Children, their parents, and social workers are forever bound by mutual interests and community partnerships. Nowhere are those linkages forged more early than at school—and nowhere but school can those linkages also be so tenuous. Creating the necessary infrastructure to fully nourish such sensitive students physically, emotionally, and academically is germane to the purpose of an education-welfare system partnership. Three nonacademic and significant person-in-environment (PIE) collaborative considerations necessary to consider for achieving more productive interagency working relationships are poverty, law, and child/adolescent development.

**Poverty**

First, the inadequate distribution of goods, services, and opportunities seems to be a nearly universal risk factor. Focusing on poverty, two experts note when family financial security is at risk, numerous unintended and draconian consequences appear:

“When you are born without adequate prenatal care, when you do not have sufficient health care as a toddler, when your parents do not know how to provide cognitive stimulation and cannot afford high-quality preschool programs, chances are you will come to school with a working vocabulary that is just a fraction of the vocabularies of middle-class children. You have already been left behind (Houston, 2007)...[so that] if...any...impoverished parent added up all of [his or] her individual problems, the whole would be equal to more than the sum of its parts” (Shipler, 2004).

As a result, school and child welfare decisions have far-flung consequences outside their own seemingly narrow boundaries because “[i]f problems are interlocking, then so must solutions be” (Shipler, 2004).

Recently, Mishel and Joydeep (2006) have drawn similar conclusions about students, poverty, and educational systems. They note that “[t]o the extent that we have a dropout crisis, it is primarily a crisis of youths at the bottom of the socioeconomic scale.” To meet and manage these issues, they recommend “comprehensive efforts to improve their schools, including offering alternative programs and developing second-chance systems.” However, the nonacademic nature of these students’ environments also...
Providing sandtray therapy to students in schools represents a vital option in the school social worker’s repertoire of intervention skills. It is one of a variety of expressive therapies that can be provided to students with and without disabilities. School social workers have a responsibility to seek out creative interventions that may reach underserved populations. School mental health literature recognizes the need for increased mental health services in schools and the particular role that the school social workers can assume in promoting strength-based, resiliency models for our current-day students who face immeasurable life circumstances (Bailey, 2000; Early & Vonk, 2001; Greene & Lee, 2001). The New Freedom Commission on Mental Health Report (2003) states 5%-9% of our country’s children and adolescents have a serious emotional disorder. Children with disabilities are deemed to be at higher risk of behavioral and emotional problems (Hollar, 2005; Witt, Riley, & Coiro (2003). The Commission’s report identifies schools as a key setting for the recognition and treatment of children with emotional disorders.

Sandtray therapy is a therapeutic approach that crosses language and cultural barriers by moving away from a clinician-driven, verbal-response focus to an approach focusing on visual and tactile responses. It is a projective technique that allows the student to project experiences and feelings onto the objects and the sand. This technique is not dependent on any particular cognitive or verbal skills. Language can present a barrier to many children in obtaining mental health services who are non-English learners, have a disability that affects language, or have difficulty expressing emotions and feelings through words. As Sue (2001) points out, the multicultural literature has criticized traditional psychological interventions as having a Eurocentric-based perspective, relying on middle-class values and individualism juxtaposed to the African Egyptian civilizations who had a perspective arising from the study of soul or spirit. The focus on remedial and verbal approaches to intervention may not adequately service minority or oppressed persons and, in fact, may create barriers to equal access to mental health services (Sue, 2001). The traditional expectation of verbal expression of trauma or emotionally laden material may be difficult for these groups of children.

(Understanding a Child’s World, continued on page 5)
needs to be a concern for school officials since “we also have to think about…the disadvantages they face before they get to school.”

The Law and Therapeutic Jurisprudence

The historical roots of therapeutic jurisprudence reach into the heart of social work practice. Dicta in Brown v. Board of Education (1954) explained “[i]t is doubtful that any child may reasonably be expected to achieve in life if he is denied the opportunity of an education. Such an opportunity...is a right which must be available to all on equal terms.” Wrightsman, Greene, Nietzel, and Fortune (2002) recognize that the law itself can be seen to function as a kind of therapeutic or anti-therapeutic agent.

An example of a school-child welfare linkage can be found in the universally mandated obligation to report suspected child abuse. This duty can be fulfilled in a number of ways depending on several situational factors or circumstances, including setting, clinician’s ability, and type of abuse. But consider the following differences and clinical outcomes in reporting procedure perspectives:

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

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

Both scenarios meet the legal duty required by the reporting requirements, but Example B also addresses the family’s clinical needs.

