Enhancing Services: Enhancing Success

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OSSTF / FEESO

A research report commissioned by the Ontario Secondary School Teachers' Federation

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Improved Outcomes for All Students: Enhancing the Role of Professional and Paraprofessional Student Support Service Practitioners

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About The Researchers

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Introduction

In an increasingly complex society, the ability of public schools to meet the wide array of student needs is continually being challenged. The provision of adequate resources is essential. Educational resources can be grouped into the "hard" resources including the building and its facilities, learning materials, and textbooks and the "soft" resources typically identified as people. The "hard" resources are only effective if used by adequate numbers of staff (soft resources) including competent and committed teachers, administrators and support services personnel.

Background

This research report represents the culmination of more than a year of research. Phase 1 began as a review of professional student support services in special education. The original research design planned for data collection through surveys and interviews. Five themes guided the development of these instruments. The themes matrix in Appendix 1 cross references the guiding themes to the data collection instruments. However, few school boards approved the application to conduct research with their staff. The research design was then modified to collect field data through focus groups. Six school boards gave permission. In situations where the school board gave permission, the focus groups were held within the regular day on school board premises. When permission was denied, the focus groups were held outside the regular day and off school board premises. Consequently, Phase 1 of the research included a review of the literature and collected field data from nineteen (19) small focus groups in various geographic regions of the province. The literature review concluded that a need exists for Ontario-based research related to best practices in service delivery. The focus group research found that across Ontario school boards' service delivery by board employed staff was complex, inconsistent and not specifically restricted to students with special needs. A wide range of service delivery exists from assessment only to models that include consultation services, participation in multidisciplinary team activities, group or class preventative programs and intervention with individual students, teaching staff and parents. The preferred model is to deliver services in the school. A significant difference was noted in the level of complexity and number of outside agencies that exist in each community between northern and southern Ontario boards. Increased population results in increased complexity.

The focus group research found that across Ontario school boards, service delivery by board employed staff was complex, inconsistent and not specifically restricted to students with special needs

When the services of outside agencies enhanced or extended school based services, they were welcomed. Concerns were expressed when government initiatives target a specific population or service that was offered by community agencies, the initiatives may not meet the needs of students.

See Appendix 1 for a summary of this research. Phase 1 concluded in May, 2007. From the data gathered in Phase 1, a set of basic assumptions about service delivery were developed. These basic assumptions are:

- The school should be the point of access for services for students.
- The presenting student need determines the range of services that boards must provide. Boards should make every effort to have their own staff.
- Professional and Paraprofessional Support Services (PPSS) should be delivered by board employed professionals, complemented by the services of community agencies.
- PPSS practitioners possess a knowledge of school and board based services, the unique problems of a school environment and are able to provide a broad range of services that are strategic and effective.
- Services should not be limited to students identified as exceptional within special education.
- Minimal delays should be experienced by students/parents in accessing services.
- Student success should be defined broadly (i.e., not based solely on academic achievement).

During Phase 1, it quickly became evident that PPSS were not limited to students with special needs. In addition, there was a great range in the number of board based PPSS practitioners and great diversity in their role descriptions. Complex and inconsistent patterns of service delivery were evident across the province due in part to the ab-

sence of any clear current policies from the Ministry of Education.

In the interval between Phase 1 and Phase 2, there was encouragement from the Ministry of Education to develop and submit a best practice model for the provision of PPSS. In this research professional denotes that the employee is registered with a professional college. These services include, Occupational Therapy (OT) and Physiotherapy (PT), Speech Language Services (SLP), Psychological Services (PS), and Social Workers (SW). In this research, the paraprofessional category includes, but is not limited, to Educational Assistants (EA), Child and Youth Workers (CYW), Child and Youth Counsellors (CYC), Communication Assistants (CA), Behavioural Counsellors (BC), Attendance Counsellors (AC), and Developmental Service Worker (DSW).

The Ontario Secondary School Teachers' Federation (OSSTF) contracted the researchers from Phase 1 to conduct a research study to determine the elements of a best practice model of service delivery based on the expertise of frontline professionals in Ontario and supported by existing research. The basic assumptions from Phase 1 framed the current Phase 2 research study.

The following literature review summarizes the American and Canadian societal context, describing the societal trends that are indicating a need for schools to develop school based services to support academic achievement. A description of the current Ontario context and current Ministry of Education initiatives illustrates a need to develop provincial policies governing professional and paraprofessional school based services. The current research study fills a need for Ontario based research using data from field based practitioners.

Literature Review

Social and Emotional Challenges for Students

Evidence from national and international studies indicate that challenges to children's social, emotional and mental health and well-being today are complex, intense and reaching epidemic levels (McNab & Coker 2006). Crockett, (2004) identified a list of critical issues facing children in the 2000s. These included abuse and neglect, child poverty, violence, bullying and harassment, teen pregnancy and early sexual encounters, alcohol and drug abuse, mental health issues and lack of services. According to a United States poll of children in 2004, 86% of more than 1,200 nine to 13-year-old boys and girls polled said they've seen someone else being bullied, 48% said they've been bullied, and 42% admitted to bullying other kids at least once in a while (Canadian Children's Rights Council, 2005.) Additional issues include the exposure through the media to sensational or traumatic events (McNab &Coker, 2006), bereavement, and divorce (Marquardt, 2006).

According to the *1999 Surgeon General's Report on Mental Health* and the *2000 Report of the Surgeon General's Conference on Children's Mental Health*, one in five children and adolescents have emotional or behavioral problems sufficient to warrant a mental health diagnosis (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007).

School aged children in Ontario are experiencing the same critical issues at alarming rates. Canadian statistics report a child maltreatment incidence rate of approximately 38 per thousand children (Public Health Agency of Canada, 2003). Child maltreatment includes exposure to domestic violence, sexual abuse, physical abuse and neglect. Ontario's increasing child poverty rate now stands at 17.4%[1]. Bullying is widespread. According to the Centre for Addiction and Mental Health (CAMH), one third of students are being bullied at school and almost a third of students report having bullied someone else (Adlaf, Paglia-Boak, Beitchman & Wolfe, 2005). Bullying includes physical assault, ethnic and racial discrimination, rumour victimization, sexual harassment and verbal assault. Chil-

1 www.uwgt.org/whoWeHelp/reports/losingGround.php. (2006)

dren who bully or are the victims of bullying may experience a range of psycho-social problems that may extend into adulthood (Ministry of Education, 2007[2]; Schonert-Reichl, & Hymel, 2007).

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The Canadian Institute of Child Health (CICH) reports that by 11 years of age, 16% of boys are exhibiting direct aggression toward others and 14% of girls are practicing social exclusion. Thirty-seven percent of children aged eight to 11 are too fearful or anxious according to their parents. A substantial number are demonstrating conduct symptoms, destroying things or are engaging in violent altercations such as school yard fights. Twenty four percent of males and 17% of females between the ages of four and eleven demonstrate symptoms related to hyperactivity or emotional disorders. Twelve percent of girls and 6% of boys between the ages of 15 and 19 experienced at least one episode of major depression (Robertson, 2000). Reports suggest that approximately 20% of children and adolescents in Canada experience mental health problems severe enough to warrant mental health services. The CAMH (2002)[3] reported that one in 20 senior elementary and secondary school aged youth reported psychological distress and hazardous drinking. One in three students reported elevated psychological distress and depression. For youth, common mental health problems are depression, social anxiety, post traumatic stress, conduct disorders and eating disorders. Children's Mental Health Ontario (CMHO, 2000) reports that one in five children under 19 (school aged children and youth) has a diagnosable emotional, mental or behavioural disorder, and struggles with their mental health.

Based on Canadian statistics, one third of marriages will end in divorce[4]. Most children are able to cope with divorce, but some require more help. Research finds that there is no consistency in children's long-term or short-term coping abilities and some will require specialized intervention (Hope & Hodge, 2006; Niolin, 2003).

There is a causal connection between media violence and aggressive behavior in some children (Jaffe, 2007). Children have increasing access to violent material through multiple sources including the Internet, video games, television, movies, sports and music (Jaffe, 2007). There appears to be an increased gun violence among youth (Fagan & Wilkinson, 1998). Increases in aggressive attitudes, values and behaviour are measurable and long lasting. Exposure to violence has been linked to post-traumatic stress disorder (Ruchin, Henrich, Jones, & Vermeiren, 2007).

In addition to the critical issues in society, some groups of students face other challenges to their social, emotional and mental health and well being. Exceptional students are especially vulnerable not only because they may experience the critical concerns that threaten many students of school age today, but also because of the unique academic and social and emotional challenges often associated with exceptionalities. In Ontario, students with identified special education needs comprise almost 14% of the student population (Drewett, 2007). Exceptional students, by definition[5] experience challenges to their physical, communication, intellectual, developmental or language development. Many exceptional students have difficulties with social skills. Studies show a relationship between poor social skills and students with Attention Deficit Hyperactivity Disorder (ADHD) or learning disabilities (Bauminger, Edelsztein, Morash, 2005; Landau & Moore et al., 1991). Social skills may include social competence (Landy, 2002), learning how to regulate personal behaviour and developing cultural competence (Klostelnik, Whirin, Soderman, Stein, and Gregory, 2002), recognizing and managing emotions, and forming and maintaining friendships (Gordon, Feldman & Chiriboga, 2005). Hammet, (2006) discusses the coincidence of learning disabilities and mental health concerns, noting that up to 60% of adolescents in treatment for substance abuse have been identified with

2 Policy Program Memorandum No. 144/2007(Bullying Prevention and Intervention)

3 According to the 1999 Ontario Student Drug Use Survey

4 www.divorcemag.com/statistics/statsCAN.shtml

5 The Ministry of Education identifies five broad categories of exceptionality. These categories are physical, behaviour, intellectual, communication, and multiple.

learning disabilities. Ferguson, Tilleczek, Boydell, & Rummins, (2005) identified that students with disabilities often coped with poor academic performance and low levels of self-esteem.

Approximately 7% of exceptional students have been identified with a behavioural exceptionality.[6] Conditions frequently leading to an identification of this exceptionality include ADHD, oppositional defiant disorder, anxiety and phobias, socialized aggression, suicidal tendencies, depression, and emotional disturbances. Students exhibiting these behaviours often require counselling and treatment.

Implications

Emotional, behavioral and psychosocial problems disrupt functioning at home, in school and in the community (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007), affect learning outcomes (Gable & Van Acker, 2000), and student engagement and graduation rates (Ferguson, Tilleczek , Boydell, & Rummins, 2005). Approximately 50% of early school leavers identified in a national sample had severe emotional and mental health problems (Ferguson, Tilleczek et al., 2005). Ferguson, Tilleczek et al., (2005) identified that early school leaving was often associated with student disengagement and engaging in risky activities such as running away from home, being homeless, aging, and sexual relations at an early age. Hammet, (2006) clearly shows there are significant negative economic and social consequences of learning disabilities and mental health concerns.

Studies show that exceptional students whose social skills were not addressed experienced serious consequences resulting in social exclusion, rejection (Glasberg, 2000; Gresham & Reschly, 1986; Stuart, Gresham & Elliott, 1991), social isolation (Denha, Hatfield, Smethurst, Tan, & Tribe, 2006), were victims of bullying (Baaron-Cohen, 2000; Whitney, Smith, & Thompson, 1994), experienced mental health problems and loneliness later in life (Parker & Asher, 1993), and experienced depression (Vickerstaff, Herriot et al., 2007). Students with disabilities are at risk for early school leaving because of poor academic performance and low levels of self-esteem (Ferguson, Tilleczek et al., 2005). Hammet, (2006) cites that 10 to 12 % of adolescents with learning disabilities become involved with the criminal justice system. Cole & Brown, (2003) reference research indicating that children with early signs of academic and social difficulties are at risk for problems later on in life if effective intervention is not provided (p. 39).

6 Ministry of Education Statistics 2004.

A growing body of research identifies the relationship between social and emotional well being and learning for all students (Schonert-Reichl, & Hymel, 2007; Elias, O'Brien & Weissberg, 2006; Zins, Weissberg, Wang &Walberg, 2002; Evans, Axelrod & Sapia , 2000). Emotions can facilitate or hamper student learning and their ultimate success in school. If children's social and emotional needs are not met, they are poorly prepared to learn academic skills (Koller & Bertrell, 2006; Norris,2003; Gable & Van Acker, 2000).

Growing recognition that some school aged children and youth require assistance to cope has prompted educators to implement programs targeting social, emotional, relationship, mental health, behaviour and self esteem issues. However, these programs are often seen as secondary to the school's primary focus on academic learning (McCombs, 2004).

These preventative programs are important but do not address students who are at risk for developing, or are displaying maladaptive behaviours because of the issues they already face (Baker, Kamphaus, Horne, & Winsor, 2006). These students require timely assessment, and more intensive counselling, treatment, therapy, health, behavioural and academic support through school based services. School based services generally refer to programs and practices available through the school or school district that address the broader social, emotional, and mental health needs of students.

The Development of School Based Services

Schools are a natural setting for supporting students' needs because schools are where children spend most of each day (Koller & Bertrel, 2006; Evans, Axelrod & Sapia, 2000). Evans, Axelrod and Sapia, (2000) offer two additional reasons for school based services delivery. First, the availability of community based services is declining and secondly, that school based, rather than clinic based treatments have a far greater rate of success. Dryfoos, (2002,1996) indicates that school based services are accessible, convenient and confidential. There is increasing recognition that mental health services delivered through community centres, hospitals and private offices are unlikely to be accessed by most families due in part to barriers which include limited knowledge of their availability, stigma and stereotyping of services, logistical accessibility including wait times, and most importantly, financial constraints (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007). Unfortunately, schools often lack the resources to handle the full range of mental health conditions presented by students and so partnership arrangements are created (Brener et al., 2007). Today's educational environment is complex and a collaborative approach is necessary to positively impact the health of all students (McNab & Coker, 2005).

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In many jurisdictions in the United States, the most common model sees mental health and social services provided through school based health centres within schools or through arrangements to provide the services off site within the community (Brener et al., 2007; Cuglietto, Burke, & Ocasio, 2007). These arrangements have often been called "full service schools" (Dryfoos, 1996, 1993) or a "Coordinated School Health Model" (McNab & Coker, 2005).

In many jurisdictions in the United States, the most common model sees mental health and social services provided through school based health centers within schools or through arrangements to provide the services off site within the community

Within this conception, the school offers the facility within which the community resources deliver their services. Delivering the services in the schools is seen as a cost effective strategy (Rusk, Shaw & Joong, 1994) and enables children to continue to participate fully in their communities. Advocates argue that attendance, graduation rates and reading and math scores have risen (Dryfoos, 2002).

Pivotal to the success of this model is the need for a full time coordinator to avoid overlap, duplication or information loss, staff stability and continuity (Dryfoos, 1996). Students' needs determine which services the school coordinator invites in to deliver the service. Another necessary element for success is that the service providers share common goals with the school (McNab & Coker, 2005).
Despite these benefits, this model for school based services has serious limitations. A full range of services is not available to all schools, therefore, the services are highly fragmented and unpredictable, resulting in the marginalization of these services in school policy and practice (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007). Further, some arrangements exist where the community school health staff are volunteers or interns or serve only part-time (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007). These are serious barriers to effective, predictable service for students.

The full service school model developed by Rusk, Shaw & Joong, (1994) attempted to describe a full service school that was responsive to the political, social and educational context of Ontario. The model envisions a team of educational and non-educational staff with a shared vision and a commitment to creating the services necessary to meet student needs. Linkages to other community services are created when the school team cannot provide the services. Clearly, the students' needs are central and the school team coordinates the service delivery. However, the range of services suggested is far fewer than the range of PPSS professionals that serve students in some Ontario school boards today. Secondly, the Rusk, Shaw & Joong, (1994) model is situated within a secondary school context. Today, students in elementary schools also need support services and a best practice service delivery model must account for these needs.

The Need for Services in Ontario

Many factors are pointing to the need to develop a coherent, province-wide service delivery model for PPSS. The range of critical issues students face is increasing (Crockett 2004). Many exceptional students have problems with social skills that need intervention. Canada's Standing Senate Committee on Social Affairs, Science and Technology report *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, (2006) , hereafter named *The Kirby Commission* recommends that mental health services for school aged children be provided in the school setting by school based mental health teams. The CICH (Robertson, 2000) and *The Kirby Commission*, (2006) identify that students' problems need urgent attention.

Many classroom based preventative programs delivered by teachers are available, but have not been proven to completely address students with mental health issues, who are engaging in high risk activities or who are demonstrating maladaptive behaviours due to the sociological issues they currently face, whether inside or outside of the school system. Nor do these programs address students who are at risk for developing, or are displaying maladaptive behaviours because of the issues they already face (Baker, Kamphaus, Horne, & Winsor, 2006). These students require timely assessment and more intensive counselling, treatment, thera-

py, health and academic support best delivered by PPSS who have specialized training in these areas.

School boards in Ontario are inconsistent in the provision of school based services. Some school boards offer a full range of professionals and paraprofessionals, while in other school boards, the services are marginalized or are only available through fee-for-service contracts with local community agencies. In a context where the scope and intensity of issues facing school aged children is increasing, there is no consistent, coherent, clearly articulated service delivery model in Ontario.

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Current Ontario Context

The Ministry of Education has articulated a goal of supporting students' social and emotional needs and also the goal of raising academic achievement. Despite research evidence of the link between social and emotional well being and academic achievement, the Ministry has failed to develop a strategy to connect these two goals.

The Ministry of Education has publicly recognized the importance of supporting students' social and emotional needs. The previous Education Minister, Gerard Kennedy, announced financial support for the *Roots of Empathy*© Program in 2004 declaring that "Enhancing children's emotional skills has been shown to reduce bullying and violence in our schools and makes students more ready to learn other skills, like literacy and numeracy" (Canadian Newswire, May 7, 2004).

The goal of the *Roots of Empathy*© program is to "build caring, peaceful and civil societies through the development of…respectful and caring relationships" (Kelders & Celenza, 2007; Schonert-Reichl & Hymel, 2007). Michael Fullen, professor emeritus, OISE/University of Toronto wrote that "the heart is the way to the mind" (Kelders & Celenza, 2007, p. 38) thereby clearly articulating that social and emotional literacy is foundational to academic literacy. In addition, the Ministry of Education currently supports *Student Success* and Character Education.

The support for the Character Education Initiative in 2006, and again in 2007 was supported by a rationale that "education is about developing well rounded citizens" (Canadian Newswire, 2006). The Character Education Initiative's goal is to develop good character in young people who will become responsible and caring citizens[7] and emphasizes the attributes of social responsibility and empathy. Character Education is closely associated with the work on Emotional Intelligence (EI) defined by Daniel Goleman (Schonert-Reichl & Hymel, 2007). According to Goleman, the four domains of self awareness, self management, social awareness, and relationship management are learned competencies and are an important determinant in relationship and job success. A growing emphasis on social and emotional learning programs is growing in popularity throughout the world (Schonert-Reichl & Hymel, 2007; www.casel.org). Character Education and the *Roots of Empathy*© programs show that how we feel about ourselves, our relationships and our environment is fundamentally important to learning (Schonert-Reichl, & Hymel, 2007).

The Ministry of Education has articulated a goal that 85% of students will graduate by 2010-2011.[8] Consequently, a consistent focus remains on improving student achievement. The goal of raising academic achievement is supported by the Literacy and Numeracy Secretariat, and the *Student Success* initiative. These initiatives focus on increasing literacy through the use of effective classroom instructional strategies, appropriate resources, providing professional development to teachers and

7 Merle Schwartz, Director of Education and Research. www.edu.gov.on.ca/eng/literacynumeracy/SchwartzWork.pdf

8 www.edu.gov.on.ca/eng/parents/studentsuccess.html

developing effective leadership (Hine & Maika, 2007).

Student Success programs for students in Grades 7 to 12 focus on addressing individual differences in motivation and capability through changes to instructional strategies that are linked to improving student engagement and therefore potentially improved academic success. Providing programs to all students to address individual differences in motivation and capability (Schonert-Reichl & Hymel, 2007; Adelman & Taylor, 1993) are important preventative strategies (Koller & Bertrel, 2006; Elias, Arnold, Steiger-Hussey, 2003). However some students will experience other issues that require more than preventative strategies.

A recent policy has the potential to increase the need for school based PPSS practitioners. In December, 2006, the compulsory school attendance age was raised from 16 to 18 or until the student earns the Ontario Secondary School Diploma. This would mean that the current Ontario dropout rate would drop from 25% to about 23-24%.[9] There will remain a group of students who drop out for a variety of reasons including mental health concerns, significant social and emotional concerns, a school to work career choice, significant academic challenges, serious chronic medical issues, disruptive family issues, pregnancy, issues of sexual identity, and involvement in criminal activity (Dufferin Peel Catholic District School Board, 2007). Predictably, there will be a significant increase in workload relative to this initiative as social workers and attendance counsellors will be required to demonstrate active outreach and intervention efforts for these students for an additional two years of their schooling.

Two recent Policy/Program Memoranda, Policy/Program Memorandum 145/2007 (Progressive Discipline and Promoting Positive Student Behaviour), and Policy/Program Memorandum 144/2007 (Bullying Prevention and Intervention) require schools to engage in prevention and early intervention strategies to create a positive school climate. Teachers, administrators, professional and paraprofessionals are identified as important to developing a positive school climate based on all personal relationships in the school. However, the examples of preventative and interventionist strategies are limited to education programs and using the services of community agencies. These policy documents fail to acknowledge that many school boards currently employ professionals and paraprofessionals who provide a range of preventative and intervention services.

Two Ministry publications, *Education for All: The Report of the Expert Panel on Literacy and Numeracy Instruction for Students with Special Educational Needs*, (2005) and *Special Education Transformation*, (2006) recognize that educators need to work in collaboration to develop the full potential of every child. However, in these reports, the collaboration is between professionals and educators. The in-school team described in *Education for All* is composed of educators. The out-of-school team mentions specialized professionals, but not paraprofessionals. By neglecting to mention the range PPSS practitioners and their work with students, the reader might assume then, that these services are non existent or considered peripheral and inconsequential.

Assuming that special education services will respond to these issues is misguided. Some students do not qualify for special education assistance because the symptoms are not severe enough or specific enough to meet the criteria of existing mandates (Baker et al., 2006) and the necessary services to assess are not readily available within the confines of the school. In addition, many of the issues that students face are not associated with an

9 The C. D. Howe research report, 2005 found that the drop out rate decreased by 1.2 and 2.1 percentage points when school leaving age was increased above 16.

exceptionality but could be related to social and emotional development, mental health or engaging in high risk behaviours (such as running away from home, being homeless, engaging in sexual relations (Ferguson, Tilleczek et al., 2005). Preventative activities are not enough for students who are unable to cope with the issues they already face.

The *Annual Report of Ontario's Public Schools, (2007)* by People for Education cites disturbing statistics collected in Toronto in 2006, concerning the shortage of in-school support for students.

- Only 34% of secondary schools had a regularly scheduled psychologist and they were available an average of 14.6 hours per month.
- Seventy-six percent of secondary schools had a regularly scheduled social worker, but they were available on average less than 10 hours per week.
- thirty-nine percent of Toronto secondary schools have a regularly scheduled youth worker, they were available an average of 76.5 hours per month.[10]

Falconer, Edwards, & MacKinnon, (2008) report that the Toronto District School Board (TDSB) is unable to successfully address the needs of "more marginalized youth who are not engaged and who are not succeeding academically."[11]

A survey completed by the Toronto District School Board on Support Services (Social Work & Attendance, Speech-Language Pathology, Occupational & Physiotherapy and Psychological Services) reports that educators placed a high value on these services. In addition, staff suggested that more PPSS staff are needed "to serve a wider number and variety of students" (p. 6).

Developing an Effective Model for Ontario

Evidence shows a recognition of the value of PPSS and an increasing need for these services. A coherent, comprehensive policy in Ontario for the delivery of school based PPSS is urgently needed. Present school based team arrangements in the United States show that a collaborative effort between educators, professionals, paraprofessionals and community agencies yields positive results. Transplanting the models that currently exist in the United States to the Ontario school system is fraught with potential problems. The arrangements currently in use in many states are resulting in unpredictable and marginalized services (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007). The full service school model developed in 1994 by Rusk, Shaw, & Joong is no longer relevant to today's political, social and educational context in relation to the 21st century student. Paternite, (2005) states that practice-based evidence is as important as evidence based practice (p. 659). This research represents the integration of practice based evidence and current research. Brener et al., (2007) identify that no one best practice model exists for the delivery of school based mental health services. Nevertheless, a best practice model for Ontario should reflect the current context.

Evidence shows a recognition of the value of PPS Services and an increasing need for these services. A coherent, comprehensive policy in Ontario for the delivery of school based PPS Services is urgently needed...

