RURAL SCHOOL PSYCHOLOGICAL SERVICES AND PRACTICAL GRADUATE TRAINING: A COOPERATIVE PROJECT

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Abstract

A rural school district with no psychological services and a nearby university education clinic designed and implemented a short-term clinical programme for the district schools. The clinic team consisted of graduate interns in school psychology, a university faculty member, and the district elementary supervisor. Objectives for the project were defined by the district and the university. Forty-one children were assessed and received follow-up treatment. Objectives for the project were evaluated and discussed. The rural placements where interns planned and worked in a programme with a district administrator and a university supervisor seemed to provide effective short-term service for the schools and a useful training experience for graduate students in school psychology.

Résumé*

Une école rurale sans service psychologique et une clinique avoisinante rattachée à une université créèrent un programme clinique de courte durée pour les écoles de la région. L'équipe de clinique comprenait des internes diplômés en psychologie, un professeur d'université, et le directeur d'éducation au niveau élémentaire du district. Les buts du projet furent définis par le personnel du district et de l'université. Quarante et un enfants furent examinés et par la suite traités. Les buts du projet furent évalués et discutés. Les emplacements ruraux où travaillaient les internes avec un administrateur du district et un professeur de l'université, semblèrent procurer un service efficace de courte durée pour les écoles, ainsi qu'une formation utile pour les internes diplômés.

BACKGROUND

Rural school districts in British Columbia commonly face lack of access to adequate psychological services. Though some rural districts employ a psychologist, difficult terrain combined with need for immediate service can make it difficult and expensive for one psychologist to perform effectively. Often, however, rural districts employ no one who is trained in diagnosis and remediation of children with school-related problems; and the community is forced to rely upon services from nearby cities, occasional visiting clinicians from mental health units, or university educational clinics. These options lack immediacy, tending to be both ineffective and expensive. Therefore, it seemed that implementing a programme for the assessment and remediation of children in rural districts which would provide immediate, effective, and inexpensive assistance within each school would be worthwhile.

The university faculty member who supervises school psychology graduate training is faced with providing meaningful internship experience in a variety of settings. Interns in a rural setting would likely encounter intervention problems different from those in districts where the school psychologist has a defined role and programme.

In our experience, interns placed in school districts with clearly defined psychological services had tended to adopt the specific routines of their supervising school psychologists. Interns' exposure to these delivery systems had often resulted in practical, useful training. What seemed lacking for them, however, was freedom to examine critical needs in the district as a whole, and opportunity to help design a framework for meeting those needs in conjunction with a district administrator. In short, we wanted our interns to have a direct hand in facing decisions that accompany the application of a new consulting system within a district.

The practice of school psychology has changed in the past few years in several ways as Bardon (1976) so clearly describes. He refers to the exciting potential of applied school psychology as being perhaps:

Footnote

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> the only speciality in psychology that gives serious consideration at any one time to almost all current practices in psychology, education and allied fields. . . . . If it is there to be tried, school psychologists will try it! (Bardon, 1976, p. 786)

So one general goal for interns was to give them a setting where they could be encouraged to apply the most appropriate intervention techniques available under responsible supervision from the university and the district.

A second overall goal through this setting was to help demonstrate to both interns and school personnel that there was *no* assessment procedure that would necessarily be applied to every referral. We formed some guidelines for assessment and intervention that reflected some of our own biases. (The interns and the district were then requested to form their own specific objectives, which appear later in this paper.)

1. Describing and alleviating the child's problem is priority through any appropriate means.
2. Forming and maintaining ongoing positive communication with central district administration and school staff members is critical.
3. Standardized testing is not always appropriate. In fact one of us has referred to school psychologists who test no matter what as "automatic black bag psychometricians" (Goetz, 1976).
4. Problem definition and clarification of data and recommendations with teachers must occur before written reports and follow-up.
5. School and community agency personnel are directly involved in treatment whenever possible.

