7th</td>
<td></td>
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<td>8th</td>
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<tr>
<td>9th</td>
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<tr>
<td>10th</td>
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<tr>
<td>11th</td>
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<td></td>
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</tr>
<tr>
<td>12th</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

REFERRAL SOURCE:
___ SELF
___ PARENT
___ TEACHER
___ ADMINISTRATOR
___ COUNSELOR
___ OTHER

PRIMARY REASON FOR REFERRAL / AT RISK FACTORS (Note on back - indicate #)
___ FAMILY
___ SCHOOL
___ INDIVIDUAL/PEER
___ ALCOHOL/DRUG
___ TOBACCO
___ COMMUNITY
___ GANG INVOLVEMENT
___ CONFLICT MEDIATION
___ ANGER MANAGEMENT

INTERVENTION STRATEGY (Indicate # receiving service)
___ INDIVIDUAL COUNSELING
___ FAMILY/INDIVIDUAL COUNSELING - COMMUNITY PROFIT AGENCY
___ COUNSELING GROUP
___ REFERRED TO 12-STEP OR AFTERCARE SERVICES
___ REFERRED NON-PROFIT PROGRAM
___ OTHER (LIST)

TOTAL* OF PARENT / FAMILY CONTACT AND / OR INTERVENTION: ____
* MAY REFLECT DUPLICATE NUMBERS

NOTE: 1ST SEMESTER--JAN 31, 2001
2ND SEMESTER--JUNE 11, 2001 & COMBINED
The Asset Approach

giving kids what they need to succeed

Why do some kids grow up with ease, while others struggle? Why do some kids get involved in dangerous activities, while others spend their time contributing to society? Why do some youth “beat the odds” in difficult situations, while others get trapped?

Many factors influence why some young people have successes in life and why others have a harder time. Economic circumstances, genetics, trauma, and many other factors play a role. But these factors—which seem difficult, if not impossible, to change—aren't all that matters. Research by Search Institute has identified 40 concrete, positive experiences and qualities—“developmental assets”—that have a tremendous influence on young people’s lives. And they are things that people from all walks of life can help to nurture.

Research shows that the 40 developmental assets help young people make wise decisions, choose positive paths, and grow up competent, caring, and responsible. The assets (see page 2) are grouped into eight categories:

- **Support**—Young people need to experience support, care, and love from their families and many others. They need organizations and institutions that provide positive, supportive environments.

- **Empowerment**—Young people need to be valued by their community and have opportunities to contribute to others. For this to occur, they must be safe and feel secure.

- **Boundaries and expectations**—Young people need to know what is expected of them and whether activities and behaviors are “in bounds” or “out of bounds.”

- **Constructive use of time**—Young people need constructive, enriching opportunities for growth through creative activities, youth programs, congregational involvement, and quality time at home.

- **Commitment to learning**—Young people need to develop a lifelong commitment to education and learning.

- **Positive values**—Youth need to develop strong values that guide their choices.

- **Social competencies**—Young people need skills and competencies that equip them to make positive choices, to build relationships, and to succeed in life.

- **Positive identity**—Young people need a strong sense of their own power, purpose, worth, and promise.

The asset framework is a framework that includes everyone. Families, schools, neighborhoods, congregations, and all organizations, institutions, and individuals in a community can play a role in building assets for youth. This brochure introduces the assets, shows their power and presence in young people’s lives, and gives concrete suggestions for what you can do to build assets.

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*The Asset Approach: Giving Kids What They Need to Succeed. Copyright © 2007 by Search Institute, 700 S. Third Street, Suite 210, Minneapolis, MN 55403. All rights reserved. Unless otherwise noted in the text, no part of this publication may be reproduced in any manner whatsoever, mechanical or electronic, without prior permission from the publisher, except in brief quotations or summaries in articles or reviews, or as individual charts or graphs for educational use. For additional permission, write to Permissions at Search Institute.*
# 40 Developmental Assets

Search Institute has identified the following building blocks of healthy development that help young people grow up healthy, caring, and responsible.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ASSET NAME AND DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support</strong></td>
<td>1. Family support—Family life provides high levels of love and support.</td>
</tr>
<tr>
<td></td>
<td>2. Positive family communication—Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s).</td>
</tr>
<tr>
<td></td>
<td>3. Other adult relationships—Young person receives support from three or more nonparent adults.</td>
</tr>
<tr>
<td></td>
<td>4. Caring neighborhood—Young person experiences caring neighbors.</td>
</tr>
<tr>
<td></td>
<td>5. Caring school climate—School provides a caring, encouraging environment.</td>
</tr>
<tr>
<td></td>
<td>6. Parent involvement in schooling—Parent(s) are actively involved in helping young person succeed in school.</td>
</tr>
<tr>
<td><strong>Empowerment</strong></td>
<td>7. Community values youth—Young person perceives that adults in the community value youth.</td>
</tr>
<tr>
<td></td>
<td>8. Youth as resources—Young people are given useful roles in the community.</td>
</tr>
<tr>
<td></td>
<td>9. Service to others—Young person serves in the community one hour or more per week.</td>
</tr>
<tr>
<td></td>
<td>10. Safety—Young person feels safe at home, at school, and in the neighborhood.</td>
</tr>
<tr>
<td><strong>Boundaries &amp; Expectations</strong></td>
<td>11. Family boundaries—Family has clear rules and consequences and monitors the young person's whereabouts.</td>
</tr>
<tr>
<td></td>
<td>12. School boundaries—School provides clear rules and consequences.</td>
</tr>
<tr>
<td></td>
<td>14. Adult role models—Parent(s) and other adults model positive, responsible behavior.</td>
</tr>
<tr>
<td></td>
<td>15. Positive peer influence—Young person's best friends model responsible behavior.</td>
</tr>
<tr>
<td></td>
<td>16. High expectations—Both parent(s) and teachers encourage the young person to do well.</td>
</tr>
<tr>
<td><strong>Constructive Use of Time</strong></td>
<td>17. Creative activities—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.</td>
</tr>
<tr>
<td></td>
<td>18. Youth programs—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.</td>
</tr>
<tr>
<td></td>
<td>19. Religious community—Young person spends one or more hours per week in activities in a religious institution.</td>
</tr>
<tr>
<td></td>
<td>20. Time at home—Young person is out with friends “with nothing special to do” two or fewer nights per week.</td>
</tr>
<tr>
<td><strong>Commitment to Learning</strong></td>
<td>21. Achievement motivation—Young person is motivated to do well in school.</td>
</tr>
<tr>
<td></td>
<td>22. School engagement—Young person is actively engaged in learning.</td>
</tr>
<tr>
<td></td>
<td>23. Homework—Young person reports doing at least one hour of homework every school day.</td>
</tr>
<tr>
<td></td>
<td>24. Bonding to school—Young person cares about her or his school.</td>
</tr>
<tr>
<td></td>
<td>25. Reading for pleasure—Young person reads for pleasure three or more hours per week.</td>
</tr>
<tr>
<td><strong>Positive Values</strong></td>
<td>26. Caring—Young person places high value on helping other people.</td>
</tr>
<tr>
<td></td>
<td>27. Equality and social justice—Young person places high value on promoting equality and reducing hunger and poverty.</td>
</tr>
<tr>
<td></td>
<td>28. Integrity—Young person acts on convictions and stands up for her or his beliefs.</td>
</tr>
<tr>
<td></td>
<td>29. Honesty—Young person “tells the truth even when it is not easy.”</td>
</tr>
<tr>
<td></td>
<td>30. Responsibility—Young person accepts and takes personal responsibility.</td>
</tr>
<tr>
<td></td>
<td>31. Restraint—Young person believes it is important not to be sexually active or to use alcohol or other drugs.</td>
</tr>
<tr>
<td><strong>Internal Assets</strong></td>
<td>32. Planning and decision making—Young person knows how to plan ahead and make choices.</td>
</tr>
<tr>
<td></td>
<td>33. Interpersonal competence—Young person has empathy, sensitivity, and friendship skills.</td>
</tr>
<tr>
<td></td>
<td>34. Cultural competence—Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.</td>
</tr>
<tr>
<td></td>
<td>35. Resistance skills—Young person can resist negative peer pressure and dangerous situations.</td>
</tr>
<tr>
<td></td>
<td>36. Peaceful conflict resolution—Young person seeks to resolve conflict nonviolently.</td>
</tr>
<tr>
<td><strong>Positive Identity</strong></td>
<td>37. Personal power—Young person feels he or she has control over “things that happen to me.”</td>
</tr>
<tr>
<td></td>
<td>38. Self-esteem—Young person reports having a high self-esteem.</td>
</tr>
<tr>
<td></td>
<td>39. Sense of purpose—Young person reports that “my life has a purpose.”</td>
</tr>
<tr>
<td></td>
<td>40. Positive view of personal future—Young person is optimistic about her or his personal future.</td>
</tr>
</tbody>
</table>
The Power of Assets

On one level, the 40 developmental assets represent everyday wisdom about positive experiences and characteristics for young people. In addition, Search Institute research has found that these assets are powerful influences on adolescent behavior—both protecting young people from many different problem behaviors and promoting positive attitudes and behaviors. This power is evident across all cultural and socioeconomic groups of youth. There is also evidence from other research that assets may have the same kind of power for younger children.

Protecting Youth from High-Risk Behaviors

Assets have tremendous power to protect youth from many different harmful or unhealthy choices. To illustrate, these charts show that youth with the most assets are least likely to engage in four different patterns of high-risk behavior. (For definitions of each problem behavior see page 7.)

The same kind of impact is evident with many other problem behaviors, including tobacco use, depression and attempted suicide, antisocial behavior, school problems, driving and alcohol, and gambling.

Promoting Positive Attitudes and Behaviors

In addition to protecting youth from negative behaviors, having more assets increases the chances that young people will have positive attitudes and behaviors, as these charts show. (For definitions of each thriving behavior see page 7.)
The Challenge Facing Communities

While the assets are powerful shapers of young people's lives and choices, too few young people experience many of these assets. Twenty-five of the 40 assets are experienced by less than half of the young people surveyed.

Average Number of Assets by Grade and Gender

The average young person surveyed experiences only 18 of the 40 assets. In general, older youth have lower average levels of assets than younger youth. And boys experience fewer assets than girls.

Youth with Different Levels of Assets

Ideally, all youth would experience at least 31 of these 40 assets. Yet, as this chart shows, only 8 percent of youth experience this level of assets. Sixty-two percent experience fewer than 20 of the assets.

What goal would you set for young people in your community, organization, neighborhood, or family?
An Asset Checklist

Many people find it helpful to use a simple checklist to reflect on the assets young people experience. This checklist simplifies the asset list to help prompt conversation in families, organizations, and communities. NOTE: This checklist is not intended nor appropriate as a scientific or accurate measurement of developmental assets.