10 Media Release January 11, 2008. Downloaded January 11, 2008 from www.peopleforeducation.com/urbanschools08

11 P. 4. Executive Summary The Road to Health: A final report on School Safety. Downloaded January 11, 2008 from: www.tdsb.on.ca/wwwdocuments/about_us/media_room/docs/SCSAP_Executive_Summaryb.pdf

Purpose

The following research outlines the critical elements of a best practice model for the delivery of professional student services in the schools of Ontario. This qualitative research study used an adapted focus group methodology to collect practice based evidence from school based frontline practitioners.

Methodology

An adapted focus group methodology was used (Fern, 2002; Krueger, 2000; Kitzinger, 1995; Morgan, 1988). Focus group research is disciplined inquiry that seeks to provide understanding and insight into a research question (Fern, 2002).

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One activity designed for Day 1 was pilot tested (Fern, 2002) with a group of about 20 union presidents from the Ontario Secondary School Teachers' Federation (OSSTF) approximately three weeks before the actual two day session. This Sector Council of Professional Student Services Presidents were asked to complete one sample activity and then to provide verbal and written feedback on the degree to which the activity's structure and guiding questions were clear and would potentially provide appropriate data to answer the research

Focus group research is often assumed to be limited in the ability to generalize from the sample to the general population. Fern, (2002) identifies that focus group results become more generalizable when the participants represent the relevant population and when the interview questions are pilot tested. In this methodology, a purposive sample technique (Fraenkel & Wallen, 2000) was used. Sampling criteria included frontline professionals in all relevant employee groups, representatives from the various geographic regions in Ontario (i.e. Greater Toronto Area, northern, southern, eastern and western Ontario), a demonstrated interest in the research topic, and a demonstration of some of the characteristics of creative thinkers as identified by Oech, (2002). These characteristics include imagining familiar things in a new way, generating unusual or unique solutions, manipulating ideas, improving the conceptual frameworks of institutions and systems, the ability to be speculative and the ability to criticize constructively.

question. The guiding questions for this activity were revised based on this feedback.

Kitzinger, (1995) advocates for group membership to be diverse in order to "maximize the exploration of different perspectives." Participants in the research were recruited in multiple ways. Initially, individuals who had organized a focus group in Phase 1 of the research were invited because these individuals had demonstrated interest and background knowledge about the research issue. Secondly, individuals who had participated in Phase 1 and demonstrated all of the other criteria were invited to participate. Thirdly, individuals who had not participated in Phase 1, but were described by others as possessing the required criteria for selection were invited. Potential participants were sent an invitation electronically with a copy of the Phase 1 research report. Upon agreement to participate, participants were sent information about dates, location and a brief agenda as well as notification that the research project would reimburse their employer for their salary, and would provide accommodation, meals and travel expenses.

Data was collected through a series of focus group activities conducted over two days (December 3, 4, 2007) in Toronto. The first day's participants included thirty-three (33) frontline professionals including educators and professional and paraprofessional practitioners in the following roles: (Psychological Services (PS), Social Work Services (SW), Speech-Language Pathology Services (SLP), Occupational (OT) and Physiotherapy Services (PT), Child and Youth Worker (CYW), Behavioural Counsellor Services (BCS), Attendance Counsellor Services (AC), Special Education Educational Assistants (EA), Developmental Service Worker (DSW) or Communication Disorder Assistant (CDA), Teacher, Guidance Teacher, Special Education Resource Teacher (SERT) Administrator (Principal and Vice Principal) and Senior Manager. See Appendix 2 for a detailed list. The participants represented union and non-union members. Each employee group, with the exception of Senior Manager was represented by more than one participant on Day 1. Inclement weather forced two participants to be absent.

A second day of data collection involved approximately eight to 12 representatives, who were a subgroup of the participants in Day 1. The criteria for selection mirrored the selection criteria for Day 1, but emphasized the attributes of broad based knowledge of the research issue, excellent communication skills, and the ability to represent the perspectives of their employee group when considering critical elements of a best practice service delivery model. See Appendix 2 for a list of groups represented. These participants received the same

electronic communication inviting their participation for two days and indicating that their salary and expenses would be paid by the research project.

For Day 1, participants were instructed to respond from an orientation of their vision of the best practice. Specifically, the participants were instructed to ignore potential barriers. The activities included independent reflection, homogenous and heterogeneous small group discussion and group consensus. Groups were constituted in two different ways: homogenous groupings within the same role and cross role groupings, providing multiple opportunities for participants to validate the data (Kitzinger, 1995). The activities focused on four types of service provide by PPSS practitioners:

1. preventative services available to all students
2. consultation services between PPSS practitioners and educators about any student
3. intervention services and
4. assessment services. The description of the activities conducted during the two days is available in Appendix 3.

The first activity asked participants to list the preventative programs, services or activities presently available to students in their school board and delivered by PPSS practitioners. These lists were shared in "same role" groups. Participants affixed their list to charts identified with specific role titles. These programs are listed in the prevention section of the report.

For consultative, intervention and assessment services, participants were given "Think Papers" with individual guiding questions. Each set of guiding questions asked participants to reflect on the elements of service excellence that focused on the student. After completing these "Think Papers," groups were formed of "same role" participants. The groups were asked to discuss and agree on key elements of service excellence. This sequence resembles a "Think Pair Share" activity (Bennett & Rolheiser, 2001). Reflecting an adapted jigsaw strategy (Bennett & Rolheiser, 2001) the groups were reconstituted to cross-role (heterogeneous) groups. Each group selected participants to fill one of four roles typically identified in co-operative learning activities: materials manager, timekeeper, reporter and discussion facilitator. To address the potential barrier of domination of the discussion by individuals (Kitzinger, 1995), the discussion facilitator's role was to ensure that everyone has equal time to contribute/talk/share and keep the discussion going and focused. The heterogeneous group was to reach consensus across role groups on the key elements of service excellence. Charts were posted and each group's Reporter shared the charts with the whole group. Charts and individual 'Think Papers" were collected by the researchers.

At the conclusion of Day 1, a summary of the recurring themes and important points was developed by the researchers. These summary charts and the original charts created by the groups in Day 1 were used in the second day's activities. These activities were designed for a smaller group of participants to critically analyze the consensus charts for the critical elements (themes) related to service delivery that were identified in Phase 1 of the research (See Appendix 1) and to recommend strategies to overcome potential barriers that might inhibit the implementation of the draft best practice model. The themes were developed in Phase 1 of the research study. See Appendix 3 for a description of the activities for Day 2.

Small groups of participants were asked to consider and apply only one of the themes to each of the summary and consensus charts from the first day's activities. The small groups were asked to identify any gaps related to their particular theme and then to recommend strategies to fill the gap. Each small group was asked to respond to the summary and consensus charts. The reflections were recorded on T-Charts (See Appendix 3). These themes included:

- **Accessibility of Service**: including considerations of who gets the service (identified and non-identified students), developing service priorities, where the service is delivered, wait lists, availability within elementary and secondary panels.
- **Quality of Service**: including minimizing delays, case load considerations, how to measure effectiveness, direct and indirect student services.
- **Continuum of Service**: including consultation, prevention, intervention and assessment services provided directly or indirectly to students.
- **Consistency of Service**: including consistency and predictability of services with an educational focus in all regions of the province (urban/rural, north/south Ontario).

Day 2's activities were readjusted following the first session. Following the discussion of intervention services, the participants elected to operate as a large group and respond to all the summary and consensus charts simultaneously. The rationale expressed by the group was that the delivery of services is a fluid continuum and compartmentalizing the activities was conceptually and operationally inaccurate. The group contributed themes-related points that were recorded on the computer and projected onto the screen. Agreement by the group was used to determine if the suggested statements were believed to be reflective of the general opinions of each representative group.

Agreement to a schematic depiction of a model proved to be a barrier to consensus. The schematic was abandoned.

Recognizing the diversity that exists in the province, and not wishing to be prescriptive, the group developed and prioritized 10 key principles that should underpin the service delivery models of all boards. The 10 principles form the discussion section of the research.

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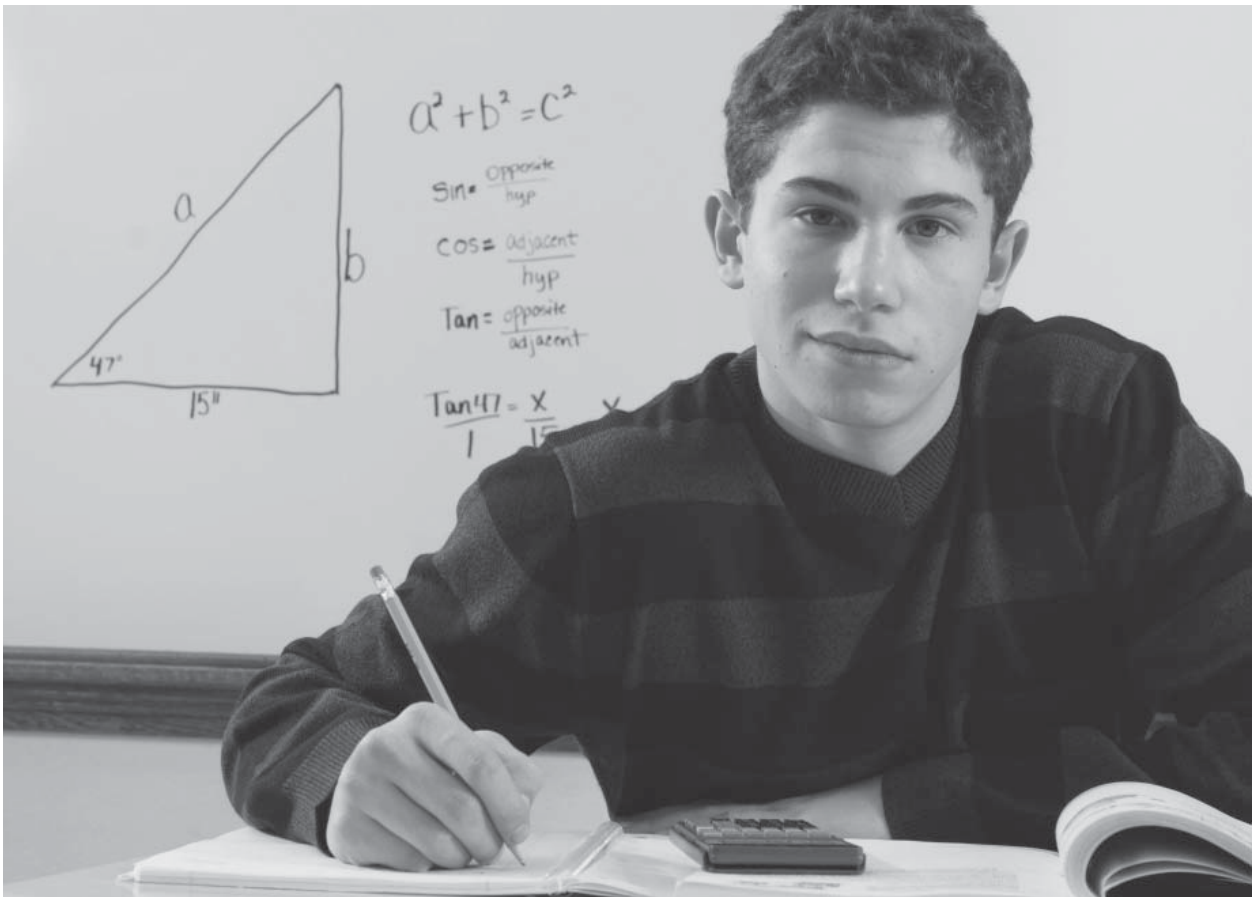

Data Analysis

Focus groups obtain perceptions of participants on a complex topic (Fern, 2002). Further, he states that the results can be assumed to be trustworthy if the researcher has adhered to procedures such as pilot testing questions, and selecting participants with special knowledge or experience in the research area from the relevant population. The research methodology has incorporated these procedures. The researchers argue that the three step process of individual reflection followed by same role group discussion and ending with cross group consensus is an additional procedure that supports the trustworthiness of the data collected. Consequently, the data was accepted as valid.

The examples of current successful programs from Day 1 were transcribed. The individual Think Papers and the group developed charts were collected following each session and transcribed. When data in the individual Think Papers enhanced or elaborated the statements in the group consensus charts, it was transcribed. When data in the individual Think Papers was contradictory to the statements in the group charts it was not included. The individual points were organized into coherent statements under the broad categories of Prevention, Consultation, Intervention and Assessment. Within each broad category subcategories may be included. At the end of each category is a section of Related Concerns. Following the four broad categories, a section on Measuring Service Effectiveness and a section on Other Related Concerns are included.

The data from Day 2 included the prioritized statements of ten principles reached by consensus for each of the elements of service delivery (preventative, consultative, intervention and assessment) were transcribed.

Findings

The following section represents the elements of a best practice service delivery model for PPSS developed from the individual Think Papers and group consensus responses resulting from two days of focus group activities with 13 employee groups of frontline professionals.

Data from Day 1 have been grouped into the four components of service delivery (i.e., prevention, consultation, intervention and assessment) followed by a section on Measuring Service Effectiveness and Other Related Concerns.

Although the reporting appears in four distinct categories, it should be noted that these components are related, but there is no presumption that the progression from one category to another is linear or sequential. The components are not listed in a hierarchy of importance.

Data from Day 2 reports the 10 principles of a best practice school based PPSS delivery model reached by group consensus.

Day 1

Consultation Structures & Activities

A systematic, predictable structure for consultation forms the basis of effective and efficient delivery of the full range of services available through PPSS practitioners. PPSS practitioners consult and liaise with teachers, administrators, school based professionals, board based professionals and with agencies in the community (hereafter described as outside agencies).

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Frequent, informal consultations with teachers occur at unstructured times and transitional times (e.g., lunch hour informal conversations with teachers), initiated by the teacher or the PPSS practitioner. Consultations may be about the class as a whole, or about some observations about an individual student. Note that non-identifying information is provided. Consultations may occur between a PPSS practitioner and a parent concerned about their child. Often these consultations are "invisible," but they are essential to ensuring that PPSS practitioners have the opportunity to provide input or to communicate with others who have valuable information about a student.

More formal consultations occur with at least three groups of stakeholders. Initially, consultations should occur with school based staff. Other consultations may include staff with area or system-wide responsibilities (PS, SW, SLP, OT/PT), or educational consultant staff. Still other consultations would occur with community agencies.

Some consultations occur as part of a Multidisciplinary Problem Solving Team's (MPST) deliberations. Operating similar to an in-school team[12] designed to refer students for assessment and possible identification, this team has a broader perspective and is available to all students in the school, not solely for students in special education.

Framed within a problem solving approach, the MPST enables a process whereby the knowledge and expertise from many PPSS practitioners collaboratively develop a comprehensive plan to address the social, emotional, behavioural and academic needs of the student and to facilitate further referrals if appropriate. For example, the sessions may be needed to facilitate and mediate family and school relationships, to assist a student at risk, to consider issues of truancy or isolation, problems socializing, violence, suicidal threats or attempts.

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Members of the MPST are knowledgeable about the range of students' needs in the school and would determine how to acquire the resources within the school board or in the community to meet students' needs. The resources currently available in the school (programs, instructional strategies and human resources) may not be available or appropriate. Resources beyond the school may be necessary. The MPST would develop protocols and procedures to respond to requests from outside agencies to deliver programs and services to students in the school setting.

The MPST is not meant to duplicate consultative processes already in existence at the school, but rather align with existing protocols and referral mechanisms existing in the school.

Membership and Meetings

The problem solving team membership needs to be fluid and determined by the student's needs. The MPST must include, as a minimum, the principal, the classroom teacher, the case manager, the referring person and any other school support staff who are directly involved with the student. Other PPSS practitioners may be invited as necessary. Meetings may be requested by classroom based professionals (EA, teacher, CYW, any PPSS professional, guidance staff, hall monitors, custodial staff, secretarial staff, parents or outside referrals from a pediatrician or psychiatrist).

Therefore it is incumbent that the school develop a fixed schedule of meetings to ensure that there is no waiting list or delay in convening the MPST meeting or initiating the appropriate actions to respond to the student's needs. A suggested sched-

12 P. C6. Special Education: A Guide for Educators. 2001. The Ministry of Education describes the in school team as people with various expertise who work together to support the student, parent and each other; collaborate, consult and share information and knowledge to identify strategies, that may increase the student's learning success.

ule is that the problem solving team meets within five school days of the referral and within 24 hours if an emergency. Participants noted that the strategies are needed in days, not weeks.

Case Managers

Critical to the success of the MPST is a case manger who schedules meetings, guides the process and attends to appropriate documentation and tracking. The case manager ensures that standardized referral forms and appropriate parental consent forms have been completed. The case manager collates relevant data and distributes background information before the meeting. Each member who has information about this student should be informed and/or invited by the case manager to provide information or attend. The background information may include a student's educational history, assessment scores, grades, relevant information from the student's Ontario Student Record folder, medical information if relevant, learning preferences, interviews with parents, observational data, information from outside agencies. A similar process occurs currently where many guidance counsellors or special education teachers in secondary schools organize in-school team meetings to accommodate consultation requests, make referrals for special education services or assessments, and organize feedback and follow up meetings.

Related Concerns

The effectiveness of a consultative process requires that PPSS have a regular presence in each school with time to engage in informal and formal consultations and participate in the multidisciplinary problem solving team.

The process needs to be streamlined by eliminating multiple layers of consent forms currently required by each professional service providers or agency. This creates a barrier to parent/student participation. Mechanisms will need to be found in consultation with professional associations that reduce the need for multiple consent forms to be completed by parents and students.

Preventative

The purpose of any preventative action should be to prevent students from engaging in behaviours that might threaten their well being, the well being of their peers and to prevent any negative impacts on the school environment. Understanding the social structures and relationships within a school as part of the school's unique culture is pivotal to effective preventative programs. Establishing various preventative frameworks acknowledge that every student and their life experience is different. These prevention programs are inclusive in design and respective of race, ethnicity, language, gender, sexual orientation, religion etc.

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Circumstances will and do arise which position the front line staff to initially recognize a situation that can be preventable. Consultation with the multi-disciplinary team could determine that a program is necessary for a group or whole class.

Many professionals are currently involved in sharing their expertise to support teachers in delivering differentiated instruction, or assisting in establishing realistic recommendations from an assessment report for the teacher to implement, or assisting staff trained to recognize the signs and symptoms indicating that a student is in need of more focused intervention.

The following lists a sample of the many preventative programs and services for students in which PPSS practitioners are participating.

Occupational Therapy and Physiotherapy

- Prior to referrals – safety consultation to teacher and classroom for developmental delay and physical disability
- Social/sexual education with public health nurses for physically disabled students
- Transitioning to community from high school for students with physical disabilities
- Linkages with community agencies
- Visiting community sites; referrals to community resources for the physically disabled;
- Transportation initiatives
- Technology needs assessment (i.e. computers)
- Equipment supplied for disabled around accessibility issue (i.e., lifting in services to staff)
- PPD/Autism education to staff and students
- Co-op work employability skills program – support for work education for students with special needs; OT/PT assessment of accessibility of workplace
- Intake assessments at primary levels (forwarded on throughout school years)
- Safety in classroom

Speech and Language Pathology Services

- Language in literacy as part of the classroom environment
- Partnership programs between teacher and Speech and Language Pathologist (SLP)
- Early intervention focus where teacher and SLP identify students
- Response to intervention model being introduced
- Curriculum kits to assist teachers
- Specialized teams (multidisciplinary) to consist of behaviour, ASD, augmentative and alternative communication
- Reading for All (pilot program in 2007) – classroom based co-instructed reading, decoding and oral language
- HOLA (pilot program) parent/teacher/SLP literacy book use at home to build home school connections
- Inservicing – variety of issues to teachers to meet school or individual needs
- Talking for Literacy – SLP trains EA over 10 sessions to develop narrative

Social Work Services

- Bridging to Grade 9
- Secondary violence prevention training for students
- Roots of Empathy program
- Suicide prevention program – trained to identify and resource – develop safety planning
- Share the Joy
- Triangle Project/conference for Gay youth
- TVNELP (Thames Valley Neighbourhood Early Learning Program
- Character Education
- Consultation – informal, ISDC, IPRC, bridges, foundations
- Direct – provide articles, professional journals, in-services
- Out reach – four social workers; two teachers
- Fresh Start as opposed to expulsion and suspension
- Accessibility to community resources and diverse network of counselling
- First Nations counsellor

Child and Youth Worker/Behavioural Disorder Counsellor/ Developmental Service Worker/ Special Education Assistant

- Invite community persons to run programs in consultation or along side board staff
- Utilize leadership programs for social skills, self-esteem, anger management
- School wide incentive programs
- Peer mediation programs
- Anti-bullying
- Breakfast programs
- Equity programs which build for inclusion (anti-racism, homophobia, anti-immigrant etc.)
- Crisis counsellors on site to address any issues that may arise (every student is at risk without being identified)
- Peer development programs without age boundaries/limits (older assisting with younger etc.); peer mediation and mentoring
- Collaborative problem solving model
- Alternative methods programs to relieve stress and anxiety (i.e., breathing, yoga, quiet time)
- Identify students' wants to relieve any issues (listen to students)

Psychological Services

- Anti-bullying
- Virtues; social skills; self esteem
- CPI – for ERWs, C4Ws
- Starting Dibels/answers and primary project through OPA grant as secondary prevention
- Collaborative problem solving approach – training of in-school personnel in dealing with behaviour in a preventative manner (i.e. conflict resolution) with support staff included
- Relationships violence (i.e. abuse) presentations for students (awareness)
- Top Kids program – responding as a team to high needs/behaviour patterns. Structure to support teacher as team of counsellors/ psychologists
- Crisis intervention training for in-school staff

Intervention

Intervention usually implies deliberate actions or activities or direct services to an individual or a group with a purpose to promote well being or to prevent behaviours that would be harmful to the individual. The decisions reached by the multidisciplinary problem solving team could involve many types of intervention delivered by the PPSS practitioner, such as (a) referral for an assessment (behavioural, educational, etc. (b) teacher consultation (c) more screening (d) monitoring of recommendations (e) direct support or treatment to the student (health, social-emotional, speech and language, occupational or physiotherapy) (f) parental involvement (g) input into IEP goals and progress supporting curriculum based and alternative goals (h) individual or group intervention (i) support with the academic program or (j) classroom intervention. Intervention activities occur along a continuum of least to most intensive. Early intervention is preferable and often prevents the escalation of student's needs to a critical point.

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PPSS professionals offer a wide variety of services, including, but not limited to: providing consultation with parents or caregivers and other education stakeholders, providing early intervention and prevention programs, assisting with reintegration to the regular class, prescribing specialized equipment, providing parent or caregiver education, developing behavioural or treatment goals and evaluation criteria, addressing attendance issues, assisting teachers and other staff to develop specialized educational plans, providing information to teachers about language and student needs, preventative screening, early intervention strategies and assessment, coordinating mental health providers, providing mental health services in school, providing counselling, providing in-service around child abuse policies and procedures, providing academic, behavioural or health support to identified students (Halton District Educational Assistants Association, 2001), conducting formalized assessments, providing post assessment monitoring and feedback. PPSS practitioners should be members of crisis intervention teams because if the crisis involves educators, other adults must be available to complete the tasks associated with crisis intervention.

Following an MPST decision, the PPSS practitioners begins the intervention process individually, or as part of a team. There is no assumption that the delivery of service must follow the same trajectory for all students. In one case, this process may involve intervention at the classroom level in consultation with the teacher, and may involve a progression to a higher intensity of services, including treatment and possibly an assessment and diagnosis for identification. In other instances, these services might be layered in that there may be group intervention in addition to one-on-one involvement. In yet other situations, the intervention with the student may be individual and short term or may necessitate referral to other PPSS practitioners or to a service provided by community agencies. Because the intervention flows from the MPST consultation process, the decision making, intervention, documentation, communication and ongoing monitoring of the student's progress are predictable, transparent processes that avoids duplication. An ongoing cycle of monitoring and observation of progress toward goal attainment should include input from parents, students and school based practitioners.

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The services provided by PPSS practitioners are not limited to supporting the teacher or the student. Developing a relationship of trust with the family is often foundational to developing a collaborative partnership that will help the student. Working with parents may include an advocacy component, teaching the parent about more effective parenting techniques, or helping the parent to understand the school system or the student's needs more fully. Services must be sensitive to

potential cultural and language barriers and be accessible to parents, the community and alternative schools during and outside the regular school day.

All intervention activities must be consistent with Protection of Health Information Act (PHIPA).