Developmental Accountability

Lastly, the developmental needs and issues of students must be properly considered. Children...
are not merely short adults. Berger (2007) states “[d]evelopment happens, ready or not. Each year brings gains and losses, continuity and discontinuity. Developmental changes may be expected or discovered by scientists...[o]r they may be quite personal.” Children think, feel, and act differently than their older counterparts because they have yet to become fully mature.

For example, upon removal, a Team Decision Making (TDM) meeting is held to determine and facilitate intervention options. However, it is imperative that child welfare workers communicate with school officials to understand students’ educational needs and help them assimilate into their new academic environments. This academic component offers a magnifying glass into the child’s developmental stage and can provide a therapeutic lens for targeted interventions. Despite this fact, education and child welfare decision makers continue to apply adult-appropriate standards to children and seem to remain undeterred by the negative and insidious cumulative effects of abuse, truancy, and retention on those in their care.

Proposal: Increase Sustainable Collaborative Efforts

Social work and collaboration go together like ham and eggs. Bronstein (2002) cites Sid Garner, the former director of the Center for the Collaboration for the Child at CSU Fullerton, who defines collaborative efforts in the following fashion:

“Genuine collaboration entails the creation of a community process to plan a service system for children where schools and public and private agencies are linked horizontally in partnerships, rather than stacked vertically or allowed to float separately...”

Adelman and Taylor (2002) contend that accountability can only be achieved through school-community linkages. Their UCLA research indicates that “[s]ystemic collaboration is essential to establish inter-program connections on a daily basis and over time to ensure seamless interventions within each system and among systems for promoting healthy development and the prevention of problems, systems of early intervention, and systems of care.”

For example, one author formed the Foster Youth Advisory Council that involved leaders from Los Angeles Unified School District (LAUSD) and from Los Angeles County Department of Children and Family Services (DCFS). The purpose of this working group was to explore ways to improve structural and organizational communication, services, and interventions between the two systems. There were spirited discussions about the identified needs of children and families served and the lack of resources and coordination to meet these needs. The complexity and dimensions associated with both systems sparked an innovative approach to move toward a unified partnership to more effectively address the needs of children and families served by both organizations.

Summary

Stronger commitments to collaboration and alliances with stakeholders are needed to improve service delivery and meet the needs of disenfranchised populations. Minority children and families who are educationally, linguistically, and economically impoverished bear additional burdens that stagnate social growth, leaving them unprepared to prevail over challenging life
circumstances. One systemic approach to remedy this situation is to nurture a stronger structural and organizational approach between educational institutions and child protective services.

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Sandtray therapy is rooted in psychodynamic theory and particularly in the theories of Carl Jung and the theoretical stance that human beings are naturally driven toward wholeness and psychic well-being (Boik & Goodwin, 2000; Green, 2009). These inner solutions are represented in the archetypes that serve as the source of energy guiding a person toward wholeness (McNally, 2001).

Sandtray therapy is particularly useful in addressing trauma and painful experiences that are beyond our ability to express verbally (Green, 2009; Green, 2008; McNulty, 2007). Through the use of miniature objects and symbolic representation of the archetypes, metaphors emerge and provide an understanding both internally and in the external space of the sandtray. One is not limited by words, nor can words serve as a defense against examining painful materials. For children and others who may not be capable of expressing their innermost thoughts and feelings through spoken language, sandtray therapy is an ideal therapeutic model for promoting mental health.
In sandtray therapy, the school social worker provides a sandtray that is 28 ½” long by 19 ½” wide and 3” inches deep and is filled with sand. The bottom and the sides of the tray are painted blue to represent water and sky. Hundreds of miniature objects representing a myriad of life’s experiences are made available. The minatures are organized on shelves and divided by categories such as animals, people, buildings, nature, vehicles, spiritual symbols, etc.

During a typical sandtray session, a student will select miniature objects and place them in the sandtray. If the child does not immediately begin to select objects for his/her “world,” the school social worker can give a prompt, such as “make your world in the sand,” or, for a younger child, “create a story in the sand using the objects on the shelves.” The child/adolescent should be told how long he/she will have to create their “world,” being sure to leave enough time to process what is placed in the sand. The school social worker’s primary task during this time is to “hold” the space, making the student feel emotionally safe to explore their conscious and innermost thoughts and feelings. Some children will create constant movement in the sand with their objects and have them come to rest only when the session is over (McNulty, 2008).

Beginning sandtray worlds are sometimes chaotic, and as sessions continue, battles of good and evil are often present. As sandtray sessions go on, they frequently will become more orderly and appear better integrated than in earlier sessions, reflecting an improvement in the student’s own psychological integration.