1. I receive high levels of love and support from family members.
2. I can go to my parent(s) or guardian(s) for advice and support and have frequent, in-depth conversations with them.
3. I know some nonparent adults I can go to for advice and support.
4. My neighbors encourage and support me.
5. My school provides a caring, encouraging environment.
6. My parent(s) or guardian(s) help me succeed in school.
7. I feel valued by adults in my community.
8. I am given useful roles in my community.
9. I serve in the community one hour or more each week.
10. I feel safe at home, at school, and in the neighborhood.
11. My family sets standards for appropriate conduct and monitors my whereabouts.
12. My school has clear rules and consequences for behavior.
13. Neighbors take responsibility for monitoring my behavior.
14. Parent(s) and other adults model positive, responsible behavior.
15. My best friends model responsible behavior.
16. My parent(s)/guardian(s) and teachers encourage me to do well.
17. I spend three hours or more each week in lessons or practice in music, theater, or other arts.
18. I spend three hours or more each week in school or community sports, clubs, or organizations.
19. I spend one hour or more each week in religious services or participating in spiritual activities.
20. I go out with friends "with nothing special to do" two or fewer nights each week.
21. I want to do well in school.
22. I am actively engaged in learning.
23. I do an hour or more of homework each school day.
24. I care about my school.
25. I read for pleasure three or more hours each week.
26. I believe it is really important to help other people.
27. I want to help promote equality and reduce world poverty and hunger.
28. I can stand up for what I believe.
29. I tell the truth even when it's not easy.
30. I can accept and take personal responsibility.
31. I believe it is important not to be sexually active or to use alcohol or other drugs.
32. I am good at planning ahead and making decisions.
33. I am good at making and keeping friends.
34. I know and am comfortable with people of different cultural/racial/ethnic backgrounds.
35. I can resist negative peer pressure and dangerous situations.
36. I try to resolve conflict nonviolently.
37. I believe I have control over many things that happen to me.
38. I feel good about myself.
39. I believe my life has a purpose.
40. I am optimistic about my future.
How You Can Build Assets

...On Your Own
Everyone—parents and guardians, grandparents, teachers, coaches, friends, youth workers, employers, youth, and others—can build assets. It doesn’t necessarily take a lot of money. But it can make a tremendous difference in raising confident, caring young people. What it takes is building relationships, spending time together, and being intentional about nurturing positive values and commitments. Some things you can do:

- Get to know the names of kids who live around you. Find out what interests them.
- Get to know what young people around you are really like, not just how they are portrayed in the media.
- Eat at least one meal together every day as a family. Take time to talk about what’s going on in each other’s lives.
- Volunteer as a tutor, mentor, or youth leader in a youth-serving program.

...In Your Organization
If you’re involved in an organization such as a school, youth organization, congregation, family service agency, health-care provider, or business—either as an employee or volunteer—you can encourage asset-building action within that organization. Some possibilities:

- Educate your constituency, employees, or customers about their potential as asset builders.
- Develop policies that allow parents to be involved in their children’s lives and that encourage all employees to get involved with kids in the community.
- Contribute time, talent, or resources to support community asset-building efforts.
- Develop or strengthen programs and activities that build assets, such as mentoring, service-learning activities, peer helping, and recreation.

...In Your Community
Hundreds of communities across the United States are discovering the power and potential of uniting efforts for asset building. They involve people from all parts of the community in shaping and coordinating strategies that will help all young people be more likely to succeed. You can use your influence in the community to:

- Talk about asset building with formal and informal leaders and other influential people you know. Get their support for asset building.
- Conduct a survey to measure the asset levels of young people in your community. (Call Search Institute for information.)
- Develop opportunities for youth to contribute to the community through sharing their perspectives and taking action and leadership.
- Celebrate and honor the commitments of people who dedicate their lives and time to children and youth.

Six Keys to Asset Building

It doesn’t cost a lot of money or require special training to build developmental assets. Here are six keys to guide asset-building action.

1. Everyone can build assets. Building assets requires consistent messages across a community. All adults, youth, and children play a role.
2. All young people need assets. While it is crucial to pay special attention to those youth who have the least (economically or emotionally), nearly all young people need more assets than they have.
3. Relationships are key. Strong relationships between adults and young people, young people and their peers, and teenagers and children are central to asset building.
4. Asset building is an ongoing process. Building assets starts when a child is born and continues through high school and beyond.
5. Consistent messages are important. Young people need to receive consistent messages about what's important and what's expected from their families, schools, communities, the media, and other sources.
6. Intentional redundancy is important. Assets must be continually reinforced across the years and in all areas of a young person’s life.
About the Research in this Brochure

Search Institute has been studying developmental assets in youth in communities since 1989, using a survey called Profiles of Student Life: Attitudes and Behaviors. In 1996, the current framework of 40 developmental assets was released. The data in this brochure is based on surveys during the 1996-97 school year of 90,462 6th- to 12th-grade public school students in 213 towns and cities in 25 states.

How Problem Behaviors and Thriving Indicators Were Defined

Here is how each of the behaviors and attitudes shown in the charts on page 3 were defined in the survey. Note that the definitions of high-risk behaviors are set rather high, suggesting ongoing problems, not experimentation.

High-Risk Behavior Patterns

- Problem Alcohol Use—Has used alcohol three or more times in the past 30 days or got drunk once or more in the past two weeks.
- Illicit Drug Use—Used illicit drugs (coca, LSD, PCP or angel dust, heroin, and amphetamines) three or more times in the past 12 months.
- Sexual Activity—Has had sexual intercourse three or more times in lifetime.
- Violence—Has engaged in three or more acts of fighting, hitting, injuring a person, carrying a weapon, or threatening physical harm in the past 12 months.

Thriving Attitudes and Behaviors

- Succeeds in School—Gets mostly A's on report card.
- Values Diversity—Places high importance on getting to know people of other racial/ethnic groups.
- Maintains Good Health—Pays attention to healthy nutrition and exercise.
- Delays Gratification—Saves money for something special rather than spending it all right away.

About Healthy Communities • Healthy Youth

This brochure is part of Search Institute's national Healthy Communities • Healthy Youth initiative, which seeks to equip communities across the country to build assets for youth. This initiative is underwritten by Lutheran Brotherhood, a not-for-profit organization providing financial services and community service opportunities for Lutherans nationwide. Search Institute's work on asset building also has received support from the Blandin Foundation, the Cargoil Foundation, the Dr. Witt Wallace-Reader's Digest Fund, and the W.K. Kellogg Foundation.

Search Institute also leads Assets for Colorado Youth, a statewide initiative that seeks to mobilize all Coloradans to build assets in children and adolescents. Major support for Assets for Colorado Youth is provided by The Colorado Trust.

Search Institute is a nonprofit, nonsectarian organization whose mission is to advance the well-being of adolescents and children by generating knowledge and promoting its application. The institute conducts research and evaluation, develops publications and practical tools, and provides training and technical assistance.

For More Information About Asset Building

Healthy Communities • Healthy Youth
Search Institute
700 South Third Street, Suite 210
Minneapolis, MN 55415
Phone: 612-376-6955
Toll-free: 800-888-7828
Web: www.search-institute.org

Assets for Colorado Youth
Search Institute—Colorado
1380 Logan Street, Suite 700
Denver CO 80203
Phone: 303-832-1587
tools for asset builders

Here is a sampling of asset-building resources available from Search Institute.

101 Asset-Building Actions is a full-color poster that lists the 40 assets and gives ideas for individuals and organizations on how to build assets. Portions of the poster are bilingual (English and Spanish).

All Kids Are Our Kids is the groundbreaking book by Search Institute President Peter L. Benson that gives in-depth information on the assets and how communities can mobilize individuals and organizations to build assets in young people.

Assets: The Magazine of Ideas for Healthy Communities & Healthy Youth offers information and strategies for building assets and promoting positive youth development in kids. The magazine has ideas, stories, and resources for individuals, organizations, and community-wide initiatives that care about young people. To subscribe, call 800-899-0882.

Parenting with a Purpose is a booklet that challenges parents to view parenting through the asset framework, highlighting how the assets can reshape major parenting tasks and suggesting ways parents can find support in their community.

Starting Out Right: Developmental Assets for Children offers new frameworks for understanding and building the foundation that children from birth through age 11 need to begin a healthy life. It blends Search Institute’s extensive research on adolescence with the literature on child development and the practical wisdom of people who work with and care for children.

What Kids Needs to Succeed is an easy-to-read book that shows the importance of helping youth make positive life choices and gives practical ideas for building each developmental asset.

Introducing Healthy Communities • Healthy Youth is an informational handout that provides an overview of the Healthy Communities • Healthy Youth initiative and Search Institute. It opens to a colorful poster of asset-building ideas.

For more information on these resources and others, contact Search Institute, 700 South Third Street, Suite 210, Minneapolis, MN 55405. Toll-free: 800-899-0882. Web: www.search-institute.org.
16. Awareness of self is the first step to self-realization; astute and sensitive understanding by social workers facilitates self-understanding by clients. A genuine desire to understand is a gift of the self.

17. People’s right to their own values and belief systems is inviolate. Nevertheless, certain values and beliefs lead to dysfunctional and self-defeating behavior. When such is the case, social workers have a responsibility to assist clients to face these aspects of their difficulties.

Roles of Direct Practitioners

During very recent years increasing attention has been devoted to the various roles that direct practitioners perform (or should perform) in discharging their responsibilities. In Chapter 1 we referred to a number of these roles. In this section we summarize these and other roles and refer to sections of the book where we discuss certain roles at greater length. We have categorized the roles based in part on a schema presented by Lister (1987).

I. Direct Provision of Services

Roles subsumed under this category are those in which practitioners meet face-to-face with clients or consumer groups in providing services. These include:

1. Individual casework or counseling.

2. Marital and family therapy (may include sessions with individuals, conjoint sessions, and group sessions).

3. Group work services (may include support groups, therapy groups, self-help groups, and skill development groups).

4. Educator/disseminator of information. The practitioner may provide essential information in individual, conjoint, or group sessions or may make educational presentations to consumer groups or to the public. For example, practitioners may conduct educative sessions concerned with parenting skills, marital enrichment, stress management, or various aspects of mental health or health care.

Roles involved in the direct provision of services are primary in the work of most practitioners, especially roles 1–3 listed above. Because this book is aimed at preparing practitioners to provide such direct services, we shall not elaborate on these roles in this section.

II. System Linkage Roles

Because clients often need resources not provided by a given social agency and lack knowledge of or ability to utilize other available resources, social workers often perform roles in linking people to other resources. System linkage roles include the following:

1. Broker. To perform the role of broker (i.e., an intermediary who assists in connecting people with resources), practitioners must have a thorough knowledge of community resources so that they can make appropriate referrals. Familiarity with the policies of resource systems and working relationships with key contact persons are essential to successful referrals. The preceding case example of Mrs. C. being referred by Ms. BSW to the mental health center was an example of performing the role of broker.

Before some people will avail themselves of resources they may require the practitioner’s assistance in overcoming fears and misconceptions. Practitioners also have responsibilities in developing simple and effective referral mechanisms and ways of monitoring whether clients actually follow
through on referrals. To assist you in gaining skills in referring clients to needed resources, we have presented relevant guidelines in Chapter 3.