PPSS work is broad in scope and often unpredictable. Flexibility to determine priorities and to adhere to the standards and ethics of other regulatory bodies may be negotiated with supervisors. However, roles for school board professional and teaching staff should be clearly delineated. An example is the Peel District School Board's Professional Student Services Baseline Service, 2007-2008 document (See Appendix 4) that describes the roles of psychology, social work and speech language pathology departments. When there are areas of overlap, the decisions of the MPST will designate the appropriate service on a case-by-case basis.

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Other potential roles for professionals and paraprofessionals include more involvement with early intervention and prevention services at the elementary level. Early intervention reduces the individual caseloads at the secondary level.

The availability of the services to all students, and the broad scope of PPSS roles requires a reconsideration of the issues of caseloads and wait lists.

Caseloads and waiting lists

Establishing a caseload management model that includes waiting lists, caseload caps, time for team meetings, school presence, early intervention services, counselling or other direct and indirect interventions is necessary. Caseloads should maintain quality of services and should reflect the educational professional standards recommended by professional associations as opposed to the clinical caseload standards for professionals operating outside the educational system.

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For example the American Speech and Hearing Association (ASHA) recommends a caseload of 40:1 SLP[13]. The School Social Work Association of America (SSWAA) states:

> "In order to more effectively assist students' focus on learning, remove barriers to achievement, decrease school violence, and improve the school climate for all students and staff, SSWAA supports a maximum ratio of one school social worker to 400 students (1:400). SSWAA believes adherence to this maximum ratio is essential if school social workers are to provide effective services and be viewed as a valuable member of the school's interdisciplinary team."[14]

Measuring Student Success

An essential element in service delivery is the ongoing monitoring of the progress of the student's success. Student success defined solely by academic achievement (i.e., credit accumulation or improved diagnostic testing or Education Quality and Accountability Office (EQAO) scores) is limiting. This research argues for broader, more comprehensive criteria. Multiple measure of student progress with respect to academic and non academic measures e.g., reduction in number of suspensions, reduction in truancy, reduction in dropout rates, reduction of office referrals for misbehaviour, improved attendance records, increases in measures of self-esteem as well as academic success, attainment of Individual Education Plan goals, improved learning skills, more positive report card comments, increased level of student engagement, are appropriate measures of success.

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13 ASHA supplement to the ASHA leader, Volume 8, Number 7, 2003 Supplement No.23.

14 School Social Work Association of America www.sswaa.org/members/resolutions/staffing.html

Community Agencies

Community agencies operate under the authority and organizational structures of different ministries resulting in differences in service delivery, caseloads and procedures for access to services. A clinical orientation to service delivery provides for maximum caseloads that may result in long waiting lists, limited or non existent services for students. The researchers heard specifically about mental health services and speech and language services. In contrast, education based professionals and paraprofessionals often serve students in a non treatment orientation. Service delivery often occurs in collaboration with teachers, administrators or other professionals and paraprofessionals necessitating the building and maintaining of relationships of trust. Planned interventions are developed within a holistic orientation that considers the student in relation to the classroom, the school, and the family contexts.

Board protocols must be developed with the involvement of PPSS providers. These protocols would specify that these outside agencies operate with the multidisciplinary team and under the guidance of the school. Protocols already exist for emergency preparedness and crisis intervention that could be used as a model.

Community agencies are a potential resource to support students and should enhance school board services, but not duplicate these services.

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Community agencies may provide whole class or small group prevention programs, specialized long term counselling or treatment programs. Some of the services provided by community agencies cannot be provided in the school (e.g., home bathing by occupational therapists; drug addiction counselling, and some speech and language therapies). Short term funding to community agencies of projects focused on a particular initiative may or may not address student needs and board priorities and interfere with the planning process.

Referral to community agencies are appropriate when the school/board resources have not resulted in goal attainment or if the services required are beyond the scope of the board's mandate or resources (i.e., medical, Children's Aid, respite care services, day treatment programs, residential and rehabilitation services for drug or alcohol abuse etc.) These referrals should be infrequent. PPSS practitioners perform an important liaison function between school boards who have identified student needs and outside agencies who can provide services that school board personnel cannot. Referral to community agencies usually involves a delay in service while consent forms and assessments are completed.

Referral to community agencies are appropriate when the school/board resources have not resulted in goal attainment or if the services required are beyond the scope of the board's mandate or resources

The potential involvement of community agencies must be purposeful and planned by the MSBT. When a service partnership is considered, an agreement clarifying roles and the details of service delivery must be negotiated with all stakeholders. Therefore, partnership agreements between school boards and community agencies are necessary. PPSS practitioners must be active participants in developing and monitoring these guidelines. For example, the Toronto District School Board (Appendix 5) and the Peel District School Board (Appendix 6), describe the administrative guidelines for developing Community Service Partnerships often called Reciprocal Agreements or Third Party Protocols.

Related Concerns

Many boards currently are not hiring certain classes of professionals (i.e., no occupational therapists, no physiotherapists, no speech language pathologists, no psychologists) possibly believing these services are available from other Ministries or possibly believing that a fee for service arrangement is preferable. Consistently, the researchers heard that these community based services are being reduced or eliminated resulting in limited or non existent services to students. PPSS practitioners are concerned that in the present climate of funding reductions, this trend will continue. PPSS practitioners will be faced with increasing caseloads, staff reductions and are concerned that services to students may be compromised.

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OT/PT services are available through only three Ontario school boards. The remaining services are accessed through community based agencies. When services are available through school boards, teachers have access to consultative and intervention services for the whole school year. These professionals can consult about safety issues for the student and support staff and assist with making plans for emergency evacuation, etc. Specific referrals may include specific equipment recommendations, specific fine and gross motor or sensory assessment, or assistance with accessing technology related to the students.

Assessment

All PPSS practitioners are involved with some aspect of assessment. Some are involved in conducting assessments for diagnostic purposes or for designing programs (i.e., functional behavioural analyses, speech and language assessments, safety plans, behaviour plans, risk assessments). Others are involved in the day to day informal assessment that is used to determine progress and improvement toward learning goals. Still others are interpreting assessments and assisting in designing programming. All these activities are part of the assessment cycle.

PPSS professionals approach the assessment process from a problem solving stance. Adopting a problem solving stance will encourage a broader spectrum of formal and informal assessments conducted over a period of time. The process begins with the development of a student profile, collecting comprehensive information from teachers, parents, the student and other professionals. The

scope of assessment tools used should be wide enough in scope to address the referral question and may be applied in whole or in part over a period of time. PSSP professionals do not rely solely on standardized assessments, but use a wide variety of sources of information e.g., observational data, year end reports, work samples, teacher notes, behaviour scales etc. After the report has been completed, the professional seeks the input of the teacher(s) to determine the order and timeline for implementing the recommendations. Selecting a few key recommendations is more manageable and will result in more co-operation from the teacher. The professional provides support and feedback to the teacher on an on going basis. Throughout the assessment process, the PPSS practitioners need opportunities to communicate regularly with other stakeholders.

Quality assessments conducted by professionals have identifiable characteristics. Quality assessments are developed in a context of coordinated consultation with parents, other PPSS practitioners and educators (Special Education Resource (SERTs), Special Education Consultants, Administrators, etc). The MPST should include procedures for pre-assessment input. The consultation process gathers high quality and relevant information and results in a plan of action with realistic short term and longer term recommendations.

Quality assessments consider the student's social, emotional, behavioural and academic needs and the interrelationships between these dimensions. A quality assessment addresses the referral question, is tied to the student's Individual Education Plan if possible, and may not necessarily involve a full battery of assessments for every student.

Quality assessments include reporting practices that recognize the history of interventions, are reader friendly, contain a few key recommendations and include person-to-person feedback. The recommendations must be discussed with the teacher who collaborates in determining the order and priority of implementing recommendations. Assessments conducted by professionals outside the school lack an understanding of the unique strengths of the school and community, its physical and human resources, programs and inter-relationships. In an atmosphere of trust, there is more likelihood that the recommendations will be accepted.

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Quality assessments are developed within a series of regularly scheduled meetings to review progress and referrals. These meetings should be part of a MPST process that provides for administrative support, communication networks, documentation and on going assessment. The professional keeps observation data and notes on progress toward action plan goals to be shared with teachers and other professionals and parents on a regular basis.

Some paraprofessionals are implementers of assessment recommendations. Implementers of assessment provide direct service to the student and they need to be part of multidisciplinary consultative meetings, getting input from all those involved with the student. These professionals keep extensive notes on the student's progress based on observational data, and hold regular consultations with the teacher or others involved with the student. Implementers advocate daily for student success and report daily changes in physical or emotional states that may be an impediment to reaching program goals. When an issue has been identified, a collaborative plan is developed. The plan should include feedback at regular intervals. These professionals seek in-service about making appropriate referrals.

An important role is to assist in transition back to the regular class. Their role is to plan and monitor. These professionals need access to the professionals who created the assessments – for consultation and support, clarification, etc.

Related Concerns

For a variety of reasons, formal assessments have been conducted by non school board professionals. The characteristics of quality assessments are not met when assessments are completed by professionals who do not understand the student within the school, family and community context.

Board staff often have to interpret the recommendations for the teachers and parents and may have to rewrite some recommendations. Contracting out assessments does not save time. Utilizing school board based professionals for conducting assessments is superior because board based staff have shorter wait times than outside professionals, there is no cost for the service and there is more follow through. The Dufferin Peel Catholic District School Board has tracked the time expended by school board staff following assessments completed by non school board professionals.

Boards need to develop appropriate mechanisms in compliance with PHIPA guidelines for this documentation to be shared, updated and retained for future use if relevant.

Measuring Service Effectiveness

Current measures of effectiveness include the number of referrals, caseloads or the length of wait lists. PPSS practitioners suggest that the number of referrals or the number of completed assessments is not a progress oriented measure of success and does not indicate the quality of service. The participants advocated for a broader range of measurement criteria. Standardized, comprehensive, progress oriented and on going success measures that take local needs into account need to be implemented across the province.

Measuring service effectiveness needs to include individual and group measures and short term and long term measures using qualitative and quantitative data. Consumer satisfaction should be considered as one measure of service effectiveness. Some examples include:

- Satisfaction surveys on service quality and effectiveness, duration and outcomes could be completed by students or parents
- Progress toward identified student specific goals (i.e., diminished problems, improved academics, reduction in negative /challenging behaviours)
- Teacher surveys to rate the degree of usefulness of the resources provided
- Feedback forms attached to psychological or speech and language reports to be returned to the professional service provider after a specified length of time.

Data Collection

Decisions about service delivery need to be made based on appropriate data. A systematic process of data collection needs to be implemented on a board and provincial level. Data to be collected may include :

- the range of student needs
- the services provided currently, including cases opened and closed
- time committed to consultative, preventative, intervention and assessment services
- time committed to enhancing, interpreting or revising assessments conducted by outside agencies
- broad based measures of service effectiveness.

The Ministry of Education could begin by examining current data collection measures used by some Ontario school boards to establish a reflection of the range of services provided and the relative time commitments of these services.

Funding

"There is wide recognition that the current student focused funding is inadequate and unable to effectively address the needs of this growing population of disengaged and complex-needs youth."[15] Funds are targeted for special education, but the services are accessed by a broader range of students. Funding must more closely reflect present realities.

There is wide recognition that the current student focused funding is inadequate and unable to effectively address the needs of this growing population of disengaged and complex-needs youth

A related concern for PPSS services is that under the present structure professional and paraprofes-

15 P. 4. Executive Summary The Road to Health: A final report on School Safety. Downloaded January 11, 2008 from: www.tdsb.on.ca/wwwdocuments/about_us/media_room/docs/SCSAP_Executive_Summaryb.pdf.

sional funding is not protected and extends to include other staffing groups, such as lunchroom supervisors, translators, etc. As these needs rise or as emergencies occur, funds are transferred to meet these needs, reducing the funds available for PPSS services.

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Findings

Day 2

Participants in Day 2 engaged in a process to reach consensus on the following ten principles. The participants believed that prescribing one model for the entire province is unrealistic. School boards across the province are extremely diverse in response to the influence of demographics, geography, distance, rural and urban centers, population density, community based services and infrastructure. The development of a local board PPSS delivery model needs to develop in response to the uniqueness of communities and school boards. However, the following ten principles should remain inviolable.

The Discussion section will elaborate on each principle and provide support from research.

Ten Principles

1. PPSS services are essential for student education, success and well being.

2. Every student across the province has access to PPSS services in the school on an ongoing basis, all year, every year in a timely fashion.

3. A school based service delivery model includes preventative, consultative, intervention, and assessment services for all PPSS practitioners.

4. A quality school based service delivery model rests on a consultative multidisciplinary team structure and process that is collaborative and flexible.

5. Planned protocols and procedures at the school level are managed and honoured by appropriate personnel.

6. PPSS practitioners must be actively involved in developing and managing the protocols that outline the services that may be provided in schools by outside agencies.

7. The full range of students' non academic needs is met by board employed practitioners.

8. Progress oriented measures of service effectiveness must include the perspectives of students, teachers, administrators and parents.

9. A school based service delivery model promotes the centrality of the PPSS practitioner's liaison with the community, the school board, the school, the class, and the individual student.

10. Funding of a school based service delivery model must be dedicated, predictable, stable and sufficient to support board employed PPSS practitioners.

Discussion

1. PPSS services are essential for student education, success and well being.

   This principle requires that the Ministry of Education and school boards demonstrate an acceptance that the goals of education and student success must respond to a student's social and emotional as well as academic needs in the school setting. PPSS professionals are trained to provide these specialized services. These services must be given greater visibility and credibility in school board and Ministry policies and procedures and curriculum and support documents.

   School aged children today may potentially be touched by bullying and harassment, abuse and neglect, child poverty, violence, bullying and harassment, teen pregnancy and early sexual encounters, alcohol and drug abuse, divorce, death and bereavement and mental health issues (McNab & Coker, 2006; Crockett, 2004, Robertson, 2000). In addition, exceptional students may also be at risk for academic and social skills challenges associated with their exceptionality (Hammet, 2006; Bauminger, Edelsztein, Morash, 2005; Landau & Moore, 1991).

   Achieving high academic standards means attending to students' social and emotional health and well being (Brener, Weist, Adelman, Taylor & Vernon-Smiley, 2007; Ferguson, Tilleczek et al., 2005; McCombs, 2004; Gable & Van Acker, 2000). But if students' social and emotional needs are not met they are poorly prepared for to learn academic skills (Koller & Bertrell, 2006; Morris, 2002; Zins, Weissberg, Wang &Walberg, 2002; Evans, Axelrod & Sapia , 2000; Gable & Van Acker, 2000). Therefore, schools must attend to this aspect of the educational process for the benefit of all students (Schonert-Reichl, & Hymel, 2007; Elias, O'Brien & Weissberg, 2006).

   Colucci & Lean, (2008) have conducted an extensive literature review of academic and non-academic barriers to learning, that concludes that school based professional service can have a positive impact on many areas of psychological and academic functioning, enhance protective factors and reduce risk factors leading to undesirable outcomes in students.

   Teachers provide some classroom preventative programs, but these programs do not address the needs of students who are already experiencing coping challenges. Neither teacher preparation programs nor in-service programs train teachers to identify mental health issues (Koller & Bertel, 2006) or to provide intervention services. These services are best delivered by professional and paraprofessional student service practitioners who have specialized training in these areas.

   The current research study argues for a comprehensive, integrated, school based service delivery model of consultative, prevention, intervention and assessment services. PPSS practitioners perform an essential consultative role. They consult widely with educators, both formally and informally, with parents, with other service providers and with community agencies. Preventative programs offered by PPSS practitioners supplement teacher delivered classroom preventative programs. PPSS practitioners are trained to provide a wide range of intervention services to individuals or groups including assessment, counselling, treatment, therapy, behavioural, health and academic support.

2. Every student across the province has access to PPSS services in the school on an ongoing basis, all year, every year,-in a timely fashion.

   This principle means that short term or long term specialized support must be available to any student equally across the province. School boards and the Ministry of Education must ensure adequate PPSS staffing levels to provide a full range of services to enable quick response to any student's presenting needs.

   Current Ontario based research articulates a need for more PPSS practitioners and services (People for Education, 2007; the School Community Safety Advisory Panel's report, 2008,[16] the Toronto District School Board's Support Services study, 2007).[17]

16 Falconer, J., Edwards, P & MacKinnon, L The Road to Health: A Final Report on School Safety, 2008.

17 Toronto District School Board. Support Services Service

Issues of student engagement (Ferguson & Tilleczek et al., 2005), bullying (Ministry of Education PPM 144 and PPM 145, 2007), mental health concerns (CAMH, 2002; Robertson, 2000), or exposure to violence (Ruchin, Henrich, Jones, & Vermeiren, 2007) are potential problems for all students. All students need access to timely early intervention to avoid the "crystallizing" of academic and social emotional problems in secondary school (Cole & Brown, 2003). Restricting services to students with special educational needs neglects other students with health, social emotional or other needs. Adelman &Taylor, (1998) report that few schools have enough resources (p. 136).

Colucci & Lean, (2008) have developed a model of support services delivery to schools. The authors conducted an extensive literature review of academic and non-academic barriers to learning, mental health services to schools, and education reform. The literature clearly demonstrates that school based professional service can have a positive impact on many areas of psychological and academic functioning, enhance protective factors and reduce risk factors leading to undesirable outcomes in students.

Respondents in this research identified that a full range of services provided by PPSS practitioners is not available consistently across the province to all students. Respondents described long waiting lists, limited or non existent services available through community based service providers. Service delivery is fragmented, unpredictable and marginalized in many regions. Occupational and physiotherapy services are especially marginalized. Only three school boards employ these professionals.

3. A school based service delivery model includes preventative, consultative, intervention, and assessment services for all PPSS practitioners.

This principle means that all components of a quality school based service delivery model should be valued as important components of the PPSS practitioner's role and should be evident in PPSS activities.

Research articulates that school based service delivery includes a wide range of services by all PPSS practitioners (Toronto District School Board, 2007. p. 63).[18] The Canadian Psychological Association, (2007) states that psychologists are an integral and important part of a [school] district's student services team, providing a wide range of services (consulting, planning, implementing and delivering prevention programs) to students. Consultation is now an indirect and accepted method of service delivery in the school setting (American Counselling Association, 2006; Scholten, 2003; Cole & Brown, 2003; Sladeczek, Kratochwill, Steinbach, Kumke & Hagermoser, 2003; Wiener & Davidson, 1990; The Association of Chief Psychologists of Ontario School Boards). The Ontario Association for Families with Children with Communication Disorders (OAFCCD) echo the importance of participation as a member of a school team and describe a wide range of preventative and intervention strategies used by speech and language pathologists.[19]

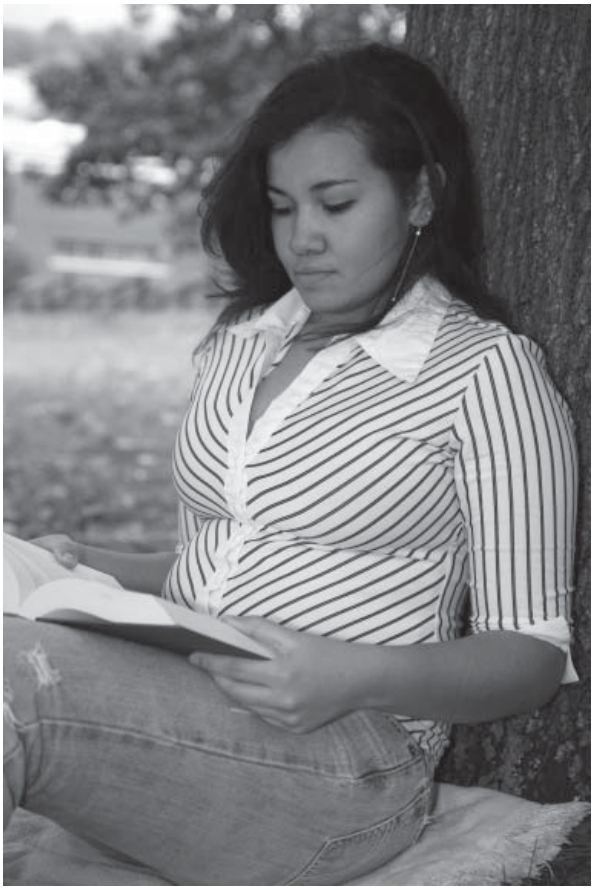
The list of preventative programs delivered by educators targeting social, emotional, relationship, mental health, behaviour and self-esteem issues is growing (McCombs, 2004). These preventative programs are shown to be effective in "reducing levels of anti social behaviour, reducing contributing factors to a mental disorder and improving school climate" (Tomb & Hunter; 2004; Cole & Brown, 2003). However these programs do not address students who are at risk for developing, or are already displaying maladaptive behaviours because of the issues they already face (Baker, Kamphaus, Horne, & Winsor, 2006).

Professional associations articulate a range of interventions delivered by their members. This practice is supported by the Learning

Evaluation Results. May 2007.

18 Toronto District School Board. 2006 Student Census, Grades 7-12.

19 OAFCCD Service Delivery Model Analysis of School Speech-Language Pathology Ratios And Costs. Downloaded January 20 from: www.oafccd.com/factshee/fact68.htm



Disabilities Association of Ontario, who recommend the involvement of professionals "from a variety of disciplines (e.g. psychology education speech language pathology, occupational therapy, medicine, audiology, etc.) in the development and implementation of a range of interventions."[20]

A three-tiered model of intervention is growing in popularity to address students who require more services. See Appendix 8 for an example from the Toronto District School Board. The universal level targets all students whether or not they have risk factors. Interventions at this level are most easily incorporated into the existing school environment. A more intensive level of intervention targets students with higher than average risk factors. The most intense level of intervention is for students who exhibit early signs of disorders (Tomb & Hunter, 2004).

Early intervention programs such as school based mental health programs for elementary students reduce "conduct disordered behaviour, attention deficit/hyperactivity and depression" and reduce special education referrals (The American Counselling Association, 2006).

Completing a battery of standardized assessments is now recognized as a limited role for professionals. The Practice Guidelines for school psychologists, (Canadian Psychological Association, 2007) articulate a comprehensive description of the services that school psychologists offer the education system. Boutrogianni & Pratt, (1990) advocate for the use of supplementary assessments that provide data about a student's learning ability. This information will assist in developing descriptive and practical recommendations when reporting assessment results.

Respondents in this research study provided detailed examples of the consultative, preventative, intervention and assessment services articulated in research as essential to a quality service delivery model. Establishing a caseload management model that includes waiting lists, caseload caps, time for team meetings, school presence, early intervention services, counselling or other direct and indirect interventions is necessary. Caseloads should maintain quality of services and should reflect the educational professional standards recommended by professional associations as opposed to the clinical caseload standards for professionals operating outside the educational system.

PPSS work is broad in scope and often unpredictable. Flexibility to determine priorities and to adhere to the standards and ethics of other regulatory bodies should be negotiated with supervisors. Nevertheless, roles for school board professionals and teaching staff should be clearly delineated. An example is the Peel District School Board's *Professional Student Services Baseline Service, 2007-2008* document (See Appendix 4) that describes the roles of psychology, social work and speech-language pathology departments. When there are areas of overlap, the decisions of the MPST will designate the appropriate service on a case-by-case basis.

20 Recommended Practices for Assessment, diagnosis and Documentation of Learning Disabilities. Downloaded Jan 10 from www.ldao.ca/what_are_lds/LDAO%20Recommended%20Practices.pdf.

The effectiveness of a consultative process requires that PPSS have a regular presence in each school with time to engage in informal and formal consultations and participate in the multidisciplinary problem solving team. Consultations with teachers, administrators, students and parents about students occur formally through the school team process or informally at unstructured and transitional times. Often these consultations are "invisible," but they are essential to ensuring that PPSS practitioners have the opportunity to provide input or to communicate with others who have valuable information about a student. Other consultations may include staff with area or system-wide responsibilities (PS, SW, SLP, OT/PT), or educational consultant staff. Still other consultations would occur with community agencies.

Many professionals share their expertise to support teachers in delivering differentiated instruction, or assisting in establishing realistic recommendations from an assessment report for the teacher to implement; or assisting staff to recognize the signs and symptoms indicating that a student is in need of more focused intervention. Early intervention and prevention services, particularly at the elementary level, reduce potential for escalation to a more critical need for service or more serious consequences for the student. Intervention services begin as a result of the deliberations and decisions of the MPST. Multiple consent forms currently required by each professional service provider or agency create barriers to parent/student participation. A continuum of intervention services from least intensive to most intensive must exist for all PPSS practitioners. A sample of an intervention model used in special education from a school within the Simcoe Muskoka Catholic District School Board is included in Appendix 7. This model is informative to a continuum of intervention service delivery. The range of services must also include individual or group interventions. For example, PPSS practitioners may assist with reintegration to the regular class, prescribing specialized equipment, providing parent or caregiver education, the development of specialized educational or behavioural goals and evaluation criteria, addressing attendance issues, providing information to teachers about language and student needs, coordinating mental health providers, providing mental health services in school, providing counselling, providing in-service around child abuse policies and procedures, providing academic, providing behavioural or health support to

identified students (Halton District Educational Assistants Association, 2001), conducting formalized assessments, providing post assessment monitoring and feedback and participating in crisis intervention teams.

