Guide to Conferencing

Conferencing is an instrumental process available to most any school or other service. Locally, it is being utilized along the Wasatch Front and other parts of the state in cooperation with the ABLE Team of the State Department of Health. Conferencing can be a means of acquiring additional information in a multi disciplinary setting. For example, using the IEP model conferencing could include other providers beyond school personnel at these meetings, as requested by the parents. If the child is an IEP recipient, the parent has authority to include others in the group. This setting offers the following options:

1. Challenges, needs and concerns are delineated.
2. Promotes respect and affirming each participant's role and nonblaming.
3. Facilitates a coping process among those concerned.
4. Identifies the balance between the risks or positive capacities or strengths within the child in his environment at home, in school, and culture.
5. Offers much needed assistance in containing the challenges.
6. Assesses intervening resources.
7. Limits the negative consequences.
8. Delegates often overwhelming intervening responsibilities that would be difficult for any one person to accomplish.

School Conferencing recognizes the following principles and values:

1. "There is strength in numbers"
2. Use what is available
3. Brings together the several "views of the elephant" and is indispensable in securing the most accurate perception
4. "Many hands make light work", especially in view of the often overwhelming complexity
5. Shares conversation from partnership as a catalyst for change
6. Listen to and acknowledge family stories
7. Explore and expand choices and decision-making

Conferencing group looks for new outcomes in the child and family:

1. Develops and carries out an intervention by building on the identified strengths and innate resources, including natural, informal and normative supports.
2. Parent/school partnership and bond needs to be nurtured so that the child is uniquely identified
   by the teacher and feels a sense of belonging, power and family-school identity.
3. Ways and means to evoke self-motivations towards actions for change, as well as measuring the progress.
4. Offers a first and most informal level of hope and strength for families and school
5. Acknowledging stronger family-school voices.

Group Composition:

The criteria used in using conference team members for a high-risk student consists of informally gathering a group of key people who are individually familiar with, important to, available to, and often already involved in the life of an identified child and family. They are gathered for the purpose of achieving collaborative understanding of/and addressing critical needs. This composition is facilitative of a ready and effective front-line service.

The members are likely to come from the school but to include the nuclear and extended family at a minimum. The composition includes both parents and hopefully with them inviting important friends or relatives for support. A "problem-defined team" is identified as whoever is connected in anyway with the problem and is invited for solutions by the parents also (other agencies who might be involved in the community as health, social service, juvenile court, mental health, or other). Finally, the family may also need to request that related service personnel from the school, such as occupational therapy, physical therapy, psychology, and nursing come to the meeting.

Group Leadership:
Group leadership is formed within the meeting where work is distributed among the members. Such roles as facilitator, scribe, and timekeeper are established at the beginning of the meeting. Some of the school personnel are likely to serve as consultants.

Group Flexibility:
The group may be generated from already existing multidisciplinary groups in school or in the community such as the Child Study Team, Child Support or Guidance Teams, Service Team, or Wrap-Around Services. Since each high-risk child is unique, the procedures for preventing, promoting or dealing with his/or crisis and individual emergencies as well as unique response time frames will be determined.

Meeting Agenda:
The meetings will usually follow the general outline of School/Community Conference Form, which includes the following:

1. The list of those attending and their roles.
2. The goals of the meeting.
3. Strength surrounding the child/school cultures.
4. Concerns and challenges.
5. An intervention plan.
6. Who will assist in carrying out the various components of the plan and when.
7. Identification of an appropriate contact person.
8. The date of the follow-up meeting.

Finally, the report that is written during the meeting is then copied and handed to the team members prior to the meetings dispersal as a backup witness of collaborative commitment and as a visual reminder of the team's transactions. A formal assessment of the meetings values and effectiveness can be completed by all present using click on ABLE's School Conference Form and School Conference Feedback Form (short and long form consumer satisfaction).

Facilitative Needs:
Invited persons may need flexibility in the way they participate. An example is when important people cannot be physically present at the meeting, but have an important role to share and can include their views by:

- Sending a representative.
- Phone conferencing with the absentee person.
- Sending a note or letter to the person.
- Consulting with the person prior to the meeting.
- E-mailing to and from the person.
- Faxing important data to the person.

Opportunities to expand service interventions to a child/family need to include, but are not limited solely to such things as bus passes, tutors, trainers, swimming lessons, recreation, daycare camps and after-school supervision. Such opportunities open the way to multiple benefits for the child, to include self-esteem and identity building, respite, socialization, and other desperately needed intervention means. Other benefits may be interest and talent enhancement—with potential use in portfolio development. The team needs to continue to identify ways to cooperate possibly with other agencies, as a participating vehicle for acquiring these kinds of activities. (link to Part IV)

Finally, Group Conferencing is not a program, but a basic process, and potentially a preliminary to core teaming involvement. Policies and procedures for core teaming are further accessed under **team collaboration and coordination** (core team) click on this**.**

School Conferencing Example

An interdisciplinary team was called. It was made up of the school child study team, which is a group already consisting of different disciplines including the principal, a special education teacher, a regular education teacher, a school psychologist, and the parents. (The parents were felt to be not quite ready to be "customers" or were ambivalent in the "contemplative stage" of change.) We joined this group as a health provider, but could have used other forms of communication with the school than the one we chose—going to the school.

Testing was reviewed along with observations. Peoples' interpretations but primarily descriptions of Adam's behavior were also offered. We were looking for evidence of anxiety (agreed by others), and possible obsessions and autistic-like behaviors (disagreed by most). Although achievement testing was normal, staff felt he seemed to have principle learning problems, and they offered Resource helps to help manage. Their impressions seemed to be verified too by separate language testing with below average and written language deficiencies. Primary concerns related to Adam's escape behaviors were that he might be having anxious attachment or at least anxious protections (reliable) with frustration (also a reframe) as a source. Sometimes he would lash out, or hit, which may have been a basis for his oppositional behaviors. (Overall, we were seeking a reliable measure of his behavior as a reflection of a background from likely losses and depression in family rather than one of being a so-called

"bad kid".)

Intervention suggestions included daily tracking and monitoring behavior shaping, using behavioral momentum. We used two-way Home Notes to increase communication both to and from parents. We also used a continuous reinforcement schedule for positive behaviors—with lots of praise statements and mystery motivators for each appropriate half day, and with rewards of allowing him to show off his car collection and doing puzzles, which he loved. Extra choices were offered (both acceptable). A crisis plan was also devised to include redirection and a quiet place where he could be given permission to leave to go (initially using his avoidance to reinforce.) The psychologist took a major role to keep up with him and see him frequently, resulting in eventual bonding and mutual respect. We would keep track of the obsessions and panic times. The Autistic Spectrum rating scale and Cars were to be screened.

Follow-up was agreed upon to include a teleconference in 30 days. Since the meeting, we have prescribed through his primary care doctor, Strattera for impulse and disorganized behaviors. This was eventually stopped as school reported at follow-up meetings that it was of little help. By policy, the schools have a way to document plans for health-related inclusion for special needs children where the health provider can have an input such considering that the child's performance would be enhanced from this information. The "Health Care Plan" might include such things as medication, special procedures, and including unusual equipment or technology that may be required during the school day.