2. Case manager/Coordinator. Some clients lack the ability to follow through on referrals to other resource systems. In such instances, social workers may serve as a case manager, a person designated to assume primary responsibility for assessing the needs of a client, arranging and coordinating the delivery of essential goods and services provided by other resources, and working directly with the client to ensure that the goods and services are provided in a timely manner. Case managers must maintain close contact with clients and with other service providers to ensure that plans for service delivery are in place and are subsequently delivered as planned. It is noteworthy that in the case manager role, practitioners function at the interface between the client and the environment more than in any other role.

Because of the dramatic increases in recent years in the numbers of people needing case management services (e.g., homeless, elderly, and chronically mentally disabled people), numerous articles have appeared in the literature concerned with those who need such services, issues related to case management, and various functions of case managers. Because we discuss these topics at some length in Chapter 16, we defer discussion of them to that chapter.

3. Mediator/arbitrator. Occasionally breakdowns occur between clients and service providers so that clients do not receive needed services to which they are entitled. For example, a client may be denied badly needed public assistance, food stamps, or health care. Service may be denied, however, because of arbitrary decisions of a provider, because clients did not adequately represent their eligibility for services, or because of strains that sometimes develop between clients and service providers that precipitate withdrawals of requests for services by clients or withholding of services by providers.

In such instances practitioners may serve as mediators with the goal of eliminating obstacles to service delivery. Mediation is a process that "provides a neutral forum in which disputants are encouraged to find a mutually satisfactory resolution to their problems" (Chandler, 1985, p. 348). In serving as a mediator you must carefully listen to and draw out facts and feelings from both parties to determine the cause of the breakdown. It is important not to take sides with either party until you are confident you have accurate and complete information. When you have determined the nature of the breakdown, you can plan appropriate remedial action aimed at removing barriers, clarifying possible misunderstandings, and working through negative feelings that have impeded service delivery. This process entails the use of communication skills that are delineated in subsequent chapters of this book.

In recent years knowledge of mediation skills has evolved to a high level of sophistication, and a small but increasing number of practitioners are working independently or in tandem with attorneys to mediate conflicts between divorcing partners regarding child custody, visitation rights, and property settlements. Mediation has also been employed to resolve differences among adult children regarding the care of their elderly parents. These same skills can be used to mediate personnel disputes and labor-management conflicts.

Because an increasing number of social workers have become full-time mediators, the professional organization (NASW) has developed standards to complement its Code of Ethics and to be consistent with the standards of major mediation organizations (NASW, 1991).

To discuss skills in mediation practice is beyond the scope of this book. For general and brief discussions of social work mediation we refer you to articles by Chandler.
(1985) and Parsons (1991). For comprehensive books on mediation we recommend Lemmon (1985), Moore (1986), and Wise-
man (1990). In addition, Folberg & Milne (1988) and Neumann (1989) have written books concerned specifically with divorce med-
iation, and Erickson (1989) has authored a family mediation casebook. Parsons and Cox (1989) have also discussed the use of med-
iation in work with families and elderly persons in reaching decisions about how caregiving for the frail elderly family mem-
ber will be provided.

4. Client advocate. Serving as an advocate for a client or group of clients has been a role assumed by social workers since the incep-
tion of the profession. The obligation to assume this role has since been reaffirmed many times, the most recent being in the
Code of Ethics adopted in 1979. With respect to linking clients with resources, advocacy is the process of working with and/or on behalf of clients to obtain services and resources that would not otherwise be provided. We discuss circumstances under which this might occur and appropriate remedial measures at length in Chapter 20. We also dis-
cuss skills involved in advocacy (including social action for groups of clients) in Chapter 16.

III. System Maintenance and Enhancement

As staff members of social agencies, practitioners bear responsibility for evaluating structures, policies, and functional relationships within agencies that impair effectiveness in service delivery. Roles that relate to fulfilling this responsibility include:

1. Organizational diagnostican. Discharging this role entails pinpointing factors in agency structure, policy, and procedures that have a negative impact on service delivery. Knowledge of organizational and admin-
istrative theory are essential to performing this role effectively. We focus on this role in Chapter 20 in the section “Organizational
Resistance.” Students will also learn more about organizational dynamics in courses concerned with organizational theory.

2. Facilitator/expeditor. After pinpointing factors that impede service delivery, practitioners have a responsibility to plan and im-
plement ways of enhancing service delivery. This may involve providing relevant input to agency administrators, recommen-
ding staff meetings to address problems, working collaboratively with other staff members to bring pressure to bear on resis-
tant administrators, encouraging and participating in essential in-service training sessions, and other similar activities.

3. Team member. In many agency and institutional settings (e.g., mental health, health care, and rehabilitation settings) practi-
tioners function as members of clinical teams that collaborate in assessing clients’ problems and delivering services. Teams com-
monly consist of a psychiatrist or physician (usually the team leader), a psychologist, a social worker, a nurse and perhaps a reha-
bilitation counselor, occupational therapist, and/or a recreational therapist, depending upon the setting. Members of the team have varying types of expertise that are tapped in formulating assessments and planning and implementing therapeutic interventions.

As team members, social work practitioners often contribute knowledge related to family dynamics and engage in therapeu-
tic work with family members. Social workers also are expected to apply their knowledge of community resources in plan-
ing for discharge of patients and facilitating their reentry into the community following periods of hospitalization. As team mem-
bers, social workers also often serve as case managers in coordinating discharge planning
for patients who would otherwise be unable to function adequately in the community.

4. Consultant/consultee. Consultation is a process whereby an expert enables a consultee to deliver services more effectively to a client by increasing, developing, modifying, or freeing the consultee's knowledge, skills, attitudes, or behavior with respect to the problem at hand. Although social workers both provide and receive consultation, there has been a trend over the past decade for MSW social workers to serve less as consumers of consultation and more as providers. BSW social workers may provide consultation regarding the availability of specific community resources but more often are consumers of consultation when needing information about how to work effectively in problem solving that entails complex situations and behaviors.

Social workers assume the consultee role when in need of expert knowledge from doctors and nurses, psychiatrists, psychologists, and other social workers who possess high levels of expertise related to certain types of problems (e.g., substance abuse, child maltreatment, sexual problems and other problems that require advanced knowledge).

Social workers serve as consultants to members of other professions and to other social workers in need of their special expertise. For example, they may provide consultation to principals and teachers who need assistance in understanding and coping with problem students; to physicians and other health care providers who seek assistance in understanding a patient's family, or ethnic and cultural factors; to attorneys and courts regarding matters that bear on child custody decisions; to judges for presentence investigations related to decisions about parole and probation; to adoptive and child welfare workers regarding the mental health of prospective adoptive parents; and in many other similar situations.

The principles and skills involved in consultation are beyond the scope of this book. Those interested in pursuing this topic further will find Dougherty's (1990) book informative. A quarterly journal, Consultation: An International Journal, published by Human Science Press, is also an excellent reference.

IV. Researcher/Research Consumer

Practitioners have a responsibility to evaluate the effectiveness of their interventions, to systematically monitor the progress of their clients, and to keep abreast of and evaluate findings reported in the research literature. Implementing these processes requires practitioners to don the mantle of researcher.

Actual research conducted by direct practitioners usually involves single-subject (also denoted as single-system) designs. This type of research design enables practitioners to obtain measures of the extent (frequency and severity) of problem behaviors before implementing interventions aimed at eliminating or reducing the problem behaviors (e.g., substance abuse, aggressive/or violent behavior, overeating) or increasing the frequency of behaviors that are absent or insufficient (e.g., doing homework, engaging in prosocial behaviors, setting realistic and consistent limits with children, sending positive messages, abstaining from drinking). These measures provide a baseline against which the results of implementing interventions can be assessed by applying the same measures periodically during the course of the interventions, at termination, and at follow-up.

Unless practitioners employ such designs to evaluate their practice, they must rely on clinical judgment, which is subject to error and bias. Assessing progress through repeated measures, by contrast, enables both client and practitioner to discern small changes that might otherwise be underestimated or to determine that interventions are
not producing the desired changes and a different approach is indicated.

Although we discuss single-subject research in Chapters 13 and 21, adequate treatment of this topic is beyond the scope of this book. Most students of direct practice learn the role of researcher in research courses, especially courses in clinical research, for which several excellent textbooks are available.

V. System Development

Direct practitioners sometimes have opportunities to improve or to expand agency services based on assessment of unmet client needs, gaps in service, needs for preventive services, or findings of one's own or other research studies that indicate more promising results achieved by interventions other than those currently employed. Roles that relate to system development include:

1. Program developer. As we noted earlier, practitioners often have opportunities to develop services in response to emerging needs of clients. Such services may include educative programs (e.g., for immigrants or unwed pregnant teenagers), support groups (e.g., for rape victims, adult children of alcoholics, and victims of incest), and skill development programs (e.g., stress management, parenting, and assertiveness training groups).

2. Planner. In small communities, rural areas, and boom towns that lack access to community planners, direct practitioners may need to assume a planning role, usually in concert with community leaders. In this role the practitioner works both formally and informally with influential people to plan programs in response to unmet and emerging needs. Varying from one area to another, such needs may include child care programs, transportation for the elderly and disabled, and recreational and health care programs, to name just a few.

3. Policy and procedure developer. Participation of direct practitioners in formulating policies and procedures typically is limited to agencies in which they provide direct services to clients. This degree of participation is largely determined by the style of administration within a given agency. Able administrators generally solicit and invite input from professional staff as to how the agency can more effectively respond to consumers of services. Because practitioners serve in the "front lines" they are in a strategic position to evaluate clients' needs and how policies and procedures serve or fail to serve the best interests of clients. It is important, therefore, that practitioners seek to be actively involved in decision-making processes related to policies and procedures.

In rural areas and small communities, direct practitioners often participate in policy development concerned with the needs of a broad community rather than the needs of a circumscribed target group. In such instances practitioners must draw from knowledge and skills gained in courses in social welfare policy and services and community planning.

4. Advocate. Just as practitioners may advocate for an individual client, they may also join client groups and other social workers and allied professionals in advocating for legislation and social policies aimed at providing needed resources and enhancing social justice. We discuss skills in advocacy and social action in the concluding section of Chapter 16.

As we have indicated previously, knowledge and skills related to some of the foregoing roles are taught in segments of the curriculum that lie outside of direct practice courses. To do justice in one volume to the knowledge and skills entailed in all these roles is an impossible task; consequently we have limited our focus primarily to the roles subsumed under I. providing direct service. Weissman, Epstein, and Savage (1983) have written an excellent book concerned with many of the administrative roles involved in direct practice.
Clinical Treatment Plan Matrix
for
AREAS AND LEVELS OF INTERVENTION

<table>
<thead>
<tr>
<th>Levels of Intervention</th>
<th>INDIVIDUAL</th>
<th>FAMILY</th>
<th>SCHOOL</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>COGNITIVE</td>
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<tr>
<td>BEHAVIORAL</td>
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<tr>
<td>AFFECTIVE</td>
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<tr>
<td>SPIRITUAL</td>
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</tbody>
</table>
Treatment Plan Development

The purpose of writing a treatment plan is to develop a "how to" or a roadmap or a give a direction to where the therapy process "should be" heading. It offers the clinician an opportunity to pull together all the information gathered about the client (presenting problems, psychosocial history, mental status exam, and diagnosis), review the options available, and select the most appropriate road(s). This experience also allows the client to react positively or negatively to the proposed trip. The treatment plan by its very nature is an evolutionary process. It is very much affected by time, new information, and results of previous interventions.