The services provided by PPSS practitioners are not limited to supporting the teacher or the student and may include working with parents. Parents may need assistance with advocacy, effective parenting techniques, or help to understand the school system or the student's needs more fully. Developing a relationship of trust with the family is often foundational to developing a collaborative partnership that will help the student. Services must be sensitive to potential cultural and language barriers and be accessible to parents, the community and alternative schools during and outside the regular school day.

All intervention activities must be consistent with Protection of Health Information Act (PHIPA).

All PPSS practitioners are involved with some aspect of assessment. Some are involved in conducting assessments for diagnostic purposes or for designing programs (i.e., functional behavioural analyses, speech and language assessments, safety plans, behaviour plans, risk assessments). Others are involved in the day-to-day informal assessment that is used to determine progress and improvement toward learning goals. Still others are interpreting assessments and assisting in designing programming. All these activities are part of the assessment cycle.

Quality assessments are conducted from a problem solving orientation in a context of coordinated consultation with parents, other PPSS practitioners and educators (Special Education Resource Teacher (SERT), Special Education Consultants, Administrators, etc). Quality assessments consider the student's social, emotional, behavioural and academic needs and the interrelationships between these dimensions. A quality assessment addresses the referral question, is tied to the student's Individual Education Plan if possible, and may not necessarily involve a full battery of assessments for every student.

Quality assessments include reporting practices that recognize the history of interventions, are reader friendly, contain a few key recommendations and include person to person feedback. The recommendations must be discussed with the teacher who collaborates in determining the order and priority of implementing recommendations. Assessments conducted by professionals outside the school lack an understanding of the unique strengths of the school and community, its physical and human resources, programs and inter relationships. In an atmosphere of trust, there is more likelihood that the recommendations will be accepted.

Quality assessments are developed within a series of regularly scheduled meetings to review progress and referrals. These meetings should be part of a MPST process that provides for administrative support, communication networks, documentation and on-going assessment.

Some paraprofessionals are implementers of assessment recommendations. Implementers of assessment provide direct service to the student (i.e., assisting with the transition back to the regular class), gather observational data and need to participate in collaborative planning with assessment professionals through the MPST.

The characteristics of quality assessments are not met when assessments are completed by professionals who do not understand the student within the school, family and community context. Data on the time expended to interpret or revise these assessments needs to be collected. The Dufferin Peel Catholic District School Board has collected this type of data.

4. A quality school based service delivery model rests on a consultative multidisciplinary team structure and process that is collaborative and flexible.

This principle means that all prevention, intervention and assessment services result from the decisions of a multidisciplinary team that includes membership of PPSS practitioners.

The multidisciplinary team concept is firmly

established in medical patient care literature. The concept is also found in literature describing effective processes for allocating special education services and the development of the Individual Education Plan (Shapiro & Sayers, 2003; *Special Education: A Guide for Educators, 2001*). Giangreco, (1997) describes collaborative teamwork as essential to quality inclusive education.

Colluci & Lean, (2008) advocate for the pivotal, central role for school based multidisciplinary professionals, (i.e., psychology staff, social workers and child and youth workers). Full service schools or school based services models describe a central role of a school based team of members from many disciplines who collaborate and make decisions about services to meet student needs (Cuglietto, Burk & Ocasio, 2007; Dryfoos, 2002, 1999; Adelman & Taylor, 1998).

Cole & Brown's, (2003) analysis of the functions of the multidisciplinary team extends beyond the referral of the student for special education services to include recommendations for school based support services. The scope of problems considered by multidisciplinary teams included academic performance, active learning and study skills, specific learning characteristics (i.e., forgetfulness, disorganized, passive learner), social skills, emotional problems, psychosocial stressors, English as a second language and refugee needs. The multidisciplinary team's work included: a) clarification of the presenting problem, b) analysis of identified problems, c) brainstorming alternative solutions, d) developing plans for intervention, e) assigning responsibilities and timelines, f) monitoring interventions and follow up (p. 25).

Giangreco, (2000) describes in detail the VISTA (Vermont Interdependent Services Team Approach), organization, membership and activities. VISTA is an example of a school based, systematic, collaborative decision-making process. The team has core and extended team membership. The team uses a consensus process to make decisions about the provision of support services that are educationally relevant and necessary for a student to either gain access to, and/or participate in his/her educational program.

Among the benefits of a multidisciplinary team, Cigno & Gore, (1999) describe an apparently seamless delivery of services that is highly valued by parents. Weiner & Davidson, (1990) cite the capacity of educational personnel to make decisions and carry out interventions. Cole & Brown, (2003) cite an additional benefit of a "cost effective sharing and co-ordination of school based services" (p.24).

Respondents in this research study strongly advocated for a systematic, multidisciplinary team process framed within a problem solving approach. The MPST must include, as a minimum, the principal, the classroom teacher, the case manager, the referring person and any other school support staff who are directly involved with the student. PPSS membership is fluid. The appropriate PPSS practitioner(s) is/are invited to the regularly scheduled team meetings.

The MPST facilitates the sharing of knowledge and expertise among PPSS practitioners and educators. As a central decision making body, the MPST creates an effective and efficient delivery of services. Any student with social, emotional, behavioural or academic needs may be assisted by the MPST. The MPST allocates resources, develops interventions, conducts on-going monitoring and facilitates further referrals if appropriate. For example, the sessions may be needed to facilitate and mediate family and school relationships, to assist a student at risk, to consider issues of truancy or isolation, problems socializing, violence, suicidal threats or attempts. The ongoing cycle of monitoring and observation of progress should include input from parents, students and school based practitioners.

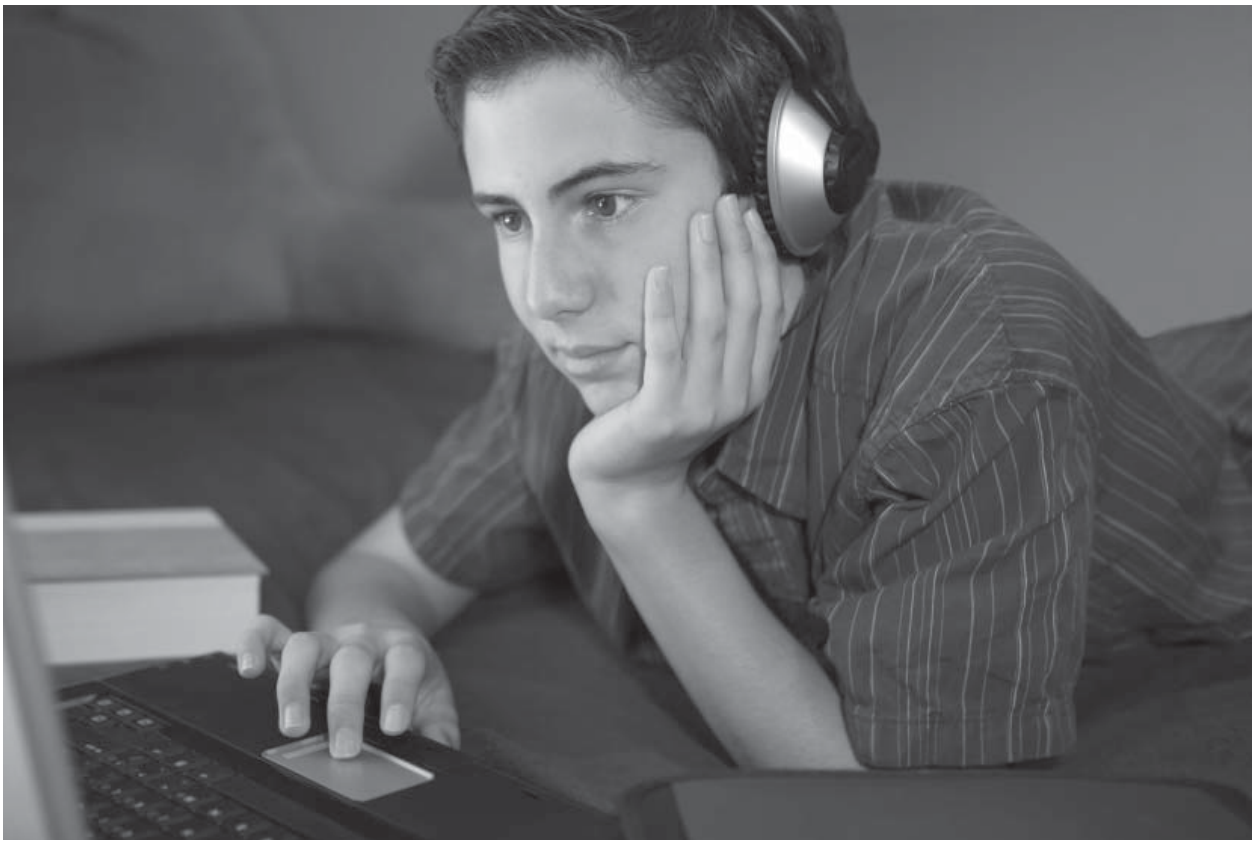
The MPST should develop local protocols and procedures based on school board protocols and in compliance with PHIPA guidelines to respond to requests from outside agencies to deliver programs and services to students in the school setting.

5. Planned protocols and procedures at the school level are managed and honoured by appropriate personnel.
   This principle means a person committed to the success of the multidisciplinary team takes an active role in developing operating procedures and managing the team processes.

   Successful teams develop protocols to address potential problems (Salend & Salinas, 2003). Equally important is the adherence to the role descriptions, procedures and forms (Cuglietto, Birl & Ocasio, 2007; Adelman & Taylor, 1998; Armbruster, Gerstein & Fallon,1997). **Cooley**, (1994) identifies potential problems of disorganization, miscommunication and misunderstanding, and lack of participation as potential barriers to effective team functioning. Establishing goals, protocols and clarifying roles will address any perceived differences in power among members (Cigno & Gore, 1999). The wraparound approach (Quinn & Lee, 2007) has emerged as an effective approach for individualized targeted intervention partly because of the adherence to a clearly articulated set of principles and procedures.

   Pivotal to the success of school based teams is the need for a full time coordinator to avoid the potential overlap, duplication or loss of information, to provide staff stability and continuity and to manage the referral to outside agencies procedures (Mc Nab & Coker, 2005; Dryfoos, 1996, 1993).

Respondents in this research study identified similar essential elements to the success of the MPST. Critical to the success of the MPST is a case manger who is responsible for scheduling, documentation, guiding the process and inviting appropriate PPSS staff to regularly scheduled meetings. The MPST operates with core and intermittent membership. Core members must include, as a minimum, the principal, the classroom teacher, the case manager and the referring person and any other school support staff who are directly involved with the student. PPSS practitioners are invited intermittently as needed. The case manager ensures that there is no waiting list or delay in convening the MPST meeting or initiating the appropriate actions to respond to the student's needs.



6. PPSS practitioners must be actively involved in developing and managing the protocols that outline the services that may be provided in schools by outside agencies.

This principle means that PPSS practitioners participate in the development and monitoring of school board protocols that outline the roles and procedures for community (outside) agencies to provide services to students in the school setting.

Schools often lack the resources to handle the full range of mental health conditions presented by students and so partnership arrangements are created (Brener et al , 2007). Paternite, (2005) provides justification for partnership agreements. According to Colucci & Lean, (2008) school based professionals serve an important liaison and intermediary function between students' needs, the school system and external agencies who deal with children and youth. Armbruster, Gerstein & Fallon, (1997) identified the central co-ordination role of the school as one of the many factors that contributed to the success of their project. The American Counselling Association, (2006) states that school employed professionals must co-ordinate with community service providers.

Paternite, (2005) states that implementing interventions in schools needs to consider "securing the on-going support of school leaders and staff and, negotiating pragmatic issues, such as time in the curriculum and school day and space." Descriptions of successful school based services projects clearly place the school based team as the central body through which referrals and services are coordinated. These important decisions must be clearly outlined in service protocols.

Respondents in this research study acknowledged the excellent programs that are currently available from community (outside) agencies. Some of the services provided by community agencies cannot be provided in the school (e.g., home bathing by occupational therapists; drug addiction counselling, and some speech and language therapies). Referral to community agencies are appropriate when the school/board resources have not resulted in goal attainment or if the services required are beyond the scope of the board's mandate or resources (i.e., medical, Children's Aid, respite care services, day treatment programs, residential and rehabilitation services for drug or alcohol abuse, etc). Providing these services in the school and streamlining the consent process would eliminate barriers for students and families. Community agencies are a potential resource to support students and should enhance school board services, but not duplicate these services. Community agencies may provide whole class or small group prevention programs, specialized long term counselling or treatment programs. Many school boards have developed written protocols and procedures delineating the appropriate roles for school board and community agency service delivery. An example from the Toronto District School Board is found in Appendix 5 and from the Peel District School Board in Appendix 6. These protocols would specify that these outside agencies operate with the multidisciplinary team and under the guidance of the school. Protocols already exist for emergency preparedness and crisis intervention that could be used as a model. The absence of clear protocols, or short term funding to community agencies for specific projects fails to consider the student's needs holistically in

relation to the classroom, the school, and the family contexts.

7. The full range of students' non academic needs is met by board employed practitioners.

This principle means that school boards must recruit and retain sufficient numbers of PPSS practitioners to respond quickly to the range of presenting student needs within their schools.

Research presents many advantages to board employed staff. Graham – Clay, (1999) highlighted that school psychologists "understand both schools and families." Other board employed PPSS practitioners may also lay claim to this depth of knowledge about schools, students and families.

Henry, (1998) argued that board hired professionals "develop relationships with staff within a school and therefore, recommendations [made] regarding program modifications or management of the student are a result of this partnership." Board hired professionals have a greater ability to reschedule activities when circumstances change or an urgent situation develops. In addition, they have developed an expertise specific to the school setting and the issues and concerns that affect students' school progress and adjustment. Board staff develop a commitment to the organization.

In a fee-for-service arrangement, the service does not include the time for consultation, referral, follow up with the teacher and monitoring the student (p. 12). Henry concludes that outsourcing these services doesn't really save money (p. 10).

Sanders & Miller, (1999) considered the advantages and disadvantages to the school board and to the practitioner of providing services under an external contract agency. They conclude that "school board hired practitioners are able to participate fully with the team to deliver a continuum of services that are educationally relevant."

Respondents in this research study supported the basic assumption articulated in Phase 1 that "Professional and Paraprofessional Support Services (PPSS) should be delivered by board employed professionals, complemented by the services of community agencies." PPSS practitioners understand the social structures and relationships within a school and the school's unique culture and so are able to provide relevant, effective services.
Many boards currently are not hiring certain classes of professionals (i.e., no occupational therapists, no physiotherapists, no speech-language pathologists, no psychologists). Specifically, OT/PT services are available through only three Ontario school boards. The remaining services are accessed through community based agencies. When services are available through school boards, teachers have access to consultative and intervention services for the whole school year. These professionals can consult about safety issues for the student and support staff and assist with making plans for emergency evacuation, etc. Specific referrals may include specific equipment recommendations, specific fine and gross motor or sensory assessment, or assistance with accessing technology related to the students.

Services provided by board employed PPSS practitioners are predictable and accessible to students. The current climate of funding reductions is also experienced by service providers in community agencies. Consistently the researchers heard that these community based services are being reduced or eliminated. If this trend continues further more services for students may be compromised.

8. Progress oriented measures of service effectiveness must include the perspectives of students, teachers, administrators and parents.

This principle means that decisions about service effectiveness should relate to student's progress toward academic and non academic goals.

Research studies conclude that criteria used in clinical practice may not be appropriate or effective in the school context (Paternite, 2005; Adelman & Taylor, (2003). Maximum caseload thresholds and number of referrals that are effective in clinical practice are counter productive to providing effective school services. A recent survey by the Ontario Association for Social Workers, (2004)

found that the number of cases assigned to a social worker per year ranged from 22 to 150. Comments by respondents indicated that the cases involved "more intense interventions with complex problems of students and families."[21] The Social Work Association of America advocates for a population based caseload "ratio of one school social worker to 400 students (1:400)."[22] A population based caseload ratio provides equitable access for all students. The Ontario Association for Families with Children with Communication Disorders recommends:

The ratio of speech-language pathologist to school age children should be 1:1500 (OAFCCD, 1996). Given the current fiscal restraints, however, a ratio of 1:2250 would be realistic and would represent the present ratio in the better serviced boards.[23] The American Speech and Hearing Association (ASHA)[24] avoids a population based ratio and recommends a caseload of 40 for each speech and language pathologist.

Whereas caseloads are often used as a criteria for service effectiveness, respondents in this research study argue that relying solely on measures of student achievement (i.e., credit accumulation or improved diagnostic testing or Education Quality and Accountability Office (EQAO) scores), number of referrals, caseloads or length of wait lists is not a progress oriented measure of success and does not indicate the quality of service.

This research argues that standardized, comprehensive, progress oriented and on going success measures taking local needs into account need to be implemented across the province. Measuring service effectiveness needs to include individual and group measures and short term and long term measures using qualitative and quantitative data. Multiple measures of student progress with respect to academic and non academic measures must be considered valid and reliable measures (e.g., reduction in number of suspensions, reduction in truancy, reduction in dropout rates, reduction in negative /challenging behaviours, improved attendance records, increases in measures of self-esteem as well as academic success, attainment of Individual Education Plan goals, improved learning skills, more positive report card comments, increased level of student engagement, usefulness of the resources provided) are appropriate measures of success.

Consumer satisfaction (e.g., satisfaction surveys completed by students, teachers or parents) should be considered as one measure of service effectiveness. These feedback forms could be attached to psychological or speech and language reports to be returned to the professional service provider after a specified length of time.

School systems and the Ministry of Education need to make decisions about service delivery based on appropriate data. Therefore a systematic process of data collection needs to be implemented on a board and provincial level. Data to be collected may include:

- the range of student needs
- the services provided currently, including cases opened and closed
- time committed to consultative, preventative, intervention and assessment services
- time committed to enhancing, interpreting or revising assessments conducted by outside agencies
- broad based measures of service effectiveness.

The Ministry of Education could begin by examining current data collection measures used by some Ontario school boards to establish a reflection of the range of services provided and the relative time commitments of these services.

21 School Social Work Survey Results, 2004 by the Ontario Association of Social Workers.

22 School Social Work Association of America www.sswaa.org/members/resolutions/staffing.html

23 OAFCCD Service Delivery Model Analysis of School Speech-Language Pathology Ratios And Costs. Downloaded January 20 from: www.oafccd.com/factshee/fact68.htm

24 ASHA supplement to the ASHA leader, Volume 8, Number 7, 2003 Supplement No.23.

9. A school based service delivery model promotes the centrality of the PPSS practitioner's liaison role with the community, the school board, the school, the class, and the individual student.

   This principle means that the PPSS practitioner is in a pivotal liaison position with a variety of education stakeholders. These interactions are focused on meeting student needs in the short and long term.

   The liaison role for paraprofessionals in special education literature has been accepted. Giangreco et al, (2006) identifies that paraprofessionals meet multiple goals of assisting students with disabilities in inclusive settings, supporting the work of classroom teachers and special educators, and being responsive to requests from parents. He cites a study by Werts, Leeper & Zigmund, (2001) that shows that highly skilled and specially trained paraprofessionals have a positive impact on academic engagement.

   Role descriptions for regulated professionals consistently cite the importance of establishing and maintaining communication networks with a range of stakeholders (Canadian Psychological Association, 2007, School Social Work Association of America, Canadian Association of Speech and Language Pathologists).[25]

   Colucci & Lean, (2008) advocate for a pivotal, central role for school based multidisciplinary professionals, (i.e., psychology staff, social workers and child and youth workers). In addition to direct service to students, educators and parents, school based professionals serve an important liaison and intermediary function between students' needs, the school system and external agencies who deal with children and youth. These agencies include organizations representing Community Health and Allied Health Services, Social service systems, Community Mental Health Services, Youth Justice, Faith based and volunteer organizations. According to the authors, the pivotal role of school based professionals in supporting academic achievement and meeting students' mental health needs cannot be underestimated.

   Respondents in this research study fully embrace and endorse the centrality of PPSS practitioners to the liaison role with a variety of stakeholders within the school system and in the broader community.

10. Funding of a school based service delivery model must be dedicated, predictable, stable and sufficient to support board employed PPSS practitioners.

    This principle means that the Ministry of Education must commit to protected and adequate funding for a full service delivery model to enable school boards to recruit and retain sufficient PPSS practitioners to meet student needs. Alternately, the Ministry of Education must provide school boards with sufficient funding to contract some or all of the full range of preventative, consultation, intervention and assessment services to meet student needs from local community agencies.

    In the United States literature, inadequate funding results in serious barriers to effective school based services. The current inadequate funding results in a limited range of services or services available only through volunteers or part time employees. Under these funding arrangements, these services are highly fragmented and unpredictable,

25 www.caslpa.ca/english/profession/mission.asp

resulting in the marginalization of these services in school policy and practice (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007)

Han & Weiss, (2005) state that when resources are discontinued or funding lapses, the programs and services degrade. Most school based mental health services initiatives remain marginalized (Weist, 2005) and unable to offer full treatment, evaluation or consultative services because of unpredictable and limited funding.

Stormshak, Dishion, Light, & Yasui, (2005) reported that budget cuts resulted in significant negative consequences for their study that included the redeployment of critical staff resulting in reductions to the program as well as tension between school and community service staff. Their findings are supported by Wenter, Ennett, Ribisl, Vincus, Rohrbach, Ringwalt, & Jones, (2002) who conclude that available resources are more significant than school climate in determining whether schools adopted the recommendations of their research findings.

The American Counselling Association, (2006) cites numerous studies that report the economic savings of school based interventions by reducing public expenditures for special education, welfare and criminal justice as well as documenting the long term social problems and costs that have been averted.

Mackenzie, (2007) identifies a continual erosion in the numbers of teaching assistants, also known as educational assistants due to inadequate funding. He further identifies that flexibility in the utilization of funds in the professional and paraprofessional categories contributes to the decline in staff.

The funding formula contains few restrictions and "boards are free to allocate their funding however they determine. When boards' funding flexibility is reduced…school board management looks for flexibility in other areas. And all too often, the path of least resistance and with least political visibility is to cut back support staff" (p. 10).

Respondents in this research study acknowledged that this aspect of the funding formula is grossly underfunded and has rendered many school boards unable to effectively address the range of complex students' needs. The restricted availability of funds seriously inhibit capacity building activities in the school system such as professional development, modeling, consultation, etc. The respondents also advised that funding for PPSS practitioners should not be part of the Special Education Amount, as the services extend beyond students in special education. Further funding for PPSS practitioners is an important, necessary and valued service and should be protected.

Respondents in this research study acknowledged that this aspect of the funding formula is grossly underfunded and has rendered many school boards unable to effectively address the range of complex students' needs

A related concern for PPSS services is that under the present structure professional and paraprofessional funding is not protected and extends to include other staffing groups, such as lunchroom supervisors, translators, etc. As these needs rise or as emergencies occur, funds are transferred to meet these needs, reducing the funds available for PPSS services.

In summary, adequate, predictable, protected funding must be available to permit PPSS practitioners to engage in a full range of service delivery.

Conclusions

The social context for students demands that non academic needs be purposefully addressed in the school setting. Schools need to support the non academic needs of students in order to achieve provincially articulated achievement targets. Policy for professional and paraprofessional service delivery must provide coherent provincial direction.

The findings of the current research study support and extend existing research literature on school based services. Differences in geography, population demographics (socioeconomic status, cultural differences, religious differences), population density and the historical school board practices indicate that a prescriptive "one size fits all" model is inappropriate.

The best service delivery model for Ontario needs to allow for flexibility within a consistent framework. The ten principles developed in this research provide a framework. Within this framework, school boards have the flexibility to respond to develop a best practice model that is responsive to local conditions.

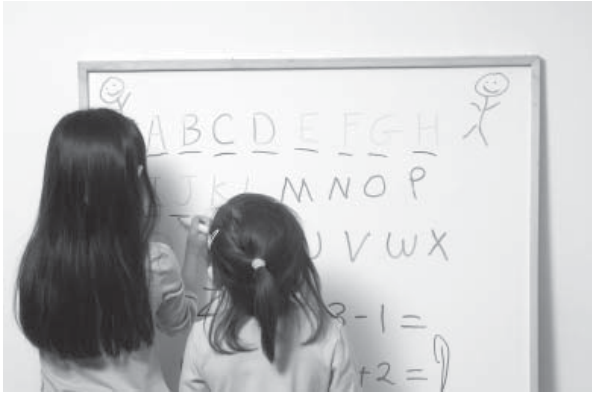
The Ministry of Education must enable the development of comprehensive best practice service delivery by ensuring adequate, stable, predictable funding.