The point of these guidelines was to form a procedural model that would help meet the mental health needs of the districts as a whole. At the same time we felt interns should learn that cooperation, communication, and rapport with district and community staff was necessary to meet those needs. Raquel Cohen (1975) had detailed a model for this kind of "co-professional collaborative school consultation," emphasizing that consultants must be aware that school system staff and mental health consultants operate from different conceptual systems. To be effective, the consulting programme "should include the objective of combining the expertise, skills, and energy of both" (Cohen, 1975, p. 213).

When this project began, the second author was elementary supervisor in a rural district without psychological services. The first author was supervising a laboratory practicum course for school psychology graduate students. The situation seemed to offer a realistic opportunity for graduate interns to help develop and implement an assessment and remediation programme with both authors.

Graduate students involved in this project included two masters' and four doctoral level interns. All had classroom teaching experience plus varying clinical experiences, ranging from special counselling and remedial teaching to previous employment as a mental health unit worker. All interns had graduate level training in individual intelligence testing. Four had advanced training and experience with additional psychometrics in areas such as projectives, perceptual-motor, and reading.

The school district is accessible from the university by a 50 minute ferry ride, stretched along a 60 mile coast line. There were 1,600 elementary students in nine widely separated schools, ranging from 12 to 425 children per school.

A survey of the district's past psychological services revealed that the need had become critical when the itinerant mental health clinic withdrew its services. During the previous year, six children received psychological assistance through referral to two clinics in the nearest city. These children were sent outside the district for assessment after waiting periods ranging from three to eight months. Treatment was limited to individual formal testing followed by detailed reports to teachers. There had been no contact with school staff during assessments and no follow-up consultation.

After reviewing this situation, we asked the district for help defining specific needs for a psychological services programme. District needs were determined from discussions with administrative staff, polling teachers' consulting with health unit personnel, and interviewing parents. Graduate interns' needs were determined through discussion with the students and their university faculty.

As a result of reviewing both district and intern needs, the school board accepted a contract with the University Education Clinic including initial pilot visits to define the programme, and 10 full-day visits spread over six months by the university clinic team. For the purposes of this project, "team" equalled both authors, and six graduate students enrolled in the university school psychology clinical practicum. The goal for each visit was to see six children, either as new or follow-up cases. The district budget for the venture included a stipend for a lecturer to relieve the first author from teaching one undergraduate course, $5.00/diem for the students; and mileage, transportation, and lodging for team members.

DISTRICT NEEDS AND CLINIC OBJECTIVES

After the past needs of the district were described, objectives were set by the team to meet each need. The following needs and subsequent objectives guided the clinic team in the definition of their programme:

1) *Need:* Referral procedure had been cumber-

some and time-consuming for teachers.
Objective: Simple referral procedures were designed so concerned teachers could telephone requests directly to the elementary supervisor.

2) *Need:* Long waiting periods for assessment had extended to eight months after referral.
Objective: The waiting period for assessment would be reduced to a maximum of two weeks.

3) *Need:* Teachers had been unable to translate detailed reports into specific programmes for classroom behaviour change.
Objective: Teachers would be provided with one or two-page point-form recommendations, formulated in a conference between teacher and clinician.

4) *Need:* Time lapse between assessment and written reports had frequently exceeded one month, sometimes lasting more than three months.
Objective: Immediate verbal suggestions for teachers on the day of assessment would be given, followed by short written reports within one week of assessment.

5) *Need:* Follow-up evaluation and revision of recommendations seldom had occurred due to the distance between clinic and school.
Objectives: Follow-up observations were planned for assessing and modifying (when necessary) remedial programmes in consultation with teachers. Verbal recommendations would be given during the consultation, followed by a one-page written progress report within a week. Termination of the case would depend upon satisfactory progress reports.

6) *Need:* Inadequate liaison had existed between medical and psychological personnel where organic difficulties and/or medication was concerned.
Objective: Initial conferences would be established with medical personnel, followed by frequent progress phone calls by the clinician to the nurse or doctor.

7) *Need:* Very few children had obtained help.
Objective: Help would be provided for 50 children over a six-month period. It was agreed by both the district and the clinicians that this goal would be sacrificed if other objectives were jeopardized.