The treatment plan concept follows a medical model with all the pluses and minuses that entails. However, one of its strengths is a clarification of the clinician's thinking and vision for the client. Therefore, the plan needs to be specific and comprehensive. It is specific because it contains at least the four Ws (who, what, when, and where) and it is comprehensive because it addresses each and every identified symptom.

The following is a sample treatment plan for 16 year old depressed female student, Amy.

Amy

1) Weekly individual sessions at school for one period focusing on reducing depressive symptoms (excessive sleeping, weight loss, lack of energy, feelings of worthlessness, and inability to concentrate especially in school) through monitoring behavior, increased physical activity, and cognitive restructuring. Review progress with clinical supervisor in one month.

2) During weekly sessions also explore with Amy her positive peer social interactions and options.

Family

1) Parents - With Amy's concurrence, schedule a meeting with both parents to explore family history of depression, environmental factors affecting Amy, and availability and strength of support.

2) Sister - Explore with Amy and parents the likelihood of including 14 year old, acting-out sister, Sara, in the family treatment plan.

School

1) During this next week, check with third period English teacher, Mrs. Jones, about Amy's level of concentration during class and her lack of follow-through on semester end assignments to avoid failing this course and jeopardizing graduation.

2) Follow-up with AP on recent discipline referral for being tardy twice to first period class.

Other

1) Send for past medical records of ulcer treatment and prior private psychotherapy.
Social Work Roles
from
Direct Social Work Practice by Hepworth and Larsen

I. Direct Provision of Services
   a) Individual Counseling
   b) Marital and Family Therapy
   c) Group Work
   d) Educator/Disseminator

II. System Linkage Roles
   a) Broker
   b) Coordinator
   c) Mediator/Arbitrator
   d) Client Advocate

III. System Enhancement
   a) Organization Diagnostician
   b) Facilitator
   c) Team Member

IV. Researcher

V. System Development
   a) Program Developer
   b) Planner
   c) Policy and Procedure Developer
   d) Advocate

Skills for Helping Clients
from
The Skills of Helping by Shulman p. 24

Manage their Feelings
Reaching inside of silences
Pulling client's feeling into words
Displaying understanding of feelings
Sharing worker's feelings

Manage their Problems
Clarifying worker's purpose & role
Reaching for client feedback
Partializing client concerns
Supporting client in taboo areas
ANAHEIM UNION HIGH SCHOOL DISTRICT

The Learning Center
1800 W. Ball Rd.
Anaheim, CA 9204
714-999-3792

CONSENT TO VIDEOTAPE

I __________________________ give my permission to The Learning Center to videotape _____________ in a counseling setting. I understand that videotapes will be used for clinical supervision of counseling interns. I also understand that this consent is limited to the 2004-2005 school year.

________________________________
signature of parent/guardian

Thank you for your cooperation. If you have any questions concerning the Learning Center’s counseling services, please contact _________________.

Counseling intern
Dear Parent(s)/Guardian(s) of _______________________

Your child has been chosen to be involved in a learning skills group which meets once a week for one class period. There will be six group sessions. The group will include education, insight/awareness, and support. The group will offer students the opportunity to learn interpersonal and problem solving skills and to discuss problems in these areas with peers and a group facilitator.

Students involved in the group do miss class. They are responsible for the work they miss. The class period missed will rotate from week to week to minimize the effect upon any one class.

All the groups will work to develop a high level of trust, so we can help each other deal with various situations. However, any information volunteered by students regarding illegal activities must be reported by the facilitator to the proper authorities, as this is a legal requirement. Students will be encouraged to keep all personal information confidential within the group. The group will be led by a trained facilitator—a Social Worker Intern.

We would like to be sure that all parents have been informed. Therefore, would you please sign this letter and have your daughter return it to the office. If you have any questions in regard to the purpose or nature of the group, please contact me or your Assistant Principal.

Your signature indicates you have read the above and approve of your daughter's participation in the group.

Sincerely,

Facilitator/School Social Worker Intern

____________________________________  ____________________
Parent signature                        Date
Dear Parent(s) of ________________________________

Your child has chosen to be involved in a learning skills group which meets once a week, one class period for several weeks. The group will include education, insight/awareness, and support. The group will offer students the opportunity to learn interpersonal, decision-making and study skills and to discuss school related problems with their peers and group facilitator.

Students involved in the group do miss class. They are responsible for the work they miss. The class period will rotate from week to week to minimize the effect upon any one class.

All groups will work to develop a high level of trust so we can help each other deal with the various situations. However, any information volunteered by students regarding illegal activities must be reported by the facilitator to the proper authorities, as this is a legal requirement. Students will be encouraged to keep all personal information confidential within the group. The group will be lead by a trained facilitator: a Social Work Intern. A brief overview of subjects covered in the group has been enclosed.

We would like to be sure that all parents have been informed. Therefore would you please sign this letter and have your son/daughter return it to his/her facilitator. If you have any questions in regard to the purpose or nature of the group, please contact me or your Assistant Principal.

Your signature indicates you have read the above and approve of your son/daughter’s participation in the group.

Sincerely,

School Social Worker Intern

(Parent Signature) (Date)
Anaheim Union High School District

Student Referral Response

To: ____________________________

From: MSW Intern

Re: ____________________________

Date of Referral: ________________

Date of Initial Session: __________

Comments: _______________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
STUDENT REFERRAL TO MSW INTERN

If a student exhibits four or more of the following symptoms, it may indicate a problem and the need for a referral. If you observe some of these symptoms, feel a student is having serious difficulties, or become aware that a student is engaging in at risk behaviors, please complete and return this form to me. Due process may necessitate that this information, if requested, be made available to the student or parent. If the form is to be delivered by a third party please place it in an envelope, marked confidential, and return to Ms. Underwood located in

__________________________________________________________________________

STUDENT ___________________________ DATE ____________

GRADE ____ PERSON REFERRING ____________________________

-CHECK APPROPRIATE RESPONSES-

A. Grades
- lower grades/achievement
- behind in class/homework
- lacks motivation, apathy

B. School/class difficulties
- absenteeism
- tardies
- not in class/in school
- frequent day dreams
- suspension
- often @ nurse/counselor
- loss of eligibility
- decreasing involvement
- has dropped-activities
- no involvement or interest

C. Physical Symptoms
- staggering or stumbling
- smelling of alcohol or pot
- glassy/bloodshot eyes
- dark glasses
- bad hygiene
- sleeping in class
- frequent Physical Complaints
- frequent bruises, injuries
- time disoriented
- inappropriate responses or behavior
- excessive weight loss
- excessive weight gain
- suspected eating disorder
- sleeping difficulties
- obsessive/compulsive
- crying frequently

Comments: (Use back if needed)

D. Social Behavior
- hangs w/ older crowd
- loner, few friends
- withdrawn, depressed
- defensive behavior
- frequent fights
- easily influenced by peers
- needy behavior
- bullies
- sexually active
- change in peer groups
- avoids contact w/ authority
- dramatic/attention-getting

E. Behavior: Act-out/@ Risk
- disruptive class behavior
- defiance of rules
- constant discipline prob.
- cheating
- irresponsible
- verbal/physical abusive
- throws objects frequently
- obscene language, gestures
- bad temper
- fire setting
- constantly in wrong area
- extreme negativism

F. Other difficulties
- family difficulties
- runaway
- alcohol/drug use
- talks freely about using
- erratic behavior changes on a day-to-day basis
To: ____________________________

From: MSW Intern

Date of Sessions: ____________________________

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Ref. Source</th>
<th>Session #</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

If you have any questions or additional information regarding the students please contact me. Please remember this list is confidential, and should be handled carefully. Thank You.
**MEMORANDUM**

DATE: ________________________________

TO: __________________________________

FROM: Social Work Intern

SUBJECT: ___________________________________________________

I recently received a referral for student, ____________, for social work services. Therefore, in order to make an appropriate assessment for this child's needs, I would really appreciate it if you could take a moment of your time to provide me with any concerns or comments you may have regarding this minor (i.e., behavior issues, excessive absences, depression, unusual comments).

Please provide your comments on the bottom portion of this memo, and return it in my box labeled "School Social Worker" by _______. Your feedback will remain CONFIDENTIAL.

Your input is crucial and it may be the missing link to helping a child in need.

Thank you in advance for your time.
Trident Social Work Intern Referral

Date: ____________________

To: Trident Social Work Intern

From: ____________________ Room #: ______

Re: ____________________

___ Please see student immediately.

(Student is a danger to self or others, or is in an
abusive environment, etc.).

___ Please see student as soon as possible.

(Student is experiencing problems at home, at school,
with peers, etc.).

___ Call student in at your convenience.

(Student is probably in need of community resources).

Brief description of the referring issue.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

You will receive correspondence from the social work intern
once the student has been seen.
________________________________________________________________________

Date referral was received: _________________

Date student was seen: _______________

Note: ___________________________________________________________________
________________________________________________________________________
________________________________________________________________________
STUDENT SUPPORT GROUP
PERMISSION FORM

Student’s Last Name,                        First

STUDENT SUPPORT GROUP

PARENT/GUARDIAN AUTHORIZATION

I grant permission for my child to attend and participate in a student support group at __________________________. The group meets one period each week. During these group sessions, such issues will be addressed as developing a healthy self-concept, appropriate decision-making, setting future goals, and effective communication techniques. The group will be led by district-approved trained facilitators.

I understand that to effect honest communications with members of the group, confidentiality must be maintained except in cases of immediate life threatening situations.

If you have any questions regarding the purpose or nature of the support group, please call ______________________ at ______________________

PARENT/GUARDIAN

Signature ______________________

Date ______________________

I do not want my child to participate in this program.

PARENT/GUARDIAN

Signature ______________________

Date ______________________
IMPACT
PARENT/STUDENT VOLUNTARY CONTRACT

_________________________ SCHOOL

Date _______________________

Dear ________________________

_________________________ has indicated a desire to participate in the
IMPACT chemical intervention program. A requirement of this program is that
the student must attend ten one-hour group meetings. These meetings will be
held during regular school hours and will require the student to miss one
class hour per week. These meetings will be rotated through the morning class
schedule so that the student will not be out of a particular class more than
two times during the IMPACT ten-week program. Below is a summary of the
requirements for the program.

1. An assessment will be done on the student to determine
   the appropriateness of placement in the IMPACT program.

2. The student must maintain a good attendance record.

3. The student must follow all rules of the campus.

4. The student must not be under the influence or any drug or
   alcohol nor be in possession of such during school time or
   at any school function.