The best service delivery model for Ontario needs to allow for flexibility within a consistent framework

Related Concerns

Currently there is inconsistency in union representation for professionals and paraprofessionals. Multiple unions represent some groups, while others are not represented by unions. Conflicting contractual arrangements and bargaining priorities may create competing funding interests that will need to be examined and managed.

The present fragmented service delivery may be related to the original provisions in Policy Program Memorandum 81/1984 (Provision Of Health Support Services In School Settings), when some services were designated to be delivered by other ministries (e.g., speech and language services). This memorandum is now generally recognized to be outdated and not reflective of the current complexities of service delivery in schools. The Ministry of Education may wish to consider taking responsibility for all children's mental health services, leaving community based services for adults. Children's mental health and treatment needs are currently provided in partnership with education in Section 23 classrooms.



References

Adelman, H., & Taylor, L. (2003). Rethinking school psychology (commentary on public health framework series). *Journal of School Psychology*. 41 (1). 83-90.

Adelman, H., & Taylor, L. (1998). Reframing Mental Health in Schools and Expanding School Reform. *Educational Psychologist*. 33. (4). 135-152.

Adlaf, E., Paglia-Boak, A., Beitchman , J., & Wolfe, D. (2005). *The Mental Health and Well Being of Ontario Students, 1991-2005*. Ontario Student Drug Use Survey, CAMH Research Document Series. No 189. Toronto Center for Addition and Mental Health.

American Counselling Association (2006). *Removing Barriers to Learning and Improving Student Outcomes: the Importance of School Based Mental Health Services*.

Armbruster, P., Gerstein, S., & Fallon, T. (1997) Bridging the Gap Between Service Need and Service Utilization: A School Based Mental Health Program. *Community Mental Health Journal*. 33.(3). 199-211.

ASHA supplement to the ASHA leader. (2003) 8, (7), 2003 Supplement No.23 Published by the American Speech and Hearing Association.

Baaron-Cohen, (2000). Is Asperger syndrome/high functioning autism necessarily a disability? *Development and Psychopathology*. 12 . 489-500.

Baker, J., Kamphaus, R., Horne, A., & Winsor, A., (2006) Evidence for Population Based Perspectives on Children's Behavioural Adjustment and Needs for Service Delivery in Schools. School Psychology Review. 31(1). 31-46.

Bauminger, N., Edelsztein, H., Morash, J. (2005). Social Information Processing and Emotional Understanding in Children with LD. *Journal of Learning Disabilities*. 38 (1)45-61.

Becker, B., & Luthar, S. (2002). Social-Emotional Factors Affecting Achievement Outcomes Among Disadvantaged Students: Closing the Achievement Gap. *Educational Psychologist*. 37. (4). 197-21.

Bennett, B., & Rolheiser, C. (2001). Beyond Monet: The Artful Science of Instructional Integration. Toronto. Bookation Inc.

Boutrogianni, M., & Pratt, M. (1990). Dynamic Assessment. Chapter 9 in *Effective Consultation in School Psychology*. Ester Cole & Jane Siegel, (Eds). Lewiston. New York. Hogrefe & Huber. 129-140.

Brener, N., Weist, M., Adelman, H., Taylor, & Vernon-Smiley, M. (2007). Mental Health and Social Services: Results from the School Health Policies and Programs Study, 2006. *Journal of School Health*. 77. (8). American School Health Association. 487-499.

Canada's Standing Senate Committee on Social Affairs, Science and Technology report "*Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*," (2006), Downloaded January 19, 2008 from: www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm

Canadian Association of Speech and Language Pathologists. Downloaded January 11, 2008 from: www.caslpa.ca/english/profession/mission.asp

Canadian Children's Rights Council. (2005) Downloaded January 12, 2008 from: www.canadiancrc.com/Bullying.aspx

Canadian Newswire, May 7, 2004

Canadian Psychological Association. (2007). *Professional Practice Guidelines for School Psychologists in Canada*.

C.D. Howe Institute. (2005). Commentary. Stay in School: New Lessons on the Benefits of Raising the Leagal SchCanadian Newswire.(2004). *Ontario Acting to Reduce Bullying and Violence in Schools*. Ministry of Education.
May 7.

Canadian Newswire.(2006). McGuinty Government Supports Character Development in Schools. Ministry of Education. October 16.

Canadian Psychological Association. (2007). *Professional Practice Guidelines for School Psychologists in Canada.*

Cigno, K., & Gore, J. (1999). A seamless service: meeting the needs of children with disabilities through a multi-agency approach. Child and Family Social Work. 4. 325-335.

Cole, E., & Brown, R. (2003). Multidisciplinary School Teams: A Five Year Follow-up Study. In *Effective Consultation in School Psychology*. Ester Cole & Jane Siegel, (Eds). Lewiston. New York. Hogrefe & Huber. 24-44.

Colucci, V., & Lean, D. (forthcoming, 2008). *An Integrated School Based Support Services Approach*. Unpublished Manuscript .

Cooley, E. (1994). Training an Interdisciplinary Team in Communication and Decision Making Skills. *Small Group Research*. 25, (1). 5-25.

Crockett, D. (2004). Critical issues children face in the 2000s. *School Psychology Review*. 33.(1). 78(5).

Cuglietto, L, Burke, R., & Ocasio, S. (2007). A Full Service School. *Educational Leadership*. 64. (6). 72-73.

Denha, A., Hatfield, S., Smethurst, N., Tan, E., & Tribe, C. (2006). The Effect of Social Skills Interventions in the Primary School. *Educational Psychology in Practice*. 22 (1) 33-51

Drewett, B., (2007). Directions for Special Education in Ontario. *Orbit*. 37. (1)

Dryfoos, J. (2002). Full-service community schools: Creating New Institutions. *Phi Delta Kappan*. 83. (5). 393-399.

Dryfoos, J. (1996). Full-service schools. *Educational Leadership*; 53. (7). 18-23.

Dryfoos, J. (1993). Full service schools: What They Are and How To Get To Be One. *NASSP Bulletin*. 77. (557). 29-35.

Dufferin Peel Catholic District School Board. (2007). *Introduction to the Resource Handbook for Social Workers/ Attendance Counsellors Post – Bill 52*. Mississauga.

Elias, M., O'Brien, M., & Weissberg, R. (2006). Transformative Leadership for Social- Emotional Learning. *Principal Leadership*. 7. (4) 10-13.

Evans, S., Bebhinn-Timmins, M., Casey White, L.,Zewelanji N., & Schultz, B. (2006). Developing Coordinated, Multimodal, School-Based Treatment for Young Adolescents with ADHD. *Education And Treatment Of Children*. 29. (2).

Elliott, S. & Busse, R. (1991) Social skills assessment and intervention with children and adolescents: guidelines for assessment and training procedures. *School Psychology International*, 12. 63-83

Evans, S., Axelrod, J., & Sapia, J. (2000). Effective School Based Mental Health Interventions: Advancing the Social Skills Training Paradigm. *Journal of School Health*. 70 (5). 191-194.

Fagan, J., & Wilkinson, D. (1998). Guns, Youth Violence, and Social Identity in Inner Cities *Crime and Justice*. 24. 105-188 .

Falconer, J., Edwards, P & MacKinnon, L. (2008). *The Road to Health: A Final Report on School Safety*. A Report of the School Community Safety Panel

Ferguson, B., Tilleczek, K., Boydell, K., & Rummins, J. (2005). *Early School Leavers: Understanding the Lived Reality of Student Disengagement from Secondary School*. Community Health Systems Resource Group and The Hospital for Sick Children.

Fern, E. (2002). *Advanced Focus Group Research*. Thousand Oaks, CA. Sage Publications.

Fraenkel, J., & Wallen, N., (2000). *How to Design and Evaluate Research in Education*. Fourth Edition. Boston. McGraw Hill.

Gable R., & Van Acker, R. (2000). The challenge to make schools safe: preparing education personnel to curb student aggression and violence. The Teacher Educator. 35. (3). 1-18.

Giangreco, M., (2000). Related Services Research for Students with Low Incidence Disabilities: Implications for Speech Language Pathologists in Inclusive Classrooms. *Language, Speech and Hearing Services in Schools*. 31. 230-239.

Giangreco, M. (1997). Key Lessons Learned About Inclusive Education: summary of the 1996 Schonell Memorial Lecture. *International Journal of Disability Development*. 44. 193-206.

Giangreco, M., Smith, C., & Pinckney, E., (2006). Addressing the Paraprofessional Dilemma in an Inclusive School: a program description. *Research and Practice for Persons with Severe Disabilities*. 31. (3). 215-229.

Gordon, Feldman & Chiriboga (2005) Helping Children with Disabilities Develop and Maintain Friendships *Teacher Education and Special Education*; 28.(1).1-9.

Graham-Clay S. (1999). Enhancing home-school partnerships: How school psychologists can help. *Canadian Journal of School Psychology*. 14. (2). 31-44.

Gresham, F., & Reschly, (1986). Social skills deficits and low peer acceptance. *Learning Disabilities Quarterly* (9) 23-32.

Hamett, C. (2006). Double Invisibility Learning Disabilities and Mental Health. *Communique*. 37 (1). Learning Disabilities Association of Ontario.

Han, S., & Weis, B. (2005). Sustainability of teacher implementation of school-based mental health rogras. *Journal of Abnormal Child Psychology*. 33.(6). 657-663.

Halton District Educational Assistants Association (2001). Educational Assistants: Our Work Downloaded January 11, 2008 from: www.hdeaa.com/ourwork.asp

Henry, T. (1998). *On the Uses and Disadvantages of Outsourcing for Education*. PSSP/OSSTF District 20.

Hine, E., & Maika, D. (2007). A Province Called To Action. The Learning Journey. *Principal Connections*. 11. (2). Catholic Principals' Council of Ontario.

Hoagwood, K., Olin, S., Kerker, B., Kratochwill, T., Crowe, M., & Saka, N. (2007). Empirically Based School Interventions Targeted at Academic and Mental Health Functioning. *Journal of Emotional and Behavioural Disorders*. 15. (2). 66-92.

Hope, R., & Hodge, D., (2006). Factors Affecting Children's Adjustment to Death of A Parent: The Social Work Professionals' Viewpoint. *Child and Adolescent Social Work Journal.* 23. (1). 107-126.

Jaffe, P., (2007). Challenging the Proliferation of Media Violence: A Call to Action for Educators. *Education Today*. 19. (1). 24-28.

Kelders, N., & Celenza, M. (2007). Mary Gordon. Roots of Empathy. *Principal Connections*. 11.(2). A Publication of the Catholic Principals' Council of Ontario. 36-38.

Kitzinger, J. (1995) *Qualitative Research: Introducing Focus Groups*. Downloaded January 13, 2008 from www.bmj.com/cgi/content/full/311/7000/299

Klostelnik, M., Whirin, A, Soderman, A, Stein, L, and Gregory, K. (2002). *Guiding Children's Social Development, Theory to Practice* 4th edition. Albany, New York. Delmar.

Koller, J., & Bertel, J., (2006). Responding to Today's Mental Health Needs of Children ,Families and Schools: Revisiting the Preservice Training and Preparation of School Based Personnel. *Education and Treatment of Children*. 29. (2). 197-217.

Krueger, R., & Casey, M. (2000). *Focus Groups*. Third Edition. Thousand Oaks, CA. Sage Publications.

Landau & Moore, S., & Moore, L. (1991) Social skill deficits in children with attention-deficit hyperactivity disorder. *The School Psychology Review*. 20 (2). 235-51.

Landy. S. (2002). *Pathways to Competence. Encouraging healthy social and emotional development in young children* Baltimore. Paul Brookes Publishing Company.

Learning Disabilities Association of Ontario. *Recommended Practices for Assessment, Diagnosis and Documentation of Learning Disabilities*. Downloaded Jan 10, 2008 from www.ldao.ca/what_are_lds/LDAO%20Recommended%20Practices.pdf.

Mackenzie, H. (2007). *Ontario's Shrinking Commitment to Funding Educational Assistants*. CUPE Ontario.

Marquardt, E. (2006). *Between Two Worlds: The Inner Lives of Children of Divorce*. Three Rivers Press.

McCombs, B., (2004) The Learner Centered Psychological Principles: A framework for Balancing Academic Achievement and Social –Emotional Learning Outcomes. Chapter 2. in Building Academic Success on Social and Emotional Learning p 23-40. Teachers College Press.

McNab, J., & Coker, J. (2005). The School Counsellor: An Essential Partner in Today's Coordinated School Health Climate. *Guidance Counsellor*. 20. (3/4). 102-108.

Ministry of Education. (2007). Bullying Prevention and Intervention. Policy/Program Memorandum No. 144. Ontario.

Ministry of Education. (2007). Progressive Discipline and Promoting Positive Student Behaviour. Policy/Program Memorandum No. 145. Ontario.

Ministry of Education (2006). *Special Education Transformation: The Report of the Co-Chairs with the Recommendations of the Working Table on Special Education*. Ontario

Ministry of Education (2005). *Education for All: The Report of the Expert Panel on Literacy and Numeracy Instruction for Students with Special Educational Needs.*

Ministry of Education. (2001). *Special Education: A Guide for Educators*.

Moran, P., Jacobs, C., Bunn, A., & Bifulco, A. (2006). Multi-agency working: implications for an early intervention social work team. *Child and Family Social Work*. 12.

Morgan D. (1988). *Focus Groups as Qualitative Research*. Newbury Park, CA. Sage Publications.

Morris, S. (2002). Promoting social skills among students with nonverbal learning disabilities. *Teaching Exceptional Children*. 34. (3). 66-70.

Norris, J. (2003). Looking at Classroom Management Through a Social and Emotional Lens. *Theory into Practice*. 42. (4). 313-319.

Niolin, R., (2003). Children of Divorce and Adjustment. Downloaded January 13, 2008 from www.psychpage.com/family/divorce/childrenadjust.htm

Ontario Association for Families with Children with Communication Disorders. *Service Delivery Model Analysis of School Speech-Language Pathology Ratios And Costs*. Downloaded January 20, 2008 from :www.oafccd.com/factshee/fact68.htm

Ontario Association of Social Workers (2004). *School Social Work Survey Results*.

Parker, J., & Asher, S. (1993). Friendship and friendship quality in middle childhood: links with peer group acceptance and feelings of loneliness and social dissatisfaction. *Developmental Psychology*. 29. (4). 611-621.

Paternite´, C. (2005). School Based mental health programs and services: Overview and introduction to the special issue. *Journal of Abnormal Child Psychology*. 33.(6). 657-663.

People for Education (2007). Annual Report. Downloaded January 12, 2008 from: www.peopleforeducation.com/research-info

Public Health Agency of Canada (2003) Canadian Incidence Study of Reported Child Abuse and Neglect - Major Findings – 2003. Downloaded January 12, 2008 from : www.phac-aspc.gc.ca/cm-vee/csca-ecve/toc_e.html

Quin, K., & Lee, V. (2007). The Wraparound Approach for Students with Emotional and Behavioural Disorders: Opportunities for School Psychologists. *Psychology in the Schools*. 44 (1). 101-111.

Robertson, H. (2000). Sad, Bad, Mad: Responding to the Health of Canada's children. *Phi Delta Kappan*. 82 (3). 255-256.

Ruchin, V., Henrich, C, Jones, S., & Vermeiren, R., (2007).Mediating Role of Posttraumatic Stress. *Journal of Abnormal Psychology*. 35. 578-593.

Rusk, B., Shaw, J., & Joong, Dr. P. (1994). *The Full Service School*. Ontario Secondary School Teachers' Federation. Toronto.

Salend, S., & Salinas, A. (2003) Language Differences or Learning Difficulties: The Work of the Multidisciplinary Team. *Teaching Exceptional Children*. 35. (4). 36-43.

Sanders, J., & Miller, H. (1999). Employment Options in the School Systems: To Contract or Not to Contract. *School System Special Interest Section Quarterly*. 6 (4). 1-3. Published by the American Occupational Therapy Association, Inc.

Schonert-Reichl, K., & Hymel, S., (2007). Educating the Heart as Well as the Mind: Social and Emotional Learning for School and Life Success. *Education Canada*. 47. (2). 40-45.

School Social Work Association of America . Downloaded January 12, 2008 from: www.sswaa.org/members/resolutions/staffing.html

Scholten, T. (2003). What Does It Mean to Consult?. Chapter 5. In *Effective Consultation in School Psychology*. Ester Cole & Jane Siegel, (Eds). Lewiston. New York. Hogrefe & Huber. 87-106.

Schwartz, M. (2006). Bringing Effective Character Education to the Schools. Downloaded January 12, 2008 from: www.edu.gov.on.ca/eng/literacynumeracy/SchwartzWork.pdf

Shapiro, D., & Sayers, K. (2003). Who Does What on the Interdisciplinary Team? *Teaching Exceptional Children*. 35 (6). 32-38.

Sladeczek, I., Kratochwill, T., Steinbach, L., Kumke, P., & Hagermoser, L. (2003). Problem Solving Consultation in the New Millennium. Chapter 4. In *Effective Consultation in School Psychology*. Ester Cole & Jane Siegel, (Eds). Lewiston. New York. Hogrefe & Huber. 60-86.

School Social Work Association of America downloaded January 11, 2008 from: www.sswaa.org/members/resolutions/staffing.html

Stormshak, E., Dishion, T., Light, J., & Yasui, M . (2005). Implementing Family Centered Interventions within the Public Middle School: Linking Service Delivery to Change in Student Problem Behaviour. *Journal of Abnormal Child Psychology*. 33.(6). 723-733.

Stuart, Gresham & Elliott, 1991. Teacher ratings of social skills in popular and rejected males and females. *School Psychology Quarterly* (6). 16-26.

The Association of Chief Psychologists of Ontario School Boards. *What do Psychologists Do?* Downloaded January 11, 2008 from www.acposb.on.ca/identity.html

Tomb, M., & Hunter, L. (2004). Prevention of Anxiety in Children and Adolescents in a School Setting. The Role of School Based Practitioners. *Children and Schools*.26. (2). 87-101.

Toronto District School Board. 2006 Student Census, Grades 7-12 October 2007.

Toronto District School Board. Support Services Service Evaluation Results. May 2007.

Vickerstaff, S., Heriot, S., Wong, M., Lopes, A., Dossetor, D. (2007) ,Intellectual Ability, Self Perceived Social Competence and Depressive Symptomatology in Children with High Functioning Autism Spectrum Disorders. *Journal of Autism and Developmental Disorders* 37 (9).1647-1664.

Weiner, J., & Davidson, I. (1990). The In-School Team Experience in *Effective Consultation in School Psychology*. Chapter 2. Esther Cole & Jane Siegel (Eds). Toronto. Hogrefe & Huber Publishers. 19-31.

Weist., M. (2005). Fulfilling the Promise of School Based Mental Health: Moving Toward a Public Mental Health Promotion Approach. *Journal of Abnormal Child Psychology*. 33.(6). 735-740.

Wenter, D., Ennett, S., Ribisl, K., Vincus, A., Rohrbach, L., Ringwalt, C., & Jones. S. (2002). *Journal of Adolescent Health*. 30 (6). 455-462.

Whitney, I., Smith, P. K., & Thompson, D. (1994). Bullying and children with special needs. In P. K. Smith & S. Sharp (Eds.), *School bullying: Insights and perspectives* (pp. 213-240). London. Routledge.

Zins, J., Weissberg, R., Wang, M., & Walberg, H. (2004) *Building Academic Success on Social and Emotional Learning*. Teachers College Press.

Appendix 1

Highlights of Phase 1

A Review of School Board Professional Services

Supporting Special Education in Ontario

Executive Summary Highlights
September 24, 2007

Research completed by Yvette DeBeer
Literature Review completed by Jawara Gairey

Commissioned by the Ontario Secondary School Teachers' Federation

Research Method

Initially, the research planned to describe the level of professional student services provided to students within a full service school team model and compare to the level of service provided through external partnership agreements. The research design included survey instruments and interviews of school board employees and a thorough literature review.

For a variety of reasons, many research applications were denied by school boards. The non participation of so many school boards posed a serious barrier to the previous research plan. In February, 2007, the research shifted from the full study to conducting focus groups. Nineteen (19) focus groups were conducted with ninety-three (93) participants. Focus groups were conducted with unionized and non unionized professional student services providers in large and small, urban and rural Public and Catholic English language school boards. None of the Francophone boards were approached in this phase of the research. A focus group was held with the Chief Psychologists of Ontario School Boards and with a group of senior administrators from a school board that volunteered to participate. Additional information was provided by a Chief Psychologist by telephone and by a Speech & Language Pathologist (SLP) in a separate meeting.

Involvement of the OSSTF Professional Student Services Personnel Sector The researcher wishes to extend appreciation for the participation of union members in approaching school board staff, organizing meeting dates, times and locations. The research could not have progressed this far without their assistance.

Data Analysis and Findings

Handwritten notes of the principal researcher were analyzed thematically and categorized by employee group. The themes included: issues and concerns, service delivery and successful programs.

Issues and Concerns

Four focus groups were held with principals. The most important concerns for principals were service delivery, the rise in complex mental health needs and behavioural issues that students are exhibiting and insufficient funding and/or funding reductions. These concerns varied in order of importance depending on geographic location, size of student population or size of school board area.

Eleven focus group sessions were held in unionized and non unionized environments with student services professionals (PSSP) in Catholic and Public English language school boards. The most commonly cited issues and concerns related to funding. Specifically, in response to service cuts by other ministries or decreases in school board funding, PSSP services are vulnerable to staff cuts, reduction in services or increasing caseloads. A related concern is that these reductions in service are occurring in an educational environment where students' needs are increasing, becoming more complex and, in come cases more violent. PSSP participants noted that previous, related research studies have identified similar concerns.

Three groups of senior administrators/managers consistently identified the increasing complexity of student needs and the challenges of maintaining staffing and service levels. One board's senior administrators identified many challenges with operationalizing the interministerial collaborative projects.

Service Delivery

Principals described large variation in existing service delivery models. In summary, principals felt that services provided by the board or outside agencies should be delivered in the school. Principals felt that service delivery was enhanced by the availability of the existing infrastructure in the board, the detailed knowledge of the student, family and community context as well as parental willingness to access the services delivered in the school.
The Chief Psychologists described many examples of moving beyond an assessment focus to "value added" services. These included, but were not limited to consulting with other teams, delivering professional development, participating in parent feedback sessions when outside providers complete assessments.

PSSP participants described large variation in their roles and responsibilities across the province. Often participants described a pattern of increasing caseloads and decreasing staff due to funding cuts or enrollment growth.
PSSP duties ranged from conducting assessments only to providing prevention, intervention and consultative services, professional development workshops for parents and teachers as well as parent/student advocacy for outside services. The most posi-

tive comments related to a PSSP role that included participation as part of a multidisciplinary team at the school level. Participants cited the benefits of immediacy of service, improved communication, the enhanced ability to respond to the complexity of student needs, parental confidence in school based services and a deep knowledge of school culture, family, school and community contexts and curriculum linkages. PSSP participants make recommendations that are aligned with this understanding.

There is a recognition that this type of service delivery is difficult to quantify. Documenting practitioner tasks fails to capture the additional PSSP time spent by board staff conducing follow up activities after outside agencies complete assessments, the informal and impromptu consultations about students not formally identified and not normally on a case load, informal support to teachers, background research, referral to outside services etc.

PSSP practitioners cited many examples where interministerial cooperation works in theory but not operationally. Targeted initiatives result in some duplication, and some inefficiencies of service delivery that may not meet the board's needs. A Third Party Protocol assists with role clarification and avoids duplication of service.

Senior board administrators described a variety of service delivery models currently operating. Service delivery is not exclusive to identified students. Participants identified the increasing complexity of students' mental health needs, decreases in funding and the sustainability requirements of targeted Ministry initiatives as challenges to service delivery. When services are delivered by non board personnel, Third Party Protocols are helpful to prevent service duplication and to help structure and define roles.

Conclusions

Participants in all groups offered many examples of successful programs for identified and non identified students at the elementary and secondary levels. The increasing incidence and complexity of student mental health and behaviour needs was identified across all participant groups. Participants in the focus groups clearly indicated that services should be delivered in a school based model.

The assumptions underpinning the government's current practice of interministerial collaborative projects and targeted funding of initiatives need to be closely examined. Interministerial collaborative projects are supported in principle, but the development of new infrastructure is a duplication of existing school board infrastructure and uses time and money that fails to reach the student population. Reductions in service or service gaps can result when outside agencies offer services based on their funding, not on student needs.