Once the student has completed his/her three dimensional “world,” the school social worker invites the student to talk about his/her tray and what it means to him/her. Through observations, comments, and questions, the school social worker will ask the child/adolescent to expand on the objects, his/her stories, and the relationship of objects to each other. For example, if the child/adolescent uses a snake to represent his/her mother and a lamb to represent his father, the school social worker would ask questions about the characteristics of the snake and the lamb, allowing the child to place some psychological distance from the family dynamics. Before the session ends, the student can be asked if there is anything he/she wants to change about his/her world. This provides the student with an opportunity to envision the possibility of a different ending or provide him/her with a sense of mastery over his/her world. Once the session is over, the school social worker takes a picture of the sandtray, which can be used to compare with future sandtrays, as well as serve as a record of the session. The school social worker waits for the child/adolescent to leave before putting any of the objects back on the shelf. To do otherwise would mean destroying one’s “world,” and perhaps cause psychological distress. While the social worker illicits the story in the tray from the student, some students may say very little. Yet healing is possible even in the absence of words, as the following case example demonstrates.

**Case Example**

Josh (name has been changed for confidentiality), age 13, was generally a pleasant and easily humored deaf student. Josh tested in the mentally retarded range and had numerous traumatic experiences, including several near brushes with death. Because of his language and cognitive limitations, he was unable to process his experiences or his feelings through the use of American Sign Language. Occasionally, something, apparently minor to others, would happen to trigger an explosion of rage in Josh. When Josh entered this rage, he became extremely aggressive and violent toward others, attacking and destroying things in his path.

For several months, Josh would come into the sandtray room, gather up all the lizards, snakes, and other amphibians he could find and bury them in the sand. Josh made sure every part of every creature was covered, no matter how much time or effort it took. At the end of each session, no objects were visible on top of the sand. The
shark, the whale, and the dolphin were almost always directing the “world” in the sand. As week after week continued in a similar way, Josh began to add animals to his underground world that were not amphibians. Incredibly small increments of change also began to appear. One day Josh left the tray allowing a few small portions of creatures emerging above the sand. This had been intolerable to him in prior sessions.

A major shift in Josh’s sandtray occurred after the tragic death of one of his classmates. Josh came in to the sandtray and as always buried creatures in the sand. When he had completed this part of the process, he found a gold box and in it, he placed a figure of a young boy. Josh used the boy’s sign name to indicate who he was. He put the gold box with the boy inside, as if it were a coffin, on top of the sand. He found flowers (representative of growth and beauty) and placed the flowers near the gold box, creating a “memorial” to his young classmate. He then took every artificial flower in the collection to ring the sandtray with flowers, and when he had exhausted all of the flowers in the collection, he asked for more. This was the first time Josh used anything representative of people and the first time a scene was left on top of the sand.

Over the next three sessions, Josh re-created this world with even more flowers and began adding other objects to represent the funeral and burial of his friend. During the second re-creation, Josh put an egg near the gold box. The egg, a symbol of birth and life, was now juxtaposed with the reality of death. In his third and final re-creation of this world, eggs of all shapes and colors surrounded the gold box and the boy. Josh had successfully integrated the death of his classmate, and perhaps also his own experience of being close to death yet allowed to survive.

Occasionally, Josh returned to the burying of miniatures, but no longer were the items buried exclusive to all of the crawling creatures. Now Josh put in other animals, people, vehicles, skeletons, containers, and numerous other items. He also brought items from home and used them in his sandtrays. Several months later, when his family moved to a new house, Josh made a community of homes with people and everyday life on top of the sand with nothing buried below. This world was organized and solidly based in everyday reality. It bore no resemblance to his earlier chaotic worlds of buried amphibians.

During the year and a half that Josh was in sandtray counseling, his explosive episodes diminished and eventually disappeared. Although other interventions were also in place, Josh’s ability to process and integrate his life experiences undoubtedly contributed to reducing the feelings of rage that led to disruptive behaviors.

A school social worker who is interested in pursuing this approach as an intervention will need to undergo training before using sandtray therapy with students. Sandplay Therapists of America (www.sandplay.org), as well as the Association for Play Therapy (www.a4pt.org) can provide information on the availability of training.

While research on the effectiveness of this intervention continues to be limited, several authors have found a positive correlation between the use of sandtray therapy and improvement in overall social, emotional, and behavioral functioning (Dale & Wagner, 2000; Flahive, 2005).

Sandtray therapy as a model for providing mental health services to deaf children in schools has tremendous potential. It creates a medium that does not discriminate or limit access in any way. Through this non-verbal intervention, children, with or without disabilities, can delve into serious trauma unreachable through verbal means. Current and future professionals serving this population have challenges and rewards on the road ahead.
SectionConnection Newsletter Going Green

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References


Len Gibbs (2003) was one of first authors to discuss evidence-based practice in social work. He describes evidence-based practice as:

Placing the client's benefits first, evidence-based practitioners adopt a process of lifelong learning that involves continually posing specific questions of direct practical importance to clients, searching objectively and efficiently for the current best evidence relative to each question, and taking appropriate action guided by evidence (p. 6).