5. The student must attend ten class meetings of the mandatory
   IMPACT program and do the required work.

Your signature indicates that you understand the seriousness of chemical abuse
and that you are willing to cooperate to make a positive change in dealing
with the problem. You further understand that, if after full evaluation, it
is determined that the degree of chemical abuse indicates that the student
will not benefit from the IMPACT program the student will not be allowed to
participate in the program.

Signature of Mother/Guardian ________________________________

Signature of Father/Guardian ________________________________

Signature of Student ________________________________

Signature of IMPACT representative ________________________________
Anaheim Union High School District

School Social Work Interns Training

at

The Learning Center

Group Social Work Practice Outline

'Why do a group in the first place?'

Content

Preparation
Administration Difficulties
Basic Decision Making
Focus of Treatment/Goal Setting
Determination of Group Rules
Importance of Ceremonies

Processes/Phases

Beginning, Middle & End

Pre-Affiliation
Power and Control
Intimacy
Differentiation
Separation

Questions and Answers
A Pathway Through the Grieving Process*

Loss

Health ← Self Esteem ← Significant Persons

Shock/Denial

Bargaining

Anger

Acting Out ← Depression

Understanding

Coping

Managing Loss


[Copyright] 1993 by Illinois Department of Children and Family Services; Published by the Child Welfare League of America.
Figure 1. The Content-Process Matrix Model for Conflict Resolution

<table>
<thead>
<tr>
<th>Content</th>
<th>Separate Person from Problem</th>
<th>Focus on Interests not Position</th>
<th>Invent Options for Mutual Gain</th>
<th>Use Objective Criteria for Eval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redirect Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reallocate Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reframe Perspectives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Realign Forces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

References


Brief School Related Conflict Scenarios

1. Matt and Phong

This disagreement was over a $10.00 bill. It seems that both saw it on the ground at the same time and claimed ownership to it. In the struggle over possession, it tore into several pieces. Each blamed the other for neither getting to use the money. The conflict escalated to the point of calling each other unflattering names, using racial epithets, and emphasizing obvious stereotypes about each other. A teacher observed the confrontation and referred them to the AP.

2. Sally and Sarah

Both young women thought Steve was very cute. Steve knew both girls from his third period English class but had never said more than hello to either one of them. During an English class assignment, Sally happened to see and read Sarah's paper about the topic "Reputation and Respect" of fellow students in her school. Sally became angry immediately and later confronted Sarah when Sally thought Sarah had written about Sally and Steve's intimate relationship.

3. Bill and Susan

Bill liked Susan but was unsure how to let her know or even how to get her attention. Since Susan was on the junior varsity basketball team, he would often attend her home games and cheer excitedly for her. He also called her at home several times for help with his history homework assignments. When she still did not respond to him on campus, Bill started a rumor about Susan's parents using drugs and her family being poor.

4. Juan and Enrique

Off campus these two young men had been neighborhood friends. Recently, Juan had relocated to another area of the city not too far away but recognized as more socially affluent. Neither had seen each other since the move, but Enrique had heard that Juan was "badmouthing" his former locale. Enrique now sees Juan on campus during a break having fun with some new friends. Enrique now wants to confront Juan about the things that he has heard. The next bell is about to ring and Enrique is not sure what to do.

5. Anicetto and Aricelli

Both students had been acquaintances since grammar school. They had been recently dating for about three months. Suddenly, according to Anicetto, Aricelli would not see or talk with him anymore. He off-handedly told some of Aricelli's girlfriends in his math class that he now knew she was a "spoiled, stuck up bitch." Anicetto's remarks angered and hurt Aricelli.

6. Bill and Bob

Bill and Bob had a long-standing habit of hitting each other each time they passed at school. On this particular day, Bill was angry with his father for getting drunk the previous night and hit Bob much harder than usual. During the next time they saw each other, Bob reciprocated by hitting Bill even harder. After school, Bob hit Bill so hard from behind that Bob knocked Bill to the ground tearing his new shirt. A brief scuffle ensued until interrupted by a PE instructor.
## Anaheim Union High School District
### Safe Schools
#### RESOURCE DIRECTORY

### Anaheim Union High School District Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Schools Office</td>
<td>220-4080</td>
</tr>
<tr>
<td>Safe School Specialist</td>
<td>Jim McGovern 936-3704</td>
</tr>
<tr>
<td>Substance Abuse Prevention Program Specialist</td>
<td>Sharon Sackett 956-5128</td>
</tr>
<tr>
<td>Family Involvement/Parenting</td>
<td>Kim Bauerle 999-2179</td>
</tr>
</tbody>
</table>

### Community Outreach

<table>
<thead>
<tr>
<th>Organization</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaheim Police Activities League</td>
<td>533-8255</td>
</tr>
<tr>
<td>Boys &amp; Girls Club of Anaheim</td>
<td>491-3617</td>
</tr>
<tr>
<td>Project S.A.Y</td>
<td>765-5246</td>
</tr>
<tr>
<td>Y.M.C.A</td>
<td>635-9622</td>
</tr>
</tbody>
</table>

### Community Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>Anaheim/Fullerton Family Resource Center</td>
<td>765-3776</td>
</tr>
<tr>
<td>Children and Youth Services</td>
<td>577-5400</td>
</tr>
<tr>
<td>La Familia/Latino Service Center</td>
<td>479-0120</td>
</tr>
<tr>
<td>Olive Crest</td>
<td>543-5437</td>
</tr>
<tr>
<td>Orange County Information Link</td>
<td>211</td>
</tr>
<tr>
<td>Paint Your Heart Out</td>
<td>758-6321</td>
</tr>
<tr>
<td>Positive Action Center</td>
<td>633-0011 x1301</td>
</tr>
<tr>
<td>Salk Family Resource Center</td>
<td>826-9867</td>
</tr>
<tr>
<td>Western Youth Services</td>
<td>871-5646</td>
</tr>
</tbody>
</table>

### Outpatient Substance Counseling

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Straight Talk Clinic</td>
<td>828-2000</td>
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</tbody>
</table>

### Support Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al-Anon/Alateen</td>
<td>746-1113</td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td>556-4555</td>
</tr>
<tr>
<td>Gang Tattoo Renewal</td>
<td>662-7456</td>
</tr>
<tr>
<td>Hate Crime</td>
<td>567-4470</td>
</tr>
<tr>
<td>Marijuana Anonymous</td>
<td>999-9409</td>
</tr>
<tr>
<td>Tobacco Use Prevention</td>
<td>834-4423</td>
</tr>
<tr>
<td>Tough Love</td>
<td>239-3533</td>
</tr>
<tr>
<td>Woman's Transitional Living Center</td>
<td>992-1931</td>
</tr>
</tbody>
</table>

### Law Enforcement - Juvenile Diversion/Intervention

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaheim Police Department - Safe Schools Officers</td>
<td>Kirt Robertson 765-1980</td>
</tr>
<tr>
<td>Ed Arevalo 765-1809</td>
<td></td>
</tr>
<tr>
<td>Shawn Boatright 765-1466</td>
<td></td>
</tr>
<tr>
<td>Kyle Bernard 765-1977</td>
<td></td>
</tr>
<tr>
<td>Dan Hurtado 765-1976</td>
<td></td>
</tr>
<tr>
<td>Jacques Laffoon 765-1510</td>
<td></td>
</tr>
<tr>
<td>Kevin Flanagan 765-1409</td>
<td></td>
</tr>
<tr>
<td>Buena Park Police</td>
<td>562-3902</td>
</tr>
<tr>
<td>Cypress Police</td>
<td>229-6600</td>
</tr>
<tr>
<td>Dan Foniss 229-6600</td>
<td></td>
</tr>
<tr>
<td>La Palma Police</td>
<td>690-3370</td>
</tr>
<tr>
<td>Anaheim Police Explorers</td>
<td>765-1521</td>
</tr>
</tbody>
</table>

### Hotlines (24-Hours)

<table>
<thead>
<tr>
<th>Hotline</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>Anaheim Union High School District Hotline</td>
<td>765-5200</td>
</tr>
<tr>
<td>Casa Youth Shelter (Teen Runaways)</td>
<td>995-8601</td>
</tr>
<tr>
<td>Child Abuse Registry</td>
<td>940-1000</td>
</tr>
<tr>
<td>Crisis Hotline</td>
<td>(800)784-2433</td>
</tr>
<tr>
<td>Graffiti Hotline: Anaheim</td>
<td>765-5200</td>
</tr>
<tr>
<td>Buena Park</td>
<td>821-8658</td>
</tr>
<tr>
<td>Cypress</td>
<td>229-6760</td>
</tr>
<tr>
<td>La Palma</td>
<td>690-3310</td>
</tr>
<tr>
<td>Stanton</td>
<td>890-4252</td>
</tr>
<tr>
<td>National Runaway Switchboard</td>
<td>(800)222-1222</td>
</tr>
<tr>
<td>National Crime Line Anonymous</td>
<td>(800)782-7463</td>
</tr>
<tr>
<td>Victims of Crime Program</td>
<td>(800)777-9229</td>
</tr>
<tr>
<td>We TIP</td>
<td>(800)78CRIME</td>
</tr>
</tbody>
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Disclaimer: This Resource Directory is designed to provide information and assistance in facilitating services for crisis intervention/counseling. A listing in this directory does not constitute an endorsement or certification of a program’s services. Revised by Lilia Arevalo 11/2005
The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was passed by Congress to promote standardization and efficiency in the health care industry. HIPAA will accomplish these goals by imposing new restrictions on how covered entities can use and share information and by creating new rights for individuals concerning their health information. HIPAA should help health care providers do business with health plans in less costly and more efficient ways, and it should give patients more rights and control over their health information.

In thinking about HIPAA, however, it's important to realize that HIPAA isn't just one big thing that you have to comply with; rather, it's four big things. These four component parts of HIPAA, much like the component parts of an engine, work together to accomplish HIPAA's purposes of streamlining the health care industry and affording patients more rights. The four component parts of HIPAA are: Privacy Requirements; Electronic Transaction and Code Sets Standards Requirements; Security Requirements; and National Identifier Requirements.

Privacy Requirements
HIPAA creates rights for patients concerning how their health information is used and disclosed by health care providers who are covered entities under HIPAA. These rights are set forth in the component part of HIPAA known as the Privacy Rule. The Privacy Rule essentially limits what you, as a health care provider, can do with a patient's health information without that patient's knowledge and consent. Furthermore, the Privacy Rule requires you to take reasonable precautions to keep patient information confidential and secure. The date set for complying with the Privacy Rule was April 14, 2003.

To understand the Privacy Rule, you need to have a working knowledge of the following terms and concepts:

1. to **Disclose** information means to release it **outside** your practice; to **Use** information means to utilize the information **inside** your practice.

2. to conduct **Health Care Operations** means to conduct certain activities such as conducting case management and care coordination activities; contacting health care providers about treatment alternatives; reviewing the competence or qualifications of health care professionals; conducting training programs for trainees and interns; conducting or arranging for legal or auditing services; or, conducting business management and general administrative activities, among others.

3. the **Minimum Necessary** standard means that when using or disclosing protected health information you must make reasonable efforts to limit the protected health information to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request.