Targeted initiatives may not address specific board needs and may raise false expectations that the service will be available in the long term. The Learning to 18 initiative has the potential for increased workload for PSSP staff.

A wide range of service delivery exists from assessment only to models that include consultation services, participation in multidisciplinary team consultation, group or class preventative programs, and direct intervention with individual students and support to teaching staff and parents. Both PSSP and Principals identified that the preferred model is to deliver services in the school.

A significant difference was noted in the level of complexity and number of outside agencies that exist in each community between northern and southern Ontario boards. Increased population density results in increased complexity. Most PSSP practitioners articulated that the programs and services of outside agencies that enhance or extend their services were very welcomed.

Next Steps

The results of Phase 1 lead us to believe that little new information would be gained by continuing with more interviews and focus groups. Consistently, participants articulated that programs and services delivered to students through the school

was preferred and offered the greatest opportunities for success. Equally common was the articulated observation that the numbers of students needing professional student services related to mental health and behavioural issues are increasing and that those student needs are increasing in complexity. Phase 2 of the research should build on the findings from Phase 1. Phase 2 should incorporate the existing successful service delivery practices to develop a school based, best practice model for the delivery of professional student services to students.

* A copy of the full Research report from Phase 1 is available upon request from Domenic Bellissimo at the Provincial Office of the OSSTF bellisd@osstf.on.ca

Commissioned by the Ontario Secondary School Teachers' Federation

Literature Review:

A Review of School Board Professional Services

Supporting Special Education in Ontario

By Independent Researcher Jawara Gairey JDG Research Consultants

Feb. 9, 2007

Commissioned by the Ontario Secondary School Teachers' Federation

Purpose

The research seeks to investigate whether the level of professional student services provided to students through external partnership agreements or specially funded initiatives is comparable to the professional student services performed by board employees who are part of the full service school team. In addition, the research will describe "best practices" in professional student service delivery in the province. Further, the research will inform the Ministry of Education's deliberations on a new special education funding and delivery model. The research is guided by five themes: (1) accessibility of services (2) quality of service, (3) the continuum of services, (4) cost effectiveness and, (5) the professional multidisciplinary team approach.

Abstract

Public schools are possibly the most integrated institutions in society. In them, students from many different religious, cultural, racial, ethnic and socioeconomic backgrounds come together on a daily basis to learn. These students bring to the classroom an eclectic mix of ideas, beliefs, ambitions, values and personalities. The role of the school goes well beyond promoting simple tolerance. At their best, public schools foster a profound understanding and respect between individuals and groups that is the basis for democratic citizenship. (Alberta Teachers' Association 2002, 48)

Parents, Students, Governments, Teachers Federations and Unions, and private provider agencies of professional student services have all contributed to the development of programs which seek to enhance the capacity of the end user, students, in the public education system. The service models created are in place to give the student (end user) every opportunity to integrate and navigate the public school setting with success. The measurement of success is limiting as it currently is framed around graduation rates and not inclusive to other aspects of societal contributions. There remain various entry points for most stake holders in the Special Education debate in order to assess a concrete success rate. The measurement process for success remains vague as each stake holder group from governments, teachers and unions, private provider agencies, communities, parents, and students have provided a variety of arguments for what and how to determine success within this field. The broad milieu of literature illustrates that there is not one simple direction and formula that can succinctly define a success rate and that would be common amongst the aforementioned group's desires. The purpose of this document is to examine the existent literature which expresses the interests of who should provide special education services and illustrate the need to conduct extensive research within the area of service providers.

Keywords

Evaluation, assessment, teacher federations, unions, special education, service providers,

Background

Introduction

With the dominant discussion within the literature around inclusion policies for integration of Special Education into the mainstream school setting there is little which addresses an evaluative component of service providers. Asking the question of who can and/or should provide the school based services is important to all stakeholders involved. In so doing an opportunity exists to allow accountability in how services are rendered and whether the implementation of such services should be relegated through a model which is diverse model that can be mandated throughout the various school boards in Ontario.

This research is guided by five themes as stated in the purpose of the research project:

1. accessibility of services
2. quality of service
3. the continuum of services
4. cost effectiveness
5. the professional multidisciplinary team approach

The relevant literature on the five themes speaks in a general term to each. The general focus of this review was to elicit literature which directly and indirectly consummated the relevance of the five themes specifically with the role of service providers. The role of service providers remains an integral part of the discourse when rationalizing the processes of change within Ontario education. The Special Education Transformation document states as a prime objective in Special Education Funding Allocation that "[School staff have the capacity to provide supports and interventions to meet the

needs of students in a timely and effective manner." (Bennett 2006, 21) This objective illustrates that teachers have maintained the knowledge and ability capacities to facilitate the learning process of students with special needs within the school setting. Although the section does not speak directly to the provider of the service it does leave open the need to interrogate the question of who the service provider is. Accountability operates amongst a layer of facets within education and the teacher's role is central to analyzing the successes and failures of such processes.

The ability to measure effective strategies which enhance the learning capacity of special needs students while determining the best practices of how the services are provided should be an integral function for all stakeholders and is the fundamental goal of this research.

Teachers in Alberta have embraced a culture of accountability and are prepared to work closely with the parents and communities served by their schools to evaluate progress, to identify local priorities for improvement and to work with the entire school community in achieving those priorities. School-based planning and reporting, when undertaken genuinely rather than in technical fulfillment of ministry requirements, can contribute significantly to this process. (Alberta Teachers' Association 2002, 51)

This accountability is a fundamental facet of the research by integrating the five themes outlined in the introduction and attempting to elicit the required tangible evidence on service providers.

Summary of Literature

The role for public education is to provide a substantial equitable base for all students so they can participate within the societal niche regardless of their social status.

Cuba's emphasis on providing access to schooling for all children extends to those with special needs and is one of the initiatives accounting for the country's virtually universal primary enrollment. "The public role in education is to be there for students who otherwise would not be able to develop their talents in full.(...) Compensatory schemes provide stability to the education system and social cohesion, which is so necessary in a society". (Gasperini 2000, 15)(15)

The case in British Columbia illustrates that members of the British Columbia Teachers Federation have been providing these services both directly and indirectly within the school system. The discrepancies that exist within Ministry guided special needs assessments have left some students who require services within a regular classroom and not designated as special needs students. These students remain under the radar but the teachers still engage with them utilizing their diverse practices to tend to the needs of the student. In British Columbia board employees are considered to be working with non-recognized special needs students within the regular classroom setting.

In terms of class composition, responses indicate that most teachers work in classrooms that integrate significant numbers of students with special needs, making integration an everyday norm of B.C.'s schools. The data also provide evidence of considerable diversity in schools, with a wide range of students with special needs in many classrooms. They also present evidence that teachers believe that many more students with special needs are in schools but are not recognized as such by Ministry designations. (Naylor 2002, ii)

When taking into account the five themes developed for the research the example of what is occurring in British Columbia it may be fair to assume that a similar system of operations may be happening in Ontario schools. This assumption recognizes a need to develop an evaluative research strategy

which can directly assess the benefits of specific service providers whether they are board employees or external agencies. The case of British Columbia does not include a component which can provide an assessment of the services provided.

The role of school boards is to allocate the resources necessary to comply with Ministry end user demands. This can be accomplished through evident practices already in place which situate the role of the teacher in the school setting as crucial to the development and implementation of successful special needs practices. The case of Alberta recognizes the appropriateness of service providers in the school setting and defines the agenda of how school boards must provide services in the Standards for Special Education:

7. School boards must:
    a. ensure teacher practice is in keeping with the Teaching Quality Standard
    b. ensure teachers know and apply the knowledge, skills and attributes to accommodate individual differences for students with special education needs
    c. support teachers' ability to monitor the effectiveness of their practices and adjust practices as necessary. (Alberta Learning 2004, 9)

The Alberta case involves a monitoring component where evaluation of services can be measured by school boards. This allows for the accountability that stakeholders may be searching for as well as providing opportunities to close gaps where success of goals has been limiting. Again the Alberta Standards for Special Education state:

14. School boards must:
    a. use planning, assessing, monitoring and reporting to improve the quality of education provided to students with special education needs
    b. monitor and evaluate the effectiveness of special education programming and services
    c. report expenditures and achievements related to special education programming and services as part of the annual planning and reporting cycle. (Alberta Learning 2004, 12)

Through the innovative research process outlined by the Principal Researcher the monitoring of board staff will be a significant contributor to assessing the difficulties that stakeholders may encounter within the school setting and also reveal the complexities of externalizing resources outside of the school. The role and impact of school boards are pertinent to developing strategies and models which are consistent with changing societal dynamics and demands amongst special needs stakeholders.

Strategies of implementation and accountability are similar within the Ontario philosophy for special education: The school board's special education plan must outline in detail the board's general philosophy and service-delivery model for the provision of special education programs and services. The board's special education plan must be designed to comply with the Canadian Charter of Rights and Freedoms, the Ontario Human Rights Code, the Education Act and regulations made under the act, and any other relevant legislation. The board must include a statement in the plan confirming that the plan has been designed in accordance with this requirement. (Ontario Ministry of Education 2000, 5)

Although this plan is dated for 2000 there is no empirical data which speaks to whether its implementation has been successful allowing for a need of the research outlined by the Principal Researcher on this project as necessary and a means to compliment any board strategies for improving the status quo.

The literature that has dominated the discourse on special needs services speaks directly to integrative models for inclusion in the classroom setting. An overwhelming argument for such practices has lead to strategies of integration which have become common throughout most global educational systems. (Anonymous 2006, Attfield, Williams 2003, Crawford, Tindal 2006, Forlin, Hopewell 2006, Kosobud 2006, Lindsay et al. 2005, Mitchell 2001, Avramidis, Norwich 2002) The importance of this mandate is to allow the students who require special needs services to accumulate the capacity to enhance their social development skills with other "mainstream" students. The argument of separating students with special needs from those who do not require the services is still prevalent in literature but has been recognized as a divisive strategy when examining issues around the models of placement into special needs programs when factoring in the relevant issues of diversity such as race, culture,

ethnicity, and language to name a few. The case of international support for integration and inclusion is specified in the Cuban educational discourse:

Regular schools with this inclusive orientation are the most effective means of combating discriminatory attitudes, creating welcoming communities, building an inclusive society and achieving education for all: moreover, they provide an effective education to the majority of children and improve the efficiency an ultimately the cost-effectiveness of the entire education system(Gasperini 2000, 16) However there still remains a need to examine specific student's needs on a case by case basis. The argument is that some needs are beyond the capacity of teachers to engage the student in a manner respective of their needs and that of their student peers:

…teachers, although positive towards the general philosophy of inclusive education, do not share a 'total inclusion' approach to special educational provision. Instead, they hold differing attitudes about school placements, based largely upon the nature of the students' disabilities. Teachers are more willing to include students with mild disabilities or physical/sensory impairments than students with more complex needs. In particular, there is enough evidence to suggest that, in the case of the more severe learning needs and behavioural difficulties, teachers hold negative attitudes to the implementation of inclusion. (Avramidis, Norwich 2002)

The debate of inclusion provides the opportunity to examine the current practices of teachers in Ontario and how they have engaged with the debate. Concrete research can outline whether strategies employed by board employees and external agencies have lead to a more inclusive setting and take into account an assessment of services through the research purpose.

An example of the Educational Psychologist (EP) reveals that their presence is relevant within the school setting to provide the varying needs of the student population. Close access to such resources can prove vital to students both with special needs and those without who encounter crisis at optimal periods throughout the schooling year. Aston and Roberts examined the EP role in the United Kingdom and concluded through their surveys that:

According to the respondents in this study, there are particular and discrete tasks that only EPs can do, such as writing psychological advice for statutory assessment, and using closed tests. The EP team also reported in this study that they feel their approach, attitude and perspective is different from that of other agencies. (Ashton, Roberts 2006, 120)

Ashton and Roberts also left open the possibility and need for further examination of such roles when stating:

…it would be helpful to elicit perceptions of the EP role from other school types (for example, nursery, secondary and special schools). This information could help the EP team to tailor its services, and perhaps its 'marketing' activities, for the type of school the EP was working in…Asking classroom teachers or head teachers what they value from the EP may well yield different results as they have different experiences and expectations. (Ashton, Roberts 2006, 121)

By studying the current practices with regard to service providers the research can lead to innovative policies, strategies and practices that can be implemented across Ontario school boards. With one of the recommendation in the Special Education Transformation document under Professional Development being the "Increased capacity of all staff to educate a wider range of learners" illustrates an innovative strategy to which many teachers are currently engaged. Again, the case of BC and Ontario illustrate that service providers are involved in a vast amount of practices which are inclusive to special needs students. The tools required for professional development pertain to the governments and school boards allocation of funding, and the additional training requirements to which board staff currently are involved. The case of Alberta illustrates additional recommendations that state:

Recommendation 11.4 (Support for school counselling services) That Alberta Learning, in consultation with teachers and other stakeholders, establish/confirm standards governing the provision of counselling services within public schools and that funding for school boards be adjusted to ensure adequate support for achieving. (Alberta Teachers' Association 2002, 50)

The literature on funding special needs services in schools illustrates the need for accountability

by school boards in the allocation of funds. There are prevalent discrepancies that exist between rural and urban boards, where the latter has more access to resources fro special needs services. Most of which are provided in the school setting by board staff. Within the rural areas boards are limited in how funding is appropriated for services thereby not being able to comply with equivalent standards of the urban boards. Various school boards of optimally decided to shift the responsibility onto external agencies to provide the services that board staff had previously been responsible for. The literature available does not deem whether this is a success or a failure. But the practical experiences of boards that reinstitute practices of rendering the special needs services by their staff has become a central opportunity to investigate what the complications were with external agencies in providing the services, if any existed at all.

The literature on evaluation focuses more specifically on the benefits and outcomes of the end user, primarily the students involved, and the implementation of various educational policy strategies that promote a basic understanding of special needs services. (Broderick 2006, Hamston, Risko & Ellis 2006, Jordan 2001, Kosobud 2006, Mitchell 2001, Bennett 2006, Rhim, McLaughlin 2001, Sartawi, Alghazo 2006, Vallecorsa 1992, Wang, Reynolds 1996, Ysseldyke 2000) There is no sufficient literature which assesses the role of the provider to the extent that can determine who the best provider of special needs services are. This raises interesting dynamics in the relationship of the providers to special education and whether the role of the services could be better situated if an evaluative component were involve. This could lead to the accountability factor that stakeholders are seeking and furthermore address specific funding decisions as to how services and programs are funded. Evaluation is a necessary component of accountability for providing Special Education services to ensure the end user stakeholders are entering and leaving a viable system which can provide diverse results.

Conclusion

The summary of the literature pertaining to the research topic is minimal. What has been discussed in this review is the role that an extensive research project can undertake in addressing the questions which circulate around the role of best practices and who should provide the special needs services in Ontario. With the diverse communities that are impacted by educational services across Ontario more research needs to be conducted in order to provide the measures for accountability that the stakeholders involved are looking for. Accountability can not be solely associated with funding requirements. It should be inclusive to design, development and implementation of practices which benefit the public interest within public education. Therefore advancing the direction of the research question can provide a formidable and ground breaking to create innovative strategies for special needs services. This research has not yet been conducted and provides an opportunity for the Principal researcher and the Ontario Secondary School Teachers Federation to discover what is occurring from the service provider perspective within special needs services.

Bibliography

Alberta Learning 2004, Standards for Special Education, Amended June 2004, Alberta Learning, Edmonton, AB.

Alberta Teachers' Association 2002, Improving Public Education: Supporting Teaching and Learning, Alberta Teachers' Association, Alberta.

Anonymous 2006, "For Spec. Ed. Teachers, Schools Look at Alternatives", Education Week, vol. 25, no. 37, pp. 42.

Ashton, R. & Roberts, E. 2006, "What is Valuable and Unique about the Educational Psychologist?", Educational Psychology in Practice, vol. 22, no. 2, pp. 111-123.

Attfield, R. & Williams, C. 2003, "Leadership and inclusion: a special school perspective", British Journal of Special Education, vol. 30, no. 1, pp. 28-33.

Avramidis, E. & Norwich, B. 2002, "Teachers' attitudes towards integration / inclusion: a review of the literature", European Journal of Special Needs Education, vol. 17, no. 2, pp. 129-147.

Bennett, S., Dr. 2006, Special Education Transformation The report of the Co-Chairs with the Recommendations of the Working Table on Special Education.

Broderick, A.A. 2006, "Review of Who Benefits From Special Education? Remediating [Fixing] Other People's Children", Mental retardation, vol. 44, no. 4, pp. 304-305.

Crawford, L. & Tindal, G. 2006, "Policy and practice - Knowledge and beliefs of education professionals related to the inclusion of students with disabilities in a state assessment", REMEDIAL AND SPECIAL EDUCATION, vol. 27, no. 4, pp. 208-217.

Forlin, C. & Hopewell, T. 2006, "Inclusion - the heart of the matter: trainee teachers' perceptions of a parent's journey", British Journal of Special Education, vol. 33, no. 2, pp. 55-61.

Gasperini, L. 2000, The Cuban Education System: Lessons and Dilemmas, Education Reform and Management Team, Human Development Network-Education, World Bank.

Hamston, J., Risko, V. & Ellis, V. 2006, "Introduction: Mapping the challenges and possibilities in teacher education", Literacy, vol. 40, no. 2, pp. 63-65.

Jordan, A. 2001, "Special education in Ontario, Canada: A case study of market-based reforms", Cambridge Journal of Education, vol. 31, no. 3, pp. 349.

Kosobud, K. 2006, "Special Education for a New Century", Teachers College Record, vol. 108, no. 8, pp. 1628-1638.

Commissioned by the Ontario Secondary School Teachers' Federation

Lindsay, G., Dockrell, J.E., Mackie, C. & Letchford, B. 2005, "The roles of specialist provision for children with specific speech and language difficulties in England

Wales: a model for inclusion?", Journal of Research in Special Educational Needs, vol.5, no. 3, pp. 88-96.

Mitchell, D. 2001, "Paradigm shifts in and around special education in New Zealand", Cambridge Journal of Education, vol. 31, no. 3, pp. 319.

Naylor, C. 2002, B.C. teachers views of Special Education Issues Data from the Spring 2001 BCTF Worklife of Teachers Survey Series, *2*: Special Education, British Columbia Teachers' Federation, British Columbia.

Ontario Ministry of Education 2000, Standards for School Boards' Education Plans, Ministry of Education, Ontario.

Rhim, L.M. & McLaughlin, M.J. 2001, "Special education in American charter schools: State level policy, practices and tensions", Cambridge Journal of Education, vol. 31, no. 3, pp. 373.

Sartawi, A. & Alghazo, E.M. 2006, "Special education teachers' perceptions of factors influencing their instructional practices", International journal of rehabilitation research.Internationale Zeitschrift fur Rehabilitationsforschung.Revue internationale de recherches de readaptation, vol. 29, no. 2, pp. 161-165.

Vallecorsa, A. 1992, Special education programs : a guide to evaluation, Corwin Press, Newbury Park, Calif.

Wang, M.C. & Reynolds, M.C. 1996, "Progressive Inclusion: Meeting New Challenges in Special Education", Theory into Practice, vol. 35, no. 1, pp. 20-25.

Ysseldyke, J.E. 2000, Critical issues in special education, 3rd ed. edn, Houghton Mifflin, Boston.

Themes Matrix

Draft November 22, 2006

The Matrix shows which instrument addresses each theme. The question number is shown after the √ mark.

S= Survey I= Interview

Theme	S-Sr. Admin v5	S-Pr V5	S-Pract V4	(I)–Sr. Admin	(I)– Pr	(I)– Pract.
Accessibility -who gets service -where -wait list		√ 2	 √ 17	√ 3,5a, 5b √ 3, 5a,5b	√ 3a,3b √ 3a,3b	√ 2,3 √ 2,3 √ 1
Quality of Service -prevention -intervention -best practices	 √ 1 √ 1	 √ 1 √ 1	 √ 5 √ 5	 √ 2a,5a √ 2c,5b √ 6	 √ 2a √ 2c √ 6	 √ 2 √ 3 √ 7
Continuum of Service -corporate knowledge -loyalty to board -policy/procedure knowledge -school community, board culture knowledge & integration -team planning -team implementation -follow up -commitment to plan -safety/liability -consulting with teachers/ parents -consulting with school administrators -consulting with senior administrators	 √ 7 √ 7 √ 7 √7 √ 7 √ 7 √ 7	 √ 3 √ 3 √ 3 √ 3 √ 3 √ 3 √ 3 √ 3 √ 3 √ 3	 √ 8 √ 16 √ 9 √ 8 √ 10 √ 12 √ 13 √ 14 √ 15		 √ 5 √ 5 √ 4 √ 4 √ 4 √ 4 √ 5 √ 5	 √ 4 √ 4 √ 4 √ 4 √ 4 √ 4 √ 4
Consistency -qualifications -supervision -predicability of service -educational focus	 √ 7 √ 7	 √ 7	 √ 4	 √ 6b		

Cost effectiveness -$ cost -cost of staff time -measuring effectiveness -long term benefits -additional services (p.d.) provided -factors in decision making	√ 3			6a,b √ 6b,7a √ 2,2d,5a,5b √ 6a,b, 7b	√ 2b,2d,3a,3b	√ 2,3
Community agencies -when to include -protocol availability -include in programming	√ 4,5 √ 7	√ 6	√ 11	√ 7a,6b √ 8b	√ 8a √ 8b	√ 5 √ 5 √ 5
Types of Services provided -in board vs contract - services provided -to Non Identified students	√ 1 √ 1	√ 1 √ 2	√ 3 √ 4,5 √ 6	√ 2,3 √7	√ 2,3 √ 3b,9	√ 1,2,3 √ 5
Suggested model	√ 6		√ 20	√ 4		√ 8

Appendix 2

Professional And Paraprofessionals

Attendance December 3, 2007

Role	Number	Geographic Region (s)
Psychological Services	5	Northern Ontario 2-GTA Eastern Ontario Beyond GTA
Social Work Services	3	2-GTA Southwestern Ontario
Speech-Language Pathology Services	4	GTA 2-Beyond GTA Southwestern Ontario
Occupational & Physiotherapy Services	2	2-GTA
Child & Youth Worker or Behavioural Counsellor Services	4	1-GTA 3-Beyond GTA
Attendance Counsellor Services	2	1 Northern Ontario 1 GTA
Special Education Educational Assistants	3	1-Northern Ontario 1-Southwestern Ontario 1-Eastern Ontario
Developmental Service Worker or Communication Disorder Assistant	2	1-Beyond GTA 1-Northern Ontario
Principal/Vice Principal	2	1-GTA 1-Beyond GTA
Senior . Manger	1	GTA
Guidance Teacher	1	Beyond GTA
SERT	1	GTA
Other	1	Southwestern Ontario
Absent Attendance Counsellor Special Education Educational Assistant	2	Beyond GTA
Total	**33**	

Professional And Paraprofessionals
Attendance December 4, 2007

Role	Number	Geographic Region (s)
Psychological Services	2	Beyond GTA
Social Work Services	1	GTA
Speech-Language Pathology Services	2	GTA Beyond GTA
Occupational & Physiotherapy Services	1	GTA
Child & Youth Worker or Behavioural Counsellor Services	0	
Attendance Counsellor Services	1	1 GTA
Special Education Educational Assistants	1	1-Northern Ontario
Developmental Service Worker or Communication Disorder Assistant	0	
Principal/Vice Principal	1	1-Beyond GTA
Senior . Manger	1	GTA
Guidance Teacher	0	
SERT	1	GTA
Other	1	Southwestern Ontario
Total	**12**	

Appendix 3

Activities Description

Day 1

9-9:30	Background and overview of the project, Review Basic Assumptions, Student focus – Visioning – no barriers Think outside the box General description of activities
9:30-11	Session 1- Focus on Hypothetical Student – "Gerry" androgenous Individually brainstorm all the preventative programs, services, activities you provide Same employee group sharing of list. "A last look" Before you post for public discussion. Think about & perhaps make notes about – When/how could/should community agencies be involved? – Elementary/secondary considerations – When/how could/should community agencies be involved? Affix pages to chart. Gallery Walk to view and possibly add more.
11-11:15 Break	
11:15-12:30	Session 2 Consultation Gerry is "flagged" Individual Think Papers develop a vision of the type of consultation activities and structures (informal and multidisciplinary team) you would most like to work with. Think about – membership (fixed or fluid), – number of meetings, – communication among members Groups of same role PPSS practitioners share main points together Groups change to heterogeneous (cross role groupings). Co operative Learning Group Roles selected *Materials Manager* – gets chart paper, markers, tape, etc *Discussion Facilitator* – ensures that everyone has equal time to contribute/talk/share & keeps discussion going and focused *Timekeeper* – informs group of time left at regular intervals *Reporter* – remains with the posted chart and reports on group's contributions Record on chart paper a description of the best possible team service delivery that would address all your different roles. Post charts. Reporting to whole group. *Materials Manager* – collects all papers and submits to Researchers
12:30-1:15	Lunch

1:15-2:30 Session 3: Intervention

Scenario 1- Gerry needs your services. In Phase 1 we heard that intervention services should be delivered by board based PSSP professionals. We are visioning the most effective way for Gerry to access your services.