These objectives were discussed and approved by the school board, principals, and teachers. From the discussions, an additional two-pronged objective was formulated. The clinical team would set a long term goal of replacing itself within two years by:

a) helping the district develop special programmes; and
b) encouraging the district to hire trained psychological personnel, preferably by subsidizing a qualified district teacher for graduate work in a clinical programme.

The second goal above was formulated because it seemed more sensible to identify a talented teacher who had been accepted as effective within the district and who was interested in advanced psychological training. In this way, if the programmes were successful, it would be possible for the team to move to another school district in the Province to begin a similar programme rather than encouraging the district to depend upon part-time university service.

GRADUATE INTERN NEEDS AND CLINIC OBJECTIVES

After interviewing interns and faculty, needs and objectives for graduate students were summarized:

1) *Need:* Students request varying "types" of cases.
Objective: Case assignments for each student would be varied over time using referral information from the district.

2) *Need:* Students requested experience with shorter reporting styles involving more contact with teachers and increased follow-up work.
Objective: Short, point-form reports written after consultation with teachers would be required. Each follow-up consultation would be summarized in a brief follow-up report.

3) *Need:* Faculty recommended close initial supervision of students by the first author on a case-teaming basis.
Objective: The first author would team at least two cases with each student in the initial stages of the programme.

4) *Need:* Faculty recommended close contact between students and the second author during visits to the district.
Objective: Whenever possible, the second author would give feedback to students regarding case decisions, reports, and programme revision during the lunch hour.

These objectives were discussed and agreed upon by graduate students, faculty, and the school district. We also decided to divide the six students into three teams, so that two students would travel together during each visit.

PROCEDURE

Each visit included classroom observation; teacher conferences; testing; checking medical, school, and home records; describing and discussing specific recommendations with teachers; often demonstrating remedial techniques before departing. Team visits were made every one to two weeks with phone contact in between.

As any school psychologist in a district knows, securing adequate teacher time during a clinical

visit to discuss and finalize recommendations is difficult because of school scheduling. In this case, the participation of the second author was invaluable. When a teacher did not have time to consult with the team, the elementary supervisor took over the class so that the teacher and clinicians had time to consult and confirm the next remedial steps.

To facilitate the written report, clinicians either left their reports in handwritten form with the school board secretaries to type, or sent them back to the district within 2-3 days in handwritten form. Because the reports were given priority by the elementary supervisor, they were typed and distributed immediately, with copies for the teacher, the supervisor, and the team.

Two actual reports (names and dates changed) from the project appear below to demonstrate the format for reporting that we chose. No attempt was made to make an all-encompassing set of remediation procedures for the child's problems at the first visit. Part of the reporting strategy was to enable us to approach priority problems first, and then to work on others using follow-up visits and short progress reports. Reports were delivered to both teachers within a week of the clinician's first visit.

The reports below were chosen to represent two approaches to assessment congruent with the consultation model described at the beginning of this paper: automatic testing is avoided; the child's present problem dictate the intervention procedure; all recommendations are discussed with and agreed to by the teacher and other appropriate persons before the report is written; and community workers are involved whenever appropriate.

In addition, the clinical team decided to protect confidential information about each child and family by eliminating most medical and personal (e.g., mental health) data from school reports. For example, Alec's report does not disclose his mother's three recent suicide attempts, and subsequent reports concerning family therapy would contain only what the medical unit chose to disclose to the school. Likewise, Sally's previous medical diagnosis of "minimal to severe brain dysfunction" would remain in the medical unit's files, available at the discretion of the school nurse.

We felt this confidentiality decision was especially important in the small rural community involved as long as specific medical and mental health contacts were named in our reports; the local medical personnel agreed to this arrangement.