4. conduct **Payment** activities means to obtain reimbursement for rendering health care and it includes such things as determining eligibility or coverage, billing, claims management, collection activities, utilization review activities, and disclosures to consumer reporting agencies, among others.

5. **Protected Health Information** ("PHI") is the information that you maintain about your patients, whether such information is kept in electronic or paper form.

6. **Psychotherapy Notes** is information recorded (in any medium) by you, as a mental health professional, documenting or analyzing the contents of your counseling sessions and that is kept separate from the rest of the patient's medical record. The definition of psychotherapy notes, however, excludes such things as medication prescription and monitoring, session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

7. to conduct **Treatment** activities means the provision, coordination, or management of health care and related services by one or more health care providers.

Electronic Transaction and Code Sets Standards
HIPAA is designed to create one national "language" for covered entities so that all
covered entities, whether they are health plans, health care clearinghouses, or health care providers, can communicate with one another in that language. The language that HIPAA has created is an amalgam of standard transactions, code sets, and identifiers, and HIPAA requires all covered entities to utilize this language when conducting transactions subject to it. These transactions and code sets standards have been created to give the health care industry a common language to make it easier for covered entities to communicate with one another electronically. Consequently, the Electronic Transaction and Code Sets Standards will improve efficiency in the health care industry by standardizing communication between covered entities. The date for complying with the Electronic Transaction and Code Set Standards is October 15, 2003.

Security Requirements
An essential part of HIPAA is keeping patient information safe and secure from a variety of threats. The Security regulation will outline the minimum administrative, technical, and physical safeguards required to prevent unauthorized access to a patient’s health information or the loss of such information. On February 20, 2003, The Department of Health and Human Services published final regulations on the Security Requirements. Although these regulations are effective as of April 21, 2003, health care providers who are covered entities have until April 21, 2005 to become completely compliant with them.

National Identifier Requirements
Another essential part of HIPAA is that covered entities be able to communicate with one another efficiently. To accomplish this objective, there needs to be a way for such entities to identify themselves when interacting with other covered entities. The National Identifier Requirement will require health care providers, health plans, and employers to have national identification numbers that identify them when they are conducting standard transactions, which are transactions governed by HIPAA. For employers, the Employer Identification Number (“EIN”), which is issued by the Internal Revenue Service, was selected as the national identifier. However, for health plans and health care providers national identifiers have not been established.

Consequently, as a health care provider, you do not have to have a national identifier right now, but you may have to have one in the future, even if you are not a covered entity. Currently, there is no date for complying with the National Identifier.

Covered Entities
No overview of HIPAA would be complete without mentioning the central concept of covered entities. The concept of a covered entity is the lynchpin that holds all of the component parts of HIPAA together. Understanding who is and who is not a covered entity is important because HIPAA is only applicable to covered entities. Consequently, if you are a covered entity, you must comply with HIPAA. Conversely, if you are not a covered entity, you do not have to comply with HIPAA, unless you choose to do so.

So who are covered entities? Right now there are three groups listed in the regulations: health plans, health care clearinghouses, and health care providers who transmit health information in electronic form in connection with certain administrative and financial transactions.

As a provider of mental health services, you are not a health plan or a health care clearinghouse. You may, however, depending upon how you utilize a computer in your practice, be a health care provider who conducts certain administrative or financial transactions electronically.

The information contained in this article is intended to provide guidelines for addressing difficult legal dilemmas. It is not intended to address every situation that could possibly arise, nor is it intended to be a substitute for independent legal advice or consultation. When using such information as a guide, be aware that laws, regulations, and technical standards change over time, and thus one should verify and update any references or information contained herein.
STUDENT SUPPORT GROUP
PERMISSION FORM

_________________________  ______________________
Student’s Last Name    First Name

Lexington Junior High has an opportunity for select students to participate in a counseling
support group at no charge. The group will meet one period per week and the class period will
rotate from week to week to minimize the students missing the same class each week.

The group will be addressing issues such as self-esteem, and appropriate ways of dealing with
anxiety and stress. The group will be led by our Social Work Intern, Lisa Tongg, BSW, under the
supervision of School Counseling staff.

All information disclosed within the sessions of the group will be kept confidential, except when
there is reasonable suspicion of child abuse, when the student presents a serious danger to self or
others or there is evidence of illegal activities. In these instances, the facilitator is mandated to
report as a legal requirement.

If you have any questions concerning the purpose or nature of the group, please contact myself,
Lisa Tongg, or Carol Payne, the Head Counselor.

Sincerely,

Lisa Tongg, BSW

________________________________________
Please sign the bottom portion of this consent form and have your child return it to Carol
Payne in the Counseling office.

I give my consent to have my child participate in a counseling group.

Parent or Guardian Signature       Date
STAGES OF AN INTERNSHIP

It is generally accepted that each internship experience is unique. Yet, researchers have detected specific stages of internship that apparently develop in a predictable order. Each stage yields concerns that require resolution in order to enhance the student's learning and growth process. Although the order of stages is predictable, the journey is not. There is always the possibility of a student becoming "stuck" in a stage if issue-related tasks are not successfully accomplished. The five stages of internship are the following: Anticipation ("What if...?"), Disillusionment ("What's wrong...?"), Confrontation ("The only way around is through."), Confidence ("The emerging professional..."), and Culmination ("Good-byes are never easy."). The following information presents a brief description of what is likely to happen in each stage as well as associated tasks that field instructors should be aware of in order to assist the student.

STAGES       ISSUES & FEELINGS
Anticipation  Along with hope and eagerness, unknowns can cause anxiety related to role, responsibilities, competence, supervision, relationships, clients and personal situation.

Disillusionment  The gap between anticipation and reality regarding the internship can cause disappointment, dip in morale, frustration, anger, sadness, and discouragement.

Confrontation  Resolving issues raised in previous stage increases independence, effectiveness, and self-empowerment.

Competence  Transition from apprentice to professional stimulates excitement, accomplishment, high morale, and investment.

Culmination  Endings in internship, semester, and possibly college experience raises issues marked by sadness, pride, guilt, anxiety, and avoidance behaviors.

STAGES       TASKS
Anticipation  * Define goals clearly and specifically
* Develop a realistic set of expectations for the experience
* Explicate, examine and critique assumptions

Disillusionment  * Feel the impact of presenting issues
* Identify feelings and their results
* Work through issues

Confrontation  * Re-examine expectations, goals, and skills
* Keep working at the issues

Competence  * Focus on progress/excellence not perfection
* Manage surfacing conflicts among home/school/internship/friends

Culmination  * Focus on feelings and express them
* Find satisfying ways to say good-bye to clients, staff, supervisor, and other interns

Reference:  Sweitzer & King's The Successful Internship (1999)
CALIFORNIA STATE UNIVERSITY, LONG BEACH
Department of Social Work

SCHOOL SOCIAL WORK and CHILD WELFARE and ATTENDANCE

REQUIRED ACTIVITIES

Applicants for the credential must have experience in working with at least two different school populations: elementary, middle, and high school; and with students of diversity which also includes regular and special education; Assess at least 10 students of a racial or ethnic background that is different from your own. A total of 450 hours is required for the School Social Work Credential with an additional 150 hours as preparation for the Child Welfare and Attendance Credential.

Required Activities:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td>At least 10 students of different racial/ethnic background</td>
</tr>
<tr>
<td>2</td>
<td>A minimum of 100 hours in working with a different school population</td>
</tr>
</tbody>
</table>

The following are recommended activities in which the applicant will participate:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Provide individual and family counseling</td>
</tr>
<tr>
<td>2</td>
<td>Make a classroom presentation</td>
</tr>
<tr>
<td>3</td>
<td>Observe at least one class, one playground period and lunch time to assist in assessment of needs.</td>
</tr>
<tr>
<td>4</td>
<td>Collaborate with key people including the principal, teachers and other support staff as necessary to meet the needs of the pupils.</td>
</tr>
<tr>
<td>5</td>
<td>Attend school team meetings i.e., SST</td>
</tr>
<tr>
<td>6</td>
<td>Attend at least one individualized Educational Plan meeting.</td>
</tr>
<tr>
<td>7</td>
<td>Attend at least one SARB meeting.</td>
</tr>
<tr>
<td>8</td>
<td>Participate in parent meetings, classes, etc., and if possible facilitate a parent group.</td>
</tr>
<tr>
<td>9</td>
<td>Do community networking, advocacy and provide referrals.</td>
</tr>
<tr>
<td>10</td>
<td>Facilitate a group of peer counseling, conflict mediation, anger management or other group.</td>
</tr>
<tr>
<td>11</td>
<td>Do home visits to assist in assessments.</td>
</tr>
<tr>
<td>Activities for Child Welfare and Attendance</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Goal is to reduce truancy and increase academic performance</td>
<td></td>
</tr>
</tbody>
</table>

1. Collaborate with Attendance Services as to job definition and field assignments.

2. Do home visits to verify addresses, address truancy issues, deliver correspondence, etc.

3. Participate in a seminar that identifies educational goals and laws as they pertain to attendance.

**Suggested Additional Activities:**

1. Participate in administrative and training meetings such as case consultation.

2. Attend at least one all-school staff meeting.

3. Present at least one client to a case consultation meeting or an intern support group.

4. Attend a PTA meeting.

5. Grant writing and program development.

6. Attend staff meeting and/or in-service training.

7. Crisis intervention.

Print Name:

Student's Name

Field Instructor's Name

Signatures:

Student Date: Field Instructor Date

F:\Marian's Files\My Documents\MyFiles\Forms\msw\PPS Required Activities 2004-05.doc 8/19/05
Psychosocial history

You can use some of the following types of questions in the course of your interview (Slattery, 2004). Your psychosocial history should follow this general format, with headers for each section. Here is an example of a psychosocial history.