Individual Think papers
Think about those students who are in elementary/ secondary. Will it be different? How?
Groups of same role PPSS practitioners share main points together

Groups change to heterogeneous (cross role groupings).

Co operative Learning Group Roles
Materials Manager – gets chart paper, markers, tape, etc
Discussion Facilitator – ensures that everyone has equal time to contribute/talk/share & keeps discussion going and focused
Timekeeper – informs group of time left at regular intervals
Reporter – remains with the posted chart and reports on group's contributions

Record on chart paper a description of the best possible team service delivery that would address all your different roles.

Post charts. "A last look" Before you post for public discussion. Bring in some of the themes Matrix points. Think about & perhaps make notes about

- Case load and waiting list What are your thoughts?
- How would effectiveness be measured?
- Parent referral/student self referral/ teacher referral
- Identified /non identified students
- When/how could/should community agencies be involved?

Reporting to whole group. Round Robin reporting

Materials Manager – collects all papers and submits to Researchers

2:30-2:45 Break

2:45-4:00 Session 4: Assessment

Gerry needs assessment to plan a program or for identification that leads to a program.

Three groups created. (1) professionals who create assessments (2) paraprofessionals who implement/use assessment (3) others who conduct informal assessments

Think papers individually completed.
Think about:

- Quick service/assessment –i.e. reduced wait times
- Reporting practices
- Consultative practices
- Programming information
- Who should be involved and when

Informal Assessment
Think about
- Consultative Practices
- Programming information
- Who should be involved and when

Implementers
Think about:
- Quick service/assessment –i.e. reduced wait times
- Reporting practices
- Consultative practices
- Programming information
- Who should be involved and when

Participants in homogenous groups share main points together

Groups change to heterogeneous (cross role groupings).

Co operative Learning Group Roles
Materials Manager – gets chart paper, markers, tape, etc
Discussion Facilitator – ensures that everyone has equal time to contribute/talk/share & keeps discussion going and focused
Timekeeper – informs group of time left at regular intervals
Reporter – remains with the posted chart and reports on group's contributions

Record on chart paper a description of the best possible service that would address all your different roles.

Post charts. Round Robin reporting. Discussion/ Comments
Materials Manager – collects all papers and submits to Researchers

4:00-4:30 Housekeeping/Administrative – expense claims and other details
Wrap Up
Recommendations for Day 2 considerations.

Consultation Structures, Activities

Think

Informal consultations & multidisciplinary team

Guiding Questions

6. What would be the steps in the process for Gerry's emerging needs to be discussed. Begin with informal involvement and advance to more intense and more formal steps. Remember to start with informal involvement (like a triage procedure).

7. What could be the multiple entry points for Gerry's needs to be identified?

8. Brainstorm ideas to measure the effectiveness of the informal process.

9. Think about how your role and the role of others facilitates this informal process.

Think about
- membership (fixed or fluid),
- number of meetings,
- communication among members

Activities Description

Day 2

9-9:30 Review activities of Day 1 , Review Timelines
Task is to apply different lenses to these components to ensure that there is applicability across the province and that the basic assumptions have been honoured

Lenses/Considerations (from Themes matrix)

- -Accessibility of service (who gets, where, wait list, Elementary/Secondary panel, identified and nonidentified students (priority??))
- -Quality of Service (minimizing delays, case load considerations, how to measure effectiveness in prevention, intervention, assessment, consultative services, safety/liability, p.d for educators & PSSP, direct and indirect student services,)
- -Measuring Student Success (considerations, strategies)
- -Continuum of Service (consultation, prevention, intervention and assessment included, direct and indirect student services, multidisciplinary team)
- -Consistency of Service (urban/rural, north/south Ontario, predictability, educational focus,
- -Cost effectiveness (case load considerations, costing staff time for direct and indirect student services, measuring effectiveness)
- -Supplemental services by Community Agencies (when to include, protocol availability, programming considerations)
- - PSSP personnel (qualifications, supervision of duties)

9:30-10 Session 1: Intervention
Post charts from Day 1. Post summary charts.

Break up into 4 groups. Each group has a different coloured paper. Write points on the paper and affix to the Summary chart from Day 1. Each group will apply one set of lenses to the part of the model from Day 1. As a group decide on the criteria you will apply. Start with the criteria I have listed.

Group 1: Accessibility of service (who gets, where, wait list, Elementary/Secondary panel, identified and nonidentified students (priority??)) YELLOW

Group 2: Quality of Service (minimizing delays, case load considerations, how to measure effectiveness in prevention, intervention, assessment, consultative services, safety/liability, p.d for educators & PSSP, direct and indirect student services,) GREEN

Group 3: Continuum of Service (consultation, prevention, intervention and assessment included, direct and indirect student services, multidisciplinary team) BLUE

Group 4: Consistency of Service (urban/rural, north/south Ontario, predictability, educational focus, MAUVE

Your task is to critique the work from Day 1, apply your lenses to identify any gaps. If there are gaps, make suggestions to close the gap (if possible)

Analyze the Intervention Part of the Model from Day 1 Give each group a T chart on their coloured paper . On one side is “Gap” on other side is “Suggestions”

Work in pairs to apply lenses. Record on sheet. Report to whole group

Brainstorm with your neighbour potential ways of measuring student success that don’t

	rely solely on test scores , credit achievement. Consider, elementary/secondary Make a group of 4. Among you come up with some criteria for measuring student success at elementary/secondary that elaborate on the current curriculum achievement measures. Will report to the group. Keep charts.
10-10:15	Break
10:15-11:30	Group decision to use whole group consensus for Consultative, and Assessment components.
11:30-12:30	Lunch
12:30-1:45	Develop Schematic
1:45-2	Break
2-3:15	Development of 10 Points. Prioritizing
3:15-3:45	Break
3:45-4:30	Wrap Up Housekeeping – Expenses

Sample T Chart

T-CHART

Gap	Recommended Action

Group 1: Accessibility of service (who gets, where, wait list, Elementary/Secondary panel, identified and nonidentified students (priority??)) YELLOW

Appendix 4

Professional Student Services Personnel Baseline Service 2007-2008

peel District School Board

Curriculum, Instruction & Special Education Support Services

Professional Student Services Personnel

BASELINE SERVICE 2007-2008

June 2007

TABLE OF CONTENTS

INTRODUCTION

The purpose of this document is to explain the nature of service provided by Professional Student Services Personnel (PSSP), comprised of members of the Psychology, Social Work and Speech-Language Pathology Departments. This information is also available on the Special Education Support Services Department Intranet website. To access the website select Board Services, click on Special Education Support Services and scroll down to PSSP.

It is important that schools and School Support Services cooperatively develop strategies to make the most effective and efficient use of available resources. Increasing enrolment, the need to support programs and regional obligations all have an impact on our service delivery model. Planning, organization and collaboration will assist PSSP staff to maintain the high quality of service students, parents and school staff have always experienced.

Please note the addition of Community Service Partnerships – Psychology, Social Work and Speech Language Pathology – SESS 18 O.P.

Debra Krutila
Superintendent of Special Education Support Services

PSSP SERVICE DELIVERY RECOMMENDATIONS

Implementation of the following recommendations will help to optimize PSSP service delivery to your school. Principals are encouraged to:

1. meet with your PSSP staff in September to review the types of service offered in their role descriptions, and establish a verbal service contract prioritizing types of service and how and where this service will be delivered during the school year. Following this meeting, invite PSSP to a school staff meeting to share service priorities established with the administration

2. take into account, when prioritizing service, that flexibility is needed due to other school commitments and system priorities such as IPRCs, case conferences, "invisible service" outside the school such as home visits, liaison with community agencies, meetings with parents, report writing

3. acknowledge that PSSP staff are unable to attend all ISRCs; therefore, requests for attendance at ISRCs should be prioritized, (for example, it may not be necessary for all the disciplines to attend all ISRCs if time is dedicated to each as necessary)

4. prepare and distribute ISRC agendas in advance with specific times for PSSP to attend

5. remember that parental consent is required for PSSP members to review SIS profiles, external reports and OSR's

6. use the ISRC to prioritize PSSP staff caseloads, and decide on referrals/closures

7. co-ordinate ISRC schedules (possibly on a family of schools basis) to facilitate staff attendance

8. process referrals only after consultation with relevant PSSP staff except in crisis situations

9. consult PSSP staff prior to contacting parents regarding possible referrals and/or having assessment consents signed

10. once a decision has been made, in consultation with the service provider, to open a case or initiate an assessment, ensure that the referral is made promptly through SIS and consent receipt sent through SIS. If parental consent is not obtained within 30 days the referral must be withdrawn from SIS. This must be done in consultation with the PSSP member

11. determine the most efficient method for communication and feedback on referrals and contact with parents, and how often feedback is required

12. provide access to phones and computers, and adequate space and privacy for interviewing/ assessing/providing intervention. The principal will give due consideration to appropriate space and discuss the location with the PSSP member

13. be aware that PSSP staff are sometimes required to respond to emergencies or system priorities (e.g. Critical Incident Response, special case conferences). As a result, needs may have to be re-prioritized, and PSSP may not be able to "make up" time at your school

Psychology Services
Service Delivery Model

Due to the number of schools assigned to Psychology staff and the doubling of caseloads over the past 10 years, many schools will be serviced on a bi-weekly or less frequent basis.

Psychoeducational Consultants provide a variety of psychological services to schools. Currently, the most frequently requested types of service from the Psychology Department are:

- psychoeducational assessment
- consultation, including behavioural
- support pertaining to ISA documentation
- counselling individual students/parents on a limited basis
- providing PD for schools, teachers, BTAs and parent groups
- facilitating requests for risk assessments
- providing intensive case management.

How Service is Delivered

Psychoeducational Assessment

- formal SIS referral and informed/signed parent consent required. Please note: Psychology staff must obtain informed parental consent in addition to the signed parental consent
- direct contact with student, parents, school personnel is involved
- an assessment of student strengths and needs in response to the questions raised and needs expressed by the ISRC and the parents is completed
- assessment may be a full (comprehensive) assessment, or a shorter, focused report which usually addresses a single, specific question or concern
- at the conclusion of a psychoeducational assessment, an interview (i.e., feedback session) will be held with the parent(s)/guardian(s) during which the assessment processes and outcomes will be shared by the Psychology staff member and any parental questions answered; the parent(s)/guardian(s) will receive a copy of the Psychoeducational Assessment report. Normally, these meetings will be scheduled for 30-60 minutes, though interviews regarding more complex assessments may require more time. (In rare instances, schools may find that even after repeated attempts to arrange an interview, the parent(s)/guardian(s) fail to attend. In such cases, and in good faith, the Psychology staff member will mail the Psychoeducational Assessment report to the parent(s)/guardian(s), and encourage them in an attached letter, to request and participate in an interview.)
- Best practice would suggest that it is beneficial to have the school administrator at the parent feedback meeting
- in cases where a diagnosis has been made as the result of an assessment, it is the legal responsibility of the psychology staff member (or their clinical supervisor, as the case may be) to formally communicate that diagnosis to the parent/guardian, or adult student.

Risk Assessment

A risk assessment is a specialized assessment that requires senior management approval. Please refer to Procedures for the Request and Follow Through of Risk Assessments.

Consultation

- in many cases, a signed/informed Parental Consent for Psychoeducational Consultation may be required *(print form from Intranet > Board Services > Special Education > Psychology)*
- no direct contact with the student is involved
- consultation encompasses all learning issues, including information processing, social/emotional and behavioural functioning

- consultation includes such things as reviewing outside agency reports, making/supporting referrals to outside agencies, consulting with teachers or parents around behavioural/social-emotional issues, discussing classroom management issues, attending Case Conferences, consulting at ISRCs/IPRCs, assisting schools to prepare ISA applications/vocational school applications, etc.
- in cases where the problem-solving dialogue between the psychoeducational consultant and others is of such importance or is so complex that a permanent record is necessary, a Consultation Report will be prepared
- psychoeducational consultants provide consultation to and support for Behaviour Teaching Assistants and are case managers for students with Behavioural exceptionalities, and other regional programs.

Counselling

- psychoeducational consultants may run a variety of group counselling programs (e.g., to address such issues as grief, parental separation/divorce, anger management, social skills, etc.).
- individual counselling of students occurs on a very limited basis

6

Procedures for the Request and Follow Through of Risk Assessments

Risk Assessment is defined as an emergency procedure aimed at determining the likelihood of whether a student will engage in behaviour considered dangerous either to self or others. When appropriate a risk assessment process will provide management suggestions to reduce this risk. Students who require a risk assessment have exhibited behaviour that is persistent and significant and supports in place at the current school, or in a former location, have been insufficient and concerns persist, generally, the assessment will be concerned with the potential for violence, sexual offence, or suicide.

Referral Protocol

When school personnel, including PSSP staff, are concerned about the safety of a student or the safety of others who may come into contact with the student, the Principal will consult with his/her Superintendent of Education.

Together the Principal and Superintendent of Education should review the following:

1. Information that will provide a profile of the student. This may include a review of a previous psychological assessment and any information relating to behavioural, social/emotional or personality functioning;
2. The need for new or additional I.Q./achievement testing. If warranted, this would be pursued through the school psychologist and be viewed as a priority need;
3. Previous involvement of the Mobile Support Team or the need for immediate referral for intervention;
4. Programs and strategies that have been pursued through the Contact Program, if at the secondary school level;
5. The involvement, if any, of the school social worker and police liaison officer.

Data gathered relative to the above will be summarized by the school special education staff/support staff and forwarded to the principal who will in turn share this information with the Superintendent of Education.

If it is determined that a risk assessment will be requested then:

1. The Superintendents of Special Education Support Services and Staff Development and School Support Services are consulted by the Superintendent of Education, who provides via e-mail a copy of the summary report collated by the school as per above;
2. The Superintendent of Special Education Support Services consults with the Chief Psychologist and Support staff as needed and appropriate;
3. Upon approval of the risk assessment the school staff will be directed to obtain written consent for the risk assessment. Consent will be voluntary and informed;
4. The Chief Psychologist will designate a Pyschoeducational Consultant to carry out the assessment. The consultant may or may not be regularly assigned to the student's home school.

Assessment Protocol

Once informed consent is obtained, the Psychoeducational consultant will work with the student and his/her family to explain the purpose of the assessment and the limits of confidentiality. Risk assessments involve two discrete steps, gathering data and evaluating risk.

Duty To Warn

In Ontario psychologists have a duty to warn if they have a reason to suspect that a person may engage in life-threatening behaviour. The individual and/or a family must be informed of the concern and steps to intervene should be taken.

Follow Up

Results of the assessment will be shared with the student, his/her family, school staff and the Chief Psychologist. The results and an appropriate placement/program will be discussed at a case conference to be held at the home school site The placement/program identified should be implemented as soon as possible, with any supports as recommended through the assessment. The development and inclusion of a Behaviour Management Plan should be an integral part of any program directions. The psychoeducational consultant will conduct a follow up within 30 days after the feedback has been given. This will involve a check of the status of the student and a review of the recommendations and their implementation.

School Social Work Services

Service Delivery Model

Service Delivery Changes Implemented

- *due to the number of schools assigned to social workers, some schools may be serviced on a bi-weekly or an as-needed basis*
- *attendance referrals will usually be accepted only after 15 consecutive or 20 accumulative days of absence*
- *the emphasis of service delivery will be on brief, solution-focused counselling*
- *all non-attendance cases will be closed at year-end*

What Service is Provided

School social workers assist schools in identifying and helping to remove those obstacles within children or within their environment which interfere with their ability to benefit from educational experiences. Currently, the most frequently requested types of social work service are:

- short-term counselling with students and families
- consultations with school personnel
- crisis intervention
- facilitation of referrals to community agencies/resources
- participation on ISRCs

Areas addressed in social work service include:

- family issues
- emotional and behavioural adjustment
- non-attendance (including Court action on Education Act charges)
- crisis situations
- child welfare
- bereavement
- child management and parenting
- S.A.L.E.P

How Service is Delivered

Consultation

- there is no direct contact with the student or family
- service consists of a problem-solving dialogue between the school social worker and others
- no consent is required

Brief Service (Time-Limited Service)

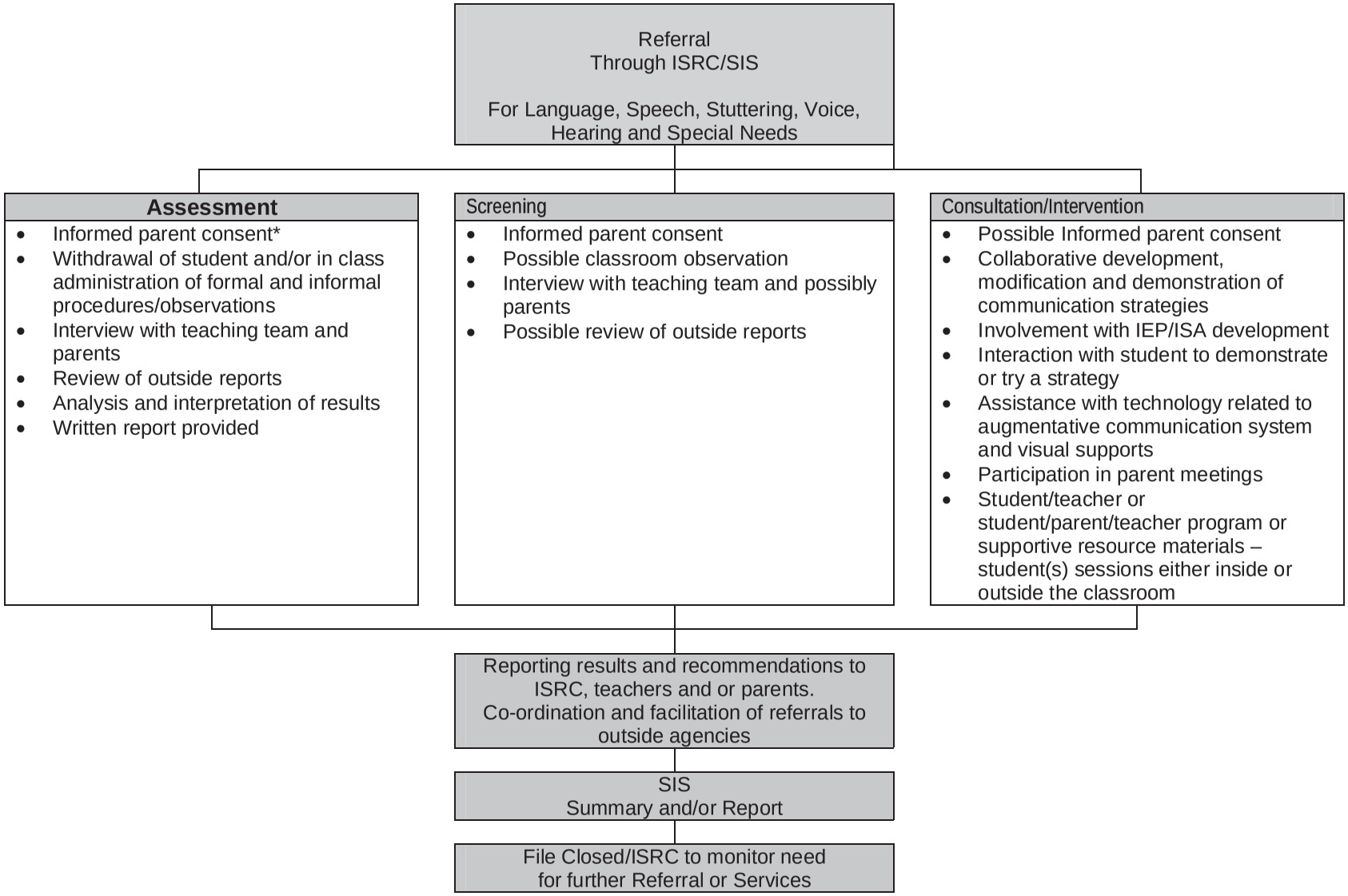
- following consultation with the social worker, an SIS referral is required if the provision of service is direct, individual contact with the student without the parent being present
- direct service to the student and/or family is provided
- this service may be brief or intensive, but is time-limited to one or two contacts

Open File

- an SIS referral is required
- following consultation with the social worker, signed parental consent must be obtained by the principal prior to service being provided
- a summary report is included in the student's OSR
- direct service is provided to the student and family over a longer time period

The exceptions to signed parental consent where there is direct contact with students are attendance referrals, which are mandated by the Education Act, high-risk student referrals (e.g. suicidal ideation etc.) and Critical Incident Response.

SPEECH-LANGUAGE PATHOLOGY SERVICES



Administrative Guidelines

A partnership is a mutually supportive, reciprocal arrangement between a school or school board and a community service provider. Its main purpose is to complement or enhance learning, although it is a given that both partnering organizations can and should benefit from the association. Whatever the partnership, it is crucial that both partners agree to and implement the stated goals and objectives.

Peel District School Board Policy #5 states, "It is the policy of the Peel District School Board to support, facilitate and encourage the development of authentic, mutually beneficial relationships between schools and the larger community, including business and non-business sectors, with due sensitivity and regard for the legitimate needs of all parties involved.

The Board also subscribes to the following ethical guidelines from the Conference Board of Canada:

Partnerships are supported which:

- enhance the quality and relevance of education for learners;
- mutually benefit all partners;
- treat fairly and equitably all those served by the partnership;
- provide opportunities for all partners to meet their shared social responsibilities toward education;
- acknowledge and celebrate each partner's contributions through appropriate forms of recognition;
- are consistent with the ethics and core values of all partners;
- are based on the clearly defined expectations of all partners;
- are based on shared or aligned objectives that support the goals of the partner organizations;
- allocate resources to complement and not replace public funding for education;
- measure and evaluate partnership performance to make informed decisions that ensure continuous improvement;
- are developed and structured in consultation with all partners;
- recognize and respect each partner's expertise;
- identify clearly defined roles and responsibilities for all partners;
- involve individual participants on a voluntary basis.

Speech and Language Pathologists, Psycho-educational Consultants and School Social Workers provide a highly valued service to Peel schools on a daily basis. As the Peel District School Board continues to grow, collaborative initiatives with community service providers are welcomed as a means of augmenting and complementing existing internal resources. The establishment of collaborative partnerships with community service providers can at times provide services which these internal Board support personnel are not providing. Such partnerships are intended to supplement and enhance (not to duplicate) the work of the school team. On-going collaborative ventures with community service providers enable the Board to offer a wider spectrum of services which ultimately will enhance student learning.

Establishment of Partnerships

When partnerships are established, certain procedures must be in place to ensure quality of service, accountability, and a smooth integration with existing support services in the Board. The following areas must be addressed:

1. Partnership Agreement

Usually external partners are offering a specific service to the school in order to meet an identified need. A written partnership agreement agreed to and signed by both parties involved will help to clarify expectations, timelines, procedures, and accountability. This service agreement will include:

- the need for service identified by the school;
- the specific service offered by the external partner to address that need;
- the qualifications/credentials of the service providers;
- when, where and how the service will be delivered (a specific location in the school and proper identification worn by service providers can reduce complications);
- the type of records which will be generated and who will have access to these records;
- an evaluation process, co-ordinated by the Principal, will determine the success of the service providers in addressing the identified need.

It is critical that Criminal Record Checks are in place before any service is provided.

2. Integration with PSSP Staff

When a service partnership is being considered, discussion with PSSP staff will assist in clarifying role expectations and generate ideas about how existing PSSP staff can facilitate the implementation of the proposed service delivery model. On-going consultation with the appropriate PSSP staff about students whom the PSSP and the external partner have in common will assist in the referral, intervention and termination process.

3. Consent/Confidentiality

Before any service is provided, it is important that written consent be obtained from parents if the student is under 16 years of age, and from students themselves if they are over 16 years. (Please note that this may vary depending upon the legislation governing the external agency). Consent must be informed and time-limited with parents/students being advised about the type of service offered, who is delivering it, the timelines involved and their ability to access information. If service providers require access to specific student information, informed consents must be completed for this as well.

4. Liability

Liability coverage must be $2 million, and the Peel District School Board must be named in the current Certificate of Insurance from the outside agency. A copy of the Insurance Certificate, including professional liability (errors and omissions) and general liability, will be kept on file at the school, and a copy forwarded to Risk Management and Security at the Board office.