Note that Gibbs defined evidence-based practice as a process, not an intervention. Furthermore, it is a lifelong process that is meant to produce practical results. Unfortunately, over the past five years, social workers have become focused on evidence-based practices rather than the process. They seem to think that if they have the correct interventions, then clients will magically improve their functioning. Nothing could be further from the truth.

Raines (2008) breaks the process of evidence-based practice into five simple steps: (1) asking answerable questions, (2) investigating the evidence, (3) appraising the evidence, (4) adapting and applying the evidence, and (5) evaluating the results. Let’s explain each step in terms of what it means and does not mean for school social workers.

Evidence-Based Practice: Steps for School Social Workers

Step 1: “Asking answerable questions” means formulating a question that can be informed by the scientific literature. Unfortunately, there are many ethical and legal questions that cannot be resolved by empirical means. Answerable questions are problem-focused. They start with the referral issue and ask, “What are the empirically supported interventions for this problem?” They do not jump the gun and ask about the social worker’s favorite intervention, such as play therapy. The key to good questions is openness to all the interventions that might help the client.

Step 2: “Investigating the evidence” requires access to and skills in searching scientific databases, such as ERIC or PsycINFO. It is likely that practitioners were introduced to this skill in their pre-service education, but many will want to team with an academic researcher to do it effectively and efficiently. Effective searches uncover all of the relevant literature on a topic. Efficient searches utilize Boolean operators (AND, OR, NOT) to sift through the relevant literature with a minimum of time and effort. Maintaining both qualities is a delicate balance that takes a long time to master.

Step 3: “Appraising the evidence” means considering the level of scientific rigor. The most rigorous studies use control or comparison groups to delimit the number of threats to internal validity. These studies are usually called randomized controlled trials or quasi-experimental designs. There are a number of excellent online appraisal tools to assist practitioners (see www.consort-statement.org).

Step 4: “Adapting and applying the evidence” means to custom-tailor the intervention so that it fits client characteristics, such as age, gender, or culture. Such adaptations might include adjusting our language to fit the client’s vocabulary or changing our metaphors to aid client understanding. It does not mean that practitioners can radically alter the intervention so that its core components are no longer present. For example, the core components in social skills instruction include direct instruction, modeling,
rehearsal, feedback, discussion, and role-playing. Any adaptation that eliminates one of these reduces the intervention’s effectiveness (Kelly, Raines, Stone, & Frey, 2010).

**Step 5:** “Evaluating the results” implies that social workers begin by establishing a measured baseline of client functioning so that they can remeasure the results of their intervention. This requirement has existed in special education since the 1997 reauthorization of IDEA, yet many school social workers are still writing nebulous Present Level of Performance statements and immeasurable goals that have little connection to the presenting problem (Raines, 2002). The reason why evaluation is so important has to do with the nature of scientific evidence. All what the evidence can show us is what works for most students. It can never tell us what works for all students. This is why the originators of evidence-based medicine cautioned that the evidence had to be applied judiciously. For some students, an empirically supported intervention may not work at all or even prove harmful, but it is impossible to know this if we do not evaluate the results.

There are internet clearinghouses that aim to combine steps 2 and 3 above. They enable practitioners to search for interventions or prevention programs already prescreened for their scientific rigor. Some of the best clearinghouses are the Campbell Collaboration (www.campbellcollaboration.org), SAMHSA (www.nrepp.samhsa.gov), and What Works (whatworks.ed.gov). Other clearinghouses, such as CASEL (www.casel.org), have a lower standard of evidence that does not meet the U.S. Department of Education’s strict standards. In Response-to-Intervention terms, most of these clearinghouses provide prevention or intervention programs at Tier I or Tier II. They seldom provide intensive interventions for Tier III, for these practitioners will need to have access to one of the scholarly databases mentioned in step 2.

It is vitally important that social workers put empirically supported interventions into a larger perspective of what helps clients get better. Research into the helping process suggests that 40% of client improvement is due to harnessing the strengths they possess (Raines, 2004). Another 30% is due to developing a strong therapeutic relationship. About 15% is instilling hope that the situation can improve through mutual teamwork. This leaves only 15% of student improvement that can be attributed to the social worker’s choice to implement the correct intervention. This may not sound like much, but as every student knows, 15% is the difference between a C+ and an A-. Which school social worker would you rather be?

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**References**


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