<table>
<thead>
<tr>
<th>Problem</th>
<th>What symptoms does the person report? How severe are they? How chronic are they? When did they begin? How much are they interfering with functioning? Are they specific to certain situations or do they occur across situations? Because people often have difficulty reporting &quot;bad&quot; symptoms, be careful to assess major concerns, especially about suicide, rather than expecting clients to freely disclose them. Ask, What else?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current symptoms</td>
<td></td>
</tr>
<tr>
<td>Beliefs about symptoms</td>
<td>What are his or her beliefs about what is wrong? about the appropriate treatment for his or her symptoms? Does he or she expect to get better?</td>
</tr>
<tr>
<td>Personal history of psychological disorders</td>
<td>Has the person experienced symptoms similar to or different from current symptoms at some time in the past? What was helpful then? If he or she received formal treatment in the past, how might this affect current treatments? Were previous therapists respectful? hopeful? effective? empowering? Is current therapy an extension of previous work or, from his or her viewpoint, working on the same old issues?</td>
</tr>
<tr>
<td>Family history of psychological disorders</td>
<td>Does the person's family have a history of psychological disorders or symptoms? How did family members handle these problems? Specifically, was suicide used to cope with psychological problems?</td>
</tr>
<tr>
<td>Current context</td>
<td></td>
</tr>
<tr>
<td>Recent events</td>
<td>What negative or positive events have occurred recently at home, work, school, and in important relationships? What ongoing stressors are present in his or her life? Are reactions proportional or disproportional to the stressor?</td>
</tr>
<tr>
<td>Physical condition</td>
<td>Can any medical conditions account for the symptoms reported? Have these been ruled out?</td>
</tr>
<tr>
<td>Drug and alcohol use</td>
<td>Is the person taking any drugs (medicinal or recreational) that could cause symptoms? Is he or she taking any street drugs that could interact with medications prescribed to treat symptoms?</td>
</tr>
<tr>
<td>Intellectual and cognitive functioning</td>
<td>What are his or her intellectual strengths and deficits? Could symptoms be caused by cognitive deficits?</td>
</tr>
<tr>
<td>Coping style</td>
<td>Is he or she engaging in generally adaptive or maladaptive coping strategies? When is he or she most successful in coping with the problem? What works? Are coping strategies generally short-term or long-term solutions?</td>
</tr>
<tr>
<td><strong>Self-concept</strong></td>
<td>What are his or her beliefs about himself or herself (e.g., I'm helpless with regard to the winds of fate)? What beliefs about self or problems in the past are particularly helpful? Does he or she have a generally strong or weak sense of self-efficacy?</td>
</tr>
<tr>
<td><strong>Sociocultural background</strong></td>
<td>In what culture was this person raised? How long has he or she been in this country? Why did he or she come to this country? What are his or her connections to his or her homeland? What is his or her level of acculturation? What other group identifications (e.g., race, affectional orientation, gender, age, physical abilities, etc.) are most important? How does his or her culture or group influence reactions to symptoms? How does cultural background influence your assessment of symptoms? Could the behavior be &quot;normal&quot; in his or her culture and not in yours (or vice versa)? Could differences in group identification influence the nature and quality of your relationship?</td>
</tr>
<tr>
<td><strong>Religion and spirituality</strong></td>
<td>What (if any) religious affiliation does he or she report? Is it important to the person? How do religious beliefs influence current functioning? Do they provide a supportive network?</td>
</tr>
<tr>
<td><strong>Resources and barriers</strong></td>
<td>What does he or she do particularly well or feel good about? How can these attributes (e.g., persistence, loyalty, optimism, intelligence) be resources for treatment? How might they undermine it?</td>
</tr>
<tr>
<td><strong>Individual resources</strong></td>
<td>How supportive are your client's family, friends, and work relationships? Are they sufficient in both quantity and quality to meet your client's needs? Do they increase or decrease your client's stress levels? Do they empower your client or undermine him or her?</td>
</tr>
<tr>
<td><strong>Social resources (friends, family and school/work)</strong></td>
<td>What agencies (if any) are involved? How supportive are they? How well do they work together? Are they at loggerheads, undermining each other's recommendations, or do they generally share information in an open and collaborative manner?</td>
</tr>
<tr>
<td><strong>Community resources</strong></td>
<td>How does your client contribute to the community? Does this feel useful and meaningful to him or her? Are contributions acknowledged by important people in his or her support system?</td>
</tr>
<tr>
<td><strong>Community contributions</strong></td>
<td>What real, historical, or metaphorical figures serve as pillars of support or spiritual guides? How have they handled similar problems? Note: Some models may be primarily negative in tone. What are the positive aspects of these &quot;negative&quot; models?</td>
</tr>
<tr>
<td><strong>Mentors and models</strong></td>
<td>What things might serve as potential obstacles to change? These can be financial, educational, social, intellectual, etc. What does he or she believe will (or might) happen when change happens (e.g., marriage dissolves, family becomes angry, loses financial support, etc.)?</td>
</tr>
<tr>
<td><strong>Obstacles to change</strong></td>
<td>What sort of relationship do the two of you have? Can he or she be honest about symptoms, actions, side effects and concerns? Can he or she honestly disclose the level of compliance with your recommendations? Does he or she feel comfortable contradicting you or correcting any misassumptions you may have made?</td>
</tr>
<tr>
<td><strong>Therapeutic relationship</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Psychosocial History

<table>
<thead>
<tr>
<th></th>
<th>Excellent (A)</th>
<th>Good (B)</th>
<th>Adequate (C)</th>
<th>Below college level work (D-E)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td>History is complete, including both strengths and weaknesses of client. When weaknesses are identified, exceptions to the problem are also. Analysis is insightful and meaningful.</td>
<td>History is cursory, although central to the issues raised. Observations are often judgmental rather than descriptive.</td>
<td>Strengths and weaknesses are described in a dichotomous manner, rather than also noting exceptions to these. Good when? Problems with what exceptions?</td>
<td>History is superficial, with little new insight into the client.</td>
</tr>
<tr>
<td><strong>Hypotheses and inferences</strong></td>
<td>Appropriate inferences are drawn about the factors maintaining &quot;the problem(s).&quot; These are insightful, useful, and expressed as hypotheses rather than conclusions.</td>
<td>Observations are accurate, but not as insightful as I would have wished. You tease rather than satisfy!</td>
<td>Major symptoms are missed. All realms of functioning (cognitive, affective, behavioral functioning) are not described.</td>
<td>Paper either (a) does not help the reader understand the client, or (b) is off-track in its conclusions.</td>
</tr>
<tr>
<td><strong>Respectful and Empathic</strong></td>
<td>Observations are reported in strength-based rather than judgmental manner. Context is given for observations (e.g., recent death of partner, a court-ordered interview, a poor night's sleep etc.). Paper is respectful and insightful.</td>
<td>Paper is neither strength-based nor really judgmental, but tends to focus more on problems and ignore strengths.</td>
<td>Paper is judgmental. Context for behavior may be overlooked. While parts of the person's behavior are described well, I have a difficult time understanding the character based on your description.</td>
<td>Paper is judgmental. Client is not approached in an empathic or insightful manner.</td>
</tr>
<tr>
<td><strong>Technical Style</strong></td>
<td>Paper is logical, clear, and nicely written. Spelling, grammar, etc. has been proofed.</td>
<td>Paper is well organized and logical, but could use a second proofing.</td>
<td>Paper is weak, although there is a conscientious effort to understand the person, symptoms, and behavior.</td>
<td>Paper is illogical, poorly proofed, and poorly thought out; not performed at a college level.</td>
</tr>
</tbody>
</table>
SUIOCAL STUDENT PROCEDURES

These suggestions are provided to assist school sites in crisis intervention for students with possible suicidal ideations:

* Notify these people as soon as possible:

1. School counselor.* In the interview with the student the Counselor should determine if student has a plan and determine level of risk. They should remain with the student until the crisis is resolved. (consider checking purses, back-packs, pockets, etc. for weapons, pills or other dangerous objects)
2. Principal – Principal will notify Special Youth Services.
3. Parent or guardian (except if child abuse is suspected, then notify Child Abuse Registry for direction on how to proceed). Have the parent come to school to pick up the student. When the parent arrives inform parent that they may call 911 if they have concerns about their child while the child is at home.
4. Call Orange County Mental Health: Officer of the Day (577-5400) if the counselor determines that the risk is imminent or has concerns about releasing student to go home.
5. Special Youth Services: Psychologists will respond as additional support.

*Note: School counselors have the same training in crisis counseling as our school psychologists. In addition, we are fortunate because our school counselors have had training through ACCESS on this issue.

*Please Note: We also provide social services for families. Contact Don Baumeyer 999-3791 for Social Worker intervention as appropriate.

Warning Signs of Suicide Risk:

These signs are general in nature. Combinations of signs are often indicators of depression and possible risk.

- Verbal or written warnings (Act immediately)
- Change in eating and sleeping habits
- Withdrawal from family friends, and regular activity
- Persistent boredom
- A rapid decline in school grades
- Running away
- Drug and alcohol abuse
- An unusual neglect of appearance
- Difficulty in concentrating
- Radical personality change
- Constant complaint of physical symptoms often related to emotions
- Gives away personal belongings
- After a long period of depression, becomes cheerful

Stressors:

Stress in these personal areas can sometimes increase the risk of suicidal thoughts:

- Loss of significant person by death, divorce, separation
- Loss of important peer relationship/breakup of boyfriend/girlfriend
- Family issues (Alienation/rejection, turmoil, abuse, unemployment, violence)
- Recent involvement with the law
• Does not belong to an identified peer group
• Other stressors (history of learning disability, gender identification issues)

**DOs**

- **LISTEN** to what the student is saying and take her/his suicidal threats seriously. Many times a student may be looking for just that assurance.

- **OBSERVE** the student's non-verbal behavior. In children and adolescents, facial expressions, body language, and other concrete signs often are more telling than what the student says.

- **ASK** whether the student is really thinking about suicide. If the answer is "yes", ask how she/he plans to do it and what steps have already been taken. This will convince the student of your attention and let you know how serious the threat is.

- **GET HELP** by contacting a counselor, administrator, parent, (and Orange County Mental Health Officer if threat appears imminent).

- **STAY** with the student. The counselor should stay with the student. The student is placing their trust in you.

**DON'Ts**

- **DON'T** leave the student alone for even a minute.

- **DON'T** act shocked or be sworn to secrecy.

- **DON'T** underestimate or brush aside a suicide threat.

- **DON'T** let the student convince you that the crisis is over. The most dangerous time is precisely when the person seems to be feeling better.
Suicide Lethality Scale

1. Is the client male or female? (Females attempt more often. Males are more often successful.)

2. Look for periods of transition. (This is significant for mental health reasons.)

3. Evaluate current plan. (ie...what is the plan; is the method accessible; is the plan realistic; is the plan detailed indicating they have thought it through.)

4. Personal history of S/A's and depression.

5. How much energy do they have to execute the plan?

   going-down
   
   bottom
   
   coming-up

6. Family history of S/A's, especially successful attempts, and depression.

7. Religious affiliation and accompanying beliefs regarding suicide.

8. Previous coping skills and level of success.

9. Extensiveness of drug history. (Need to know what they know about drugs to determine level of sophistication.)

10. Who, if anyone, would they miss if they died? What, if anything, would they miss if they died?
Legal, Ethical and Clinical Implications of Informed Consent

by

Donald E. Baumeister

The concept of informed consent is an important one in the social work profession because it intersects with so many other legal, ethical and clinical issues. Informed consent can become part of the legal duty requirement in a malpractice claim, it forms a fundamental tenet of client self-determination, and it is mentioned in three of the NASW Standards for Clinical Practice. The Social Work Dictionary (3rd Edition) defines informed consent as the "granting of permission by the client to the social worker and agency or other professional person to use specific intervention, including diagnosis, treatment, follow-up, and research." Justice Cardozo stated the principle succinctly near the turn of the century when he wrote that "every human being of adult years and sound mind has a right to determine what shall be done with his own body."

Legal

Generally, in tort law a defendant may argue consent as a defense against plaintiff's intentional or negligent allegations except one may not consent to a criminal act. Several significant questions arise as to the consent obtained in a particular clinical context:

1) Was the consent valid (e.g., no fraud or duress)?

2) Was the consent properly obtained (e.g., intelligently made by a sufficiently clear detailing of the risks and rewards involved)?

3) Was the scope or boundaries of the consent exceeded?