U.B.C. EDUCATION CLINIC
INTERIM REPORT (1)

NAME: Alec Black, Grade Four
SCHOOL: Harris Elementary
TEACHER: Mrs. White
DATE:
BIRTHDATE:
CLINICIAN:

OBJECTIVES: Mrs. White reports that Alec has a history of low school achievement. Recently he has become increasingly truant (2-3 times per week), and has been acting out in the community to the extent that the R.C.M.P. are involved. His mother is described as currently being in severe emotional crisis. Alec is described as appearing very unhappy. Mrs. White has requested an intellectual assessment plus recommendations that can help Alec become a happier, less aggressive child.

BEHAVIOR DESCRIPTION AND RELEVANT DATA: Classroom observation and two individual interviews indicated that Alec is an insecure and frustrated little boy who is prone to acting-out right now. He is quite vulnerable emotionally and has limited resources for coping with stress.

Alec's primary difficulties at the moment seem to come from his family situation. For more information regarding the family, one may contact the Black's family doctor, Dr. _____ .

In class and with me, Alec responded very favorably to positive behaviors of verbal praise, acceptance, and warmth. His acting-out appeared to increase markedly in both situations from lack of success and non-positive behaviors.

Because Alec and I seemed to have developed satisfactory rapport after our second interview, I decided to administer the following standardized tests. Data from them should be interpreted as CURRENT level of functioning, from which to operate until his affective state has stabilized, at which time further assessment may be requested.

1. Wechsler Intelligence Scale for Children

Verbal Tests	
Information	6
Comprehension	6
Arithmetic	7
Similarities	5
Vocabulary	5
Verbal Scale IQ	74
Performance Scale IQ	79
Full Scale IQ	74
Performance Tests	
Picture Completion	10
Picture Arrangement	6
Block Design	7
Object Assembly	6
Coding	6

Alec is currently functioning within the educably retarded range, being surpassed by 95 percent of those in his age group. This means that Alec is currently capable of limited school progress — if he can advance one-half of a grade level each school year, then he will be likely working up to his capacity. Alec is not currently capable of anything approaching average school performance over the total school curriculum.

2. Wide Range Achievement Test

Reading Grade Level (Word Recognition)	3.6
Spelling Grade Level	2.7
Arithmetic Grade Level	3.9

RECOMMENDATIONS:

1. As Alec is achieving in school at the level roughly expected from children functioning at his current level, he should not be urged to perform at significantly higher levels until family problems stabilize and until he is then reassessed.

2. A family referral to the local mental health unit attached to the medical unit is in progress through this clinician and the family doctor.

3. In the interim, Mrs. White, the principal, and I have discussed ways for avoiding failure, social rejection, and negative criticism with Alec at school, as well as means for providing him with opportunities for a wide gamut of positive experiences with sharing, peer interaction, helpfulness, etc.

4. The possibility of having Alec join an age appropriate activity group outside class is being investigated by the school staff. Several options will be discussed in the next few weeks with Alec, and with the mental health worker.

5. I will follow-up the above recommendations with the medical unit, Mrs. White, and the principal in one week so that the above recommendations can be formalized and additional ones formulated if necessary.

The follow-up visit confirmed that all recommendations were finalized for Alec. Second conferences a month later with teacher and principal indicated that truancy had lessened, Alec was participating in a soccer team (where he was demonstrating a high skill level), and that the family had begun to see a mental health worker who had established contact with the school staff. At this point, the worker and the school were told to request further intervention from U.B.C. when they felt we could be useful for re-assessment of Alec's skills.

U.B.C. EDUCATION CLINIC
INTERIM REPORT (2)

NAME: Sally Smith, Grade One
SCHOOL: Harris Elementary
TEACHER: Miss Jones
DATE:
BIRTHDATE: December 6, 1970
CLINICIAN:

OBJECTIVES: Sally's teacher, Miss Jones, asked the clinical team to observe Sally on their one-day visit to the district. Miss Jones' specific request was that the team help her evaluate her program for Sally and suggest any specific changes that might help lengthen Sally's attention span.

BEHAVIOR DESCRIPTION AND RELEVENT DATA: Classroom observation by the team showed Sally exhibiting non-attending behavior (e.g., looking around the room) over 2/3 of the time. The longest time Sally worked on a teacher-assigned problem during the two 20-minute observation periods was 45 seconds. Each time there was a cough, laugh, or other sudden noise from children around her, Sally quickly turned her head toward the noise.