These areas are summarized in the attached checklist (Appendix A). A sample partnership agreement is also attached (Appendix B).

CHECKLIST FOR PARTNERSHIP AGREEMENTS

_ identify specific needs to be addressed
_ identify how specific services provided will address need
_ involve appropriate PSSP in initial and on-going discussions
_ discuss service delivery plan with agency
_ determine how students will be identified
_ develop communication plan with PSSP, when appropriate, for student referrals and intervention
_ determine plan for informing parents/guardians of service
_ develop service agreement
_ sign service agreement
_ decide on location for service provision
_ develop schedule for specific hours of service
_ review credentials of service providers
_ ensure Criminal Record checks are in place
_ obtain copy of current Certificate of Insurance naming the Peel District School Board and ensuring $2 million liability coverage for professional liability (errors and omissions) and general liability
_ file Certificate of Insurance for professional liability (errors and omissions) and general liability at the school and send a copy to Risk Management and Security at the board office
_ provide identification badges for service providers
_ delineate roles of all staff involved
_ ensure all staff at school are aware of the service being provided
_ inform other key personnel (e.g. Superintendent of Education) re: service agreement
_ determine type of documentation and records, location of records and who has access
_ establish specific meeting times during service provision to review progress
_ develop a communication plan for sharing information with parents
_ obtain written consent for:
    1. service provision
    2. access to school information (not OSR)
_ develop an evaluation plan

PARTNERSHIP AGREEMENT
between

Name of School

and

Name of External Partner

This educational partnership is a mutually supportive reciprocal agreement between __*school*__ and __*external partner*__ to provide the following service:

description of service to meet identified need

Both parties acknowledge and agree that _____*external partner*_____ is not an agent of the Board and none of the service providers are employees or agents of the Board.

__*External partner*____ agree that no fees are payable to it by the Board, and neither the Board, students/parents or staff of the Board are responsible for any expenses of ___*external partner*____ in connection with this provision of service.

The service will be provided by ___*external partner*____ effective from ____*date*____ until ____*date*____; however, either the ___*school*____ or ____*external partner*_____ may terminate this agreement for any reason with reasonable notice to the other. Reasonable notice shall be 30 days.

During the time of this agreement, the following responsibilities are agreed upon:

EXTERNAL PARTNER

1. **Procedures** operate within the context of the Peel District School Policies, Operating Procedures and Collective Agreements, including but not limited to the Certificate of Insurance (professional liability (errors and omissions) and general liability), Criminal Record Checks, Reporting Children in Need of Protection, Human Rights Policy and Procedures, and the Code of Conduct for the school. The Board's Policies and Procedures are available on the Board's internet @ www.peelsb.com

2. **Accountability** provide credentials of service providers to the school and ensure that they comply with the rules of professional conduct for their profession

3. **Liability** provide the board with a copy of a current Certificate of Insurance for $2 million relating to professional liability (errors and omissions) coverage and general liability. The Peel District School Board must be named on the Certificate of Insurance

4. **Location** service providers meet with students only on school premises in a specified location unless prior written consent is obtained from the parent/guardian of the student, and the Principal is given prior notice

5. **Identification** service providers sign in at the school office for each visit and wear proper identification (preferably photo ID and visitor's badge) while in the school

6. **Records** keep a record of services provided, and monitor access

7. **Evaluation** cooperate with the board in evaluating the effectiveness of the service provided

SCHOOL

1. **Consent** obtain appropriate written informed consent from the parent/guardian of the student or student (over 16) to whom the service will be provided

   assist in obtaining written consent from the parent/guardian or student (over 16) if access to the OSR or other relevant school information is necessary for provision of service

2. **Location** provide a private room for the provision of service recognizing the need to co-ordinate the use of space with PSSP staff allocated to the school

3. **Monitor** monitor the service and provide advice to service providers if necessary

4. **Evaluation** cooperate with the external partner in evaluating the effectiveness of the service provided

Both Peel District School Board and ____*external partner*_____ agree that all information obtained during the provision of services will remain confidential.

_____ _____

Principal External partner

_____ _____

Date Date

c: Superintendent of Special Education Support Services
Superintendents of Education
Security and Risk Management Department

Appendix 5

Toronto District School Board

External Partnerships: Supplemental Student Services

Toronto District School Board

Operational Procedure PR.XXX BUS

TITLE: EXTERNAL PARTNERSHIPS - SUPPLEMENTAL STUDENT SERVICES

1.0 OBJECTIVE

To provide schools with a framework for creating and implementing partnerships with external mental health, physical health or social service agencies, professionals or paraprofessionals (private or public):

- Regulated professionals such as audiologists, nurses, occupational therapists, physiotherapists, psychiatrists, psychologists, social workers, speech-language pathologists;
- Paraprofessionals such as behaviour therapists, child therapists, youth counsellors, child and youth workers, OT or PT assistants, communication disorders assistants.

who work with students in TDSB schools, in accordance with Board policy P.024 BUS: External Partnerships.

2.0 DEFINITIONS

CSPD: Contract Services and Partnership Development

Description of Program or Service: A written record of the school's and the external mental health, physical health or social service agency's, professional's or paraprofessional's goals, objectives, roles and responsibilities for carrying out collaborative activities that occur on a continuous basis.

External Partnership – Supplemental Student Services (EP-SSS): An ongoing, mutually beneficial and supportive arrangement between a school and an external mental health, physical health or social service agency, professional or paraprofessional, to enhance or expand opportunities for student success. Partners share values, objectives, resources and responsibilities to achieve desired learning outcomes.

External Providers: The external mental health, physical health or social service agency (including its staff), professionals or paraprofessionals providing service within the EP-SSS.

Paraprofessionals: Individuals with relevant post-secondary or on the job training who work under the supervision of a member of a relevant regulated professional College in Ontario.

Partnership Agreement: A formal, written document which outlines the terms and conditions of an external partnership. The agreement is signed prior to the implementation of the partnership activities.

Professionals: Individuals who are members of a regulated professional College in Ontario.

SIP: School Improvement Plan

Support Services Professional Staff: Board staff of professional Support Services, which includes the staff from Social Work, Speech-Language Pathology, Occupational Therapy & Physiotherapy and/or Psychological Services.

3.0 RESPONSIBILITY

Executive Superintendent, Business Services
Executive Superintendent, School Services – Special Education and Support Services

4.0 PROCEDURES

4.1 Partnership Expectations
The EP-SSS partnerships will address needs identified in the school's SIP and provide expanded opportunities for student success.

4.2 Screening Potential Partners
Prior to entering into an EP-SSS agreement, the Principal, or his/her designate, in consultation with the relevant Board professional Support Services staff, will collect and review the following information to determine partnership eligibility (the CSPD or the Senior Manager of Professional Support Services may be contacted for advice). Any potential external partner will be required to complete the *Application for Consideration of an Educational Partnership - Supplemental Student Services (EP-SSS)* – (see Appendix A), to provide information about and attest to the following:

- Description of the program or service to be offered (summarized in the *Description of Program or Service* – Appendix B):
  - With sufficient detail to address issues such as:
    - History and ownership/funding base of the external provider.
    - Nature of the service to be provided.
    - Anticipated outcomes of involvement.
  - Evidence of congruence with the Board's mission, vision and values (information available at www.tdsb.on.ca).

- Names of representatives of the external provider.

- Qualifications/supervisory relationships for external staff providing service:
    - For external staff who belong to a regulated professional College, evidence of current qualification appropriate to the services to be provided (e.g., current membership in the relevant regulated College of Ontario and a declaration that services will be delivered in accordance with professional standards of practice) is required.
    - For external staff who are unregulated (paraprofessionals), evidence that they are working under the supervision of a staff member from the external provider who is a regulated member of the relevant College in Ontario. For example, a behaviour therapist must be working under the supervision of either a member of the College of Psychologists of Ontario or a member of the Ontario College of Social Workers and Social Service Workers. Details of the paraprofessional's role, responsibilities, the name of his or her immediate supervisor, the supervision plan (including time) and the supervisor's qualifications must be provided.

- Informed consent procedures:
    - Documentation of the informed consent process for the parent/legal guardian(s) or student who is of age, for the services to be provided is required. A sample form is to be appended to the *Application for Consideration of an External Partnership – EP-SSS* (Appendix A) by the external provider.
    - The external provider agrees to complete TDSB *Consent to the Release of Confidential Information* (Appendix D) forms (e.g., forms to permit the two-way exchange of information between the Board and the external provider) which will be submitted prior to any involvement with a student.

- Police reference check:
    - The TDSB has responsibility under law to provide a safe and secure learning environment. External providers must obtain and produce a valid police reference check that is in compliance with the standard check used by the Board (Full Disclosure) and dated within the past 12 months (with annual review).

- Liability/insurance:
    - External providers must carry their own insurance which includes professional malpractice coverage (minimum $1,000,000) to insure against civil litigation alleging incompetence, professional errors, omissions or charges laid by professional Colleges or parents/ legal guardians.

- The external provider is required to provide assurances that their staff are covered while working on board property.

- Supervision while in the school:
  - The Principal will be responsible for the operational activities of the external provider within the school (as per the Education Act).
  - Clinical supervision of the external provider's staff who are not registered with a College will be provided by the external provider's College registered supervisor under whom the external staff member works.
  - Chiefs of Psychological Services, Social Work Services, Occupational Therapy & Physiotherapy Services and Speech-Language Pathology Services are available to consult with the Principal regarding issues of professional conduct, service delivery and quality assurance.

- Respect for the Board's collective agreements with unionized staff:
  - Services provided by external providers must not be in conflict with provisions of collective agreements with Board staff (e.g., CUPE, OSSTF, PSSP and ETFO agreements).

- Expectations for space and material resources:
  - Given the paucity of space and material resources, any needs for space and material resources by the external provider must be clearly articulated and approved.
  - Space for Board staff to execute their duties will be ensured prior to offering space to external providers.

- Willingness to participate in a conflict resolution process.
  - A joint advisory committee, which shall consist of no less than three representatives from the Board and no less than three representatives of the external provider, will be convened in the event that a disagreement or dispute between the parties must be resolved.

- Agreement to adhere to the Board's standards of confidentiality, equity and human rights.

- Statement of any fees or payment required.

- Proposed method of evaluation along with proposed tools.

4.3 Process for Establishing and Maintaining an EP-SSS:

The Principal shall:

- Assess needs (review SIP).
- Identify potential partner(s).
- Establish a school based EP-SSS Committee:
  - This school-based committee will provide input at the school level. In addition to the principal and relevant school-based Board Support Services professional staff, this committee may consist of additional participants representing some or all of these stakeholder groups: school staff, school council representative(s), and where appropriate, student representative(s).

The Principal and EP-SSS Committee shall:

- Have the potential external provider complete the *Application for Consideration of an Educational Partnership - Supplemental Student Services (EP-SSS)* form (Appendix A) and submit the required information on the *Description of Program or Service* form (Appendix B).
- Finalize the *Description of Program or Service* form in consultation with the external provider. The CSPD or the Senior Manager of Professional Support Services may be contacted for advice.
- Ensure that services to be provided enhance (do not duplicate) current service delivery by Board staff (services provided by external providers must not be in conflict with provisions of collective agreements with Board staff, e.g., CUPE, OSSTF, PSSP and ETFO agreements).
- If the application and description of program or service provided by the external provider are approved by the school based EP-SSS Committee, forward these documents to the Central EP-SSS Review Committee (see 4.4) for review.
- Receive approval from the Central EP-SSS Review Committee to initiate the EP-SSS.
- Create a formal *Partnership Agreement* (Appendix C), which clarifies roles and responsibilities (including responsibilities in the case of a participant's trauma or crisis situation) in collaboration with the external provider.
- Have external provider's staff who will be working within the school sign and provide copies of:
  - *Consent to the Release Confidential Information* (two forms to permit the exchange of information between the Board and the external provider) (Appendix D) - copy to be filed in the OSR.
  - *Conditions of Access Agreement* (Appendix E) - two copies, with one to be forwarded to the CSPD Department, and one to be filed at the school.
  - A signed Consent Form for student participation (provided by the agency) – copy to be filed in the OSR.

The External Provider, with the approval of the Principal, the Superintendent of Education for the school and the Central EP-SSS Review Committee, shall:

- Implement partnership activities/programs.
- Evaluate partnership activities/programs annually.

4.4 Central EP-SSS Review Committee

This Committee is established to review all EP-SSS proposals approved by school based EP-SSS Committees. It provides a second check to ensure issues such as accountability, liability, confidentiality and consent have been examined and requirements have been satisfied. It also is charged with maintaining a record of the schools where EP-SSSs have been undertaken. Participants will include representation from School Services - Special Education and Support Services and Business Services - CSPD and others as required by the Central Review Committee.

4.5 Approval of External Partnerships

The EP-SSS will be approved after it has been evaluated and found to be consistent with the Board's policies, procedures and standards and to be of value to the school by the school based EP-SSS Committee and the Central EP-SSS Review Committee. Due diligence must be integral to the screening of potential partners.

4.6 Partnership Agreements

The Principal, with the school based EP-SSS Committee, will be responsible to set out the terms of the partnership agreement using the template shown in Appendix C. The agreement will clearly define activities, roles and responsibilities, including responsibilities in the case of participant crisis situations.

All sections included in the template form must be included in the *Partnership Agreement (EP-SSS)*. The "Terms of Partnership" should reflect needs identified in the school's SIP and will be unique to each school.

To ensure liabilities are minimized and appropriate central departments are consulted, the Principal must send the draft agreement to CSPD for review, at partners@tdsb.on.ca. The Principal and Superintendent of Education will sign the draft agreement after it has been reviewed centrally. One copy of the signed agreement will be kept on file at the school and a copy will be sent to:

- Each external provider
- The Board's Contracted Services and Partnership Development, 5050 Yonge St. 3rd Floor, Attention: Partnership Development

4.7 Terminating a Partnership Agreement

Either the school as determined by the Principal or the external provider has the right to terminate an existing EP-SSP after appropriate notice has been given. The term(s) of termination will be stated in the *Partnership Agreement.*

4.8 Evaluating External Partnerships (Annual Review)
The Principal will ensure that every external provider partnership is reviewed annually, on a go forward basis. An appropriate evaluative or assessment tool is required to ensure that the partnership is meeting required goals. Sample forms are available from CSPD.

5.0 APPENDICES

Appendix A: *Application for Consideration of an External Partnership - Supplemental Student Services*
Appendix B: *Template for Description of Program or Service - EP-SSS*
Appendix C: Template *for Partnership Agreement - EP-SSS*
Appendix D: *Consent to the Release of Confidential Information*
Appendix E: *Conditions of Access Agreement - EP-SSS*

6.0 REFERENCE DOCUMENTS

Board Policy P.024 BUS: External Partnerships
Board Policy P.002 DIR: Mission and Values
Board Operational Procedure PR.667 BUS: External partnerships

Appendix 6

Peel District School Board

Community Service Partnerships -
Psychology, Social Work, Speech Pathology And Special Education

Special Education Support

Administrative Guidelines

A partnership is a mutually supportive, reciprocal arrangement between a school or school board and a community service provider. Its main purpose is to complement or enhance learning, although it is a given that both partnering organizations can and should benefit from the association. Whatever the partnership, it is crucial that both partners agree to and implement the stated goals and objectives.

Peel District School Board Policy #5 states, "It is the policy of the Peel District School Board to support, facilitate and encourage the development of authentic, mutually beneficial relationships between schools and the larger community, including business and non-business sectors, with due sensitivity and regard for the legitimate needs of all parties involved.

The Board also subscribes to the following ethical guidelines from the Conference Board of Canada:

Partnerships are supported which:

- enhance the quality and relevance of education for learners;
- mutually benefit all partners;
- treat fairly and equitably all those served by the partnership;
- provide opportunities for all partners to meet their shared social responsibilities toward education;
- acknowledge and celebrate each partner's contributions through appropriate forms of recognition;
- are consistent with the ethics and core values of all partners;
- are based on the clearly defined expectations of all partners;
- are based on shared or aligned objectives that support the goals of the partner organizations;
- allocate resources to complement and not replace public funding for education;
- measure and evaluate partnership performance to make informed decisions that ensure continuous improvement;
- are developed and structured in consultation with all partners;
- recognize and respect each partner's expertise;
- identify clearly defined roles and responsibilities for all partners;
- involve individual participants on a voluntary basis.

Speech and Language Pathologists, Psycho-educational Consultants and School Social Workers provide a highly valued service to Peel schools on a daily basis. As the Peel District School Board continues to grow, collaborative initiatives with community service providers are welcomed as a means of augmenting and complementing existing internal resources. The establishment of collaborative partnerships with community service providers can at times provide services which these internal Board support personnel are not providing. Such partnerships are intended to supplement and enhance (not to duplicate) the work of the school team. On-going collaborative ventures with community service providers enable the Board to offer a wider spectrum of services which ultimately will enhance student learning.

Establishment of Partnerships

When partnerships are established, certain procedures must be in place to ensure quality of service, accountability, and a smooth integration with existing support services in the Board.

The following areas must be addressed:

1. Partnership Agreement

Usually external partners are offering a specific service to the school in order to meet an identified need. A written partnership agreement agreed to and signed by both parties involved will help to clarify expectations, timelines, procedures, and accountability. This service agreement will include:

- the need for service identified by the school;
- the specific service offered by the external partner to address that need;
- the qualifications/credentials of the service providers;
- when, where and how the service will be delivered (a specific location in the school and proper identification worn by service providers can reduce complications);
- the type of records which will be generated and who will have access to these records;
- an evaluation process, coordinated by the Principal, will determine the success of the service providers in addressing the identified need.

It is critical that Criminal Record Checks are in place before any service is provided.

2. Integration with PSSP Staff

When a service partnership is being considered, discussion with PSSP staff will assist in clarifying role expectations and generate ideas about how existing PSSP staff can facilitate the implementation of the proposed service delivery model. On-going consultation with the appropriate PSSP staff about students whom the PSSP and the external partner have in common will assist in the referral, intervention and termination process.

3. Consent/Confidentiality

Before any service is provided, it is important that written consent be obtained from parents if the student is under 16 years of age, and from students themselves if they are over 16 years. (Please note that this may vary depending upon the legislation governing the external agency). Consent must be informed and time-limited with parents/students being advised about the type of service offered, who is delivering it, the timelines involved and their ability to access information. If service providers require access to specific student information, informed consents must be completed for this as well.

4. Liability

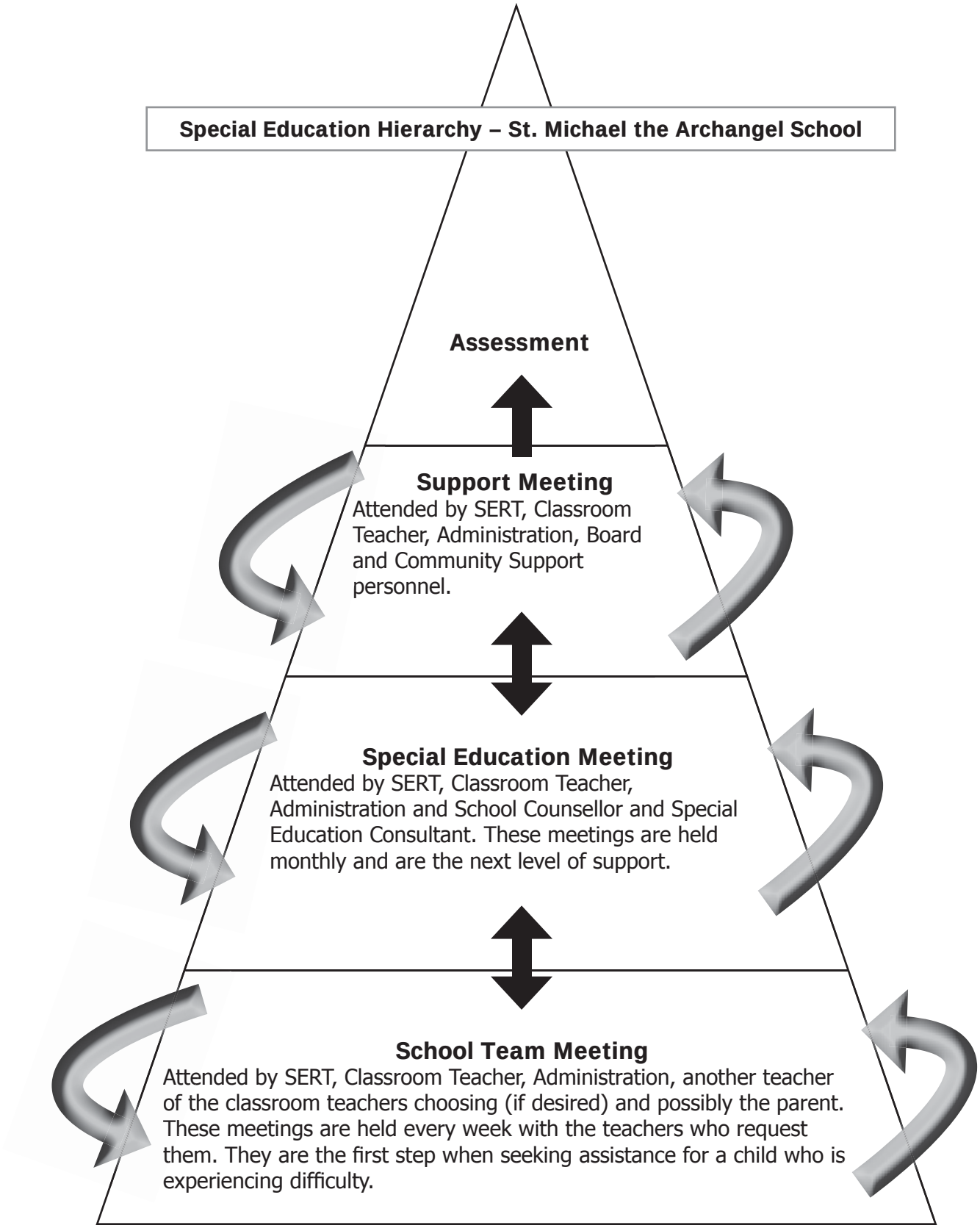
Liability coverage must be $2 million, and the Peel District School Board must be named in the current Certificate of Insurance from the outside agency. A copy of the Insurance Certificate, including professional liability (errors and omissions) and general liability, will be kept on file at the school, and a copy forwarded to Risk Management and Security at the Board office.

These areas are summarized in the attached checklist (**Appendix A**). A sample partnership agreement is also attached (**Appendix B**).
Printable Version Appendix A – Checklist for Partnership Agreements
Appendix B – Sample Partnership Agreement

Appendix 7

Sample Special Education Intervention Model from St. Michael the Archangel School

Simcoe Muskoka Catholic District School Board



Appendix 8

Three Tiered Intervention Sample Toronto District School Board

Tier III

Specialized Instruction
More intense remedial instruction through special education, remedial programs or regular classroom instruction modification (5% of students at any time; approx ≤ 12% of the students at this level identified as exceptional)

Tier II

Supplemental Instruction
Remedial service instructional additions and/or modification to regular classroom instruction for students who are not making progress consistent with standards; target small group service (approx 20% of the students)

Tier I

Classroom Instruction
High quality general education instruction/curriculum and early intervention for at risk students; any support occurs on a school-wide level (all students)

This model is built or can be viewed as a triangle and is meant to address both the academic learning needs and social behavioural needs of students. At the Bottom of the Triangle = Tier 1 because it addresses the needs of all students. As you move up the triangle students in greater need are identified, so the number should decrease.

This model can address and/or incorporate the continuum of service delivery model, as different services can be slotted at different levels. For example, in a situation addressing the social emotional needs of student(s), this is how professional support staff would progressively become involved:

Tier 1: Guidance counsellor
Tier 2: CYW or CYC
Tier 3: Social Worker or Psychologist

Of note, each of these job classes can potentially function at any other level on the triangle. For example, any of the aforementioned PSSP job classes could provide in-service training to teachers about classroom management.

The CODE DIBELS project in place at the TDSB was designed to support academic learning. It involved consultants from psychology training classroom teachers how to screen for students in K-Grade 6 who might be at-risk for developing reading problems; DIBELS measured student performance on the 5 big ideas of literacy learning (all evidence based). The teachers, at Tier 1, in essence are trained to act somewhat like a 'triage nurse' in an emergency ward; students with "symptoms" would be deemed to be at-risk and would then subsequently be provided w/ supplemental programming at Tier II. If the student continues to fail to respond to intervention (which is part of the RTI--Response to Intervention Model), then there would be the possible need to move to Tier III (at this stage a full psychological assessment might be considered to identify the need to access service at this Tier III level).