4) Was the person giving consent capable of doing so (e.g., incompetent, inebriated, or an infant)?

Informed consent is a concept with both elasticity and continuity. Specific circumstances are critical to knowing the level of informed consent required. A defendant is generally not liable for intentional torts if the plaintiff expressly

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1 NASW Article: Informed Consent
agreed to the defendant's conduct with several exceptions. A mistake may undo an express consent if the defendant knew of or took advantage of the mistake. If the consent is induced by a misrepresentation which goes to the essence of the matter involved, the consent could be vitiated. Duress will invalidate the consent unless it refers to a matter in the future. Implied consent is that which a reasonable person would infer from common custom and usage or the plaintiff's conduct. Consent implied in law arises where some action is necessary to save a person's life or some other important interest.

When it comes to a minor consenting to outpatient counseling services, California has a specific Family Code Section 6924 on point:

"A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis...if both of the following requirements are satisfied:

(1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services...
(2) The minor (A) would present a serious physical or mental harm to self or to others without the mental health treatment or counseling..., or (B) is the alleged victim of incest or child abuse."

California even goes further in permitting counseling in schools under Education Code Section 4909.12:

"Nothing in this chapter shall be construed to affect a pupil's right or ability to obtain confidential medical care or confidential counseling relating to the diagnosis or treatment of a drug- or alcohol-related problem, or mental health treatment or counseling on an outpatient, without the consent of his or her parent or guardian."

At the same time a respect for self-determination needs to be balanced against protecting those who are not legally able to make decisions for themselves.

**Ethical**

The NASW Code of Ethics (1996) lists six social work core values which flow from its mission statement. These core values include the following: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These professional values are teamed with corresponding ethical principles. These principles are "ideals to which all
social workers should aspire." The first ethical standard which discusses ethical responsibilities to clients addresses informed consent [1.03a-f]. In summary, this section answers the initial inquiries and goes on to include "clients who are receiving services involuntarily" and through "electronic mediums."

Fundamental to any ability to choose and control care is access to essential information. Reinforcing such access are the concepts of informed consent, the right to review one's medical records, and the right to participate in one's own treatment planning (Encyclopedia of Social Work, 1995).

Additionally, in reaction to abuses found in research studies like the Tuskegee syphilis study or the Willowbrook institution in New York, protocols have been developed to require individuals participating in research to sign informed consent documents which include risks, benefits, purposes and procedures. The provision of informed consent also includes the knowledge that participation is voluntary and that participants can withdraw from the study at any time. The more dangerous the study, the more important it becomes to obtain informed consent. It becomes absolutely essential when participants may be exposed to serious risks or required to suspend their individual or civil rights. Typically, vulnerable persons include, at least, minors, those inflicted with the AIDS virus, and those in the criminal justice system (Encyclopedia of Social Work, 1995).

The patients' rights movement addresses the need for patients to be well-informed, active participants in medical decisions for themselves including the decision to refuse treatment. By the late 1980s, the right of competent adults to refuse treatment was well established. Bentley (1993) explored certain practice dilemmas that confront social workers especially in refusing unwanted psychiatric medication. She notes that advocating for a patient's right to refuse medication "makes sense for social workers legally, empirically, and ethically, especially in light of the profession's mandate to respect an individual's dignity and worth and right to self-determination."

Clinical

Informed consent for treatment and patient participation in decision making implicate social workers because of their role in facilitating communication and mutual understanding between patient and family professional caregivers. As part of informed consent interviews, social workers explore cultural, religious, and socioeconomic factors. Reamer (1987) contends that "practitioners must be sensitive especially to cultural and ethnic differences among clients related to the meaning of concepts such as self-determination, autonomy, and consent."
The three standards of clinical practice including numbers four, six and nine below, address informed consent for clinical social workers.

Standard 4: **Clinical social workers shall be knowledgeable about the services available in the community and make appropriate referrals for their clients.**

When the is client involved with more than one clinician, collaborative consultation shall be maintained as necessary to ensure delineation of the specific areas of responsibility. The clinician shall share information about a client only with the client's informed consent.

Standard 6: **Clinical social workers shall safeguard the confidential nature of the treatment relationship and of the information obtained within the relationship.**

Except for such clear and explicit duties, the clinical social worker shares information only with the written and informed consent of the client.

Standard 9: **Social workers shall maintain confidentiality in their relationships with youths and of the information obtained within that relationship.**

Except for federal, state, or local legal and other overriding requirements, the social worker will share information only with the informed and signed consent of the youth, the family, or both.

Conceptually, informed consent is a relatively simple process based on a social worker's legal, ethical and clinical responsibilities. However, the devil is in the details and each situation and circumstance must be approached with knowledge, clarity and common sense.
References


California Education Code Section 4909.12

California Family Code Section 6924


*Schloendorf v. Society of New York Hospital*, (1914) 105 NE Rptr 92


*Special thanks to LeRoy Kellogg, Esq. for his review.*

*Citation:* Baumeister, D. "Legal, ethical and clinical limitations of informed consent" *NASW California News, National Association of Social Workers, Sacramento, CA: Vol. 25, No. 7.*


5 NASW Article: Informed Consent
Therapeutic Jurisprudence:
Emerging Clinical Social Work Implications

by

Donald E. Baumeister

According to David Wexler and Bruce Winick, therapeutic jurisprudence is, simply stated, using the law to benefit others. Clinical social workers can, certainly, support this notion. However, learning what therapeutic jurisprudence is and its various social work applications forms the substance of this article.

Wexler and Winick expand on the term they coined early this decade by saying that "the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or antitherapeutic consequences" (1991) is the very essence of therapeutic jurisprudence. However, not everyone agrees with this approach. Thomas Szasz (1963) warned of unnecessary and ineffective psychiatric treatment throughout the 60s and 70s. Likewise, Nicholas Kittrie (1971) was highly wary and critical of the therapeutic state. Additionally, all those who are familiar with the well-intentioned benevolence of governmental power gone awry are certainly less than enthusiastic about punishment being called treatment and vice versa. The common critical axiom is framed thusly: absolute power corrupts absolutely; or more pointedly here: therapy corrupts the law while the law reinforces corrupt therapy.

The historical roots of therapeutic jurisprudence reach into the heart of social work practice. The articulated core values of the NASW ethical code -- service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence -- fit well within the mental health law origins of therapeutic jurisprudence. Therapeutic jurisprudence is something of a nineties phenomenon label. Supporters of this approach quickly moved from their mental health law beginnings and applied the principles of therapeutic jurisprudence to many other areas of the law including: criminal law, corrections, civil commitments of pregnant substance abusers, family and juvenile law, military law (Don't ask; don't tell policy), disability and health law, and many other areas as well.

Wexler (1990) recognized that "the law itself can be seen to function as a kind of therapist or therapeutic agent" focusing especially on the emotional life impacts it has on those who come in contact with it. He stated that therapeutic jurisprudence is "the study of the use of the law to achieve therapeutic
objectives." He summarized these goals into four topics of inquiry: (1) the role of the law in producing psychosocial dysfunction(s); (2) the therapeutic and antitherapeutic consequences of the law; (3) the clinical aspects of the legal system itself; and (4) the impact of judicial and legal roles. These four areas deserve the attention of social work researchers.

What It is Not

Therapeutic jurisprudence is not merely a recycled or repackaged label for "Law and Social Work." In the early 1970s, the National Conference of Lawyers and Social Workers developed a series of statements focused mostly in family law and public assistance issues (NASW, 1973). This booklet ignored the law as a clinical tool but focused on the areas of interaction between social workers and the lawyers. That analysis is currently inadequate but a "presumption then and now is that each [profession] strengthens the other through fellowship in common pursuit."

How is Therapeutic Jurisprudence Related to Clinical Social Work?

The advocates of therapeutic jurisprudence point to the famous California case of Tarasoff as an example of how clinical intervention can improve the outcome of client treatment. The traditional approach would be to respond to the unwanted duty requirements in a simplistic, legalistic, or passive-aggressive fashion.

A better social work example can be found in the universally mandated obligation to report suspected child abuse. The California requirement is found in Penal Code Section 11172. This duty can be fulfilled in a number of ways depending on several situational factors or circumstances including setting, clinician's ability, and type of abuse. But consider the following differences and clinical outcomes in reporting procedure perspectives:

Example A: Pam, a clinical social worker in a school setting, is asked to assess young Juanita, age 11, who she learns in the past week has been moderately physically abused by her stepmother. The conventional wisdom advises Pam to report the incident to the local Child Abuse Registry by phone immediately, keeping the referral source confidential from the family, while sending Juanita home to wait for the eventual knock-on-the-door intervention. Pam follows up the meeting with a written report within 36 hours.

Example B: In another version of this scenario, Pam learns of the abuse from Juanita and with her permission calls the stepmother at home and invites her to the school for an immediate meeting. The stepmother is
briefly evaluated during the family joining process and informed during the session that a child abuse report will be necessarily filed and that she has several options to consider prior to the emergency response worker's initial visit. The stepmother is informed that an important first step would be to become involved immediately in treatment services which address several presenting issues like her anger, parenting style, stress, and impulse control issues. The call to the registry is then made in her presence and the mystery of who made the report is never in question. The linkage to the referral source is cemented.

Example A seems to create as many clinical problems and legal issues as it purports to solve while Example B engages the family from the beginning of service delivery, makes the stepmother part of the solution not just the problem, and focuses on practical problem resolution by avoiding blaming the stepparent for hitting her child. Both scenarios meet the legal duty required by the reporting requirements but Example B meets the family's clinical needs in addition. It is important to keep in mind that everything a therapist does has clinical implications. For an expansive and detailed discussion of this issue, see Murray Levine's article (1996) on this topic.

Five Dilemmas to Ponder

Christopher Slobogin (1996) has laid out several paradigms and pitfalls of a therapeutic jurisprudence analysis.

1. **Identity** - The concept is so amorphous and broad that understanding what it is and what it is not is virtually impossible.

2. **Definition** - The words separately can be given understandable meanings but together they are unclear, untested, and maybe untrue.

3. **Empirical Indeterminacy** - How and what measuring device can be used to indicate "the therapeutic effect of a given rule."

4. **Rule of Law** - When mixed results are achieved, what conclusion is to be drawn as to the rule of law analyzed? Is it therapeutic or not?

5. **Balancing** - If a positive therapeutic effect is accurately demonstrated, how much weight should the rule be given in relationship to other rules of law?

Slobogin (1996) admonishes the naysayers with encouragement that therapeutic jurisprudence "will force policy makers to pay more attention to the actual, rather than the assumed, impact of the law and those who implement it."

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3 NASW CA News Article: Therapeutic Jurisprudence: CSW Implications
Remember to keep in mind an applicable oxymoron, "I'm from the government and I'm here to help you." Or if you prefer, its time to put mental health back into mental health law.

References

California Penal Code Section 11172


Tarasoff v. Regents of the University of California (1976) 17 Cal.3d 425, 131 Cal.Rptr. 14


4 NASW CA News Article: Therapeutic Jurisprudence: CSW Implications