Miss Jones reports Sally is very excitable, has poor balance and uncoordinated movement, feels uncomfortable closing her eyes (especially when standing), has good auditory discrimination for initial sounds, and recognizes a few sight words. Sally's social skills are apparently much better than at the first of the year, and now, when she begins to move rapidly, laugh, or scream, the other children take her arm, lead her back to the group, and she becomes quiet again. When given a series of three simple directions, Sally can perform the first and sometimes tell Miss Jones what the second one was.

Background and medical data are available through Mrs. Black, the Public Health Nurse.

RECOMMENDATIONS: The team and Miss Jones decided to work on three behaviours with Sally as follows:

1. *Eye contact with teacher.* In class, Miss Jones will say to Sally several times, "I like it when you look at me when I talk to the class." When around Sally's desk, Miss Jones will praise Sally if eye contact behavior has increased, repeat the instructions if it has not.

2. *Number of directions Sally can follow.* In the gym, where Miss Jones works with direction-following through physical activities, most of the children in the class can follow three directions ("Hop to that wall, run to me, and sit down.") Sally, however, will be asked to follow one. Then she will be asked what the second is. Praise will follow her successes. Task difficulty will be increased slowly as she is successful to two, then three tasks.

3. *Task performance time.* In reading, Miss Jones will define a short portion of seat work that Sally can do (based on her 45 second observed performance). Then she will say, "If you do this much all by yourself without coming to me, you may _____ " (outline something she likes to do). If she does that, Miss Jones will begin a chart, with an animal sticker for each success as outlined, with the statement, "This is for doing your work all by yourself without coming to me." If Sally does not complete the task, or if she comes to Miss Jones during the process, she will not be allowed the agreed reward or given a sticker. Nor will Sally be scolded. Miss Jones will simply say, "Now, Sally, we will try it again," and repeat the direction, this time decreasing the difficulty of the task requirement. When Sally is successful, tasks will be increased slowly. Also, Sally will be assigned a "study booth" at the back of the room for this assignment.

The above plan will be tried for two weeks, then reassessed.

On the first follow-up visit, after Miss Jones had been trying the above recommendations for two weeks, Sally's attending behavior was up from 45 seconds to 7 minutes on task. She was watching Miss Jones every time she talked to the class. Her direction-following skills had not increased to three, but she could usually manage two if Miss Jones reminded her to look at her (Miss Jones) during the instructions. The clinician discussed these data in an interview with the teacher. A one-page follow-up report described these results to reinforce Miss Jones and encouraged her to maintain the program for the time being. Miss

Jones agreed to call the clinic team when it seemed revisions could be useful.

Termination of this case was made when subsequent follow-up reports seemed consistently positive and when there were no additional requests from Miss Jones.

EVALUATION

After the contract was completed, the district objectives were assessed. The second author administered verbal and written questionnaires to individual teachers who had made referrals to the team, relative to the first five objectives. Twenty-five teachers found the referral procedures adequate; two did not. There was unanimous approval of the reduced waiting period for assessment, with two requests for an even shorter waiting period. Teachers agreed that immediate verbal and written recommendations following each visit had been achieved. Three teachers suggested they would prefer detailed programmed remediation preferable to the short reports plus consultations with them for modification purposes. Twenty-one teachers approved of the reporting system, finding the termination satisfactory after several progress reports.

The authors, clinicians, and the medical personnel agreed that liaison between clinicians and medical personnel had been greatly improved. Furthermore, the amount of liaison increased as the project progressed. Both physicians and public health nurses indicated increased willingness to assist with referrals as the project continued. Conferences with nurses and doctors regarding student referrals became common toward the end of the project.

Forty-one rather than 50 children were assessed and followed-up during the project. Table 1 summarizes the number and "categories" of children seen over the six-month period.

TABLE 1
NUMBER AND "CATEGORIES" OF CHILDREN REFERRED BY TEACHERS

"Category"	*N*
Reading	20
Other learning difficulties	7
Behavior problems	8
Organic disability	3
Serious emotional disturbance	3
	41

Graduate students were interviewed by both authors throughout the project. At the beginning of the project students felt pressure from school staff to take extra referrals, particularly when the second author was unable to accompany them. This situation was used to discuss strategies a school psychologist can use with principals and teachers who need to learn what kinds of intervention are reasonable to expect within a limited time period in the best interests of the child. It seemed to us that making expectations congruent between school staff members and clinicians was critical to the reasonable success of this project, an issue that Bergan and Tombari (1975) have described, examined, and verified in clear and useful fashion for practicing school clinicians.

In interviews following the project, students reported they had worked with an insufficient variety of case "types" due to a preponderance of reading problem referrals. This point was used to encourage the district to hire trained remedial teachers for each school. Working with the short reports written after consultation with teachers was viewed as very positive, both in terms of experience with a different reporting style and its apparent effectiveness with teachers. The first author was able to team only one case with each student at the beginning of the project rather than two. During remaining visits, her role often included observation of students interviewing children, teachers, and parents. This decision was made because often the student clinicians would be working in teams in three different schools on the same day. It was usually possible to observe more than one team working for part of the day rather than teaming an entire case with clinicians in one school. In addition, the authors teamed four emergency cases which arose during clinic visits. We agreed, however, that students would have experienced more realistic training if we had included them in the four crisis cases which were located 16-20 miles away from where they were working. Such inclusion would have allowed them to make decisions about the casework that had to be postponed and to communicate those decisions to the appropriate school staff, a skill that any practicing school clinician knows is often useful! Close contact with the second author was perceived as extremely important by students, who felt they learned that co-operation and communication with central office school administration seemed to precede effective programme development and implementation in the district.

CONCLUSION

The project time in the rural district helped facilitate the hiring of a learning assistance teacher with special remedial training within each school so that referrals and remedial procedures could be more efficiently processed through that person. Primarily, the learning teachers conduct remedial reading programmes in each school. Additionally, the district agreed to sponsor a sound teacher with an outstanding record in the district through a Masters degree in Counselling and remediation at the graduate level, who is now full-time back in

that district. During the year he was in training, the district paid for a counselling graduate student's internship in the district, supervised by the first author. The district has now hired a full-time person with psychometric and remediation skills.

Finally, the second author left the district at the completion of this project to do a doctoral degree. Though the clinic team made fewer assessments during the following year on request by the new administration, the communication, co-operation, and organization that had existed the previous year was seriously impaired. To us, this was another indicator of the importance of a key district administrator's direct co-operation in "visiting" psychological programmes. Perhaps Gallessich's (1973) warning that central administrative changes in a district produce a period of "uneasiness and stress" (p. 58) is also important for the continuance of programmes like the one described here.

Optimistically, however, our long-term goals were met, and the district now has its own psychological services, allowing us to move along to another district. We still return to the district for one-day in-service workshops.

One such workshop is worth noting. We had noted that there were about six deaf children ranging from pre-school to high school age. These children had no special educational facilities or expert help in the area. A deaf education expert from our university spoke to the remedial teachers, the children, their parents, several Public Health nurses, the superintendent, and two board members for a day. As a result, the district employed on a part-time basis through Provincial funding, a graduate student in deaf education.

At this time, the U.B.C. Education Clinic has had contracts with seven rural British Columbia school districts ranging from 50 to 850 miles from the campus. These contracts are designed to provide interim psychological services for schools along with rural training for school psychology interns. Two kinds of internships are pre-requisite to rural placement. These include individual case work in the Education Clinic and internships with local school psychologists whose role and programme are clearly defined. We feel the addition of the rural internship contributes to the student's ability to function as what Vane (1973) has named a "change agent". The change agent is the school clinician who has the ability to introduce change "without causing chaos and disturbing teachers, staff, parents, and children" (Vane, 1973, p. 159) perhaps the contemporary school psychologist's most trying task.

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